Board of Directors Meeting (Public)
will be held on Wednesday 25th May 2022 from 9.00am – 1.00pm
To Be Held at the Pavilions, Harrogate

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal	9.00
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	Verbal	
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chair	Note	**Attached**	
1.4	**Minutes of the Previous Board of Directors meeting held on 30th March 2022**	Chair	Approve	**Attached**	
1.5	**Matters Arising and Action Log** *No open actions*	Chair	Discuss/ Note/ Approve	Verbal	
1.6	**Overview by the Chair**	Chair	Discuss/ Note	**Attached**	9.20
SECTION 2: CEO Updates					
2.1	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.30
2.2	**Corporate Risk Register**	Chief Executive	Discuss/ Note	**Attached**	
SECTION 3: Strategy & Partnerships					
3.1	**Board Assurance Framework**	Chair	Note	**Attached**	9.45
3.2	**Director of Strategy Report**	Director of Strategy	Note	**Attached**	
SECTION 4: Patients and Service Uses (Quality and Safety)					
4.1	**Quality Committee Chair's Reports – 25th April 2022 & 23rd May 2022***	Quality Committee Chair	Note	Verbal	10.20
4.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Discuss/ Note	**Attached**	
Comfort Break (10.35 – 10.45)					
4.3a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	10.45
4.3b	**Ockenden Report**	Director of Nursing, Midwifery and AHPs	For Information	**Attached**	
4.3c	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	

4.3d	**Continuity of Care Plan**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	
4.3e	**FTSU update (quarterly)**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	
4.3f	**Safer Nursing Care Tool**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	
4.3g	**Guardian of Safe Working (quarterly)**	Guardian of Safe Working	Discuss/ Note	**Attached**	
4.4a	**Medical Director Report**	Medical Director	Note	**Attached**	11.30
4.4b	**Learning from Deaths (quarterly - Jan to Mar 2022)**	Medical Director	Note	**Attached**	
SECTION 5: Use of Resources and Operational Performance					
5.1	**Resource Committee Chair's Reports – 25th April 2022 & 23rd May 2022***	Resource Committee Chair	Discuss/ Note	Verbal	12.00
5.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	**Attached**	
5.3	**Director of Finance Report**	Finance Director	Discuss	**Attached**	
5.4	**Chief Operating Officer's Report**	Chief Operating Officer	Discuss	**Attached**	
5.5	**Statement – eliminating mixed sex accommodation**	Chief Operating Officer	Discuss	Verbal	
5.6	**Workforce Report**	Director of Workforce and Organisational Development	Discuss	**Attached**	
SECTION 6: People and Culture					
6.1	**People and Culture Committee Chair's Report – 16th May 2022**	Committee Chair	Note	**Attached**	12.20
6.2	**Integrated Board Report –** Indicators from Workforce Domains	Executive Directors	Note	**Attached**	
6.3	**Organisational Development Report**	Director of Workforce and OD	Approve	**Attached**	
SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Reports – 4th May 2022 & 25th April 2022 18th May 2022 (Year End)***	Committee Chair	Note	**Attached (*Verbal – timing of meeting)**	

7.2	**Senior Management Team Report 20th April 2022 & 18th May 2022**	Chief Executive	Note	Verbal	
8.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal	12.50
9.0	**Board Evaluation**	Chair	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 27th July 2022				
Confidential Motion – the Chair to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*					

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interests
As at 25th May 2022

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing partner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	Date	1. Company director for the flat management company of current residence 2. Chief Executive of the Ewing Foundation
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	No interests declared	
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd (ended September 2021) 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
Matt Graham	Director of Strategy	September 2021	Date	Governor (Chair of Finance & Premises Committee) – Malton School
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)	No interests declared		
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)		Date	1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Jordan McKie	Acting Director of Finance (From March 2022)	No interests declared		
Russell Nightingale	Chief Operating Officer	April 2021	Date	Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing Deputy Chief Executive from March 2022	April 2021	Date	No interests declared.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society

Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board 4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. 7. Trustee for the Harrogate District Climate Change Coalition CIO (effective November 2021)
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	April 2017	Date	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018 January 2022 May 2018	Date January 2022	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Member of the Association of Directors of Children's Services 5. Member of Society of Local Authority Chief Executives 6. Local Government Information Unit Associate 7. Local Government Information Unit (Scotland) Associate 8. Fellow of the Royal Society of Arts 9. Member of the Corporation of the Heart of Yorkshire Education Group 10. Chair of the Corporation of Selby College
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

Deputy Directors and Others Attendees (providing advice and support to the Board)

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Kate Southgate	Company Secretary (from June 2021)	No interests declared

Directors and Attendees
Previously recorded Interests – For the 12 months period pre May 2022

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	31 March 2022	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Member of the Yorkshire & Humber NHS Chairs' Network 4. Volunteer with Supporting Older People (charity). 5. Member of Humber Coast and Vale ICS Partnership
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	31 March 2022	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jonathan Coulter	Finance Director Chief Executive from March 2022	November 2017	31 March 2022	(Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Mrs Laura Angus	NExT Non-executive Director	January 2021	March 2022	1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG 2. Chair of York and Scarborough Medicines Commissioning Committee 3. Interim Chief Pharmacist at Humber, Coast and Vale ICS 4. MTech Associate; Council Member PrescQIPP 5. Chair of Governors at Kirby Hill Church of England Primary School
Steve Russell	Chief Executive	March 2020	March 2022	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber (ended July 2021) 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board 3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS 4. Co-Chair of WY&H Planned Care Alliance 5. Chair of Non-Surgical Oncology Steering Group 6. NHS Employers Policy Board Member (September 2020 and ongoing) 7. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 8. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)
Lynn Hughes	Interim Company Secretary (until June 2021)	Familial relationship with KLS Martin Ltd, a company providing services to the NHS		
Jordan McKie	Deputy Director of Finance (Until March 2022)	No interests declared		

Board of Directors Meeting
Wednesday,30th March 2022 from 9.00am – 1.30pm
At the Pavilions, Harrogate

Present
Angela Schofield, Chairman
Sarah Armstrong, Non-executive Director
Jeremy Cross, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Wallace Sampson OBE, Non-executive Director (*In attendance from minute 12.0)*
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Jacqueline Andrews, Executive Medical Director
Jonathan Coulter, Acting Chief Executive
Emma Nunez, Director of Nursing, Midwifery and Allied Health Professionals and Acting Deputy Chief Executive
Matthew Graham, Director of Strategy
Jordan McKie, Acting Director of Finance
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Laura Angus, NExT Non-Executive Director
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Natalie Lyth, Clinical Director for Community and Children's Directorate
Matt Shepherd, Deputy Chief Operating Officer
Kate Southgate, Associate Director of Quality and Corporate Affairs

Observing
5 members of the public of which 3 were Governors. An ED Clinical Lead and a colleague from NHS Professionals

Item No.	Item
BD/03/28/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting. Thanks were expressed to Jonathan Coulter for stepping into the Chief Executive role, Emma Nunez for becoming Deputy Chief Executive and Jordan Mckie for Director of Finance.
1.2	It was noted that Emma Edgar had been appointed as Clinical Director for Long Term and Urgent Care but was unable to attend today.
1.3	Thanks were also expressed to Laura Angus, it was her last meeting with the Trust and it was noted what a support and asset she had been to HDFT. All at the Board wished her well for the future.
1.4	Apologies were received from Russell Nightingale, Chief Operating Officer and Emma Edgar, Clinical Director for Long Term and Urgent Care
BD/03/28/2	**Patient Story**
2.1	Two Community Nurses from South Harrogate attended Board to provide a patient story. The case focused on a 34-year-old lady who had been referred for diabetes management who had a needle phobia. This was preventing her from undertaking her own independent self-care. The team worked with her to overcome this issue and it was now noted that through self-care she was now in full control of her diabetes care.

2.2	Thanks were expressed to the team for sharing their story and for all of their hard work.
BD/03/28/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	It was noted that Jonathan Coulter was no longer Interim Chief Executive of HIF. Sarah Armstrong is a Director of Harrogate Integrated Facilities (HIF). Wallace Sampson is Chief Executive of Harrogate Borough Council, and Angela Wilkinson and Russell Nightingale are Directors of the Pathology Joint Venture.
3.3	An update register would be circulated following the meeting.
3.4	**Resolved:** the declarations were noted.
BD/03/28/4	**Minutes of the Previous Board of Directors meeting held on 26th January 2022**
4.1	**Resolved:** the minutes of the last meeting held on 26th January 2022 were agreed as an accurate record.
BD/03/28/5	**Matters Arising and Action Log**
5.1	No matters arising not included on the agenda or action tracker were noted. Updates were given on all closed actions.
5.2	Thanks were expressed to all for ensuring no remaining open actions on the action log.
5.3	**Resolved:** sufficient assurance was received to close actions as detailed in the action log.
BD/03/28/6	**Overview by the Chairman**
6.1	Thanks were expressed to the Board by the Chairman. The team were noted as an outstanding set of colleagues, who had been a delight to work with, it was a team that put patients, staff and service users at the centre of everything they do.
6.2	**Resolved:** The Chairman's report was noted.
BD/03/28/7	**Remuneration Committee Report**
7.1	The Chairman presented the report of the Remuneration Committee on 3rd March 2022.
7.2	**Resolved:** the changes as detailed in the report were confirmed and approved.
BD/03/28/8	**Chief Executive Report**
8.1	The Chief Executive presented his report as read.
8.2	The public satisfaction national survey was referenced and it was noted that the organisation would continue to focus on putting patients first.
8.3	Staffing levels were noted, including the impact of Covid related absence.
8.4	Ambulance handover pressure was highlighted as an issue nationally. The organisation was working to ensure we were meeting requirements and how we are providing assurance on a regional basis.

8.5	ED Performance was noted as an area that requires improvement. An alternative model of care was in development with the intention that this would impact on the pressures within the Department. This would be overseen by Board Level Committees as well as the Board itself. The organisation continues to work well as a system. Over 100 diverts had been accepted from other organisations in March 2022.
8.6	The 104 week wait target to be 0 by the end of March was nearly met. There may be small numbers waiting over 104 weeks, however, this had been a significant achievement by the Trust.
8.7	As part of planning for 2022-23, work was ongoing to develop additional theatre capacity.
8.8	Pressures continue in the 0-19 service. The number of safeguarding strategies continue to remain at higher than previous levels. Appropriate actions are being taken and this includes a more flexible approach. It was noted that the 12-15 school based Covid Immunisation Programme would be completed by 31st March 2022.
8.9	Systems planning for 2022-23 continues across the Humber Coast and Vale system, to date financial plans indicate significant financial challenges.
8.10	Quality governance was noted, with changes to the structure and processes in place.
8.11	The publication of Ockenden 2 was noted as being published today, with discussions held on the immediate actions and future requirements.
8.12	Staff survey results had been received but were current embargoed. Information would be brought to the Board in due course.
8.13	As part of the fuel crisis, changes had been made on an interim basis to mileage costs.
8.14	Wallace Sampson, declared an interest as a member of North Yorkshire Safeguarding Board. He queried how we were receiving assurance that our safeguarding responsibilities were being met. Jonathan Coulter confirmed that staffing levels were fluctuating and discussions were ongoing with commissioners. In terms of assurance, it was noted that the issue was on and managed through the risk register and additional resources were inputted as a result. The risk has reduced but is continued to be monitored. Natalie Lyth noted that individual's caseloads were reviewed each month, deep dive audits are also undertaken to assess quality. Strategy meetings are also held. Laura Robson confirmed that this is overseen at Quality Committee. Richard Stiff noted that the risk was discussed in detail at the Audit Committee and assurance was given.
8.15	Andy Papworth noted the staff who were absent due to Covid. It was queried whether those with Covid could still work from home. Some could work from home, provided that they were well enough to do so, however, those who were clinical colleagues could not always do this. Virtual clinics etc. were still being utilised, but it was not always practical for clinical colleagues to deliver remote care.
8.16	Andy Papworth queried the resources required for Lead Investigators in the new SI Framework. It was noted this was being reviewed with the introduction of the new Patient Safety Incident Response Framework (PSIRF).
8.17	**Resolved:** The Chief Executive's Report was noted.
BD/03/28/9	**Corporate Risk Register**

9.1	The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks.
9.2	RTT (Referral to Treatment) was highlighted as an area of work that continues and was being closely monitored by the Executive Risk Management Group.
9.3	The Health and Safety Risk remained on the Corporate Risk register but the rating had reduced due to the increased mitigation in place. It was confirmed that the Executive Board lead would be transferred to Emma Nunez in her role as Acting Deputy Chief Executive.
9.4	Sarah Armstrong noted the range of activities for supporting staff wellbeing. She also noted that this was also regularly reviewed at the People and Culture Committee.
9.5	Sarah Armstrong noted autism referral rates for assessment and queried if there was capacity in the voluntary sector to help. Natalie Lyth confirmed that the organisation has been commissioned to provide a package of care for those who were waiting for formal assessment.
9.6	Andy Papworth noted the format of the report and how it was easy to note the changes to risks and the mitigations. He also queried the security arrangements in the ED and where this would be reported to. Jonathan Coulter confirmed that it would be reviewed at an Executive Level as well as via People and Culture Committee
9.7	Maureen Taylor noted the nurse staffing risks. Angela Wilkinson, noted the figures reported for the Care Support Worker (CSW) figure for vacancy rates. It was confirmed that the intention was to have zero vacancies for CSWs in-patient areas. It was confirmed the overall vacancy level for CSWs was 12.3% not 20.5% as noted in the report.
9.8	**Resolved:** the updates were noted.
BD/03/28/10	**Board Assurance Framework**
10.1	The Chair noted that from April 2022 the Sub-Committees of the Board will receive their relevant section of the Board Assurance Framework (BAF).
10.2	Jonathan Coulter noted that with the development of the new Trust Strategy, a revised BAF will be developed.
10.3	**Resolved:** the updates were noted.
BD/03/28/11	**Director Strategy Report**
11.1	The Director of Strategy noted the Trust Strategy continues to progress well with high level discussions continuing at an Executive Level and through the Senior Management Team.
11.2	The Urgent and Elective Care and Planned Care Board programme structure was now in place and working well.
11.3	HDFT continues to focus on its role in community diagnostic centres.
11.4	The revised Business Case Review process was noted as working well.
11.5	Sarah Armstrong noted the golden thread through the strategy work that was ongoing.
11.6	Maureen Taylor queried if the range of strategies such as Digital, Estates, Clinical Strategies would be linked to one another. Matt Graham confirmed that this would be overseen and connected via the overarching Trust Strategy.

11.6	The Board discussed the term Anchor Institution and the role that HDFT plays in this.
11.7	**Resolved:** The Director of Strategy Report was noted.
BD/03/28/12	**The Green Plan**
12.1	The Chief Executive presented the Green Plan to the Board for discussion.
12.2	The structure of the report is based on the national framework and had been discussed and developed at length within HIF (Harrogate Integrated Facilities) and then agreed with HDFT SMT (Senior Management Team).
12.3	Sarah Armstrong noted that there was clear reference to how it connects to individuals as well as the wider organisation.
12.4	Maureen Taylor queried the supply chain and how this was impacted on by the Green Plan. Jonathan Coulter noted that the organisation is signed up to the WYAAT procurement standards.
12.5	Wallace Sampson noted how comprehensive the Plan was. He noted that there was piece of work across the region of adopting a Circular Economy Strategy. The focus for this was on designing out waste at the source.
12.6	Jeremy Cross noted that Salix would deliver 25% of this work and queried where the remaining carbon reductions would be made. Jonathan Coulter noted that this related to travel and transportation costs as well as procurement changes. It was also noted that changes in technology would impact as well.
12.7	Andy Papworth praised the format of the report especially the focus on the action plan. There was some improvement suggested to make it very clear what the targets were to achieve. Jonathan Coulter confirmed that the majority of targets were directed nationally. Further explanations would be included in the Plan.
12.8	Thanks were expressed by the Board to the considerable work undertaken by the HIF team.
12.9	**Resolved:** The Green Plan was approved by the Board.
BD/03/28/13	**HARA Section 75**
13.1	The Director of Strategy presented the report. It was noted that the report recommended a 12-month extension to the Section 75 agreement to allow time to develop the plan further.
13.2	**Resolved:** The extension to Section 75 was approved.
BD/03/28/14	**HIF Shareholder Director**
14.1	The Chair presented the report to the Board.
14.2	**Resolved:** The Board approved Matt Graham, Director of Strategy as the Executive Shareholder Director.
BD/03/28/15	**Quality Committee Chair's Report**
15.1	The Chair of the Committee noted that a presentation had been received at the February 2022 meeting from the Theatres Matron, Continuity of Care and the Safeguarding Annual Report. The Committee were humbled by the range of work that was being undertaken.
15.2	At the March meeting, a presentation was received on the new Quality Team. It was also noted that the revised Quality Report was presented and provided greater

	triangulation of quality metrics. In addition, Ockenden was discussed. It was noted that national issues were raised regarding listening to patients and this impacts across the organisation not just within Maternity.
15.3	**Resolved:** The Board noted the content of the report.
BD/03/28/16	**Integrated Board Report**
16.1	Laura Robson noted complaints response times.
16.2	Andy Papworth queried care hours per patient per day. Emma Nunez confirmed that this was being monitored at a senior nurse level on a daily basis.
16.3	Jeremy Cross queried readmissions within 30 days, partly explained by the level of Covid admissions recently. Matt Shepherd confirmed that discharge remains based on a clinical assessment and it was confirmed that no major changes have been undertaken in process.
16.4	**Resolved:** The Board noted the content of the report.
BD/03/28/17	**Director Nursing**
17.1	Significant recruitment activity in the Quality Team as well as within the senior Nursing Team with a Head of Nursing for LTUC and a Deputy Director of Nursing was noted.
172	Work was in process on the introduction of the Patient Safety Incident Response Framework (PSIRF) and what the impact on lead investigator model means.
17.3	Project Implementation team introduced for Datix Cloud.
17.4	It was noted that the CQC peer review process had re-commenced for clinical areas.
17.5	Issues were noted in relation to staffing levels. In addition, Pressure Ulcers were noted as having increased across inpatient and community services.
17.6	**Resolved:** The Board noted the content of the report.
BD/03/28/18	**Strengthening Maternity and Neonatal Safety**
18.1	The Director of Nursing presented the report and noted key issues regarding middle grade doctors. As a result of staffing pressures, multi-disciplinary training has seen low attendance from certain professional groups. Continuity of carer has also been impacted on by staffing levels.
18.2	The Chairman queried national levels of compliance with Continuity of carer. Emma Nunez noted that the impact nationally was variable.
18.3	**Resolved:** The Board noted the content of the report.
BD/03/28/19	**Ockenden Review**
9.1	The Director of Nursing presented the report and noted the immediate and essential actions. It was also noted that the full report would be published nationally today. The Team would work to review and develop an updated action plan as required. Maternity will remain a high focus at a national level.
9.2	The Chairman noted that with the national publicity, women delivering at HDFT could have a heightened level of anxiety.

9.3	Sarah Armstrong noted the importance of providing clear and up to date information to women. Emma Nunez noted the role of the Maternity Voices Partnership forum in this as well.
9.4	Andy Papworth noted the work that was continuing regarding how we assure women using our services.
9.5	Laura Robson noted the importance of the continuity of care between a woman and her midwife.
9.6	**Action:** A patient story to be presented to Board on a maternity case.
9.7	**Resolved:** The Board noted the content of the report and the current compliance position.
BD/03/28/10 **10.1**	**Medical Director Report** The Executive Medical Director noted the content of her report and highlighted the work ongoing with clinical audit and triangulation of claims information. A positive medical director workshop had been held and it was noted that the Chief Registrar scheme was working well with a clear focus on improvement programmes. A review of staffing levels was ongoing.
10.2	Work continues regarding the development of standardised policies, guidelines and standard operating procedures.
10.3	An update was provided on the development of the digital strategy and the potential digital options available to the organisation with soft market testing continuing.
10.4	CMDUs (Covid Medicines Delivery Unit) have been commissioned however, the financial model has not yet been clarified by the CCG/ICS causing a risk to sustainability.
10.5	Sarah Armstrong noted the work regarding digital patient records. Jackie Andrews confirmed that there was some national steer regarding work on an ICS footprint, in addition there was consideration at a national level “data lake” where information would be accessible nationally. It was also confirmed that there were some paper records still in circulation. Natalie Lyth also noted that individuals can download the NHS App which holds information on your own personal healthcare records including medical history, allergies and medication.
10.6	Andy Papworth queried the claims masterclass. Jackie Andrews confirmed this was a discussion with partners in NHS Resolution and Legal Colleagues regarding the journey of a claim as well as understanding themes and trends.
10.7	Andy Papworth queried long Covid. Jackie Andrews confirmed that research was ongoing with regards to Long Covid. It was noted that a significant increase in cases at HDFT had not been noted.
10.8	The Chairman queried the impact on Covid isolation with medical staffing. Jackie Andrews confirmed that this had impacted on staffing levels. Levels of risk were still unknown regarding new waves and variants of Covid.
10.9	**Resolved:** The Board noted the content of the report.
BD/03/28/11 **11.1**	**Learning from Deaths Quarterly Report** The Executive Medical Director noted the content of the report and highlighted the Covid element.

11.2	The report was presented to Quality Committee and Laura Robson confirmed a robust discussion had occurred.
11.3	**Resolved:** The Board noted the content of the report.
BD/03/28/12	**Covid Serious Incident**
12.1	The Executive Medical Director presented the Covid SI report.
12.2	The report described the process undertaken to investigate the 10 Covid ward outbreaks and 2 non-outbreak linked hospital-onset Covid 19 infection (HOCI) deaths at HDFT.
12.3	28 patients who were associated with the outbreak sadly died within 28 days of testing positive for Covid 19.
12.4	Good practice was noted and no lapses in care were identified.
12.5	The report recommended that :- • Future outbreaks be given a unique reference number to aid correct identification • To use all of the cumulative learning gained from managing these outbreaks if future outbreaks occurred.
12.6	Jeremy Cross queried the issues raised in 2020 and how this impacted on the cases in 2021. Jackie Andrews confirmed that mitigations of the risk were implemented but due to the nature of a respiratory disease, full mitigation was not possible in confined environments such as hospital settings.
12.7	**Resolved:** The Board noted the content of the report.
BD/03/28/13	**Resource Committee Chair Report**
13.1	The Chair of the Committee noted that a break even position was forecast for the end of the year.
13.2	It was noted that Emergency Department Performance had been discussed in detail at the Committee and welcomed a further discussion at the Board.
13.3	Discussions had been held on the moves towards digital progression.
13.4	The revised consistent approach to Business Cases was highlighted.
13.5	The Chair of the Committee took the opportunity to thank the Chairman for her support and guidance at the Committee.
13.6	**Resolved:** The Board noted the content of the report.
BD/03/28/14	**Integrated Board Report**
14.1	**Resolved:** The Board noted the content of the report.
BD/03/28/15	**Director of Finance Report**
15.1	The Director of Finance presented his report as read and highlighted the financial break even position.
15.2	A spike in agency spend was noted and it was highlighted that work was ongoing to understand this and bring spending in line with plan.
15.3	**Resolved:** The Board approved the organisation as A Going Concern.

BD/03/28/16	**Annual Planning 2022-23**
16.1	The Director of Finance noted the content of his report. It was noted that the Trust continues to balance the overall position, however there remains pressures in some areas, with underspending issues as much as issues as those areas overspending.
16.2	There remains three key areas of work:- • Further system discussions on the planned system distribution of Elective Recovery Funding • Closure of the current planning gap in relation to efficiency savings • Work still required on the prioritisation of the developments put forward by directorates.
16.3	The final plan will be reviewed by Resource Committee in April 2022 before submission to NHSE.
16.4	**Resolved:** The Board approved the use of the framework for financial plan for 2022-23
BD/03/28/17	**Chief Operating Officers Report**
17.1	The Deputy Chief Operating Officer presented the report as read. He provided focus on ED actions. Clarification was given that there were 3 over 60-minute ambulance handover waits, not 14 as had been reported in the pack.
17.2	The region continues to see pressures across the system with many partners reporting Opel 4 levels of activity. HDFT continues to support as a system partner taking diverts from organisations within the region. This equates to 2 additional patients per day being admitted to the organisation which increases difficulties with patient flow. It is however, important for patients that HDFT continues to support regional partners.
17.3	There has been additional national focus on ambulance handover times due to the increased risks in the community for ambulances attending to patients. The region has been tasked with ensuring that the risk of handover is distributed across the system. Work is progressing at HDFT on processes in place for reducing ambulance handover times.
17.4	ED performance was highlighted. Admitted performance was low and the impact on this related to IPC and testing delays, deep cleaning reducing flow, discharge issues due to staffing gaps. Measures were in place to provide improvements such as updating of Infection Prevention Control guidelines, improved access to community care. Extending Same Day Emergency Care (SDEC) hours, virtual; beds and reorganisation of wards.
17.5	Non-admitted patients were higher in number. Performance was impacted on by the higher demand with the wider system under pressures, a lack of independent streaming and staff absences. The improvement needed to address this was the new mode of streaming to be fully implemented. In addition, alternatives offered at check in, primary care stability and increased SDEC capacity.
17.6	The main focus for HDFT will be the implementation of the streaming model. It was noted that a progressive impact would be seen over the next 4 – 6 months.
17.7	The Deputy Chief Operating Officer also highlighted the work on 104 week waits for treatment. The target had been set at zero patients by 31st March 2022. There would be just over 10 patients who remain on the list at the end of March 2022 with the greatest number in community dental patients.
17.8	Laura Robson noted the discharge presentation received at the Quality Committee. The internal audit re-audit of discharge would be receiving a limited assurance status.

	It was queried if the plan for discharge was given enough focus. Matt Shepherd confirmed that work was ongoing with the senior leadership team for discharge with granular detail being available on a daily basis for review.
17.9	Andy Papworth queried the support and impact on the wider system. Matt Shepard confirmed that Russell Nightingale would chair the Urgent and Emergency Care Programme within the Trust. This would provide focus and clarity to the work that was required to move forward the improvements. Jonathan Coulter confirmed that there is a need to focus on the non-admitted pathway within the ED.
17.10	**Resolved:** The Board noted the content of the report.
BD/03/28/18	**Workforce Report**
18.1	The Director of Workforce and OD presented her report as read.
18.2	Demand and capacity imbalance continued during the month. This impacted upon recruitment campaigns, occupational health, EDI, HR operations and ER casework.
18.3	The roll out of HealthRoster to areas of the Trust designated to use the system is now virtually complete. The old system will now be decommissioned.
18.4	The Chairman noted the scrutiny received at the Resource Committee.
18.5	**Resolved:** The Board noted the content of the report.
BD/03/28/19	**Integrated Board Report**
19.1	**Resolved:** The Board noted the content of the report.
BD/03/28/20	**People and Culture Committee Chairs Report**
20.1	The Committee commenced with a staff story. The Committee also had a discussion of the staff survey and themes and trends were noted.
20.2	The Committee has received a comprehensive update on the People Plan and the Culture Plan. It was noted that changes had been made to the chairmanship of some of the staff networks. Thanks were expressed to previous chairs of the networks.
20.3	Discussions were held on the latest Inpulse survey which had a focus on kindness.
20.4	A deep dive into the Employee Assistance Programme (EAP) would take place and reported at the next meeting of the Committee.
20.5	**Resolved:** The Board noted the content of the report.
BD/03/28/21	**Workforce Development Report**
21.1	The Director or Workforce and OD presented her report as read.
21.2	Two risks noted in the report were now mitigated against. Interim arrangements had been put in place for an increase in mileage provision. It was also noted that EAP provision was being mitigated with the introduction of a new provider.
22.3	Ramadan was due to commence and the Board were updated on provision and support for colleagues.
22.4	The Board was updated on the “Leading At Our Best” programme and the EDS2 work stream.
22.5	Thanks were expressed to Helen Law, Clinical Lead who has led on the development of the Schwartz rounds.

22.6	**Resolved:** The Board noted the content of the report.
BD/03/28/23	**Audit Committee Chair's Report**
23.1	The Chair of the Committee presented his report as read.
23.2	It was noted that there had been changes to colleagues within the Internal Audit Team and thanks were expressed to colleagues who were leaving.
23.3	Gifts and Hospitality had been discussed and changes to the process was noted.
23.4	The Committee had received assurance that the internal audit programme would be delivered within year. There had been some delays due to staffing absences.
23.5	The work in relation to fraud and counter fraud was reviewed and national issues were noted. Andy Papworth noted the impact this could also have on suppliers.
23.6	The Acting Director of Finance confirmed the current situation with Internal Audit.
23.7	**Resolved:** The Board noted the content of the report.
BD/03/28/24	**Senior Management Team Report**
24.1	**Resolved:** The Board noted the content of the report.
BD/03/28/25	**2022-23 Board Workplan**
25.1	**Resolved:** The Board noted the content of the workplan.
BD/03/28/26	**Policy on Policies**
26.1	**Resolved:** The Board approved the Policy on Policies.
BD/03/28/27	**Aseptic Business Case**
27.1	**Resolved:** The Board approved the Aseptic Business Case on the basis of: • The replacement of the Trust's pharmacy aseptic unit in order to mitigate the quality and service delivery risks. • Noted the indicative costs for the project of up to £1.5m capital and £50k revenue. • Approved the initiation of the procurement process to appoint the suppliers and obtain final costs for the project.
BD/03/28/28	**Any Other Business**
28.1	Jonathan Coulter on behalf of the Board expressed thanks to Angela Schofield for her leadership.
28.2	Claire Illingworth, Lead of Governors noted Angela's commitment and dedication to the Council of Governors. It was noted that the governors were very fortunate for the engagement and support offered by Angela Schofield.
BD/03/28/29	**Board Evaluation**
29.1	Andy Papworth noted the triangulation of the information discussed today.
29.2	Maureen Taylor noted how focused the meeting had been on key issues.

BD/03/28/30 **30.1**	**Date and Time of the Next Meeting** The next meeting would be held on Wednesday, 25th May 2022.
BD/03/28/31 **31.1**	**Confidential Motion** **Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Board of Directors (Public)
25th May 2022

Title:	**Chair's Report**
Responsible Director:	Chair
Author:	Chair

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates from the Chair.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	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	X
	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	X
	BAF3.5 To provide high quality public health 0-19 services	X
	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	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	None	
Recommendation:	The Board is asked to note this report.	

Board of Directors (Public)
25TH MAY 2022

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
MAY 2022

CHAIR REPORT

Introduction

This is my first report since being appointed as Chair. I would like to take this opportunity to say thank you to everyone who was part of the recruitment process; I am aware of how much time and energy this involved. I would also like to thank Angela (Schofield) as we worked together from January, and she generously gave me her time and shared her expertise to help me to prepare for the role.

Since being appointed, I have focussed on meeting as many people as possible, both internally and externally. This has included becoming part of the Chairs networks and getting to know other Chairs in the region.

I was delighted to attend the Friends of Harrogate Hospital fundraising event in early April. This was their first major event of the year and was extremely well supported by members of the local community. It was fantastic to see the work of our Friends 'in action.'

During my first few weeks in the role, I have also focussed on the recruitment process for new Non-Executive Directors, and an associate Non-Executive Director. I am delighted to report that we have attracted interest from a wide range of candidates and look forward to the interview process in July.

In addition, we have needed to appoint new Non-Executive Directors for HIF (Harrogate Integrated Facilities) and I am very pleased that Richard Stiff will be appointed as the Stakeholder Non-Executive Director for HDFT and Gary Barratt has been appointed as a new HIF Non-Executive Director.

Finally, I am very much looking forward to working closely with our Council of Governors. We have a development session in early June, which will enable us to get to know each other better, share experiences, and understand how we can work most effectively as a Council. We have also begun the election process to recruit new Governors and I will very much look forward to welcoming them to the Council later in the year.

Sarah Armstrong
Chair
May 2022

Board of Directors (Public)
25th May 2022

Title:	**Chief Executive's Report**
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held on 30th March 2022. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	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	X
	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	X
	BAF3.5 To provide high quality public health 0-19 services	X
	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	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
MAY 2022

CHIEF EXECUTIVE'S REPORT

Introduction

1. Since the last Board meeting at the end of March, we have collectively been continuing to respond to the urgent care pressures across the system. These pressures have been exacerbated by the continued impact of the pandemic, where we have had a number of Covid positive patients within the hospital with the infection control challenges this brings. More importantly has been the impact on colleagues across the Trust where we have experienced significant staff absences at points in time over the last few months.

2. These issues have combined to impact upon our services as can be seen through the barometer of urgent care delivery both locally and across the system which has been very challenging, and has meant that colleagues have struggled to deliver the standard of care that they would like to.

3. The current position however in relation to CoVid patients is that as of this week we have a much improved position, with c15 patients in hospital who are CoVid positive. In addition, staff absence as a result of Covid has dropped from over 200 colleagues to the current position of around 70. This is a welcome change and will assist colleagues to provide the support and care that we ask of them and they expect to deliver.

4. At a national level, as of 19th May, the CoVid incident level has been reduced from level 4 to level 3. This signifies a significant change, as we have been at level 4 for over 2 years, and is an indication of reduced risk and an opportunity to refocus our collective efforts on recovery in all areas. This will continue to be a challenge, but also an opportunity to improve services for the patients and population who rely on us for support.

5. Alongside this, we have also responded to the change in Infection, Prevention, and Control Guidance, which has assisted in the way in which we plan our elective admissions. Our visitor guidance has also been amended, and we now have a much more accessible visitor policy which allows more visitors to attend and support their friends and families when in hospital.

Urgent and Emergency Care

6. Urgent and emergency care provision continued to challenge ourselves and the system during April. Our 4 hour performance was around 66%, we had 43 12-hour waits, and we continued to offer system support through diverts from York, who at times were significantly stretched.

7. There is significant concern in respect of ambulance handover delays across the system, with the risk of members of the community not being able to access an ambulance when needed. Our ambulance handover performance is very good, and in this way we are able to release the ambulance back into the community as soon as possible following arrival at the hospital.

8. Whilst there are a number of causes of the current pressures, it should be noted that this isn't caused by a significant increase in people presenting at the Emergency Department. It is more a reflection of how we organise care through the department and then the flow both in the hospital and more crucially out of hospital.

9. We currently have significant number of patients who are medically fit within hospital, our length of stay has increased, and we have many times more patients in hospital over 14 days and 21 days than we ever had before the pandemic. This reflects the pressure in care services out of hospital, and we are discussing across the system how we can reduce this risk. We know that if people stay in hospital for a significant time that outcomes deteriorate, and we are currently at risk of worsening care for our population as a result of some of the urgent care pathway pressures being felt across all organisations.

10. In terms of actions within the organisation, we have approved and committed funding to a new ED streaming model, and we are progressing with the recruitment plans, and we have recently undertaken a week-long improvement event to improve flow through the hospital. In addition and in parallel, work is ongoing in respect of hearing from colleagues within the ED about any concerns that they have with a view to further improvements and action being taken.

11. It should also be noted that we are currently working with commissioners in respect of a 'virtual ward' model of care to increase out of hospital capacity. This, combined with the roll out of the 2-hour response service and our existing adult community services should enable people to be seen in more appropriate settings with improved outcomes. Once the new models are in place we will be assessing how all of our services link together and whether there is further room for transformation and improvement in this area.

Planned care

12. There is significant focus nationally and regionally on the delivery of elective recovery. This is absolutely a priority for the whole NHS and one in which we recognise the need to improve access for our population.

13. Plans have been submitted by ourselves and the system to deliver the 104% activity when compared with 2019/20. We have also committed (and will achieve) having no over 104 week waiters by the end of June, but there are some challenges within the HNY system to deliver this requirement and also concerns about the collective delivery of the cancer standards.

14. Discussions are being held across HNY about the role of the Collaborative of Acute Providers (CAP) in helping to deliver the improvements necessary, and as always, there is a balance between what can be achieved locally and what support can be offered or received on a wider footprint.

15. All organisations recognise the need for collaboration and improvement, and we need to work through the governance model and the programme of work that adds value. We have an opportunity to reshape the current way of working with the advent of the ICB and the fact that we have a senior Director vacancy within the CAP.

16. It should be recognised by the Board that the expectation of national and regional colleagues is that the CAP is the vehicle through which elective care recovery will be delivered and overseen. It is important therefore to deliver some improvements in our collective delivery to allow us to undertake our development work within the CAP and agree a future way of working.

17. As the Board is aware, as part of our planning for 22/23 and the next three years, we submitted a proposal that has been agreed to develop additional theatre capacity on the hospital site that would effectively be managed as 'green' capacity. This proposal will be funded by the Targeted Investment Fund, and we are in the process of developing the short-form business case for submission to Regional and National colleagues, who have committed to turning round approvals in a short period of time.

0-19 services

18. We continue to experience pressure across our 0-19 services, with OPEL levels in April being 3 for most of the month. Support is being delivered across all of our 0-19 service areas to ensure that we manage the risk across the services. The number of safeguarding strategies continues to be higher than in previous years.

19. We have a number of vacancies within the 0-19 services which increases the challenges to the service. We are currently recruiting students who will be able to commence work in September that will improve the staffing position.

20. As a result of the continued pressure, appropriate actions are being taken, including a more flexible approach to the timelines for mandated contacts in some areas. It should be noted though that the service continues to deliver the contacts as required in most of our geographic areas.

21. As part of our integration of Northumberland services into HDFT we are currently consulting with staff about the future service model and resulting staffing structure.

22. We are in discussion with Darlington in respect of the future provision of services and how we work together and strengthen our partnership arrangements in that area.

Quality and Safety

23. As the Board will be aware we are introducing a new process for SI investigations. We have had good interest from colleagues in taking on a role as lead investigators, and we have training available. We have introduced the SI committee internally which met recently to review SIs, ensure we have undertaken appropriate investigation, generate themes, analyse the collective information, and identify any thematic learning.

24. We have had a recent never event within theatres, with an incident picked up last week that was as a result of a failure in process in March. There is a consistent theme with other previous events, however the reaction and action of colleagues within the team has been positive. The event has been reported quickly and openly, and actions taken. More importantly the team are disappointed and upset that this has happened, and we need to build on the more open culture and ownership as we continue with our theatre improvement work.

25. The Board will be aware of our risk in relation to Health and Safety. We have received an initial report from our Health and Safety consultant and are taking action in a number of areas – access to the Goods Yard, review of our ligature assessment process, and use of Sharps bins – and we are currently out to advert for the necessary people to manage the service going forward. We are also developing a strategy to go alongside the immediate workplan, which will be overseen by our revised committee and governance arrangements.

26. Since our last Board meeting the latest report from Donna Ockendon in relation to maternity services has been published. We had a helpful workshop last month and you will see information later in the agenda with regard to maternity services. We will also be considering how the learning can be used across all of our services, in particular, creating an open culture where colleagues can raise concerns, and ensuring that we listen to patients as we deliver care and support them.

Finance

27. There is continued national and regional concern in respect of the financial plans that have been submitted, with material deficits across many part of the country.

28. In HNY, the collective deficit plan currently totals over £50m, which is not out of line with other areas.

29. We understand that some additional funding will be provided to systems to cover the additional inflationary pressures that have emerged over the last few months (especially in relation to energy costs) and we will need to assess the position once this funding is formally known. The expectation is that this funding will be provided on the understanding that balanced plans are submitted from local system.

30. Since our last Board meeting we have completed our year-end accounts. The organisation delivered the financial plan for 2021/22, and we are now awaiting the year-end audit process.

Workforce and wellbeing

31. We have received the national staff survey and also our latest quarterly Inpulse survey that provides feedback about how colleagues are feeling.

32. The latest Inpulse engagement score for the Trust has improved, which is great, and the detailed information is with Directorates and teams to understand and respond to.

33. The high level message from the national staff survey is that in common with most organisations within the NHS, the morale and wellbeing of staff has fallen, in some cases quite significantly. The key driver for ourselves in relation to morale is workplace stress.

34. Triangulating our local surveys and comments made, I would summarise the key three things that would improve morale, wellbeing and reduce workplace stress as:

    - Having people here (recruited, in work, rostered well)
    - Having a decent workplace environment (physical environment, equipment)
    - Appreciation and understanding of people's work and challenges

35. These are the key things that we will be focussed on as we seek to support colleagues and enable all of us to do our job to the best of our ability.

36. We responded to the fuel cost increase by temporarily increasing the mileage rate for colleagues who travel as part of undertaking their work. This 'cost of working' crisis has had a major impact on our community colleagues in particular, and we agreed that this would be in place for three moths whilst we awaited a national response.

37. We are formally reviewing this policy, and comparing our approach to other local organisations, but in the absence of any further national intervention and with the 'cost of working' issue unchanged from when we agreed the recent change, we will be extending this for a further period of time.

Other

38. Attached is a statement in relation to Modern Slavery that the Board should consider and approve as part of our annual report disclosures.

Jonathan Coulter
Chief Executive
May 2022

Modern Slavery and Human Trafficking Annual Statement

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

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

Policies relating to Modern Slavery

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

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

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

Our People

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

Our Supply Chain

Our procurement senior team are all Chartered of Institute of Purchasing and Supply (CIPs) qualified and abides by the CIPs code of professional conduct. The procurement team follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.
When procuring goods and services, we additionally apply NHS Terms and Conditions (for nonclinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Our Performance

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

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

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

Approval for this statement
This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2022.

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

Jonathan Coulter
Chief Executive

Trust Board

Title:	**Corporate Risk Register**
Responsible Director:	Chief Executive
Author:	Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Board with key updates and actions since the previous meeting. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and previous Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	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	X
	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	X
	BAF3.5 To provide high quality public health 0-19 services	X
	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	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings, Executive Risk Review Meeting and the Senior Management Team meeting.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
TRUST BOARD (PUBLIC)
MAY 2022

CORPORATE RISK REGISTER

1.0 INTRODUCTION

The Corporate Risk Register consist of operational risk scoring 12 or above. It is reviewed monthly at the Directorate Performance Reviews and at the Executive Risk Management Group. This report provides a summary of the position in March 2022.

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

The risk remains with nurse staffing and the risk has been elevated from a 12 to a 16 to reflect the current circumstances. A review of the gathering and analysis of the date in terms of vacancies was underway to ensure the true picture was know.

In terms of mitigation the following were noted:

- a successful bid (87k) to NHSE/I to recruit additional CSWs to bring to zero vacancy (inpatient units)
- Additional focused HCSW recruitment day 14th February resulted in 57 offers of posts to HCSWs – on boarding now taking place with total of 54 new recruits remaining in the process
- Redefining of CSW Development Programme to support new recruits, programme has commenced and evaluating well
- Clarity of career progression from CSW to RN and points between
- Agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own'
- Exploration of training and education space and accommodation with York St John University for current and new staff members
- International Recruitment and associated funding to increase capacity, continue to review opportunities to increase IR intakes
- Refreshed recruitment and retention operational group now meeting monthly with two focused task and finish groups established – one for recruitment and one for retention
- Preceptorship programmes to retain newly qualified and new starters refreshed
- Working with Directorates re bed bases / establishments and staffing models
- Focused work on HealthRoster KPIs and performance of effective rostering practice

The Target Risk is 9 (3x3) – March 2023 (from March 2022).

The Current Risk is 16 (4x4) – April 2022. This is an escalated risk from March 2022 which had a position of 12 (3x4).

To note the increase in risk to a 16 for Nurse Staffing.

2.2 CRR6 – Wellbeing of Staff

Work continues with the support and development programme to assist in colleagues wellbeing. Of note is that a Mental Health Nurse and a Colleague Wellbeing Programme Lead role have both been recruited to and are due to commence in Quarter 4 2021-22

The following key actions have taken place:

- TIME OUT room in the Education Centre (Enterprise Room) with resources for any staff that would benefit from some time away. I'm aiming to be on site - previously a

room at the back of Herriotts Restaurant was used for this purpose, but due to the refurbishment of Herriotts this has had to be relocated on 3rd floor, Strayside Wing.
- Refreshed Trust Wellbeing webpage & intranet with updated support offers & in-the-moment self-help -
- Enhanced promotion around support offers with updated emails and poster circulation - please see poster in Appendix 2
- Re-tendering for EAP – subject to OH business case approval and funding.
- Mental Health Champions asked to enhance out-reach where they can & scheme re-promoted via Champion specific posters around site
- Thrive wellbeing conversations promoted & guidance provided
- A reminder sent via OMG about lessons learnt from Wave 1 and a reminder about End Well - checking out at the end of a shift as a process to support wellbeing –
- Psychology drop-in/easy book sessions to be offered on main site from 21/12/2021 (location & timings currently being confirmed).
- Wider psychology staffing pool being approached to see if additional support is feasible via other specialities/TEWV if needed.
- Wellbeing answerphone checked & responded to daily

The Target Risk is 9 (3x3) – March 2023 (from March 2022).

The Current Risk is 16 (4x4) – April 2022. This is an escalated risk from March 2022 which had a position of 12 (3x4).

To note the increase in risk to a 16 for Staff Wellbeing.

2.3 CRR34 – Autism Assessment

The Current Position is noted as:
- Numbers on the Waiting list – 486
- Longest Wait – 71 weeks (up from 61 weeks in March 2022 but there are exceptions on this case – it is 42 weeks with no exceptions applying).

The rolling 6 month average monthly rate is at 57 and is higher than baseline commissioned capacity of 40 assessments per month. Capacity is 60 with funded additional capacity until August 22.

Due to continuing higher referral numbers and assessment model, we are predicting we would end the year with a waiting list of 630 children with a 16month wait to commence assessment. If the WLI had been extended this year, the year end projection would be 474 on the waiting list and a wait of 10 months to commence assessment. Unfortunately, the date has passed to be able to continue the WLI due to our fixed term psychologist handing in their notice.

The organisation is still awaiting further updates from the commissioners as to whether any additional WLI funding can be made available. Any further WLI discussions would need to consider a 6month lead in time as the psychology support is critical in delivering a WLI.

The Target Risk is 6 (3x2) – amended to March 2026 from March 2022

The Current Risk is 12 (3x4) – May 2022. This is the same rating as November and December 2021, and January to April 2022.

2.4 CRR41 – RTT

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

implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.

The current position is as follows:

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22 (provisional)	Apr-22 to date (provisional)
Total incomplete RTT pathways	17,690	19,476	20,631	21,785	22,168	22,648	22,423	22,714	23,464	23,323	23,900	*24,633*	*24,728*
> 52 weeks	1,190	1,087	1,006	988	955	1,008	1,070	1,097	1,177	1,138	1,157	*1,150*	*1,156*
> 104 weeks	3	5	13	20	23	27	33	34	47	52	50	*23*	*20*
RTT clock stops	4,790	4,776	5,428	5,001	4,783	4,865	5,381	6,093	4,657	5,245	4,759	*5,660*	*740*

Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.

lists)

Validation and real-time updating of RTT waiting lists

The following actions are underway/ completed to improve accuracy of waiting list, which will further reduce the numbers allowing closer scrutiny of genuine waiting patients.

- Standardised Reporting Dashboard : piloted & in place
- Elective recovery meeting: weekly in place, using new data/ format. Directorates implementing equivalent at service level.
- 6:4:2 – booking levels and utilisation improving (confounded by covid absence to some degree)
- RTT outcoming: business case written, funding through HCV digital fund applied for and successful. Resource identified to support business change and implementation of this is outpatients. In place by Q2
- RTT team – move to embedding in directorates. Final model to be agreed , then consultation with affected staff needed. In place June 2022
- National Data submission data quality: work completed. Data Quality now 97.5%
- Validation of full waiting list: Options appraisal in progress: preferred: AI supported validation tool for 1 year. Implementation target: start Q2.

The Target Risk is 6 (3x2) – March 2024, amended from March 2021

The Current Risk is 12 (3x4) –May 2022. This is the same rating as November and December 2021 and January to April 2022.

2.5 CRR61 – ED 4-hour Standard

A&E 4 hour standard remained below the 95% standard in April 2022.

A&E 4 hour standard – remained below the 95% standard in April 2022 at 61.76% (however this figure has improved – highest since Jan 22). There continues to be an increase in presentations, 10% above 2019/20 levels, and divert support provided for York Hospital. 6 hour harm indicator - equates to 10 harms due to longer stay in April. 43 – 12hour breaches occurred in April. Improvement in ambulance handover was noted.
The same mitigations are in place – approval for new staffing model has been obtained.
The risk reduction target date has been moved back to July to reflect the timescales of implementing the new streaming model.

The Target Risk is 10 (2x5) – March 2024, amended from March 2021 and target risk updated from (3x3) 9.

The Current Risk is 15 (3x5) –May 2022. This risk rating has been reviewed and upgraded from a 12.
To note the increase in risk to a 15 for the ED 4-hour standard.

2.6 CRR63 – Violence and Aggression (ED)

The number of incidents relating to violence and aggression were:

- Datix incidents for aggression in the ED – 31 episodes through July
- Datix incidents for aggression in the ED – 28 episodes through August.
- Datix incidents for aggression in the ED – 12 episodes through September.
- Datix incidents for aggression in the ED – 8 episodes through October.
- Datix incidents for aggression in the ED – 11 episodes through November.
- Datix incidents for aggression in the ED – 9 episodes in December.
- Datix Incidents for aggression in the ED – 8 episodes through January 2022
- Datix Incidents for aggression in the ED – 17 episodes through February 2022
- Datix incidents for aggression in the ED – 11 episodes through March 2022
- Datix incidents for aggression in the ED – 9 episodes through April 2022

Due to the continued reduction in incidents the risk score has now reduced to 8.

The Target Risk is 8 (2x4) – May 2022 - target risk rating changed from September 2021

The Current Risk is 8 (2x4) – May 2022

Target risk rating has been reached and has reduced to 8 and therefore this has been removed from the Corporate Risk Register to be managed at a Directorate Risk Register level.

2.9 Health and Safety

Work to formalise the Health and Safety Risk has been undertaken – information from the external report which was presented at SMT has been included in this. Current position with plans to deliver the reduced risk is noted below:

- Notification to organisation to cease using the Goods Yard access with immediate effect – reduction in some footfall but not all
- Work ongoing with plans to section off the yard so access is not possible.
- Health and Safety manager recruitment underway. Interim Health and Safety manager also being sought until recruitment complete
- Exec lead for H&S identified who will Chair H&S Committee
- Revisions to ToR for Health and Safety Committee
- Procurement of Datix to support wider risk register roll out, including H&S

The Target Risk is 8 (2x4) – May 2022 – revised from December 2021

The Current Risk is 12 (3x4) – May 2022 this is the same as November and December 2021 and January to April 2022.

2.10 Pharmacy Aseptic

The Replacement of the Aseptic Unit is required to permanently reduce the risk.

Replacing the unit will require it to close for approx 12 months. The impact of this will be mitigated by a combination of: ward based preparation of products, outsourcing products to LTHT and the private sector; HDFT aseptic staff working in the YSTHFT unit to increase its production capacity so it can supply products for HDFT.

Investment will be needed to build a new Aseptic Production Unit. A project is underway to develop the plans and a BC is planned for SMT in Mar 22 with construction of the new unit planned to start in Jun 22 (aligned with the replacement of the Air Handling Unit through the SALIX programme) subject to completion of the procurement process and availability of the chosen contractor to start the work.

Capital funding for 2022/23 has been agreed. A business case has been recommended for approved.

There is a risk that the replacement will not be able to start immediately after the replacement of the AHU by Salix in Jun 22. This is because the procurement process needs to have been completed and the chosen contractor needs to be available to begin the work. If the work cannot start immediately it will extend the shut down period which will increase the costs of the mitigation plans and increase the workforce risk because staff will be working at YTHFT for longer.

The Target Risk is 4 (1x4) – March 2023

The Current Risk is 12 (3x4) – May 2022, this is the same rating at January to April 2022.

2.11 Immunisation Services

A review was undertaken of the last 6 months incidents and confirmed that 18 children had received duplicate vaccination in error. The administration of a duplicate vaccine is low harm (especially compared with the risk of not being vaccinated) but it is an unnecessary procedure. A proposed improvement trajectory will be agreed with the Executive team at the CC resources meeting in April.

It was noted that the COVID 12-15 school base programme concluded at the end of March 22 which has reduced the pressure on the service and means we are no longer sub-contracting to other providers.

No incidents were noted in April 2022.

An experienced Service Manager from 0-19 team seconded to support Clinical Lead with review and transformation of service. Band 7 Leadership capacity increased to support capacity to deliver change.

The Target Risk is 4 (1x4) – March 2023

The Current Risk is 12 (3x4) – May 2022, the risk remains the same as April 2022.

3 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Associate Director of Quality and Corporate Affairs
May 2022

3.1

Board of Directors(Public)
May 2022

Title:	**Board Assurance Framework**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting in March 2022. Each Board Assurance Framework risk has been reviewed and assessed with the designated responsible Executive Director. The changes to the BAF made since the last meeting are detailed within the report	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	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	X
	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	X
	BAF3.5 To provide high quality public health 0-19 services	X
	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	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Board Assurance Framework

1. STRATEGIC OBJECTIVE: TO BE AN OUTSTANDING PLACE TO WORK

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	May 2022 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Mental Health Nurse – recruited Colleague Wellbeing Programme Lead – recruited Quiet room developed in the Education Centre Refreshed wellbeing intranet Mental Health Champions in place Thrive Wellbeing Conversations	Board of Directors Senior Management Team People and Culture Committee Sarah Armstrong – Non-Executive Director for Wellbeing Guardian	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data is being analysed by directorates and managers. Actions are being reviewed and implemented. Presentation was made by each directorate at November SMT. Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF remains outstanding.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated as has the related corporate risk register. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Becoming and Anti-Racist Work programme EDS2 Programme commissioned	Board of Directors SMT People and Culture Committee Wallace Sampson – Non-Executive Director for Inequality and Diversity	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.

2. STRATEGIC OBJECTIVE: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE																	
Risk ID	**Principle Objective**	**Principle Risk to the Delivery of Objective**	**Inherent Risk Rating**			**Residual (Current) Risk Rating**			**Target Risk Score**	**Target Date Risk Score will be met/closed**	**Corporate Risk Register**	**Assurances in Controls**			**Gaps in Assurances/Controls**	**Responsible Committee**	**Lead Executive Director**	**May 2022 Update**
			Likelihood	**Conseq**	**Rating**	**Likelihood**	**Conseq**	**Rating**				**Existing Key Controls**	**Internal**	**External**				
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	3	3	9	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy has increased capacity to work with strategic partners	Medical Director Board Report Director of Strategy Board Report SMT	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation. Currently no strategic Harrogate Place Forum – discussions are ongoing to develop forum. Further work required on Harrogate as an anchor institution.	SMT	M Graham, Director of Strategy J Andrews, Executive Medical Director	With the appointment of Matt Graham, the Lead Executive has been updated to include the Director of Strategy. In addition, assurance controls and gaps have been updated to reflect the current position. 7 Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members	Appointment of Director of Strategy Executive Team are key members of strategic groups across the two ICSs.	ICS Groups eg the Provider Collaborative	The required input across the two local ICS may lead to a lack of clarity of funding arrangements. Requirement for HDFT to be members of two ICS means that Executive capacity needs to spread across two structures rather than one.	SMT	M Graham, Director of Strategy	With the appointment of Matt Graham, the Lead Executive has been updated to the Director of Strategy and not the Executive Medical Director. In addition, assurance controls and gaps have been updated to reflect the current position Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.

3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	May 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement. Governance structure has received a root and branch review and the creation of the three forums above will ensure greater control. Safe Staffing Review completed. Procured Perfect Ward with planned roll out in January and February 2022.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation Weekly Quality Summit and Learning Summit in place Complaints back log cleared	CQC Inspections Bi-monthly Assurance meetings with CCG Internal Audit Report – Board to Board reporting – significant assurance	Do not have consistent quality control in place Workforce challenges impacting	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	The appointment of the Director of Strategy has given renewed focus and increased resource on the development of the Clinical Strategy and a strategic governance programme is under development	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	Trust and Clinical Strategy under development however they are not yet in place.	Quality Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in assurance have been updated. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visibility of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports CQC Trust Wide Action Plan – now closed.	CQC Outstanding Report OFSTED Reports JTAI Reports	Metrics required to monitor the embedding of CQC Actions. Paediatric Emergency Department – workforce and environment	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 23	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings to track weekly progress against activity targets Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review Use of independent sector to increase inpatient, day case and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review Operational Management Group	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	Current controls updated Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.

BAF#3.5	To provide a high quality public health 0-19 service	There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors.	5	4	20	4	4	16	2x4=8	Apr-22	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing) Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work. Request made for support from wider Trust (needs to be nurses with experience of working with children and families) Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures Increased safeguarding activity referrals have continued into 2022 with an increase in workforce pressures. See CRR57 for activity information.		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

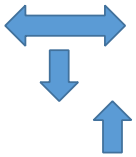
4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	May 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating					Internal	External				
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	4	16	2	4	8	2x4=8	Mar-22	None	Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT WYATT – creating financial framework to look at opportunities. The piece of work is being mirrored internally.	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation and the requirement to move to pre Covid levels of activity No new long-term productivity programme currently in place **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS Ongoing discussions with the ICS future allocation Site development group developing plan	Capital Oversight Group H2 efficiency programme	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place with efficiency programme.	**Internal:** No efficiency programme	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the capital is available but potential risks as no long term site development plan currently in place. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
BAF#4.3	To provide high quality care and to be a financially sustainable orgnisation	There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety	4	4	16	3	4	12	2x4=8	Apr-22	None	Digital Strategy Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme Working with digital aspirant programme to create strategic outline case for digital funding.	Capital Oversight Group Digital Strategy Group		Ongoing refresh of the Clinical Strategy and the Digital Strategy	Resource Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in control update. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	2	4	8	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities	Lack of system wide financial plan New financial allocations need to be agreed. Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Current risk rating updated to 8. Target risk met. Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. Full review of the BAF to take place in June 2022 for presentation at the July 2022 Board.

Risk Matrix

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost Certain
5. Extreme	5	10	15	20	25
4. Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Changes in Ratings



No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

1 Fully on plan across all actions
2 Actions defined - most progressing, where delays are occurring interventions are being taken
3 Actions defined - work started but behind plan
4 Actions defined - but largely behind plan
5 Actions not yet fully defined

Director of Strategy

Matters of concern & risks to escalate

Trust Strategy / Clinical Strategy
- Completion of Clinical Strategy will be delayed to align with management restructure and appointment of group tri-teams

Programme Governance & Delivery
- Environment, People programmes not yet fully established – programme management resources to support them needs to be identified
- Responsibilities for estates, capital etc need to be clarified

HNY ICS
- Role and relationships of HNY CAP need significant development

Major actions commissioned & work underway

Strategy Team
- Establishing team structures; reviewing priorities and workplans with teams

Trust Strategy / Clinical Strategy
- Trust Strategy on track to be launched in July
- Service clinical strategies reviewed; areas for further work identified.

Programme Governance & Delivery
- UEC and Elective projects captured. UEC projects prioritised by Programme Board; Elective projects to be prioritised on 18 May.
- 0-19 service profile, stakeholders and strategy for Board WG
- Capital, Environment (estates, equipment, green) and People governance
- Developing decision making principles to link to programme, operational and quality governance

Continuous Improvement
- Planning to develop and embed QI/continuous improvement further

Anchor Institution
- Armed Forces: developing approaches to identifying patients and staff in AF community; planning launch in Jun with AF Day
- Project SEARCH: internships from Sep 22, update to People & Culture

WY / WYAAT
- WYAAT clinical strategy re-started with fragile services (Haem, Neuro)

HNY / Harrogate Place
- CDC: Trust, primary care workshops on 6 & 13 July

Positive news & assurance

Trust Strategy / Clinical Strategy
- Final draft of Trust Strategy agreed by Directors' Team; wider engagement with staff, governors, external stakeholders underway. Attached as supporting paper for Board.

Programme Governance & Delivery
- Business Cases: Theatres Establishment BC approved by CEO & DOF

Anchor Institution
- Project SEARCH: intern recruitment event, interviews for tutor and job coach planned for May/June

HNY / Harrogate Place:
- DoS, MD, COO have very positive meeting with Harrogate primary care leads and agreed workstreams on: health inequalities and care sector.

Decisions made & decisions required

HDFT Strategy

Final Draft

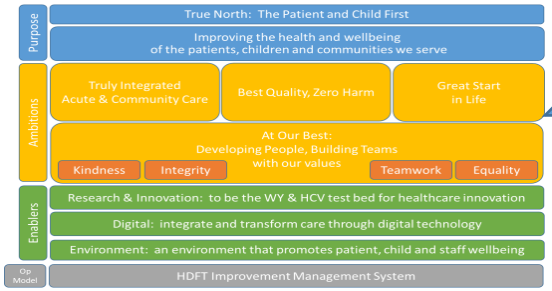
Background

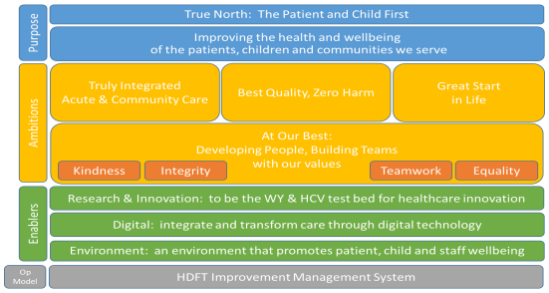
- Our Trust Strategy is based on the feedback about what is important to them from staff (through the Staff Strategy Survey and Clinical Strategy Workshops), patients and public (through the Public Survey), and stakeholders (from 40+ stakeholder interviews) – see slide 3
- Deployment of the Trust Strategy (slide 4) will be through:
  - 4 Core Strategies: Quality, Clinical Services, Children's, People & Culture
  - 3 Supporting Strategies: Research & Innovation, Digital, Environment
  - 4 Directorate + HIF Strategies: CC, LTUC, PSC, Corporate, HIF
  - Clinical Service Strategies
  - Corporate Service Strategies
  - Individual objectives and priorities
- Together these create the "Golden Thread" which mobilises and aligns all 5000 members of TeamHDFT to enable us to deliver our purpose
- Our Annual Plan will set "SMART" objectives for each ambition to define our improvement priorities for the year.
- The Clinical Service Strategies are being developed through the Clinical Strategy Workshops and subsequent work with service teams. Each service has completed a template which describes their future service model. These will form the chapters of a "book" which together will be the overall Trust Clinical Services Strategy. Each chapter will be based on the same framework as the Trust Strategy.

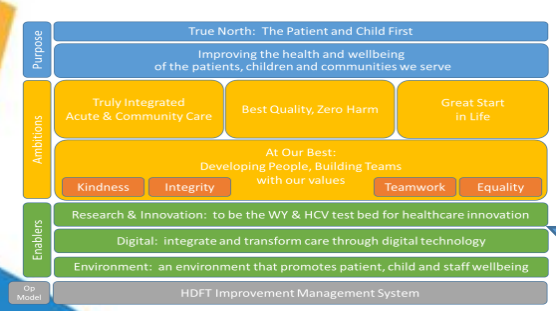
Key Feedback

- **Staff Survey**
  - **Purpose** (why we exist)**:** improve quality and outcomes of care; support NHS staff; increase health & wellbeing of population
  - **Objectives** (outcomes we need to achieve)**:** high quality care with good outcomes; a great place to work with focus on health and wellbeing; understanding and focusing of what is important to patients, families, communities; improving the health and wellbeing of our communities (reducing health inequalities)
  - **Capabilities** (what we need to be able to do): Great leadership and management at all levels; Efficient, effective processes and systems; Caring, professional and supportive culture (KITE); Understanding our patients and families, and their experience of our services; Education and training; Continuous learning and improvement
  - **Resources** (physical assets we need): Sufficient, skilled staff; Sufficient equipment and facilities; Digital technology to support service delivery;
- **Patient Survey Themes**: Communication (with patients); Staffing; Great care; Staff attitude; Support (for patients); Covid impact; Ideas for improvement – willing to try new ways of care being delivered (eg outpatients, support at home) if right approach used in the right situation for the right patient
- **Stakeholders:** Importance of a clear strategy (including rationale for 0-19 and acute services; partnerships with WY & HCV); service sustainability (partnerships; what we will do, partner, build, let others do for us); leadership & culture; workforce plan!; partnerships (focus on frailty, PH, wider health outcomes); integration across primary, secondary and tertiary care; digital to support clinical care; But maintain focus on quality and current delivery as well as strategy

Strategy Deployment







Aignment & Mobilisation

Trust Strategic Ambitions & Goals

Directorate Strategic Ambitions & Goals

Service/Team Strategic Ambitions & Goals

Trust Annual Plan, Priorities & Projects

Directorate Annual Plan, Priorities & Projects

Service/Team Annual Plan, Priorities & Continuous Improvement

Delivery & Improvement

Only 3-5 goals or priorities at each level at any time

Trust Strategy

NB Not final design or colours – published version will be professionally designed to match the TeamHDFT and KITE branding

Trust Strategy - Framework

Purpose

- The Patient and Child First
- Improving the health and wellbeing of our patients, children and communities

Ambitions

- Best Quality, Safest Care
- Person centred, integrated care; strong partnerships
- Great Start in Life
- At Our Best: Making HDFT the best place to work
  - Kindness
  - Integrity
  - Teamwork
  - Equality

- Our KITE Behaviours -

Enablers

- An environment that promotes wellbeing
- Digital transformation to integrate care and improve patient, child and staff experience
- Healthcare innovation to improve quality

Op Model

- HDFT Improvement Management System

Trust Strategy - Narratives

Purpose to People

Everything we do at HDFT is focussed on the patients and children we serve.

We exist to improve the health and wellbeing of our patients, children and communities by providing the best quality, safest services, person centred care through strong partnerships and by supporting children to have a great start in life.

Healthcare is provided by people for people. We want to be the best place to work: where great people feel part of brilliant teams, are supported physically and emotionally, can develop themselves and their career and where everyone demonstrates our values of kindness, integrity, teamwork and equality. An organisation with the right people with the right skills, in the right roles, to care for the patients and children, who are the focus of everything we do.

To support our people we will provide an environment that promotes patient and staff wellbeing, digital transformation will enable integrated care and improve patient and staff experience, and we will encourage innovation and research to improve quality.

People to Purpose

At HDFT we want to be the best place to work: where great people feel part of brilliant teams, are supported physically and emotionally, can develop themselves and their career and where everyone demonstrates our values of kindness, integrity, teamwork and equality. An organisation with the right people with the right skills, in the right roles, to care for the patients and children, who are the focus of everything we do.

Only with great people, working together in brilliant teams, can we give children a great start in life, can we provide person centred care through strong partnerships and can we deliver the best quality, safest services which will improve the health and wellbeing of our patients, children and communities.

To support our people we will provide an environment that promotes patient and staff wellbeing, digital transformation will enable integrated care and improve patient and staff experience, and we will encourage innovation and research to improve quality.

Best Quality, Safest Care

Best Quality, Safest Care

Ever safer care through continuous learning and improvement

Excellent outcomes through effective, best practice care

A positive experience for every patient by listening and acting on their feedback

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. Through continuous learning and improvement will we make our processes and systems ever safer – we will never stop seeking improvement. We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. Finally we want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to improve.

Caring at Our Best (Quality Programme)
SMART objectives agreed each year to improve towards our goals

Person centred, integrated care; strong partnerships

Person centred, integrated care; strong partnerships

The best place for person centred, integrated care

An exemplar system for the care of the elderly and frail

Equitable, timely access to best quality planned care

For Harrogate and District, our ambition is to support person centred care through strong partnerships between local health and care organisations, Our goal is for Harrogate to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail. By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

Planned Care Programme **Urgent & Emergency Care Programme**

SMART objectives agreed each year to improve towards our goals

Great Start in Life

Great Start in Life

The national leader for children and young people's public health services

Hopes for Healthcare: services which meet the needs of children and young people

High quality maternity services with the confidence of women

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life. We have the opportunity to lead development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the "Hopes for Healthcare" principles co-designed with our Youth Forum. Providing high quality, safe care and a great patient experience for mothers and their babies is the starting point for a Great Start in Life and, following recent revelations, rebuilding confidence of women is critical

Children & Young People's Programme
SMART objectives agreed each year to improve towards our goals

At Our Best – making HDFT the best place to work

An environment that promotes wellbeing

An environment that promotes wellbeing

A patient and staff environment that promotes wellbeing

An environment and equipment that promotes best quality, safest care

Minimise our impact on the environment

The environment in which we work and are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and high quality. As the largest employer in Harrogate and covering a huge geographic area across Northeast England we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport, food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 20XX?

Environment & Sustainability Programme
SMART objectives agreed each year to improve towards our goals

Digital Transformation to integrate care and improve patient, child and staff experience

Digital transformation to integrate care and improve patient, child and staff experience

Systems which enable staff to improve the quality and safety of care

Timely, accurate information to enable continuous learning and improvement

An electronic health record to enable effective collaboration across all care pathways

Digital technology is an essential part of delivering high quality healthcare but it is also important to remember that it is a tool, not an end in itself. Our ambition at HDFT is provide digital tools which make it easier for us to provide high quality, safe care and which help us provide person centred, integrated care that improves patient experience. Through digitisation we can also collect huge amounts of data about our services – we will improve our ability to create useful information which enables us to learn and improve our services. Finally over the next few years we intend to implement a new electronic health record which will revolutionise how we provide care.

Digital Programme

SMART objectives agreed each year to improve towards our goals

Healthcare Innovation to improve quality and safety

Healthcare innovation to improve quality and safety

To be a leading trust for the testing, adoption and spread of healthcare innovation

To be the leading trust for children's PH services research

To increase access for patients to clinical trials through growth and partnerships

As a DGH and the largest provider of children's PH services in England, HDFT has two key opportunities. First, to use our agility to become the first choice for testing healthcare innovations to improve care for patients. We will develop partnerships with industry, academia, government, the voluntary sector and our local system to offer a real world testbed for healthtech and digital innovations. Second, to use our size and expertise to be the leading NHS trust partner for research in children's public health services. Access to research and clinical trials improves quality and outcomes for patients so we will improve access for our patients through more clinical trials at HDFT and through partnerships with our NIHR Clinical Research Network

Innovation & Research Programme

SMART objectives agreed each year to improve towards our goals

Harrogate and District NHS Foundation Trust

4.2

Board of Directors held in Public
25th May 2022

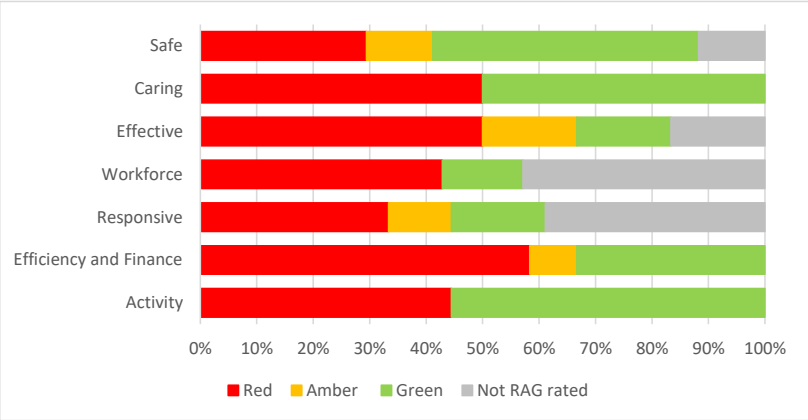
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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

Integrated Board Report - Summary of indicators - April 2022

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	5	2	8	2
Caring	4	2	0	2	0
Effective	6	3	1	1	1
Workforce	7	3	0	1	3
Responsive	36	12	4	6	14
Efficiency and Finance	12	7	1	4	0
Activity	9	4	0	5	0
Total	**91**	**36**	**8**	**27**	**20**



Integrated Board Report - Summary of Apr-22 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	1.21
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.11
Safe	1.3	Inpatient falls per 1,000 bed days	6.9
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	27.62
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	5
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	81.1%
Safe	1.8.2	Safer staffing levels - CHPPD	6.9
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	98.6%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	5.8%
Safe	1.12	Infant health - % women initiating breastfeeding	82.9%
Safe	1.13	VTE risk assessment - inpatients	96.1%
Safe	1.14.1	Sepsis screening - inpatient wards	88.6%
Safe	1.14.2	Sepsis screening - Emergency department	94.0%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	94.8%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	94.4%
Caring	2.2.1	Complaints - numbers received	20
Caring	2.2.2	Complaints - % responded to within time	71%
Effective	3.1	Mortality - HSMR	113.26
Effective	3.2	Mortality - SHMI	1.07
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	1.5%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	8.5%
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	30.9%
Workforce	4.1	Staff appraisal rate	56.9%
Workforce	4.2	Mandatory training rate	85.0%
Workforce	4.3	Staff sickness rate	5.90%
Workforce	4.4	Staff turnover rate	15.7%
Workforce	4.5	Children's Services - 0-19 Services - vacancies	74.94
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting across all posts	

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	10
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	44
Responsive	5.1.3	RTT Incomplete pathways - total	24714
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1176
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	11
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	66.0%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	93.4%
Responsive	5.6	A&E 4 hour standard	66.2%
Responsive	5.7	Ambulance handovers - % within 15 mins	90.3%
Responsive	5.8	A&E - number of 12 hour trolley waits	43
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	75.9%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	8
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	85.7%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	79.7%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	97.0%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	1531
Responsive	5.13.2	Children's Services - 2-3 years caseload	1701
Responsive	5.14	Children's Services - Safeguarding caseload	910
Responsive	5.15	Children's Services - Ante-natal visits	81.4%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.2%
Responsive	5.17	Children's Services - 6-8 week visit	92.3%
Responsive	5.18	Children's Services - 12 month review	89.6%
Responsive	5.19	Children's Services - 2.5 year review	92.2%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	1/2/3
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	30.8%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	97.2%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 654
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-£ 265
Efficiency and Finance	6.3	Capital spend	£ 1,900
Efficiency and Finance	6.4	Cash balance	£ 40,077
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	167
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	83
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	61.2
Efficiency and Finance	6.7.1	Length of stay - elective	2.25
Efficiency and Finance	6.7.2	Length of stay - non-elective	5.86
Efficiency and Finance	6.8	Avoidable admissions	227
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	79.8%
Efficiency and Finance	6.10	Day case conversion rate	1.8%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	99.2%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	109.9%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	82.3%
Activity	7.3.1	Elective activity against plan	122.7%
Activity	7.3.2	Elective activity against 2019/20 baseline	75.8%
Activity	7.4.1	Non-elective activity against plan	100.6%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	90.5%
Activity	7.5.1	Emergency Department attendances against plan	92.10%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	95.6%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.06	0.61	0.74	0.80	0.50	0.75	0.58	1.21	EN	Quality	>0		0
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.38	1.36	0.61	1.01	1.25	0.66	0.56	0.89	1.51	0.88	1.24	0.74	1.11	EN	Quality	>0		0
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.4	8.6	6.0	7.6	8.0	8.0	6.7	9.1	6.9	EN	Quality	above HDFT average for 2021/22 (7.0)	0-20% below HDFT average for 2021/22	20% below HDFT average for 2020/21
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	1	0	0	1	1	1	1	0	0	0	0	EN	Quality	>29 YTD (total cases)		<=29 YTD (total cases)
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	50.76	66.71	43.38	37.50	56.65	39.91	27.62	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	3	1	4	1	3	0	0	1	2	6	1	1	5	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	0	0	1	1	1	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	86.2%	89.6%	88.0%	81.2%	80.8%	81.5%	81.1%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	7.5	7.4	7.1	6.8	6.8	6.9	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	99.3%	95.7%	99.2%	100.0%	98.6%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC														EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	7.2%	4.6%	6.6%	5.6%	4.2%	5.8%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	88.2%	85.9%	83.5%	81.7%	86.2%	82.9%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	96.8%	96.3%	95.9%	95.7%	95.5%	96.1%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	89.8%	92.3%	89.3%	90.6%	87.7%	88.6%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	92.5%	92.9%	91.9%	94.6%	94.8%	94.0%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	92.7%	93.9%	94.7%	92.0%	91.8%	94.8%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	90.5%	95.4%	96.6%	98.7%	97.3%	94.4%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	31	19	13	9	18	11	14	22	20	EN	Quality	above HDFT average for 2021/22 (18)		On or below HDFT average for 2021/22 (18)
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	53%	53%	53%	55%	58%	71%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.45	95.61	91.58	95.56	98.45	99.68	102.34	105.86	108.72	113.26	113.15			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.964	0.978	0.988	1.008	1.021	1.047	1.066	1.062	1.073	1.077				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	1.6%	1.6%	1.8%	2.1%	1.6%	2.0%	1.5%	1.5%	1.5%	1.9%	1.5%		RN	Resources	> 3%	2% - 3%	<= 2%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	9.5%	8.2%	7.3%	8.2%	8.4%	7.9%	8.0%	7.4%	7.4%	8.9%	7.2%	8.5%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC														RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	7.4%	20.4%	20.8%	25.0%	12.0%	30.9%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	58.2%	59.8%	56.3%	63.0%	63.9%	56.9%	AW	People and Cultu	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	AW	People and Cultu	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	5.53%	5.42%	6.67%	5.74%	5.54%	5.90%	AW	People and Cultu	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	13.8%	13.7%	14.3%	14.8%	15.7%	15.7%	AW	People and Cultu	>15%		<=15%
Workforce	4.5	Children's Services - 0-19 Services - vacancies	CC			33.99	33.54	36.94	35.33	36.21	37.28	66.64	71.17	70.46	74.94		AW	People and Cultu	tbc		
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	All														AW	People and Cultu	tbc		
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting across all posts	All														AW	People and Cultu	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	9	10	10	10	9	10	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	41	42	43	43	43	44	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	22714	23464	23323	23900	23931	24714	RN	Resources	>15,000	14,000 - 15,000	<=14,000

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1196	1082	993	968	932	1008	1037	1063	1130	1086	1107	1118	1176	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	34	47	52	50	22	11	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All														RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All														RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All														RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	86.1%	82.4%	78.7%	81.9%	76.5%	66.0%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	All														RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	94.5%	92.8%	92.5%	92.9%	92.5%	93.4%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	76.0%	68.9%	71.5%	65.6%	61.9%	66.2%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	92.8%	91.8%	86.5%	87.6%	89.1%	92.8%	86.1%	89.2%	88.4%	92.9%	89.8%	87.2%	90.3%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	2	23	4	37	25	43	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	89.1%	81.8%	80.7%	84.8%	79.8%	83.2%	87.4%	75.9%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	LTUC	3	2	2	5	2	6	3	3	3	2	3	6	8	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.8%	88.2%	83.4%	86.0%	92.2%	83.8%	82.5%	87.3%	84.6%	92.5%	87.9%	85.7%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.7%	68.7%	70.3%	73.9%	73.4%	78.7%	77.0%	77.7%	74.7%	79.6%	80.8%	79.7%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.6%	99.1%	100.0%	97.5%	98.0%	98.1%	98.1%	97.0%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC	1457	1455	1459	1453	1545	1503	1876	1698	1871	1779	1642	1658	1531	RN	Resources	tbc		
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC	1625	1591	1496	1583	1476	1536	1662	1762	1784	1857	1708	1918	1701	RN	Resources	tbc		
Responsive	5.14	Children's Services - Safeguarding caseload	CC	951	1026	1118	1006	727	1002	992	947	986	992	980	1278	910	RN	Resources	tbc		
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	86.0%	80.1%	80.0%	75.3%	78.7%	75.9%	81.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.0%	92.6%	95.7%	95.6%	95.4%	93.5%	95.2%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.7%	89.7%	90.7%	91.4%	93.3%	93.4%	92.3%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.1%	93.8%	92.5%	92.8%	93.7%	90.9%	89.6%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	90.9%	91.7%	92.3%	91.5%	92.0%	91.7%	92.2%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC														RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC														RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC									2/3	2/3	1/2/3	2/3	1/2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC														RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	CC														RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC														RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC									3	3	3	3	3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	36.7%	35.5%	39.9%	38.6%	34.5%	40.6%	40.3%	38.5%	28.5%	39.1%	41.1%	32.5%	30.8%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	97.4%	90.5%	86.7%	83.3%	92.9%	94.4%	93.5%	97.2%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	£ 485	£ 745	£ 685	£ 630	£ 829	£ 654	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	-	-	-	-	-	-£ 265	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	£ 10,861	£ 11,503	£ 14,559	£ 17,301	£ 29,657	£ 1,900	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	£ 40,119	£ 46,027	£ 44,921	£ 44,615	£ 42,004	£ 40,077	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	151	152	162	177	162	167	RN	Resources	>90	70-90	<=70

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	67	65	71	86	79	83	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	50.8	53.9	50.7	55.3	56.4	52.8	60.5	58.4	61.6	61.8	57.8	63.7	61.2	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	2.35	2.78	3.17	2.24	2.43	2.25	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	5.26	5.76	5.37	5.80	5.39	5.86	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	263	228	206	240	267	229	222	200	227		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	81.0%	84.7%	81.3%	75.7%	78.0%	79.8%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	1.1%	1.7%	1.3%	1.9%	1.6%	1.8%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	95.4%	94.1%	113.1%	99.6%	101.1%	112.0%	97.1%	109.1%	111.5%	99.9%	109.7%	167.2%	99.2%	RN	Resources	<95%		>=95%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	103.2%	111.6%	111.3%	96.1%	103.1%	110.9%	109.9%	RN	Resources	<95%		>=95%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	80.1%	100.6%	95.9%	84.7%	93.8%	117.7%	82.3%	RN	Resources	<95%		>=95%
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.4%	104.1%	105.2%	95.8%	88.7%	101.6%	122.7%	RN	Resources	<95%		>=95%
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.9%	79.7%	84.9%	72.7%	73.3%	112.7%	75.8%	RN	Resources	<95%		>=95%
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.2%	87.1%	89.4%	84.3%	85.2%	105.5%	100.6%	RN	Resources	<95%		>=95%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.1%	84.1%	88.8%	84.7%	84.5%	119.1%	90.5%	RN	Resources	<95%		>=95%
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.5%	99.2%	91.9%	95.6%	94.4%	114.92%	92.1%	RN	Resources	<95%		>=95%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.5%	104.3%	96.6%	98.3%	97.6%	149.7%	95.6%	RN	Resources	<95%		>=95%

Integrated Board Report - April 2022

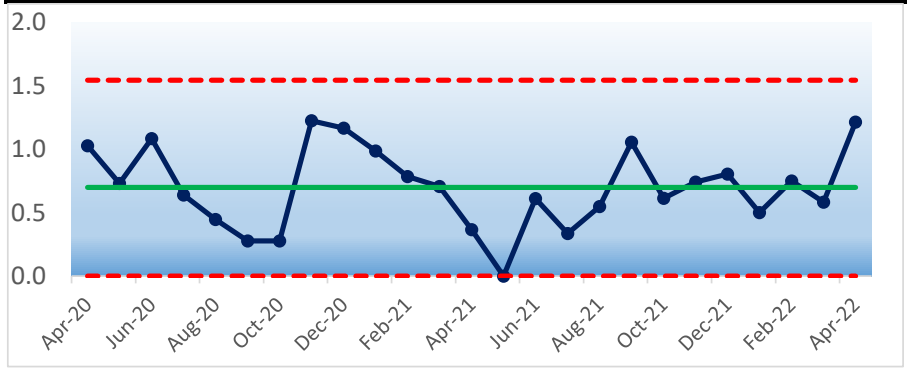
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	1.21

Indicator description

The number of hospital acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 bed days.

SPC chart



Narrative

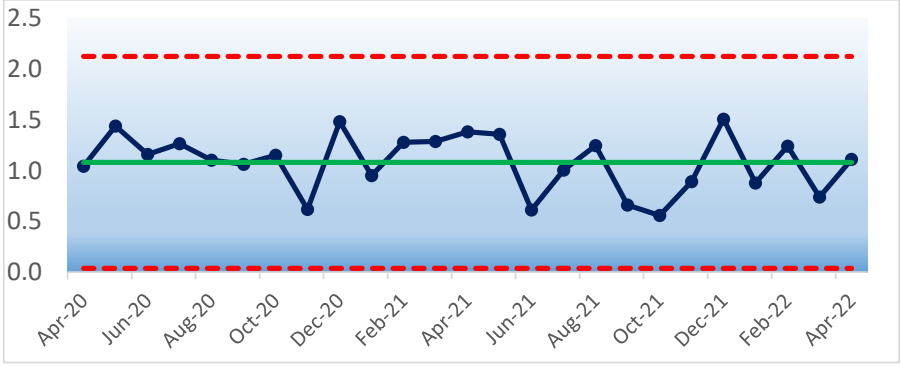
April has seen an increase in Pressure Ulcers, particularly on inpatient wards. The Tissue Viability Nurses have undertaken a recent audit to verify every Datix report to enable targeted support to those areas who require it, especially during time of staffing challenges or particularly vulnerable patients. Some of this work has led to re-categorisation of Moisture Associated Skin Damage (MASD) to a Pressure Ulcer. Also acuity of patients and longer lengths of stay in a hospital environment will have contributed to this increase. Further work is required to understand the proportion of patients who develop a pressure ulcer whilst awaiting onward care.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	1.11

Indicator description

The number of community acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 community patient contacts.

SPC chart



Narrative

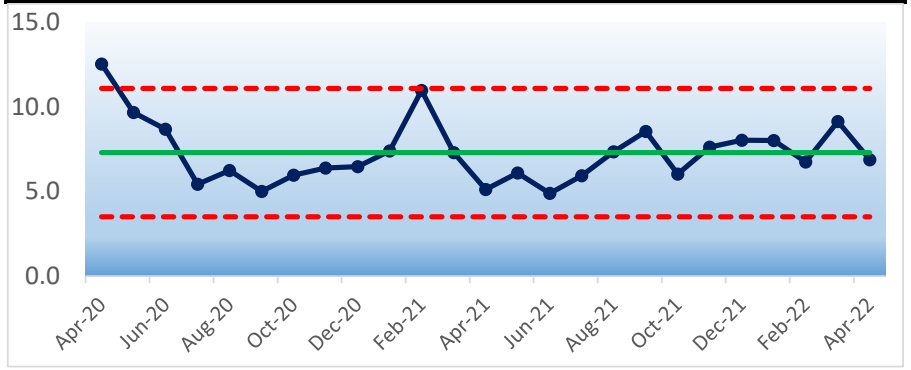
April has also seen an increase in Pressure Ulcers reported in the Community. Challenges in community services have mirrored those seen in acute care and most teams have been operating at OPEL level 3 throughout April.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	6.9

Indicator description

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

SPC chart



Narrative

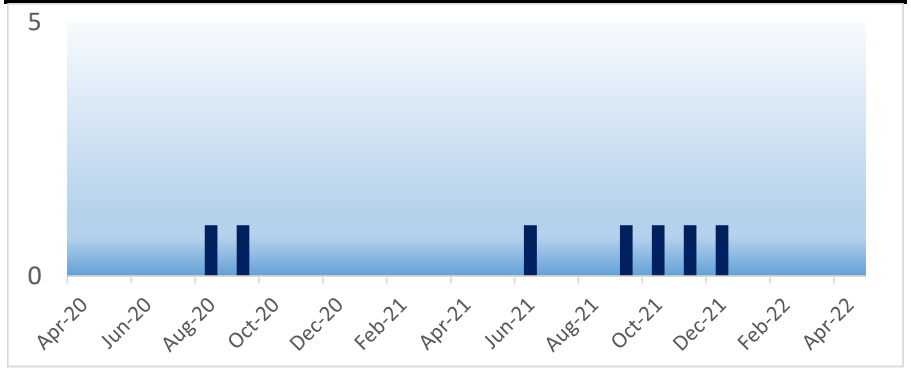
We have seen a slight decrease in inpatient falls throughout April. This may be due to a reduction in those inpatients who were identified as at risk of frequent falls. Despite this, there is an overall increase in the average and further work is required to understand the proportion of those patients who fall while awaiting onward care outside of the hospital setting.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT is awaiting confirmation of its C. difficile trajectory for 2022/23.

Trend chart



Narrative

There were 5 hospital acquired cases of C.difficile reported in April. The review meeting to confirm whether any of these cases would be deemed as due to a lapse in care has not yet taken place.

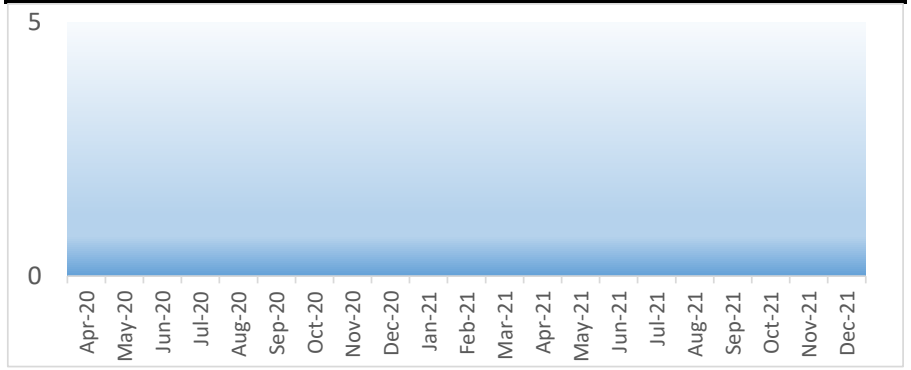
The Trust is also awaiting confirmation from NHS England of its C. difficile trajectory for 2022/23.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	0

Indicator description

The number of hospital acquired MRSA cases where root cause analysis has identified a lapse in care. HDFT's MRSA trajectory for 2021/22 is 0 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

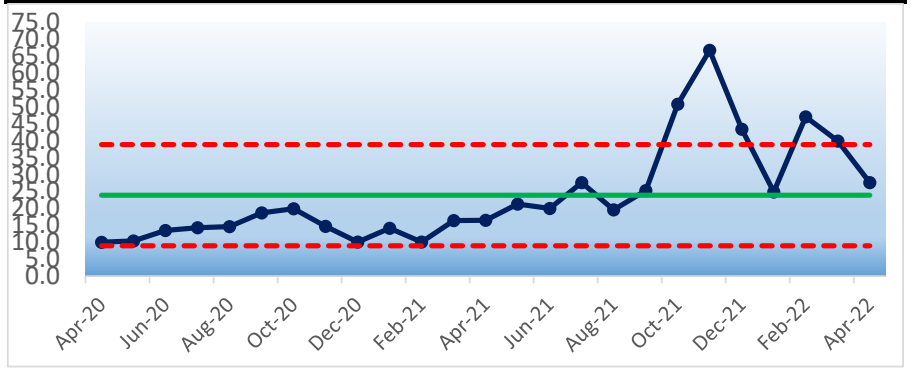
No hospital acquired MRSA cases where lapses in care identified for April.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	27.6

Indicator description

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

SPC chart



Narrative

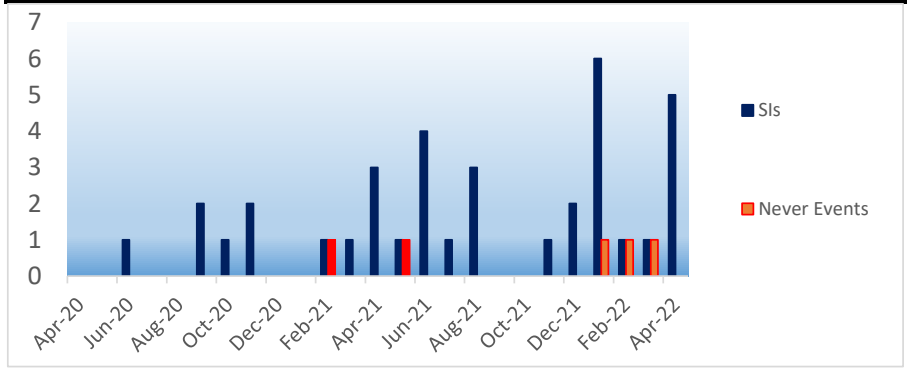
April saw a further dip on the previous month in the reporting of low harm incidents. Whilst the number of low harm incidents remains generally high, the Quality Summit has observed a dip in reporting across all three directorates over the last number of weeks. The reasons for this are unclear. This position will be closely monitored and staff continue to be reminded of the importance of reporting all low harm and no harm incidents

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	5 (SI), 0 (Never Events)

Indicator description

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

Trend chart



Narrative

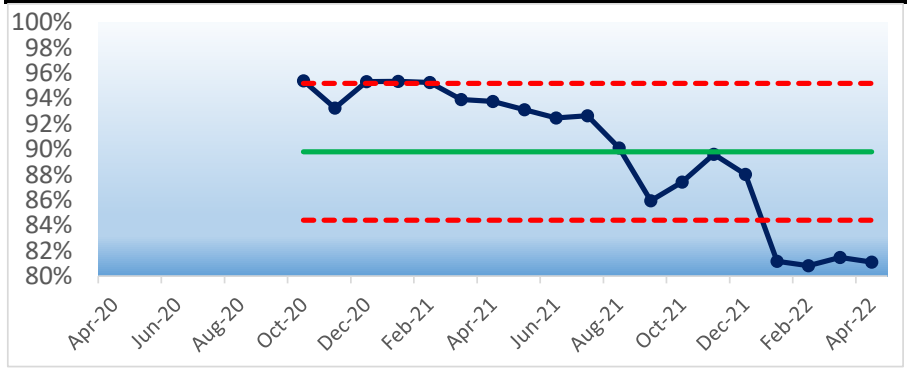
In April 2022, 5 Comprehensive Serious Incidents were declared.
All incidents have been appropriately reported onto STEIS, Duty of candour has been provided and the investigations have all commenced.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	81.1%

Indicator description

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

SPC chart



Narrative

April data presented identifies that fill rates have plateaued. Covid absences have remained high until early May. Teams continue to work hard to onboard the pipeline of CSW's through recruitment and to fill registered nurse vacancies.

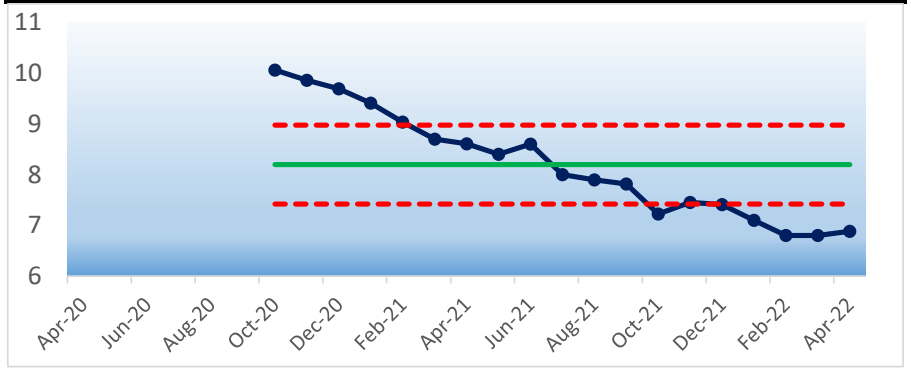
Incentive payments have been extended to the end of June with a new internal process in place for reviewing the need for future incentive payments.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	6.9

Indicator description

The chart shows the care hours per patient per day (CHPPPD). This is caclulated by comparing the total hours worked by reigstered and unregistered nurses and midwives and comparing these to the number of patients on the wards during the month.

SPC chart



Narrative

CHPPPD has also plateaued over the last few months in line with fill rates. Continued need to staff escalation beds with no additional workforce in addition to continued COVID staff sickness and existing staff vacancies. As escalation beds close and we successfully recruit to vacancies, we expect to see a rise in CHPPPD.

The second SNCT report will align the CHPPPD with the acuity and dependency to assist in decision making for setting establishments and skill mix reviews.

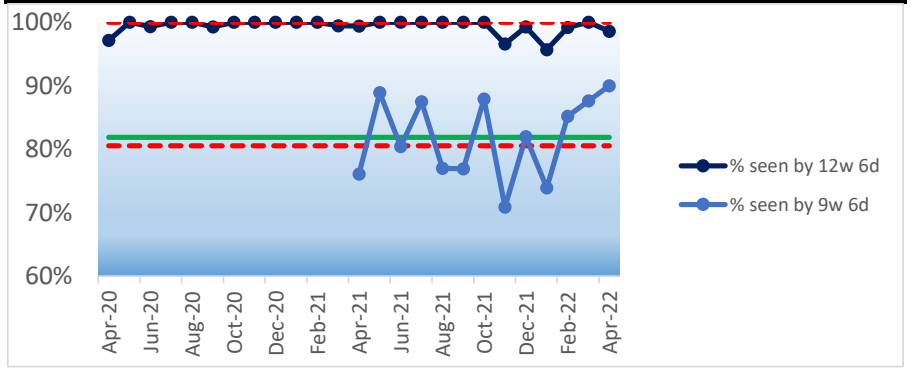
We are currrently undertaking analysis against peers in relation to CHPPPD.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	98.6%

Indicator description

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

SPC chart



Narrative

Performance against this standard remains high

Indicator	**1.10 - Maternity - % women with Continuity of Care pathway**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

We continue to submit 0% compliance with this model, as we are providing continuity during the antenatal and postnatal periods but not intrapartum care to women. This is due to reduced midwifery staffing levels and the need to maintain safe staffing levels across the unit.

Following the publication of the Ockenden Report, further consideration is being given to the safest way to progress the planned implementation of one integrated team which was discussed in the April Board Workshop. The Board approved plan remains in place for this transformation and the Trust received a national visit on 12th May to support ongoing peer review of plans.

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	5.8%

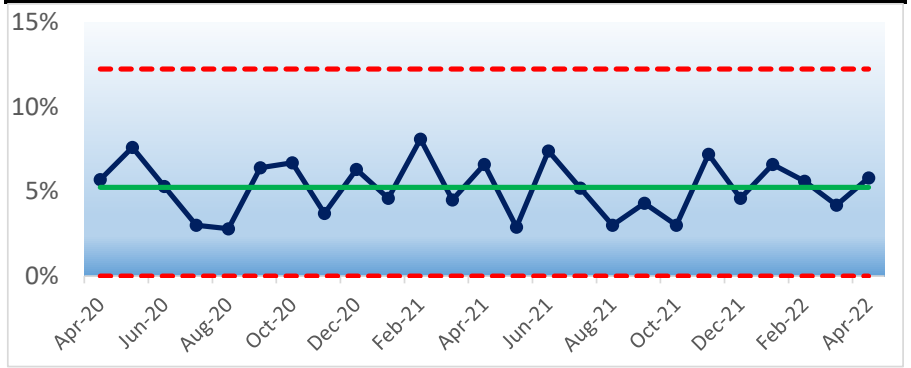
Indicator description

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

Narrative

The Trust continues to have a low rate of women smoking at the time of delivery which is positive.

SPC chart



Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	82.9%

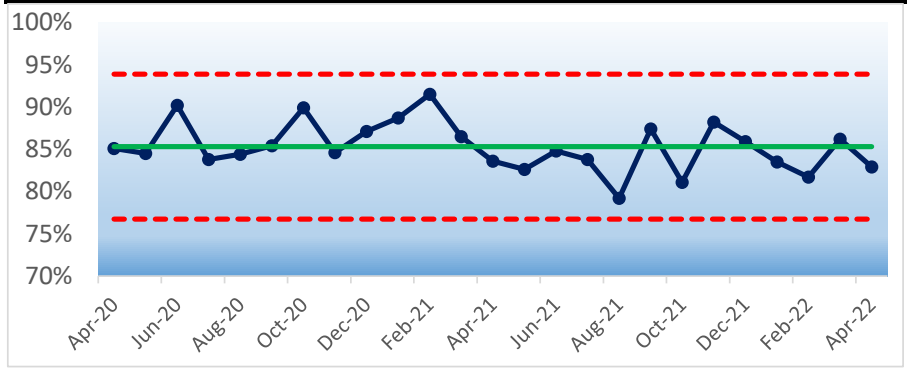
Indicator description

The % of women initiating breastfeeding

Narrative

April saw a slightly decline in number of women initiating breastfeeding, however overall rates remain high.

SPC chart

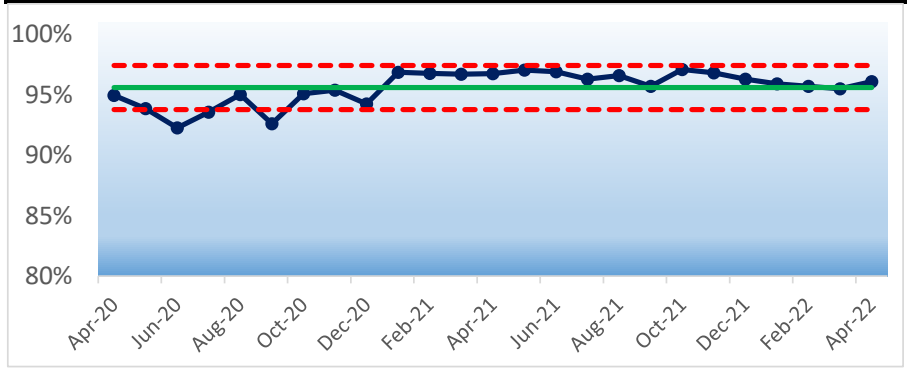


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	96.1%

Indicator description

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

SPC chart



Narrative

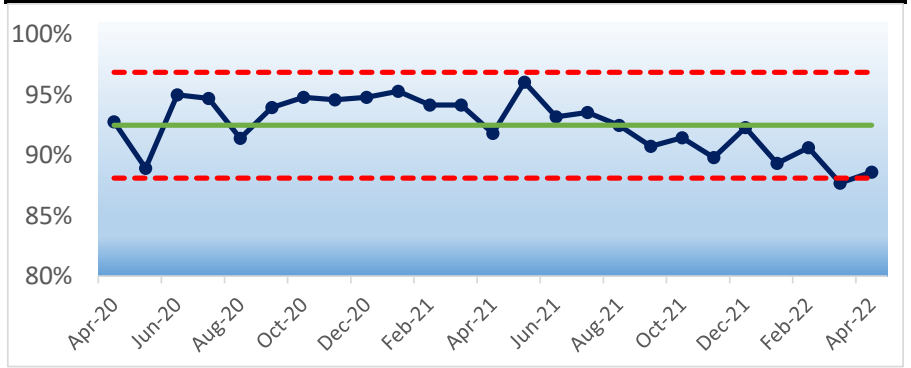
Monitoring of VTE risk assessment compliance is now within the Matron assurance processes. We are currently above the 95% standard however the priority on this indicator remains high.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	88.6%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

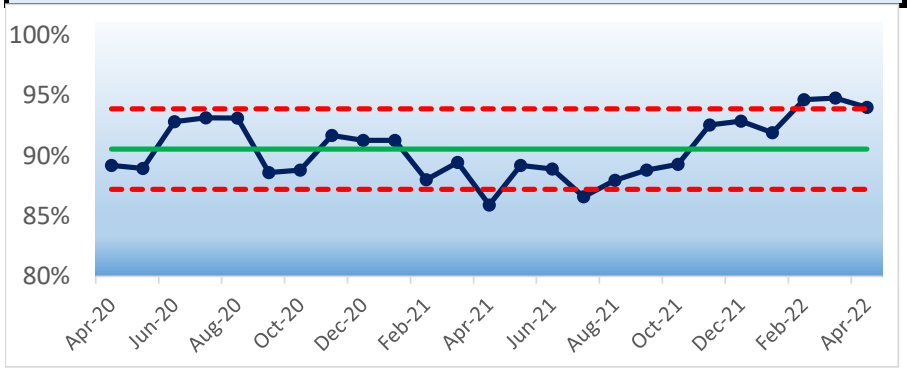
Compliance with this standard has slightly improved for April, however there is still further work to do. We have identified an issue with the alerting mechanism via ASCOMs which we are currently working to resolve to improve compliance further.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	94.0%

Indicator description

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

SPC chart



Narrative

Performance on ED screening has dipped in April, however remained at 94% despite some of the operational challenges.

Integrated Board Report - April 2022

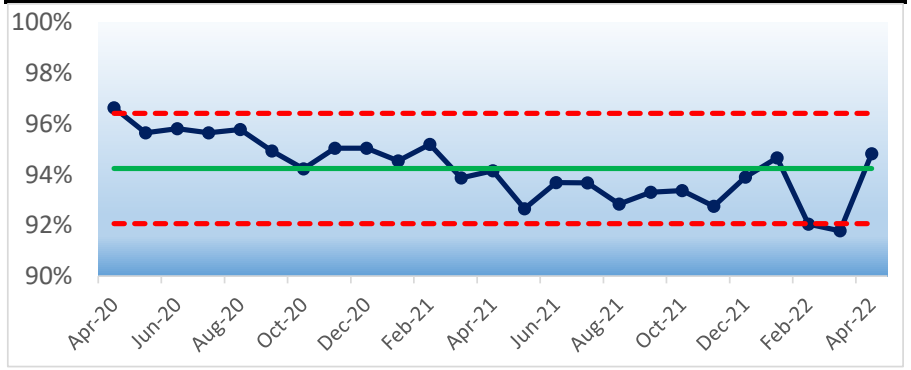
Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	94.8%

Indicator description

The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment.

SPC chart



Narrative

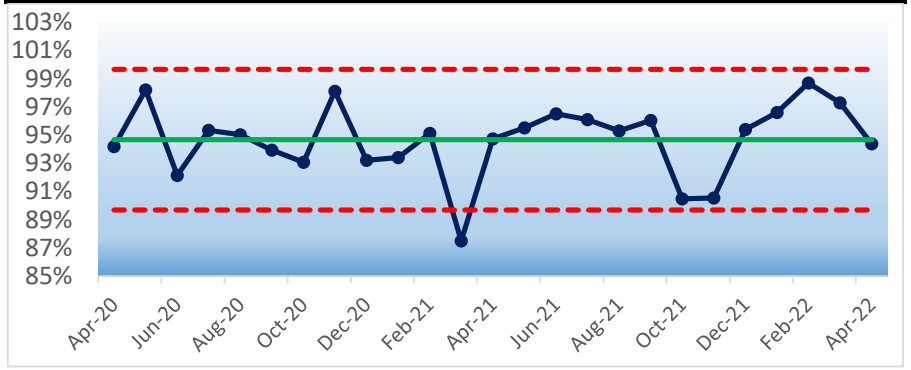
April saw an improved position in relation to this indicator. Ongoing work to triangulate via Making Experiences Count forum continues.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	94.4%

Indicator description

The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment.

SPC chart



Narrative

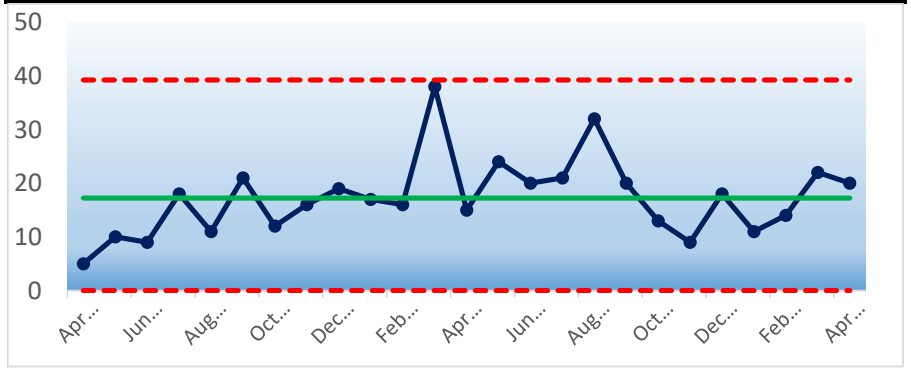
Performance in April reduced but remained above 94% despite some of the operational challenges of the services.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	20

Indicator description

The number of complaints received by the Trust, shown by month of receipt of complaint. The data includes complaints relating to both hospital and community services.

SPC chart



Narrative

In total, there were 22 complaints recorded in April 2022 (3 multi-agency). For the 17 non-multi-agency, there were 4 in Community and Children's, 5 in Long Term and Unscheduled Care, 7 in Planned and Surgical Care and 1 in HIF.

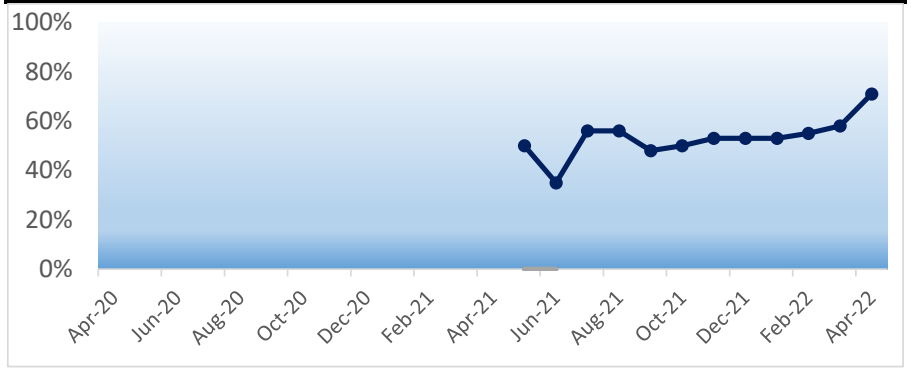
The main reason for complaints during April 2022 by sub-subject, was delay or failure to diagnose (inc missed fracture) (18% of all complaints), communication with patient (14% of all complaints) and delay or failure in treatment or procedure (9% of all complaints).

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-22
Value / RAG rating	71%

Indicator description

The number of complaints responded to within 25 days, shown as the year to date position. The Trust's improvement trajectory for 2021/22 is to respond to 95% of non-multi-agency complaints on time by December 2021.

Trend chart



Narrative

The number of complaints responded to within the 25 day standard in April was 71%.

The aspiration to deliver the 95% agreed standard sustainably is still a primary focus for the organisation. Despite the excellent performance in February (100%), there are elements of the complaints pathway that still require further refinement to ensure consistent delivery of the 95% standard moving forwards.

It is pleasing to note that the quality of complaint responses is much improved in recent months, with the majority of complaints achieving Chief Executive sign off the first time that they are presented.

Integrated Board Report - April 2022

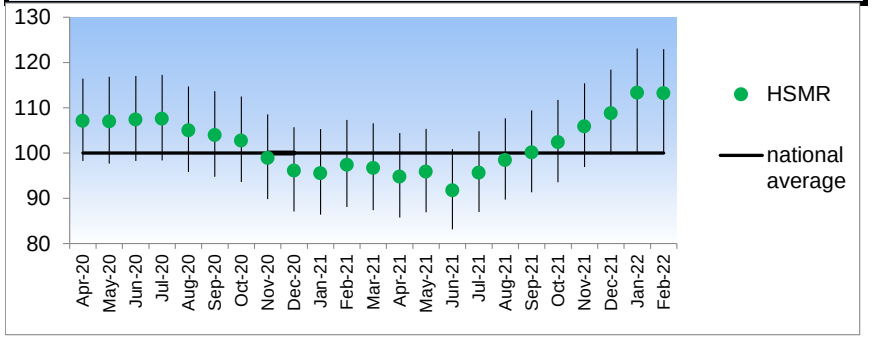
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	113.15

Indicator description

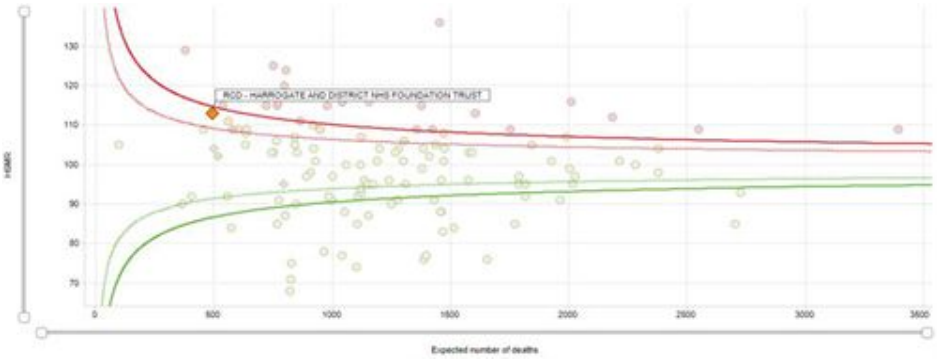
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains above the expected range but there has been a slight reduction on last month. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts. The HDFT Mortality Review Group have commenced a deep dive into the rise in our mortality indicators commencing with a review of our coding policy, processes and training and any impact the introduction of the Medical Examiner (ME) system may have had on clinical coding. Mortality indicators are triangulated with ME scrutiny and Structured Judgement Reviews, national mortality alerts, incidents, complaints and claims and no concerns have been identified via these additional indicators.



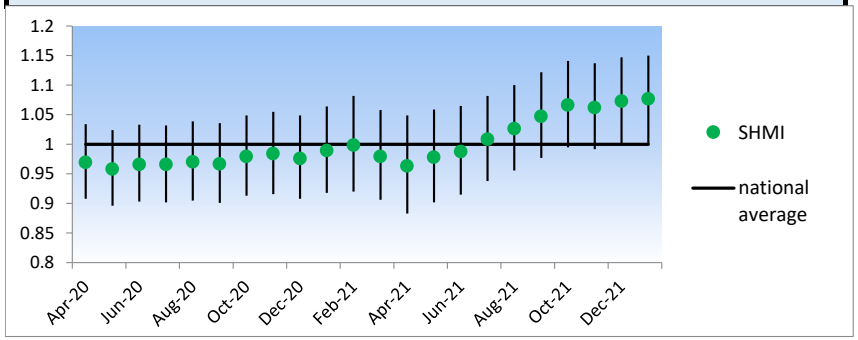
4.2

Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jan-22
Value / RAG rating	1.08

Indicator description

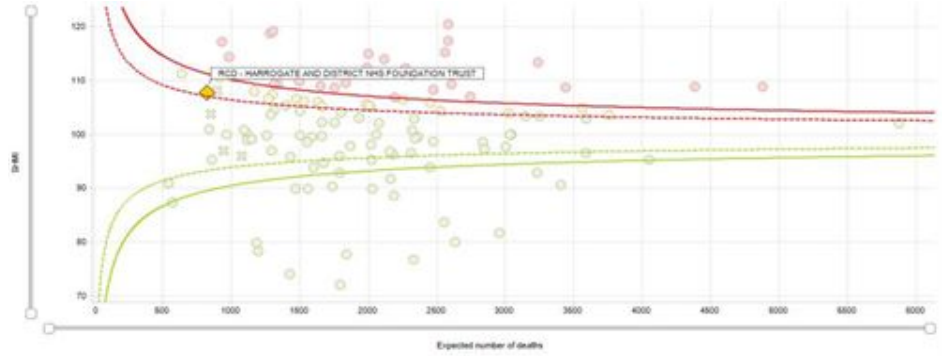
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

National average is 1. HDFT remains above the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts. The HDFT Mortality Review Group have commenced a deep dive into the rise in our mortality indicators commencing with a review of our coding policy, processes and training and any impact the introduction of the Medical Examiner (ME) system may have had on clinical coding. Mortality indicators are triangulated with ME scrutiny and Structured Judgement Reviews, national mortality alerts, incidents, complaints and claims and no concerns have been identified via these additional indicators.

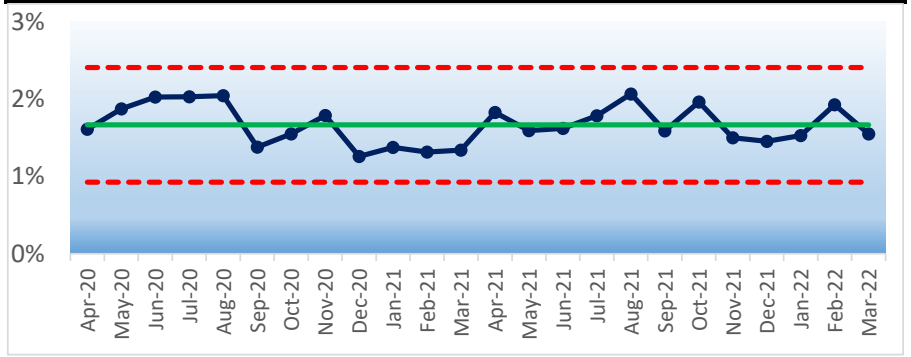


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-22
Value / RAG rating	1.5%

Indicator description

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

SPC chart



Narrative

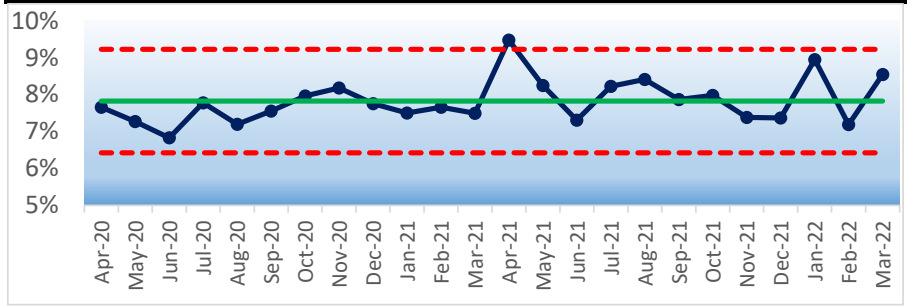
Readmissions following an elective admission increased to 1.5% in March and remain within control limits and less than national average.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-22
Value / RAG rating	8.5%

Indicator description

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

SPC chart



Narrative

Readmissions following a non-elective admission increased to 8.5% in March but remain within the control limits so not a cause for concern.

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

Indicator description
This indicator is under development.

SPC chart

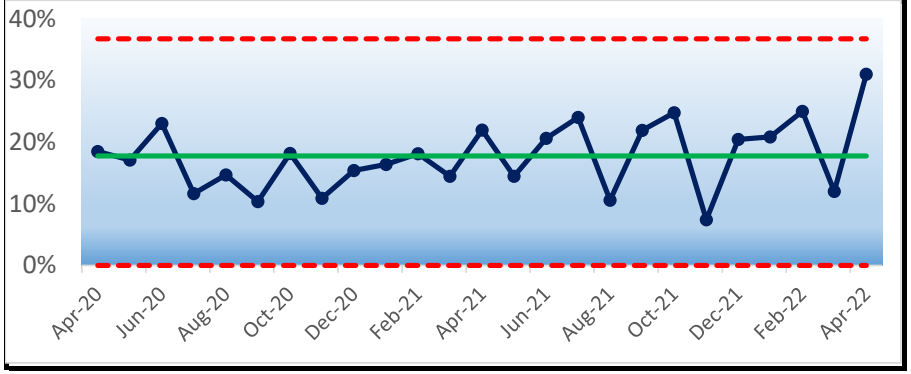
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	31.0%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep. This is a snapshot position as reported on the last Thursday of the month.

SPC chart



Narrative

Delayed transfer of care increased in April to 31%. The Trust have now purchased a system using funding from NHSE that will allow the ward teams to electronically capture the criteria to reside of every patient. Roll out and training commenced in March 2022.

This will enable real time viewing of delayed patients, however the major blockage with hospital outflow currently is the social care crisis. 66% of MFFD (medically fit for discharge) patients are waiting for PoC or Care home placements. The reduction reflects higher acuity of patients thus more meeting criteria to reside rather than a significant change in 'delays'. This reflects the 50-60 patients consistently awaiting PoC , residential or nursing home placement. (COVID impacting providers of these).

Trust Board Report May 2022

Report: Executive Director of Nursing, Midwifery and AHPs

Author: Emma Nunez

NHS Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Staffing Fill Rates have plateaued in April as Covid related absences remained high into early May. Care Hours Per Patient Day also plateaued in line with the fill rates and increased bed occupancy/open escalation beds.
- Pressure Ulcers – (*IBR 1.1 & 1.2*) have seen an increase across inpatient and community services. Correlates with reduced fill rates and CHPPD for inpatient areas, but also follows a validation audit by Tissue Viability Nurses on inpatient areas where a number of moisture associate skin damage (MASD) reports were re-categorised as pressure ulcers. High acuity and dependency of patients continues and longer lengths of stay for those patients awaiting packages of care increases the risk of harm.

Major actions commissioned & work underway

- Further detailed analysis of Pressure Ulcer and Falls incidents to understand the impact on those patients with longer length of stay

Positive news & assurance

- Completion of second SNCT data collection, report included in Board Papers
- Expressions of interest received for Patient Safety Investigators and Team Leaders – training commences at the end of May
- Interim Health and Safety Manager appointed and commenced substantive recruitment to Health and Safety Team.
- First Serious Incident Committee took place in early May
- Peer Review Well Led Assurance programme initial evaluation positive

Decisions made & decisions required of Board

Ockenden

Emma Nunez – Executive Director of Nursing, Midwifery and AHPs

Danielle Bhanvra – Acting Head of Midwifery

April 2022

Final Report published 30th March 2022

- Secretary of State for Health asked Donna Ockenden to review Maternity Services at Shrewsbury and Telford NHS Trust

- She and her team reviewed 1,592 clinical incidents involving 1,486 families. The majority of these incidents were between 2000 and 2019
- In addition to actions from the interim report, the final report proposes:
  - Over 60 Local Actions for Learning for the Trust
  - 15 areas for national action (with 90+ individual points)
  - Three asks of the Secretary of State

- Implications beyond Maternity services relating to governance, learning from incidents, culture, complaints, listening to patients and Freedom to Speak Up

NHSE/I Response

- NHSE have accepted the report in full
- Letter of 1st April asked Trusts to:
  - Consider the report at our next public Board looking at all 4 key pillars
  - Provide feedback on themes from discussion via your regional maternity lead by the end of May
  - Share the report with all staff
  - FTSU: ensure training, regular listening events and schedule a maternity and neonatal listening event in the coming months
  - Provide health and wellbeing support to all staff but especially maternity and neonatal staff
  - Provide local support and information to women to ensure they can make safe personalised choices about their care
  - Review the detailed paragraph in the letter sent about Continuity of Carer and ensure any decisions are appropriately managed at Board level
  - Report progress on 7 IEAs from the first report – these will be published in the May Board paper
  - Ensure Trusts provide accurate returns to the regular provider workforce return

Continuity of Carer – IEA 2, Safe Staffing page 164

- All Trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain
- The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction

MCoC Decision Making

Response:

- In line with the maternity transformation programme trusts have already been asked to submit plans by 15th June. Therefore immediate assessment of staffing position and make one of the following decisions:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision

Areas requiring further scrutiny

- Band 5 – 'All NQMs must remain within the hospital setting for a minimum period of one year post qualification…opportunity to develop essential skills…and provide structured period of transition from student to accountable midwife'
- HDU – All Trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.
- Local Maternity Systems, Maternal Medicine Networks and Trusts must ensure that women have access to pre-conception care. Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have
- Education – all Trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings

Ockenden Immediate and Essential Actions final report

Danielle Bhanvra – Acting Head of Midwifery

April 2022

Background

The final report from the Ockenden review of maternity service at Shrewsbury and Telford Hospital NHS Trust (SaTH) was published on the 30th March 2022

This follows the first report from the inquiry that was published in December 2020, which outlined a set of local actions for learning as well as immediate and essential actions (IEAs) to improve the quality of care and patient safety across maternity services nationally

This second and final report identifies several new themes to be shared across all maternity services in England with a further 15 immediate and essential actions

Current workforce

Current workforce

Midwives	A	B	C	D	E
Bands	Funded establishment	Staff in post (WTE) includes staff awaiting start date column C	Staff recruited awaiting start date (WTE)	Vacancies out to advert (WTE)	CofC additional requirements
Band 8	2.00	1.00	0	1	
Band 7	17.10	15.12	0	1.98	
Band 6	46.07	42.96	4.80	3.11	8.31
Band 5	9.00	7.62	1.60	1.38	
Band 3	8.00	6.25	0	1.75	
Band 2	10.24	7.40	0	2.84	
Clinical midwifery vacancies				6.47 (band 5-7)	14.78 (band 5-7)Includes current vacancies

Ockenden recommendations		
Quality & Safety midwife	Patient safety specialist	Currently have band 7 risk midwife
Governance lead		Currently have band 7 risk midwife
Consultant midwife	Guidelines, audit, research	Currently have band 7 risk midwife
Midwife	Fetal monitoring lead 0.4 WTE	In post
Midwife	HDU trained	Women currently transferred to HDU , basic HDU care provided on delivery suite
Midwife	Supernumerary clinical educators	Retention lead and professional development midwife both supernumerary
Obs & Gynae consultant	SI lead	Awaiting agreed PA's
Obs & Gynae consultant	Governance lead	Awaiting agreed PA's
Obs & Gynae consultant	Fetal monitoring lead	Awaiting agreed PA's

1:Workforce Planning and Sustainability

1. Essential action – financing a safe maternity workforce
2. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented

Strengths	Weaknesses
• Funding in place for additional 5 midwives • Funding for additional obstetric PA's • HDFT uplift in place • LMNS agreed preceptorship programme in place • Birthrate plus acuity tool completed , ongoing recruitment • AIMS training for senior midwives to recognise the seriously unwell	• Require LMNS agreement of minimum staffing levels • Currently have one NQM working in an integrated community /hospital model • No dedicated leadership training in place for coordinators • Currently no coordinator specific orientation plan • HDFT uplift not reviewed 3 yearly • No recognised training for HDU
Opportunities	**Threats (RISK)**
• Gap analysis required of all leadership and management roles • Obstetric workforce planning – need dedicated SI , governance and fetal monitoring lead • Development of maternal medicine centres	• Lack of midwives to recruit to additional funding • No current increase in student places

2: Safe Staffing

Essential action

1. All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

Strengths	Weaknesses
• Currently staffing is escalated through bed meetings and LMS daily sitrep • Staffing concerns escalated through Datix, board reports, monitored by safety champions • Current escalation policy in place based on OPEL ratings • Labour ward coordinator specific JD in place • Both clinical retention lead and professional development midwife both have supernumerary status	• Medical staffing guideline – further work required to review staffing for elective sections, review for risk assessment for weekend inductions • Insufficient time for medical staff for training • No dedicated mentoship for band 7/8
Opportunities	**Threats (RISK)**
• With HR support to review labour ward coordinator JD • Discussion to be had with Jo Parker (general manager) 2 training days to be built into job plans • Improvement to communication pathways between community and acute settings • Review RCOG guidance on management of locums and discuss requirements with agencies	• Insufficient safe staffing levels to currently implement MCoC

3: Escalation and Accountability

Essential action

Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.

Strengths	Weaknesses
• Embedded use of communication tools, escalation and 'stop the line' within emergency PROMPT training • Fresh eyes approach to fetal monitoring with pathways for escalation in case of disagreement • Current agreement of levels of required competency for working without direct consultant presence • Escalation policy includes guidance for mandatory requirement of consultant • Consultant residence increase from 1st April to 08:00-20:30 as part of obstetric job planning • Clear escalation policy in place for increased activity, includes on-call CSM and consultant	• No midwifery manager on-call
Opportunities	**Threats**
• For formal inclusion of conflict management in guideline • For review and update of obstetric induction checklists	

4: Clinical Governance –Leadership

Essential action

1. Trust boards must have oversight of the quality and performance of their maternity services.
2. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems

Strengths	Weaknesses
• Regular progress, exception reports and assurance reviewed reported to Board through Strengthening board report • Risk Management Midwife currently filling role as patient safety specialist within unit • Risk Management Midwife has had internal human factors training through PROMPT. Professional Development Midwife has received external training and leads Human Factors group • Obstetric lead for audit in place • Clinical Audit and Effectiveness Advisor in post	• National Materntiy Self-Assessment Tool not completed • No dedicated Patient Safety Specialist role dedicated to Maternity within trust • No dedicated Obstetric Governance Lead • No consultant midwife, risk manager oversees guidelines with input from clinicians, ratified through MRMG • No midwifery lead for audit. • Additional governance roles required • Requirement for additional RCA and family engagement training
Opportunities	**Threats**
• To undertake Maternity Self-Assessment using tool • Dedicated Safety Specialist requested through 2022/23 Workforce Plan • Obstetric Governance Lead to be recruited and appropriately job-planned • Plan for additional Obstetric co-lead for guidelines and audit as part of 2022/23 Workforce Plan	

5: Clinical Governance – Incident Investigation

Essential action

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner

Strengths	Weaknesses
• Use of appropriate language in investigation reports already in place • Lessons from clinical incidents inform subsequent TNA • Learning from incidents shared directly with staff groups through feedback, learning boards, newsletters • All Sis have audit plan associated with action plan • All HSIB cases meeting criteria are referred and managed as SI. • SI policy in place • Complaints discussed within MRMG, and PSC Quality Huddle/Summit	• Maternity aim for change in practice within 6 month and as soon as practicable, however not always achieved • Limited definition of SI criteria • Processes and timescales for complaints set by CCG. MVP not currently involved. • Lack of clear SI criteria and decision-making process requires improvement
Opportunities	**Threats**
• For review of SI policy and clarifications to maternity governance pathways • Existing plan for triangulation of maternity complaint themes and trends as Patient Experience report	

6: Learning From Maternal Deaths

Essential action

1. Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.

2. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.

Strengths	Weaknesses
• Current processes in place for working with Coroner in accordance with national requirements • Maternal deaths reported to MBRRACE and HSIB • Joint review panel in place • Maternal death guideline in place • HSIB findings discussed at LMS SI Panel, and learning disseminated through LMS Safety Forum	• No Trust-wide process for notification of maternal deaths up to 1 year occurring elsewhere in the Trust • Lack of clarity about process for maternal deaths occurring elsewhere in the trust so learning may not be effectively shared
Opportunities	**Threats**

7: Multidisciplinary Training

Essential action

1. Staff who work together must train together
2. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.
3. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training

Strengths	Weaknesses
• MDT attend PROMPT training • All staff have allocated time for joint training • Use of communication handover tools included within PROMPT and embedded within practice • Human factors training included within PROMPT	• Not all staff groups represented governance and audit groups • Staffing pressures leading to issues in attendance at multidisciplinary training, and requires job planning • No agreed human factors content in the LMS
Opportunities	**Threats**
• Facilitate increased attendance of all staff groups at governance and audit events • For increased work on civility training and safety culture	

8: Complex Antenatal Care

Essential action

1. Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.

2. Trusts must provide services for women with multiple pregnancy in line with national guidance

Strengths	Weaknesses
• Specialist clinics in place to accommodate women with multifetal pregnancies • Diabetic women are provided with documented evidence based advice • All women seen in a specialist hypertension clinic and seen by the consultant, Aspirin prescribed	• No current provision for preconception care for women with complex medical disorders , with a specialist familier in managing the disorder • Diabetic guidance update
Opportunities	**Threats**
• Training of dedicated midwifery staffing to support specialist clinics	

9: Preterm Birth

Essential action

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.

Trusts must implement NHS Saving Babies Lives Version 2 (2019)

Strengths	Weaknesses
• All women and partners receive expert advice regarding fetal monitoring dependent on gestation and what mode of delivery by the consultant • All in utero transfers are reviewed through the MDT professional advisory panel	• Current discussion between local and tertiary neonatal teams take place however not in current guidelines and does not include the family
Opportunities	**Threats**
• In practice women are counselled when at risk of very preterm birth – needs to be added to the guidelines	

10: Labour and Birth

Essential action

1. Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.

2. Centralised CTG monitoring systems should be mandatory in obstetric units

Strengths	Weaknesses
• Pathways in place for induction of labour	• Currently no centralised CTG monitoring available – awaiting EPR • No current written information provided to women who choose to birth outside of guidance , including transfers into the unit – needs to be developed with YAS • No current pathway for delayed induction of labour – needs an SOP
Opportunities	**Threats**
• All women undergo a full clinical assessment when presenting in early labour as part of the admission records – needs to be added to guidance – potential audit	

11: Obstetric Anaesthesia

Essential action

1. In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.
2. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.
3. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

Strengths	Weaknesses
• Women are followed up as inpatients if complications of anaesthesia are recognised • Anaesthetists currently are involved with relevant debriefs for inpatients • Operational policy gives 5 dedicated consultant sessions with experience SAS covering on call and out of hours • Anaesthetic team attend governance and audit meetings, PROMPT, AIMS and joint governance leads • MDT ward rounds attended twice daily • All anaesthetists covering obstetrics maintain competencies through ad-hoc perspective cover and appraisals	• No formal pathway to follow up complications of anaesthesia once discharged
Opportunities	**Threats (Risk)**
	• No documentation audit process in place • National action required for resources to be made available to determine the contents of a core dataset and what constitutes a satisfactory anaesthetic record

12:Postnatal Care

Essential action

1. Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.
2. Postnatal wards must be adequately staffed at all times

Strengths	Weaknesses
• All postnatal readmissions are reviewed by the consultant on call , this includes women in a non maternity setting • Women are all seen within 14 hours of readmission – consultants review all women on twice daily ward rounds	• Post natal readmissions need to be added to the guideline • Funding in post to have appropriate staffing levels on the postnatal ward 24/7 – unable to fully recuit into vacancies
Opportunities	**Threats**

13: Bereavement Care

Essential action

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services

Strengths	Weaknesses
• Currently have 0.4WTE bereavement midwife in post • Coordinators and core midwives are trained to provide bereavement care • Bereavement midwife, consultants and SAS doctors trained to take post-mortem consent • All families referred to bereavement midwife initially and offered a consultant appointment at 6 or 12 weeks • National Bereavement Care Pathway in place	• Women can be supported in hospital setting 24/7 , community support available 7 days per week
Opportunities	**Threats**
• Training opportunity for coordinators in post-mortem consent	

14: Neonatal care

Essential action

1. There must be clear pathways of care for provision of neonatal care.
2. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

Strengths	Weaknesses
• Currently level 1 unit with agreed pathways • Exception report is completed as per requirements for all babies that step off pathway • Guidance to support at least 85% of births less than 27 weeks take place in a unit with NICU • Consultant available by telephone if not present for real – time dialogue during resusication	• Previous rotation of nurses to Bradford to enable the sharing of best practice – stopped since Covid and only for nurses and not medical staff • Awaiting information from consultant to establish process for early consideration for increasing inflation breaths
Opportunities	**Threats (RISK)**
	• A decision is required by the network on what measures are in place to prevent units from working in isolation

15: Supporting Families

Essential action

1. Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision

2. Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care

Strengths	Weaknesses
• Currently have weekly debrief clinics and referrals IAPT	• Pathways and access to support could be improved
Opportunities	**Threats**
• Birth trauma clinics – 2 midwives currently have received the training	

Wider considerations – Patient Safety

- Workforce – Safe Staffing – unsafe levels will create unsafe services. Pandemic has affected every area of health and social care services and most are now stretched beyond any levels previously. Focused strategic workforce plans for HDFT.
- Clinical Governance – revisions of Quality Governance systems and processes across HDFT with embedding. Links to investigation training and education and implementation of Patient Safety Strategy and PSIRF. Strengthening of data to support early warning.
- Clinical Leadership – recognition of early warning signs. Review of operational clinical structures within HDFT and supporting clinical leadership at every level with dedicated time and professional development
- Supporting Families – complaints handling and effective incident investigation. Linked to established ongoing work, improvement in complaints management, timely and quality responses to patients and families and early resolution of issues.
- Multidisciplinary Team Training – wider considerations for how we support those teams who work together to train together. Compliance with mandatory training requirements and where appropriate review of effectiveness of mandatory training programmes and updates.
- Culture – links to work on FTSU, Whistleblowing and staff and patient feedback.

Trust Board Report May 2022 MatNeo Safety
Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

NHS Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Staffing:
- Middle grade rota challenges remain however longer term solution has been identified
- Fluctuation in vacancy position (6.47 WTE against current establishment and a further 8.31 required for Continuity of Carer calculations which is currently running through the Trust Business Case process)
- Band 7 Delivery Suite Co-ordinators roles – some short term absence and maternity leave

- 1 case referred to HSIB – awaiting confirmation of progress

Major actions commissioned & work underway

- Preparation for National Ockenden Assurance visit 7th June
- Maternity Incentive Scheme – revised timescale for year 4 submission 5th January 2023
- Planning in place for FTSU Guardian to agree specific focused visit to Maternity

Positive news & assurance

- Maternity electronic system programme implementation continues
- Midwives across HDFT celebrated the International Day of the Midwife on 5th May
- HDFT position included in national publication of progress against Ockenden 7 IEAs

Decisions made & decisions required of Board

- Approval of plans to risk assess Continuity of Carer plans on a 3 monthly basis to increase or pause roll out/further roll out in line with Ockenden Recommendations

Harrogate and District NHS Foundation Trust

4.3

Strengthening Maternity and Neonatal Safety Report

Board Meeting

25th May 2022

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Alison Pedlingham (HOM), Andy Brown (Risk management Midwife), Danielle Bhanvra (Matron, Maternity), Kat Johnson (Clinical Director), Julie Walker (Matron Paediatrics)

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of November as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
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	✓
	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	✓
	BAF3.2 To provide a high quality service	✓
	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	
Report History:	Maternity Services Forum Maternity Safety Champions meeting	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of March as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

The new quality surveillance model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. To aid implementation there are local, regional and national elements of this model.

At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the Trust board.

2.0 Proposal

2.1 The report covers the provider Board level measures required as part of the perinatal surveillance model. The report now includes additional neonatal measures.

2.2 SMT is asked to note the information provided in the report which provides a local update on progress.

3.0 Quality Implications and Clinical Input

3.1 The report provides a narrative on the key measures set out in the Perinatal Quality Surveillance model and has been analysed and presented by members of the maternity midwifery, neonatal and obstetric teams.

4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

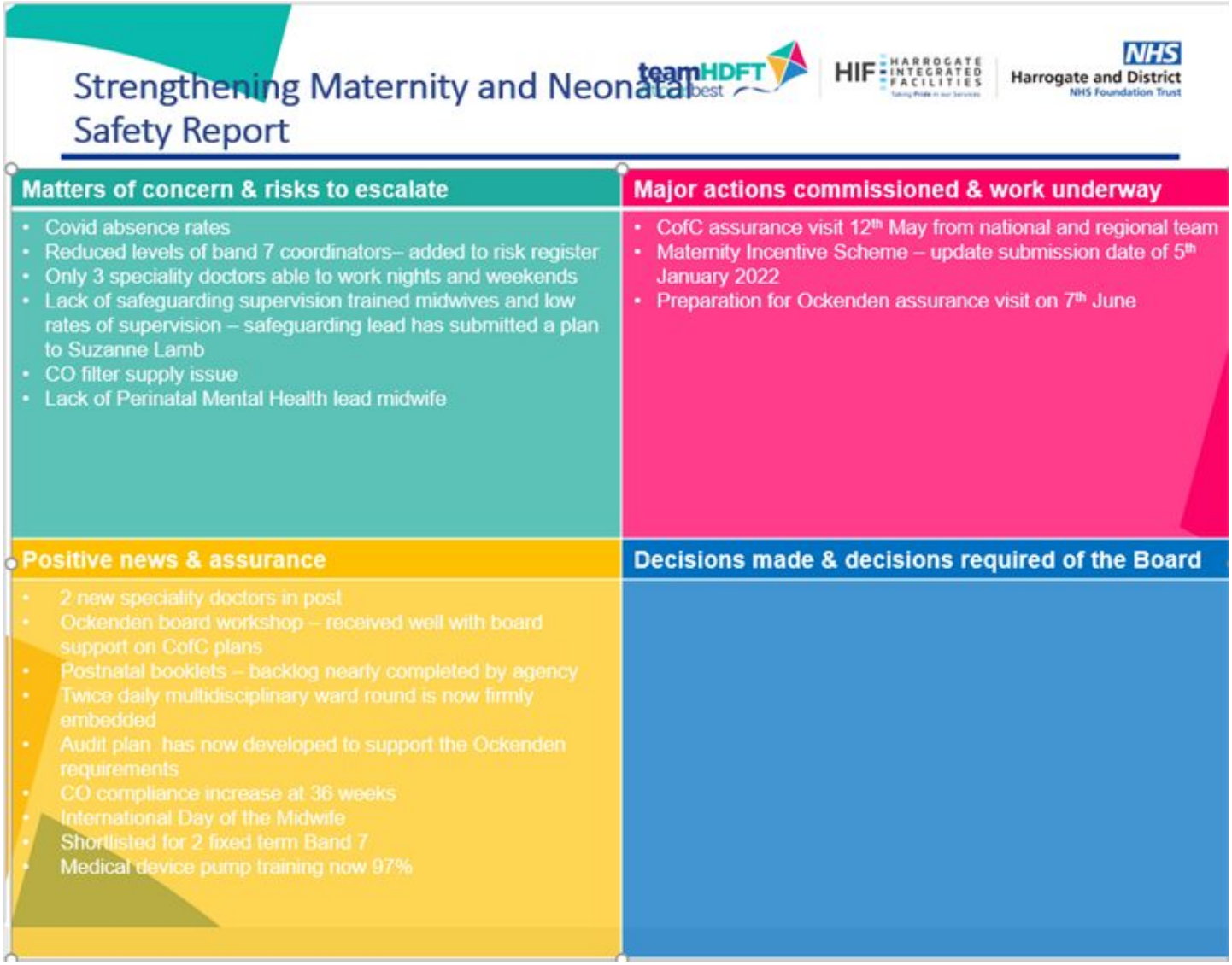
5.0 Risks and Mitigating Actions

6.1 The middle grade staffing remains a concern however there are plans in place, explained below in the obstetric cover on delivery suite, gaps in rota section of the report. The staffing position remains challenging and is also impacted by annual leave and compassionate leave. This is stabilised by resilience from consistent use of agency.

6.2 Midwifery staffing levels have continued to be a challenge in March due to the impact of Covid (staff testing Covid positive). We have successfully recruited new staff who are starting to work in the department.

7.0 Recommendation

7.1 The Board is asked to note the updated information provided in the report and for further discussion.


Strengthening Maternity and Neonatal Safety Report
teamHDFT
HIF HARROGATE INTEGRATED FACILITIES
NHS Harrogate and District NHS Foundation Trust
Matters of concern & risks to escalate
• Covid absence rates
• Reduced levels of band 7 coordinators– added to risk register
• Only 3 speciality doctors able to work nights and weekends
• Lack of safeguarding supervision trained midwives and low rates of supervision – safeguarding lead has submitted a plan to Suzanne Lamb
• CO filter supply issue
• Lack of Perinatal Mental Health lead midwife
Major actions commissioned & work underway
• CofC assurance visit 12th May from national and regional team
• Maternity Incentive Scheme – update submission date of 5th January 2022
• Preparation for Ockenden assurance visit on 7th June
Positive news & assurance
• 2 new speciality doctors in post
• Ockenden board workshop – received well with board support on CofC plans
• Postnatal booklets – backlog nearly completed by agency
• Twice daily multidisciplinary ward round is now firmly embedded
• Audit plan has now developed to support the Ockenden requirements
• CO compliance increase at 36 weeks
• International Day of the Midwife
• Shortlisted for 2 fixed term Band 7
• Medical device pump training now 97%
Decisions made & decisions required of the Board

Narrative in support of the Provider Board Level Measures – April 2022 data

Introduction
The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

- A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
- All maternity Serious Incidents (SIs) are shared with Trust Boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

Obstetric cover on the delivery suite, gaps in rotas

The middle grade rota remains a challenge as only three doctors are able to work without a consultant on site alongside them. However, the longer term solution to this is more promising. The two new specialty doctors have now both started in post and are being well supported during their induction phase. Excellent feedback has been received about both appointments and in time it is anticipated that they will be able to work without consultant on site presence. In addition a further specialty trainee has been reallocated to Harrogate for some targeted training and a specialty trainee is on a phased return after a prolonged period of sickness. This means that in week staffing is excellent with opportunities for training and support.

The consultant rota has been amended and consultants are now resident 08:00 – 20:30h when on call which is allowing the day and evening cover to be undertaken by the less experienced middle grades with on site consultant cover. The consultant team has shown significant flexibility with this change to their job plan and this allows a multi professional evening ward round at handover, an essential action from Ockenden.

Recruitment of agency locums to support the out of hours work remains challenging and the middle grade and consultant work force are at risk of fatigue with the additional pressure this brings.

To assure the board, with mitigations as described above, the maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below.

The maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below. There is no change to obstetric staffing since the last report in October.

Staffing Gaps and Contingencies			
Grade of doctor	**Staffing gaps**	**Contingency**	**Risks**
First on call rota FY2/ GPVTS/ ST1/2	None	Internal cover for short term sickness as required	None identified
Second on call rota ST3-7/ specialty doctor	Gaps now due to need for on-site consultant supervision rather than reduced dumber of doctors in post	Consultants working 08:00h – 20:30h on site Mon- Fri from 1st April 2022 Internal cover for short term sickness as required Specialty doctors covering majority of night and weekend shifts	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover overnight/ weekend

		Consultants covering shortfall	Added to risk register March 2021
Consultant	No gaps		

Midwifery safe staffing, vacancies and recruitment update

Midwifery minimum safe staffing planned cover versus actual prospectively.

Average fill rate

Average fill rate	Midwives	MSW's
Delivery Suite	94%	86%
Pannal ward	93%	76%

SICKNESS

Delivery suite Midwives

Long term Sickness (more than 28 days)	2 midwives (1 x work related stress, 1 x undergoing medical tests)
Short Term Sickness	9 midwives (total 480.75 hours) 1- 68 hours initially flu then Covid 2- 57.5 hours due to Covid 3- 19 hours due to Covid 4- 73.5 hours due to Covid 5- 37.5 hours due to Covid 6- 98.75 hours due to gynaecological issues 7- 34.5 hours due to Covid 8- 57.5 due to Covid 9- 7.5 due to migraine 10- 15.5 due to gastrointestinal bug Excluding Covid 152.25 hours (4 midwives)
Maternity Leave	2 midwives (1.5 WTE)
Paid Absence/Unpaid Absence	2 midwives (30.5 hours) 1- 7.5 carers leave 2- 23 redeployment due to clinical incident
Non patient facing	0 midwives
Medical Isolation (Covid)	7 midwives (317 hours) 7 x COVID positive
Common Sickness Themes	Covid 19

MSW's

Long term Sickness (more than 28 days)	1 MSW (90 hours- planned surgery)
Short Term Sickness	3 MSW's (total 80.5 hours) 1- 11.5 ENT 2- 46 stress (family member unwell)
Maternity Leave	1 MSW (0.5 WTE)
Paid Absence/Unpaid Absence	1 MSW 30 hours compassionate leave
Non patient facing	None
Medical Isolation Covid	None

PANNAL WARD Midwives

Long term Sickness (more than 28 days)	0 midwives
Short Term Sickness	3 episodes – 1 sinus infection (7.5 hours), 1 episode (11.5 hours) gastro, 1 6 day Covid absence
Maternity Leave	4 midwives totalling 410 hours (1 completed during April)
Paid Absence	None
Non patient facing	None
Unpaid absence	None
Household isolation	None
Common sickness themes	respiratory

MSW's

Long term Sickness (more than 28 days)	1 Member of staff on Long Term Sick
Short Term Sickness	3 episodes- 1x 10 day Covid absence, 1 x 7.5 migraine, 1x 11.5 sinusitis
Maternity Leave	1 maternity support worker (135 hours)
Paid Absence	None
Non patient facing	None
Unpaid absence	None
Household isolation	None
Common sickness themes	respiratory

Staffing and vacancies

April 2022

Midwives	A	B	C	D	E
Bands	Funded establishment	Staff in post (WTE) includes staff awaiting start date column C	Staff recruited awaiting start date (WTE)	Vacancies out to advert (WTE)	CofC additional requirements
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Band 2	10.24	7.40	0	2.84	
Clinical midwifery vacancies				6.47 (band 5-7)	14.78 (band 5-7)Includes current vacancies

Vacancies, retirements and resignations – in the month of April

Our staffing levels have improved and we have recruited:

- 9 midwives- 7.4 WTE, 4 of whom have now started, 5 are starting in May.
- We have MSW vacancies that are going out to advert for 2.84 WTE
- We have recruited 1 WTE band 7 coordinator who will start working for us in July and currently have 2 fixed term band 7 posts out to advert to cover maternity leave.

Use of NHSP and agency for April

Delivery Suite

Midwifery

- From 1st- 30th April 2022, a total of 3105 hours were required to safely staff Delivery Suite and Maternity Assessment Centre. During this period, 7.3% of hours were covered by NHSP (227hours). 207 hours (7%) were left uncovered meaning that 86% of the midwifery hours were covered by contractual hours.

MSW's

- Between 1st- 30th April 2022, 1035 maternity support worker hours were required for the unit to be fully staffed. During this period, 134 hours (12.9%) were covered by NHSP and 207 hours were left uncovered (20%).

Pannal

Midwifery

- Day shifts. During April there were 1155 hours to cover including both long days, Early and late shifts . 79% of shifts were covered by contracted hours and 19% 238 hours were covered by NHSP.
-
- Night Shifts- During April there were 60 night shifts (690 hours) requiring staffing. 2 (23 hours) of these remained uncovered. 96% of shifts were covered. 87% of shifts were covered with contracted hours and 11.2% (80.5 hours) covered by NHSP.

MSW's

For the same period, there were 90 (807.5 hours) maternity support worker shifts to cover. 72% of these shifts were covered by contractual hours. 7% (70.5 hours) were covered by NHSP. 20% of shifts remained uncovered.

Staffing summary

We are still under recruited on band 2,3,5 and 6 positions and will advertise further to fill these.

We have employed a permanent Band 7 1 WTE and are out to advert for 2 fixed term posts to cover maternity leave 1 WTE and 0.7 WTE

We have had an increase in number of elective caesarean sections performed on delivery suite. We are currently in communication with theatres to discuss creating an additional theatre list to prevent this in future.

We have had an unprecedented amount of sickness/absence in April with 480.75 hours compared to 183 previous month. Most common theme is still Covid related illness.

Better cover of MSW shifts and increased uptake on NHSP but still 20% of hours left uncovered, need to go back out to recruitment to cover these.

There has been an increase on the uptake on MSW shifts in general.

In April, non-clinical staff were utilized to help support the unit in times of high acuity

- Review of staff on management time- 1 occasions (0.6%).
- Use of Specialist midwife – 2 occasions (1.4%)

Number of times the maternity unit was closed to further admissions/women diverted and action

Number of times the unit closed to further admissions and women diverted to other maternity units in the region December 21 – March 22

	December 21	January 2022	February 2022	March 2022	April 22
No. of times maternity unit closed to admissions	1	5	3	8	0
Reason Increased activity Staffing below minimum levels	 1 1	 4 4	 3 0	 7 1	 N/A
No. of women diverted to other maternity units	0	5	5	3	0

The changes to the maternity escalation guideline are now in place including Opel criteria level

April data – BR+ acuity tool

138 women delivered, 140 babies born

3 BBA's – investigated through Datix

1:1 care in labour - 100% 1 to 1 care for women birthed (100% for those born within unit at HDFT)

Labour ward coordinator supernumerary - 98 %

Midwife: birth ratio - 27.87% (gold standard 1:26)

Percentage of specialist midwives in post - 7.2 WTE

Red Flag events (Birthrate +)

Delivery Suite

There was one red flag identified from the Birth Rate Plus Data.

- Midwife unable to provide 1:1 high dependency care for AN or PN patient on 1 occasion.

Pannal Ward

There were 3 occasions where Red Flags identified from the Birth Rate Plus Data which were:

- Delay between admission for induction and beginning of process (1 occasion)
- Delay in providing pain relief (2 occasions)

Neonatal services
Safer staffing

1.0WTE recruited into, newly qualified nurse who is very interested in BFI but will not start until September.
Vacancy at present 0.53 WTE band 5.

10%of our workforce in April was covered by agency, this was due to vacancy, LTS and short term sickness.

Qualified in Speciality (QIS) – 85% (aim for above 70%)

Sickness

SCBU	Nurses	Nursery Nurse
Short Term	Sickness – equivalent of 0.58WTE	None
Long Term	0.61WTE	None
Maternity leave	None	None
Medical Isolation	As above in sickness	None

SCBU perform an annual neonatal workforce tool to review safer staffing requirements

Copy of Harrogate - Neonatal Workforce

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

Training figures for PROMPT include those who have completed training in the last 12 months (includes both face to face and online training)

Prompt emergency skills training

	Medical staff (including anaesthetists)	Midwives
February 2022	90 %	93%
March 2022	78 %	90%
April 2022	78%	87%

All MW have been allocated a date.
2 Anaesthetist and 4 Obstetricians Need to book on training (the remainder are booked)
If all attend we will achieve > 90% attendance for MIS4.

Midwives	**67/77**
MSW's	**4/10**
Obstetric staff (inc Junior doctors)	**15/21**
Anaesthetic staff	**08/21**

Fetal surveillance training (K2 online training package)

	Obstetric staff	**Midwives**
February 2022	9% (1/11)	18% (11/61)
March 2022	9% (1/11)	18% (11/61)
April 2022	15% (2/13)	39% (18/66)

Safeguarding children's' level 3 (midwives)

Completion of e-workbooks and/or reflective discussions **– overall 65% compliant in April 2022**

Neonatal resuscitation

	Midwives
January 2022	92%
February 2022	84%
March 2022	91%
April 2022	90%

SCBU

Training compliance
We have secured a place on each NALS course this year, we have 1 x RN out of date however all others currently in date.

Overall learning lab training compliance for SCBU staff is 87.3%

Risk and Safety

Risk register summary

Risk Register was last reviewed with PSC Quality Assurance Lead on 23rd Nov 2021. Risk Register was transferred to Datix. Currently nine open risks.

- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 12).** Some gaps in Middle Grade rota though some improvement. New staff still awaited. Anticipate reduction in risk score following commencement in post but no change at present.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 12).** Additional staff recruited and staffing at Band 5/6 improved. However, some remaining vacancies being advertised.
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 12).** Plan ongoing and anticipated full implementation by end 2022. Scoping work ongoing for additional network facility to support system, and test environment being reviewed. For downgrade once system in place.

- **Delay in review of clinical guidelines (Score 10).** Risk relating to out-of-date clinical guidelines. Work ongoing to undertake routine reviews but delayed due to clinical demands and lack of capacity. Current guidelines remain in place but risk that not up to date with best evidence.
- **Risk to patient safety and experience from GP surgeries removing support for midwifery clinics (Score 10).** Situation continues to be challenging. Previously escalated to CCG and PCN Link GP. No change.
- **Failure to meet national targets in relation to Continuity of Carer (Score 10).** Remain unable to meet specified targets. Local plan to relaunch team in April has been suspended. Latest Ockenden report recommends suspension until able to evidence that continuity can be safely staffed. For discussion about whether this remains a risk.
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 8).** Commissioning of service has now been approved. For downgrade once initiated.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance rates significantly improved. Planned downgrade
- **Postnatal care plans not being filed within hospital notes in timely manner when discharged from midwifery care (Score 6).** Agency staff working through backlog and almost complete. Planned downgrade

Agreement at Maternity Services Forum to add new risk related to pressures on Band 7 Coordinator staffing due to two upcoming maternity leave, and change in job role of a further Coordinator.

The number of incidents logged graded as moderate or above and what actions are being taken

In April 2022 there were 48 total incidents reported through Datix. Of these, there was one incident recorded as Moderate Harm which was reported to HSIB for therapeutic cooling. Reported to LMS SI Panel for discussion, and planned investigation. DoC initiated.

One additional incident of concern was reported, relating to admission at 28^{+6} weeks gestation, with abdominal pain and bleeding since the previous day and progressed to normal delivery. Considered to have been incorrect telephone triage and missed opportunity to have admitted the patient the previous day. The baby was born in good condition and transferred to tertiary unit for follow up due to prematurity. Earlier admission could have facilitated administration of full course of steroids. Considered to require SE investigation and DoC initiated.

Concern also expressed by tertiary unit consultant regarding incident from end March, relating to fetal loss at 23^{+4} weeks. Patient was known to have had a cervical loop excision and cervical length scan completed at 16 weeks, which was normal. This is outside of local guidance and has been suggested that scan should have been completed at 18-22 weeks, though no evidence that outcome may have been different. Being investigated as SE. DoC letter sent.

SCBU

SCBU Incidents

No moderate harm. No Datix for SCBU other than ATAIN and 1 x loss of consumables.

Risk Register
There are no new risks to the risk register in April

Cot occupancy (Cots available on the unit = 7).
Remain at open with 7 cots, 4 babies at present. 9 admission, 1 repatriation back to us

ATAIN
4 ATAIN babies in April:

- 1 baby – Hypothermia
- 1 baby - HIE
- 1 baby – ambiguous genitalia
- 1 x baby – hypothermic, low BM
-

Babies transferred out.

2 transfers out 1 term baby ,meconium, seizures needed cooling, 2nd imperforate anus

Findings of review of all perinatal deaths using the real time data-monitoring tool

Perinatal Monitoring Review Tool Report:

Death of Twin at 28+4 – prematurity and anaemia

The PMRT was held at Leeds where the baby had died with input from HDFT

The mother was initially seen by EPAU at 7/40 weeks and was advised to refer to maternity as soon as possible. She attended Antenatal clinic at 15 weeks pregnant asking to self-refer for maternity care. She informed staff that she had not been able to attend sooner as her phone was broken.

Subsequently she was booked for Maternity care within 3 days. She missed her initial Consultant appointment but attended the next one 7 days later. A Safeguarding referral was made at booking due to concerns re risky behaviour and lifestyle choices.

A PMRT was held locally and the issue of booking later in pregnancy was considered as 'relevant but managed appropriately'.

An audit of patients who book later than the recommended 10 weeks is currently in process looking at trends and/or inequalities to health.

Service User feedback

Maternity Voice Partnership group – a new MVP chair has been in post since December 2021, Jen Baldry. This is a paid role by North Yorkshire CCG. Meetings with the MVP group continue with the following projects agreed – parent and baby safety, reducing mortality, continuity of carer, personalised care and support plan, equity and equality.

Complaints / concerns to PET / compliments

FFT – No data on dashboard in April 2022. This has been followed up with the information analyst team.

Regular positive feedback is received on a daily basis through the Social Media Facebook pages and shared (with permission) to the public and maternity team.

During April, we had one concern that has been responded to and no new complaints.

Parents feedback received by SCBU
User feedback
Comments

Equality & Diversity Comments

We are Jehovah's witnesses and over the Christmas period all the staff were informed and knew our beliefs in not celebrating, but were respectful of this and were so lovely and kind.

A fabulous demonstration of cooperation with diverse needs".

The SCBU experience is incredible. The staff, environment, support and interaction with other parents in the same situation makes this the ideal start with a premature baby.

Everybody was very friendly and welcoming. When we met new members of staff they all introduced themselves

All communication has been clear and very well explained.

From start to finish the staff at SCBU were all fantastic. We felt we could talk to everyone freely and openly like close friends/family.

Staff are always friendly and available to talk to when needed.

Fantastic reassurance. The fact a SCBU nurse came into the labour room and showed dad the unit really helped.

Every member of staff, whether permanent or agency completely excelled in the level of attention and care we felt we received

Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in April 2022.

Request for action from external bodies – NHS Resolution, HSIB

In April 2022: One new case notified to HSIB in this period.

Case relates to a baby that was transferred out for therapeutic brain cooling. Some concerns have been identified relating to lack of escalation of CTG abnormalities and raised maternal blood pressure. MRI normal. Awaiting decision about HSIB investigation.

Action plans from previous cases are being progressed with monitoring of the action plans through MRMG.

Maternity incentive scheme – year 4 (NHS Resolution)

The revised timeframe for the year 4 Maternity Incentive Scheme is January 5th 2023

Key staff in the maternity department continue to work towards compliance with the ten maternity safety actions for year 4 of the scheme.

National priorities

Midwifery Continuity of carer (MCofC) update

Following the the final Ockenden report the recommendation that all trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. Revisions are being made to the HDFT MCofC long-term plan with a full risk assessment to ensure safe staffing levels are in place for both community and acute areas.

Estates and hubs remain a significant risk with a lack of community-based provision. Approaches to leisure centres, libraries, NYCC and HTC have been unable to secure appropriate accommodation. Plans for Leon Smallwood Unit awaiting response from NHSPS regarding leasing. The Acting HOM and Director of Strategy have met to discuss approaches to the estates problem.

Ockenden report *(December, 2020)*

Update on Ockenden action plan

Regular updates of the local action plan are completed and has recently been shared with the regional chief midwife and deputy and with the WY&H LMS.

The updated action plan is attached below:

Ockenden Action Plan June 2021 (Revi

Outstanding actions from the action plan:

- The completion of an audit schedule to address ongoing, regular audit of planned place of birth, ongoing audit of risk assessment throughout pregnancy, named consultant for women with complex pregnancy and personalised care plans – the clinical audit & effectiveness role has now been appointed (to start in post early April).
- A named obstetric fetal monitoring lead has been identified but requires designated time to perform the role (additional PA) – agreement with the clinical lead and PSC Directorate is required
- Multi-disciplinary training – staff who work together must train together. Multi-disciplinary training has not been possible between October – February due to reduced middle grade doctors and subsequent impact on the consultant obstetrician & Gynaecologists. A plan has been agreed and close monitoring will continue over the next 3-6 months.
- We are compliant with all aspects of Saving Babies Lives care bundle (V2) but need standard operating procedures to support the five criteria – currently in progress.

Progress

- A clinical audit & effectiveness role (maternity specific) to support the ongoing audits recommended in the Ockenden report has now commenced in employment has an agreed yearly audit plan in place
- A plan is now in place to review and update patient information leaflets (maternity specific) – approval by the MVP group
- We are now working closely with the new chair of the local MVP group to ensure the voices of services users are heard via this forum, meetings are planned for the next few months. The MVP chair has met with key staff within and outside the organisation.

Following significant financial investment into maternity services across England, NHSE/I have requested a local update on progress with implementation of the seven Immediate and Essential Actions (IEA's) recommended in the Ockenden report (2020) and an update on maternity services workforce plans. The Assurance Assessment tool completed in February 2021 also included recommendations from a previous maternity investigation report at Morecambe Bay (Kirkup report, 2015).

The local report has been completed for discussion and reviewed at Trust Board 30th March.

The second part of the Ockenden report was published on the 30th March with a further 15 immediate and essential actions added to this report. An initial gap analysis has been completed and work has commenced to address these findings. The national team has not yet published any requirements.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

In summary for Quarter 3:

Regional data received for Quarter 3 shown below. Next update 17th May Q4.

- *Bookings less than 10 weeks are 74.0%, an improvement from Q2 (72.5%), and amongst the highest in the region (range 45.7-80.7%). No Y&H Trust has met the 90% target.*
- *1:1 care in labour was 98.3%. Again, this compares very well against other Trusts (regional average 94.7%).*
- *Normal delivery rate was 55.6% (an improvement over Q2 [52.2%]), against a regional average of 57.3%.*
- *Total Caesarean section rate was 30.3% (compared with the regional average of 32.0%). Of these, there were 16.9% elective Caesarean sections (compared with 13.2% regional average), and is the highest in the region.*
- *Induction rate (32.1%) was lower than the Y&H average (35.3%), with the highest induction rate in the region being 50.9%.*
- *Significant PPH rate was again lower in this quarter (3.8%), and is now similar to the regional average (3.6%).*
- *There were 2 stillbirths at HDFT in Q3. Rolling annual antenatal stillbirth rate is currently 3 per 1000 births compared with the Y&H average of 4.2 per 1000.*
- *Breastfeeding initiation rates remain very high at 85.4% compared with the regional average of 67.2%, and remains the highest in the region.*
- *Smoking rates at booking and time of birth are the lowest in the region (4.1% and 5.1% respectively), compared with Y&H average of 13.8% and 11.5% respectively.*

Local data capture for carbon monoxide testing at booking and 36 weeks remains a challenge, but consider needs significant improvement.

Local HDFT dashboard information

For month of April:

- 138 mothers delivered (and 140 babies born)
- Elective Caesarean section rate 16.4% (increase since March, 18.8%)
- 17.9% emergency Caesarean section (increase since March, 12.6%)
- 50% normal delivery rate (increase from March, 48.3%)
- 15.7% instrumental delivery rate
- 32.6% induction rate (increase from March, 25.2%)
- 2.9% significant PPH ≥1500ml rate (decrease compared to March [3.5%]; 4 patients)
- Four 3rd degree tear [all at normal delivery]
- 82.9% breastfeeding initiation rate
- 5.8% smoking rate at time of delivery [4.2% in March]
- No stillbirths

OASI2 Project

We are currently in the implementation period of the trial where we are trying to raise awareness and train staff. Data collection has now commenced from mid-February. The midwifery team are attending PROMPT and Dr's meetings to ensure they are reaching as many people as possible to raise awareness of the project and to train all staff. A date will be decided to start assessing outcomes.

Conclusion and recommendation

Please see the grid attached for concerns/risks to escalate and positive news and assurance.

Appendix - Supporting information – (applicable to some sections of the report)

This section provides additional information around individual sections in the report.

Obstetric cover on the delivery suite, gaps in rotas

The obstetric cover for delivery suite runs 24 hours a day, 7 days a week. There is always an onsite first on call doctor and second on call doctor. The consultant is on site Monday – Friday 08:00h – 16:30h and on call thereafter within 30 minutes of the hospital.

The second on call rota is staffed by permanent specialty doctors (establishment 4 WTE), and doctors in training in obstetrics and gynaecology (establishment 3 WTE). At specialty doctor level one of the permanent posts is filled by a locum appointment because of difficulties in recruitment. Due to clinical skills and experience required a consultant is required to be present on site.

The department is working towards consultant on site cover 08:00h – 20:00h seven days per week in line with the recommendations form the Ockenden Report. This would alleviate some of the issues around on site supervision of doctors in training.

Birthrate + acuity tool

The Birthrate Plus acuity tool is currently the only midwifery specific, national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services. It provides a valuable resource that can routinely support operational and strategic decision making in

maternity services. The tool is a prospective “real time” tool that assesses the numbers of midwives and support staff required to safely operate intrapartum and ward services. Birthrate Plus can calculate an individual ratio of clinical midwives to births for maternity services by reviewing activity, case mix, local demographics and skill mix.
Using NICE guidance and available evidence and best practice, Birthrate Plus calculates how many midwives would be required to meet the needs of women across the whole service.

Birthrate Plus makes a distinction between midwives who provide direct clinical care and those employed in management, development and governance roles, essential to the safe running of the service but not directly involved in clinical care of women. Birthrate Plus recognises that not all of the clinical work in maternity needs to be undertaken by midwives and that by enriching skill mix to include maternity support workers (MSWs) and nursery nurses, midwifery time and expertise can be better focused and targeted. Individual units will make their own judgement about the proportion of midwifery time that can safely be replaced by other roles.

- The suggested skill mix adjustment is 90:10 for clinical support staff who replace midwifery hours.
- Support staff who assist midwives but do not provide direct care e.g. clerical staff and housekeepers should not be included in this ratio.

Safer staffing – neonatal services (SCBU)

- Each shift has 2 registered nurses on duty one being Qualified in Speciality (QIS) meeting BAPM Professional guidance regarding optimal nurse staffing as described in the BAPM Service Standards for Hospitals providing Neonatal Care (2010)
- The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

Qualified in speciality

In the last five years the response to the National Audit Office report (NAO, 2007) into neonatal care delivered in the UK has resulted in the publication of government and professional standards (DH, 2009; BAPM, 2010, NICE, 2011). Within all these frameworks for care, clear recommendations are made for the role of the QIS nurse as a central member of the nursing workforce. QIS nurses provide a pivotal role in workforce strategy, not only in providing direct clinical care to babies and families. Once qualified they are able to develop further into more specialised clinical practice areas (e.g. stabilisation and transport, breast feeding advisor, outreach nurse), or enhance their practice skills/knowledge (eg intubation, cannulation, surgical nursing), and undertake development to advanced practice
level. They are also vital for supporting the foundation learning of novice nurses in neonatal areas.

National drivers for nursing include standardisation of levels of competence (DH, 2008). Competence in practice relies on the assessment of knowledge and understanding, and in skills performance. At QIS level the expectation is for the neonatal nurse to be able to apply knowledge to practice in terms of rationalising judgements, problem solving and making clinical decisions in order to optimise infant outcomes.

Maternity escalation guideline

The maternity escalation guideline was updated in January 2022 in line with the Y&H regional maternity escalation guideline to ensure consistency in systems/processes and terminology used. The level of escalation, based on activity, acuity and staffing levels now uses **Opel level criteria** and not the traffic light system (previously used).

OPEL 1 - Green
OPEL 2 - Amber
OPEL 3 - Red
OPEL 4 - Black

The decision to divert or close the maternity unit is the responsibility of the Executive Director on-call in close communication with key senior staff within the maternity unit. An SBAR form has been introduced to enable clear and accurate communication between the maternity unit, the clinical site manager on duty and the Director on call. The form includes staffing levels, activity, acuity of women and babies and the Opel level to aid in the decision-making.

CQC Maternity Survey 2021

The 2021 maternity survey involved 122 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1st and 28nd February 2021 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2021. Responses were received from more than 23,000 women, an adjusted overall response rate of 52%.

The CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used to support CQC inspections.

Perinatal Mortality Review Tool (PMRT)

Commissioned in 2016, the national Perinatal Mortality Review Tool places at its core the fundamental aim of supporting objective, robust and standardised review to provide answers for bereaved parents about why their baby died. A further aim of the tool is to ensure local and national learning to improve care and ultimately prevent future baby deaths.

The national PMRT was developed with clinicians and bereaved parents in 2017 and was launched in England, Wales and Scotland in early 2018. Unlike other review or investigation processes, the PMRT makes it possible to review every baby death, after 22 weeks' gestation, and not just a subset of deaths. For 92% of parents the PMRT process will likely be the only review of their baby's death they will receive.

Further refinement and development of the PMRT continued through 2019 and 2020. In addition, the tool was adapted in mid-2020 to enable the impact of SARS-CoV-2 on service delivery be reflected in reviews.

It remains the case that the PMRT is only a tool, and will therefore, only be as good as the information that is inputted into it and the way it is used. If it is to achieve the original vision set out by the Task and Finish Group in 2012, it is up to Trusts and Health Boards to improve the way this process is supported and implemented.

ATAIN

ATAIN (Avoiding Term Admission into Neonatal unit) is a national programme designed to reduce avoidable admissions of Term gestation babies, and reduce the harm caused by separation of mothers and their babies. The work focuses on quality improvement work in four main areas:

- respiratory conditions
- hypoglycaemia

- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

To aid this, all Term admissions to SCBU are reviewed against a standardised proforma through a monthly multidisciplinary panel (midwifery, obstetric and paediatric/neonatal) to determine whether the admission could have been avoided and whether there is any learning or practice changes that could be embedded.

Data for Term admissions is captured through an ATAIN dashboard, submitted through the WY&H LMS, together with an action plan of learning points.

Coroner Reg 28 made directly to Trust

A Coroner has the power to make a report to prevent future deaths, provided under Regulation 28 of Coroner (Investigations) Regulations 2013.

Maternity Voice Partnership (MVP)

A Maternity Voice Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. It includes a team of service users, midwives, doctors and commissioners, working together to review and contribute to the development of local maternity services.

A successful MVP needs:

- Structure
- Membership
- Role Descriptions
- Terms of Reference
- Funding
- Women's feedback

The Harrogate MVP launched in November 2018, before this date there was no equivalent group at local level. Since the end of 2018, we have been on an extensive journey.

A chair was nominated at the beginning of this process on a voluntary basis to help set up, develop the group and to chair the meetings. The chair successfully recruited a small number of local women to take part. Apart from close communication with the WY&H LMS senior Midwife, we have had little guidance and support in developing this group. From the beginning, the chair of the group did not request payment for performing this important role. At the time, none of us appreciated the amount of work that would be required and the necessary commitment to the role at both local and regional level.

Since the start of the group in late 2018, we have achieved the following:

- Had quarterly meetings of the main group with sub-meetings arranged for members of the committee and local women in-between
- Before Covid-19, the meetings were held face to face in a local children's centre with attendance by a small number of women, the CCG, the chair, HOM, Matron, the parent education midwife
- The chair is invited to the bi-monthly Maternity Services Forum (MSF) and receives minutes of this meeting if unable to attend
- Agreed TOR for the group
- Before Covid – 19, members of the MVP group completed 15 steps challenge in all areas of the maternity department, walk the patch and worked with the maternity service to survey women's experiences of maternity services during Covid-19. There is an action plan in place monitored by the MVP group and MSF

Healthcare Safety Investigation Branch (HSIB)

HSIB conduct independent investigations of patient safety concerns in NHS-funded care across England. The maternity investigation programme is part of a national action plan to make maternity care safer. The organisation is in a unique position as a national and independent investigating body to:

- Use a standardised approach to maternity investigations without attributing blame or liability.
- Work with families to make sure we understand from their perspective what has happened when an incident has occurred.
- Work with NHS staff and support local trust teams to improve maternity safety investigations.
- Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.

All NHS trusts with maternity services in England refer incidents to the teams at HSIB.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. HSIB investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations made aim to improve healthcare systems and processes in order to reduce risk and improve safety. HSIB, as an organisation values independence, transparency, objectivity, expertise and learning for improvement. Work closely with patients, families and healthcare staff affected by patient safety incidents, they never attribute blame or liability to individuals. HSIB is funded by the Department of Health & Social Care and hosted by NHS England and NHS Improvement.

During the investigations, all clinical and medical aspects of the incident are reviewed, as well as aspects of the workplace environment and culture surrounding the incident.

Criteria for inclusion:

- All incidents that meet the Each baby Counts criteria or defined criteria for maternal deaths
- Eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes
- Where the baby was thought to be alive at the start of labour but was born with no signs of life
- When the baby died within the first week of life (0-6 days) of any cause

Potential severe brain injury diagnosed in the first 7 days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) - brain injury caused by the baby's brain not getting enough oxygen.
- Was therapeutically cooled (active cooling only) - when the baby’s body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

Maternity incentive scheme – year 3 (update)

Following submission of an FOI from Baby Lifeline, all trusts were asked to reconfirm whether on further review, the Trust had met the minimum evidential requirements in year three of the maternity incentive scheme for safety standards 6 & 8 surrounding training compliance. There were discrepancies identified in the information some trusts had submitted for the FOI request and what had been submitted to NHS Resolution. Harrogate did submit the FOI request and

re-confirmation was completed in the timeframe requested. We are waiting for confirmation from NHS Resolution of these actions for safety actions 6 and 8 of the scheme and therefore reconfirmation of compliance with all 10 maternity safety standards.

Maternity Incentive Scheme (NHS Resolution) – Year 4

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year three, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions. Trusts that can demonstrate full compliance with all of the requirements in the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated fund. The ten maternity safety actions include:

1. Can you demonstrate the use of the national PMRT to review perinatal deaths to the required standard?
2. Can you demonstrate submission of data to the Maternity Services Data set to the required standard?
3. Can you demonstrate transitional care services to support the ATAIN programme?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of Saving Babies Lives care bundle?
7. Can you demonstrate patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and Newborn life support, starting from the launch of MIS year 4?
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme for 2021/22?

Update from NHS Resolution (24th December)

In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) **10 safety actions are paused with immediate effect for a minimum of 3 months**. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples include:

- Continuing to undertake midwifery workforce reviews
- Continuing to ensure that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continues
- Continuing to use available on line training resources where applicable
- To continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB)
- Every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

The reporting period for MIS year 4 will be kept under review and may potentially be extended by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022.

Continuity of Carer

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth (Better Births 2017).

The Cochrane Review by Sandall showed that there are significant improvements to the outcomes of mothers and babies when a Continuity of Carer (CofC) model is used (Sandall et al 2017). This model of care (if implemented correctly) provides a mechanism whereby midwives can gain a holistic understanding of women's needs and as such be the vehicle that drives improvements in many aspects of maternity care.

The value placed on continuity of carer is highlighted in key national documents such as the NHS Long Term plan, 'Saving Babies Lives Vs2' (NHS, 2016), and most recently the Maternity Incentive Scheme and the workforce review section of the Ockenden report. There are also indications that CofC will be linked to CQC and maternity tariff requirements. It is therefore essential that as a trust this element of maternity transformation is prioritised.

HDFT maternity has been on an unprecedented journey to achieve the national ambition since late 2018. We have faced a number of achievements as well as challenges along the way. Our workforce understands the national direction of travel and through working closely with Human Resources: we have been able to provide opportunities for staff to share their views and create fair processes to support staff through the change. In early 2019 we started with our willing volunteers, which resulted in the launch of two consecutive continuity teams; Ivy and Willow during 2019, taking us to 24% of women booking onto a pathway. For a period of time these teams worked well and were evaluated positively by women and many of the midwives.

Currently 3 teams of midwives are providing antenatal and postnatal care in the community. Providing intrapartum care is not currently possible due to staffing and skill mix issues within the community and in-patient areas. Whilst we have needed to take a step back, the end goal has remained our focus. In light of COVID-19 and the impact on our local midwifery staffing, our continuity of carer plans were revised and a new rollout plan was proposed, agreed and launched in January 2021. Due to the nature of facilitating a large scale change through a global pandemic it has been essential that the project management takes an agile approach to implementation. The journey we have been on so far demonstrates how essential it is to have a transformation strategy that will allow us to continually adapt to the unpredictable nature of the current climate, whilst continuing to move towards the national goal. Since the revised rollout was launched in January 2021 the national ambition has been updated again to stipulate that all eligible women must be in receipt of continuity of carer by March 2023.

Our revised plan has meant that the percentage of women in receipt of continuity of care has fallen back to 0% from May 2021 and will sit at this level for some time. However, this will not undo the progress we have made so far. The midwives will continue to work together in the 3 geographical mixed risk teams and will over time increase the number of midwives able to provide the full spectrum of maternity care as we recruit and continue to upskill our existing workforce.

Our continuity strategy will focus on the below key areas, which will provide the building blocks to maintain safe care and drive effective and sustainable change.

The key building blocks:

Workforce planning – ensuring we have the right number of midwives in the right places at the right time.

Positive Culture – develop a strategy for positive workforce engagement centred on the trust values of kindness, integrity, teamwork and equality.

Hubs – community hubs will provide an environment that fosters effective teamwork and the enhancement of relational care

'Follow the data' - An action plan for the evaluation of our models and integrating continuity of carer into our new electronic system.

The Health and Social Care Committee provided clear support in its July report for the importance of Midwifery CofC, and the strength of its evidence base. It highlighted longstanding challenges in local implementation, and the need for sufficient resources and support to deliver it. The NHS Operational Planning Guidance for 2021/22 requires that MCoC is established as the default model of midwifery care and to be offered to all women by March 2023.

Ockenden Report (2020)

This independent maternity review focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at Shrewsbury & Telford NHS Trust. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

This first report was published in December 2020, the review panel, led by Donna Ockenden identified important themes which were shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make early recommendations for the wider NHS Immediate and Essential Actions.

The families who contributed to the Ockenden Review wanted answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They were concerned by the perception that clinical teams had failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future. After reviewing 250 cases and listening to many more families, this first report identified themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Immediate and essential actions

1) Enhanced safety

- Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

2) Listening to women and families

- Essential action - Maternity services must ensure that women and their families are listened to with their voices heard.

3) Staff training and working together

- Essential action - Staff who work together must train together.

4) Managing complex pregnancy

- Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

5) Risk assessment throughout pregnancy

- Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,

6) Monitoring fetal wellbeing

- Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

7) Informed consent

- Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

Ockenden part 2 is expected mid-end March 2022.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

Comparative summary data from Trusts within with Yorkshire & Humber region is produced on a quarterly basis.

OASI2 Project

An obstetric anal sphincter injury (OASI), is the combined term for a third- or fourth-degree perineal tear, a severe complication of vaginal childbirth. Long-term outcomes of OASI include chronic pain, sexual dysfunction, and urinary and/or anal incontinence. OASI rates are increasing in many countries. In the UK, OASI rates tripled among primiparous women over a 10-year period. The rise in OASI rates was linked to improved recognition of tears, changes in the characteristics of women giving birth as well as to changes in practice. These include an increased use of a ‘hands-poised/hands-off’ approach, opposed to a ‘hands-on’ approach to protect the perineum during childbirth, a reluctance to perform an episiotomy, and gaps in the training of midwives and obstetricians.

In response to rising OASI rates, a multidisciplinary team of national experts, supported by the RCM and the RCOG, developed The OASI Care Bundle. The OASI Care Bundle has four elements: antenatal education of women, manual protection of the perineum during delivery, consent for episiotomy if required and rectal examination following delivery.

Through OASI1, the OASI Care Bundle proved to be acceptable, appropriate, and feasible for clinicians and women and is clinically effective in reducing OASI rates. In this follow-on project – OASI2, the focus is on studying and optimising the implementation of the care bundle for eventual national scale-up in the UK, with the primary focus shifting from clinical to implementation effectiveness.

The OASI2 project was launched in Harrogate on 13th December 2021, facilitated by Andrea Stephenson, Rachael Fawcett (DS team leaders), Louise Wills (research midwife) and supported by Mr. Justin and Mr. Altanis (Consultant Obstetricians & Gynaecologists). We have previously implemented some of the aspects of the OASI care bundle and these elements have become embedded in clinical practice however we have not succeeded in reducing our OASI rate. As a multi-disciplinary team, we have identified that we would benefit from the additional support and training offered within this project.

Harrogate and District NHS Foundation Trust

Board of Directors (PUBLIC)
May 2022

Title:	Continuity of Carer Plan
Responsible Director:	Executive Director of Nursing, Midwifery and AHPs
Author:	Rachel Askey, Midwifery Continuity of Carer Project Lead

Purpose of the report and summary of key issues:	The purpose of this report is to provide a position update on the progress against the national Maternity Transformation programme. The grid details the risks and current issues associated with this including: • Current position of 0% against the Continuity of Carer trajectory • Staffing gaps contributing to pressure on ability to deliver the transformation • Environmental and Accommodation risks impacting staff wellbeing and engagement • Ability to effectively monitor data The attached strategy and action plan sets out mitigations and progress to achieve delivery of the transformation requirements by March 2024 in line with the national objectives.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	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	X
	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	X
	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	Not currently offering continuity of carer. Submitting figures to LMS of 0% from May 2021. The Risk Register has been updated to reflect this. The reasons are discussed in the attached strategy and action plan.	
Report History:	Maternity Governance Meeting	

Harrogate and District NHS Foundation Trust

	Maternity Safety Champions Meeting
Recommendation:	SMT is asked to review the contents of the strategy and action plan and support delivery.

HDFT Continuity of Carer

Strategy and Action Plan

May 2022

Presented for:	Harrogate and District NHS Foundation Trust Senior Management Team (SMT)
Author (s):	Rachel Askey (Continuity of Carer Project Lead)

Links to Trust's Objectives

To deliver high quality care	✓
To work with partners to deliver integrated care	✓
To ensure clinical and financial sustainability	✓

Recommendation:
The information in this report is for review and approval.

Background

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff supported to deliver high quality care, which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth (Better Births 2017). The national ambition is for Midwifery Continuity of Carer to be the default model of care with all eligible women offered the opportunity to receive continuity of carer through the antenatal, intrapartum and postnatal periods. Where safe staffing allows and key building blocks are in place, the target is for achieved this is March 2024. In order to deliver the ambition HDFT must put in place the clinical capacity to provide MCoC to all those receiving all aspects of their care at the Trust.

There is high quality evidence that Midwifery Continuity of Carer improves safety and outcomes, reduces interventions and improves women's experience (Sandall et all 2016) and that MCoC reduces pre-term birth (Medley et al 2018) and Stillbirth (Ota et al 2020). When correctly implemented this model of care provides a mechanism whereby midwives can gain a holistic understanding of women's needs and as such be the vehicle that drives improvements in many aspects of maternity care.

This plan sets out the steps towards achieving this ambition including

- The number of women we expect to receive MCoC
- Redeployment plan of staff into MCoC Teams to meet this provision alongside maintaining safe staffing throughout the service
- How we will configure our teams
- How we will monitor delivery
- The building blocks we have in place or are working towards to ensure we are able to implement MCoC safely and sustainably

The Current Position

HDFT maternity has been on an unprecedented journey to achieve the national ambition since late 2018. We have faced a number of achievements as well as challenges along the way. Our workforce understands the national direction of travel and through working closely with HR we have been able to provide opportunities for staff to share their views and create fair processes to support staff through the change. In early 2019, we started with our willing volunteers, which resulted in the launch of two consecutive continuity teams; Ivy and Willow during 2019, taking us to 24% of women booking onto a MCoC pathway. For a period, these teams worked well and evaluated positively by women and many of the midwives.

Currently (Jan 2022) 3 teams of midwives are providing antenatal and postnatal care in the community. Providing intrapartum care for their women is not currently possible due to staffing and skill mix issues within the community and in-patient areas. However, a number of midwives are continuing to work across both community and delivery suite in order to maintain their skills in both areas. Whilst we have needed to take a step back, the end goal continues to be our focus. In light of COVID-19 and the impact on our local midwifery staffing, we revised our continuity of carer plan and a new rollout plan was proposed, agreed and launched in January 2021. Due to the nature of facilitating a large-scale change through a global pandemic, it has been essential that the project management take an agile approach to implementation. The journey we have been on demonstrates that it is essential to have a transformation strategy that will allow us to adapt

continually to the unpredictable nature of the current climate, whilst continuing to move towards the national goal. Since the revised rollout in January 2021, the updated national ambition stipulates that all eligible women must be in receipt of continuity of carer by March 2024. Eligible women are those who receive all their antenatal, labour and postnatal care within the trust.

This gives us an opportunity to take stock of all the learning from the past few years and to revisit and refine our strategy and propose a plan that secures the building blocks needed to achieve sustainable change. The revised strategy includes a period of stability for our midwives, whilst work around staffing and our workforce focuses on how to adapt our service to support our continuity teams and in-patient areas simultaneously.

The last few years have taught us that as a small maternity unit any movement of staff can very quickly destabilise clinical areas, potentially affecting patient safety. Therefore, our strategy focuses on ensuring that our Ante/Postnatal ward (Pannal) and the Maternity Assessment Centre are appropriately staffed and that delivery suite has the appropriate number of core midwives to both support the continuity teams and provide intrapartum care to our out of area women (whom make up around 30-35% of births).

This is a transformation of how we deliver our maternity services. Whilst the crucial date to work towards is now March 2024 it will likely take another 2-3 years for continuity to embed fully as the default model of care. Successful transformation is therefore reliant on the support from ward to board. Our strategy therefore focuses not only on ensuring we have appropriate staffing but also encouraging positive workforce engagement and building and maintaining board level involvement, influence and a commitment to investment.

Our revised plan has meant that the percentage of women in receipt of continuity of care has fallen back to 0% from May 2021 and will sit at this level for some time. Our midwives will continue to work together in the three geographical mixed risk teams and will over time increase the number of midwives able to provide the full spectrum of maternity care as we recruit and continue to upskill our existing workforce.

Workforce planning

Utilising the findings from Birthrate plus (BR+) and the nationally produced and adopted NHS workforce-modelling tool (https://uat.continuityofcarer-tools.nhs.uk/tools/midwifery-workforce-modelling-tool), we now have the intelligence and insight needed to be able to model midwifery numbers, skill mix and deployment. The strategy below demonstrates how we have used this data to plan a roll out of continuity of carer that is both safe and sustainable as advocated by our national lead for Continuity of Carer (Trixie McAree).

In April 2021 HDFT maternity received the preliminary BR+ midwifery workforce report. Appendix 1 outlines a breakdown of the BR+ plus recommended staffing. We then used the NHS continuity workforce-modelling tool was then used insight into how and where midwives need to be deployed to provide continuity of care (appendix 2). The tool assumes the recommended 1:36 caseload for continuity midwives with a ratio of 1:96 for midwives continuing to work in the traditional community model during the transition.

Our Birthrate+ data shows 1725 women gave birth at HDFT with 25 of those taking place at home. Of these 581 are women who receive their antenatal and postnatal care out of area but choose to give birth at HDFT. It may be that once MCoC embeds fully at neighbouring trusts that this number reduces as women choose to remain in their local area for intrapartum care when they are able to benefit from receiving MCoC. We do currently provide Antenatal and postnatal care to women

living in two areas outside Harrogate and may look to extending this provision (subject to staffing) if this occurs. An additional 38 women receive antenatal and postnatal care from our community midwifery teams but give birth elsewhere. There is attrition of 110 women who book with HDFT but do not complete their pregnancy (due to either pregnancy loss or moving out of area). This leaves 1144 women eligible for MCoC. It is important to note that there can be significant month-by-month variation in the number of women booking and it is vital to ensure that we have the process in place to monitor this and evaluate if the numbers women accessing care meet our expectations and modelling.

Black Asian and mixed race women are more likely to experience poor outcomes during pregnancy and birth, having four times higher rates of maternal mortality and two times higher rates of stillbirths. Plans should target those women as a priority to reduce this inequity with a target that we offer the majority of Black, Asian and Mixed Ethnicity women a MCoC pathway by March 2023. At HDFT 3.9% of women booking their pregnancies are from Black, Asian and Mixed Ethnicity backgrounds. These women do not live in a clearly defined geographical area, however it is of note that one PCN (Mowbury Square) has higher proportion of Black, Asian and Mixed Ethnicity women (6.7% compared to 2.3-4.3% in other PCNs).

Most LSOAs within the HDFT footprint are not areas of deprivation with only one LSOA falling within the bottom 10% of deprivation measured by IMD and one within the 30% most deprived areas. 2021 data showing only nine women from within the bottom 10% most deprived population booked a pregnancy. The majority of these women fall within the Heart of Harrogate PCN.

Staffing

Current staff deployment in in-patient areas is four midwives within Labour Ward (including 1 supernumerary co-ordinator) and 3 on Pannal Ward during the day and 2 at night. Birthrate + identified safe staffing at 3 midwives for 24 hours on Pannal ward and 7 days per week opening of MAC 12 hours a day. A bid was made to the NHSEI funding released in response to the Ockenden Report and funding was secured to recruit an additional five WTE midwives. Current staffing as at 1/5/2022 is 66.7 WTE against an establishment of 74.2 WTE.

In line with the CNO's compassion in practice strategy, it is essential that we have the right number of midwives in the right places at the right time. Every Chief Executive must be able to assure the trust Board that staffing levels are adequate to provide safe high quality services that maximise productivity and efficiency. MIS-YR 4 highlights this and requires trusts to develop a plan that redeploys midwives into continuity of carer teams, phased alongside the fulfilment of safe staffing levels. The rollout plan below (appendix B) demonstrates how it is possible to achieve this (with adequate financial investment) alongside the transformation agenda. Ensuring we have the right number of midwives in the right places at the right time, this plan demonstrates the deployment of midwives into Midwifery Continuity of Carer teams, phased alongside the fulfilment of safe staffing levels in all areas of maternity phasing up to continuity being the default model of care for all eligible women.

All new recruitment to Band 5 and 6 Midwife posts is to Continuity Teams with all new starters having a clear understanding and expectation that they will work in a team as the plan rolls out, usually after a period of orientation in each area. Six midwives (4.8 WTE) are currently working across both community and intrapartum areas. In view of the recommendations in the final Ockenden Report (March 2022) regarding deployment of Band 5 midwives we will review the placement of newly qualified Band 5 midwives into continuity teams once the national task force looking at this issue makes it recommendation. Our preceptorship programme will ensure that all

band 5 midwives will have an opportunity to consolidate their skills in the intrapartum area before or whilst working in continuity teams. The retention and support midwife will support midwives of all bands to develop their clinical skills so they feel supported in the transformation of the workforce.

Configuring our Teams

Best practice from the national guidance indicates that teams should be no larger than 8 headcount midwives to enable women to get to know a small number of midwives who will deliver her care. In order for the out of hours care to be provided staffing within teams needs to be at least 6.9 WTE, with a large proportion of the HDFT workforce working part time (many 0.6 WTE) it may be challenging to achieve this with 8 midwives. Where we configure teams with a larger headcount of midwives we need to ensure we evaluate the impact on women's experience of care and how much relational continuity we achieve.

Evidence suggests that mixed risk geographical teams are the most effective way of configuring teams, with each WTE midwife taking 3-4 bookings per month with a view to 3 women birthing each month (to allow for attrition). Our teams with be mapped to the existing Primary Care networks as this will allow women from GP practices to be seen in clinics situated in other GP practices within the same PCN whilst Community Hubs are established in the longer term. There is also some cross over with our current Community Teams, which will allow for a smoother transition and less disruption to existing caseloads.

Several approaches for delivering MCoC are available. Integrated models offer a hybrid approach whereby midwives split their working week between community shifts (antenatal clinic appointments and postnatal care) and ward shifts (labour care). Engagement work with staff has indicated that there is a strong preference amongst midwives for working in this way. It is important to note that in a shift based model, in order for a team to cover a 24/7 service, in reality around 64% of their working hours will be spent on delivery suite and a proportion of this will involve caring for other women not on their caseload. This is due delegation of workload on a shift and the unpredictable nature of labouring women.

Birth Availability models place midwives within community settings where the majority of time is spent building relationships with women on their caseload, providing antenatal care, antenatal education and postnatal care. When a woman labours, the midwife will attend the labour ward (or home) to provide intrapartum care. Out of hours intrapartum care is 'on call', shared by all team members. It is important that there are opportunities for women to meet other midwives within the team during the antenatal period so the woman knows them. This model anticipates that with caseloads of 1:36 approximately 20% of time will be spent providing intrapartum care.

It has been important to acknowledge that achieving a sustainable service in a shift-based model of continuity is challenging. As a trust we must be mindful of this when rolling out teams and deciding on the models. However, the midwifery workforce is currently in very high demand, with many vacant posts across the region. Midwives are able to choose jobs in trusts that they feel will offer their preferred approach to working, and as such it is felt that to support recruitment and retention we make efforts to configure teams that midwives find the most acceptable. Ideally as teams roll out we will offer both integrated and birth availability approaches we can evaluate so both outcomes for women and satisfaction of midwives and configuration adapted accordingly.

In essence, for continuity teams to work effectively (provide relational care, avoid midwifery burnout), our service needs to change its provision approach from one that has traditionally staffed

a building to one that follows the women. Shift based models may struggle to achieve this. Part of our long-term strategy therefore needs to be around how to challenge midwives' perceptions of working in birth availability models.

Outlined below is the proposed transition of our workforce from the current fragmented model of maternity care to a model where 100% of our eligible women will be in receipt of continuity of carer across the maternity pathway.

Summary

Phase	% continuity	
1	0%	Recruitment will focus on addressing shortfalls in our current budgeted establishment (currently ongoing) and staffing Pannal and MAC as per BR+ recommendations
2	25%	1 continuity team with integrated midwife from MCoC team providing cover 24/7 within LW deployment of 4 midwives (8.3 WTE in integrated team)
3	50%	2 Continuity Teams with integrated midwives from MCoC teams providing cover 24/7 within LW deployment of 4 midwives (8.3 WTE in 2nd integrated team)
4	75%	3 continuity teams, 1 birth availability team will allow for local evaluation of different types of models and shape future rollout. Will have 1 additional midwife available for births over our current deployment (6.9 WTE in Birth Availability Team)
6	100%	4 continuity teams. Will have 1 additional midwife available for births over our current deployment (6.9 WTE in 2nd Birth Availability Team)

Our approach to moving through the phases will be dependent on a number of factors relating back to the key building blocks needed for successful transformation with particular focus on staffing, estates, creating a positive culture and evaluation. The goal is to adapt our maternity service to support our continuity teams and in-patient areas simultaneously. With the correct staffing in place, as per BR+ /NHS continuity toolkit recommendations, it should be possible to achieve phase 1 relatively quickly utilising staff currently working across both inpatient and community areas. However, our ability to move through any phase will depend on successful recruitment and retention of the outlined number of midwives. Full implementation can only be achieved when funding is secured for the 8.3 WTE midwives identified in the NHSEI Midwifery Workforce modelling tool (Appendix 2), a business case is currently has been drafted to secure funding for substantive posts and is currently with finance.

In order to maintain safety, it is important that continuity teams only launch in the following conditions (in relation to staffing):

1. When there is appropriate staffing of in-patient as per BR+ recommendations. This will give assurance that the launch of a continuity team will not have a negative impact on in-patient rosters. Appropriate in-patient staffing will also prevent asking continuity midwives to plug gaps in rosters allowing them to focus on the provision of relational care.

2. The provision of intrapartum care will commence once the team reaches at least 8.3 WTE. Furthermore, each team will need to demonstrate through mock rosters that they are able

to cover their service 24/7. With the proposed reduction in core midwives over time, continuity team rosters need to be watertight.

The workforce-modelling tool demonstrates that using an integrated approach we can achieve 2 teams once we achieve our current establishment staffing. We preserve the headcount midwives within the inpatient areas and deploy existing staff into continuity teams. To achieve a third team would require additional midwives funded through the business case. Once these midwives are in post we are able to commence Birth Availability Teams and add additional headcount midwives to the numbers available to provide labour care. A 4th team providing 2 integrated teams and 2 birth availability teams, with a total of 5 midwives available for birthing women could be achieved with 8.3 additional clinical midwives and give us 100% of women booked onto continuity pathways. With 5 midwives available for births at any one time this should help alleviate some of the short term pressures that exist within the unit and reduce the occasions on which the unit is in escalation or closed.

The table below demonstrates our current staffing position (as at 1/5/22) compared to the Birthrate+ recommendations and indicated that wth a staffing gap to establishment of 6.47 WTE clinical midwives that we are not currently in a position to safely implement continuity of carer. Work is ongoing to recruit to establishment and a retention plan is in place. Regular staffing reviews are ongoing to decide when it will be safe to proceed.

	Funded WTE	Current WTE	Staffing Gap	BR+ MCofC WTE	Gap between funded establishment and BR+ MCofC	Gap between current staffing and BR+ MCofC
B8	2.00	1.00		2.00		
B7 specialist				7.55		
B7 clinical	17.10	15.12		5.99		
B6	46.07	42.96				
B5	9.00	7.62		63.97		
Total	74.17	66.70	7.47	79.51	5.34	12.81
B7 clinical	6.59	4.61		5.99		
B6	46.07	42.96				
B5	9.00	7.62		63.97		
Total	61.66	55.19	6.47	69.96	8.30	14.77

BR+ recommended clinic staffing MCoC 69.96		Funded clinical establishment					Deliveries		
	Actual staffing (1/5/22)	BR+ reccomendation clincial staffing		% on MCoC pathway	Eligible women	% of women delivered	In area: 1144 OOA: 581	Time scale	Recruitment Plan
Care Location			**Per Shift**		**1144**	**0.00%**	**1725**		
Current									
C of C team	0	0							
DS and Pannal	40.69	23.96	4						
		19.09	3						
MAC	2.2	6.54	1						
ANC	2.7		varies						
Community	9.6	12.1	varies						
TOTAL	**55.19**	**61.69**	**3**						
Wave 1		**1 Team**		**26.12%**		**17.32%**			
C of C team		8.30	1	299		299		Mar-23	Subject to achieving full establishment. Open advert, Band 5 NQM
DS		17.95	3				1426.2		
Pannal		19.09	3						
MAC		2.65	1						
ANC		3.9							
Community		9.20			883				
TOTAL	**0**	**61.09**	**3**						

Wave 2		**2 Teams**		**52%**		**34.64%**			
C of C team		16.60	2	598		598		Jul-22	Staff engagement. Decision about core/ formal consultation
DS		11.97	2				1127.4		
Pannal		19.09	3						
MAC		2.64							
ANC		3.9							
Community		6.09			584				
Total	**0**	60.29	3						
Wave 3		**3 Teams**		**73.95%**		**49.04%**			
C of C team		23.5	2+1 BA	846		846		Sep-22	Will require additional 3.6 WTE midwives fom business care. Introduce birth availability team.
DS		11.97	2				879		
Pannal		19.09	3						
MAC		2.64	1						
ANC		3.9							
Community		3.50			336				
Total	**0**	**64.60**	4						
Wave 4		**4 Teams**				**66.32%**			
C of C		31.78	2+2 BA	1144		1144		Jan-23	Will require additional 8.3WTE midwives fom business care.
DS		11.97	2				580.92		
Pannal		19.09	3						
MAC		2.64	1						
ANC		3.9							
Community		0.58			38				
Total	**0**	**69.96**	5						

1. Recruitment and retention of midwives	
Risk	**Mitigation of risk**
A significant increase in our establishment is required to achieve continuity of carer at scale. Significant local investment is needed	Recruitment to the calculated staffing gap will require trust board support and recurring investment. A business case is currently with finance to secure additional funding.
Recruitment to the current budgeted establishment is challenging due to our high turnover of staff. Similar challenges are being faced across West Yorkshire and Harrogate LMS Retention of midwives is a concern. Only a small number of midwives live in the Harrogate area, possibly due to the high cost of living, which may affect the number of applicants, and midwives may choose to live closer to work when working in continuity models.	Concerns over retention of midwives were escalated at the WY&H LMS HOM/DOM meeting in June 2021 Exit interviews are taking place in order to do a qualitative assessment of why midwives have chosen to resign. Retention and support midwife post created to provide both pastoral and clinical support and is having 1:1 conversations with all staff about retention, upskilling to continuity and support needs.

2. Core community midwives

A large proportion of our current community workforce have retired and returned to work on part time contracts. It is not appropriate for these midwives to provide intrapartum care in an obstetric unit. In keeping with our trust values, it is important that we do our upmost to support them. In doing so we will retain their experience and skills, which will be invaluable for new midwives joining continuity. We are making efforts to ensure they feel valued so that they feel able to make the decision to retire fully when the time is appropriate for them.

Risk	Mitigation of risk
This will make it more difficult to achieve continuity of carer at pace and may affect our ability to achieve 70% intrapartum continuity.	Utilise the skills and experience of these midwives to contribute to the upskilling of our workforce. Making the midwives part of the change will result in better-prepared and sustainable continuity teams. Having appropriate staffing levels in community throughout the rollout will free up our core community midwives to support our junior staff.
It may delay us reaching 100% continuity	The proposed phased rollout (needed to increase our midwife establishment) will support the gradual reduction in core posts over time.
3. Shift based models of continuity of carer and its potential impact on midwife burnout and the ability to achieve the desired improvement in outcomes	
Risk	**Mitigation of risk**
In order to cover a 24/7 service midwives will spend an inequitable period on delivery suite to guarantee full cover. Less time is then available to achieve relational care **therefore s**hift models may therefore not achieve the desired improvement in outcomes.	Evaluate if continuity is being achieved in integrated models and review delivery model if not

Communication and engagement

We were able to commence our continuity journey at the end of 2018 with willing volunteers, resulting in positive evaluations from women and midwives. However for many staff working in traditional teams Continuity of Carer remained unpopular for a variety of reasons. To remain on our trajectory towards the targets set by NHSE/I it was decided that midwives wishing to remain in an area could apply for core positions. Following an internal application process, designed in conjunction with HR, we identified which midwives would eventually join continuity and which would form part of the in-patient and community core team.

In the context of the response to COVID-19, rapidly adopted changes to ways of working and service delivery undoubtedly placed stress on our frontline maternity staff. Our continuity teams struggled to continue and by mid-2020 they began to destabilise as the midwives who remained patient facing needed to all work together to keep women and babies safe. Being a small and close knit unit the challenges faced by our teams were open and clear for all to see. Midwives across the maternity unit witnessed continuity not working particularly well, which has left us with significant rebuilding to do.

It is therefore important that our strategy focus on addressing the cultural challenges around continuity by building and maintaining midwives' perception and trust in the model. This will involve taking learning from the past 2 years to identify and minimise the stresses that cause teams to function poorly. Furthermore, we know that lasting cultural change can have a positive impact on the development of safe and improving maternity services. Our aim therefore, is to work towards a

goal where midwives feel empowered to work to the best of their abilities in a system that values and supports them.

We are actively working with the local Maternity Voices Partnership (MVP) to seek engagement with service users. Initial meetings indicate a good awareness of the benefits of MCoC from women in our communities and a strong desire to receive continuity of carer. There are some concerns around communicating how the model we be implemented to ensure those later in the phased roll out do not feel disadvantaged. The MCoC Project Lead with attend MVP user group meetings to present the plan and seek feedback on how we can strengthen it to ensure it meet the needs of our service users. The MVP will also be invaluable partners in seeking feedback for evaluation through promotion and distribution of surveys, focus groups with service users as well as capturing more feedback that is ad hoc.

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Culture Action plan

Culture Action plan Develop a strategy for positive workforce engagement centred around the trust values of kindness, integrity, teamwork and equality.			
Action Plan		Progress	
Plan	Actions	Progress	Further Actions
Improve information reach to staff to be sure they are receiving and engaging with updates	Provide monthly continuity updates - via email, social media and walk rounds.	Listening event in May to discuss national March 2023 trajectory - however poorly attended. Continuity update then sent via email and social media.	Plan further drop-in sessions and walk rounds. Develop update posters for staff containing simple overview of our strategy. Attend team meetings to provide updates and opportunities for discussion.
Improve engagement with senior leaders - to help promote positivity around maternity transformation.	Weekly catch up meetings with team leaders planned to discuss strategy and share updates and work collaboratively. Band 7 coordinators asked to attend continuity training day	Meetings scheduled and team leaders informed. Emphasised importance of senior team involvement and support with maternity transformation. Two band 7 coordinators recently attended continuity IPIP training – evaluated well and improved their understanding of the model.	Arrange meeting with new delivery suite managers to start the process of collaborative working. Continue weekly continuity catch up meetings Attend band 7 coordinators meetings once liaised with new managers.
Plan an engagement day with Trixie McAree present (national lead for MCoC) - who is offering to do support visits. These have helped to improve culture and understanding of continuity in other units.	Once we are clear of our staffing needs invite Trixie to attend. Sessions tailored to audience - midwives, senior team, exec team etc.	Assurance visit arranged for May2022	Plan agenda for day and invite stakeholders including board, Maternity Safety Champion, MVP, midwives from all areas.
Enable staff to feel empowered, listened to and valued	Provide opportunities for reflection through group PMA sessions. Co-design teams and rosters with midwives. Communicate ny necessary changes clearly with staff.	Group PMA session in June 2021 with Wren Team - provided forum for debrief and refection following team resignations.	Consider regular team PMA sessions for all teams. Regular team meetings/communication with teams and continuity project manager.

Skills Mix

The LMS has developed a new structured preceptorship package for Band 5 midwives. New midwives have protected time twice monthly to meet, undertake clinical skills training and achieve their required competencies. Whilst newly qualified midwives (NQM) are often enthusiastic about MCoC it is important that they are facilitated to consolidate their skills in all areas. NQM will have opportunities to strengthen their learning and skills in all areas including appropriate supernumerary time and clinical support. Teams should have a maximum of one NQM who should have a reduced caseload until they are confident in managing all aspects of their work. The deployment of Band 5 midwives to Continuity Teams under review at a national review and we await guidance on this.

Long term sustainability of the service and relies on developing midwives skilled in all areas and being able to provide care to women throughout their pregnancy journey. Reducing core staffing in the intrapartum areas provides limited opportunities for NQM to embed and consolidate their skills whilst ensuring safe staffing and the skill mix within the inpatient areas. Utilising an integrated approach means more midwives rostered on each shift and should help ensure a better skills mix.

An appropriately trained and skilled Maternity Support Worker (MSW) working at Band 3 will also support each team. Four community based MSW are already in post and will be support with both antenatal and postnatal care. In some trusts MSW also provide support at homebirths and this is something to consider moving forward.

In order for MCoC to embed fully as the default model of care it essential that Labour Ward Co-ordinators have confidence in the skill mix of the workforce providing intrapartum care. They also need to feel well prepared and confident in navigating this new way of working. One to one meetings have taken place with co-ordinator to improve engagement and understanding of the model and they will contribute to our SOP.

Training

All midwives will undertake a personal training needs assessment prior to moving into a continuity team to identify any gaps in knowledge and skills. There will be supernumerary time provided to work in unfamiliar areas. For midwives who have worked in community settings for a long period, providing intrapartum care may feel extremely challenging. We will ensure the transition supports their individual needs with protected time, strong action plans and opportunities for review and feedback to ensure they feel empowered to provide safe and effective care. Midwives will be supported by the professional development midwife, fetal wellbeing lead and retention and support midwife to meet individual needs.

Link Obstetrician

A link obstetrician has been identified to work with each of the 3 ongoing geographical teams and others will be identified as further teams roll out. The link obstetrician will not necessarily be the named consultant for each woman needing obstetric led care within the team but will provide expert advice and support to the midwives. Work is underway at writing a SOP to ensure that referral pathway and processes are clear. The named consultant will be invited to attend regular team meetings to ensure effective MDT working.

Standard operating procedure

We will produce Standard Operating Procedures for both integrated and birth availability models outlining roles and responsibilities within MCoC teams and from the wider maternity team to support the delivery Continuity of Carer with all relevant stakeholders and passed through Governance prior to the roll out of teams. Ongoing evaluation will ensure that the SOP are fit for purpose.

Pay

No midwife should be financially disadvantaged for working in Midwifery Continuity Model. Midwives working within integrated models are unlikely to experience financially impact by moving to MCoC teams, as they will still have opportunities to work antisocial shifts. For those working in birth availability models various methods can be utilised to ensure pay adequately reflects workload. Some trusts have negotiated a percentage pay uplift. Prior to the roll out of the trusts second wave of continuity teams pay protection arrangements were put in place for those staff working in the proposed model, these are still in place and will need reviewing with payroll to ensure they function as intended and offer a suitable solution moving forward.

Estates and Equipment

The Better Births vision is that community hubs should be established, where maternity services, particularly antenatal and postnatal are provided alongside other family orientated health and social services provided by statutory and voluntary agencies (Better Births, 2017)

As we grow continuity at HDFT, we will have increasing numbers of continuity midwives spending a large proportion of their working week out in the community. This will probably be around 30+ WTE midwives, which is a significant increase from the original 16 strong (approx. 12WTE) community midwife team. Whilst all continuity/community midwives currently have access to laptops with VPN (or similar) making working from home possible, there is a need for midwives to meet as a team and to see their women in appropriately sized and resourced spaces. The midwives also need access to desktop computers and printers in order to do their work. Midwives are now working from home more, but the current community office in the hospital can often become quite full as midwives queue for desk space and printers.

Whilst GP surgeries will probably start to open up their doors as we ease out of lockdown/return to normal, running midwife clinics in these locations is far from ideal. Clinics are in multiple locations across Harrogate, Ripon and Knaresborough, resulting in a fragmented service and teams of midwives that do not see one another.

Midwifery hub requirements

- Car parking space
- Waiting area
- Clinic room with HDFT computer and printer
- Office space
- Large room for parent education classes and team meetings
- Room with telephone and wifi for bookings and other remote consultations

	Team Name	Potential Location
Hub 1	Wren Team	**Mowbray square Health Centre** currently accommodates clinics 5 days a week. If we are able to expand our use to include the option of seeing women here at the weekends, office space, bookable meeting space and bookable parent education space this would work well as a hub location. Meeting arranged with operational director to progress this Jan 2022
Hub 2	Kingfisher Team	**Bilton Children's Centre** - We are currently in Bilton CC for a number of our antenatal clinics but it is not clear how secure this is in the long term as they agreed to accommodate us only in the short term due to the pandemic.
Hub 3	Robin Team	**Knaresborough children's and family hub** would be a good opportunity to create a midwifery hub here for the Knaresborough, Boroughbridge and East Harrogate women**.**
Hub 4	Team 4	**Harrogate Town Children's Centre** was used for drop in clinics and a fully equipped clinical space is available, however since the start of the pandemic, this has not been available to us and the building handed back to the school whose site it is on.
Hub 5	Ripon Hub	**Leon Smallwood Centre** is an ideal location for Ripon midwives. It would provide all the above requirements. DON/M currently looking into the feasibility of us gaining this space. Capital investment needed to bring facilities up to date.

Risk	Mitigation
Current use of Mowbray square does not currently fulfil the requirements of a community hub. Any expansion of use to include weekends, use of meeting room space and parent education space will have financial implications.	Find out what the financial implications will be to expand our use of this building. May need to consider incorporating this into the continuity business case.
North Yorkshire County Council is not clear about how it intends to use children centre space following the pandemic. No firm decisions made.	Children's centres are aware that maternity services are interested in using the buildings. Need to consider board level liaison with NYCC commissioners to raise the profile around how valuable it will be for us to secure this space.
Suggestions have been made that NYCC will begin to charge for the use of the children's centre buildings	May need to consider incorporating any recurring costs into the continuity business case.
A delay in securing appropriate hub space will jeopardise the ability to roll out continuity effectively and sustainably.	Work closely with HOM and DOM to pursue appropriate contacts and raise the profile of this challenge with the trust board.

Funding for additional equipment will be o resource community hubs and is sought in the business case. Each individual midwife will also need equipment to enable them to provide antenatal care including a laptop and smartphone as well as clinical items. We have submitted a bid for LMS funding and any shortfall identified requested via the business case.

Evaluation

Monitoring and evaluating continuity of carer is essential so that we can measure consistently the level of continuity of carer provided over time. This monitors delivery and evaluates the extent to which particular models realise the benefits expected as set out in evidence. It will also help us to evaluate locally the impact that this model of care has on women and babies but also the impact that it has on the work/life balance of midwives.

Nationally defined measures to monitor continuity of carer (Sandall J, 2018):

A service reported measure of which person manages a specific care episode for the women concerned.

By recording which midwife provided the care for each woman at each contact and how many times lead midwife, 'buddy' or a team midwife provided care.

Barrier to achieving this: Changes made to the Maternity Services Data Set (MSDS) will eventually enable this. This is still some time away as nationwide maternity IT systems are struggling to meet the requirements**.**

Solution in WY&H LMS:

WY&H LMS have developed a data collection tool, requiring manual input for each maternity contact alongside key outcome measures. Data submitted quarterly to WY&H LMS.

Positives: The tool is a great way for midwives to see the data as it emerges. Midwives can take ownership and develop a sense of pride over their work. When teams engage with data collection, it can encourage a bit of healthy competition. It is also very useful to share the data amongst colleagues.

Negatives: It relies on midwives taking responsibility for recording each care episode. If this does not happen, it becomes a very time consuming task for one person to take responsibility for, particularly when staffing is tight and clinical care takes priority.

How is HDFT working towards meeting the requirement?

We made amendments to ICS, and the development of antenatal and postnatal templates within SystmOne to capture the data required. This involved a change to the way midwives work as prior to this the default place to record maternity contacts was in the written handheld notes. The IT analysts were then able to create a local electronic report that mirrors the LMS reporting tool, accessed with appropriate permissions via the trust intranet.

Positives of the local report: It eliminates the need for manual input and it is very quick and easy to pull the data. A midwife from one of our teams has taken responsibility for data collection, which is working well.

Negatives: It relies on midwives consistently and accurately recording care episodes in SystmOne for both antenatal and postnatal care, which is still problematic. It is not currently possibly to accurately record 'care in labour'. Delivery notes are paper based and it is challenging to record with any level of accuracy the midwives present during labour as part of the ICS birth summary.

A woman-reported measure of whether women feel they have had continuity.

National survey

The CQC maternity survey includes a question on continuity. This is a nationally used indicator. By asking women their experiences, the survey tests whether the service-reported measure is having the expected impact. The woman is the ultimate arbiter of whether she felt she had sufficient continuity.

Local survey

Locally, WY&H LMS have recently launched a survey designed to capture women's experiences and perceptions of continuity, found at the following location:

https://www.smartsurvey.co.uk/s/LMSCoC/

The action plan below highlights a strategy to ensure women start to receive this survey in the early postnatal period. It will be useful to gather responses, despite women not currently being in receipt of intrapartum continuity, so that we can measure changes over time.

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Evaluation and Review

Action plan		Progress	
Plan	Actions	Progress	Further Actions
Develop the in-house tool to include postnatal contacts	Work out the SystmOne codes and then liaise with IT analysts	IT willing to develop the report	
Monitor compliance and offer support to midwives not compliant with SystmOne data input.	Use report to identify gaps in data.	Improved compliance with recording all ante and postnatal contacts	
Increase designated time CoC manager spends on data collection.	Identify 1 day a week initially and review as progress made.	Currently no data to collect	Once teams running one day per week will be allocated for data collection and reporting Identify midwife within each team to support others with data collection
Work closely with digital midwife to ensure the new electronic system is able to meet future MSDS requirements for continuity.		Meeting arranged with Digital Midwife	Cascade to staff and review to ensure processes are understood and being followed
Once the accuracy of data collection has improved, share widely with team and the maternity department to celebrate work.	Develop infographic for sharing monthly/ quarters stats and progress	Currently no data to collect or share	
Increase responses to LMS continuity survey for women	Distribute survey to midwives and encourage them to share with women.	Survey distributed and clerk asked to create a simple flyer for midwives to give to women.	Review use with midwives at team meetings. Work with MVP to distribute to service users and gather additional feedback
Collect feedback on midwives experiences of working in different models to evaluate	Design survey to measure job satisfaction, life/work balance, expectations and experiences of midwives		

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NHS Long Term plan. See: https://www.longtermplan.nhs.uk/

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NHS Resolution: Maternity Incentive Scheme, Year Two. See: (https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf)

Ockenden, D. (2020) *Independent report: Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust.* Department of Health and Social Care

NHS midwifery workforce modelling tool. See: (https://uat.continuityofcarer-tools.nhs.uk/tools/midwifery-workforce-modelling-tool)

Department of Health and Social Care. (2021) Safer Maternity Care: Progress Report 2021. See: https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-9.4-safer-maternity-care-progress-report-2021-amended.pdf)

Cumberlege J. (2016) Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. See: england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Appendix 1

Breakdown of BR+ recommended staffing:

	WTE
Core Hospital Delivery Suite • Core Births (581) • Caseload births (230 - 20%) • A/N cases (310) • Escorted transfers out (13) • Non-viable pregnancies (27)	11.97
Pannel Ward: • IoL (720 doses) • A/N Admissions (465) • AN Ward attendees (405) • P/N women (1610) • NIPE/Tongue Ties • Extra Care babies (205) Outpatients/MAU	19.09 6.54
Core Community	0.58
Caseload Teams	31.78
Total Clinical wte	**69.96**
Additional Specialist and Management (excluding B8 2 WTE)	7.55
Total Clinical, Specialist & Management wte	**77.51 WTE**

Appendix 2

NHSE workforce modelling tool:

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Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care: 1873

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	38
Out of area referrals	581
Attrition	110
Total women not eligible	729

Total women eligible for full Continuity of Carer pathways: 1144

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway: 1,144 Women

Number of eligible women not on full C of C pathway: 0 Women

Current budgeted establishment: 74.17 WTE

Midwives for 1,144 women on full Continuity of Carer pathway

Midwife to woman ratio: one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE MWs per team (between 4 & 8): 6.8

You will need **31.78 Midwives** to look after **1,144 Women** on full Continuity of Carer pathway, working in **5 teams** of **6.8**

Midwives for 729 women not on full C of C pathway

These are the 729 women who are not eligible for C of C plus the 0% (0) not on full pathway

Midwife to woman ratio for 38 women requiring postnatal and antenatal care: one to 96

This will be **0.40 midwives** looking after **38 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 581 out of area referrals (care for birth only): 0

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	31.06
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, FMU)	6.54
Specialist midwives (breast feeding, bereavement, etc)	8.3
Midwives in non clinical management (ward sisters, matrons)	3.4
Other	1
Total needed for minimum safe staffing	50.300000000000004

Service Breakdown

Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	1,873 Women
- of which number not eligible for C of C pathway	729 Women
- of which number eligible for C of C pathway	1,144 Women
In this scenario 100 % of eligible women receive care on C of C pathway	1,144 Women
- Midwives required to provide C of C @ 1:36 ratio	31.78 Midwives
- No. of C of C teams required @ team size of 6.8	5 Teams
Total not cared for on Continuity of Carer pathway	729 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	50.70 Midwives
Workforce establishment required to provide care for all women	82.47 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 74.17 WTE	-8.30 Midwives

4.3

Trust Board

May 2022

Title:	Freedom to Speak Up Guardian update
Responsible Director:	Emma Nunez – Executive Director of Nursing, Midwifery & AHP's
Author:	Head of Nursing – Interim FTSU Guardian

Purpose of the report and summary of key issues:	To provide The Trust Board with an update on Freedom to Speak Up at HDFT	
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	
	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	√
	BAF3.2 To provide a high quality service	√
	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		
Report History:	Update provided to People & Culture Committee 16/05/22	
Recommendation:	Trust Board members are asked to receive this report for information.	

Board of Directors Meeting

Freedom to Speak Up Guardian update

1.0 Executive Summary

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

2.0 Background

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

3.0 Introduction

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

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

4.0 Proposal – this report proposes further action on:

4.1 The proposed rebrand of Freedom to Speak Up at HDFT “Listening at Our Best” and update on the project plan

5.0 Quality Implications and Clinical Input

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

6.0 Equality Analysis

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

7.0 Financial Implications

7.1 Minimal cost implications for rebranding materials

8.0 Risks and Mitigating Actions

8.1 The impact of the Covid-19 pandemic during 2020/2021

8.2 Substantive FTSUG on maternity leave, interim FTSUG in place

9.0 Consultation with Partner Organisations

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

10.0 Monitoring Performance

10.1 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.

11.0 Recommendation

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

12.0 Supporting Information

11.1 The following paper appended makes up this report:

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

Date: May 2022

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.

At HDFT, as discussed at the last Board we are starting to implement the training across the Trust. All Fairness Champions have been asked to complete the Speak Up and Listen Up training. Following the Mandatory Training Review Panel, all members of HIF and HDFT will be required to complete "Speak Up" and all people in a Line Management or Leadership position will be required to complete "Listen Up". The final module, "Follow Up" will be undertaken by members of the Senior Management Team. This is to raise the profile and awareness of FTSU across the organisation and also provide staff with opportunity to reflect and consider how they can support and promote a Just Culture. There has been some delay in ensuring this training is available for the relevant staff members and the FTSU Guardian is working closely with the Learning and Development Team.

Local work

Freedom to speak up current data

The following table captures the numbers of cases received by the Freedom to Speak Up guardians between January – April 2022, common themes identified and a summary of learning points.

Numbers of referrals to the guardians has remained the same as the previous quarter, and these numbers remain fairly low. However, it is evident that FTSU cases are brought to other members of the team, including the Executive Directors and therefore this data is not always captured and reported directly to the NGO. Recently, following review of this data, the FTSU and the Executive Team have agreed that concerns raised directly will also be captured through the NGO data submission.

Numbers of cases brought by professional level	Worker Manager Senior leader Not disclosed	6 2 0 0
Numbers of cases brought by professional group	Allied Health Professionals Medical Registered Nurses and Midwives Nursing Assistants or Healthcare Assistants Administration, Clerical & Maintenance/Ancillary	1 1 3 4
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		3
Response to the feedback question; 'Given your experience, would you speak up again?	Total number of responses The number of these that responded 'Yes'	6 6
Common themes identified	HR processes not explained to staff involved adequately Bullying/Harassment from line manager Miscommunication regarding patient safety element.	
Summary of learning points	Communication around HR processes already ongoing	

The Freedom to Speak Up Guardian role update

The interim FTSU Guardian is Charly Gill to cover maternity leave of the substantive post holder. Leza Layton is the Associate Guardian and there is currently a vacancy for a second Associate Guardian.

Next steps/Action Plan:

- Regular meetings with Executive Director of Nursing to capture anonymised data from the concerns raised directly to the Director team
- To include the FTSUG role in the current work on the organisational culture, values and behaviours.
- A rebrand of FTSU at HDFT "Listening at Our Best" to embed FTSU into the #teamHDFT values and "At our Best" programme, current project plan:

Action Required	Lead	Date for completion
To formalise and agree a job description for the associate role	Charly Gill	May 2022
Continue with the relaunch and rebranding "Listening at Our Best" as part of "At our Best", including visible "Pledge Wall"	Giles Latham	June 2022
Undertake the NGO Gap Analysis and Just Culture Gap Analysis alongside Deputy Director of OD	FTSU Lead & OD	April 2022
Launch the e - learning package as mandatory training	Learning & Development	June 2022
Scoping exercise around app based reporting system for staff; being mindful of how this will be acted upon and followed up	Darran Miller	April 2022

Harrogate and District NHS Foundation Trust

4.3

Trust Board (Public)

28th May 2022

Title:	Safer Nursing Care Tool (SNCT) Report incorporating: Adult Inpatient Ward SNCT, Paediatric SNCT, Emergency Department SNCT and Community Nursing Safer Staffing Tool
Responsible Director:	Executive Director of Nursing, Midwifery & AHP's
Author:	Workforce Assurance & Compliance Matron

Purpose of the report and summary of key issues:	The organisation undertook the second of three adult inpatient safer staffing review using the licenced SNCT over a four week period commencing 7th February 2022. Paediatrics and the Emergency Department have also adopted the SNCT tool appropriate to these areas. This report contains the first and second data collections from these reviews (January and March 2022. Community Nursing where invited to take part the in the Community Nursing Safer Staffing Tool trial. The report attached forms part of the trial. The above SNCT tools recommend that changes in establishment should not be undertaken until there have been three data collections. It is also important to note that there continues to remain daily safe staffing risk management processes in place to manage and mitigate any staffing risks. The purpose of this report and data collection is to ensure effective nursing workforce planning for HDFT. This report is being provided to Board to ensure transparency of the data collection and triangulation and Board is asked to note the content of the report and acknowledge the recommendations underway within the organisation.	
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	
	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	
	BAF3.2 To provide a high quality service	
	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	

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	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	No Change	
Report History:	Workforce Governance Group Professional Forum	
Recommendation:	The Board is asked to note and discuss the contents of this report	

Safer Nursing Care Tool Report incorporating: Adult Inpatient Ward SNCT, Paediatric SNCT, Emergency Department SNCT and Community Nursing Safer Staffing Tool

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4.3

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date: May 2022

Author: Brenda Mckenzie (Workforce Assurance and Compliance Matron)

Situation

The organisation undertook its second adult inpatient safer staffing review using the licenced SNCT over a four week period crossing February and March 2022. Senior colleagues are asked to note the content of the report and support proposed recommendations.

Background

The trust currently operates a 'winter and summer' establishment model that was previously agreed in order to reflect seasonal trends. Increasing staffing challenges has meant that this model has become harder to operate and nowadays the demand tends to be much the same all year around. In addition to this SNCT review a gap analysis for winter preparedness and safer staffing is being worked through. At the time of writing this report the organisation are still staffing an average of 20 COVID escalation beds which continues to impact on the ability to provide consistent safer staffing levels.

This is the first data collection during the 'winter' months and unsurprisingly shows increased acuity and dependency. In addition, teams are reporting increasing levels of enhanced care requirements on a daily basis. This report will include enhanced care data *(patients who require an increased level of care to prevent them harming themselves, others or absconding)* for each area as well as compare, where appropriate, dependency data from the first SNCT data collection.

Although staffing levels are agreed annually during 'budget setting' prior to the new financial year, these establishments are historical with no real evidence base behind them. The Shelford Group (2018) SNCT is a validated licensed, evidence-based tool that incorporates acuity and dependency, quality indicators, patient flow information and professional judgement. In May 2021 the organisation purchased the license for the SNCT and the first data collection took place over June and July of 2021. The scope of this data collection included all adult inpatient wards.

The second data collection ran from 7th February to 6th March 2022. Prior to this collection the Workforce Matron facilitated an extensive training programme; a one and a half hour training session, that was conducted via MS Teams. The staffing pressures during the beginning of the year brought real challenges in terms of attendance; therefore the Workforce Matron went 'ward to ward' during the data collection period to do 'on site' training and assist with the peer review process. It is acknowledged that not all staff that collected the data have been assessed as competent in this activity; however all the data was peer reviewed by the Matrons to validate and add assurance that the data was an accurate reflection of the patients o the ward and activity during the time of the audit. It is advised that a third SNCT collection is carried out prior to any formal recommendations to Board regarding nursing establishments.

The SNCT was used with a 60:40 ratio Registered Nurse (RN) to Care Support Worker (CSW) for all wards with exception of Farndale, our admissions ward. For this ward a ratio of 70:30 was used to take into account the additional registered nurse input required when

admitting acutely unwell patients, which is recommended by the tool with regards to assessment areas.

Over the data collection period, the hospital bed occupancy was at an average of 101% with a range of occupancy across all 13 areas from 79.5% up to 126.6% with the majority of areas running between 90 and 100% bed occupancy over the study period the data was collected at the same time each day (15:00hrs).

Assessment

With ongoing restrictions on visiting it is imperative to acknowledge the additional pressures this currently has on the ward staff. Ward clerks are required to book visiting slots and often families and carers call the ward daily to arrange these. The ward staff are required to support visitors at the entrance of the ward with donning and doffing PPE, when the visitors are on the ward, as this is more infrequent, they require more support and information from the ward staff. Pre-pandemic visitors would be able to support their families with enhanced care needs, relieving ward staff. This may be providing some distraction or supervision of patients with delirium or dementia or supporting with ensuring the nutritional needs of their relative are met. There has also been a significant reduction in the amount of volunteers within the hospital, who may also support with the nutritional needs of patients, providing activities and supporting ward staff.

Almost 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 are described in the additional information sections. 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 on a minimum of three separate study periods. This is to ensure robust data and analysis over different data collection periods/times of the year.

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

During the SNCT collection period the total combined bank and agency spend was: £383,597.

NHSP: £261,535.00

1. **Agency:** £122,062.00

Ward	
Harlow Suite	£44,819.00
Bolton Ward	£56,344.00
Byland Ward	£43,373.00
Oakdale	£44,725.00
Wensleydale Ward	£27,320.00
Granby	£20,101.00
Trinity Ward	£20,669.00
Farndale MAU	£26,211.00
Rowan Ward	£4,725.00
Littondale	£15,848.00
Nidderdale Trauma & Orthopaedics	£38,486.00
Fountains Ward	£8,161.00
Jervaulx Ward	£32,815.00
Total	£383,597.00

It is worth noting that the highest spending area, Harlow, is an escalation ward and is staffed entirely by redeploying substantive staff from other areas and the use of NHSP/agency staff. The next highest spending areas have some of the highest 'enhanced' care numbers. Additionally, during this data collection period, there were significant staff sickness levels relating to the Omicron variant of COVID 19.

As part of the SNCT process, the Director and Deputy Director of Nursing, Midwifery and AHP's, Head of Nursing (HoN) for Planned and Surgical Care and Long Term and Unscheduled Care, Matron and Ward Manager from each ward and the Matron for Workforce Assurance and Compliance met via MS Teams to review the SNCT results, quality data, patient flow information, environmental factors, and apply professional judgement. The discussions have been found to be useful in identifying support roles that would enhance patient care and improve working lives of each team. These are specific to each ward and will be outlined in the summary section of the report.

Throughout our discussions, it was highlighted that there were some anomalies with some of the patient flow data; specifically the bed occupancy. This data had to be re calculated manually from the Sitrep submissions as previous data was skewed due to incorrect bed establishments. This is a result of the constant changes in bad bases as a result of escalation beds. Another consideration is that since the last data collection many of the wards have moved. This makes comparing results tricky, as bed bases have changed significantly. These factors highlight some of the complexities of undertaking a review of this kind during substantial times of change.

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 and assessment areas and those that host COVID positive patients including those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a critical care environment at HDFT.

Recommendations

1. To note the content of this report and support the proposal to run the SNCT bi-annually moving forwards. It is recommended that future data collections are undertaken for a full calendar month. Bringing it in line with other data collection streams.

2. HoN, Matrons and Ward Managers to continue to take forward the recruitment of additional support roles as suggested in the report.

3. Ensure non clinical management time amongst Band 7 managers is consistent across both directorates; it is recommended that each ward manager gets 30 hours (0.8WTE) management time to enable them to undertake their roles, as detailed in the national Ward Leaders Handbook.

4. The safer nursing care tool advises caution in the interpretation of ward with a lower bed base. The wards that this is applicable to are Rowan and Trinity, at the time of the study. It is acknowledged that these wards have increased their bed base due to operational bed pressures. Note: the minimum number of staffing required to run these wards safely has been applied.

5. To ensure further governance of safer staffing and the daily safe deployment of staff the adult inpatient wards need to have live and accurate rosters (Health Roster). It is recommended that once key performance indicators have been met, the organisation procures and implements the additional 'safe care' module of Health Roster (Allocate).

6. In preparation for the next SNCT data collection, an audit cycle planner will be created and circulated to all adult inpatient areas via the HoN and Matrons. This will clearly explain the requirements of each area. On the run up to the data collection period training sessions will be made available and an updated data collection tool distributed. Weekly meetings will be established, in advance, with the Matrons and HoN to address any complications that arise in a timely manner.

7. The Matron for Workforce Assurance and Compliance will draft an SOP to futureproof the SNCT data collection process at HDFT and outline individual responsibilities for collecting data.

8. It is recommended that there is one annual ward budget and annual establishment rather than a mixed summer/winter establishment.

9. For the wards that have no comparable data, as a result of ward moves, an additional data collection should be considered before changing any establishments.

10. In preparation for the next data collection the Deputy Director of Nursing Midwifery and AHP's and Workforce Assurance and Compliance Matron will review the 'Model Hospital' data and agree a baseline, Care Hours Per Patient Day (CHPPD) for each ward so that we can compare against our peers in this field.

11. There are recommendations within the report to use some unused band 2 establishment to recruit additional ward clerk, nutritional assistant, Housekeepers and discharge support worker hours. Some wards require part WTE's and should consider recruiting full time WTE's to share over two areas. This would also ensure more robust cover in times of annual leave and sickness and will form part of planned future workforce modelling

12. To feedback themes to the professional forum, workforce governance, recruitment and retention groups for consideration.

Littondale Ward

Littondale is a 32 bedded surgical ward. The ward cares for mixed sex (previously all male) surgical, gastroenterology, urology and gynaecology and breast patients. The ward rarely takes direct admissions, the majority are admitted via surgical or medical admission wards.

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, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Managers supervisory time for management and alternative leadership responsibilities and duties is three management days per week, however this is often not the case and the ward manager can be pulled to provide direct patient care.

Whilst this is a surgical ward there are mainly gastroenterology patients who can present with delirium and confusion and can be challenging to manage and require one to one enhanced care. These patients are often on very complex intravenous treatment courses which require two nurses to check and administer. Frequently patients require a nurse escort to neighbouring hospitals for treatments. The ward is the only ward in the Trust with the skills to administer TPN and this adds an additional pressure to the ward. As a direct result of the COVID pandemic many of the regular patients that were admitted with alcohol associated illness have not been presenting until 'crisis'. These patients are deconditioned beyond normal limits and therefore increasing their symptoms and length of stay.

Patient care is allocated by:
The ward is split into three, each having an RN and CSW
2 x 6 bedded bays
1 x 6 bedded bay and four single rooms
1 x 6 bedded bay, double side room and two single rooms

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th Feb – 6th March 2022	96%	86.9%	89.3%	100%

The current shift establishment is (for 32 beds):

Day		**Night**	
RN	CSW	RN	CSW
4	3	3	2

At the time of the study the bed occupancy was 97% based on 32 beds.

The budgeted establishment is for 32 beds is 20.32wte RNs and 16.03wte CSW

Contracted for the time of data collection was 17.58wte RN and 13.39wte CSW

At the time of data collection there were vacancies of 2.74wte RN and 2.64wte CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£10,326
Cost of Agency spend during the data collection period	£5,521

RN Demand 365 hours (2.4wte)
Fill 275 hours (1.8wte)
75.4% fill

CSW Demand 568 hours (3.8wte)
Fill 222 hours (1.5wte)
39.1% fill

CHPPD

June 2021	**5.5**
July 2021	**5.6**
2nd data collection 2022	**5.0**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	1.71%	0.82%

Quality indicators

Falls	4 (6 during the last data collection)
Hospital acquired pressure ulcers	1 x deep tissue injuries 1 x Cat 3
Medication incidents	1
Staffing Datix	1
Formal Complaints	3 Concerns regarding discharge communication Incorrect information re patient diagnosis and visiting. Concern re discharge from ward.

Enhanced care: There were total of **29** enhanced cares. This averages at 1.04 enhanced care patients per day.

Flow:

	Total in data collection period	Average per day
Admissions	99	3.53
Discharges	74	2.64
Transfers In	73	2.6
Transfers Out	87	3.1
Deaths	6	0.21

Admin Support:

	Establishment	Contracted
Band 2	1.0wte	1.0wte The ward use NHSP and 2 CSW's to staff this role 7 days a week 8-8

Nurse Associates:

	Establishment	Contracted
Band 4	0.0wte	1.0wte at the time of the data collection. This employee has now left.

Nutritional Assistant:

	Establishment	Contracted
Band	0.0wte	1.0wte comes out of the band 2 budget

As a summary of the SNCT study period

Bed occupancy was 97%

The **budgeted** RN establishment is **20.32wte**

SNCT indicates the ward requires **22.4wte** RN. This suggests an under established variance of 2.08wte. The previous SNCT results from 2021 suggested that Littondale required 20.98wte. Highlighting that dependency on this ward has slightly increased during the latest data collection period. The increase in RN WTE would be supported as the mix speciality patient group on Littondale have many complexities. These include acute surgical patients, cancer patients requiring advanced psychological support, gastroenterology patient requiring intensive feeding regimens and end of life patients. As many as sixteen patients a day can require intravenous antibiotics three to four times a day.

The **budgeted** CSW establishment is **16.03wte**

SNCT indicates the ward requires **14.9wte** CSW. This suggests an over established variance of 1.13wte. The previous SNCT results from 2021 suggested that Littondale

required 14.2wte CSW; highlighting a stable measurement of dependency for support workers over the two data collection periods.

The ward has a 1.0 WTE nutritional assistant (Band 2) and a 1.0 WTE ward clerk (Band 2). It is recommended that the Ward clerk cover on the ward should be increased to 2.15 WTE to enable cover 08:00 – 20:00, seven days a week. The ward try to cover the 7 day admin role by using existing band 2 CSW's doing extra shifts. Recruiting to these hours would be a more cost-effective option and reduce the burden and risk of 'burn out' of existing staff doing extra hours. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and assisting with visiting arrangements. It is also recommended that the Nutritional assistant cover be increased to 1.4 WTE to increase the cover across the weekend. The fill rates for CSW were excellent during the data collection period and there are remaining band 2 hours in the ward establishment. It is recommended that this surplus is used to recruit to these positions.

Through our SNCT discussion it was highlighted that this ward has a high requirement to address psychological requirements and has multiple complex discharges. In addition, during the data collection period there were three complaints that involved communication issues. It is recommended that this report is shared with the Lead Nurse for Learning and Professional Development and for the Matron and Ward manager to consider communication development opportunities for RN's and CSW's working in this complex ward environment. There is currently a band 2 discharge co-ordinator 1.0 WTE that comes out of the band 2 budget. This post is likely to transfer over to the management of the Discharge Team in the near future.

Wensleydale Ward

Wensleydale ward is a 30 bedded Surgical admissions unit that became a multi-specialty COVID ward during the pandemic. Jervaulx were based on this ward last year; therefore, there is no direct comparable data.

The ward is one single corridor with a centrally located work base. The ward kitchen and staff room are located at the entrance corridor to the ward out of sight of the patient areas. The top half of the ward comprises three four bedded bays, three single rooms, one of which has en-suite and a two bedded bay. There are patient bathroom facilities centralised opposite the bays. The bottom half of the ward has three four bedded bays and three single rooms. Behind the central staff base is a dirty utility, an MDT room and a clean utility. The Ward Manager's office is located at the entrance to the ward.

There is a fire escape leading to concrete steps at the bottom of the ward, the fire doors lock and alarm if opened. Only one patient in one single room is visible from the central staff base, no other patients are visible from the staff base. No bays have a base for staff. Off the centre of the ward are storage areas.

There are no bed head light facility and the call bell, if unanswered within three minutes, converts to an emergency (crash alarm) bell. This has been highlighted as a risk to patient safety and is on the departmental risk register.

The ward layout is compounded due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers. As a result of the COVID pandemic these patients are being admitted in a deconditioned state which had directly impacted on the raising numbers of patient requiring enhanced care and increasing length of stay. The length of stay is also impacted by the unavailability of continuing care, also caused by implications of the COVID pandemic.

There is a full-time ward clerk who works 08:00 – 20:00hrs 3 days a week. The rest of the hours are filled using bank. During the SNCT data collection there was no visiting on Wensleydale (Red Ward). The ward clerk plays a vital role, answering the phone to anxious relatives and reducing the admin burden on the nursing staff.

At the time of the study the ward was led by an experienced Ward Manager and Matron. There are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is 3 management days (22.5 hours) per week. However these are not always taken due to clinical commitments, resulting from staffing pressures.

Refurbishment of the Wensleydale ward is planned for 2022 and is overdue. Once completed it will house the Acute Medical Ward and CCU, which is currently on Bolton.

Patient care is allocated by: (Currently at 30 beds)

Bay 1 and 2 and annex (10 patients) 1 nurse

Bay 3 and 4 single rooms 1, 2, 3 (10 patients) 1 nurse

Bay 5 and 6 single room 4, 5, 6 (10 patients) 1 nurse

The 4th nurse is the nurse in charge and supports RNs and with all of the complex discharges that are required. It is extremely rare that there is a forth nurse; although planned and rostered, staffing challenges on the neighbouring escalation result in this forth nurse being redeployed. In addition, two escalation beds are used on an adhoc basis for ‘ward attenders’, these additional patients are the allocated responsibility of the nurse in charge.

When patients require scans ‘out of hours’ an escort is required. The acuity of the patient dictates the need for this escort being a CSW or RN. Escorts can be absent from the ward for 30-40 minutes at a time.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th Feb – 6th March 2022	87%	75.5%	75.9%	97.6%

The current shift establishment is (for 30 beds):

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

At the time of the study the bed occupancy was 90%

The budgeted establishment is for 30 beds is 19.72wte RNs and 20.06wte CSW

Contracted for the time of data collection was 14.61wte RN and 14.89wte CSW

At the time of the data collection there were vacancies of 5.11wte RN and 5.17wte CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£12,554
Cost of Agency spend during the data collection period	£16,767

RN Demand 1138 hours (7.6wte)
Fill 484 hours (3.2wte)
42.5% fill

CSW Demand 990 hours (6.6wte)
Fill 340.5 hours (2.3wte)
34.4% fill

CHPPD

June 2021	
July 2021	
2nd data collection 2022	**6.0**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	4.26%	2.42%	1.82%

The CSW turnover rate is raised as new to post CSW's found that the role was not what they were expecting. In addition ward management expressed that there were significant issues getting agency staff to work on Wensleydale due to it being a RED COVID area.

Quality indicators

Falls	10
Hospital acquired pressure ulcers	6 x Cat 2 2 x Deep tissue injury
Medication incidents	1
Staffing Datix	0
Formal Complaints	0

Enhanced care: There were a total of **21** enhanced cares. This averages at **0.75** enhanced care patients per day.

	Total in data collection period	Average per day
Admissions	23	0.82
Discharges	39	1.39
Transfers In	78	2.78
Transfers Out	29	1.03
Deaths	7	0.25

Admin Support:

	Establishment	Contracted
Band 2	1.0wte	1.0wte

Nurse Associates:

	Establishment	Contracted
Band 4	0.0wte	1.0wte (on mat leave)

Nutritional Assistant:

	Establishment	Contracted
Band	0.0wte	1.0wte awaiting a start date

As a summary of the SNCT study period

Bed occupancy was 90%

The **budgeted** RN establishment is **19.72wte**

SNCT indicates the ward requires **19.80wte** RN. This suggests that the RN staffing establishment is set correctly for the dependency during the data collection period.

The **budgeted** establishment is **20.06wte** CSW

SNCT indicates the ward requires **13.2wte** CSW. This suggests an over established variance of 6.86wte. However this ward is running two pathways (Red and Yellow); therefore there needs to be two separate teams functioning within the team to ensure compliance with infection prevention and control guidelines as donning and doffing procedures are timely and take away from delivering direct patient care. Reducing the CSW establishment would inevitably impact negatively on quality indicators, increased staff burnout, reduce morale and patient care.

The data from the first SNCT review is not comparable as the wards have moved (increased bed base) and the speciality has changed from a surgical admissions unit to a multi-speciality COVID ward. The SNCT uses a different ratio for admissions ward 70:30 and base wards use a ratio of 60:40. Due to the change in speciality of Wensleydale ward and in consideration that it is awaiting a complete environmental refurbishment for it to be transformed in to a flagship Acute Medical Ward and CCU, the SNCT data collected for this ward would not be suitable in setting the establishment. It is recommended that once the ward has been refurbished, the data collected from Bolton to be considered along with the new environment and professional judgement in a triumvirate approach.

Through discussions at the SNCT review meeting the importance of seven-day ward clerk cover was highlighted. Having full day cover seven days a week has a positive, direct impact on patient care and communications with families. It is also recommended that the nurse call system be replaced at the time of refurbishment; ensuring that clinical expertise from the Matrons and clinical staff is sought in choosing a suitable replacement.

It was noted that the CSW turnover rate was raised as new to post CSW's found that the role was not what they were expecting. This will be fed back to the 'Retention' Sub Group and CSW Practice Educators as an area to be investigated and developed.

Harlow Ward - Escalation

Harlow ward is a 15 bedded short stay escalation ward (mixed speciality). Previously a 25 bedded surgical admissions unit. It is a straight ward with the ward kitchen, one single room on the approaching corridor. The remainder of the ward is in a singular corridor with the two staff bases. The former private end of the ward there are 10 single rooms each with en-suite facilities, all have limited or zero visibility from staff bases (used for infectious or end of life patients) and if used, are additional to the 15 beds. Two of the single side rooms are currently being used as a Male and a Female communal shower rooms. There is a dirty and clean utility opposite the first staff base and behind the second staff base. The former escalation ward area provides three bays of four beds and three single rooms. None of which have en suite facilities. Patient bathroom facilities are either opposite the bays or in the link corridor to the neighbouring ward; which is out of sight of the ward. The ward manager's office is it at the entry to the ward away from the main staff base.

The ward is led by a Ward Manager who is new in to post and an experienced Matron. There were 2.0 wte substantive registered staff on Harlow at the time of data collection. Resulting in a high reliance of staff being redeployed, NHSP and agency to staff the bed base; hence the high expenditure on NHSP and agency staffing.

The complexities and logistics of opening and leading an escalation ward should not go unnoticed. The ward takes multi-speciality patients, being flexible with admission criteria to enhance the quality of care provided to patients and their families. For example, taking end of life patients. The availability of large single side rooms provides an improved environment for optimal holistic patient care. The excellent feedback that this escalation ward receives is a credit to the leadership and teamwork of the staff and a measure of the quality care HDFT provides its patients in such difficult and unpredictable times.

Patient care is allocated by:

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Although there should be two RNs on each day shift. Each shift the nurse in charge coordinates the admissions and transfers and has an allocation of patients.

Over the data collection period the fill rates were:

	Day	Night

Data collection period	RN	CSW	RN	CSW
7th Feb – 6th March 2022	58.5%	41%	54.5%	57.1%

The current shift establishment is (for 15 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	2	2	2	2	1

At the time of the study the bed occupancy was 118.5%. This is due to additional escalation beds being opened at a time of extreme bed pressures at HDFT. The data collection period was during the spike of the Omicron variant of COVID.

No budgeted establishment

Contracted for the time of data collection was 2.0wte RN and 3.88wte CSW

RN's and CSW's have been redeployed from other areas to staff this escalation ward.

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£29,528
Cost of Agency spend during the data collection period	£15,291

RN Demand 1486 hours (9.9wte)
Fill 869 hours (3.3wte)
58.5% fill

CSW Demand 1004 hours (6.7wte)
Fill 526 hours (3.5wte)
52.4% fill

CHPPD: no comparable data from first SNCT review

June 2021	
July 2021	
2nd data collection 2022	**5.3**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	4.26%	2.42%	1.82%

Quality indicators

Falls	0
Hospital acquired pressure ulcers	1 x device related 1 x Cat 2
Medication incidents	3
Staffing Datix	3
Formal Complaints	0

Enhanced care: There were a total of **0** enhanced cares. This averages at 0 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	68	2.42
Discharges	40	1.42
Transfers In	84	3
Transfers Out	99	3.53
Deaths	4 (EoL patients)	0.14

Admin Support:

	Establishment	**Redeployed**
Band 2	0.0wte	0.6wte redeployed from Littondale. Also use band Ward Clerk's to cover unfilled duties.

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	0.0wte

Nutritional Assistant:

	Establishment	**Contracted**
Band	0.0wte	0.0wte

As a summary of the SNCT study period

Bed occupancy was 118.5% based on a bed base of 15 beds as this ward has been staffed of 15 beds.

No **budgeted** RN establishment

SNCT indicates the ward requires **15.6wte** RN.

No **budgeted** CSW

SNCT indicates the ward requires **10.4wte** CSW.

This ward was opened during the Omicron variant of the pandemic as a short stay escalation ward and is due to close in May 2022. Therefore, it is recommended that this data is taken into consideration, applying professional judgement if an escalation ward should be required again in the future.

Nidderdale Ward

Nidderdale is a 30 bedded orthopaedic trauma ward. The ward is a "T" shaped ward. With four adjacent bays 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 single rooms 27 and 28 are opposite bay 6. The two remaining single rooms are out of sight off the entry corridor. 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.

At the time of the data collection the ward was led by an experienced band 6 Sister; covering for the Substantive Ward Manager who was on extended leave. The leadership of the ward was overseen by an experienced Matron and supported by experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is three management days per week; although these frequently change to clinical days due to staffing pressures.

As this is an orthopaedic trauma ward, a significant number of patients are frail and elderly. They often experience a post-operative delirium and have an increased risk of falls. Due to this there is a daily request for an additional CSW overnight and increasingly for the additional long day shift. The ward exits by single room 2 and single room 27 are swipe card activated to prevent at risk patients leaving the ward. At risk patients are cohorted in bay 5 and 6 as these bays are the closest to the staff base. As a direct result of the COVID pandemic many patients that are admitted to Nidderdale have been found to be deconditioned. This has increased their care needs and impacted on length of stay.

Patient care is allocated by splitting into three teams of ten. Each team consists of the single rooms and bays. For example: Team 1 includes single room 1 and 2 and B3 -B10.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is sometimes done to support junior nurses who require a less acute team. The nurse in charge overarches all the patients and provides support as needed. If there are 3 RN's on shift the nurse in charge overarches and cares for a team of 10 patients.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW

7th Feb – 6th March 2022	72.3%	107.7%	82.1%	164.2%

At the time of the study the bed occupancy was 99.2%

The current shift establishment is:

Day		**Night**	
RN	CSW	RN	CSW
4	3	3	2

The budgeted establishment is for 30 beds is 20.32wte RNs and 18.32wte CSW

Contracted for the time of data collection was 11.81wte RN and 11.20wte CSW

At the time of the data collection these were vacancies of 8.51wte RN and 7.12wte CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£31,552
Cost of Agency spend during the data collection period	£7,133

RN Demand 1122 hours (7.5wte)
Fill 380.5 hours (2.5wte)
33.9% fill

CSW Demand 1451 hours (9.7wte)
Fill 968 hours (6.5wte)
66.7% fill

CHPPD

June 2021	**6.4**
July 2021	**5.9**
2nd data collection 2022	**5.6**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	9.47%	5.25%%

Quality indicators

Falls	4
Hospital acquired pressure ulcers	3 x deep tissue injuries 2 x Cat 2 2 x unstageable
Medication incidents	3

Staffing Datix	5
Formal Complaints	2 Communication re discharge Inpatient stay and transfer between wards.

Enhanced care: There were a total of **164 enhanced** cares. This averages at **5.86** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	45	1.6
Discharges	16	0.57
Transfers In	31	1.1
Transfers Out	49	1.75
Deaths	0	0

Admin Support:

	Establishment	**Contracted**
Band 2	1.0wte	1.0wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	1.0wte (present during the data collection period but has since left to work in another department)

Nutritional Assistant:

	Establishment	**Contracted**
Band	1.0wte (comes out of the band 2 establishment)	1.0wte

As a summary of the SNCT study period

Bed occupancy was **99.2%**

The **budgeted** RN establishment is **20.32wte**

SNCT indicates the ward requires **25.0wte** RN. This suggests an under established variance of 4.68wte. The previous SNCT results from 2021 suggested that Nidderdale required 20.45wte. Highlighting that dependency on this ward has increased during this data collection period. It is recommended that a further SNCT data collection is completed before changing this RN establishment.

The **budgeted** CSW establishment is **18.32wte**

SNCT indicates the ward requires **16.7wte** CSW. This suggests and over established variance of 1.62wte. The previous SNCT results from 2021 suggested that Nidderdale

required 20.49wte CSW; highlighting a lowered measurement of dependency for support workers over the second data collection period.

The ward has a 1.0 WTE nutritional assistant (Band 2) and a 1.0 WTE ward clerk (Band 2). It is recommended that the Ward clerk cover on the ward should be increased to 2.15 WTE to enable cover 08:00 – 20:00, seven days a week. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and assisting with visiting arrangements. It is also recommended that the Nutritional assistant cover be increased to 1.4 WTE to increase the cover across the weekend. The fill rates for CSW were above the set establishment. This was to ensure the safety of our enhanced care patients of which Nidderdale averaged 5.86 enhanced care patients a day over the data collection period. These additional CSW hours were achieved using NHSP and agency. It is for this reason that we strongly recommend that the CSW establishment is not reduced and that the surplus is used to recruit to these support positions as described above.

Fountains Ward (ESU)

Fountains ward is an elective surgery ward with 15 beds. Previously this ward had 28 beds; however due to COVID there has been a shift in bed base to allow for escalation beds to be opened on Bolton. The longer-term plan is for Fountains to be moved to a newly refurbished and appropriately designed surgical ward environment. Currently, there are two bays of six and three single rooms, two of which are en-suite. The ward is an “L” shaped ward. Along the entry corridor is the ward office, clean utility, 2 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 and kitchen are immediately adjacent. There is some visibility of bay 1 and one single room from the staff base but the remaining bays, HOB and three single rooms have no visibility. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay. There are dedicated orthopaedic beds which are required to be separated from the general surgery beds for infection control reasons.

The ward is led by a newly appointed Ward Manager and experienced Matron. The ward manager is currently covering two areas (Fountains and Nidderdale); and therefore allocated 4 management days per week (30 hours 0.8WTE). There are also experienced Band 6 Ward Sisters.

Patient care is allocated by:

1 x Nurse in Charge

1 X RN & CSW for orthopaedic patients

1 x RN & CSW for general surgery patients

If there is a patient in the HOB an additional RN is required.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were: it is worth noting that the fill rates appear to have been calculated using the 28 beds rather than the revised 15 beds.

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th Feb – 6th March 2022	50.9%	51.8%	66.7%	26.8%

The current shift establishment is (for 15 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	2	2	2	2	1

At the time of the study the bed occupancy was 79.5% based on 15 beds.

The budgeted establishment is for 28 beds is 19.62wte RNs and 11.51wte CSW

Contracted for the time of data collection was 14.95wte RN and 8.95wte CSW

At the time of the data collection there were vacancies of 4.67 RN and 2.56 CSW. It should be noted that the over establishment of staff, as a result of a bed base reduction, have been redeployed to other areas of need and the staffing of these beds has been reduced as described above to reflect a bed base of 15.

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£6504
Cost of Agency spend during the data collection period	£1658

RN Demand 483 hours (3.2wte)
Fill 224 hours (1.5wte)
46.3% fill

CSW Demand 88 hours (0.6wte)
Fill 22.5 hours (0.15wte)
25.6% fill

CHPPD:

June 2021	**10.4**
July 2021	**9.6**
2nd data collection Feb/March 2022	**6.7**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	8.29%	0.87%

Quality indicators

Falls	0
Hospital acquired pressure ulcers	0
Medication incidents	2
Staffing Datix	0
Formal Complaints	0

Enhanced care: There were a total of **0** enhanced cares. This averages at **0** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	107	3.82
Discharges	46	1.64
Transfers In	22	0.78
Transfers Out	77	2.75
Deaths	1	0.03

Admin Support:

	Establishment	**Contracted**
Band 2	1.19wte	0.6wte (increased to 1.2WTE after data collection period)

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	1.0wte (left after data collection period)

Nutritional Assistant:

	Establishment	**Contracted**
Band	Comes out of the band 2 establishment	0.8WTE

As a summary of the SNCT study period

The bed occupancy data way calculated on a 15 bedded capacity. Over established staff are redeployed to Nidderdale ward to help fill the RN and CSW gaps. Two members of staff on a long term redeployments and the others are redeployed on a daily basis and allocated dependant on skill mix.

The **budgeted** RN establishment is **19.62wte**

SNCT indicates the ward requires **8.6wte RN.** This suggests an over established variance of 11.02wte. The previous SNCT results from 2021 suggested that Fountains required 14.75wte. Highlighting the reduction in bed base since the first data collection.

The **budgeted** CSW establishment is **11.51wte**

SNCT indicates the ward requires **5.7wte CSW**. This suggests and over established variance of 5.8wte. The previous SNCT results from 2021 suggested that Fountains required 7.92wte CSW. Again, highlighting a lowered measurement of dependency as a result of the reduced bed base.

It has been highlighted that due to the reduction in beds, as a result of COVID ward flipping, the data for this area is skewed and not comparable to the first SNCT review. Although the SNCT recommends a significant reduction in registered nurses and care support workers; the senior nursing team have discussed the dependency data aligning professional judgement, informed by quality data to conclude that the establishment on Fountains should be left unchanged until the ward have been relocated to their new environment and new SNCT data collected and reviewed. At this stage a full establishment skill mix review will be undertaken, including support roles such as, Nutritionists, Ward Clerks and House keepers.

Rowan Ward

Rowan Ward is a 12 bedded rehab ward; however, during the data collection period had 1 escalation bed open, increasing the bed base to 13. This is planned to reduce back down to 12 beds at the end of May 2022. The staff also have additional skills to manage up to two patients who are at the end of their life and who can be cared for in a quieter environment than an acute ward.

Although on the main hospital site, it is in a separate wing to all other wards and has no neighbouring wards. The ward is a “L” shaped ward. With two four bedded bays and four single rooms. All bays and rooms are in the same area of the ward. Immediately adjacent linen room, patient toilets and staff room. There are no en-suites. The staff base is at the apex of “L” shape. Other supporting areas such as the ward office, dirty utility, assisted bathroom and storerooms are off the entry corridor; all of which are a distance from the patients. The ward also has a large rehabilitation therapy room, ward education room where a practice educator is based, outpatients clinic room often utilised over the weekends and the radiology department use the ward for access to a CT Scanner – this increases footfall on the ward and often requires ward staff to answer the door as appropriate. The ward has a dining room (of which half is used as a store room) and a quiet room and a small outdoor area for patient use; this means that often patients are located in numerous places across the ward. During periods of increased demand, the ward admit patients who are awaiting complex discharges and also has a 13th bed for escalation – however this reduces clinic capacity if this is used.

At the time of the study the ward was led by an experienced Ward Manager, supported by an experienced Matron, there is one experienced Band 6 Ward Sister. The Ward Manager gets one 9-hour management day per week. Professional judgement by the

Matron of the ward is that the ward management days would be adequate at two days per week (18 hours) due to the lower staffing levels with regard to HR management and reduced patient numbers.

The patients on the ward often require assistance of two (or more) to support with the delivery of their care needs; this might be due to mobility or end of life care needs. The patients at the end of their life often need additional intensive support, both physical and psychological for themselves and their families. 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.

In addition, patients have complex needs 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.

Rowan used to be based on Lascelles, where their environment was appropriately equipped for rehabilitation of patients (they had ceiling tracks for/with hoists, appropriate bathrooms, grab rails for patients to utilise at the bed spaces). This meant that some of the care needs could be performed safely by one member of staff. Because of the environment on Rowan, patients are reliant on two staff members, which puts the SNCT dependency scores higher.

Patient care is allocated by the nurse in charge, who also takes an allocation of patient. The nurse in charge will have oversight of all patients and will support the CSW with personal care requirements of the patients.

Over the data collection period the shift fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th February – 6th March 2022	100%	70.7%	100%	92.8%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	1

The budgeted establishment is for 12 beds is 11.76wte RNs and 10.6wte CSW

Contracted for the time of data collection was 11.08wte RN and 8.2wte CSW

At the time of data collection there were vacancies of 0.68wte RN and 2.4wte CSW.

One of the 3 'early' CSW's gets redeployed each morning to other areas of need. This can inhibit the ability to provide all the 2 hourly turns in a timely manner (This risk has been escalated).

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£4,309
Cost of Agency spend during the data collection period	£616

RN Demand 167 hours (1.11 wte)
Fill 112 hours (0.75 wte)
67.3% fill

CSW Demand 250 hours (1.66 wte)
Fill 36.5 hours (0.25wte)
14.6% fill – this low fill rate is a result of CSW redeployment.

CHPPD

June 2021	**10**
July 2021	**8.7**
2nd data collection 2022	**6.9**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	5.68%	0.78%

Enhanced care: There were a total of 20 enhanced cares. This averages at 0.71 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	0	0
Discharges	6 complex discharges	0.21
Transfers In	8	0.28
Transfers Out	0	0
Deaths	2	0.07

Admin Support:

	Establishment	**Contracted**
Band 2	0.0wte	0.53wte (comes out of band 2 CSW budget)

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	0.0wte

Nutritional Assistant/Housekeepers:

	Establishment	Contracted
Band	0.0wte	0.0wte

Quality indicators

Falls	1
Hospital acquired pressure ulcers	0
Medication incidents	0
Staffing Datix	1
Formal Complaints	0

As a summary of the SNCT study period

Bed occupancy was **108.3%**

The **budgeted** RN establishment is **11.08 wte**

SNCT indicates the ward requires **12.7wte RN**. This gives an under established variance of 1.06wte. The previous SNCT results from 2021 suggested that Rowan required 8.51wte. Highlighting that dependency on this ward has increased. This is commensurate with an extra bed being open over the data collection period; which will have increased the WTE results slightly.

The **budgeted** CSW establishment is **10.68wte**

SNCT indicates the ward requires **8.5wte CSW**. This suggests an over established variance of 2.18wte. The previous SNCT results from 2021 suggested that Rowan required 8.51wte CSW; highlighting a consistent measurement of dependency for CSW's over the two data collection periods.

However, SNCT recommendations should be used cautiously for small wards as at least 2 RN (which is at least 11.2 plus a ward manager) are required per shift and professional judgement should be used to inform staffing levels. Due to the patient profile, as above, the recommendation would be that the CSW and RN establishment remains the same; allowing for additional roles such as a Nutritional assistant and increased ward clerk cover should be considered.

The CHPPD has fallen from last year; however the fill rate has reduced to 75% for CSW's on a day shift, as a result of redeployment to other clinical areas of need. In addition, there is an additional escalation bed opened with no additional staff and the bed occupancy was at 108.3%. Quality indicators suggest that a high standard of care is being maintained on Rowan and this should be highly commended, showing excellent leadership and teamwork in such challenging times.

There is a part time ward clerk covering 4 hours a day for 5 days a week. Our SNCT review discussion highlighted the requirement for 7-day admin cover. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and doorbell, and assisting with visiting arrangements. Our review meeting highlighted that a discharge support worker would be beneficial, to assist with the complex discharges and ensure the right to reside data collection is completed daily. In addition a Nutritional Assistant to be considered, using the remaining band 2 establishment.

Oakdale Ward

Oakdale ward is a 30 bedded stroke, rehab, neuro, acute oncology, inpatient SACT and medical ward; however, the establishment is set for 26 beds. There are three, six bedded bays, one four bedded bay and eight single rooms. The ward is not uniformly laid out. Bay 1, room 12 and the Haematology/Oncology single rooms are out of sight and distant from the main staff base. Room 1, day room, ward manager office, kitchen and staff room are distant to the remainder of the ward. The six bedded rooms (4 & 5) and four of the single rooms are located around the main staff base. There is a further staff base located within line of sight of the four bedded (room 12) and the four oncology single rooms. The six bedded bays (4 & 5) have a toilet and six single rooms have en-suite facilities.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is one management days per week.

During the data collection period a RN from Oakdale held the 'Acute Oncology Helpline' bleep from 18:00 to 0800 every evening and 24 hours over the weekends and bank holidays. This is a helpline for patients to get immediate advice and in necessary, treatment for symptoms relating to their cancer or side effect of their treatment. Each call can take up to an hour and can only be taken by a competency assessed RN; usually the Nurse in charge. Advice will be given or the patient will be signposted appropriately/admitted to the hospital. From June 2022 The Acute Oncology Team will hold bleep on weekends between 08:00-16:00, leaving Oakdale RNs to cover from 1600 on weekends, 1800 week days and all day on bank holidays.

When patients are on the ward receiving inpatient Chemotherapy, staffing numbers need to be maintained with the appropriate skill mix of staff, as this requires intensive periods of level 2 care. When this is not achievable the SACT Unit supports by sending RN's over to check and administer the Chemotherapy. The Lead SACT Nurse also provides extensive training for the RN's on Oakdale to ensure knowledge and skills are kept up to date.

There continues to be a requirement for the ward to take Gastroenterology patients due to the capacity on Littondale Ward. This brings additional challenges such as complex IV regimes, treatment and often, enhanced care needs.

The ward is required to manage the Botox Clinic which requires three RNs six hours each to do so, a total of eighteen hours per month. However, for the data collection period this was reduced to two RNs. This requirement comes directly from the nurse establishment on the ward. The ward is a multi-speciality ward and therefore the nurse in charge is required to attend multiple ward rounds and MDT discussions.

Due to the dependency of the patients on Oakdale being extremely high due to mainly having stroke patients a medications round compared to other areas take twice as long due to most medications needing to be crushed and administered down an nasal gastric (NG) tube which requires several checks that it is placed correctly before usage or

crushing and placing down a percutaneous endoscopic gastrostomy (PEG) tube and for the patients without feeding tubes they require extra time to have their medications administered orally and swallowing techniques assessed. It is a rarity that any patients are independent taking medications on Oakdale ward.

This ward often has a high level of patients who are confused, an absconding risk or require enhanced care. The patients on the ward usually require intense rehabilitation and this may need more than two members of staff to support with this. The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised. Due to this, there is a daily request for an additional CSW overnight and sometimes for the additional long day shift.

Oakdale ward has its own speciality allied health professionals; they support with the ward huddle daily. The geographical location is next to Granby Ward, therefore mutual aid is often provided from each ward.

Patient care is allocated by:
Days:

Bay 1: 6 patients, usually the least dependent patients

1 x RN and 1 X CSW – normally during the day that nurse is the nurse in charge.

Single room 2 & 3 and bay 4 : 8 patients in total.

1 X RN and 1 X CSW

Single room 6 & 7 and bay 5: 8 patients in total.

1 RN and 1 CSW

Single rooms, 8, 9, 10 & 11 and bay 12: 8 patients in total

1 RN and 1 CSW
As a contingency during the day if there are 3 RNS or 3 CSWs the divide is:

Bay 1 and bay 4: 12 patients

Bay 5 and single room 2, 3, 6, 7: 10 patients nurse in charge

Bay 12 and singleroom 8, 9, 10, 11: 8 patients.

Many shifts have just 2 RN's; therefore the patients are divided equally, being responsible for 15 patients each.

Nights:

2 RNS and 2 CSWS allocated to bay 1, bay 4, bay 5 and single rooms 2, 3, 6, 7

1 RN and 1 CSW allocated to bay 12 and single rooms 8, 9, 10, 11

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Data collection period	Day		Night	
	RN	CSW	RN	CSW
7th February – 6th March 2022	81.7%	62%	94%	83%

The current shift establishment for the funded 26 beds is:

Day				Night	
Early		Late			
RN	CSW	RN	CSW	RN	CSW
4	4	4	3	3	3

At the time of the study the bed occupancy was 95.9%, data collected at 15:00hrs.

The budgeted establishment based on **26 beds** is: 19.92wte RNs and 18.47wte CSW

Contracted for the time of data collection was 14.2wte RN and 16.43wte CSW

Vacancies at the time of data collection: 5.72 RN and 2.04 CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£23,628
Cost of Agency spend during the data collection period	£21,297

RN Demand 1081 hours (7.20wte)
Fill 515.64 hours (3.44wte)
47.7% fill

CSW Demand 1895 hours (12.63wte)
Fill 1030.88 hours (6.87wte)
17.7% fill

CHPPD

June 2021	**6.4**
July 2021	**6.6**
2nd data collection 2022	**5.4**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	5.71%	5.74%	20.44%

Quality indicators

Falls	12
Hospital acquired pressure ulcers	1 x DTI

Medication incidents	2
Staffing Datix	5
Formal Complaints	0

Enhanced care: There were a total of **119 enhanced cares**. This averages at 4.25 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	24	0.8
Discharges	39	1.39
Transfers In	47	1.67
Transfers Out	25	0.89
Deaths	5	0.1

Admin Support:

	Establishment	**Contracted**
Band 2	1.0wte	1.0wte
Band 3 data clerk	0.73wte	0.73wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	2.0wte

There are 2 band 4 nursing associates, one on mat leave and one working, they are funded from the band 5 establishment.

Nutritional Assistant:

	Establishment	**Contracted**
Band 2	0.0wte	1.0wte (comes out of band 2 budget until June 2022)

As a summary of the SNCT study period

Bed occupancy was 95.9%

The **budgeted** establishment is **19.92wte** RN (26beds)

SNCT indicates the ward requires **26.6wte RN**. This suggests an under established variance of 6.7wte. The previous SNCT results from 2021 suggested that Oakdale required 21.87wte. Highlighting that dependency on this ward has increased during the data collection period.

The **budgeted** establishment is **18.47wte CSW** (26 beds)

SNCT indicates the ward requires **17.7 CSW**. This suggests and over established variance of 0.77wte. The previous SNCT results from 2021 suggested that Oakdale required 23.63wte CSW; highlighting a lowered measurement of dependency for support workers during this data collection period.

Oakdale had a high volume of enhanced care patients. 119 over the 4 weeks, averaging 4.25 enhanced care patients per day. In addition, the number of falls, compared to the last data collection, has significantly increased. This could be due to the reduced shift fill

rates for CSW's. Therefore, it is not advised to reduce the CSW hours within this establishment and to review again after the third data collection, aligning to quality data and professional judgement.

Bank and agency spend is high, which could be because the bed base is higher (30) than the funded bed base (26). In addition, the staff sickness rates are high; mainly due to COVID related sickness absence. It is also worth noting that there is a high percentage of staff on maternity leave; 3 RN's and 1 CSW. CHPPD has fallen since the last data collection. This may be as a result of poor fill rates for shifts that remain unfilled due to staff sickness, vacancy and maternity leave. It should also be noted that Allied Healthcare Professionals assist in providing direct patient care to patients on Oakdale. For example, washing and dressing assessments, hoisting and rehabilitation. These hours are not currently included in our CHPPD data; therefore, skewing this measurement in a less favourable light.

The additional workload from the 'Acute Oncology Helpline' bleep during the data collection period equated to approximately 14 hours. The average amount of calls per week, calculated on a years' data, is 5 contacts. The Acute Oncology team are increasing the hours that they will hold the Acute Oncology bleep from June 2022. This should have a positive impact, reducing the amount of hours Oakdale RN's spend providing support to this patient group.

There is no specific staffing ratio that can be easily aligned for when administering chemotherapy as an inpatient. This is because each chemotherapy regimen is unique in its complexity; therefore, guidance should be sought from the Lead SACT nurse when planning inpatient chemotherapy and additional support provided from the chemotherapy unit to supplement knowledge and skills in this area, thus providing optimal patient care.

Although Oakdale have additional support staff (ward clerk, nutritional assistant) to supplement the nursing workforce, it would be advised to ensure that these services are increased to operate across the 7 day week. In addition, our review meeting highlighted that a discharge support worker would be required full time (currently only part time) to assist with the complex discharges and ensure the right to reside data collection is completed daily.

The SNCT calculator used for this ward was 60:40; however, it should be noted that Oakdale has direct admissions as well as repatriation from York and Leeds that require a full admission. Admissions require a substantial amount of RN time to complete all the assessments and admin. Professional judgement should be considered when reviewing future SNCT data to ensure that the RN establishment is adequate to meet all the complexities of this specialist ward.

It is advised that the RN and CSW establishment is increased to represent the current bed base (30 beds).

Granby Ward

Granby ward is budgeted as a 16 bedded respiratory/endocrine ward. There are also six escalation beds which takes the ward up to 22 beds.

The ward is a “Z” shaped ward. There are three six bedded bays, and four single rooms, two of which are en-suite. Two of the bays have toilet facilities. Upon entering the ward immediately on the left is the six bedded escalation bay which is out of sight of the remainder of the ward. Therefore, care is taken when assigning patients to that bay. The entry corridors to the main area of the ward have a therapy kitchen, patient shower facilities, staff kitchen, linen cupboard, dirty utility, and staff room. The main area of the ward has a central staff base surrounded by the two bays and four single rooms. The visibility of patients, except for the escalation bay, is good. Granby Ward request one to one enhanced care in exceptional circumstances.

The ward has a high turnover of patients who are either transferred or discharged directly from the ward, there are also occasional direct admissions.

Due to the high levels of patients requiring oxygen, there is often the requirement of a RN to escort a patient for any scans, X-Rays or appointments; this directly affects the capacity of the ward. The ward is a multi-speciality ward and therefore the nurse in charge is required to attend multiple ward rounds and MDT discussions.

Anecdotally there are frequently complex discharges required of the ward. The ward frequently transfers patients to neighbouring hospitals which requires a RN escort, who can then be absent from the ward for the majority of the shift. The ward often cares for patients with Learning Disabilities; this often requires complex discharge planning and additional care requirements.

The geographical location is next to Oakdale Ward, therefore mutual aid is often provided from each ward.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters and Charge Nurse. The budgetary allocation for the Ward Manager is two management day per week (15 hours). However, she frequently forfeits these to deliver direct patient care due to staffing challenges. The ward managers’ office is on the corridor that connects on to Oakdale ward.

Patient care is allocated by:

1 Bay and 2 single rooms – 1 RN

1 Bay and 2 single rooms – 1 - RN

Bay 1 to the Nurse in Charge as these patients are usually the least dependant.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the SNCT study period the ward was fully escalated at 22 beds

Over the data collection period the fill rates were:
This data is based on 16 beds – not 22 where additional staff are in the establishment.

Month	Day		Night	
	RN	CSW	RN	CSW
7th February – 6th March 2022	82.1%	65.5%	100%	94.6%

The current shift establishment is:

	Day				Night	
	Early		Late			
	RN	CSW	RN	CSW	RN	CSW
16 beds	3	2	2	2	2	2
22 beds	3	3	3	3	2	2

At the time of the study the ward had 22 beds open and based on the bed occupancy was 97.4%.

The budget establishment for 22 beds is 15.23wte RNs and 14.32wte CSW.
The budget establishment for 16 beds is 13.47wte RNs and 12.51wte CSW

Contracted for the time of data collection: 12.9wte RN and 9.08wte CSW

At the time of SNCT data collection there was a vacancy of: 2.33wet RN and 4.52wte CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£15,364
Cost of Agency spend during the data collection period	£4,736

RN Demand 479 hours (3.19wte)
Fill 234.23 hours (1.56wte)
48.9% fill

CSW Demand 852 hours (5.68wte)
Fill 558.06 hours (3.72wte)
53.2% fill

CHPPD

June 2021	**7.1**
July 2021	**6.2**
2nd data collection 2022	**5.2**

Turnover %		Sickness %	
RN	CSW	RN	CSW
6.9%	0%	1.10%	2.96%

Enhanced care: There were a total of 9 enhanced cares. This averages at 0.32 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	8	0.28
Discharges	63	2.25
Transfers In	82	2.92
Transfers Out	18	0.64
Deaths	7	0.25

Admin Support:

	Establishment	**Contracted**
Band 2	0.92wte	1.0wte (covering 5 days)

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	0.0wte

Nutritional Assistant:

	Establishment	**Contracted**
Band	0.0wte	1.0wte (using band 2 establishment).

Quality indicators

Falls	3
Hospital acquired pressure ulcers	2 x Cat 2
Medication incidents	1
Staffing Datix	9
Formal Complaints	1 – communication regarding ward transfer

As a summary of the SNCT study period

Bed occupancy was 97.4% based on a bed base of 22.

WTE RNs Budgeted 15.23wte for 22 beds.

SNCT indicates the ward requires **15.7wte RN.** This gives an under established variance of 0.47wte. The previous SNCT results from 2021 suggested that Granby required 16.43wte. Highlighting that dependency on this ward has marginally changed.

WTE CSW's Budgeted 14.32wte for 22 beds.

SNCT indicates the ward requires **10.5wte CSW.** This suggests an over established variance of 3.82wte. The previous SNCT results from 2021 suggested that Granby

required 16.43wte CSW; highlighting an inconsistent measurement of dependence for support workers over the two data collection periods.

The current budget is set for 16 beds, SNCT recommends additional RN establishment which is commensurate to the additional staffing put in place for 22 beds. The recommendation is that the budgetary funding is brought in line with 22 beds for the entire year; having one agreed establishment and budget.

Granby has seen a reduction in CHPPD; which is expected, as the fill rates are lower than they should be to staff 16 beds. In addition, the agency/NHSP fill rates are at 50% and the ward was fully open at 22 beds. This has also been compounded by staff COVID sickness and RN turnover.

The ward SNCT was calculated using the 60:40 ration; however, it was noted that direct patient admissions have been increasing, resulting in an increased RN workload.

There is a ward clerk (1.0wte), working 5 days a week (07:15-15:15hrs). Discussions at the SNCT review highlighted the requirement for cover 7 days a week working 08:00-20:00hrs. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and assisting with visiting arrangements. This also could have prevented the communication failing that resulted in a formal complaint.

There is a full time Nutritional Assistant based on Granby. This position is funded out of the band 2 CSW budget and provides cover 5 days a week; however it is recommended that the Nutritional assistant cover be increased to provide the cover across the 7 day week. In addition, our review meeting highlighted that a discharge support worker would be required full time (currently only part time) to assist with the complex discharges and ensure the right to reside data collection is completed daily.

Farndale Ward

Farndale ward is 23 bedded medical admissions and COVID ward. There are two three bedded bays with en-suite facilities and 17 en-suite single rooms.

The ward is “L” shaped leading off the short entry corridor is the staff room and storeroom. There are three staff bases spread across the ward. Behind the central staff base is a fire exit corridor where the ward kitchen is located. Opposite the central staff base are the two three bedded bays which provide limited visibility. The remaining single rooms have very limited or zero visibility from any staff base. Storerooms, linen cupboard and ward managers office are located along the main corridor of the ward.

The ward is led by a dedicated Ward Manager (0.78wte) and experienced Matron, there are a mixture of experienced and junior Band 6 Ward Sisters. The ward manager has a budgetary allocation of two 9.5 hour management days per week, however this is often not the case and the ward manager can be pulled to provide direct patient care.

The patients that are admitted to the ward are usually acutely unwell and require enhanced nursing intervention in the first instance until the patient is stabilised. This includes 4 monitored telemetry beds, in theory monitored by the nurse in charge.

Throughout the pandemic there are patients who require Non-Invasive Ventilation (NIV) and as well as the nursing intervention that is required with this there are also the additional requirement of donning and doffing of PPE. There are also additional requirements for the monitoring and observations of these patients. As mentioned, the ward is primarily single rooms, which creates challenges with the visibility of these patients.

Patient care is allocated:

Ideally the patients are split into four teams however when there are only four RNs on duty they are split into three to allow a Nurse in Charge.

Team 1 consists of single room 1,2,3,4,5,6,23

Team 2 consists of Bay 1 (3 BEDS) Bay 2 (3 BEDS) and single rooms 13 &14

Team 3 consists of single rooms 15,16,17,18,19,20,21,22

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team. It should be noted that although the establishment requires 5 RN's, due to staffing challenges there are 4 RN's on the early and late shifts. Therefore, the Nurse in Charge (NIC) takes an allocation of patients in addition to co-ordinating this busy admissions unit.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th February – 6th March 2022	76.4%	68.4%	76.7%	90.5%

The **budgeted** establishment is for 23 beds is 28.3wte RNs and 21.86wte CSW

Contracted for the time of data collection was 16.33wte RN and 10.06wte CSW

Although only 16.33wte RN's are in post Farndale have 4.20wte associate nurses (Band 4). These members of staff are allocated RN shifts whilst trying to ensure a safe mix of skills on each shift. The allocation is for one NA per shift.

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
5	4	5	4	5	3

The bed occupancy was **97.2%** during the time of the study

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£21,361

Cost of Agency spend during the data collection period	£4,909

RN Demand 1167 hours (7.78wte)
Fill 382 hours (2.55wte)
32.7% fill

CSW Demand 924 hours (6.16wte)
Fill 415 hours (2.76wte)
44.9% fill

CHPPD

June 2021	**12.3**
July 2021	**12**
2nd data collection 2022	**9.1**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	4.75%	1.84%

Quality indicators

Falls	18
Hospital acquired pressure ulcers	1 x Cat 1 1 x Cat 2
Medication incidents	11
Staffing Datix	6
Formal Complaints	0

Enhanced care: There were a total of 21 enhanced cares. This averages at 0.75 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	439	15.67
Discharges	106	3.78
Transfers In	23	0.82
Transfers Out	266	9.5
Deaths	13	0.46

Admin Support:

	Establishment	**Contracted**
Band 2	2.07wte	2.19wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	4.2wte (out of band 2 budget but cover band 5 gaps)

Nutritional Assistant:

	Establishment	Contracted
Band	0.0wte	0.0wte

<u>As a summary of the SNCT study period</u> - using the SNCT for acute admission units and based on a 70:30 ratio

Bed occupancy was 97.2%

WTE RNs Budgeted **28.33wte**

SNCT indicates the ward requires **22.7wte** RN. <u>This gives an over established variance of 5.6wte</u>. The previous SNCT results from 2021 suggested that Farndale required 19.21wte. Highlighting that dependency on this ward is variable and, on this occasion, increased.

WTE CSW Budgeted **21.86wte**

SNCT indicates the ward requires **14.9wte** CSW. <u>This suggests an over established variance of 6.96wte.</u> The previous SNCT results from 2021 suggested that Farndale required 8.2wte CSW; highlighting an increased level of dependence for support workers over the two data collection periods.

As mentioned earlier 4.20wte within the CSW numbers are band 4 associate nurses covering RN gaps in the roster. During the SNCT review meeting it was highlighted that maintaining an adequate skill mix could be challenging and that Farndale would like a full review of the number of nursing associates moving forward. It is recommended that the Practice Learning Facilitator be involved in this to gain better oversight across all the adult inpatient wards.

Staffing ratios for nursing patients with Non-invasive Ventilation (NIV) across the country have varied throughout the pandemic. Organisations have had to effectively deploy staff with specialist skills and knowledge to meet the raising numbers of NIV patients whilst meeting infection prevention and control guidelines and maintaining patient safety within a pandemic situation. Additionally, guidance is dependent on the environment, skills set of the nurse and how long the patient has been on NIV. A report by the British Thoracic Society (2022) 'A respiratory workforce for the future' highlights multifactorial challenges within this speciality. Although a ratio of 1:2 would be preferred, mitigation of risk can be addressed when staffing challenges are met. For example, introducing additional CSW support and cohorting patients within the same bay.

The NIC on Farndale usually has an allocation of patients, which prevents effective co-ordination of the admissions unit, the ability to support junior members of staff, and directly impacts on patient flow through ED. During our SNCT review meeting it was highlighted that although Farndale has a high throughput of patients, it is increasingly being used like a base ward for some patients. Therefore, requiring increased input for complex discharges and ongoing care needs. In addition, there were many patients requiring enhanced care. This highlights the need for the CSW establishment to be maintained and to revisit after another data collection.

RN sickness rates were high due to COVID staff sickness. Shifts were put out to agency and NHSP with only 32.7% being filled. There has been an increase in quality indicators which correlates to the fill rates for the shifts. A reduction of one RN each shift has impacted on direct patient care (increased quality indicators). Anecdotally, when Farndale

are staffed to their full establishment the fifth RN is usually redeployed to other areas of need. This deters staff from booking additional shifts, despite the incentive rates offered. The CHPPD has fallen slightly since the previous data collection; this aligns with the reduction in fill rate as described above.

The ward has 2.19 WTE ward clerk, enabling cover 08:00 – 20:00, seven days a week. There are currently no other support roles. In addition, it is recommended that a 'Housekeeper' role be considered within this area, covering the seven-day week. For example, taking responsibility for stock, cleaning beds and bed spaces in between patients, helping to transfer patient belongings. The SNCT discussion highlighted that there is also a requirement for a Nutritional Assistant covering seven days a week. These additional roles will enhance patient care and free up nursing time. Supporting the nursing team with these aspects may help reduce quality indicators, such as, falls and hospital acquired pressure ulcers whilst improving the working lives for the staff within the department.

Bolton Ward

Bolton ward is a Medical Short Stay and Coronary Care Unit with 28 beds funded beds. At the time of data collection 10 escalation beds were opened, using bays from the neighbouring ward (Fountains), increasing the bed base to 38. There are three bays of 6 (Bay one &2 and escalation), CCU is a 4 bedded bay and a single room and there are 6 further single rooms, a 4 bedded bay (HOB), and a 5 bedded bay.

The layout and footprint of the ward is large and long and is an "L" shaped ward. Along the entry corridor is the day room, ward office, linen room, staff room, Doctors office, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area. The kitchen is just to the side of the apex opposite bay 1.

The staff base is at the apex of the "L" and the dirty utility is immediately adjacent. There is some visibility of bay 1 and bay 2 and limited visibility of one single room from the staff base but the remaining bays and side rooms have no visibility.

None of the bays have patient bathroom facilities; shared facilities are located opposite each bay. Two of the side rooms have en-suite. The escalation bay has a toilet.

The CCU is in bay 3 where an RN is designated to work. That nurse also cares for the patient in the CCU single room, which is across the corridor from CCU and also monitors up to four more patients on telemetry (maximum 9 patients on cardiac monitoring). A maximum of 8 patients should be monitored by 1 nurse.

The ward also takes patients who require NIV, and therefore there is an increase in time spent providing intense care and the time spent donning and doffing of PPE.

The ward has significant turnover of patients; in the study period there were (see admissions, discharges, transfers in and out below), however patient's numbers have varied due to COVID cases and subsequent isolation.

There is also often a requirement for an RN to escort a patient to neighbouring hospital for cardiac MRI; this often means the RN is out for the entire day.

The RN NIC working on the ward is required to support the CCU nurse with double checking medication, break relief and infusion preparations.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

Patient care is allocated by:

Bay 1 and escalation bay (12 beds) – 1 RN

Bay 2 and single rooms 1, 2, 3, 5 & 6 (11 beds) – 1 RN

Bay 3 (CCU) and single room 4 (5 beds) – 1 RN

Bay 4 and HOB bay and single room 7 (10 beds)– 1 RN

On the Early shift there is a nurse in charge (NIC) to direct flow, plan and complete discharges and support CCU, however when staffing gaps occur the NIC will have a bay allocated to them.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were (based on 28 beds):

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th March – 6th April 2022	97.6%	80.8%	110.7%	175%

The **budgeted** establishment is for 29 beds is 21.68wte RNs and 12.91wte CSW

Contracted for the time of data collection was 16.13wte RN and 15.49wte CSW

Vacancies at the time of data collection were: 5.38wte RN

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
5	3	4	4	4	1 + twilight

The bed occupancy was 126.6% during the time of the study based on 28 beds.

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£30,806

Cost of Agency spend during the data collection period	£25,539

RN Demand 1711 hours (11.4wte)
Fill 1055.5 hours (7.0wte)
61.7% fill

CSW Demand 1332 hours (8.9wte)
Fill 667.5 hours (4.45wte)
50.1% fill

CHPPD

June 2021	**7.5**
July 2021	**7.4**
2nd data collection 2022	**5.8**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	15.12%	6.96%

Quality indicators

Falls	4
Hospital acquired pressure ulcers	4 x Cat 2
Medication incidents	3
Staffing Datix	18
Formal Complaints	0

Enhanced care: There were a total of 16 enhanced cares. This averages at 0.57 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	76	2.71
Discharges	139	4.96
Transfers In	129	4.6
Transfers Out	44	1.59
Deaths	3	0.1

Admin Support:

	Establishment	**Contracted**
Band 2	1.0wte	1.0wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	1.59wte

Nutritional Assistant:

	Establishment	**Contracted**
Band	0.0wte	0.0wte

As a summary of the SNCT

Bed occupancy was 126.6% based on 28 beds.

WTE RNs **Budgeted** 21.68wte (28 beds)

SNCT indicates the ward requires **29wte** RN, based on 38 beds. This gives an under established variance of 7.32wte. The previous SNCT results from 2021 suggested that Bolton required 15.74wte. Highlighting that the escalation beds has increased the WTE of RN's as well as an increased dependency.

WTE CSW **Budgeted** 12.91wte

SNCT indicates the ward requires 19.3wte CSW. This suggests an under established variance of 6.39wte. The previous SNCT results from 2021 suggested that Bolton required 10.49wte CSW; again, highlighting that the escalation beds has increased the WTE of CSW's

The increase in bed base means that the SNCT data from 2021 cannot be directly compared. Therefore, this report will focus on other nuances within the data to make recommendations for future establishment setting.

Coronary care staffing ratios across the country have varied throughout the pandemic with organisations having to effectively deploy staff with specialist skills and knowledge to meet the raising numbers of CCU patients whilst meeting infection prevention and control guidelines and maintaining patient safety, within a pandemic situation. Additionally, guidance for Non-invasive Ventilation (NIV) staffing ratios are dependent on the environment, skills set of the nurse and how long the patient has been on NIV. A report by the British Thoracic Society (2022) 'A respiratory workforce for the future' highlights multifactorial challenges within this speciality and although a ratio of 1:2 would be preferred; mitigation of risk can be addressed when staffing challenges are met. For example, introducing CSW support and cohorting patients within the same bay.

It is noted that the fill rates are based on 28 beds, which explains why agency and NHSP spend is high. In addition, staff sickness rates were extremely high (COVID illness and Norovirus), which meant backfill of these shifts was required. However, the agency and NHSP fill rates are little over 50% which could account for the reduction in CHPPD since the last SNCT data collection. It is noted that there are a high number of DATIX related to staffing and during our SNCT review meeting it was highlighted that there would have been more if staff would have had time to complete them.

Other than an increase in staffing DATIX the quality indicators have remained at the same level. This suggests that a high standard of care is being maintained on Bolton and this should be highly commended, showing excellent leadership and teamwork in such challenging times.

There is a full-time ward clerk covering 5 days a week. Our SNCT review discussion highlighted the requirement for 7-day admin cover 08:00 – 20:00hrs. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and doorbell, and assisting with visiting arrangements. It should also be considered that a Nutritional Assistant and Housekeeper to be appointed to this ward, again covering the 7-day week.

The SNCT calculator used for this ward was 60:40; however, it should be noted that Bolton had 74 direct admissions during the 4-week period. Admissions require a substantial amount of RN time to complete all the assessments and admin. Professional judgement should be considered when reviewing future SNCT data to ensure that the RN establishment is adequate to meet all the complexities of this specialist ward.

Jervaulx Ward

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, 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”. 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. The budgetary allocation of management days for the ward manager is one per week (7.5 hours). It was discussed that more management time is required and acknowledgement made that a ward manager review is currently being undertaken, which will address this.

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. Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this. As well as this the ward RNs can sometimes be required to escort the patients to scans, X-rays and appointments.

Patient care is allocated by:

Team 1- bay 1 (6 patients and single-rooms 1,2,3) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay due to support with the enhanced care needs of patients

Team 2- bay 2 (6 patients and single-rooms 4,5,6) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay to support with enhanced care needs

Team 3- bay 3 and 4= 12 patients

1 RN and 1 CSW allocated to this team

The 4th CSW is allocated the 6 single-rooms and support team 3

The 4th RN on duty who acts as the coordinator will also help support nurse in team 3 with 12 patients.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were: (Based on establishment for 30 beds)

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th February – 6th March 2022	87%	81.9%	85.8%	119%

The current shift establishment is:

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

The bed occupancy 99.6%

The budgeted establishment is for 30 beds is 22.9wte RNs and 21.69wte CSW

Contracted for the time of data collection was 16.32wte RN and 18.18wte CSW

Vacancies of 6.58 RN and 3.51 of CSW

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£24,546
Cost of Agency spend during the data collection period	£8,269

RN Demand 538 hours (3.6wte)
Fill 286hours (1.9wte)
53.1% fill

CSW Demand 1288 hours (8.6wte)
Fill 908hours (6.1wte)
70.5% fill

CHPPD

June 2021	**6.9**
July 2021	**6.2**
2nd data collection 2022	**5.8**

Turnover % for data collection period		Sickness % for data collection period	
RN	CSW	RN	CSW
0%	5.71%	7.02%	6.59%

Quality indicators

Falls	4
Hospital acquired pressure ulcers	8 x Cat 2
Medication incidents	2
Staffing Datix	5
Formal Complaints	0

Enhanced care:
During the data collection period there were a **total of 387** enhanced cares on Jervaulx, averaging 13.8 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	6	0.21
Discharges	41	1.46
Transfers In	50	1.78
Transfers Out	9	0.32
Deaths	3	0.1

Admin Support:

	Establishment	**Contracted**
Band 2	1.0wte	1.0wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	2.88wte (with 0.88wte leaving)

Nutritional Assistant:

	Establishment	**Contracted**
Band	0.0wte	1.0wte (taken from the band 2 budget)

As a summary of the SNCT study period

Bed occupancy was 99.6%

The budgeted RN establishment is **20.32wte**

SNCT indicates the ward requires **30.3wte RN**. This gives an under established variance of 10.02wte. The previous SNCT suggested 25.14wte; highlighting an increased dependency.

The budgeted CSW establishment is **21.69 wte**

SNCT indicates the ward requires **20.2wte CSW**. This suggests an over established variance of 1.49wte. The previous SNCT suggested 20.99wte, which shows as slight decrease in dependency for CSW's.

The ward has a 1.0 WTE nutritional assistant (Band 2) and a 1.0 WTE ward clerk (Band 2). It is recommended that the Ward clerk cover on the ward should be increased to 2.15 WTE to enable cover 08:00 – 20:00, seven days a week. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and assisting with visiting arrangements. It is also recommended that the Nutritional assistant cover be increased to 1.4 WTE to increase the cover across the weekend.

The agency and NHSP spend is raised due to staff sickness (mainly COVID related), and to provide adequate staffing to address the large volumes of patients with enhanced care needs. The CHPPD has reduced and again the fill rates against our bed occupancy percentage would confirm this. There are still a number of quality incidents and this would support an increase in establishment in line with the SNCT data; however it would be advantageous to wait until after the third data collection before any adjustments are made.

The fill rates for CSW on night duties, were above the set establishment. This was to ensure the safety of our enhanced care patients of which Jervaulx averaged 13.8 enhanced care patients a day over the data collection period. These additional CSW hours were achieved using NHSP and agency. It is for this reason that we strongly recommend that the CSW establishment is not reduced and that the surplus is used to recruit to these support positions as described above.

The turnover rates for CSW's on Jervaulx was high. It is recommended that this is fed back in to the recruitment and retention groups for consideration.

Trinity Ward

Trinity ward is a 16 (funded) bedded rehab ward (there is space to increase to 19 beds however no staffing/funding to go with this), with one palliative care beds. The ward is based at Ripon Community Hospital and the only inpatient facility there.

The ward is "T" shaped. The ward managers office and ward kitchen are beyond the Minor Injury Unit (MIU) on the entrance corridor to the ward. On entering the ward there is the staff base with an adjoining clinical utility room. To the right of the ward is a four bedded female bay with a direct link through to a three bedded female bay, a female single room with ensuite facility, leading to a two bedded female bay with en-suite. The supporting patient bathroom facilities and dirty utility are out of site of the ward.

On entering the ward to the left, there is a male single room with en-suite, a male partitioned bed space leading directly to a six bedded male bay. The supporting patient bathroom facilities and dirty utility is out of sight at the end of the ward.

On entering the ward and straight ahead there is a link corridor to the two bedded palliative care room. This has collocated en-suite facilities. There is also a day room leading from the link corridor to the palliative care room.

At the time of the study the ward was led by an experienced Ward Manager and Matron, there are also two experienced and one junior sister. The budgetary allocation for the Ward Manager is two management days (15 hours per week) with only one budgeted. SNCT recommendations should be used cautiously for small wards as at least 2 RN are required per shift and professional judgement should be used to inform staffing levels. It is also to note that due to fire regulations there needs to be at least four members of staff on site on each shift on the case of evacuation being required.

The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised, this is considered when reviewing patients who are suitable for transfer and rehabilitation at Trinity Ward. Criteria has recently been extended and the ward has taken many patients outside the criteria to aid capacity on the main site.

Clinical oversight of the patients is provided by local GPs and an elderly care physician and ACP are on site once a week. In an emergency, as there is no medical cover 24/7, 999 is used for medical support. The ward nursing staff closely work alongside therapy teams (physiotherapist or occupational therapist) to maximise patient rehabilitation potential. There are weekly MDT meetings that the RN in charge is required to attend.

Between 18:00 and 08:00 the ward staff are the only staff in the building of Ripon Hospital. It is worth noting that the ward manager has site responsibilities at Ripon Community Hospital in addition to Trinity and therefore needs protected management time.
It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
7th Feb – 6th March 2022	100%	69%	100%	98.2%

The current shift establishment is (for 16 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	2

At the time of the study the bed occupancy was 109.8% Based on 16 beds

The **budgeted** establishment is 16 beds is 12.01wte RNs and 13.27wte CSW

Contracted for the time of data collection was 9.53 RN and 11.88wte CSW

Vacancy: RN's 2.48 wte and CSW 1.39wte

Bank or Agency Fill:

Cost of NHSP spend during the data collection period	£20.669
Cost of Agency spend during the data collection period	£0

RN Demand 423 hours (2.8wte)
Fill 404.5hours (2.7wte)
95.6% fill

CSW Demand 370 hours (2.5wte)
Fill 220hours (1.5wte)
59.4% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	9.49%	10.87%

CHPPD

June 2021	**8.8**
July 2021	**7.3**
2nd data collection 2022	**5.9**

Quality indicators

Falls	2
Hospital acquired pressure ulcers	2 x Cat 2
Medication incidents	0
Staffing Datix	4
Formal Complaints	0

Enhanced care: There were a total of 7 enhanced cares. This averages at 0.25 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	3	0.1
Discharges	23	0.82
Transfers In	20	0.71
Transfers Out	0	0
Deaths	1	0.03

Admin Support:

	Establishment	**Contracted**
Band 2	1.92wte	1.83wte

Nurse Associates:

	Establishment	Contracted
Band 4	0.0wte	0.0wte

Nutritional Assistant:

	Establishment	Contracted
Band	0.0wte	0.0wte

As a summary of the SNCT study period

Bed occupancy was 109.8% due to escalation beds being used (up to 3 additional beds in use throughout the data collection period).

The **budgeted** establishment is **12.01wte** RNs

SNCT indicates the ward requires **15.2wte** RN. This suggests an under established variance of 3.19wte. The previous SNCT results from 2021 suggested that Trinity required 10.09wte. Highlighting that dependency on this ward has increased during the data collection period. The increase from this year's SNCT correlates directly with opening 3 additional escalation beds. It is recommended that he baseline bed base should be agreed prior to making any changes to this establishment. It is also worth noting that the increased bed base along with the COVID staff sickness has reduced the CHPPD and that the quality indicators have slightly increased.

The **budgeted** establishment is **13.27wte** CSW

SNCT indicates the ward requires **10.1wte** CSW and there is 13.27wte in the establishment. This suggests and over established variance of 3.17wte. The previous SNCT results from 2021 suggested that Trinity required 10.9wte CSW; highlighting a stable measurement of dependency for support workers over the two data collection periods.

The SNCT review meeting highlighted the requirement for a rehab assistant and would support this role funded out of the remaining band 2 budget. This would improve rehabilitation opportunities for patients, improve outcomes. Currently 'Mobility Practice' has reduced due to the shortfall in CSW hours, resulting from COVID staff sickness and an increased bed base due to escalation beds. In addition, it was highlighted that support from the discharge co-ordination team would assist in more timely discharges.

It is also recommended that the ward manager 'management' time allocation is reviewed. Trinity Ward is 'off site'; this presents additional management challenges that need timely attention. Therefore, it is recommended that the management time for Trinity is increased to 30 hours per week.

SNCT recommendations should be used cautiously for small wards as at least 2 RN are required per shift and professional judgement should be used to inform staffing levels. It is also to note that due to fire regulations there needs to be at least four members of staff on site on each shift on the case of evacuation being required.

Byland Ward

Byland ward is a 30 bedded elderly care ward that can increase to 31 with one escalation bed. 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 Ward Manager who has one years’ experience and an experienced Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

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. Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this. Additionally, the ward RNs are often required to escort the patients to scans, X-rays and appointments.

Patient care is allocated by:

Team 1- bay 1 (6 patients and single-rooms 1,2,3) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay due to support with the enhanced care needs of patients

Team 2- bay 2 (6 patients and single-rooms 4,5,6) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay to support with enhanced care needs

Team 3- bay 3 and 4= 12 patients

1 RN and 1 CSW allocated to this team

The 4th CSW is allocated the 6 single-rooms and support team 3
The 4th RN on duty who acts as the coordinator will also help support nurse in team 3 with 12 patients.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW

7th February – 6th March 2022	64.3%	87.2%	64.3%	247.6%

The current shift establishment is:

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

At the time of the study the ward had 30 beds opened and the bed occupancy was 102.4% as a result of using the one escalation bed.

The **budgeted** establishment is 20.63wte RNs and 18.65wte CSW

Contracted for the time of data collection was 13.98wte RN and 15.51wte CSW

Vacancies of 6.65wte RN and 3.14wte CSW at the time of data collection.

Bank or Agency Fill:

Cost of NHSP spend during the data collection period (4 weeks)	£30,581
Cost of Agency spend during the data collection period (4 weeks)	£12,792

RN Demand 1305 hours (8.7wte)
Fill 678.5hours (4.5wte)
52% fill

CSW Demand 1319 hours (8.8wte)
Fill 737.5hours (4.9wte)
55.9% fill

CHPPD

2nd data collection 2022	**5.3**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	0.28%	0.12%

Enhanced care: There were a total of **199** enhanced cares. This averages at 7.11 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	6	0.21
Discharges	36	1.28
Transfers In	71	2.53

Transfers Out	18	0.64
Deaths	11	0.39

Admin Support:

	Establishment	**Contracted**
Band 2	0.6wte	1.0wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.0wte	1.59wte

Nutritional Assistant:

	Establishment	**Contracted**
Band	0.0wte	0.6wte (out of band 2 establishment)

Quality indicators

Falls	7
Hospital acquired pressure ulcers	8 x Cat 2
Medication incidents	2
Staffing Datix	4
Formal Complaints	0

As a summary of the SNCT study period

Bed occupancy was 102.4% based on 30 beds.

The budgeted RN establishment is 20.63wte, based on 22 beds at the time of data collection as the intention was to keep 8 beds closed. This did not happen and the bed base has now increased to 30; however the budget remains the same and will need increasing at the next budget setting opportunity.

SNCT indicates the ward requires **28.2wte RN**, based on 30 beds. This suggests an under established variance of 7.57wte. This is the first data collection for Byland ward as the pervious data collection was when the ward was based on Jervaulx and there was an invalid amount of data reported for the month.

These results highlight that dependency on this ward is significantly higher than the establishment allows for. This is aligned to the increased bed base and the extremely high numbers of enhanced care patients.

The budgeted CSW's establishment is 18.65wte

SNCT indicates the ward requires **18.8wte CSW**. This suggests and under established variance of 0.15wte. Again there is no data from the first SNCT collection to compare; however the amount of agency and NHSP usage required to fill the staffing gaps on this ward is extremely high; requesting 8.8wte in additional CSW staffing, with 4.0 wte being additional staffing.

The CHPPD is low on Byland, even though fill rates on night shifts were 247% for CSW's. This highlights the requirement for the establishment to be increased, aligning with 30

beds. It is also important to mention that there are 4 RN's on maternity leave, explaining the increased agency and NHSP spend.

The ward has a 1.0 WTE ward clerk (Band 2). It is recommended that the Ward clerk cover on the ward should be increased to 2.15 WTE to enable cover 08:00 – 20:00, seven days a week. Achieving this would take the pressure off the nursing staff, relieving them of many admin tasks that take them away from direct patient care. For example, updating the Health Roster (keeping it live and accurate), answering the telephone and assisting with visiting arrangements. It is also recommended that a Nutritional assistant be considered to help support he care requirements of this patient group.

Summary of the Second SNCT data collection

The tables below contain the SNCT results from the first and second data collections, measured against the ward budgeted establishments for registered nurses (band 5-7) and Care Support Workers (band 2-4).

The context of these results should be carefully considered, taking into account the nuances and professional judgement described in each ward report.

As described within this report, due to ward moves since the first data collection, some wards have no comparable data.

Recommendations drawn from these results and review meetings have been described on page 5 of this report.

As stipulated by the licence for SNCT; establishments should not be changed *as a result of the acuity and dependency data.* At least three data collections should be undertaken and triangulated against patient flow data, quality indicators and professional judgement.

Registered Nurses band 5-7

Ward	RN establishment	1st SNCT	2nd SNCT
Littondale	20.32wte	20.98wte	22.4wte
Wensleydale	19.72wte	Not comparable	19.8wte
Harlow	No establishment	Not comparable	15.6wte
Nidderdale	20.32wte	20.45wte	25.0wte
Fountains	19.62wte	14.75wte	8.6wte
Rowan	11.8wte	8.51wte	12.7wte
Oakdale	19.92wte	21.87wte	26.6wte
Granby	15.23wte	16.43wte	15.7wte
Farndale	28.33wte	19.21wte	22.7wte
Bolton	21.68wte	15.74wte	29.0wte
Jervaulx	20.32wte	25.14wte	30.3wte
Trinity	12.01wte	10.09wte	15.2wte
Byland	20.63wte	Not comparable	28.2wte

Care Support Workers band 2-4

Ward	RN establishment	1st SNCT	2nd SNCT
Littondale	16.03wte	14.2wte	14.9wte

Wensleydale	20.06wte	Not comparable	13.2wte
Harlow	No establishment	Not comparable	10.4wte
Nidderdale	18.32wte	20.49wte	16.7wte
Fountains	11.51wte	7.92wte	5.7wte
Rowan	10.68wte	8.52wte	8.5wte
Oakdale	18.47wte	23.63wte	17.7wte
Granby	14.32wte	16.43wte	10.5wte
Farndale	21.86wte	8.2wte	14.9wte
Bolton	12.91wte	10.49wte	19.3wte
Jervaulx	21.69wte	20.99wte	20.2wte
Trinity	13.27wte	10.9wte	10.1wte
Byland	18.65wte	Not comparable	18.8wte

Safer Paediatric Nursing Care Tool (SNCT)

Date: January 2022 and March 2022

Author: Julie Walker (Matron Children's Services)

Ward Description

Woodlands ward is a 17 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 is a high dependency unit (HDU).

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

The ward is led by an experienced paediatric Ward Manager and Matron with an establishment that can provide band 6 ward sister cover 24/7. The Ward Manager has three management days per week.

Children and families can attend at any time with varying health needs from simple reviews requested by GP's to very sick patients requiring immediate resuscitation and stabilization. Elective surgical lists and emergency surgical procedures can run side by side, however we do also staff two days per month of paediatric day surgery which requires two registered paediatric nurses, a clinical support worker and a play specialist. Ward attenders are booked into the ward for procedures or preparation for procedures, such as cannulation prior to radiology tests which are time specific, sedation prior to hearing tests etc. Escorting children to various locations around the hospital for procedures and treatment does impact on nursing time. Urgent reviews by the medical team return to the ward for children that perhaps need to be seen two days post discharge.

We have a Ward Clark Monday to Friday 08.30- 16.30 but no cover the rest of the time.

Oral challenges and specialty bloods are undertaken on a Tuesday and Wednesday using CAU or a bed spaces, but colleagues from Children's Outpatients care for these patients.

Patient allocation is decided at handover, it is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. The nurse in charge usually takes an allocated workload, close working relations with SCBU nurse in charge is required as the two units cross cover and support each other as the work demand requires. Resilience

has been developed between the two units so if SCBU has an emergency requiring their two nurses at a resuscitation on delivery suite the Woodlands nurse can assist with looking after the remaining babies on the unit.

The Woodlands paediatric nurses will also attend the emergency department resuscitation room to assist with any sick child if the ward acuity allows. Over the period of data collection the paediatric staff on Woodlands have assisted the adult wards on numerous occasions, especially on a night during the January collection but less so in March. Due to their only being one paediatric ward in the hospital we need sufficient colleagues on duty to cover all eventualities as we cannot pull as many resources from other areas of the hospital.

The Current shift establishment

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

If the ward is busy between Monday to Friday we are budgeted to staff a 10.30-23.00 RN shift which is useful for handover from day to night shift and settling the ward down for the night. In the data collection period for January we filled 7 of the 21 available shifts a fill rate of 33%. In March we filled 11 of the 21 available shifts a fill rate of 52%

The budget establishment is 19.2 RNs and 6.6 CSW this also includes staffing for the two days of DSU work per month, at the time of data collection contracted in post was 16.7 RNs and 3.6 CSW.

Over the data collection period the fill rates were

Month	**Day**		**Night**	
	RN	**CSW**	**RN**	**CSW**
January 22	**77%**	**49%**	**94%**	**73%**
March 22	**84%**	**66%**	**98%**	**72.5%**

Bank agency fill January
RN Demand: 749hrs
Bank Fill: 46.5% (349 hrs)
Agency Fill: 29.2% (219hrs)
CSW Demand: 471 hrs
Bank Fill: 63.4% (299 hrs)
Agency Fill: 0

Bank agency fill in March
RN Demand: 570 hrs
Bank Fill: 33.9% (193.23 hrs)
Agency Fill: 26.6% (151.62 hrs)
CSW Demand: 316 hrs
Bank Fill: 65.2% (205.72 hrs)
Agency Fill: 0

Turnover		**Sickness**	
RN	**CSW**	**RN**	**CSW**
4.55% (1 leaver)	**0.00% (0 leavers)**	**1.31%**	**3.81%**
0.00%	**0.00%**	**1.89%**	**2.27%**

Quality indicators January	Quality Indicators March
9 datix all no harm	6 datix all no harm
1 Diagnosis, treatment, tests	2 Medication related
1 Equipment	1 Obstetrics & maternity readmission
5 Medication, IV fluids and med gases	1 Diagnosis, treatment, tests
1 Obstetrics & maternity readmission	1 Discharge
1 Records & Consent	1 Security / safety

Activity	Beds Occupied	% Occupancy	Admissions	Discharges
January	**208**	**41.9%**	**234**	**237**
March	**293**	**61.0 %**	**302**	**310**

Summary of SNCT study period

In January WTE RN's actual 16.7wte (including ward manager) and CSW actual 3.6wte

In March WTE RN's actual 16.7 wte (including ward manager) and CSW actual 4.6wte

January SNCT recorded at 15.00 indicates the ward requires 8.0 RN's giving a variance 8.7wte and 4.0 CSW's giving a variance of -0.4wte.

In March we undertook the data analysis at two different times as the ward does seem to vary at different times of the day. SNCT indicates the ward requirement 13.8 RN's at 10.00 and 13.3 RN's at 15.00 giving a variance of 2.9wte and 3.4 wte. For CSW's 7.0 wte at 10.00 and 6.8 at 15.00 giving a variable of -2.4 wte at 10.00 and – 2.2 wte at 15.00

Woodlands ward is a combined general paediatric ward and a children's assessment unit with quick turnaround, our average length of stay last year was 0.76 and year to date is 0.87, the tool only measures a patient in a bed at 10.00 or 15.00 each day. Our bed occupancy is unpredictable each day, in January varying between 6.25%-68.75%, while March varied between 31.25% - 100% occupancy, we will flex over by using CAU as our escalation.

The RCN guidance "Defining staffing levels for children and young people's services: RCN guidance for clinical professionals and service managers. Second addition 2013 states for general paediatric wards

In addition to the band 7 ward sister/ charge nurse, a nurse competent experienced Band 6 is required throughout the 24-hour period to provide necessary support to the nursing team. This will provide an experienced nurse to advice on clinical nursing issues relating to children across the organisation 24-hours a day.

Standards for:

Bedside, deliverable hands-on care

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

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

Recomendations

Although the SNCT recommends a significant reduction in registered nurses in the January audit and a slight reduction in March bed occupancy can vary greatly requiring sufficient RN's to provide safe care. Using professional judgement, factoring patient flow, quality standards and the results of this initial SNCT; it is recommended that the establishment is left unchanged and a further two data collections undertaken.

It is also recommended that a review meeting with the Deputy and Director of Nursing, Midwifery and AHP's, Workforce Matron, Paediatric Matron and Ward manager be held to review the results and agree further recommendations.

Community Nursing Safer Staffing Tool (CNSST)

Harrogate Community Nursing Service (three teams): Patient Dependency/Acuity, Staff Activity, Workload, Quality and Staffing.

Author: Keith Hurst, keithhurst.research@yahoo.co.uk, Nov 2021

Method

1. Harrogate staff working in three community teams collected data in the same way as information gathered elsewhere in 59 trusts and 617 (and growing) community teams (Table 1, B1 and C1).
2. English community teams in the Community Nursing Safer Staffing Tool (CNSST) Database are subdivided into pre-covid and covid eras (Row 1 and 2).

Harrogate community teams are benchmarked against covid era teams (Row 2).

3. Harrogate community staff:

(a) kept work diaries for up to seven days; and

(b) recorded patients they visited each day for up to seven days, assessing and logging each patient's dependency/acuity score (Table 2).

4. If community staff delivered direct and indirect care, then they aligned activities to patient dependency/acuity scores so that precise care times per patient category could be calculated (Table 2).
5. Harrogate community staff, patients, relatives, and record audits in each team provided up to 502 answers to community service quality questions per team (Table 1, Col. I).

Service quality data were used to remove suboptimal teams from the analysis.

6. Service managers provided staffing establishments so that differences between funded, actual, temporary, and recommended staffing could be determined.
7. Data are used to benchmark Harrogate's community patient and staff information, and calculate FTEs required to meet current workloads.

Table grey rows and columns are main benchmarks.

Section 1: Data Summary

Table 1: Main Data

	A	B	C	D	E	F	G	H	I
	Locality	*Trusts*	*Teams*	*Participants*	*Diaries*	*Unusable%*	*Patients*	*Interventions*	*Quality questions*
1	Pre-Covid	20	460	4386	15871	0.31	6.72	706640	163623
2	Covid Era	39	125	1574	5333	0.92	7.27	252606	37745
3	Harrogate All	1	3	38	138	1.4	6.56	6989	1367
4	Harrogate Sth	1	1	15	53	0	6.51	2666	502
5	Knaresborough	1	1	10	36	5.3	8.82	1825	491
6	Rippon	1	1	13	49	0	5.16	2499	374

Comment:

1. Table 1 underlines the comprehensive community service workload, staffing and quality evaluation work currently underway in England (latterly commissioned by NHSE/I).
2. Table 1's extensive data are analysed in detail. Outcomes and outputs fall into four main sections:

(i) Caseload; i.e., daily visits, and patient dependency/acuity mix (Section 2).

(ii) Staff activity, as:

(a) Direct (face-to-face) care, including clinics (Section 3);

(b) Indirect care (interventions one-step removed from patient such as record keeping) (Section 3);

(c) Associated (administrative and clerical) Work (Section 3);

(d) Travelling between patients' homes and other work locations (Section 3);

(iii) Service quality scores (Section 4).

(iv) Funded, actual, temporary and recommended staffing (Section 5).

3. Sections 2 to 5 below embellish 2 (i) to (iv) above.
4. Explanations, unique to Harrogate's teams, appear below each table as 'Comment'.

5. These data form an excellent platform from which to conduct future Level 1 (dependency/acuity census) analyses in the trust.
6. Around 5% of Knaresborough's staff activity data were unusable owing to double counting or data recording errors (Col. F).

Section 2: Caseload

1. Harrogate staff working in three community teams assessed the patients they visited each day for up to seven days, including evenings and weekends.
2. Patients were placed into four categories ranging from low- to high-dependency/acuity; i.e., Cat.1 to Cat.4.
3. Table 2 summarises Harrogate's contact rate and case mix.

Table 2: Dependency/Acuity and Caseload

Key: *Cat. 1* = independent; *Cat. 2* = low-medium; Cat*. 3* = medium-high; *Cat. 4* = dependent; *WI* = workload index; TBC = to be confirmed

	A	B	C	D	E	F		G
	Locality	*Patients*	*Cat.1%*	*Cat.2%*	*Cat.3%*	*Cat.4%*	*Clinics*	*WI*
1	England pre-Covid	6.72	13	36	38	14	0.32	1.1
2	England Covid Era	7.27	37	31	25	7	0.12	1.12
3	Harrogate All	6.56	29	34	30	7	0	1
4	Harrogate Sth	6.51	25	38	28	10	0	1.01
5	Knaresborough	8.82	33	33	33	1	0	1.16
6	Rippon	5.16	32	30	29	9	0	0.83

Comment:

1. England's pre-covid community patients leant towards middle-dependency/acuity (Table 2, D1 and E1), which suggests that dependent/acute patients aren't being admitted to hospital; i.e., significant acute and long-term care has shifted from hospital to community.
2. Patients swung markedly to lower dependency/acuity in the covid era, possibly explained by reduced clinic sessions normally attended by less dependent/acute patients who, consequently, received home visits (Row 2).
3. In the covid era, staff throughout England visited, on average, 7.27 patients per practitioner per day (Col. B) compared to Harrogate's overall 6.56 patients per practitioner per day.

4. There's shift to medium-high dependency/acuity patients in the Harrogate teams (Col. D and E).
5. There's an argument about asking mobile Cat.1 patients to attend clinics rather than receiving home visits, which reduces community staff workload and travelling time (see Table 3, Col. H for Harrogate's above average travelling time).

Harrogate's managers, therefore, might review caseloads and prioritise staff visits.

Covid constrained clinic sessions, on the other hand, will trump any decision to ask Cat. 1 patients to attend clinics.

Up to 38% of Harrogate patients fell into the highest two dependency/acuity categories (Col. E and F), which implies that dependent/acute patents are being diverted from inpatient care, thereby reducing inpatient pressures.

6. The workload index (WI) (Table 2, Col G) is a useful, one-value indicator that spotlights heavy and light workloads, and is easier to visualise and interpret than Table 2 Col's C to F.

The WI is calculated from daily visits, dependency/acuity mix and face-to-face time.

Column G shows that Harrogate's WIs are in line with teams' daily contact rates and dependency/acuity mix. Overall Harrogate's WI is below average owing to its lower patient daily contact rate.

7. The differences between Harrogate's and England's covid era data in Table 2 indicate that regular monitoring is required.

Harrogate's data are a seven-day summer snapshot and there's merit in repeating a winter census.

Section 3: Staff Activity

1. Data classified as 29 individual work activities collected by Harrogate staff using standardised daily diary sheets were categorised in six ways:

(i) Direct (face-to-face) care, such as redressing a wound.

(ii) Indirect care (activity one-step removed from patient); e.g., updating patient records.

(iii) Clinic time (e.g., leg ulcer redressing sessions).

(iv) Associated Work; e.g., non-patient administrative and clerical tasks.

(v) Travelling between patients' homes and other locations.

(vi) Exceptions (unproductive) time such as car breakdown.

2. Only main staff activities are shown in Table 3 because full activity tables (i.e., Appendix 1) are dense, and the main messages can be lost.

Table 3: Main Activity – All Staff

Key: TBC = to be confirmed.

	A	B	C	D	E	F	G	H	I
	Locality	*Interventions*	*Direct%*	*Indirect%*	*Clinics%*	*Associated%*	*RP%*	*Travel%*	*Exception%*
1	England pre-Covid	706640	32	24	3.3	23	78	15	0.45
2	England Covid Era	46888	35	25	1.1	21	72	19	0.2
3	Harrogate All	252606	29	25	0	28	59	18	0.93
4	Harrogate Sth	2666	30	23	0	25	55	20	2.44
5	Knaresborough	1825	33	17	0	29	60	21	0
6	Rippon	2499	26	32	0	29	62	12	0

Comment:

Direct (face-to-face) Care

1. Harrogate staff overall are less patient centered than staff in the covid era working elsewhere (Table 3, Col. C).
2. Appendix 1 (Row 10) shows that clinical procedures, unsurprisingly, were the most common activity.

Indirect Care (interventions one-step removed from the patient)

3. There's an argument that indirect care; e.g., telephoning rather than visiting a patient or his/her relatives, where appropriate, is more efficient and should be encouraged.
4. Harrogate's overall indirect care time is the same as the covid era average (Table 3, Col. D), but Harrogate's percentages fluctuate.
5. Harrogate's charting and reporting time is higher than the covid era average (Appendix 1, Row 16).

Staff who spend excessive time recording and reporting patient information, despite patient record's medico-legal importance, may be criticised.

Associated (hotel-type) Work

6. Harrogate's Associated Work time is higher than average (Table 3, Col. F).

Most Associated Work time was administration (Appendix 1, Row 24).

7. The Harrogate teams have a dilute staff mix (i.e., proportionally fewer registered practitioners [RPs] than other teams) (Table 3, Col G), and the trust has a lower Associated Work percentage.

It's arguable that registered practitioner RPs in teams with a dilute staff mix and high associated work time are being used effectively - the case in Harrogate.

Associated Work is especially important because staff can spend unpaid overtime (see Table 5b) catching up with paperwork.

Travelling Time

8. Harrogate staff travelling time is below the covid era average (Table 3, Col. H).

Exception Time

9. Harrogate's exception (unproductive) time, like the covid-era average, is non-existent/negligible (Table 3, Col I) and can be ignored.

Section 4: Service Quality

1. If community service quality, workload and staffing are measured concurrently, then three important datasets can be linked; i.e., to determine if understaffing is affecting service quality.
2. A workload-sensitive 169-item service quality audit, therefore, was used to generate community service-quality scores using Donabedian's healthcare quality triad in pre-covid and covid eras:

(i) Service structure (e.g., staffing and equipment), which governs …

(ii) Treatment and care processes (e.g., how teams and individuals work), which drives …

(iii) Outputs and outcomes (e.g., patient, carer and staff satisfaction).

3. Service quality questions are answered using three data sources:

(i) Community staff self-assessed their service quality.

(ii) Patient and family service-quality perceptions were gathered concurrently.

(iii) Patient records were audited.

4. The service quality audit's main purpose is to filter teams delivering sub-optimal care, so that staffing multipliers (built from dependency/acuity and activity data) recommend appropriate staffing establishments.

Table 4: Service Quality

	A	B	C	D	E	F
	Locality	*Questions*	*Structure%*	*Process%*	*Outcome%*	*Overall%*
1	England pre-Covid	163623	78	62	67	66
2	England Covid Era	37745	85	87	82	85
3	Harrogate All	1367	79	83	76	80
4	Harrogate Sth	502	78	83	74	79
5	Knaresborough	491	74	77	76	76
6	Rippon	374	84	89	79	85

Comment:

1. Table 4's pre-covid service quality scores aren't brilliant (Table 4, Row 1).

Staff, patients, and carers, therefore, are applauded for their honesty.

2. The covid era quality scores improved markedly.

However, caution is required because covid era questionnaires included more infection control questions; i.e., pre-covid and covid era datasets aren't like-for-like.

3. Harrogate's overall quality scores (Col. F) are below the covid era average.

Section 5: Community Staffing and Grade-mix

1. Table 5a's community service full-time equivalents (FTEs) are categorised in four ways:

(i) Funded staffing; i.e., what the budget allows.

(ii) Actual or in-post FTEs include permanent (substantive) staff.

(iii) Temporary staff (overtime, bank and agency workers hired to replace staff on leave and to plug unfilled vacancies).

(iv) Recommended staffing, which is based team workload.

Table 5a: Staffing – Community Staffing
Key: *FTE* = full time equivalent; NA = not available; Recom = recommended; Act = actual; Temp = temporary; RP = registered practitioners; TBC = to be confirmed.

A	B	C	D	E	F	G	H	I	J	K	L	M	N
			FTEs		%		FTEs		%	FTE Gap			
	Team	Workload Index	Funded	Actual	RP	Time-out	Temp.	Recom.	Quality Score	Funded-Actual	Recom-Funded	Recom-Actual	Recom-Act+Temp
1	Pre-Covid	1.1	9.9	8.6	78	23.9	0.41	9.5	66	-1.28	-0.43	+0.85	+0.44
2	Covid Era	1.12	16.9	14.6	72	24.9	1.39	16.4	85	-2.31	-0.53	+1.78	+0.39
3	Harrogate All	1	23.6	19.2	59	36	0.46	19.2	80	-4.4	-4.4	+0	-0.46
4	Harrogate Sth	1.01	23	16.3	55	48.9	0.69	16.5	79	-6.7	-6.5	+0.2	-0.49
5	Knaresborough	1.16	23.8	17.9	60	22.9	0	20.7	76	-5.9	-3.1	+2.8	+2.8
6	Rippon	0.83	24.1	23.4	62	36.9	0.7	19.4	85	-0.7	-4.7	-4	-4.7

Comment:

Interpretation

1. Rows 1 to 3 are multiple-team averages.

Rows 4 to 6 are totals per team.

Team Size

2. Harrogate team sizes are consistent; overall, they are larger than the covid era team average (Table 5a Col. E).

Larger teams are more efficient because back office work, for example, is centralised.

Funded-Actual Staffing Differences

3. Funded-actual staffing gaps are important (Table 5a, Col. K) because they represent frozen or unfilled vacancies, which have service-quality and funding implications.

England's covid era community service funded-actual staffing gap has increased compared to pre-covid times (Col. K) and may reflect austerity measures, and/or recruitment and retention problems.

Harrogate's funded-actual gaps (Col. K) vary and aren't filled by temporary staffing (Col. H), so the trust's F-A staffing gap effects are acute.

Recommended Staffing

4. Overall, Harrogate's recommended staffing is less than funded (Col. L), so investment isn't needed.
5. Harrogate teams' recommended staffing, based on current workload, compared to actual staffing show equity, surpluses and shortfalls (Col. M).
6. Owing to geographical spread, Harrogate's managers may have less scope to deploy staff from teams with staffing surpluses to other teams according to workload.

Staff Mix

7. Harrogate's overall staff mix is dilute compared the covid era average; i.e., all teams have proportionally fewer RPs compared to covid-era average) (Col. F).

Harrogate's RPs are working appropriately; i.e., doing less non-patient related administrative/clerical work (Appendix 1, Row 23 and 24) owing to their dilute staff mix.

If new staff can be appointed, then staff mix should be maintained so that RPs are released for clinical care.

Headroom

8. Recommended FTEs (Table 5a, Col. I) include no headroom to cover staff who might be on leave for any reason.

Adding headroom to recommended establishments requires careful thought to avoid unnecessary cost. There are three options:

(a) If it's usual to redeploy patients normally looked after by staff going on leave to remaining colleagues in the team (or other teams), then adding headroom is inappropriate.

(b) If staff have no capacity to absorb absent staff's caseloads, and temporary staff are required (but not employed), then a headroom uplift is appropriate (so that temporary staffing isn't required).

(c) If managers combine caseload redeployment with hiring temporary staff, then a full headroom uplift also may not be appropriate.

Options 8a and 8c seem to characterise Harrogate's teams.

Table 5b: Staffing – Contracted Hours vs. Worked Hours

Key: TBC = to be confirmed.

	A	B	C	D
	Locality	*Average Contracted Hrs*	*Average Worked Hrs*	*Difference (minutes)*
1	Pre-Covid	7.2	7.3	+6
2	Covid Era	7.4	7.7	+18
3	Harrogate All	7.5	8.2	+42
4	Harrogate Sth	7.6	8.1	+30
5	Knaresborough	8	8.4	+24
6	Rippon	8.1	8.6	+30

Comment:

1. Table 5b illustrates a striking community care phenomenon.

Column B and C compare contracted daily hours with daily hours worked (team averages).

2. Staff working extra unpaid hours either started early, stayed late, worked their lunch breaks, were delayed by extra travel at shift end, and/or continued working at home after finishing substantive work.

3. Harrogate's unpaid overtime (Col. C minus Col. B) are consistently above average.

Managers, therefore, should monitor community service workloads.

4. Tables 5a and 5b don't show TOIL (time off in leu) that may have occurred outside the census period; i.e., unpaid overtime given back to staff isn't known.

5. England's community staffing shortfalls (Table 5a) are corroborated by cumulative unpaid overtime community staff worked during the census.

Appendix 1: Harrogate Community Staff Activity in Detail (see Table 3 for summary and commentary).

	A	B	C	E	F	G	H
	Locality	*pre-Covid*	*Covid*	*Harrogate*	*Harrogate Sth*	*Knaresborough*	*Ripon*
	Interventions	706640	252606	6989	2666	1825	2499
1	*Medical proced.%*	0.8	1.5	2.0%	0.8%	4.2%	1.8%
2	*Patient com'nctn %*	5.1	3.5	3.7%	6.1%	0.2%	3.6%
3	*Nutrition %*	0.2	0.2	0.3%	0.2%	0.5%	0.1%
4	*Hygiene %*	0.7	0.7	1.1%	2.1%	0.0%	0.9%
5	*Elimination %*	0.2	0.2	0.1%	0.1%	0.0%	0.1%
6	*Medication %*	4.6	7.5	6.4%	5.0%	10.4%	5.1%
7	*Movement %*	0.4	0.3	1.4%	1.3%	1.7%	1.2%
8	*Vital signs %*	1.1	2.6	1.0%	1.2%	0.0%	1.6%
9	*Specimens %*	1.2	0.3	0.1%	0.2%	0.0%	0.2%
10	*Nursing proced. %*	17.5	17.7	12.1%	11.7%	15.6%	10.1%
11	*Escorting %*	0.1	0.2	0.2%	0.1%	0.0%	0.4%
12	*Teaching patients %*	0.2	0.2	0.4%	0.5%	0.0%	0.6%
13	*Assisting others %*	0.1	0.8	0.4%	0.3%	0.3%	0.6%
14	*Direct Care %*	32.2	35.7	29.2%	29.5%	32.8%	26.3%
15	*Charting %*	8.4	5.7	8.0%	4.5%	17.3%	5.0%
16	*Reporting %*	8.3	12.2	10.0%	14.8%	0.0%	12.0%

17	*Cmnctng - staff %*	6.5	4.6	5.2%	3.1%	0.0%	11.2 %
18	*Cmnctng - rel's %*	1.3	1.1	1.7%	0.7%	0.0%	3.9%
19	*Indirect Care %*	24.4	23.6	24.8%	23.1%	17.3%	32.2 %
20	*Clinics %*	3.3	1.1	0.0%	0.0%	0.0%	0.0%
21	*Teach/learn %*	3.9	2.8	2.4%	3.8%	2.0%	1.2%
22	*Cleaning %*	0.3	0.2	0.7%	0.6%	0.0%	1.3%
23	*Clerical %*	11.1	4.7	1.1%	1.7%	0.0%	1.4%
24	*Administration %*	3.2	6.6	14.7%	11.3%	16.8%	16.6 %
25	*Errands %*	0.4	0.8	0.5%	0.5%	1.0%	0.3%
26	*Supplies %*	0.6	0.9	3.1%	3.7%	1.9%	3.3%
27	*Meetings %*	1.9	3.3	4.1%	3.4%	6.9%	2.8%
28	*Supervising %*	1.4	0.9	0.9%	0.2%	0.0%	2.3%
29	*Associated %*	22.8	20.2	27.5%	25.0%	28.7%	29.3 %
30	*Travel %*	16.7	19.1	17.6%	20.0%	21.3%	12.2 %
31	*Exception %*	0.45	0.2	0.93%	2.44%	0.00%	0.00 %

Summary

The CNSST process and outputs have been found to be beneficial and although this tool was in the trial phases during the data collection it has produced sound triangulated data supporting change that community teams already had a understanding of. As with any tool, the importance of professional judgement cannot be underestimated when applying to clinical practice.

Recommendations

Some of the recommendations taken forward from this review are:

- Reviewing System One to make it more intuitive, eliminate the repetition of assessment and improve care plans to reduce the admin burden on clinical staff and releasing time to care.
- Moving the Ripon boarder to include Boroughbridge to even up case load size and remove some of the burden from Ripon
- Reviewing Cat 1 (low dependency) patients on caseloads. Working with partners to scope a more appropriate place of care which would reduce the amount of travel time by the nursing teams. For example clinics for catheter changes.
- Looking at educating residential homes to administer insulin to some of their patients with type 2 diabetes.
- Looking at the possibility of getting diabetes specialist nurse resource in community. – this would help with education for staff and patients plus help with specialist review of patients

NHS England and NHS Improvement have offered HDFT the license for the Community Nursing Safer Staffing Tool (CNSST) at zero cost. The Matron responsible for these services has applied for the license and attended the Webinar. It is proposed that we continue to use this tool to review our community services so that we can continue to benchmark Harrogate's community patient and staff information, and calculate FTEs required to meet current workloads. It is proposed that the CNSST process is repeated biannually.

Emergency Department SNCT

Department Description

The Emergency Department (ED) is open 24 hours a day delivering unscheduled care for acutely ill/injured adults and children. The department has a range of cubicles spread over a large and awkward area. This includes the original ED footprint plus what was fracture clinic, now known as Emergency Department 2 (ED2). The ED2 area brings much needed space; however, the cubicles do not have piped oxygen or wall-based suction within them and observation of these cubicles from the main work base in ED is not possible.

The ED is led by the Senior Leadership Team- (triumvirate model), which consists of ED Consultant Clinical Lead, General Manager, Matron with ED Lead Nurse (department manager). There is a cohort of Band 6 Sister / Charge Nurses and each shift is led by one of these department senior nurses. Additionally, there are band 6 Emergency Nurse Practitioners (ENP's) who are autonomous practitioners assessing, diagnosing, treating and discharging patients with minor injuries.
The budgetary allocation for management time for the Band 7 Lead Nurse is currently 15 hours per week. There is no formal allocation of management time or CPD time allocated additionally within the budget for band 6 roles. The department has a band 6 Practice Educator 22.5 hours per week.

The Nurse In Charge (NIC) of each shift allocates staff to patient care areas (department plan in Appendix 1) on a shift basis: Resuscitation room (2 enclosed cubicles and 1 curtained cubicle), Cubicle areas 1-4 (4 cubicles), B-9 (6 cubicles), 10-15 (5 cubicles), Triage, ED2 (up to 8 cubicle spaces) and "Fit to Sit" patient area. The NIC will consider staff experience, skill and competence when allocating staff to work areas, and re-allocate during the day as required, considering skill mix, workload and patient dependency. The NIC is responsible for overseeing the team of Registered Nurses (RN's) and Care Support Workers (CSW's), ED reception clerks, patient flow in and out of the department (supported by a non-clinical patient flow coordinator 1100-0000 daily), and having an overview of patient acuity within the department. The NIC works closely with the ED senior doctor and can escalate any concerns regarding prioritisation of patients to be seen. The ENP's are based in ED2 and when 2 are available per shift (10:00-22:00) patients with minor injuries are streamed directly to ED2 for them to see.

Background

The ED has faced significant challenges throughout the past 24 months during the COVID-19 pandemic. During this time the workforce has adapted considerably to enable delivery of safe and effective care. Following initial phases of the pandemic patient attendances to ED have increased considerably returning to near pre-COVID attendance figures. ED performance against the 4-hour standard has deteriorated significantly. Bed capacity in the hospital has been high and the impact of this has resulted in long delays for admission beds with frequent 12-hour breaches from decision to admit time. Delays for beds and the need to isolate COVID positive patients has impacted on patient flow.

Additional tasks brought about as a result of the COVID pandemic have also impacted on our ability to see patients quickly. There is increased downtime in between patients using cubicles due to infection prevention and control measures. These same guidelines dictate the use of personal protective equipment which has a strict 'donning and doffing' routine, FIT testing, risk assessments and training requirements. In addition to this, the emotional impact of working on the front line throughout the pandemic has seen a rise in the need for pastoral support from managers and leaders

Key changes to have taken place during past 24 months include:

- Increase in department size to incorporate ED2 area (previously fracture clinic). The layout of department is not conducive to a safe environment without the adequate number of nursing staff to oversee the whole area.
- Streaming of patients with minor injury to ENPs
- Development in progress of additional ENP/ Urgent Care Practitioners to support streaming service, and development of those roles so that practitioners will have training and competency to see patients with minor illness.
- Segregation of resuscitation room spaces to form 2 enclosed cubicles with increased ventilation to enable safe environment for Aerosol Generated Procedures. The 2 Enclosed cubicles require an RN in each cubicle when both in use.
- Doors added to the area with cubicles 1 to 4 to enable a closed area for patients with known or probable COVID.
- Compliance with social distancing rules throughout the department to reduce the risk of spread for patients and staff
- Additional RN and CSW posts were added during the pandemic which enabled the current planned staffing numbers. Budget support for this ended in November 2021.

Establishment changes in response to Covid-19:

During the COVID-19 pandemic significant changes were made to the nursing establishment to enable the workforce to meet the demand and challenges encountered. The core numbers per morning, afternoon and night shift are listed below, however these consist of staggered shift start and finish times.

Pre COVID shift establishment:

Day		**Night**					
AM	AM	PM	PM	NIGHT	NIGHT	1800-0200	1800-0200
RN	CSW	RN	CSW	RN	CSW	RN	CSW
6	2	7	2	4	1	2	1

During COVID:

Additional assistance was provided from staff from other areas which were stepped down during the initial COVID pandemic phase. This increased the RN and CSW workforce considerably. Additionally, student nurses in their final year of training were released to work in clinical areas as “aspirant” nurses, thus further supporting the team in a supernumerary capacity.

Day		**Night**						
AM	AM	PM	PM	NIGHT	NIGHT	1800=-0200	1800-0600	1800-0200
RN	CSW	RN	CSW	RN	CSW	CSW	RN	RN
7	3	8	3	5	2	1	1	1

Current budgeted establishment:

Day		**Night**					
AM	AM	PM	PM	NIGHT	NIGHT	1800-0200	1800-0200
RN	CSW	RN	CSW	RN	CSW	RN	CSW
6	2	7	2	4	1	2	1

Capacity and demand and working at COVID numbers but not budgeted

An increased establishment is required to deliver a responsive and flexible service outlined below.

- A segregated area for confirmed / probable COVID, which is currently located in cubicles 1 to 4 in ED segregated by doors.
- Segregated resuscitation room cubicles for patients having Aerosol Generated Procedures. The resuscitation room is located in a low visibility area some distance from the main department work area.
- The delivery of streaming patients and provision of ENP service to manage this demand
- The delivery of social distancing, as per trust and national guidance, with extended waiting areas over ED 1 and ED2.
- Shift patterns have been reviewed to align with activity increases. Start times have been staggered across the morning which delivers increased nursing workforce in the evening and night when activity is predictably higher, both in adults and paediatrics.
- Transfers from the department to radiology and wards (All CT transfers out of hours now require a member of the nursing team to escort)

- Point of Care Testing (POCT) COVID swabbing (Abbott) for asymptomatic admissions
- Maintaining these workforce numbers also adds resilience for cross covering Same Day Emergency Care (SDEC) to support safe staffing across the organisation.
- To maintain a CPD plan for the ED workforce without risk of cancellation
- Improve mandatory training compliance
- To allow time for service/quality improvement
- To allow rostered management time to band 6 Sister / Charge Nurses to support role development and succession planning and enable dedicated management time for Paediatric lead.

Data Collection Period 1: December 2021

The budgeted establishment for RN 37.6 and CSW 15.4 **(total 53wte)**

Contracted for the time of data collection was 38.2 RN and 14.32 CSW **(total 52.52)**

Over the data collection period 1st-13th December 2021 the fill rates were:

Bank or Agency:
RN
Fill hours 337.5
CSW
Fill hours 133.5

Quality indicators
Total of 32 Datix:

- 2 medication incidents
- 6 Datix regarding staffing
- 2 incidents of violence and aggression
- 0 Complaints
- 5 informal concerns

Summary of the SNCT study period December 1st to 13th 2021

Daily attendances to the Emergency department during data collection were: 54394 over 12 months average of 149 per day

Budgeted RN establishment: 37.6wte

SNCT indicates the department requires 42.8wte RN. This shows an under established variance of 5.2wte.

Budgeted CSW establishment: 15.4wte

SNCT indicates the department requires is 18.3wte, a variance of 2.9wte under established.

Data Collection Period 2: March 2022

The budgeted establishment for RN 37.6 and 13.8 CSW **(51.4 total)**

Contracted for the time of data collection was RN 40.96 and 14.79 CSW **(55.75 total)**

Over the data collection period 3rd – 16th March 2022 the fill rates were:

Bank & Agency:
RN:
Demand 967 hours
Fill 657 hours

CSW:
Demand 426 hours
Fill 286 hours

Quality indicators
Total of **49 Datix:**

- 3 medication incidents
- 6 Datix regarding staffing
- 4 Incidents relating to violence and aggression
- 1 Complaint
- 2 informal concerns

Summary of the SNCT study period 3rd to 16th March 2022

Daily attendances to the Emergency department during data collection were: 55037 over 12 months, average of 150 per day

Budgeted RN establishment: 37.6wte

SNCT indicates the department requires 45.7wte RN. This highlights an under established variance of 8.1wte.

Budgeted CSW establishment: 13.8wte

SNCT indicates the department requires is 19.6wte, a variance of 5.8wte under established.

ED Attendances Between 01-12-2020 and 31-12-2021 and Attendances for the Last 5 Years

Month	Number of Visits
2021-01	3106
2021-02	2940
2021-03	3838
2021-04	4407
2021-05	4852
2021-06	4930
2021-07	5041
2021-08	4663
2021-09	4617
2021-10	4736
2021-11	4539
2021-12	4340
Total	52009

Year	Number of Visits
2017	50475
2018	52936
2019	53815
2020	42308
2021	52009

ED attendances from 16/3/21 to 17/3/22 have been 55037

Recommendations

1. Continue with the COVID workforce staffing model (Figure 1). The rationale for this recommendation is that it bridges the gap between the SNCT tool recommendation (Table 1) and pre-pandemic staffing. It enables the team to continue to comply with social distancing rules, maintain patient and staff safety as well as respond to increased activity.

2. Repeat ED SNCT (June 2022 & September 2022) to inform future budget and workforce modelling. Train all Band 6's in SNCT data collection, ensure staffing correct to be able to collect live data and not to score retrospectively.

3. Consider uplift in headroom from 21% to 27% to align with national recommendation due to complexity of training requirements within the ED.

4. Consider management time requirement for band 7 (propose 30 hours per week) and band 6 team (propose 15 hours per month for Paediatric lead and 7.5 hours per month for other band 6 leaders), and CPD time for Emergency Nurse Practitioners (propose 7.5 hours per month).

5. Review skill mix of roles and banding, and consider increase in band 7 and band 6 to support new ways of working and implementation of quality improvement projects from recent RPIW and development of minor illness stream.

6. Implement band 2 to 3 Care Support Worker to Clinical Support Worker role to support role development and career progression and improve retention rates.

7. Review flow coordinator working hours to support patient flow and release of nursing time.

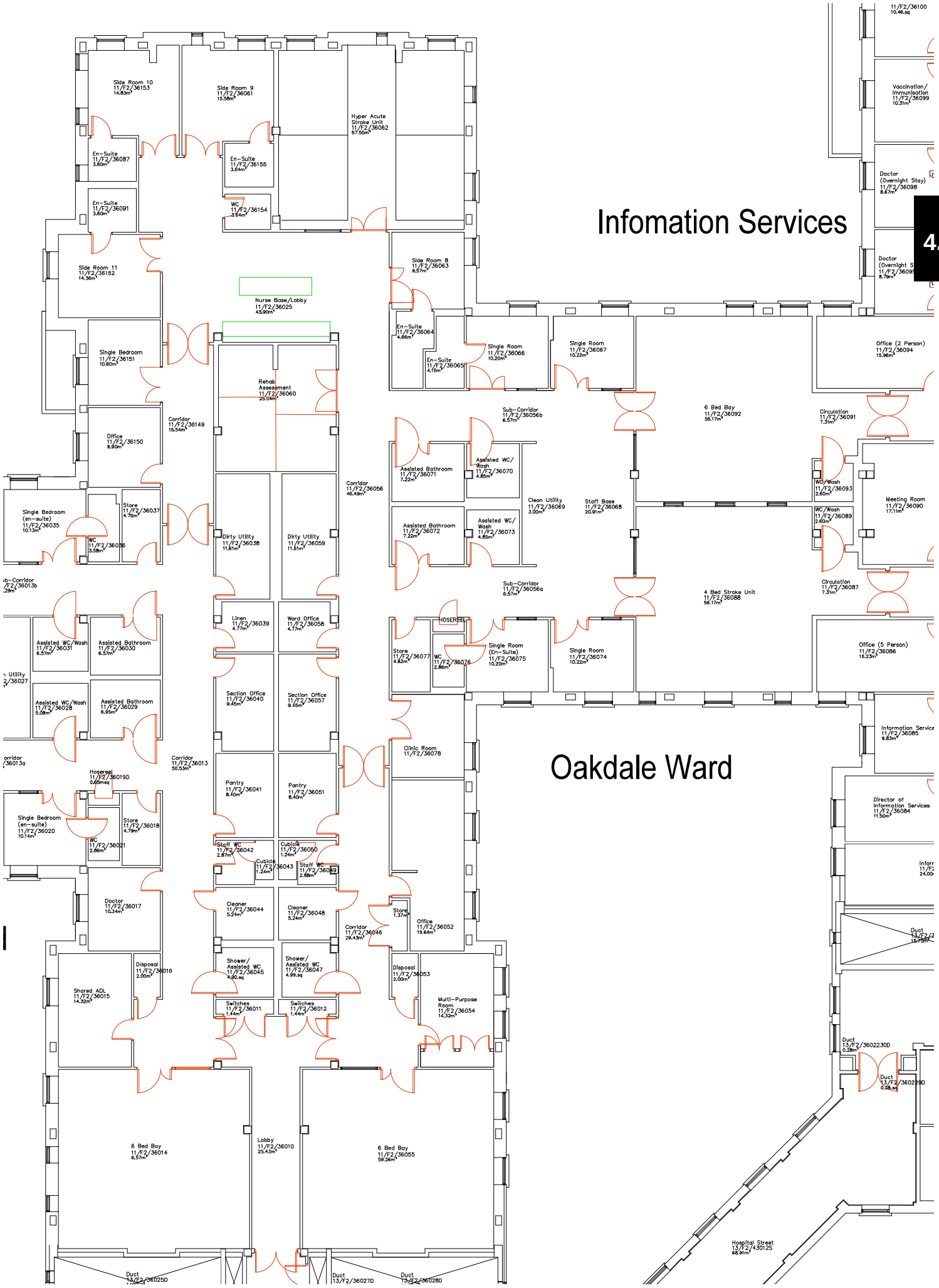
8. Organise and visit a Peer ED to review establishment, foot print and new ways of working.

9. Organise and visit peer ED with Peer Urgent Treatment Centre model to support establishment review and development of the new model at HDFT.

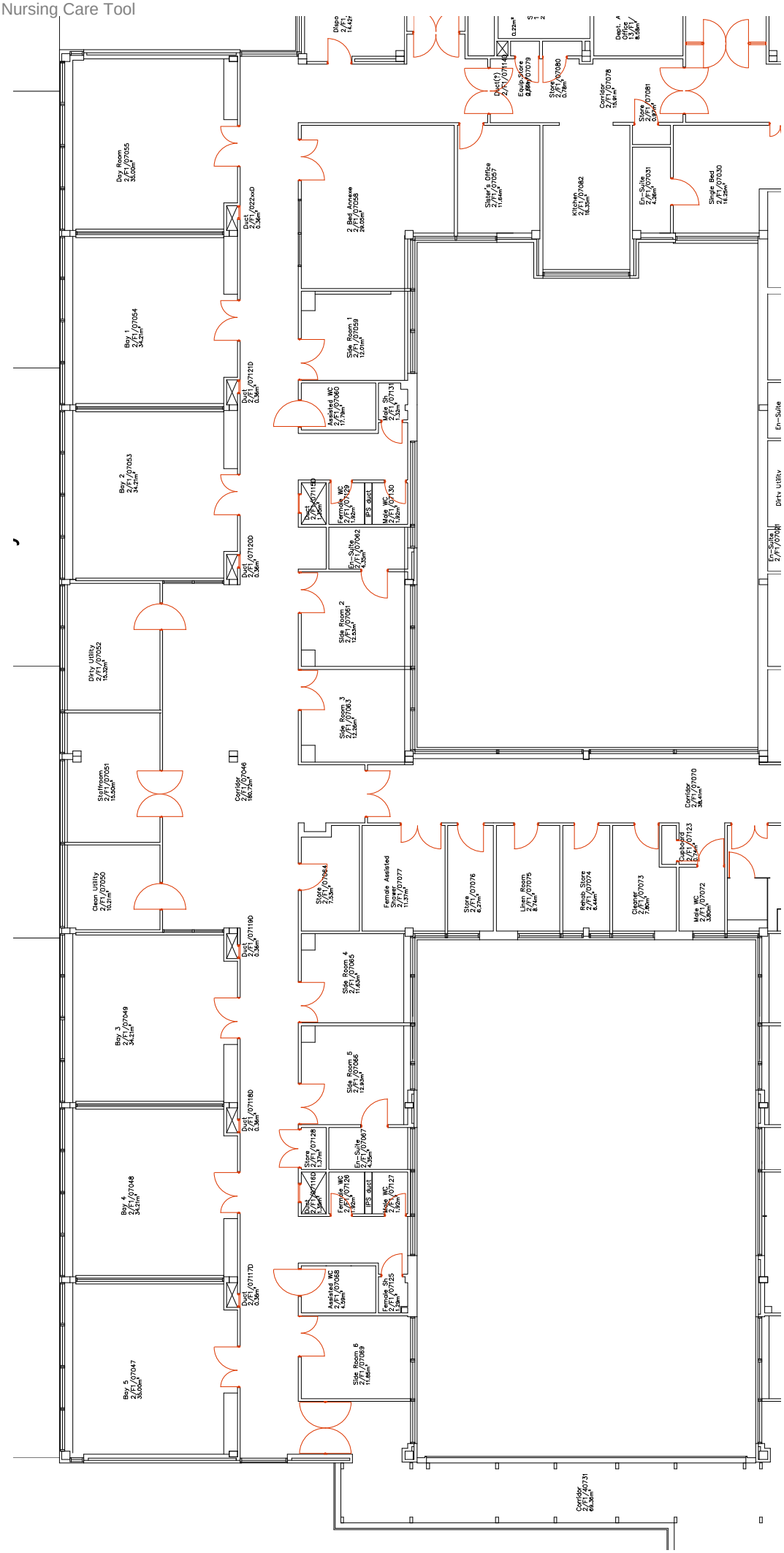
10. Scope out induction packages for new members of staff depending on experience and proactively use the Emergency Care Association Emergency Nursing Competency Framework – to aid staff retention and optimise quality patient care, training and development and experience. Feed this in to the recruitment and retention groups.

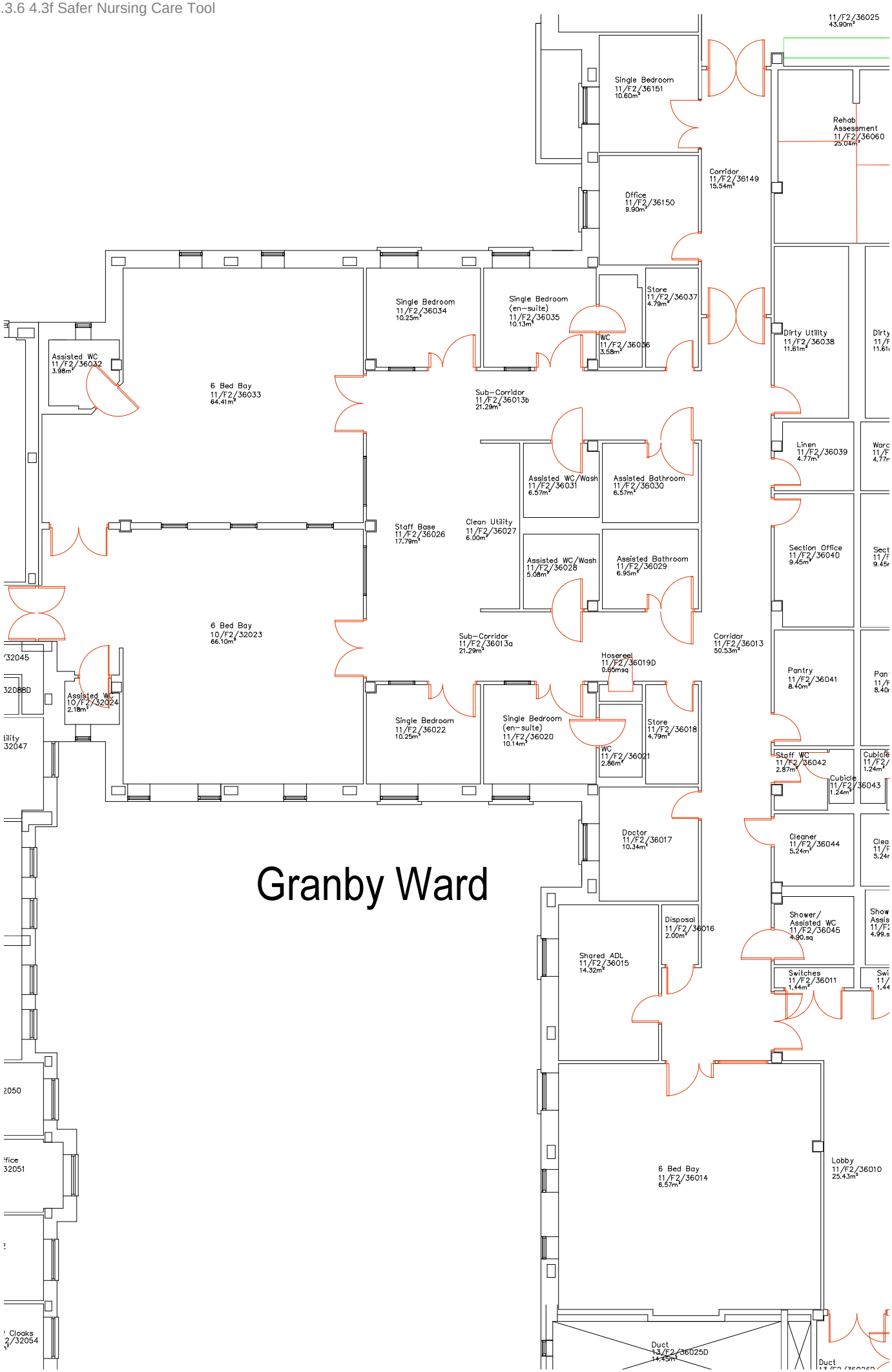

Nidderdale Ward
6 Bed Bay 6/F1/17019 57.23m²
6 Bed Bay 6/F1/17020 58.04m²
6 Bed Bay 6/F1/17021 57.95m²
6 Bed Bay 6/F1/17022 57.35m²
Stair 6/F1/17025 26.07m²
Riser Duct 6/F1/17024 0.11m²
Corridor 6/F1/17001 108.64m²
Lobby 6/F1/17023 7.16m²
Electrical Sw 6/F1/17014 0.44m²
Store 6/F1/17018 2.77m²
WC 6/F1/17015 2.96m²
Assisted Bath/WC 6/F1/17013 13.15m²
Bath/WC 6/F1/17012 4.08m²
Shower/WC 6/F1/17011 4.75m²
Linen Room 6/F1/17010 4.24m²
Single Bedroom 6/F1/17017 13.43m²
Single Bedroom 6/F1/17016 12.98m²
Dirty Utility 6/F1/17009 12.63m²
Staff Base 6/F1/17030 11.97m²
WC 6/F1/17029 2.23m²
Single Bedroom 6/F1/17026 7.00m²
Roof Access 6/F1/17032 0.81m²
Duct 6/F1/17047D 0.66m²
SWITCH CUPBOARD 6/F1/17033 1.56m²
Utility 6/F1/17031 8.88m²
Observation 6/F1/17028 11.67m²
Single Bedroom 6/F1/17027 12.20m²
WC 6/F1/17035 2.24m²
Observation 6/F1/17034 12.82m²
Single Bedroom 6/F1/17008 11.72m²
Clean Utility 6/F1/17007 8.88m²
Single Bedroom 6/F1/17036 12.90m²
WC 6/F1/17037 2.24m²
Ward Kitchen 6/F1/17006 7.63m²
Day Room 6/F1/17038 19.56m²
TBA 6/F1/17005 8.88m²
WC 6/F1/17004 1.71m²
TBA 6/F1/17003 8.62m²
Cleaner 6/F1/17039 5.93m²
WC 6/F1/17041 1.62m²
Staff Room 6/F1/17040 5.74m²
Duct 6/F1/17046D 0.23m²
Ward Office 6/F1/17002 9.67m²
Disposal 6/F1/17042 4.93m²
Duct 6/F1/17044D 1.85m²
Electrical Sw 6/F1/17043 1.08m²
Duct 6/F1/17045D 2.16m²
Hospital Street
Hospital Street 13/F1/42028S

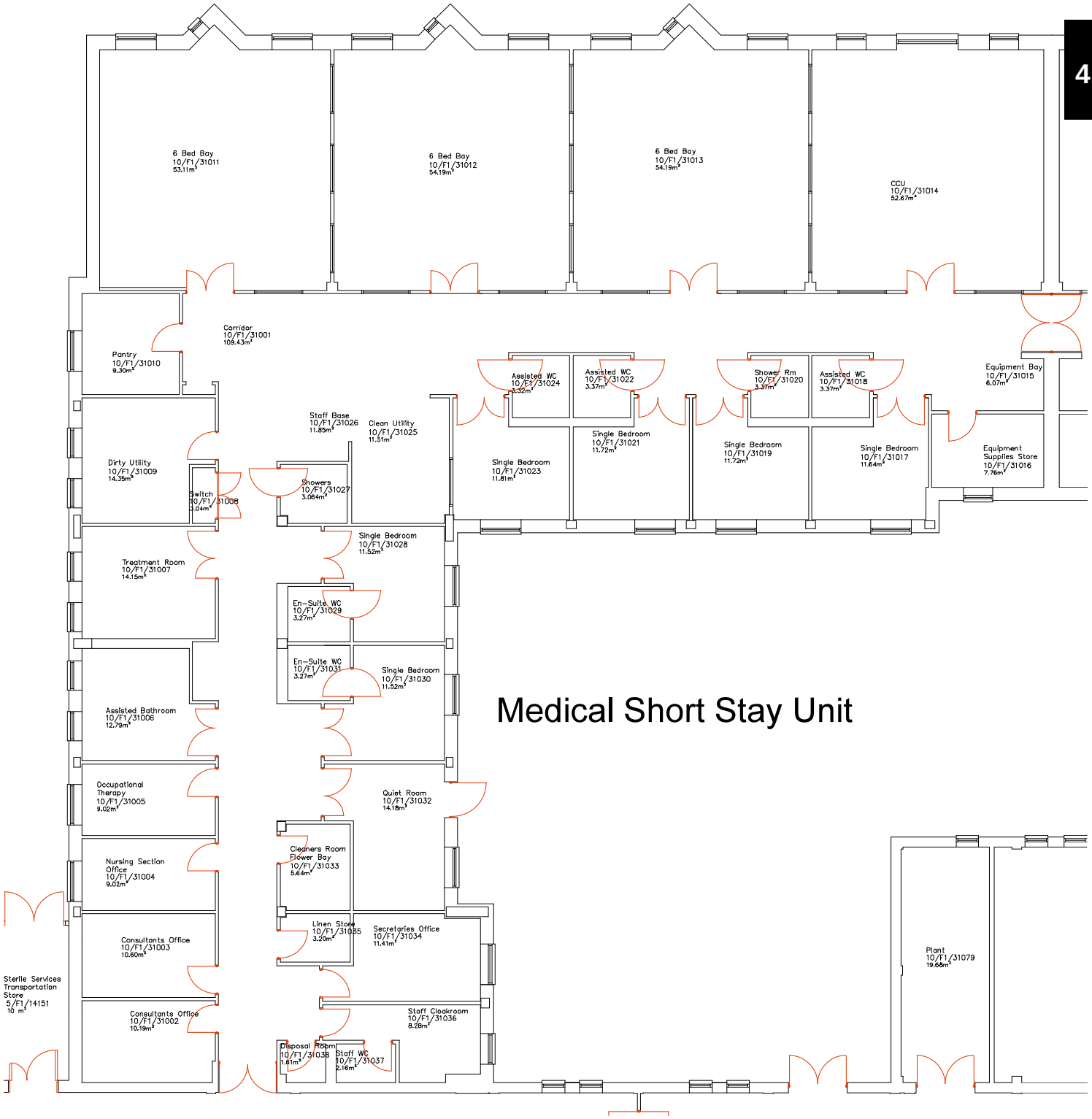

Dining/Sitting
9/F1/29089
4.14m²
Quiet
9/F1/29090
24.99m²
4 Bed
9/F1/29105
36.02m²
4 Bed
9/F1/29108
36.14m²
Patient WC
9/F1/29104
3.33m²
Assisted WC
9/F1/29106
5.27m²
Patient WC
9/F1/29107
3.30m²
Disposal
9/F1/29109
5.26m²
Pantry
9/F1/29088
11.84m²
Corridor
9/F1/29103
31.29m²
Switches
9/F1/29093
1.12m²
Store
9/F1/29095
2.62m²
Store
9/F1/29094
2.48m²
Cleaner
9/F1/29092
6.72m²
Assisted Bathroom
9/F1/29114
12.18m²
Dirty Utility
9/F1/29113
8.26m²
Clean Utility/Treatment
9/F1/29112
8.95m²
Doctor Office
9/F1/29111
9.73m²
Section Office
9/F1/29110
8.31m²
Activity
9/F1/29087
15.53m²
Corridor
9/F1/29079
76.30m²
Patient WC
9/F1/29085
3.37m²
1 Bed
9/F1/29086
10.39m²
4 Bed
9/F1/29084
3.04m²
1 Bed
9/F1/29097
10.52m²
Bathroom
9/F1/29083
5.38m²
1 Bed
9/F1/29098
10.68m²
Patient WC
9/F1/29082
3.07m²
4 Bed
9/F1/29081
38.30m²
1 Bed
9/F1/29099
10.83m²
Linen
9/F1/29080
5.28m²
Bathroom
9/F1/29100
6.80m²
Woodwork
9/F1/29091
26.94m²
Clerical
9/F1/29074
12.75m²
Office
9/F1/29096
12.79m²
Staff
9/F1/29102
3.25m²
WC
9/F1/29101
2.09m²
Store
9/F1/29073
1.18m²
ADL - Kitchen
9/F1/29067
30.63m²

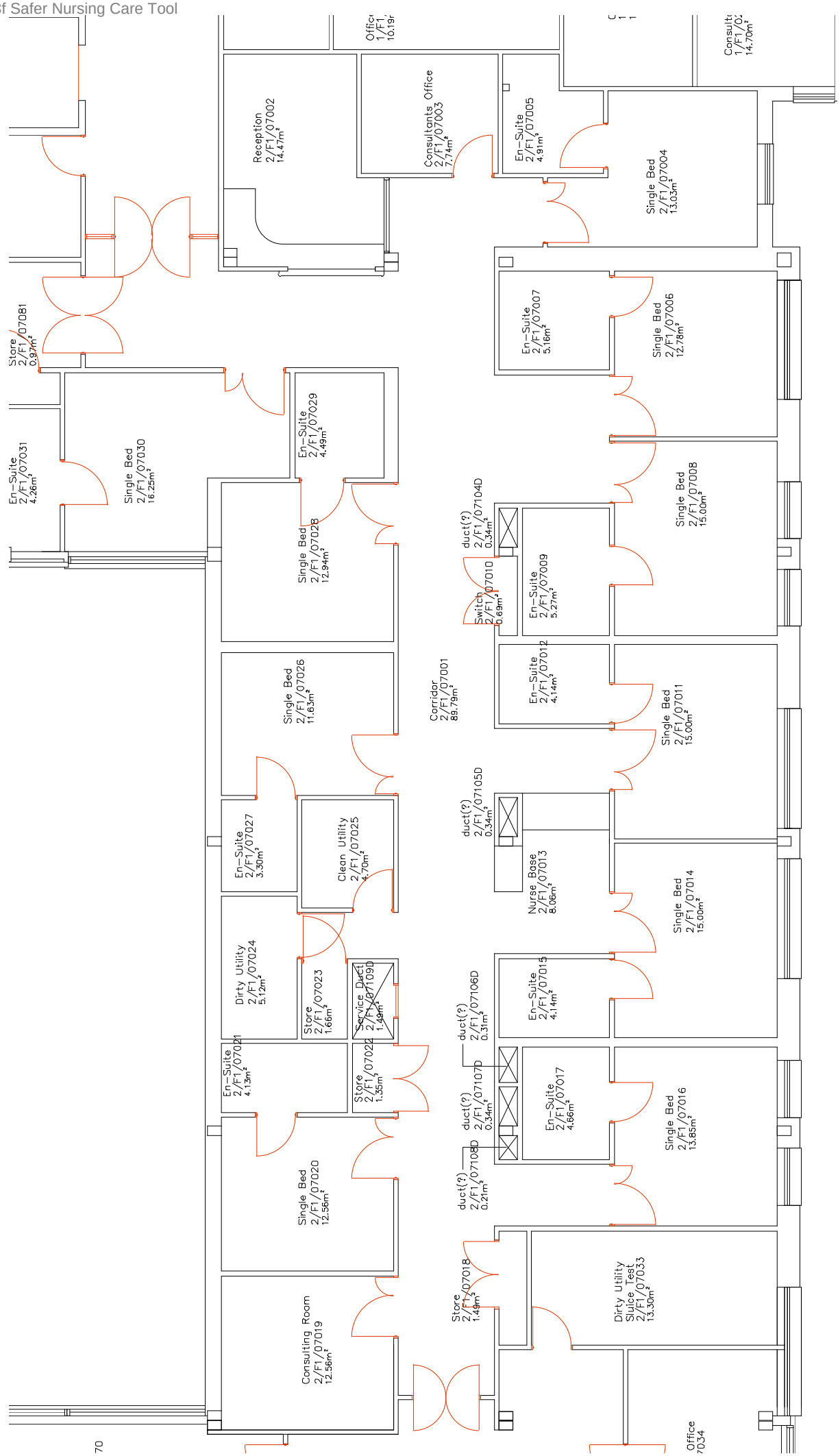

Infomation Services
4.3
Oakdale Ward
Side Room 10
Side Room 9
Hyper Acute Stroke Unit
En-Suite
WC
Side Room 8
Side Room 11
Nurse Base/Lobby
Single Bedroom
Rehab Assessment
Corridor
Office
Single Bedroom (en-suite)
Store
Dirty Utility
Assisted WC/Wash
Assisted Bathroom
Linen
Ward Office
Section Office
Pantry
Hosereel
Staff WC
Cubicle
Cleaner
Shower/ Assisted WC
Switches
Doctor
Disposal
Shared ADL
6 Bed Bay
Lobby
Duct
Single Room
Assisted Bathroom
Assisted WC/ Wash
Clean Utility
Staff Base
Sub-Corridor
6 Bed Bay
4 Bed Stroke Unit
Circulation
WC/Wash
Meeting Room
Office (2 Person)
Office (5 Person)
Vaccination/ Immunisation
Doctor (Overnight Stay)
Clinic Room
Multi-Purpose Room
Director of Information Services
Information Service
Hospital Street

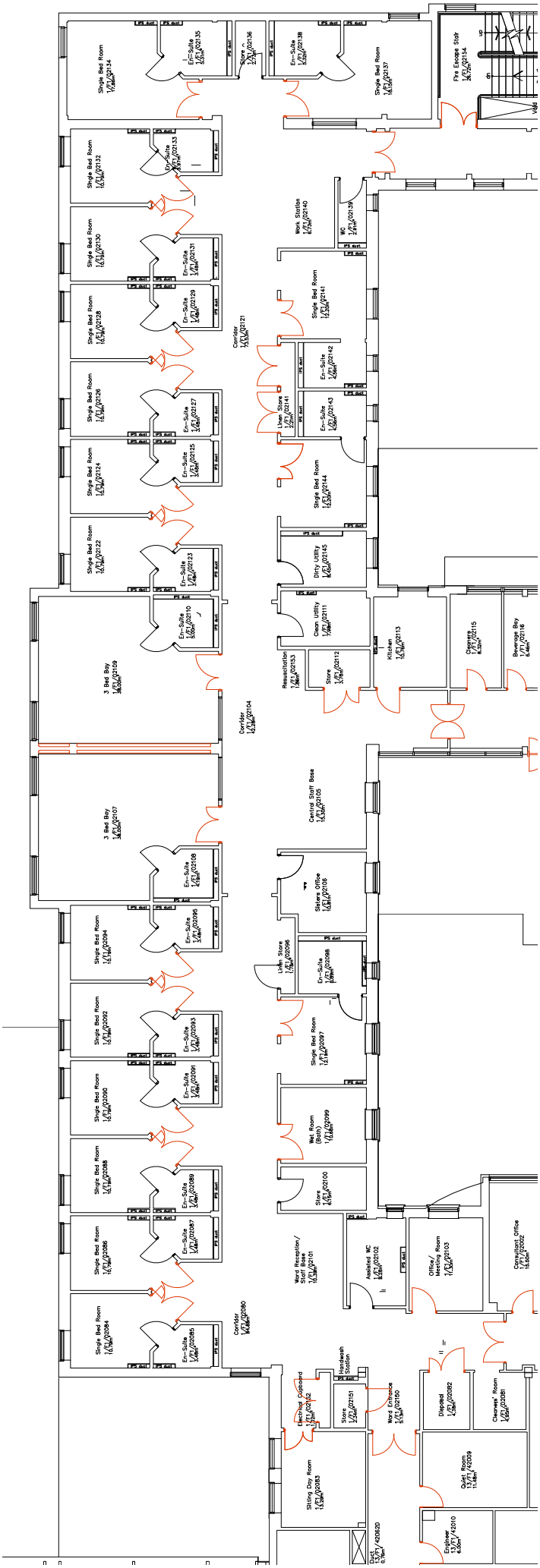

Plant room R1/G/1086
Gas Bottle Store R1/G/1081
Ass. Shower R1/G/1082
Female W.C. R1/G/1083
Dirty Utility R1/G/1084
Female Bathroom R1/G/1085
R1/G/1080
2-bed bay R1/G/1073
Female Isolation Room R1/G/1076
En-Suite R1/G/1077
2-bed bay R1/G/1074
single-bed bay R1/G/1075
ensuite R1/G/1073
FEMALE WARD
Linen Store R1/G/1053
Store Lobby R1/G/1052
R1/G/1051 Store 2
Dirty Linen Collection R1/G/1050
Treatment Area R1/G/1047
Clean Utility R1/G/1048
Staff Base
Dirty Utility R1/G/1049
Food Trolley's R1/G/1012
R1/G/1068
Palliative Care En Suite R1/G/1070
R1/G/1069
Palliative Care Store 1
Palliative Care Store 2
R1/G/1071
2-bed bay R1/G/1073
2-bed bay
Trolley Bay Minor Injuries R1/G/1046
Exam Room R1/G/1093
Disabled W.C. R1/G/1042
Female Locker Room R1/G/1039
R1/G/1014 shaft R1/G/1015 air
Lift
Palliative Care Room R1/G/1067
Clean Utility R1/G/1072
Corridor R1/G/1055
Staff Base R1/G/1054
Reception
Ward Link Corridor R1/G/1036
Store
Waiting Minor Injuries R1/G/1043
Ward Kitchen R1/G/1041
Ward Managers Office R1/G/1038
Cleaners Room R1/G/1037
Staff W.C.
Day Hospital Link Corridor
R2/G/8001
Male Single Bay R1/G/1058
R1/G/1059
Male Isolation Room R1/G/1056
En-Suite
Reception R1/G/1044
R1/G/1045
Day Room/Interview/Quiet Room R1/G/1086
Male 6 Bed Bay R1/G/1060
dirty utility R1/G/1063
Male Bathroom R1/G/1064
Dark Room R1/G/1033
Staff Rest R1/G/1034
Processing R1/G/1032
X-Ray Room R1/G/1028
X-Ray Store R1/G/1031
R1/G/1030
Wash
Male Shower Room R1/G/1065
R1/G/1062
Male Bath Changing R1/G/1061
Staff Lounge R1/G/1029


Dispo 2/F1 14.42m²
Duct(?) 2/F1/071140
Equip Store 2/F1/07079 0.88m²
Store 2/F1/07080 0.78m²
Corridor 2/F1/07078 15.91m²
Dept. A Office 2/F1/07082 13.58m²
Store 2/F1/07081 0.84m²
Day Room 2/F1/07055 35.00m²
Duct 2/F1/7022xD 0.36m
2 Bed Annexe 2/F1/07058 26.05m²
Sister's Office 2/F1/07057 11.64m²
Kitchen 2/F1/07082 16.35m²
En-Suite 2/F1/07031 4.28m²
Single Bed 2/F1/07030 16.25m²
Bay 1 2/F1/07054 34.21m²
Duct 2/F1/07121D 0.36m
Side Room 1 2/F1/07059 12.01m²
Assisted WC 2/F1/07060 1.78m²
Male Sh 2/F1/07133 1.53m²
Bay 2 2/F1/07053 34.21m²
Duct 2/F1/071150 1.36m²
Female WC 2/F1/07129 1.92m²
IPS duct
Male WC 2/F1/07130 1.58m²
Duct 2/F1/071200 0.36m
En-Suite 2/F1/07062 4.53m²
En-Suite 2/F1/07061
Dirty Utility
Side Room 2 2/F1/07061 12.53m²
Dirty Utility 2/F1/07052 16.32m²
Side Room 3 2/F1/07063 12.18m²
Staffroom 2/F1/07051 15.50m²
Corridor 2/F1/07046 160.72m²
Corridor 2/F1/07070 34.41m²
Clean Utility 2/F1/07050 10.01m²
Store 2/F1/07064 7.53m²
Female Assisted Shower 2/F1/07077 11.37m²
Store 2/F1/07076 8.27m²
Linen Room 2/F1/07075 8.74m²
Rehab Store 2/F1/07074 8.44m²
Cleaner 2/F1/07073 7.80m²
Cupboard 2/F1/07123 0.73m²
Male WC 2/F1/07072 3.80m²
Duct 2/F1/071190 0.36m
Side Room 4 2/F1/07065 11.83m²
Bay 3 2/F1/07049 34.21m²
Side Room 5 2/F1/07066 12.83m²
Duct 2/F1/071180 0.36m
Bay 4 2/F1/07048 34.21m²
Duct 2/F1/071160 1.36m²
Store 2/F1/07128 1.37m²
En-Suite 2/F1/07067 4.35m²
Female WC 2/F1/07126 1.92m²
IPS duct
Male WC 2/F1/07127 1.58m²
Duct 2/F1/071170 0.36m
Assisted WC 2/F1/07068 4.66m²
Female Sh 2/F1/07125 1.53m²
Bay 5 2/F1/07047 34.00m²
Side Room 6 2/F1/07069 11.68m²
Corridor 2/F1/40731 68.26m²


11/F2/36025
43.90m²
Single Bedroom
11/F2/36151
10.60m²
Rehab Assessment
11/F2/36060
25.04m²
Corridor
11/F2/36149
15.54m²
Office
11/F2/36150
9.90m²
Store
11/F2/36037
4.79m²
Single Bedroom
11/F2/36034
10.25m²
Single Bedroom
(en-suite)
11/F2/36035
10.13m²
WC
11/F2/36036
3.58m²
Dirty Utility
11/F2/36038
11.61m²
Assisted WC
11/F2/36032
3.98m²
6 Bed Bay
11/F2/36033
64.41m²
Sub-Corridor
11/F2/36013b
21.29m²
Linen
11/F2/36039
4.77m²
Assisted WC/Wash
11/F2/36031
6.57m²
Assisted Bathroom
11/F2/36030
6.57m²
Staff Base
11/F2/36026
17.79m²
Clean Utility
11/F2/36027
6.00m²
Section Office
11/F2/36040
9.45m²
Assisted WC/Wash
11/F2/36028
5.08m²
Assisted Bathroom
11/F2/36029
6.95m²
6 Bed Bay
10/F2/32023
66.10m²
Sub-Corridor
11/F2/36013a
21.29m²
Corridor
11/F2/36013
50.53m²
Hosereel
11/F2/36019D
0.66msq
Pantry
11/F2/36041
8.40m²
32045
Assisted WC
10/F2/32024
2.18m²
Single Bedroom
11/F2/36022
10.25m²
Single Bedroom
(en-suite)
11/F2/36020
10.14m²
Store
11/F2/36018
4.79m²
WC
11/F2/36021
2.86m²
Staff WC
11/F2/36042
2.87m²
Cubicle
11/F2/36043
1.24m²
Doctor
11/F2/36017
10.34m²
Cleaner
11/F2/36044
5.24m²
Granby Ward
Disposal
11/F2/36016
2.00m²
Shower/
Assisted WC
11/F2/36045
4.90.sq
Shared ADL
11/F2/36015
14.32m²
Switches
11/F2/36011
1.44m²
6 Bed Bay
11/F2/36014
6.57m²
Lobby
11/F2/36010
25.43m²
Duct
13/F2/36025D
14.45m²

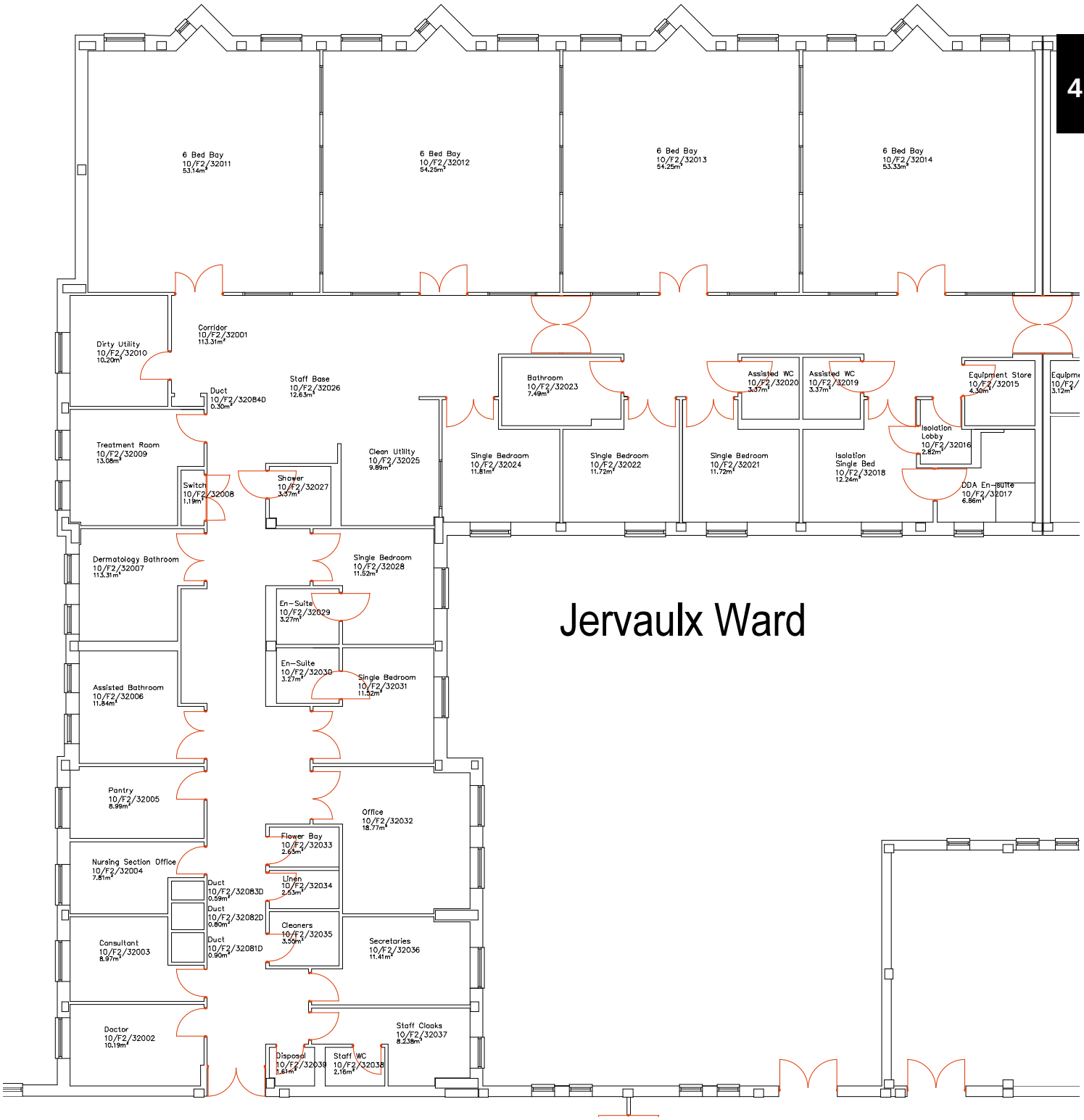

6 Bed Bay
10/F1/31011
53.11m²
6 Bed Bay
10/F1/31012
54.19m²
6 Bed Bay
10/F1/31013
54.19m²
CCU
10/F1/31014
52.67m²
Corridor
10/F1/31001
108.43m²
Pantry
10/F1/31010
9.30m²
Assisted WC
10/F1/31024
2.32m²
Assisted WC
10/F1/31022
3.37m²
Shower Rm
10/F1/31020
3.37m²
Assisted WC
10/F1/31018
3.37m²
Equipment Bay
10/F1/31015
6.07m²
Staff Base
10/F1/31026
11.85m²
Clean Utility
10/F1/31025
11.51m²
Single Bedroom
10/F1/31021
11.72m²
Single Bedroom
10/F1/31023
11.81m²
Single Bedroom
10/F1/31019
11.72m²
Single Bedroom
10/F1/31017
11.64m²
Equipment Supplies Store
10/F1/31016
7.76m²
Dirty Utility
10/F1/31009
14.35m²
Switch
10/F1/31008
3.04m²
Showers
10/F1/31027
3.064m²
Single Bedroom
10/F1/31028
11.52m²
Treatment Room
10/F1/31007
14.15m²
En-Suite WC
10/F1/31029
3.27m²
En-Suite WC
10/F1/31031
3.27m²
Single Bedroom
10/F1/31030
11.52m²
Medical Short Stay Unit
Assisted Bathroom
10/F1/31006
12.79m²
Occupational Therapy
10/F1/31005
9.02m²
Quiet Room
10/F1/31032
14.18m²
Cleaners Room
Flower Bay
10/F1/31033
5.64m²
Nursing Section Office
10/F1/31004
9.02m²
Linen Store
10/F1/31035
3.20m²
Secretaries Office
10/F1/31034
11.41m²
Consultants Office
10/F1/31003
10.60m²
Plant
10/F1/31079
19.68m²
Sterile Services Transportation Store
5/F1/14151
10 m²
Consultants Office
10/F1/31002
10.19m²
Staff Cloakroom
10/F1/31036
8.28m²
Disposal Room
10/F1/31038
1.61m²
Staff WC
10/F1/31037
2.16m²

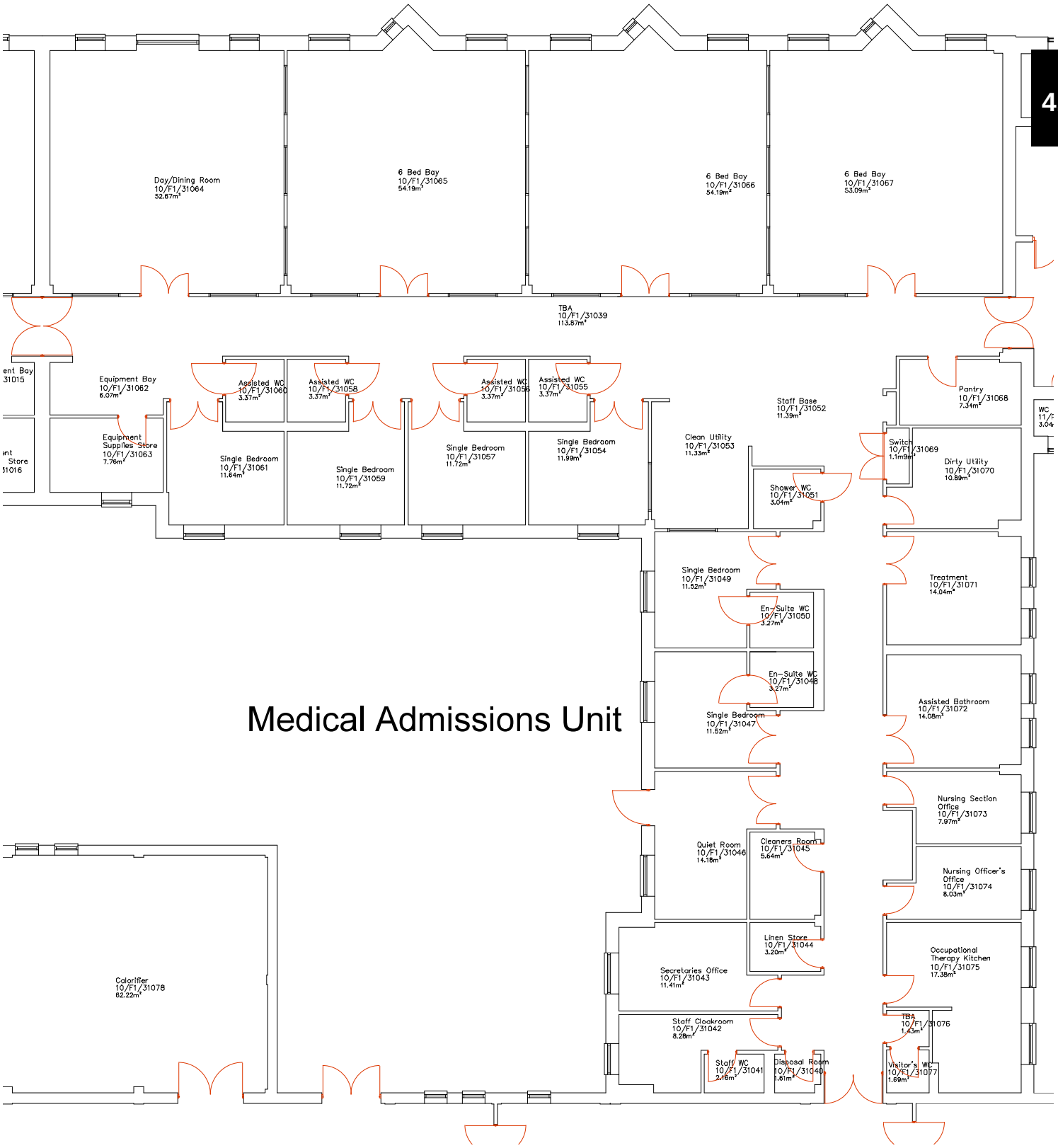

Reception
2/F1/07002
14.47m²
Consultants Office
2/F1/07003
7.74m²
En-Suite
2/F1/07005
4.91m²
Single Bed
2/F1/07004
13.03m²
Store
2/F1/07081
0.97m²
En-Suite
2/F1/07007
5.16m²
Single Bed
2/F1/07006
12.78m²
En-Suite
2/F1/07031
4.26m²
Single Bed
2/F1/07030
16.25m²
En-Suite
2/F1/07029
4.49m²
Single Bed
2/F1/07028
12.94m²
duct(?)
2/F1/07104D
0.34m²
Switch
2/F1/07010
0.69m²
En-Suite
2/F1/07009
5.27m²
Single Bed
2/F1/07008
15.00m²
Corridor
2/F1/07001
89.79m²
En-Suite
2/F1/07012
4.14m²
Single Bed
2/F1/07011
15.00m²
Single Bed
2/F1/07026
11.63m²
duct(?)
2/F1/07105D
0.34m²
En-Suite
2/F1/07027
3.30m²
Clean Utility
2/F1/07025
4.70m²
Nurse Base
2/F1/07013
8.06m²
Single Bed
2/F1/07014
15.00m²
Dirty Utility
2/F1/07024
5.12m²
Store
2/F1/07023
1.66m²
Service Duct
2/F1/07109D
1.49m²
duct(?)
2/F1/07106D
0.31m²
En-Suite
2/F1/07015
4.14m²
En-Suite
2/F1/07021
4.13m²
Store
2/F1/07022
1.35m²
duct(?)
2/F1/07107D
0.34m²
En-Suite
2/F1/07017
4.68m²
Single Bed
2/F1/07016
13.85m²
Single Bed
2/F1/07020
12.56m²
duct(?)
2/F1/07108D
0.21m²
Store
2/F1/07018
1.49m²
Dirty Utility
Sluice Test
2/F1/07033
13.30m²
Consulting Room
2/F1/07019
12.58m²
Office
7034


Single Bed Room
En-Suite
Fire Escape Stair
Work Station
WC
Corridor
Linen Store
Single Bed Room
Dirty Utility
Clean Utility
Resuscitation
Store
Kitchen
Office
Beverage Bay
3 Bed Bay
Central Staff Base
Sisters Office
Single Bed Room
Wet Room (Bath)
Store
Ward Reception / Staff Base
Assisted WC
Office / Meeting Room
Consultant Office
Corridor
Electrical Cupboard
Standpipe Station
Store
Ward Entrance
Sitting Day Room
Disposal
Cleaners' Room
Quiet Room
Engineer
Duct


Chapel
Littondale Ward
Corridor 6/G/16001 119.32m²
Room 3 (6 Bed Bay) 6/G/16002 57.25m²
Room 4 (6 Bed Bay) 6/G/16003 56.04m²
Room 5 (6 Bed Bay) 6/G/16004 57.96m²
Room 6 (6 Bed Bay) 6/G/16005 57.36m²
Stair 6/G/16006 22.6m²
Store 6/G/16007 0.6m²
Duct 6/G/16054D 0.43m²
Room 7 (2 Bed Bay) 6/G/16008 18.36m²
Treatment Room 6/G/16009 11.70m²
Bathroom 6/G/16010 4.16m²
WC 6/G/16011 2.06m²
Room 8 6/G/16012 14.42m²
Room 9 6/G/16013 11.82m²
WC 6/G/16014 2.10m²
Nurse Base 6/G/16015 20.09m²
Store 6/G/16016 3.25m²
WC 6/G/16017 2.24m²
Room 10 6/G/16018 12.25m²
Room 11 6/G/16019 12.25m²
WC 6/G/16020 2.24m²
Sitting Room 6/G/16021 19.56m²
Domestic 6/G/16022 5.57m²
Staff WC 6/G/16024 1.62m²
Changing 6/G/16023 5.74m²
Disposal 6/G/16025 4.82m²
Duct 6/G/16051D 0.23m²
Electrical Switch 6/G/16026 1.05m²
Duct 6/G/16052D 0.02m²
Linen 6/G/16035 3.66m²
Shower 6/G/16036 4.68m²
Bathroom 6/G/16037 4.08m²
Dirty Utility 6/G/16034 12.63m²
Electrical Sw. 6/G/16053D 0.14m²
Assisted Bathroom 6/G/16038 13.15m²
WC 6/G/16039 2.97m²
Room 1 6/G/16040 12.98m²
Store 6/G/16042 2.77m²
Room 2 6/G/16041 13.43m²
Treatment 6/G/16033 11.72m²
Store 6/G/16032 8.88m²
Kitchen 6/G/16031 7.63m²
Seminar Room 6/G/16030 8.88m²
Visitors WC 6/G/16029 2.86m²
Staffroom 6/G/16028 7.26m²
Ward Office 6/G/16027 9.67m²
Sprinkler 6/G/16 22.05m²
Chapel 6/G/16048 34.10m²
Office 6/G/16047 11.88m²
Vestry 6/G/16045 4.85m²
Store 6/G/16046 0.72m²
Female WC 6/G/16044 1.63m²
Duct 6/G/16055D 0.23m²
Duct 6/G/16056D 0.23m²
Entrance Lobby 6/G/16043 27.10m²

4.3


6 Bed Bay
10/F2/32011
53.14m²
6 Bed Bay
10/F2/32012
54.25m²
6 Bed Bay
10/F2/32013
54.25m²
6 Bed Bay
10/F2/32014
53.33m²
Corridor
10/F2/32001
113.31m²
Dirty Utility
10/F2/32010
10.20m²
Duct
10/F2/32084D
0.30m²
Staff Base
10/F2/32026
12.63m²
Bathroom
10/F2/32023
7.49m²
Assisted WC
10/F2/32020
3.37m²
Assisted WC
10/F2/32019
3.37m²
Equipment Store
10/F2/32015
4.30m²
Isolation
Lobby
10/F2/32016
2.82m²
Treatment Room
10/F2/32009
13.08m²
Switch
10/F2/32008
1.19m²
Shower
10/F2/32027
3.37m²
Clean Utility
10/F2/32025
9.89m²
Single Bedroom
10/F2/32024
11.81m²
Single Bedroom
10/F2/32022
11.72m²
Single Bedroom
10/F2/32021
11.72m²
Isolation
Single Bed
10/F2/32018
12.24m²
DDA En-suite
10/F2/32017
6.86m²
Dermatology Bathroom
10/F2/32007
113.31m²
Single Bedroom
10/F2/32028
11.52m²
En-Suite
10/F2/32029
3.27m²
En-Suite
10/F2/32030
3.27m²
Single Bedroom
10/F2/32031
11.52m²
Assisted Bathroom
10/F2/32006
11.84m²
Pantry
10/F2/32005
8.99m²
Office
10/F2/32032
18.77m²
Flower Bay
10/F2/32033
2.53m²
Nursing Section Office
10/F2/32004
7.81m²
Duct
10/F2/32083D
0.59m²
Duct
10/F2/32082D
0.80m²
Duct
10/F2/32081D
0.90m²
Linen
10/F2/32034
2.53m²
Cleaners
10/F2/32035
3.55m²
Consultant
10/F2/32003
8.97m²
Secretaries
10/F2/32036
11.41m²
Doctor
10/F2/32002
10.19m²
Staff Cloaks
10/F2/32037
8.23m²
Disposal
10/F2/32039
1.61m²
Staff WC
10/F2/32038
2.16m²
Jervaulx Ward


Day/Dining Room
10/F1/31064
52.67m²
6 Bed Bay
10/F1/31065
54.19m²
6 Bed Bay
10/F1/31066
54.19m²
6 Bed Bay
10/F1/31067
53.09m²
TBA
10/F1/31039
113.87m²
Equipment Bay
10/F1/31062
6.07m²
Assisted WC
10/F1/31060
3.37m²
Assisted WC
10/F1/31058
3.37m²
Assisted WC
10/F1/31056
3.37m²
Assisted WC
10/F1/31055
3.37m²
Staff Base
10/F1/31052
11.39m²
Pantry
10/F1/31068
7.34m²
Equipment Supplies Store
10/F1/31063
7.76m²
Single Bedroom
10/F1/31061
11.64m²
Single Bedroom
10/F1/31059
11.72m²
Single Bedroom
10/F1/31057
11.72m²
Single Bedroom
10/F1/31054
11.99m²
Clean Utility
10/F1/31053
11.33m²
Switch
10/F1/31069
1.19m²
Dirty Utility
10/F1/31070
10.89m²
Shower WC
10/F1/31051
3.04m²
Single Bedroom
10/F1/31049
11.52m²
Treatment
10/F1/31071
14.04m²
En-Suite WC
10/F1/31050
3.27m²
En-Suite WC
10/F1/31048
3.27m²
Medical Admissions Unit
Single Bedroom
10/F1/31047
11.52m²
Assisted Bathroom
10/F1/31072
14.08m²
Nursing Section Office
10/F1/31073
7.97m²
Quiet Room
10/F1/31046
14.18m²
Cleaners Room
10/F1/31045
5.64m²
Nursing Officer's Office
10/F1/31074
8.03m²
Linen Store
10/F1/31044
3.20m²
Occupational Therapy Kitchen
10/F1/31075
17.38m²
Secretaries Office
10/F1/31043
11.41m²
Calorifier
10/F1/31078
62.22m²
Staff Cloakroom
10/F1/31042
8.28m²
TBA
10/F1/31076
1.43m²
Staff WC
10/F1/31041
2.16m²
Disposal Room
10/F1/31040
1.61m²
Visitor's WC
10/F1/31077
1.69m²

A3

(1:200)

0 1 2 4 6 8 10

(M)

Harrogate and District NHS
NHS Foundation Trust

Planning Department
Capital Design Team

Harrogate District Hospital
Lancaster Park Road
Harrogate HG2 7SX

Site
Harrogate District Hospital

Project
Wing A
Emergency Department

Drawing Subject
Existing Plan

Date	Designed	Drawn	Checked
Feb' 2022	R.C	R.C	

Scales	Drawing No.	Revisions
1:200	xxx/xxx	

4.3

Ward	RN current WTE	RN March 2022 SNCT recommentation WTE	RN Varience from establishment WTE	CSW current WTE	CSW March 2022 SNCT recommentation WTE	CSW Varience from establishment WTE
Rowan	11.76	12.7	0.94	10.68	8.5	-2.18
Oakdale	19.92	26.6	6.68	18.47	17.7	-0.77
Granby	13.47	15.7	2.23	12.51	10.5	-2.01
Farndale	28.3	22.7	-5.6	21.86	14.9	-6.96
Jervaulx	22.9	30.3	7.4	21.69	20.2	-1.49
Trinity	12.01	15.2	3.19	13.27	10.1	-3.17
Byland	20.53	28.2	7.67	19.45	18.8	-0.65
Bolton	21.68	29	7.32	12.91	19.3	6.39
Nidderdale	20.32	25	4.68	17.03	16.7	-0.33
Fountains	19.62	8.6	-11.02	11.51	5.7	5.81
Harlow	18.31	15.6	-2.7	2	10.4	8.4
Littondale	19.62	22.4	2.78	17.03	14.9	-2.13
Wensleydale	19.72	19.8	0.08	20.06	13.2	-6.68

Board of Directors (held in Public)
25th May 2022

4.3

Title:	**Guardian of Safe Working Hours Report Q4 2021/22**
Responsible Director:	Executive Medical Director
Author:	Guardian of Safe Working Hours

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous update from the Guardian of Safe Working	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	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	X
	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	X
	BAF3.5 To provide high quality public health 0-19 services	X
	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	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

MAY 2022

1.0 Executive Summary

This is the Seventeenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st January 2022 to 31st March 2022 - the 4th quarter of 2021/22. There is also the complete chart data for 2021/22.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

38 exception reports have been submitted in Q4; this is on a par with the previous quarter (38) and brings the total for the year to 212. There was 1 further education exception report submitted. This brings the total for 2021/22 to 18 (compared to 3 in 2020/21).

Exception reporting remains comparable to other Trusts across the region although it is unclear whether the other trusts are seeing the same increase in educational exception reports.

There have been a further 6 reported breaches of contract, bringing the total number of breaches to 12, and fines totalling £1981.20 have been levied. These breaches relate to working beyond the maximum 13hr shift length, mostly within general surgery on SDEC and now one in acute medicine.

There has been no regional meeting for Guardians since the last report. Trainee doctors' fora have been held jointly with the Deputy Director of Medical Education. These continue in both a face-to-face and virtual capacity but have been reduced back to the usual quarterly schedule.

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. The pandemic has had a significant impact on the training delivered and the subsequent progress through the respective training programs of the junior doctors. In turn this is likely to have resulted in a shift of priorities for those junior doctors affected and potentially increasing the likelihood of an exception report being submitted.

With the latest wave of the pandemic, there has been a significant and sustained impact on junior doctor staffing across the organisation, especially from the New Year period onwards. Rota coordinators are reporting difficulties in staffing rota gaps with increasing frequency, surgical rotas seem to be particularly difficult to find cover for. However, communication to the affected teams of said staffing gaps has improved significantly in recent weeks with virtually daily emails highlighting the shortfall.

This is the key quality assurance statement for the Board:

'The Board is advised that whilst rostered hours across the organisation are compliant, feedback suggests that workload is unmanageably high. This quarter has seen further Guardian fines levied against the trust. The concerns over workload on SDEC and within acute medicine have yet to be successfully addressed.'

2.0 Introduction

All doctors in training posts at HDFT are now employed under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) (hereafter referred to as the New Contract). As part of the new contract, the trust has appointed a Guardian of Safe working, the primary responsibility of which is to:

1. To act as the champion of safe working hours for doctors in approved training programmes within the Trust.
2. Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the new terms and conditions of service.

In accordance with Schedule 6 of the new contract the Guardian of Safe Working should provide the Board with a Guardian of Safe Working Report not less than once per quarter. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This is the Sixteenth quarterly report of the Guardian of Safe Working Hours.

The Trust now has all junior doctors employed on the 2016 Terms and Conditions of Service (TCS) contract. These have moved to Version 5 of the contract.

The trusts Guardian of Safe Working reports continue to run out of synchronization with the regional quarterly reporting pattern. The Trust's reports are alternately in and out of phase with the quarters. The effect of this is that there is always an incomplete quarter encompassed within the timeframe of the report. Moving forward, the reports will focus on just one quarter at a time.

3.0 High Level Data

3.1 Vacancy information

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty.

The continual successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but is challenged by the availability and willingness of suitable doctors to apply.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees but are not included in the exception reporting process. There are about 60 SAS grade doctors in the Trust.

Junior Medical Rota

Feedback from multiple sources has demonstrated that the junior medical rota has not been functioning well for some time. Attempting to improve this, a working group was established, led by the Chief Registrar and Operational Director for LTUC. Quick improvements have been implemented and 3 fellows have been recruited into General Medicine, in post until August.

There are plans to recruit 4 fellows for August 2022 start, who will work covering the general medicine rota. Adverts closed 6th May.

- 1x Clinical Teaching Fellow (Registrar Level – ST3+, 12 months)
- 3x Clinical Teaching Fellow (FY2-CT2, 12 months)

Changes to Medical Curricula

Changes to several postgraduate medical curricula have come into effect during 2020-2022. Integral to many of these is a requirement for additional supervision for early year registrars. These changes to entrustability (More holistic approach to judging a trainee than simply looking at competencies – "they can do it but are they ready for the responsibility of doing it on their own"), means that in some specialties, only trainees at ST5 level or above are allowed to be left to do the role unsupervised, out-of-hours.

It is likely that Harrogate will have HEE trainee doctors rotating who are unable to fulfil out of hours commitments to the same level of independence as their predecessors. Specialties particularly at risk are obstetrics and gynaecology, and medicine. The result of this may be increased staffing requirements and/or diversion of consultant activity from elective work to emergency out of hours care. Within obstetrics specifically, this means there have been 3 WTE "gaps" on the senior rota from February 2022 – there has been some successful recruitment, but gaps still remain, and the burden of the additional hours has been placed on 3 SAS doctors.

May 2022

Trainee posts: the position is similar to previous reports. At any time, there are rota gaps of around 5% in established NHS training posts. These from time to time include maternity and other leave, resigners and vacant posts not filled. The Medical Workforce Department continuously seeks recruitment to vacant posts.

The current position is 13.8 Whole time equivalent (WTE) gaps. There should be 137 junior doctors in the trust. This increases to 166 when GP trainees are included.

The following table explains the breakdown of gaps by directorate.

	Dept	Rotates	Grade	Deanery or Trust	WTE	Recruitment
LTUC	Acute Medicine	12 months (-Aug)	ST3+	Deanery	2	Successful recruitment of 1 MTI fellow, 1 post unfilled.
LTUC	Acute Medicine	12 months (Aug-Aug 23)	ST3+	Deanery	1	As above – 1 post filled by LAS doctor.
LTUC	Acute Medicine	4 months (Apr-Aug)	FY2	Deanery	1	Due to trainee going LTFT. Not recruited to
LTUC	Cardiology	6 months (Feb-Aug)	ST3+	Deanery	1	Failed recruitment
LTUC	Elderly Medicine	4 months (Apr-Aug)	IM1	Deanery	1	Gap due to maternity leave. No plans to recruit cover.
LTUC	Elderly Medicine	11 months (Aug-Jul 22)	ST3+	Deanery	1	Gap due to maternity leave. Failed recruitment – trainee due back Jul 22

LTUC	Diabetes & Endocrinology	6 months (Feb-Aug)	IM3	Deanery	1	Advert request submitted (May 22). Awaiting approval
LTUC	Emergency Medicine	6 months (Feb-Aug)	ST3+	Deanery	1	80% GAP due to trainee CCT. Dept filling internally
CC	Paediatrics	6 months (Mar-Sept)	ST1-3	Deanery	1.8	Successful recruitment to 1 post, June start date. Dept looking at reserve list for remaining 0.8
CC	Paediatrics	12 months	ST4+	Deanery	1	Failed recruitment. Advertised twice, no suitable candidate found. Re-advertised
PSC	Psychiatry / Orthogeriatrics / Gastro medicine	12 months	FY1	Deanery	1	Student failed to graduate. No plans to recruit to this gap.
PSC	Dermatology	12 months	ST3+	Deanery	1	Dormant post – no plans to fill

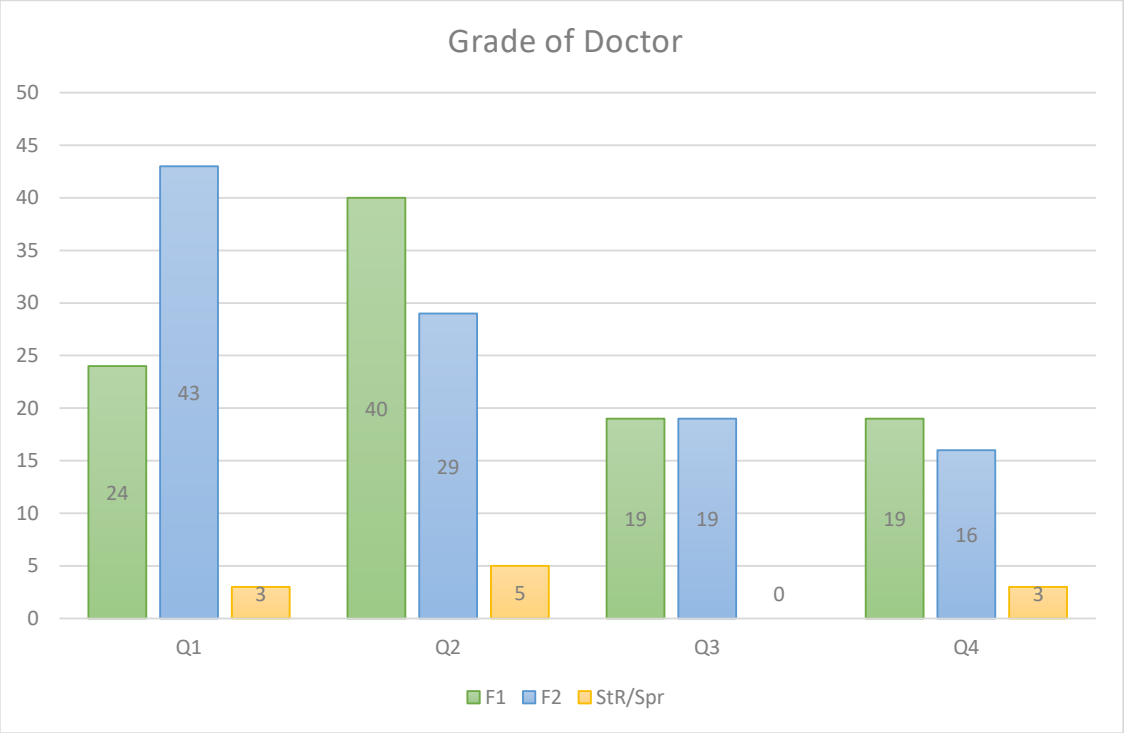
4.0 Exception Reports – Qualitative Analysis

Exception reports are individual notifications to the DRS system by trainee doctors who have experienced an issue causing them to vary their working hours from the contracted work schedule. This may be repeatedly missing breaks during the day, being unable to attend scheduled teaching (either internal or external) or more likely workload requiring them to stay beyond the scheduled hours to complete tasks.

Clinical supervisors are, in most cases, poor at responding to exception reports within the required time frame. This task was added to the supervisors without consultation by the 2018 review of the New Contract and has never had an enthusiastic response. Significant effort has been put in to try and improve the status quo, most notably weekly reminder emails and participation in the supervisor workshops. Following a role change agreed in V5 of the TCS, any overdue reports must be reviewed and agreed by the Guardian.

The reports quoted below were all highlighted to supervisors, directorate management and the Director of Medical Education (where appropriate) at the time of submission/review by the Guardian.

The following pages detail the breakdown of data.


Grade of Doctor
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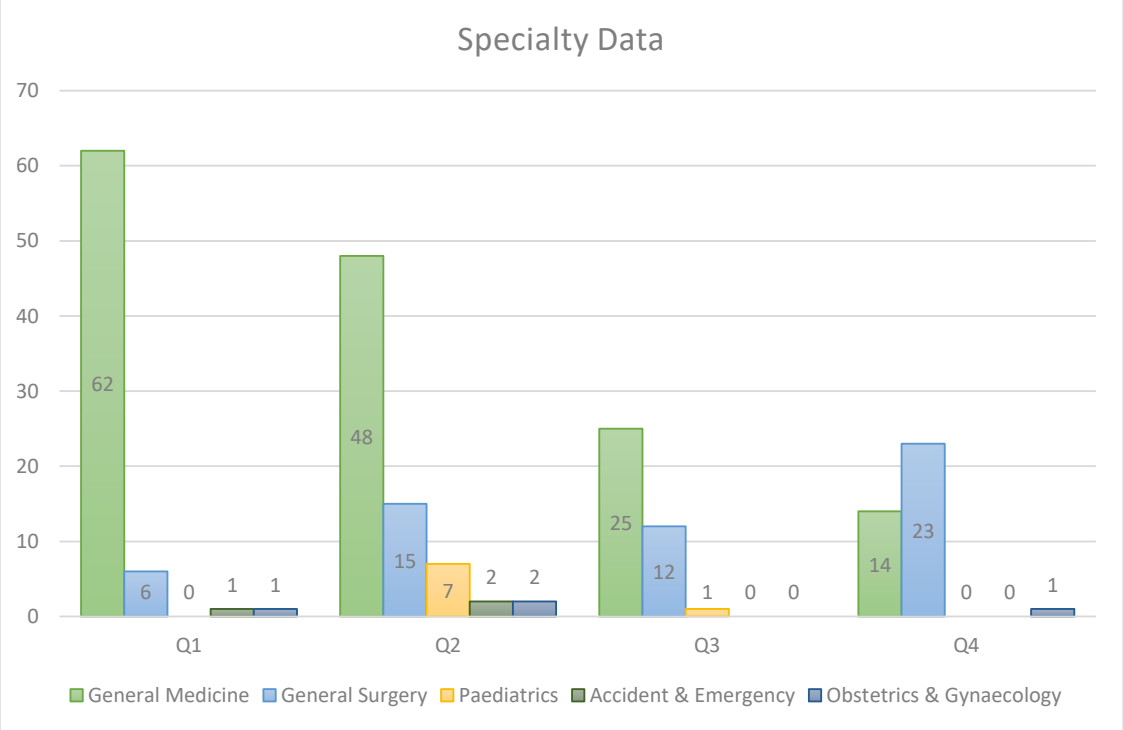
45
40
35
30
25
20
15
10
5
0
24
43
3
40
29
5
19
19
0
19
16
3
Q1
Q2
Q3
Q4
F1
F2
StR/Spr


Specialty Data
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60
50
40
30
20
10
0
62
6
0
1
1
48
15
7
2
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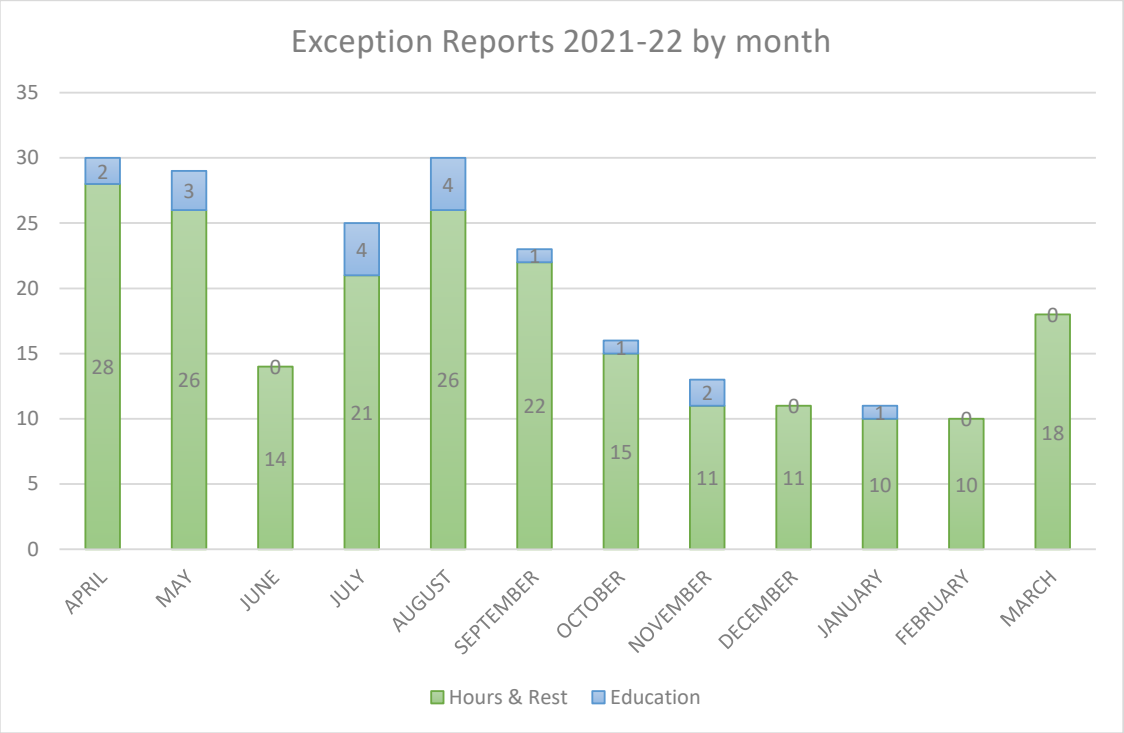
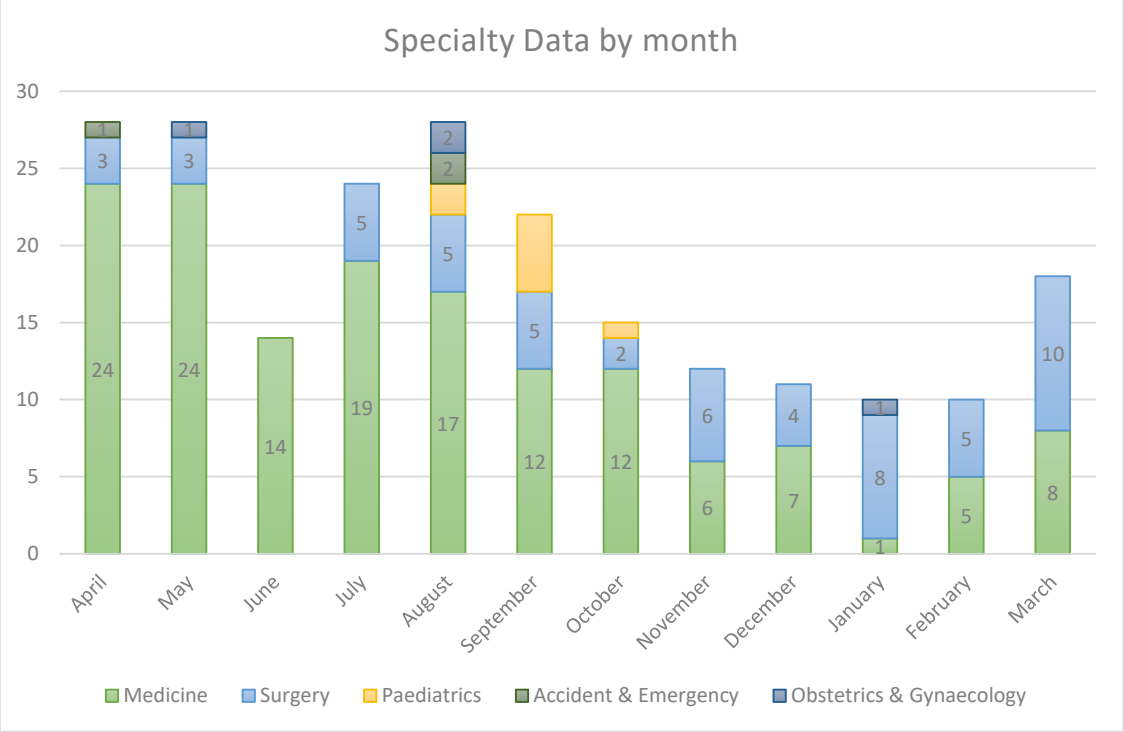
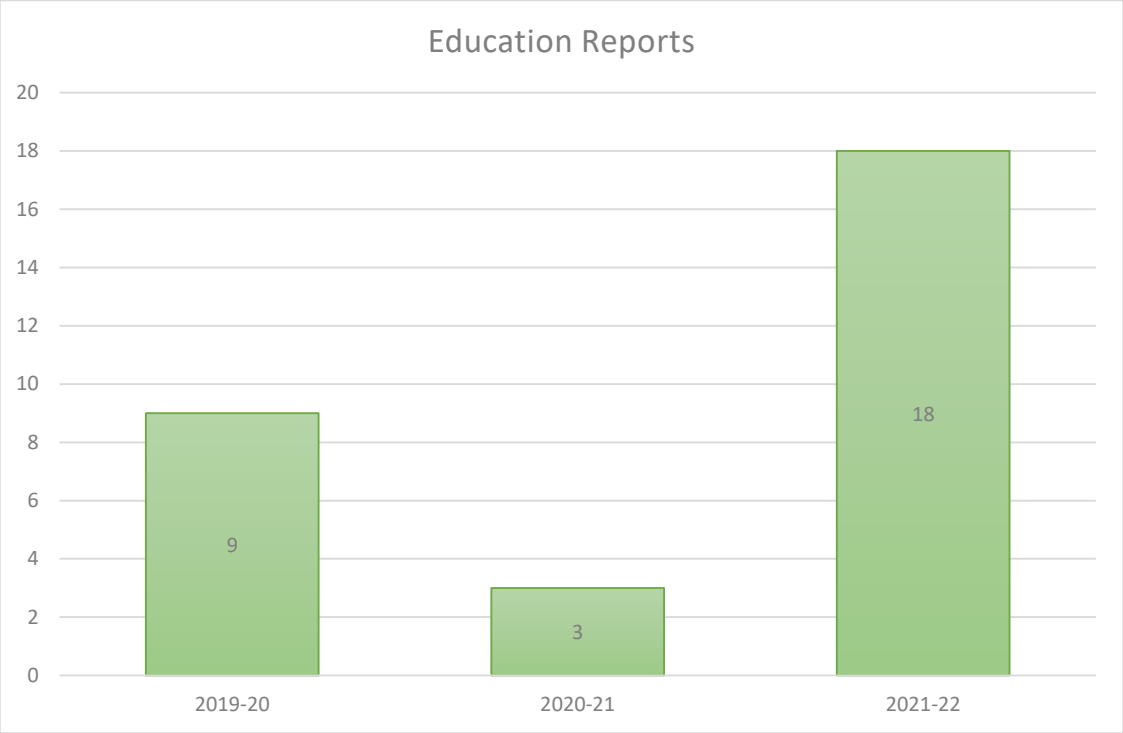
25
12
1
0
0
14
23
0
0
1
Q1
Q2
Q3
Q4
General Medicine
General Surgery
Paediatrics
Accident & Emergency
Obstetrics & Gynaecology


Exception Reports 2021-22 by month
35
30
25
20
15
10
5
0
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
Hours & Rest
Education


Specialty Data by month
30
25
20
15
10
5
0
April
May
June
July
August
September
October
November
December
January
February
March
Medicine
Surgery
Paediatrics
Accident & Emergency
Obstetrics & Gynaecology



There was 1 further education exception report in Q4, bringing the total to 18 for the year – a significant and troubling increase when compared to the 3 reports for the entire 2020/21 year. In fact, this represents more education exception reports than in the last 3 years combined. All education exception reports have been discussed with the Director of Medical Education who reviews them all. Whilst some are erroneously tagged as education reports, there is still a significant enough number to be concerned.

Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine which usually accounts for 65-80% of all exception reports submitted (70% 2021-22). During the last quarter there has been a reversal of this trend, with general surgery accounting for the majority of the reports. Anecdotal feedback from the Junior Doctors Forum suggests that this reflects doctors not submitting reports in medicine due to dis-satisfaction with the response from directorate management rather than a resolution of issues leading to reports being submitted – *"nothing ever comes of them"*.

The number of exception reports submitted is known to underestimate the actual amount of routine over-working.

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgement. Clinical supervisors are expected to guide their trainees in efficient working, prioritising clinical activities and making timely handovers to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is usually over-spent on medical locum costs for consultants and trainees.

4.1 Verbatim exception report excerpts

The following are verbatim excerpts from Q4 exception reports. Due to the publicly available nature of this report any names or other identifiable material have been removed.

Medicine

103795: Hours & Rest

"Medical long day F1 ward cover No SHO. Had to carry SHO bleep with, only junior doctor covering all medical wards. Would like to escalate this as I was very unsupported with a completely unmanageable workload with concerns that I inevitably may have missed patients / details of their care. Unable to achieve any break in the 12.5-hour shift."

Steps taken to resolve

"Highlighted to medical registrar at start of shift who made site manager aware."

103797: Hours & Rest; Education

"Stayed 1 hour late due to ward pressures. Other members of the team asked to help on other wards leaving us understaffed."

Steps taken to resolve

"none"

104247: Hours & Rest

"On Monday night I came in to find there was only one-night sho for medicine and myself (an IMT3 as the medical registrar). Someone had called in sick with covid and the gap had been unfilled. Due to the exceptional work load I was unable to take a break and was working continuously for the full shift. Due to things afterwards, I needed to stay an additional half an hour to debrief and calm down before driving home."

Steps taken to resolve

"I spoke to the consultant on call in the morning to explain, immediately escalated on Tuesday morning to the rota coordinator for the rest of the week. I have since spoken to my clinical supervisor above to talk about it to debrief. Also, as an added note as it doesn't quite fit into its own exception - I subsequently came in to find on Wednesday there was no SHOs at all planned for Thursday night. I immediately escalated this to the consultant on call and we managed to arrange cover at short notice on the Wednesday for Thursday thanks to our own efforts."

As has been previously stated, junior doctors are frequently spending a considerable amount of time speaking to rota coordinators to highlight staffing issues that should already be known about, have been discussed with directorate management and an action plan put in place. The Guardian can find nothing that suggests that the discussion with directorate management is either occurring or if it is, that a suitable solution is enacted. Junior doctors will feel comfortable going to their consultant supervisors but are not familiar with whom directorate managers are or what their role should be in finding a solution.

Surgery

101006: Hours & Rest

"Only junior member of staff on for Gastroenterology during the day (until 4pm) - no physicians associates due to Covid isolation and annual leave, no other FY1 due to rest day post on call Farndale shifts, no IMT doctor due to rota gap, no long-term locum cover due to them having an exam that day. High volume of jobs from day shift for Gastroenterology patients which were not completed by 4pm despite help from the Gastroenterology registrar on call. Was then the only doctor covering the medical wards from 4pm-8pm as Tier 2 gaps in the medical rota. This was for both the Tier 2 long day on the ward and Tier 2 on call on Farndale. In fact, there was

only 3 doctors (2 FY1s and 1 SpR) covering medical admissions and the medical wards from 4-8pm. This resulted in unsafe levels of staffing for the medical take and inpatients."

Steps taken to resolve

"Rota coordinator and clinical supervisor for Gastroenterology notified prior to shift - locum shift for Gastroenterology 8am-4pm advertised, but unfortunately was not filled. Rota coordinator and senior management also aware of missing 2-3 doctors for the medical long day/on call on this day."

Due to the often shared surgical/medical nature of gastrointestinal problems, the DRS system classifies these as surgical related reports. The junior doctors covering these wards will cover both medical and surgical patients, even if they only working one of the rotas.

102416: Hours & Rest

"Several days ahead it became clear that the normal staffing levels on a weekend (2FY1s+2FY2s) would not be achieved and the day before I was informed that it was only me as a Tier2 doctor and a Tier 1 doctor covering both ward rounds, wards, SDEC and admissions. A day ahead when I was informed that I had to do cover all Tier 2 responsibilities and that there would be only 1 FY1 doctor stay additional time (8:30 in spite of 6:00) I already gave a detailed account to the rota coordinator that these staffing levels are horrendously unsafe, and that patient safety could no longer be achieved on that day. There was no extra support on that day available however. As expected, we were not able to achieve any breaks during this day to attend urgent reviews on the ward and in A&E. An unexpected trauma call with an arresting patient consumed additional time as did an urgent strangulated hernia repair among several high NEWS on the ward and the death of two patients on the wards. All in all, we were only able to prioritise jobs and reviews of patients in order to achieve some degree of patient safety. Certainly, many things were overlooked on those day. I asked the clinical site manager more than 2 times to get help by one of the medical ACPs to facilitate any discharges that we were not able to facilitate due to the workload. I raised this with the medical team and the ACP directly additionally who agreed to this upon notification of the site manager that never came through."

Steps taken to resolve

"Prioritised tasks Informed A&E consultant and staff of staffing issues and that only limited and urgent referrals could be answered. Asked nursing staff on all wards to limit bleeps to urgent matters only. Handed over routine jobs to night staff later and stayed an additional 30 minutes to finish documentation of urgent jobs Asked ortho and gen surg registrar to see patients directly in A&E and general surgeon consultant came in to assist in one procedure with the gen surgical registrar. All these steps were not sufficient to ensure a safe work environment for patients or personnel."

This exception report highlights severe patient safety concerns that stem from significant staffing issues that were known about more than 48hrs prior to events taking place. Despite this prior knowledge, there was a failure to adequately cover the gaps or seemingly to devise a plan that would ensure patient safety for the wards affected.

102632: Hours & Rest

"I was supposed to be on ward support over the weekend 8am-6pm. However, there were severe rota gaps resulting in no FY1 or FY2 on call meaning the team was 50% below minimum staffing levels. This resulted in myself and the F2 on ward cover having to carry the on-call bleeps in addition to covering general surgery/urology wards rounds/ward jobs/A&E (thankfully SDEC was shut due to staffing issues). The day was exceptionally busy. A trauma call in A&E resulted in the ward rounds being delayed until midday creating severe backlog of workload. Unable to take any breaks throughout the day. Several members of the nursing team put in datix reports as I was unable to complete discharge summaries in the elective unit due to clinical prioritisation of tasks. Resulting in many patients remaining in hospital for an

extra 24h. My shift was due to finish at 6pm, however there was no one to hand the bleep over to until the night team arrived and so it was unsafe to leave. Due to workload, I did not finish until 9pm - 3 hours after my shift was due to end. Overall, I felt this shift was completely unsafe."

Steps taken to resolve

"Rota team were aware of this gap several days before the shift but were unable to fill the shifts. On the day of the shift the F2 on ward cover escalated concerns of being unable to safely manage and further support was needed to the site manager however no action was taken."

This exception report provides a corroborating account to the report above. It also highlights the additional pressures junior doctors face when workload is unmanageable. At the junior doctor's forum, this junior doctor described nursing staff using the "threat" of datix reports being submitted against the junior doctors as a way of trying to get them to prioritise certain tasks over those with greater clinical urgency. This was corroborated by other juniors. This is a worrying reflection on the culture on the wards at the moment.

103757: Hours & Rest

"Extreme short staffing in the general surgical rota - this has been a big problem this rotation but staffing levels today in particular have been extremely unsafe. This puts undue pressure on junior doctors, affects patient flow with delays in TTOs, affects patient management as patients' bloods and investigations do not get added to the handover list (low priority job compared to clinical reviews and TTOs), and leaves a precariously bare-boned and overworked team to manage any acutely unwell patients across these specialties (there were at least 2 today), perpetuating an environment where mistakes can occur. Today: General Surgery - 1 junior (me) (minimum staffing is 2) Urology - NO JUNIORS (minimum staffing is 1) SDEC - NO JUNIORS NO WARD COVER FOR SURGICAL SPECIALTIES 5-8 PM Fountains - 1 junior (achieves minimum staffing) Orthopaedics - 1 junior (achieves minimum staffing) SHO Long Day on-call - 1 junior (achieves minimum staffing) I am not sure how other junior doctors managed exactly with regards to breaks etc. today, although I know that it was a difficult day for everyone, and I myself did not take any breaks and left 1.5 hours late. Ironically, having received training on Human Factors just yesterday, I can recognize how conducive this environment is to errors that may adversely affect patient care and junior doctor wellbeing. This seems to be a recurrent problem - I don't know if this rota can be reviewed?"

Steps taken to resolve

"Issues reported to rota-coordinator in the morning and throughout the day shift with regards to staffing on General Surgery FY1 on the 12.5 hour night shift prior asked to stay for an additional 2 hours in the morning to go on the Urology ward round, breaking the junior doctor contract (exceeded max 13 hour shift) Urology jobs from ward round completed by Urology SpR Junior doctor on fountains ward asked to cross-cover SDEC (instead of SDEC being closed to surgical patients due to completely inadequate staffing) Junior on Orthopaedics asked to stay till 8 PM to cover wards"

These reports were chosen due to the level of detail and insight they provide into the problems created by inadequate staffing. A work-schedule was requested by the junior doctor, and this is being looked at as part of the SDEC working group.

Obstetrics & Gynaecology

100978: Hours & Rest

"Stayed 2 hours late for a surgical list"

Steps taken to resolve

"None"

It is not uncommon for junior doctors to stay late to complete elective surgical lists that overrun. It is neither appropriate nor possible for the on-call emergency team to be utilised for over-running elective surgery.

5.0 Work schedule reviews and interventions

5.1 Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No individual work schedule review has been necessary during this quarter. The working model for surgical juniors is being looked at as part of a SDEC working group.

5.2 Interventions

The Guardian suggests that isolated cases of over-working are to be expected in emergency conditions. The Trust is grateful for trainees' flexibility on occasion and in ensuring patient safety. However, repeated instances raise the question of whether the rotas and workload are appropriate for the trainees in this specialty. Junior doctors have responded magnificently to the challenge of COVID – as have all health-care staff – but the Trust is contractually obliged to ensure that the trainees balance their service work with educational opportunity and rest.

The rota gaps during the last quarter due to covid isolation/sickness have placed significant strain on the junior doctor workforce. There have been numerous days when staffing has fallen drastically short of minimum safe staffing levels, and this is reflected in the reports submitted. What remains unclear is what processes have been enacted to try to minimise the risk to patient safety. With junior doctors highlighting that they have escalated the issues to their consultants and rota co-ordinators the feedback has been that they have not received the additional support – from either redeployment of workforce or senior staff "acting down" – that they have requested.

Previous reports have mentioned the on-going issues with routine overworking within medicine, particularly on the acute medical rotas. Considerable work has been undertaken within LTUC to improve the current situation. This includes recruitment to short-term posts to cover gaps for 6 months. There are plans to continue these fellow posts with adverts for August 2022 entry having recently closed and interviews due to take place shortly.

As the exception reports above demonstrate, there is still cause for concern regarding the current workload and working patterns of the FY1 doctors covering SDEC. A working group has already been established to look at making changes to the current working model, but any solutions agreed upon will have a mid-to-long term timeline horizon (diversification of workforce, additional recruitment).

6.0 Fines

Due to the stipulations of the New Contract, the Guardian has the power to penalize departments/directorates for failure to ensure safe working hours and particularly repeated breaches of the TCS of the new contract. This section lists all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report indicates the total amount of money levied in fines to date, the total amount disbursed and the balance in the Guardian of Safe Working Hours' account. A list of items against which the fines have been disbursed will be attached as an appendix if applicable.

This last quarter has seen further fines levied against the trust. There have been 12 reported breaches of the TCS of the new contract caused by the Trust.

Fine number	Directorate	Total Amount	Amount within GOSW Fund
1	PSC	£ 249.48	£ 155.94
2	PSC	£ 249.48	£ 155.94
3	PSC	£ 205.94	£ 128.73
4	PSC	£ 162.40	£ 101.51
5	PSC	£ 118.86	£ 74.30
6	PSC	£ 150.64	£ 94.16
7	PSC	£ 75.32	£ 47.08
8	PSC	£ 190.68	£ 119.19
9	PSC	£ 261.51	£ 163.46
10	PSC	£ 110.34	£ 68.97
11	PSC	£ 73.56	£ 45.98
12	LTUC	£ 132.99	£ 83.13
TOTAL		**£ 1,981.20**	**£ 1,238.41**
TOTAL DISBURSED			**£ -**
REMAINING BUDGET			**£ 1,238.41**

7.0 Meetings

There has been no regional meeting of Guardians in the previous quarter. The Guardian is due to attend a National Guardian workshop in June 2022.

8.0 Trainees' Forum

Trainees' fora increased to monthly during the pandemic but have now been stepped back to the usual quarterly meetings. The importance of exception reporting has been canvassed to the trainees at each meeting.

At the last forum meeting (Apr 2022), junior doctors working across multiple directorates reported that they were being actively told not to submit exception reports by their supervisors. This is very worrying. Not only is exception reporting a protected privilege for the junior doctors it is also an important information stream and barometer of sentiment within the junior medical workforce. To actively discourage junior doctors from exception reporting goes against the ethos of the changes to the contract as well as the trust KITE values. Unfortunately, with reluctance to provide names it has not been possible to identify who has been responsible for this behaviour and address it at the source. Clinical and Educational supervisors were contacted as a group and the importance of the exception reporting process was reiterated.

The COVID-19 emergency has greatly affected post-graduate medical training. Educational opportunities, assessments, courses, and examinations have been discontinued and the amount of clinical experience in their home specialties has been curtailed due to redeployment. Some trainees will have delayed completion of examinations and completion of training programmes.

The full impact of the pandemic on the training and successful progression through training programmes only became apparent when the first round of ARCPs were completed. Two new ARCP outcomes were created (10.1 & 10.2) to denote trainees whose training has been adversely affected by COVID-19. There are likely to be some trainees that will require additional training time before they can progress (Outcome 10.2) – this may be playing a part in the increasing number of educational exception reports being submitted as the priorities of the Junior Doctors shift and they feel they need to become more vocal to achieve their training requirements.

There is concern at high level within HEE on the impact on future doctor numbers that the pandemic is having. Burn-out, mental health issues, and an increasing trend in working less than full time will all have an impact on the ability to fill trainee posts, rota gaps and overall junior doctor numbers.

9.0 Disclosure

These regular Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at each regional meeting. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. This information is collated and shared upon request.

Health Education England will be undertaking a “deanery visit” to assess the trust, triggered by the exception reports submitted previously and feedback through alternative mechanisms (GMC survey/BMA). This visit will take place on 24th May.

10.0 Confidentiality

Given that Guardians’ reports may be in the public domain, the identities of any individual doctors and supervisors are concealed in the Guardian’s quarterly report. Full data are available to the Board of Directors in private session on request.

11.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in the previous quarter.

12.0 Extending the scope of the Guardian to the inclusion of SAS Doctors

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change.

The Guardian has been informed that the system used by the junior doctors cannot be used for the non-training grades and an alternative system will be necessary. The Guardian has discussed implementation of this process with the medical workforce department and unfortunately there has been no progress in facilitating the inclusion of SAS doctors over the last 12 months. Despite this, the Guardian remains committed to bringing this ambition to fruition, but it will need input from medical staffing to ultimately succeed. Until such time as SAS doctors, working on the same rotas as the junior doctors, have the ability to exception report the extra hours they work, there exists an inherent inequality.

13.0 Issues arising

a) The trust continues in comparable standing to other trusts in the region. Exception report numbers have remained at the same level in the last quarter.

b) There is an on-going problem of over-working and late finishes for trainee doctors owing to colleagues off sick, rota gaps and pressure of clinical work. This is especially true in General Medicine and now for surgery on SDEC.
c) Staff sickness due to covid-19 infection and isolation has had a significant impact on overall junior doctors staffing.
d) Reluctance of trainees to report exceptions exists regionally and nationally.
e) Exception reports are being received and processed within the accepted time limits. There remains reluctance from supervisors in signing-off the reports. >50% are signed off by the Guardian alone.
f) There are gaps on rotas, but recruitment cycles continue.
g) No national Guardian meeting has yet been announced for 2022.
h) The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed in principle: However, no progress has been made in implementing this since agreement and without action by medical staffing to facilitate this it will not be possible.

14.0 Actions taken to resolve issues

a) 5 further fines have been levied against the PSC directorate and 1 against LTUC during this quarter.
b) The Guardian has been involved in several interventions in the last quarter, started as a result of systematic overworking within the respective areas.
    i. Acute Medical staffing improvement work – recruitment of fellows.
    SDEC workshop – highlighting information from exception reports.
    ii. HEE “deanery” visit (scheduled for 24th May).
c) At the date of reporting, the Board of Directors is assured from the evidence that:
    i. The exception reporting system is operational for all trainees; they are now all converted to the 2016 TCS Version 5.
    ii. Over-working owing to pressure of workload and rota gaps is a chronic problem in general medicine, currently exasperated by the latest wave of the pandemic.
    iii. The Guardian can only intervene on notified problems.

15.0 Questions for consideration by the Board of Directors

a) The board is asked to receive the quarterly report of Q4 2021-22 and to consider the assurances provided by the Guardian.
b) The issues around persistent overworking of juniors outlined in this report is now a significant concern and urgent action is needed by directorate management teams.
c) Significant pressure on staffing is currently being felt across the organisation and is concerning. There is evidence that support mechanisms are not working adequately.
d) The Guardian asks the board to be aware of the increasing pressures on junior medical staffing and the need for a long-term sustainable workforce model.
e) Issues of medical (and indeed all healthcare professional) workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies in trainee doctor posts; these currently run at about 10%.
f) The Guardian asks the board to consider whether medical workforce sustainability should be included on the Trust risk register.

Dr Matthew Milsom

Guardian of Safe Working Hours

15th May 2022

Medical Director Report
Date: May 2022 Public Board

NHS Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Mortality- HSMR/SHMI currently above expected range- mortality group reviewing all potential triggers (see Q4 LFD report)
- R&I - risk of financial reduction by Y&H CRN due to reduced research activity due to lack of dedicated research estate –options continue to be explored
- Health technology and Digital Innovation roundtable planned for HG and district following conversation with HBC and Primary Care
- Cybersecurity threat remains at high level- mitigated by large scale programme of security patching
- Y&H HEE to visit Surgical SDEC due to surgical trainee feedback
- A number of CDI identified YTD (6) - await CCG feedback and also further typing to identify if any patient to patient transmission

Major actions commissioned & work underway

- Legal (clinical claims)- now standing item on dept/directorate quality governance meetings, thematic learning shared at learning summit
- Clinical Effectiveness:
  - Update guidelines for 1. audit (trust and local) and 2. best practice guidance out for consultation.
  - Updating of polices/procedures/guidelines ongoing
- Medical Workforce systems- electronic appraisal, job planning and leave management now in place. Soft market testing to commence for medical e- rostering
- Review of systems to support non substantive/non training grade doctors with annual medical appraisal and revalidation being undertaken
- Digital Aspirant Programme:
  - Electronic Health Record- soft market testing undertaken
  - SOC being prepared for HNY Board and Finance team review.
  - Ongoing dialogue with NHSE to clarify potential funding

Positive news & assurance

- Showcase event June 8th – celebrating the work of junior doctors and dentists, doctors and dentists in training, SAS doctors and dentists, advanced clinical practitioners (ACPs) and Physicians Associates (PAs)
- HDFT top recruiting site for NIHR IMID BioResource research study last month (100 patients)
- SAS Doctor Advocate role agreed- will be separate to GSW role, due to be advertised Trust wide shortly

Decisions made & decisions required of Board

Harrogate and District NHS Foundation Trust

4.4

Board Meeting Held in Public
May 25th 2022

Title:	Learning from Deaths Quarterly Report 4: January-March 2022
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. Trust mortality has risen since mid-2021 values. Details are provided in the report for areas where any concerns have been identified.	
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:	No prior scrutiny before Board. Paper is also discussed at Patient Safety Forum	
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

25th May 2022

4.4

Learning from Deaths Quarterly Report 4

Executive Medical Director

1.0 Executive Summary

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

Standardised mortality rates continue to be rising since mid-2021. No immediate cause has been identified but further investigation is continuing.

14 structured judgement reviews have been undertaken since the last report. Median score for overall care were classed as “good” with only 1 case of overall care being classed as “poor” – a case which is being investigated as a Serious Incident.

There continues to be a significant number of patients testing positive for Covid-19, with the majority of deaths after a positive test occurring in the over 75s.

The HDFT Medical Examiner team continues to perform well when benchmarked against regional data.

2.0 Introduction

Mortality data in Q4 continues in a similar manner to Q3, with a gradual increase in mortality indices. The time period covered in this report includes a significant Omicron Covid-19 positive casemix.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality rates. In total, 203 deaths were recorded in Q4, up from 198 in Q3. However this represents a small fall as a percentage of activity. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years.

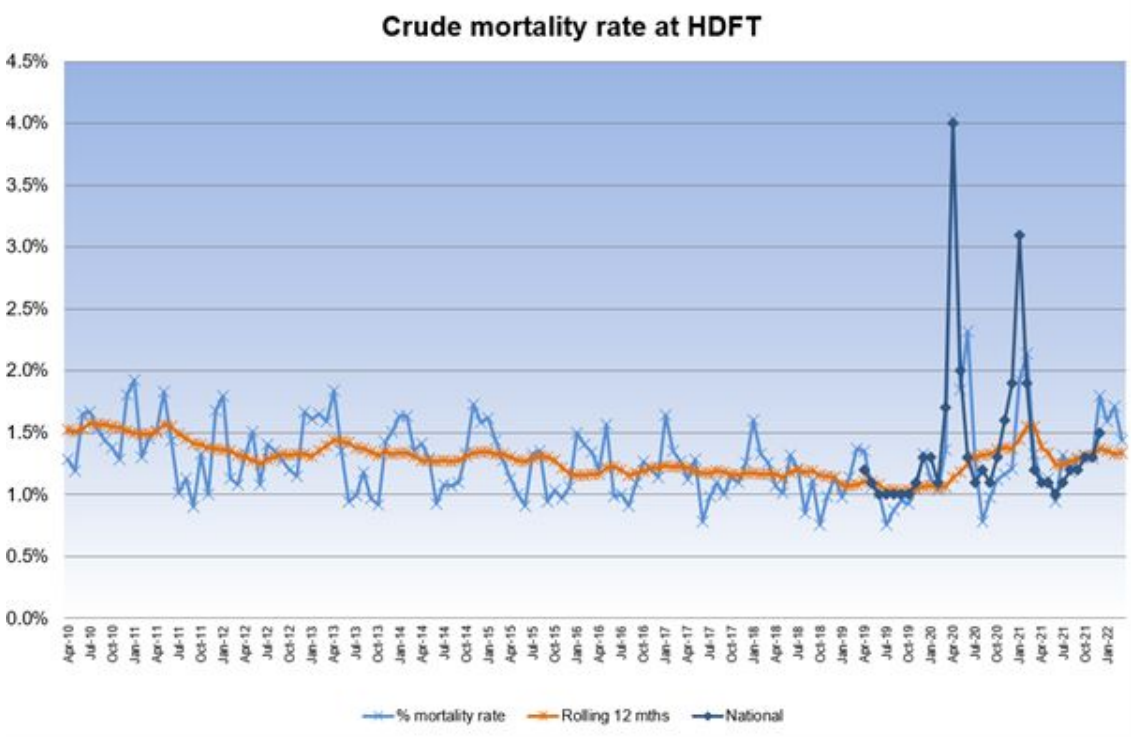


Figure 1: Crude mortality rates over the last 11 years (%deaths per qualifying admission activity)

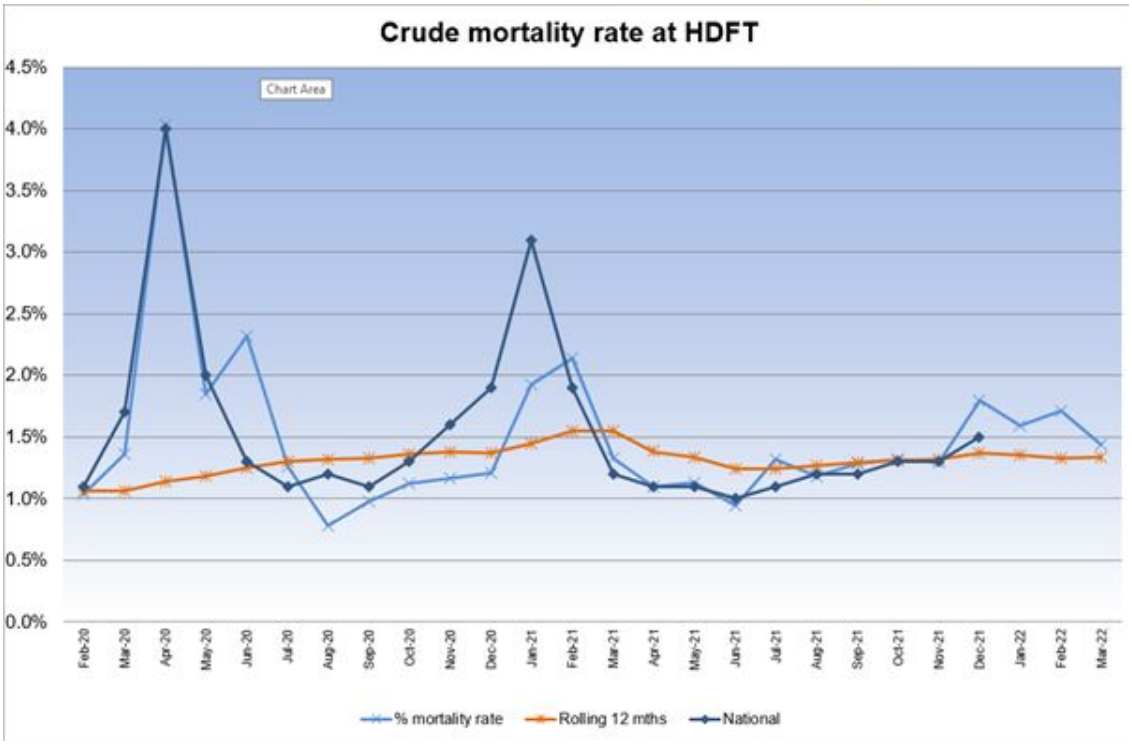


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital admission)

3.2 Standardised Mortality Rates (HSMR and SHMI)

Figures 3-8 show the most recent data available for HSMR and SHMI. Overall, our results from both indices have slowly increased since mid 2021. Please note that Figures 3, 4 and 6 show the 12 month rolling data.

3.2.1 HSMR

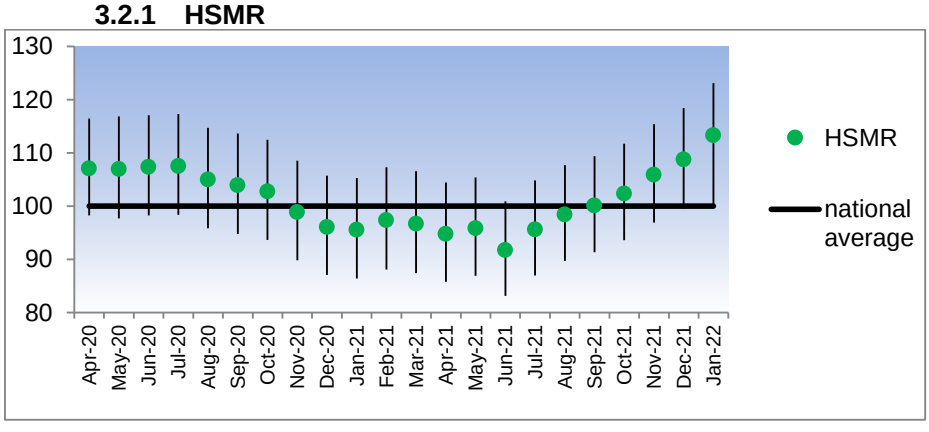


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

Harrogate and District NHS Foundation Trust

Figures 4, 5 and 6 show our most recent HSMR data in comparison to national and regional peers. Figure 5 demonstrates the significant monthly variation in HSMR, including the unexplained spikes at HDFT in July 2021 and November 2021.

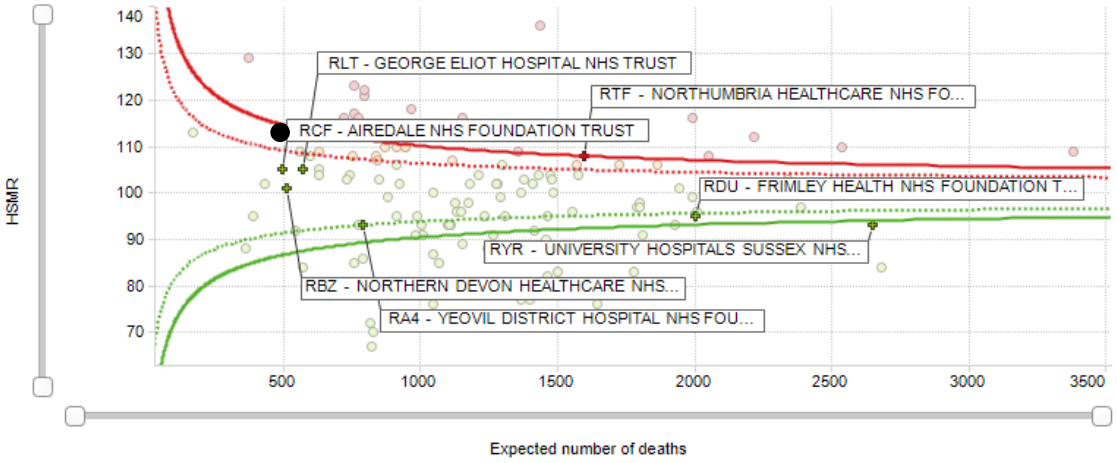


Figure 4: HSMR data for national peer organisations

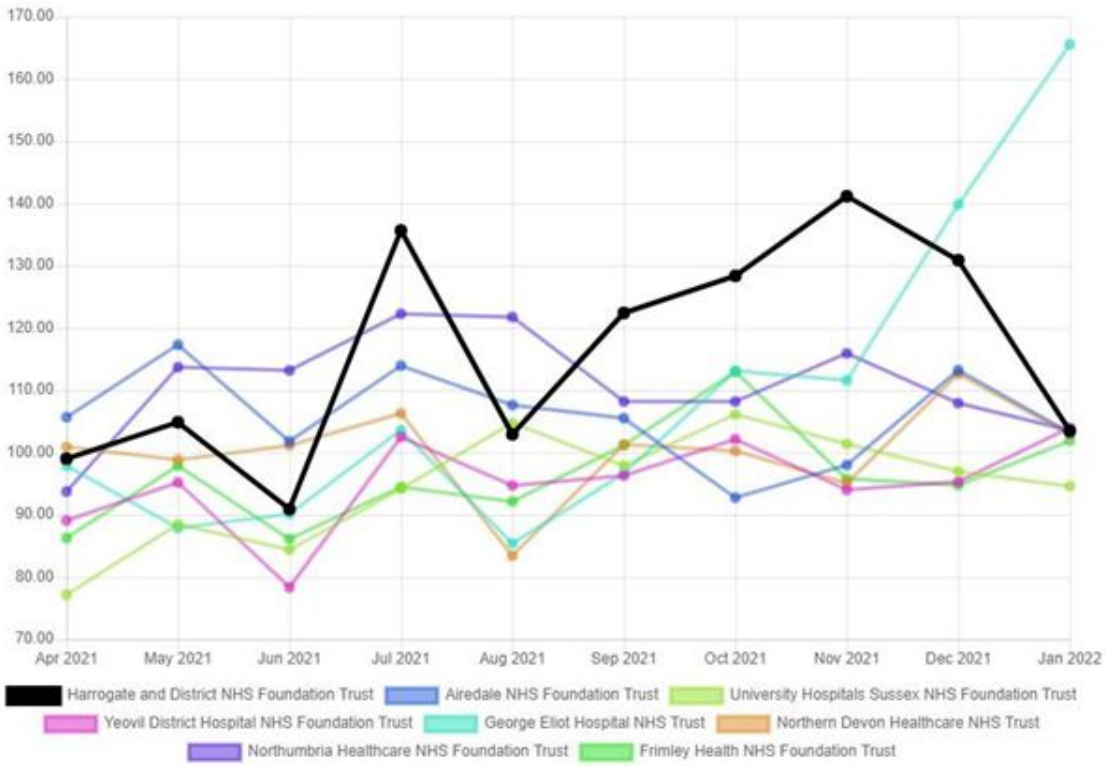


Figure 5: Monthly HSMR for national peer organisations

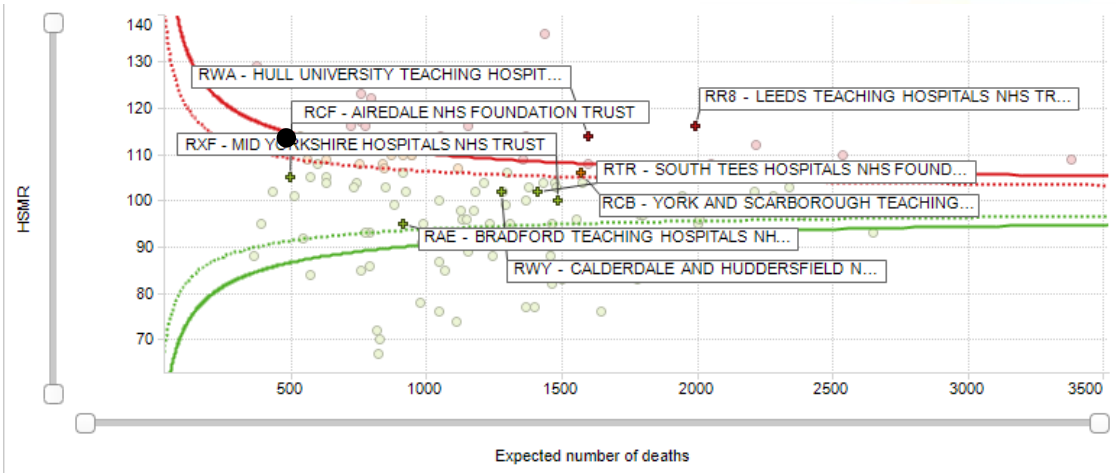


Figure 6: HSMR data for regional organisations

3.2.2 SHMI

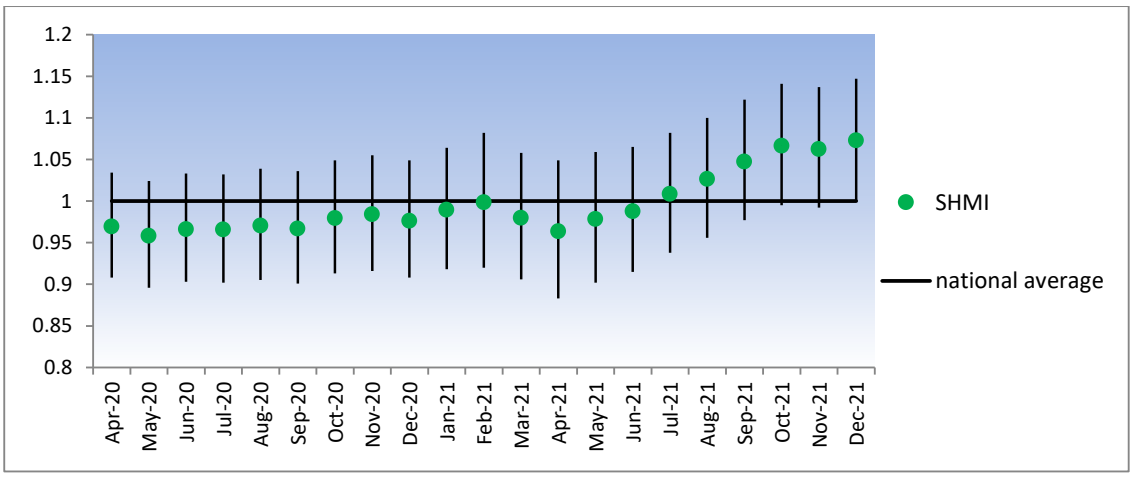


Figure 6: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figures 7, 8 and 9 demonstrate our SHMI against that of peer and regional trusts. Again, HDFT is marked as a black circle. Figures 7 and 9 represent annual SHMI data, whereas Figure 8 shows the monthly variations.

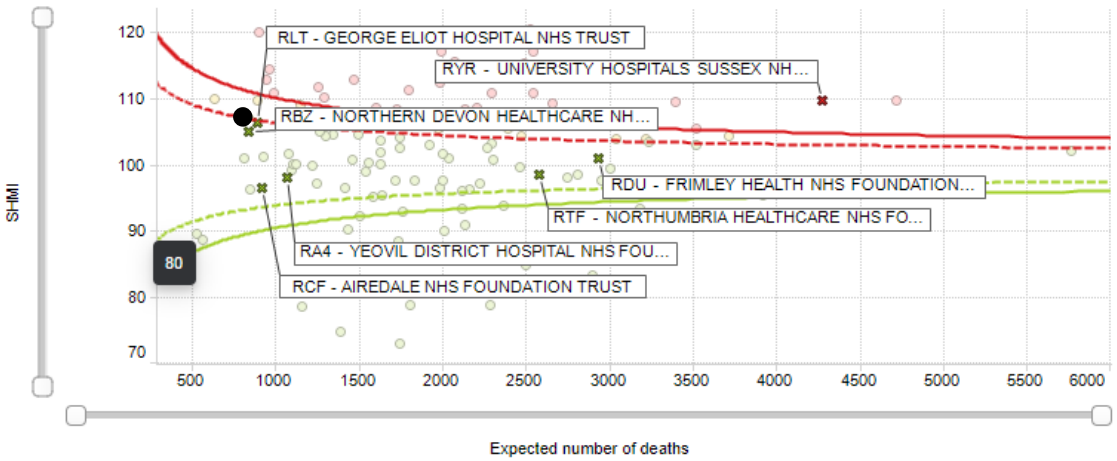


Figure 7: SHMI data for national peer organisations

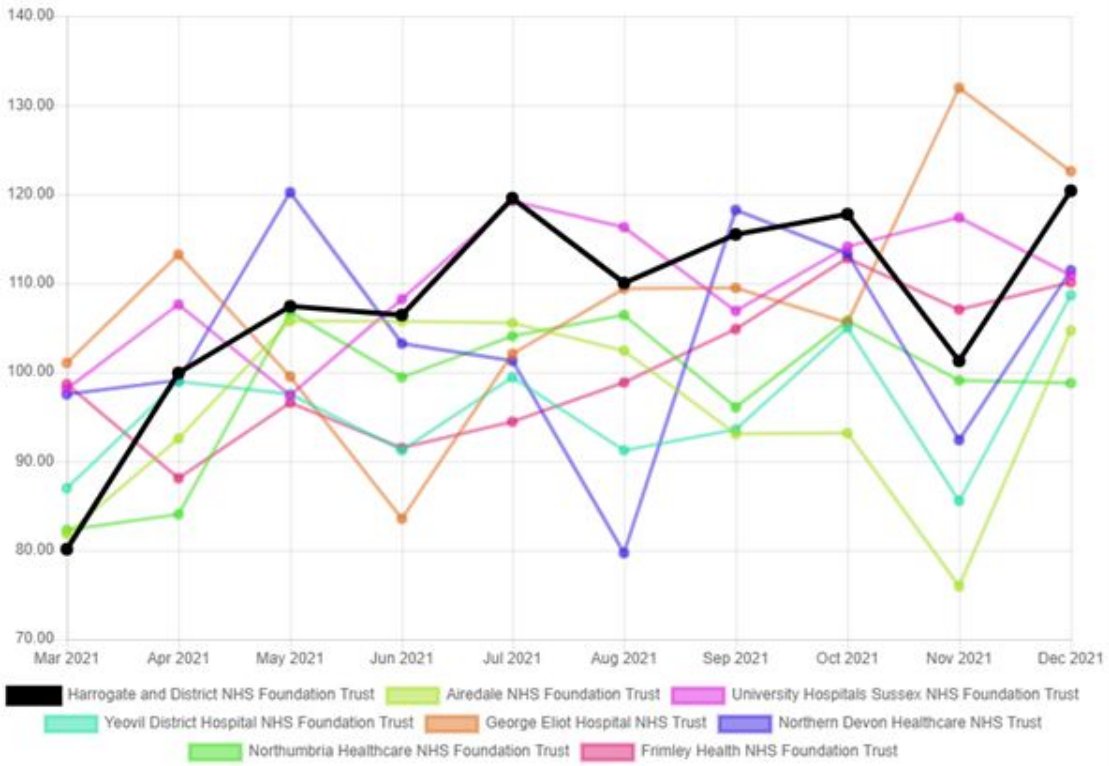


Figure 8: SHMI monthly data for national peer organisations

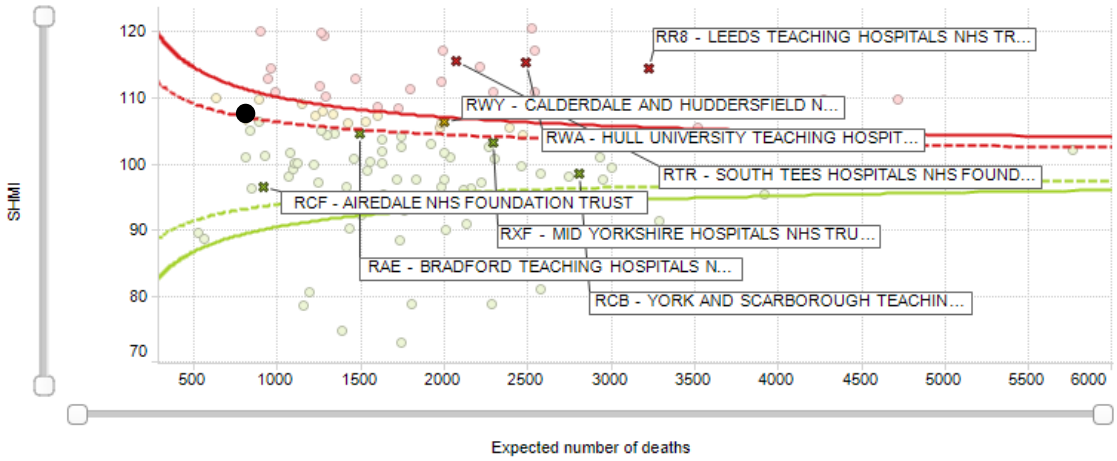


Figure 9: SHMI data for regional organisations

Both the HMSR and SHMI have risen over the last 6-9 months. The exact causes for this are unclear. The SJRs over this period (section 3.3 in this and previous reports) have not highlighted any thematic lapses in care. During this rise in SHMI, a group of 10 cases with the same coding diagnosis of “Other Gastrointestinal Disorders” have been highlighted as an area with statistically raised mortality. These occurred across a number of specialities, both surgical and medical. On preliminary review, none of these cases was an unexpected death, and likely reflects the initial coding on admission of symptoms, rather than a diagnosis. However an SJR has been requested for all these cases to provide assurance and further learning.

I will submit a paper to the board with the next quarterly Leaning from Deaths report which will detail further investigations into the rising mortality indices if the current trend is not reversed.

3.3 Structured judgement reviews (SJR)

14 cases have been reviewed in this quarter, with 9 relating to deaths in this quarter and 5 from Q3.

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

Case ID	Admission Date	Learning Disability	Serious Mental Health Issue	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Jan 22	No	No	3	N/A	3	**3**	4
2	Jan 22	No	No	4	5	5	**4**	4
3	Jan 22	No	No	4	N/A	3	**4**	4
4	Nov 21	No	No	4	4	3	**4**	4
5	Dec 21	No	No	4	4	3	**4**	4
6	Jan 22	No	No	4	4	3	**4**	3
7	Jan 22	No	No	4	N/A	N/A	**4**	4
8	Oct 21	Yes	No	4	4	4	**4**	4
9	Jan 22	Yes	No	3	4	4	**4**	4
10	Dec 21	No	No	4	4	4	**4**	4
11	Jan 22	No	No	2	N/A	4	**2**	4
12	Mar 22	Yes	No	3	3	3	**3**	2
13	Feb 22	No	No	4	4	4	**4**	4
14	Dec 21	No	No	4	4	4	**4**	4
Median Score				4	4	4	**4**	4

Table 1: Structured Judgemental Reviews (SJR) conducted in Q3 2021-2022

No recurrent themes have been identified in these reviews. 4 cases died soon after admission, so ongoing care beyond 24 hours was not available. In one of these cases (an out-of hospital cardiac arrest) there was insufficient evidence for the reviewer to comment on the quality of End of Life care.

1 case was reported as “poor” for the overall quality of care. This relates to a death in the Emergency Department which is being investigated as a Serious Incident.

1 case was reported as “poor” for the quality of note-keeping. The reviewer noted from other sources that various clinical investigations and interventions had been performed but these had not been documented in the medical notes.

3 cases were identified as having a Learning Disability. These will be subject to an external review as part of the LeDeR process, and feedback from that will be provided in a future report.

Overall, the quality of care being delivered during this period remained of a high quality. This is despite the previously noted rise in both HSMR and SHMI. As previously explained at a board workshop, SJRs are a more reliable method of detecting poor quality clinical care and provide assurance that the rising mortality indices, although warranting further investigation, have not been mirrored by concerns in the subjective case reviews.

From June, a monthly Mortality Review Group will commence where individual cases will be discussed and learning identified. A summary of the outcomes of these meetings will be included in future Learning from Deaths reports.

3.4 Covid-19 Deaths

Table 2 shows the hospital's Covid-19 mortality for Q2 to Q4 2021/22. Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion. The data in the 1st column titled "Total" represents all inpatients with a positive test. The 2nd column "Death within 28 days" refers to deaths that occurred after hospital discharge and is therefore in addition to the in-hospital deaths shown in column 3.

The Q4 data shows that Covid-19 is still having a significant impact. This period would be predominantly the Omicron variant, and this, combined with the vaccine program, is the likely reason for fewer deaths in the younger age groups. The single death in the under 55 group was due to a Covid related sudden pulmonary embolism.

However in the over 75 group, Covid-19 still has a significant prevalence and mortality. It should be noted that this data will include patients who die with an incidental finding of Covid-19 but actually died of an unrelated condition, as it does not reflect what appears on the death certificates of patients.

Harrogate and District NHS Foundation Trust

Confirmed Covid-19 inpatient discharges (Jul-Sep 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	11	0	0	0.0%	0.0%
6-17	10	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	17	0	0	0.0%	0.0%
35-44	24	0	0	0.0%	0.0%
45-54	15	0	0	0.0%	0.0%
55-64	26	0	2	0.0%	7.7%
65-74	17	0	2	0.0%	11.8%
75-84	15	1	2	6.7%	13.3%
85+	16	0	5	0.0%	31.3%
Total	155	1	11	0.6%	7.1%

Confirmed Covid-19 inpatient discharges (Oct-Dec 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	13	0	0	0.0%	0.0%
6-17	15	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	3	0	0	0.0%	0.0%
35-44	19	0	1	0.0%	5.3%
45-54	17	0	1	0.0%	5.9%
55-64	33	0	3	0.0%	9.1%
65-74	39	1	8	2.6%	20.5%
75-84	38	1	6	2.6%	15.8%
85+	39	3	6	7.7%	15.4%
Total	220	5	25	2.3%	11.4%

Confirmed Covid-19 inpatient discharges (Jan-March 202				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	50	0	0	0.0%	0.0%
6-17	21	0	0	0.0%	0.0%
18-24	10	0	0	0.0%	0.0%
25-34	15	0	0	0.0%	0.0%
35-44	19	0	1	0.0%	5.3%
45-54	15	0	0	0.0%	0.0%
55-64	30	0	1	0.0%	3.3%
65-74	55	7	1	12.7%	1.8%
75-84	97	5	13	5.2%	13.4%
85+	121	7	22	5.8%	18.2%
Total	433	19	38	4.4%	8.8%

Table 2: Covid19 deaths for admissions in Q2 and Q3 either whilst still an inpatient or after discharge but within 28 days of positive test. Note that “Confirmed Covid-19” relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

Harrogate and District NHS Foundation Trust

3.5 Medical Examiner Service

We have now been able to obtain data from all Medical Examiner Offices in the North of England. Table 3 shows the performance of HDFT's Medical Examiner team benchmarked against our regional colleagues (regional data for Q4 is not yet available). This confirms that we are performing well above the regional average in 3 of the most significant metrics. We were unable to issue an MCCD within 72 hours in 18 cases which reflects the difficulty of a Bank Holiday. As Registrar Offices were also closed in these periods, we are unaware on any impact or concern raised by the bereaved in this period.

In addition to the metrics below, in Q4 the Medical Examiner team highlighted 5 cases for review at departmental Mortality meetings.

	Q1		Q2		Q3		Q4
	Regional	HDFT	Regional	HDFT	Regional	HDFT	HDFT
Deaths Scrutinised	**5205/7915 (66%)**	**147/147 (100%)**	**6772/9527 (71%)**	**179/179 (100%)**	**8355/10932 (76%)**	**213/213 (100%)**	**214/214 (100%**
Death certificate takes longer than 3 days	**663 (13%)**	**6 (4%)**	**650 (10%)**	**2 (1%)**	**1048 (13%)**	**17 (8%)**	**18 (8%)**
Death certificate rejected by Registrar	**27 (0.7%)**	**0**	**34 (0.7%)**	**0**	**44 (0.5%)**	**0**	**1**

Table 3: Performance of HDFT Medical Examiner team compared to the Regional Average

The service is now being rolled out to deaths from GP practices in the region. We now have 7 Medical Examiners (MEs), including 2 GPs. All MEs will scrutinise both hospital and community deaths. Funding for the service continues to be provided

4.0 Recommendation

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

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Jeremy Cross
Date of meeting:	25 April 2022
Date of Board meeting this report is to be presented	May 2022

Summary of key issues

- **Finances**. After the impact of Salix and donated assets have been taken into account, the trust has successfully closed the year in a breakeven position. Congratulations to Jonathan (initially) and Jordan for steering the ship to this destination. Given the current issues with appointing an external auditor these numbers will not be audited for some time – though a smaller audit firm has now been approached and will be recommended to the Governors appointment committee.
- In addition, we successfully completed a significant amount of capital spend in the final month of the financial year bringing us close to our anticipated spend at the start of the planning process.

- **ED/A&E**. The issues (reflected nationally) with ED performance continued in the month. This also included some trolley waits, and delayed ambulance handovers. This is mainly as a result of flow issues through the hospital The plan to improve is being implemented and the committee agreed the business case required to improve the streaming of patients.
- **Other operational updates**. The majority of cancer metrics were met. The vast majority of 104 week waiters were addressed before the year end (with a handful left as a result of patient or clinician covid issues). This will be an ongoing metric that is monitored. RTT performance is in line with previous months, and the recovery programme will be a key focus for the coming year.

- **People**. We discussed the vacancy levels including some key vacancies which are pushing up the costs of temporary and agency staff significantly. Significant effort is being made to improve the recruitment pipeline, and we reviewed the plans for the coming year where this will be a key focus. Monthly sickness levels remain high but are forecast to return to normal levels next year.

- **Business Development.** We had an update on develpoments – particularly within the Children's services team. In addition, there is some work progressing with Business Development within HIF

- **Committee Annual Report.** The report highlighted that the committee had fulfilled its function under the agreed terms opf reference. A questionnaire will be sent out in coming months regarding Committee Effectiveness.

Any significant risks for noting by Board? (list if appropriate)

- The ED performance will be discussed at Board
- The level of vacancies – particularly in CC – will be followed carefully in future meetings

Any matters of escalation to Board for decision or noting (list if appropriate)

- The ED Business Case was accepted and will be presented to Board for full approval

Integrated Board Report - April 2022

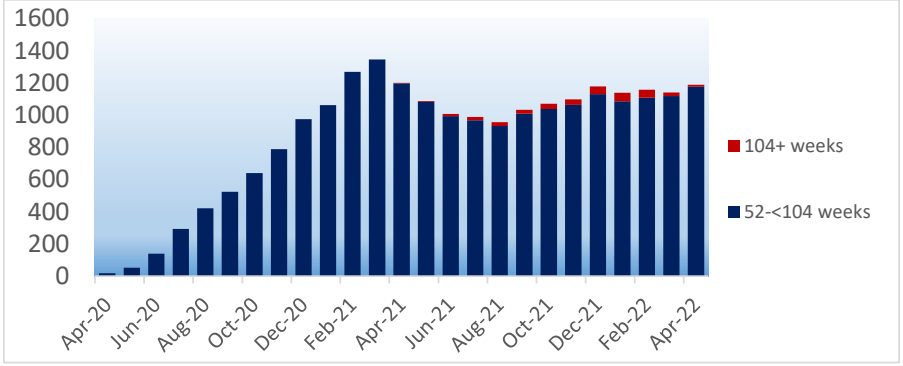
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	1187

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

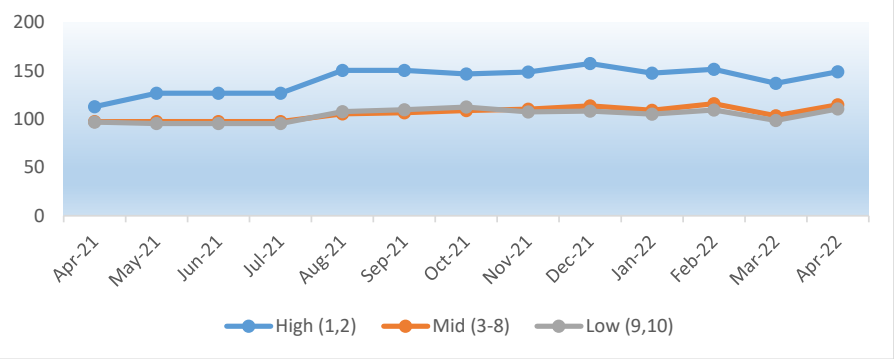
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Plans in place to reduce this number to 750 by March 2023. There has been a significant reduction in over 104 week waiters since November 2021.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. There does appear to be a difference in waiting times by deprivation with patients from the most deprived postcodes waiting longer. A further analysis of this is being carried out looking at the data by clinical priority and by specialty.

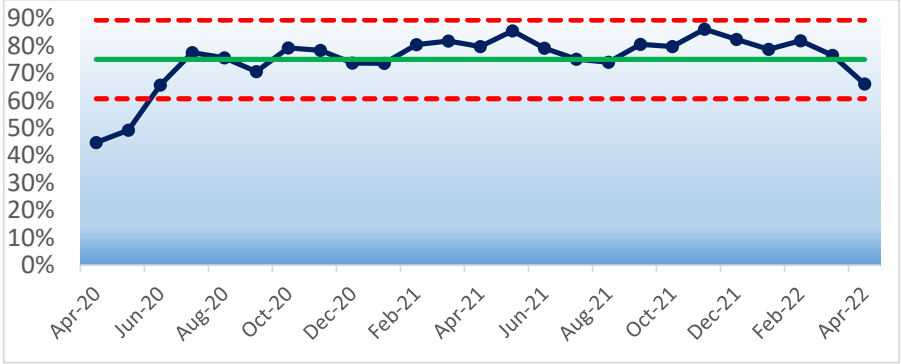
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	66.0%

Indicator description

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

SPC chart



Narrative

There has been a further detrioration in performance this month with 1,850 waiting over 6 weeks (1,174 last month) – including 538 Dexa, 418 ultrasound and 413 MRI.

It is anticipated that the new Dexa scan kit will be delivered next month. For ultrasound, there are significant staffing pressures. There has been a recent successful recruitment and all posts are now filled, but there will be some shortfall in the coming month whilst people start in post. The backlog is in routine MSK cases. For MRI, there continues to be significant staffing pressures meaning that the mobile unit is not running to full capacity. Improvement is expected in July with staff returners expected at the end of June.

Indicator	**5.4 - Outpatients lost to follow-up - number of follow up patients past due date**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

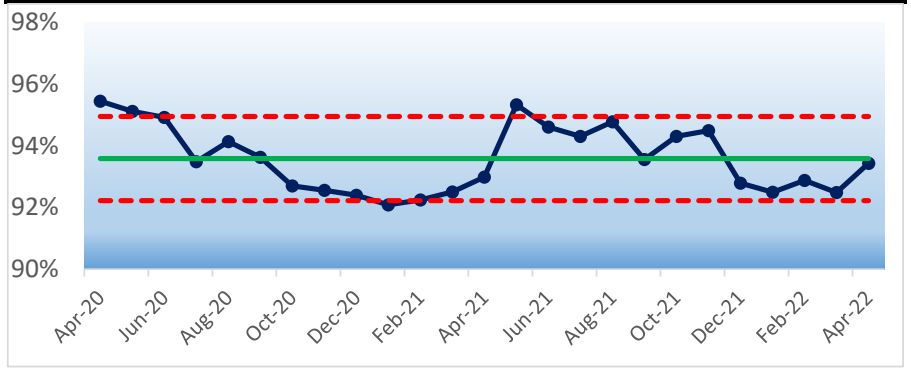
A data quality exercise is underway to review the follow up outpatient waiting list data and to understand the full scope of this problem and determine how many patients still require a follow up appointment. This work includes reviewing the way that we store and retain information from our follow up waiting lists to enable easier reporting of historical data. It is likely that we will refine the metric for reporting in this report as part of this work.

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	93.4%

Indicator description

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

SPC chart



Narrative

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

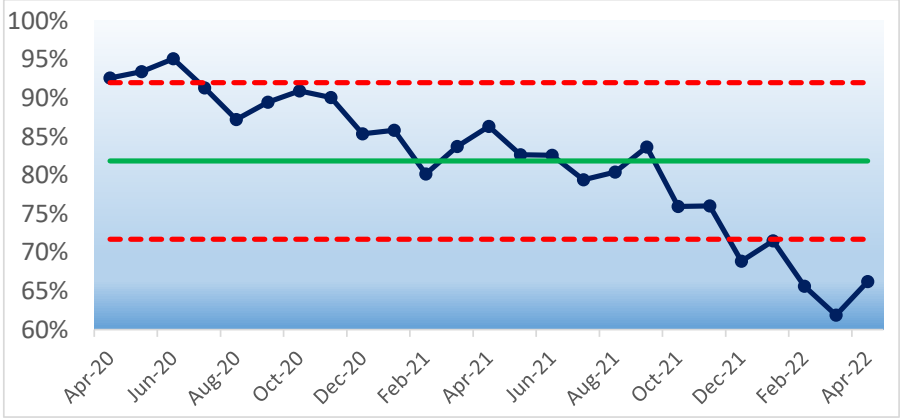
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process.
- Exploring option of sending electronic forms to patients for completion and return.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	66.2%

Indicator description

Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The data includes all A&E Departments, including Minor Injury Units (MIUs). The operational standard is 95%.

SPC chart



Narrative

Performance against the A&E 4-hour standard remains below the 95% standard. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses. The Trust continue to support the HNY system which is significantly pressured (OPEL 4) with regular diverts of ambulance patients to Harrogate - this negatively impacts on HDFT's 4 hour performance and length of stay.

Current work underway to improve this position includes:

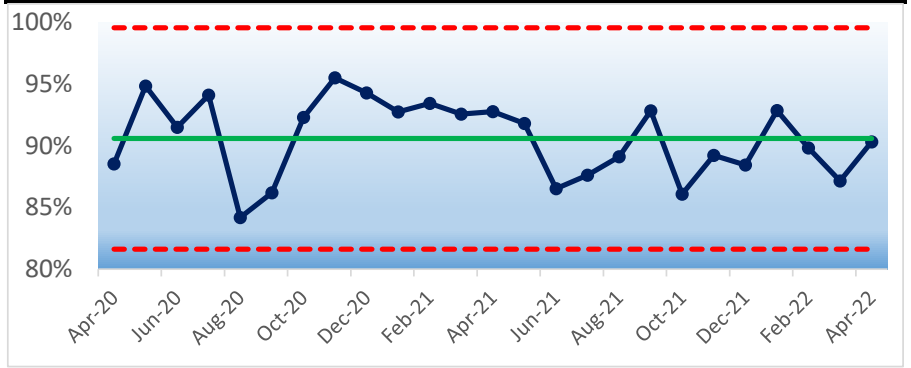
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising SDEC opportunities;
- educating other specialties to avoid using ED as their triage and assessment service;
- increased GP Out of Hours provision to avoid Primary Care attendance;
- revision of infection control procedures as soon as national guidance changes to allow more rapid flow;
- implementing a 'fit to sit' area to improve flow when cubicle capactiy becomes an issue;
- external independent operational review of ED and hospital flow processes commissioned for March.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	90.3%

Indicator description

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

SPC chart



Narrative

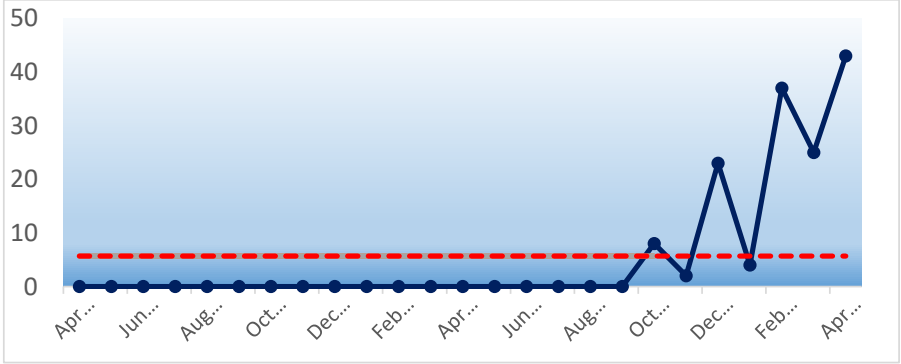
90% of ambulance handovers took place within 15 minutes in April. There were 15 over 30-minute handover breaches with none over 60-minutes in April. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared across the region by NHSE/I. Despite the high bed occupancy, acuity and activity, the lost hours to handover in Harrogate remains very low.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	43

Indicator description

The number of patients spending more than 12 hours in the Emergency Department between a decision to admit and being admitted.

SPC chart



Narrative

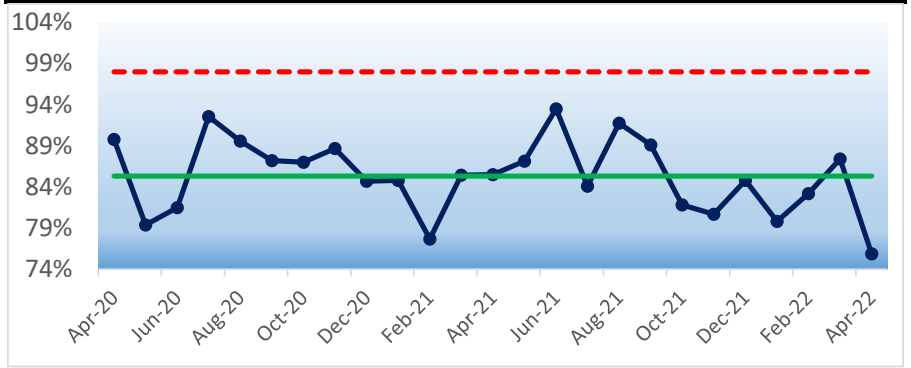
43 over 12 hour trolley waits were reported in April. RCAs have been completed and reviewed at internal quality and performance meetings. The long waiting patients are linked to times when there are no available beds in the hospital.

Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	75.9%

Indicator description

Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.

SPC chart



Narrative

Provisional data indicates that the 62 day standard was not delivered in April (75.9%). There were 58.0 accountable treatments (70 patients) in April with 14.0 treated outside 62 days. Of the 11 tumour sites treated in April, performance was below 85% for 6 (Colorectal, Gynaecology, Haematology, Lung, Upper GI, Urology). All pathway delays will be reviewed by the breach panel at the end of May.

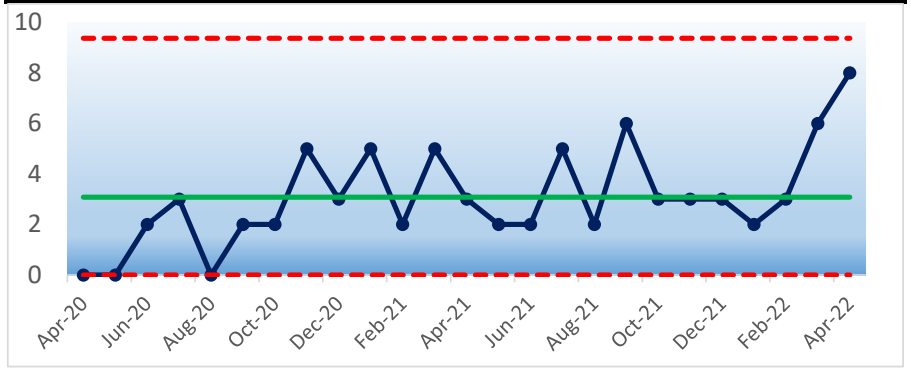
Provisional data indicates that 47.6% (10/21) of patients treated at Tertiary centres in April were transferred for treatment by day 38.

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	8

Indicator description

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

SPC chart



Narrative

8 patients waited 104+ days for treatment in April (2 x Harrogate Colorectal; 2 x Tertiary Prostate; 1 x Leeds Lung; 1 x Leeds Gynae; 1 x Leeds Sarcoma; 1 x Harrogate Skin).

Of the 5 Tertiary patients, 1 was transferred by day 38 (Prostate). For those patients transferred after day 38 delays were predominately due to diagnostic/medical complexity and patient choice.

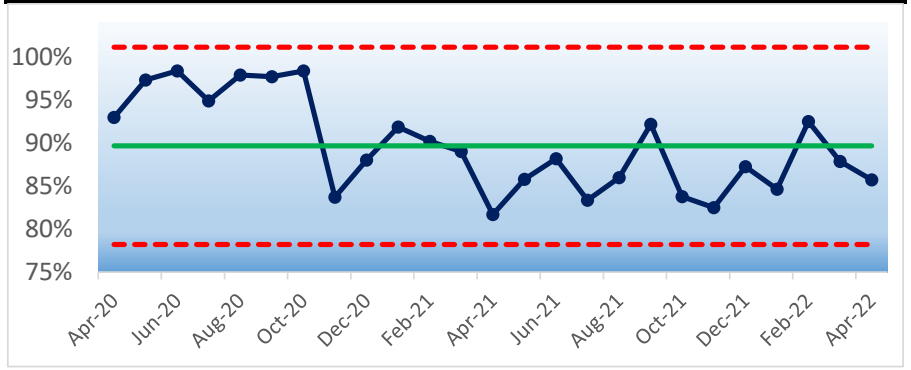
All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of May.

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	85.7%

Indicator description

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

SPC chart



Narrative

903 patients attended their first appointment for suspected cancer in April.

Outpatient capacity for 2ww GI referrals continues to be challenging for patients not going straight to test. This will begin to impact on the Trust long waiter position for pathways that remain open.

The Trust is continuing to support Leeds with their breast referrals and have taken around 30 patients over the last month.

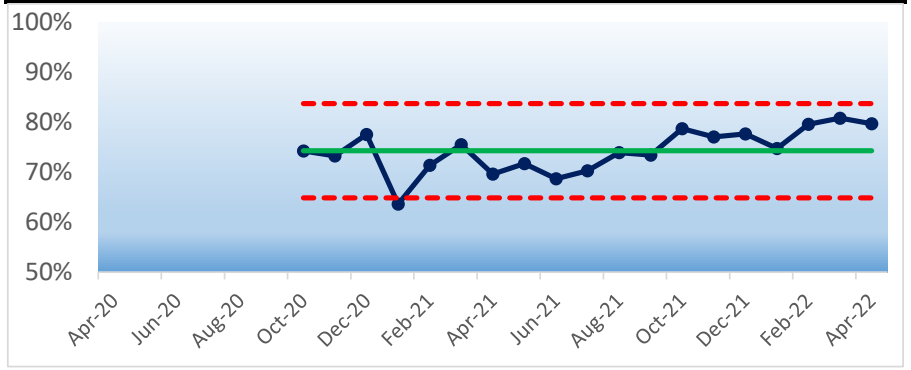
Performance for the breast 2WW standard was at 86.2% in April which is still below the operational standard but an improvement on last month (79.8%). Predicted performance for all 2WW breast attendances in May is currently above the operational standard at 95%.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	79.7%

Indicator description

From October 2021, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

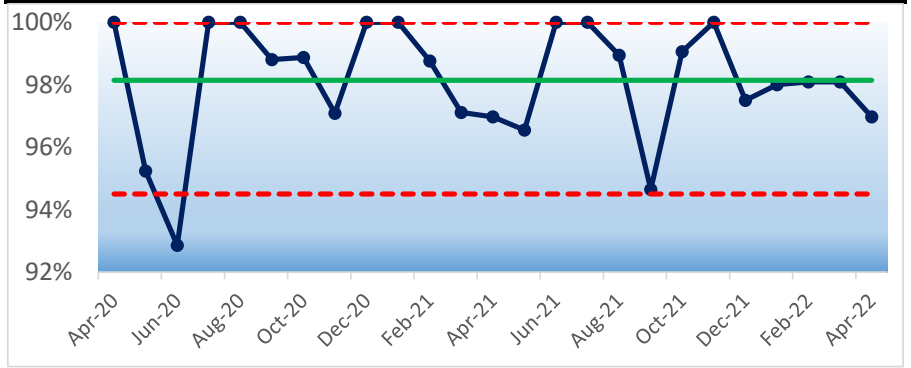
Provisional data indicates that in April combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has remained above the proposed operational standard of 75%.

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	97.0%

Indicator description

Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.

SPC chart



Narrative

Provisional data indicate that 99 patients received First Definitive Treatment for cancer at HDFT in April.

One Breast patient was treated outside 31 days of decision to treat and this was due to consultant leave. 2 Colorectal patients were treated after day 31 and these pathways were also delayed due to consultant leave.

Overall peformance was above the expected standard of 96%.

GI Oncology – fragility in the service due to staffing challenges at York. Temporary mitigations are in place for York to provide specialist GI oncology advice.

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

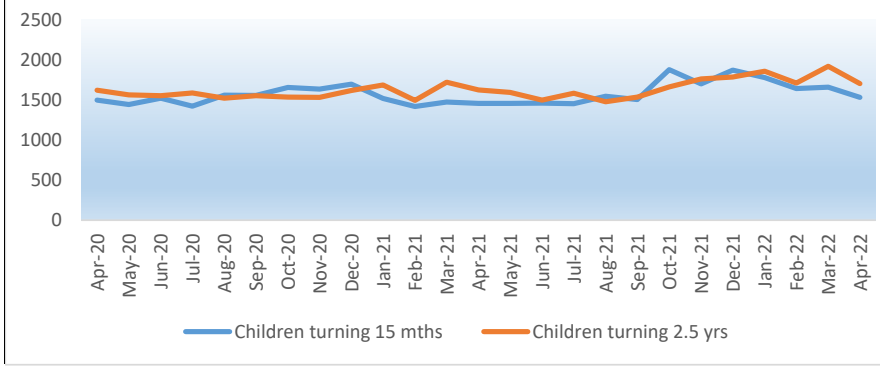
Indicator description

The chart shows the number of children turning 15 mths and 2.5 yrs across the full footprint of HDFT's 0-19 Services.

Narrative

Both caseloads reduced in April.

SPC chart



Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	910

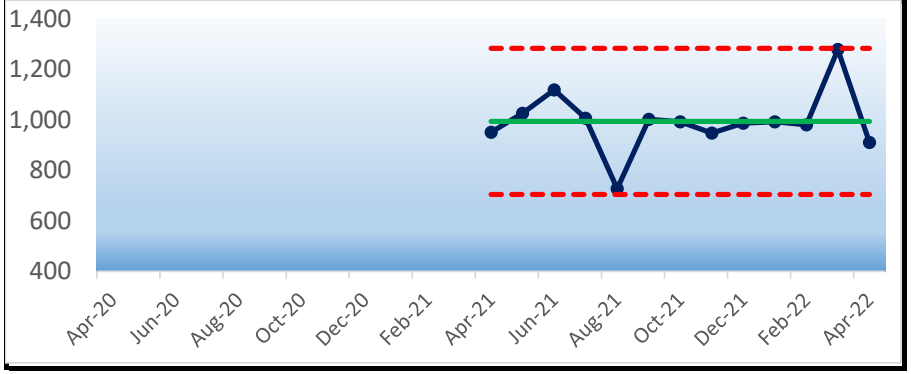
Indicator description

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

Narrative

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

SPC chart

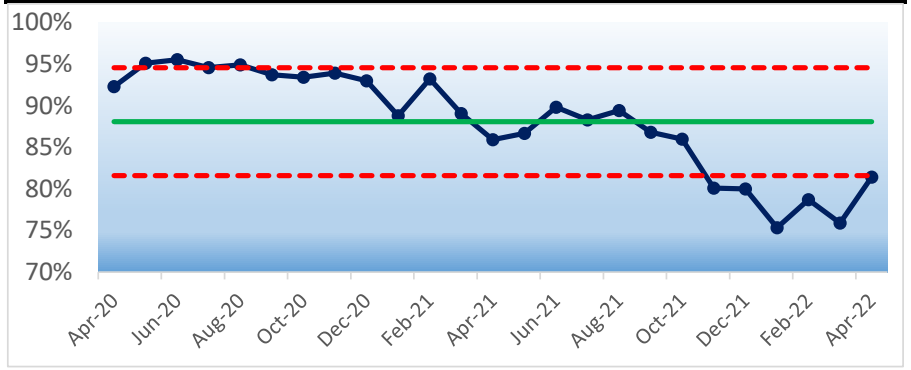


Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	81.4%

Indicator description

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

SPC chart



Narrative

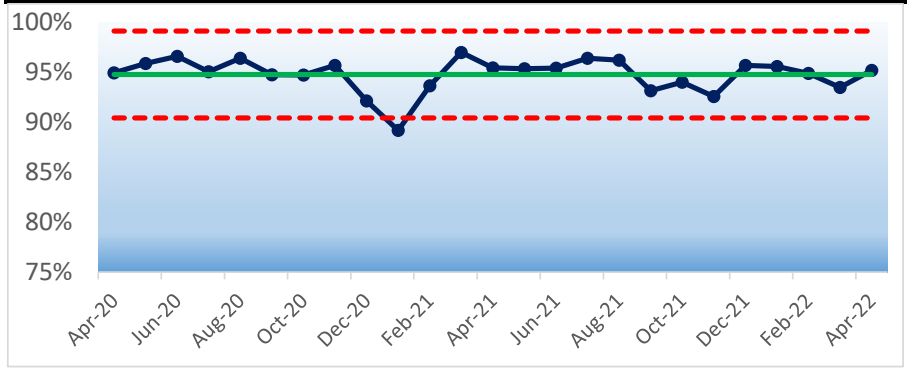
81% of eligible pregnant women received an initial antenatal visit in April, an improvement on last month. Middlesbrough performance (which is the main reason for the deterioration seen in recent months) improved to 49% (41% last month).

Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	95.2%

Indicator description

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

SPC chart



Narrative

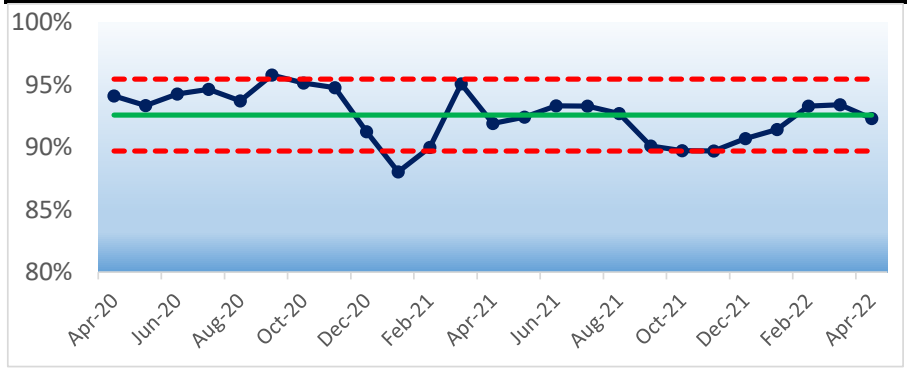
95% of infants received a new birth visit within 10-14 days of birth during April.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	92.3%

Indicator description

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

SPC chart



Narrative

92% of infants received a 6-8 week visit by 8 weeks of age during April.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	89.6%

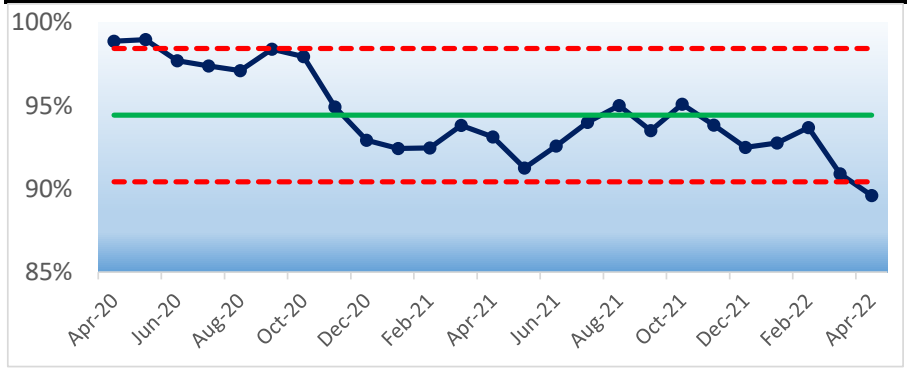
Indicator description

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

Narrative

89.6% of eligible children received a 12 month review by 15 months of age during April.

SPC chart

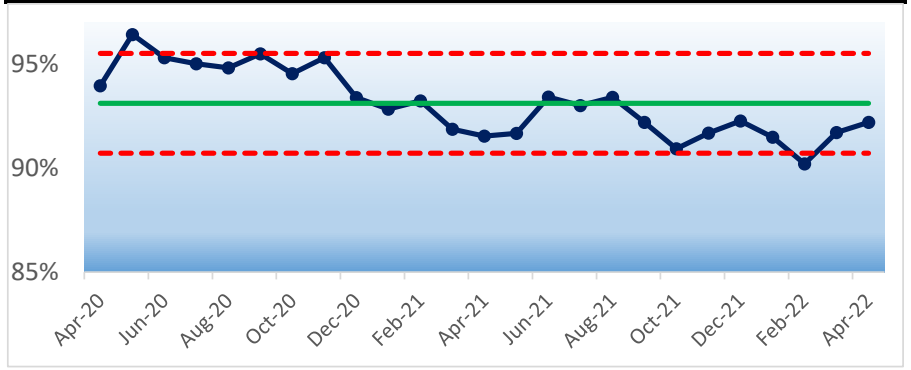


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	92.2%

Indicator description

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

SPC chart



Narrative

92% of eligible children received a 2-2.5 year review by 2.5 years of age during April.

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

Indicator	**5.21 - Children's Services - Delivery of Immunisation trajectory**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.22 - Children's Services - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The position for April was:
Sunderland 3
Gateshead 3
Darlington 3
Durham 3
Stockton 1
Middlesbrough 3
North Yorkshire 2
Northumberland 3
Safeguarding 3
Acute Paediatrics 1
Immunisation 1

Indicator	**5.23 - Community Care Adult Teams - performance against new timeliness standards**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

The NHS Operational Planning and Contracting Guidance 2021/22 set out the first stage for implementing the community two-hour crisis response standard in England by March 2022. All integrated care systems (ICSs) in England must ensure that crisis response care is available to all people within their homes or usual place of residence, including care homes, within two hours.

From March, the Trust has started to submit data related to this standard as part of the monthly Community Services Data Set submissions to NHS England. We are awaiting confirmation from NHS England as to how organisations wil be assessed against the standard. Once this is available, we will be able to start reporting HDFT's performance.

Indicator	**5.20 - Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.25 - Community Care Adult Teams - Number of cancelled routine visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.26 - Community Care Adult Teams - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

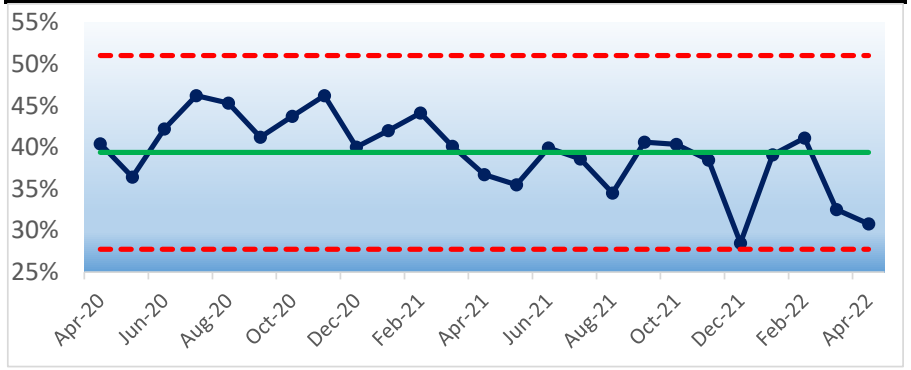
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for April remained at level 3.

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	30.8%

Indicator description

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

SPC chart



Narrative

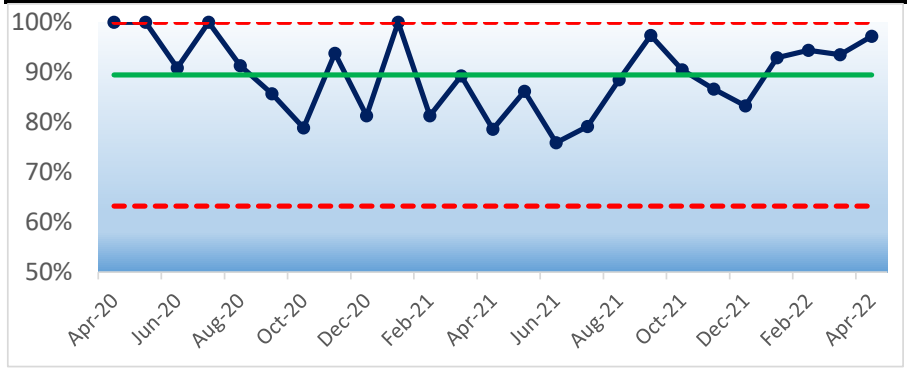
In April, 31% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target.

Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	97.2%

Indicator description

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

SPC chart



Narrative

In April, 97% of urgent GPOOH cases received a home visit face to face consultation within 2 hours, an improvement on recent performance and above the 95% standard.

Integrated Board Report - April 2022

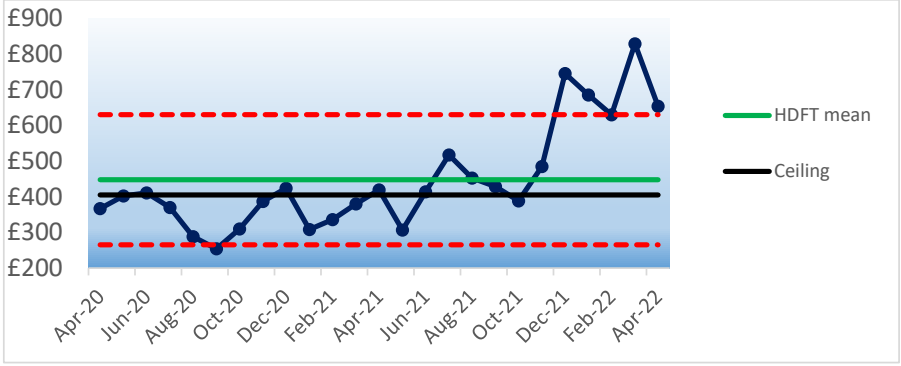
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	£654

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

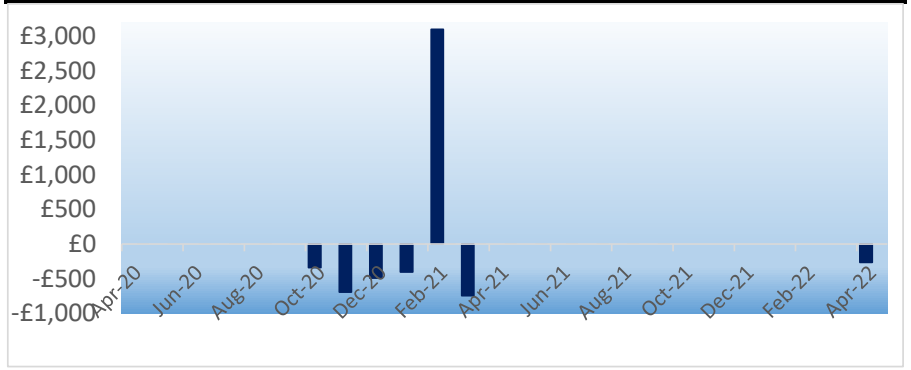
Agency Expenditure continues to be a concern, with expenditure remaining above historic performance and Agency ceilings.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	-£265

Indicator description

Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.

Trend chart



Narrative

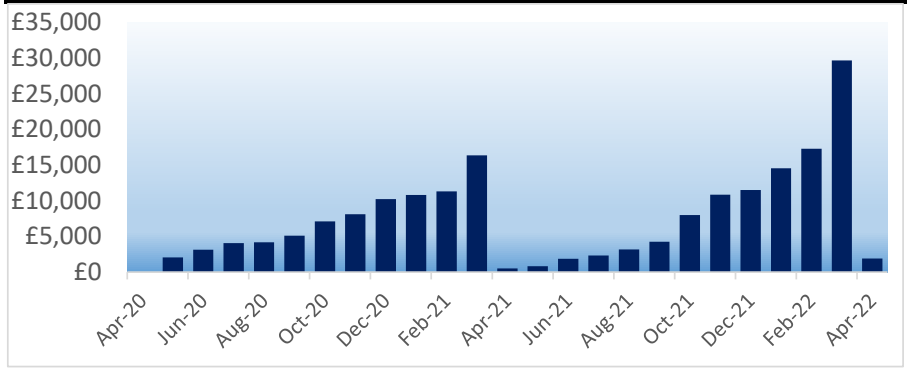
The Trust reported a £265k deficit in month 1. This is aligned to the plan submitted to NHSE/I. The Trust is awaiting feedback and confirmation of this plan.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	£1,900

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

Capital expenditure has been estimated for month one at £1.9m. This will be verified in month 2.

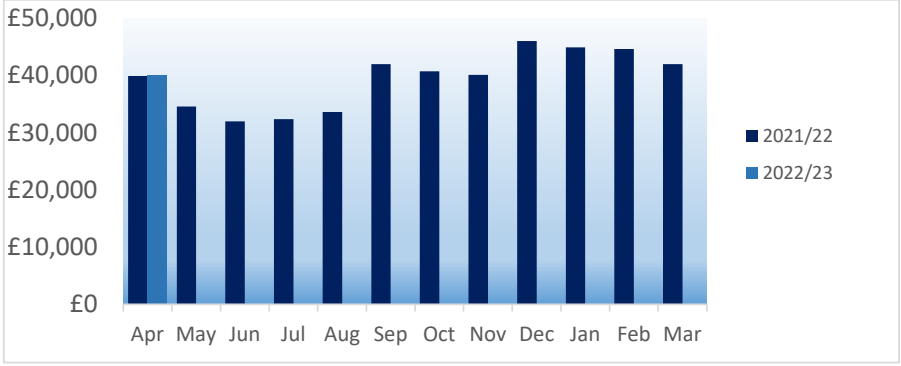
The redrafted capital plan is being discussed at this month's Resources Committee.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	£40,077

Indicator description

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

Trend chart



Narrative

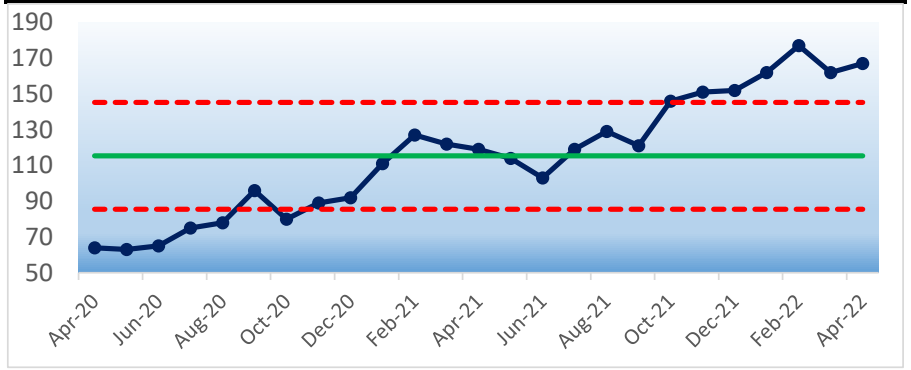
The Trust cash balance remains positive.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	167

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

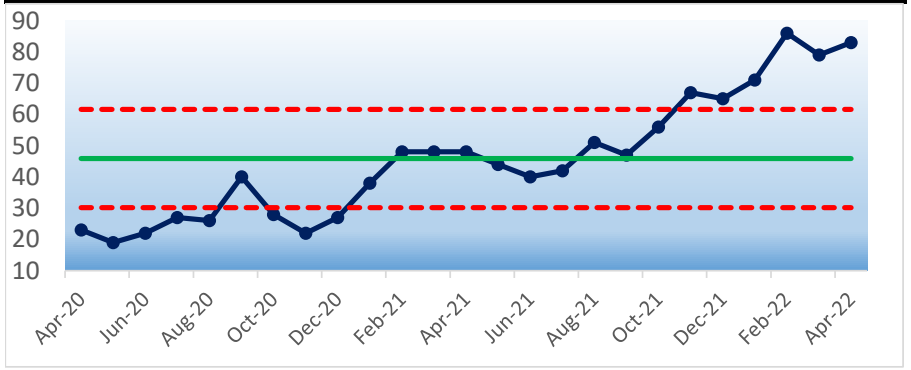
The number of long stay patients (> 7 days) increased to 167 in April. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	83

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

The number of long stay patients (> 21 days) increased to 83 in April. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	61.2

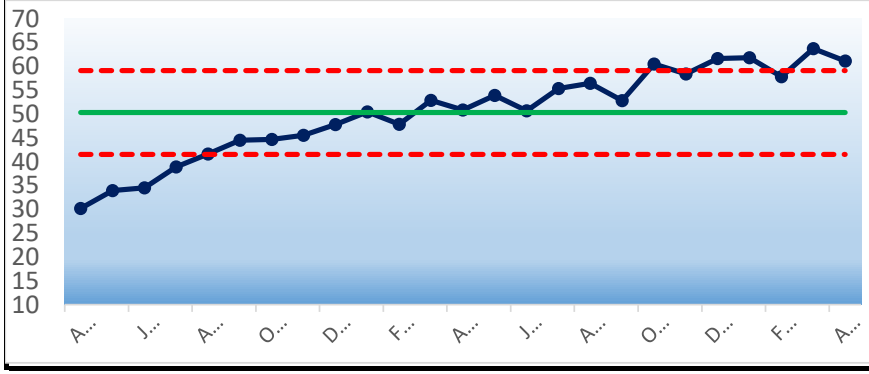
Indicator description

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

Narrative

Occupied bed days decreased in April but remain high. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, below the current level.

SPC chart

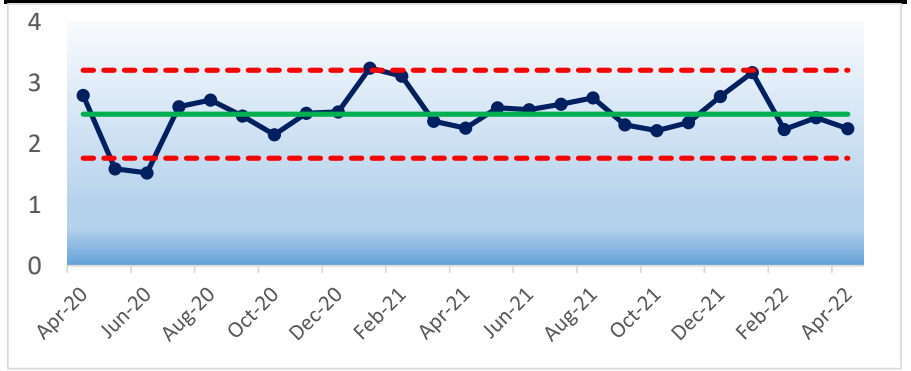


Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	2.3

Indicator description

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

SPC chart



Narrative

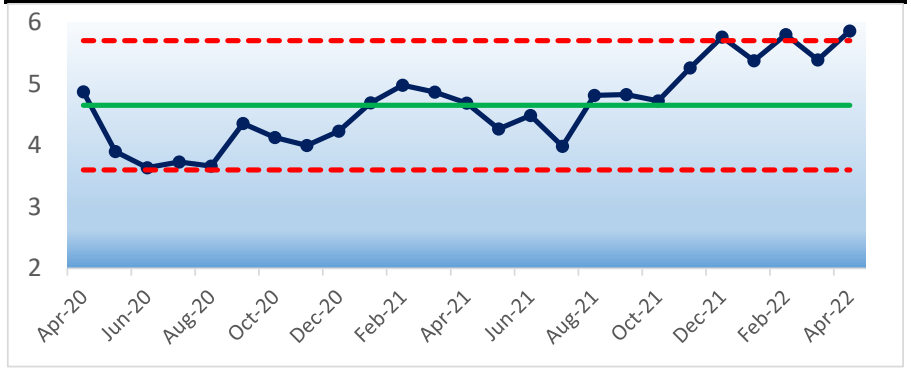
Elective length of stay decreased in April and remains below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	5.9

Indicator description

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

SPC chart



Narrative

Non-Elective length of stay increased in April and remains above our local stretch target. There is a combination of factors affecting patient flow, as described in indicators 6.5.1-6.7.1.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-22
Value / RAG rating	227

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart

Narrative

There were 227 avoidable admissions in March, an increase on February but in line with the average for 2021/22. The most common diagnoses remain as urinary tract infections and pneumonia. Excluding children and admissions via CAT/SDEC, the March figure was 132.

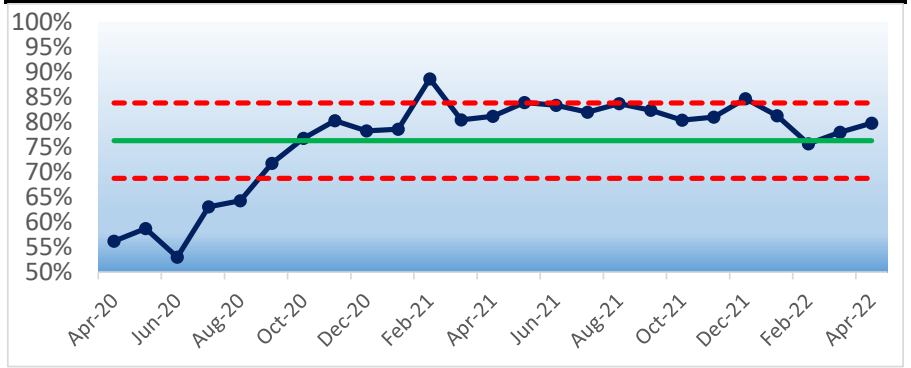
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	79.8%

Indicator description

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

SPC chart



Narrative

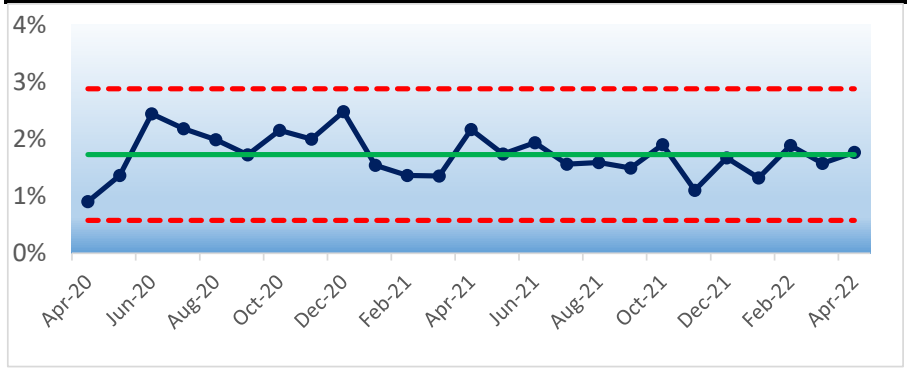
Theatre utilisation remains below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	1.8%

Indicator description

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

SPC chart



Narrative

1.8% (40 patients) of intended day cases stayed overnight or longer in April.

Integrated Board Report - April 2022

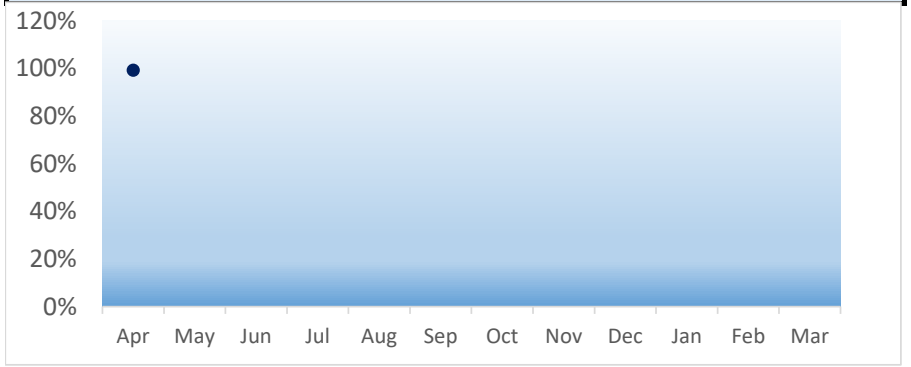
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	99.2%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

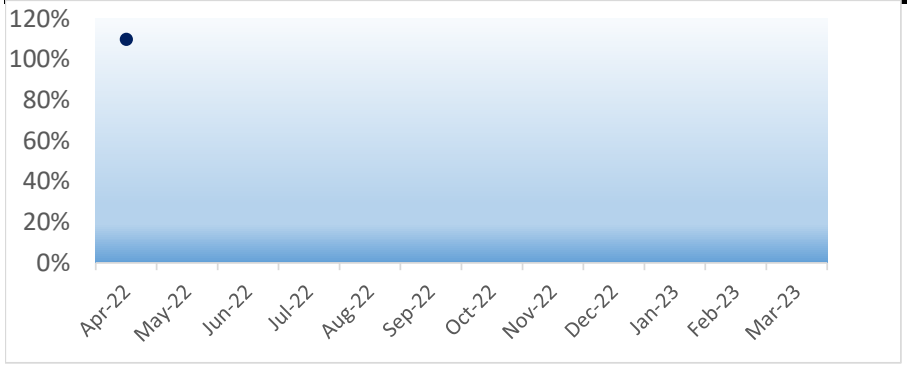
In April, GP referrals were 1% below the equivalent month in 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	109.9%

Indicator description

Outpatient activity (consultant led) against plan and 2019/20 baseline. The data includes new and follow up attendances.

Trend chart



Narrative

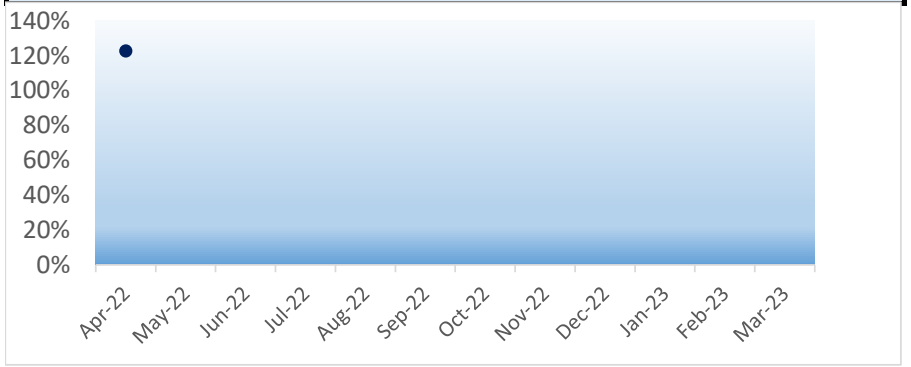
Outpatient activity was 10% above plan in April.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	122.7%

Indicator description

Elective activity against plan and 2019/20 baseline. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

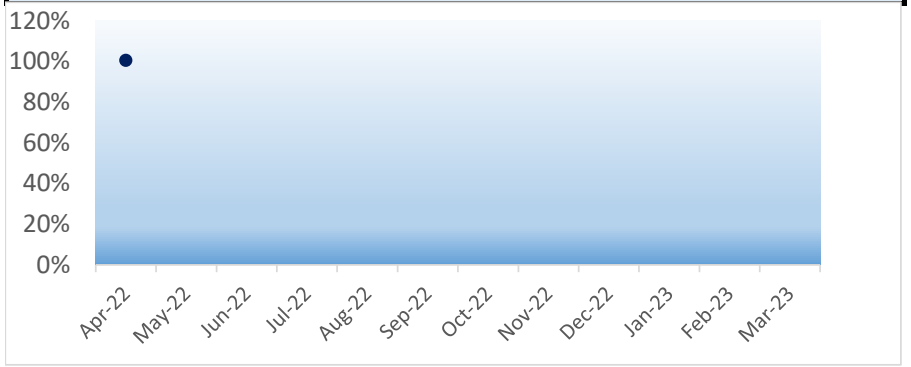
Elective admissions were 23% above plan in April. Elective day cases were 26% above plan and elective inpatients were 11% below plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	100.6%

Indicator description

Non-elective activity against plan and 2019/20 baseline.

Trend chart



Narrative

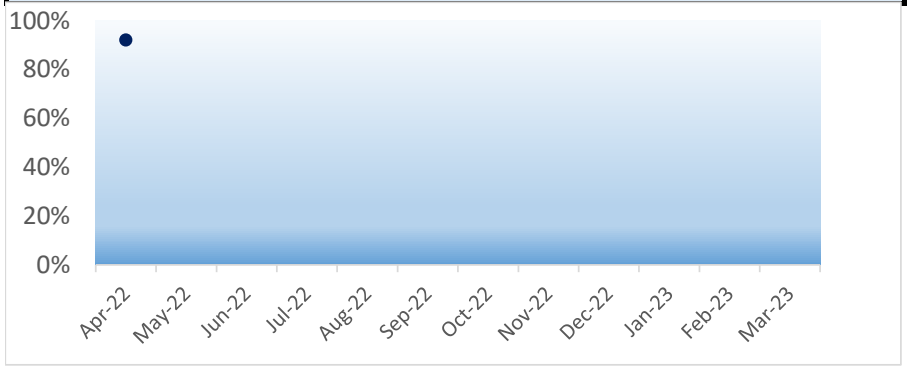
Non-elective activity was 1% above plan in April.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-22
Value / RAG rating	92.1%

Indicator description

Emergency Department attendances against plan and 2019/20 baseline.

Trend chart



Narrative

Emergency Department attendances were 8% below plan in April.

Finance Report
Board of Directors – 25/05/2022

Matters of concern & risks to escalate

- Month one has achieved the plan submitted to NHSE/I, however, within this are a number of variances.
- Underspending continues in CCs with trajectories to improve this position.
- Overspending within PSC and LTUC has been the focus of review this month.
- No ERF benefit assumed in current position whilst plans being finalised.
- Agency spend continues to be high in a number of areas
- The wider Humber and North Yorkshire ICS plan currently does not meet regulatory requirements, meaning greater asks on system resources

Major actions commissioned & work underway

- Working with ICS to ensure resources available to support 2022/23 plan
- Continued focus on delivering plan and identifying efficiencies.
- Directorates to present to Resource Committee over the year use of model hospital.
- Focus on Internal Audit recommendations and process following changes in audit team.

Positive news & assurance

- Cash Position remains positive.
- Accounts submitted to NHSE/I within national timescales.
- External auditors have been appointed

Decisions made & decisions required of the Board

- Capital programme for 2022/23 revised following delays and changes in original agreed programme.
- Support for £2.7m case to finalise plant rooms linked to Salix work. This is included within the revised Capital Programme.

Harrogate and District NHS Foundation Trust
Board of Directors
Financial Position – April 2022

1. Purpose of the report

This paper has been developed to update the Board of Directors on progress against the annual Financial Plan. The Board of Directors is asked to note the contents of the report.

As described below, the Trust Revenue position is aligned to plan.

2. Introduction

The paper is an update on the Trust Financial Position, and continues the monthly updates received by the Board. The paper aims to provide assurance on the financial position, as well as provide opportunity to discuss the key financial issues across the organisation.

Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.

3. Financial Position

High Level Analysis	Mth Budget £000's	Mth Actual £000's	Variance £000's
Commissioner Income	**22,379**	**21,726**	**-653**
Directorate Income	**3,633**	**3,837**	**204**
Pay Costs	-15,785	-16,489	-704
Non Pay Costs	-8,622	-9,339	-717
Expenditure	**-24,407**	**-25,828**	**-1,421**
Surplus / (Deficit)	**1,605**	**-265**	**-1,870**

3.1 Revenue

The position above is aligned to the Trust plan submitted to NHSE/I for 2022/23, a deficit of £-265k. The Budget position recognises income deferred from 2021/22.

The income position does not include any Salix Income, £1.6m is expected in 2022/23 to cover the remaining programme.

The Income position does not include anticipated income for ERF, Local Authority Pay Awards, and some smaller items we are awaiting further guidance.

There is significant pay overspends within PSC and LTUC, both of which are being reviewed and will be updated at the meeting.

Agency continues to be above the agency ceiling and the main drivers include Medical Staffing, Wards and Theatres.

The capital programme of £9.1m has been detailed in the report and there are cases being built for further external funding, EPR and Theatres.

The pay position does incorporate an assumption around the anticipated pay award as this was phased into the plan from April but this is being held centrally as budget has not been allocated to Directorates yet. We are awaiting the national outcome of this position.

Community &Childrens	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**166**	**164**	**-2**
Pay Costs	-5,537	-5,421	115
Non Pay Costs	-475	-384	91
Expenditure	**-6,011**	**-5,805**	**206**
Total	**-5,845**	**-5,641**	**204**

LTUC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**600**	**661**	**61**
Pay Costs	-4,849	-5,299	-450
Non Pay Costs	-1,663	-1,761	-97
Expenditure	**-6,512**	**-7,060**	**-548**
Total	**-5,912**	**-6,399**	**-487**

PSC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**175**	**150**	**-25**
Pay Costs	-4,559	-4,885	-326
Non Pay Costs	-1,611	-1,422	189
Expenditure	**-6,170**	**-6,308**	**-137**
Total	**-5,995**	**-6,158**	**-163**

Corporate	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**584**	**609**	**25**
Pay Costs	-1,548	-1,585	-37
Non Pay Costs	-2,983	-3,044	-61
Expenditure	**-4,531**	**-4,629**	**-98**
Total	**-3,947**	**-4,020**	**-73**

HIF	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**1,740**	**1,681**	**-59**
Pay Costs	-793	-757	35
Non Pay Costs	-906	-870	35
Expenditure	**-1,698**	**-1,627**	**71**
Total	**42**	**54**	**12**

There is a clear importance in managing directorate budgets to ensure the Trust financial plan is achieved.

Directorate performance is outlined to the side.

Within the Directorate positions are some common areas of risk.

These include –

- Ward pay expenditure position – £237k overspend in month, This is a £77k increase in comparison to the previous month. Some of the pressure is from wards still in escalation.
- Medical Staffing pressures – £454k overspend in month, this does include some non recurrent costs, backdated salaries 20 claims, £151k and CEA payments of £21k. Agency is still being used to backfill substantive vacancies.
- Significant underspend within Adult Community Services - this area is actively recruiting.
- Third party costs for addressing activity backlog.
- General risk of covering staff in, particular in Acute settings, from Covid sickness/Isolation.
- Utility pressures now emerging.

These areas will continually monitored.

3.2 Agency

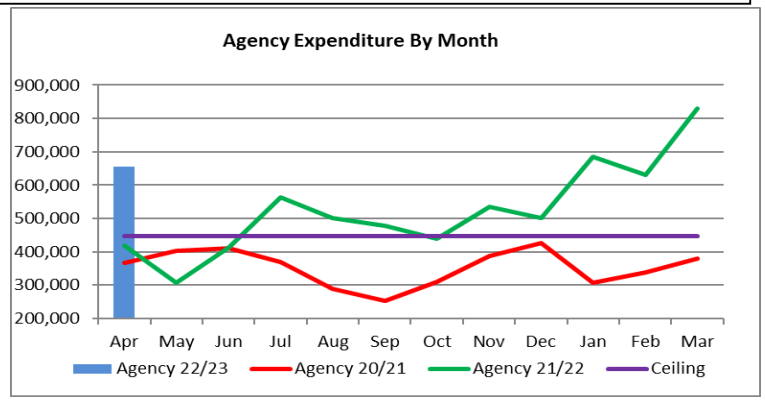
Month 1 expenditure on agency is £654k, this is a reduction from the previous month however spend continues to be above the agency ceiling.

The below highlights the increase in agency nursing and non clinical agency use since April 2021 to April 2022. The main areas of change have been the wards, Theatres and Corporate.
Nursing - Wards £88k to £199k and Theatres £9 to £46k.
Non Clinical – Theatres £0 to £58k (Gutcare) and Corporate £3k to £24k

Directorates have incorporated agency reduction in their CIP plans which is encouraging for 2022/23 however need to establish timescales around this.

Total Agency	Actual Apr-21 £000's
Medical	-216
Nursing	-123
Other Clinical	-17
Non Clinical	-63
Total Agency	**-419**
Agency Ceiling	-448
Variance	**-29**

Total Agency	Actual Apr-22 £000's
Medical	-208
Nursing	-326
Other Clinical	-7
Non Clinical	-113
Total Agency	**-654**
Agency Ceiling	-448
Variance	**206**



3.3 CIP

There has been a positive start to the delivery across the Directorates, £4,851.5k has been delivered, 45% of this has been delivered recurrently. This also includes the £1.5m stretched ICS efficiency ask.

PSC are still establishing a robust programme and no CIP was actioned in M1.

An update by Directorate is presented below.

	Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age
CC	1,670,500	1,540,600	93,300	20,000	97,500	-80,900	1,751,400	**105%**	1,664,735	5,765	**100%**
	% of target	**92%**	**6%**	**1%**	**6%**	**-5%**					
LTUC	**Target**	**Actioned**	Low	**Medium**	**High**	**Unidentified**	**Total**	**Total %age**	**Risk Adjusted Plans**	**Risk adjusted shortfall**	**Risk Adj %age**
	2,849,100	965,900	321,000	601,200	837,700	123,300	2,725,800	**96%**	1,919,350	929,750	**67%**
	% of target	**34%**	**11%**	**21%**	**29%**	**4%**					
CORP	**Target**	**Actioned**	Low	**Medium**	**High**	**Unidentified**	**Total**	**Total %age**	**Risk Adjusted Plans**	**Risk adjusted shortfall**	**Risk Adj %age**
	1,141,400	845,000	152,000	50,000	0	94,400	1,047,000	**92%**	1,029,400	112,000	**90%**
	% of target	**74%**	**13%**	**4%**	**0%**	**8%**					
OTHER	**Target**	**Actioned**	Low	**Medium**	**High**	**Unidentified**	**Total**	**Total %age**	**Risk Adjusted Plans**	**Risk adjusted shortfall**	**Risk Adj %age**
	1,500,000	1,500,000	0	0	0	0	1,500,000	**100%**	1,500,000	0	**100%**
	% of target	**131%**	**0%**	**0%**	**0%**	**0%**					

3.4 Capital

The capital programme for 2022/23 is discussed further in a separate document for Board of Directors. The Trust has a CDEL limit of £9,114k. We are still anticipating £1.6m in relation to Salix and a PDC allocation of £0.7m in relation to Scan for Safety.

The programmes spend will continue to be monitored monthly.

There are also cases being prepared for

- Electronic Patient Records - £12m approx.
- Theatres - £15m approx.

Digital Ward	500
Schemes carried forward from 21/22	500
CT Scanner/Radiology reconfiguration	1,000
Maternity EPR	300
Estate Maintenance (Backlog)	686
Aseptics Refurbishment	750
Deployment of IT Hardware	100
Contingency	500
Health and Wellbeing (Working Environment)	646
Scan for Safety	734
Salix	1,600
Plant Room	2,700
IT Printers/Hardware	363
Trustwide EPR	700
IT Software	369
Clinical Equipment Replacement	0
Estate refurbishment (SSD/Lascelles/Swaledale/Harlow/Mortuary)	0
Total Schemes	**11,448**
PDC - S4S	734
Grant - Salix	1,600
CDEL	9,114

3.5 Better Payment Practice

The Trust is required to adhere to the Better Payment Practice Code, which targets the payment of 95% of invoices within 30 days.

There has been great progress with achieving the BPPC.

Payments and Procurement are now actively promoting the use of purchase orders with the future aim of no PO no payment.

Better Payment Practice Code	In Month	
	Number	£000's
Total Invoices paid in Period	3,153	7,696
Total Invoices paid within target	2,875	5,631
% Paid within target	91%	73%

3.6 Aged Debtors

There a number of invoices outstanding.

Over 90days includes £404k with NHS Airedale and £363k with Darlington Council. These are being reviewed.

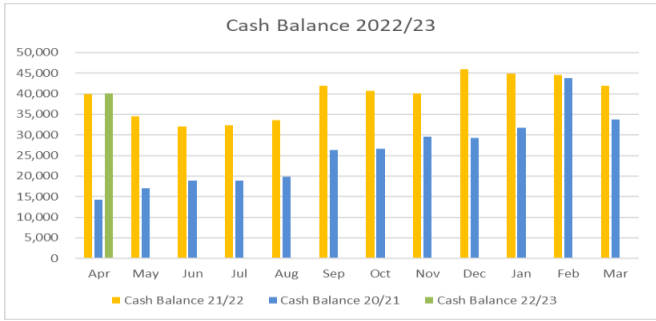
There are a large number of invoices sent to individuals for prescription charges etc.

	31-60 Days Past Invoice Due Date	61-90 Days Past Invoice Due Date	Over 90 Days Past Invoice Due Date
Total Trust	1,259,063	232,381	1,234,474
*Includes HIF			

3.7 Cash Balance

The Trust cash balance continues to remains positive as at the end of April.

There are a number of capital schemes in relation to 2021/22 to be physically paid.



4. Financial Implication/Risk assessment

As described within the report. The Trust continues to balance the overall position, however, there remains pressures in some areas, with underspending issues as much an issue as those areas overspending.

5. Risks

There are a number of risks to be updated on the Finance risk register relating to 2022/23. Risks are being managed within local risk registers, and will be escalated when appropriate. Based on the current risks faced by the organisation the following items were escalated to Executive Risk Review Group –

1. Financial Position, risk scoring of 12.
2. Agency Expenditure, risk scoring of 15.

6. Recommendation

The Board of Directors is asked to note and discuss the content of this report.

Jordan Mckie Acting Director of Finance
Karen Scarth Acting Deputy Director of Finance

Resource Committee
May 2022

Title:	Capital Plan – 2022/23
Responsible Director:	Acting Director of Finance
Author:	Acting Director of Finance Deputy Director of Finance

5.3

Purpose of the report and summary of key issues:	This report has been developed to outline the updated capital plan for 2022/23. The scope of the plan is to meet the Capital Departmental Expenditure Limit (CDEL) for the Trust, whilst also utilising further funds external to this.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	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	
	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	
	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	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No change	
Report History:	Continuation of annual planning process.	
Recommendation:	Resource Committee is asked to note and discuss the attached report, as well as support the recommendation to the Board of Directors to approve this plan.	

Capital Planning 2022/23
Resource Committee
May 2022

Summary Position

During the planning phase of the 2022/23 Annual Plan it appeared the Capital elements of the plan would be relatively straightforward, with a number of items prioritised in 2021/22 and detailed work already commenced for these. The Trust CDEL allocation was agreed at £9.1m, following various discussions which enabled the original plan. This plan is outlined in the table below, alongside a revised position.

Scheme (£'000s)	Original Plan	Revised Plan	Movement
Schemes brought forward from 2021/22	-	500	500
Digital Ward/Ventilation Upgrades	4,500	-	- 4,500
Digital Ward/Ward Upgrade	-	500	500
Ventilation Upgrades/Plant rooms	-	2,700	2,700
Upgrade ED and Relocation of 2nd CT Scanner	2,500	1,000	- 1,500
Maternity EPR	300	300	-
Lexmark	113	113	-
Estate Maintenance	500	686	186
Aseptics	1,000	750	- 250
IT Hardware	100	350	250
Contingency	500	500	-
IT Software	-	369	369
Health and Wellbeing (working environment)	-	646	646
Trustwide EPR (WebV)	-	700	700
CDEL total	**9,513**	**9,114**	**- 399**
Scan 4 Safety	734	734	-
Salix completion	1,600	1,600	-
Total Capital Plan	**11,847**	**11,448**	**- 399**

The revised the position reflects delays expected from interdependencies and operational issues.

The Resource Committee is asked to note and discuss the above, as well as support the approval at Board of Directors of the revised plan.

Key Elements Influencing Changes

Whilst the overall programme remains consistent in terms of the impact on CDEL, there are a number of material changes within the programme. These are described below.

1. Ventilation Upgrades/Plant Rooms

   When working through the various interdependencies associated with the work within the Emergency Department, CT and Wensleydale (digital ward) there has always been a need to ensure the Salix works are complete. One of the complications of these activities has been finding a solution to the ventilation and associated plant with this area of the hospital, whilst also minimising disruption to the hospital site. In February/March 2022, this proposal has been developed, as well as the significant costs associated with this work.

The solution involved craning a plant room onto the roof of Wensleydale to provide the various needs of this area of the site, as well as ensuring the Salix works can be functional.

As well introducing the cost above, there is also a disruption to the timelines for both the Wensleydale and ED/CT works. ED/CT is discussed further below. As a result of the disruption, no work could be undertaken on Wensleydale until winter 2022. Given the operational constraints this would introduce it has been decided to delay these works.

Separately we are reviewing the process and oversight of how this material change linked to Salix has come to light relatively late.

2. Upgrade ED and Relocation of 2nd CT Scanner

   Linked to the above, this scheme has been revisited, alongside operational changes as part of the Emergency Department development. It has been agreed that these schemes would be uncoupled. The second CT will be housed in the Radiology department, with ED2 being dedicated to improving flow.

3. Schemes brought forward from 2022/23

   These are currently being reviewed but an estimate has been made based on the slippage from 2021/22.

4. Aseptics

   The overall cost of this development will remain the same, but as per the business case that was recently approved it will be phased differently over 2022/23 and 2023/24.

5. IT Hardware and Software

   Changes to these costs cover hardware and software requirements which have been outlined by the IT team. Whilst the hardware would have been managed in year, the original plan did not include software developments required to manage some cyber security risks.

6. Trust EPR (WebV)

   There are many discussions associated with EPR systems at present, however, there remains costs associated with WebV that are being capitalised. The original plan was for external funding to support this but this is not available.

7. Health and Wellbeing (environment)

   It was always anticipated that this would be the first call on slippage within the programme and therefore has been prioritised as part of the 2022/23 programme.

The plan has therefore been adjusted for these movements.

Other items to note

It should also be noted that the Trust is actively involved in further capital bids. These include implementing a Trustwide EPR (£12m est) and the TIF bid associated with theatre capacity (£15m).

Harrogate and District NHS Foundation Trust

Trust Board
25 May 2022

Title:	Operational Update
Responsible Director:	Chief Operating Officer
Author:	Chief Operating Officer

5.4

Purpose of the report and summary of key issues:	To inform the Trust Board of the ongoing work and current position linked to operational performance	
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	✓
	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	✓
	BAF3.2 To provide a high quality service	✓
	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	ED 4hour Performance, RTT Performance, Autism Assessment Delivery	
Report History:	March 2022 Update	
Recommendation:	It is recommended that the Trust Board note the items contained within this report.	

Trust Board - Operational Update

May 2022

Russell Nightingale
Chief Operating Officer

Operational Update May 2022 (April Performance)

Matters of concern and risks to escalate

- Referral to treatment total waiting list increased in April, (5.1.3); 92nd percentile at 44 weeks (5.1.3)
- Cancer 62-day wait target not achieved at 75.9% (5.9.1)
- Two week wait cancer performance was below the 93% target at 85.7% (5.10)
- Non-Elective demand remains a challenge and the Trust continues at full capacity (109% av. bed occupancy for April)
- Demand for new outpatient ECHO test has increased by 40% based on 2019 demand (5.3) and Dexa scanner failed installation.
- YOS LLP trial signed off yet no lists have commenced
- 4-hour ED performance - April performance remains below the standard at 66.6%, significant bed pressures impacting on flow, continued increase in presentations and divert support provided to York FT. (5.6)
- 43 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- TIF2 delivery timescales

Major actions commissioned and work underway

- Successful TIF2 bid (c.£14m) to increase on site theatre provision
- ED business Case approved; recruitment underway – go live November 2022
- Glaucoma review list reduction on trajectory for Q1 compliance
- Creation of additional pre-assessment capacity through move back to vaccine centre (improving resilience in elective recovery)
- HDFT chair WYAAT independent sector steering group which has been heralded as exemplar, contract form being rewritten for the system
- Closer working with HIF, attendance at site meetings and OMG
- Flow RPIW commissioned to commence in May
- 'Back 2 Home' trial developed and to be rolled out in May 22'

Positive news and assurance

- COVID admissions continued to reduce throughout April
- The Trust had no 60-minute ambulance handover breaches in April
- Cancer 31-day wait target achieved at 97.0% (5.1.2)
- Cancer 28 days faster diagnosis 81.5%, above the 75% standard (5.11)
- 208 elective theatres lists were undertaken out of a possible 219 (94%)
- M01 plan met 11 of 13 measures for April, routine IP below plan and reduction in 104+,
- Highly successful reduction in >104 week waiters from initial position of 299 patients and finished end of April at 10. All of those had been offered dates and either declined due to choice, were unable to have their operation due to covid /surgeon had covid.
- Top quartile national performance for Ambulance handover delays
- Continued to support York District Hospital with acute patient diverts when required and able to support
- 96% of ambulances were offloaded under 15-mins, in top 10 nationwide
- Agreed proposal to utilise Duchy Hospital to deliver further treatment capacity across 2022/23 – 1,000 cases up from 300 in 2021/22. 63 patients transferred in April

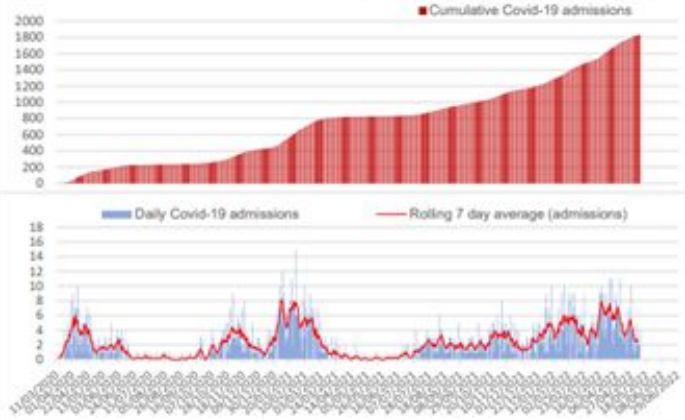
Decisions made and decisions required of the Board

- Ring-fenced Orthopaedic beds agreed on fountains
- Security trial started 09/05/2022
- Additional winter bed capacity remains open due to social care blocks
- Waiting list Ai tool now approved and rollout to beginning May 2022
- Operational restructure approved; consultation due to launch in May 22
- Reduced routine covid testing for inpatients and moved to lateral flow for electives

COVID-19 Management Report

Inpatients with confirmed Covid-19 (NHSE Daily Sit Rep)

Admissions (admitted with known Covid-19 OR diagnosed while inpatient)



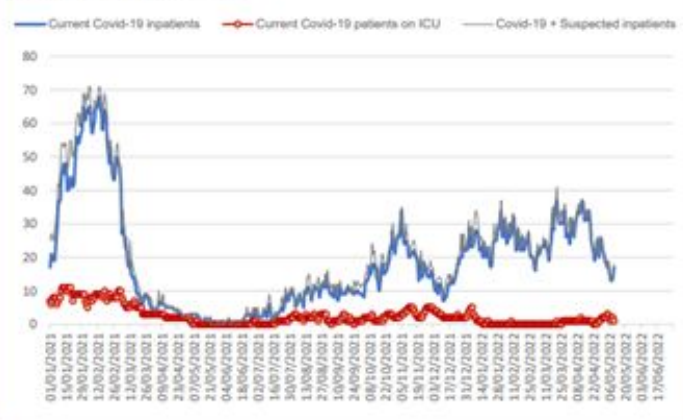
Yesterday **4**

To date **1834**

Last 7 days **19**

8-14 days ago **28**

Current Covid-19 inpatients



Today **17**

Yesterday **14**

7 days ago **18**

14 days ago **22**

Covid-19 admissions by age

Today

0-5 **1**

6-17 **0**

18-24 **0**

25-34 **0**

35-44 **0**

45-54 **1**

55-64 **0**

65-74 **2**

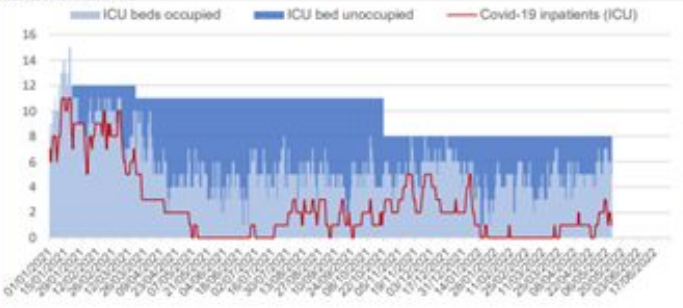
75-84 **5**

85+ **8**

Bed occupancy

Adult G&A wards

Intensive Care Unit



G&A (Adult)

% occupied **96.3%**

% Covid-19 **5.6%**

ICU

% occupied **62.5%**

% Covid-19 **20.0%**

% Covid (Adult G&A + ICU) **5.5%**

Planned Care Recovery

Elective Recovery - HDFT

Outpatients

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) Plan	450	500	550	600	675	750	825	875	925	1,000	1,050	1,100
Actual												
Consultant-led first outpatient attendances (Spec acute) Plan	4,319	4,477	4,548	6,219	5,451	5,773	6,595	6,129	5,465	6,329	5,622	4,601
Consultant-led first outpatient attendances (Spec acute) Actual	3,874											
Consultant-led follow-up outpatient attendances (Spec acute) Plan	6,493	6,804	6,578	10,078	8,919	9,333	11,051	9,850	8,790	10,380	9,054	8,244
Consultant-led follow-up outpatient attendances (Spec acute) Actual	8,110											

Elective Admissions

Total number of Specific Acute elective spells in the period Plan	1,945	2,337	2,120	2,859	2,753	2,578	3,600	3,518	3,039	3,505	3,241	2,574
Total number of Specific Acute elective spells in the period Actual	2,386											
Total number of Specific Acute elective day case spells in the period Plan	1,766	2,117	1,904	2,536	2,492	2,333	3,265	3,177	2,758	3,127	2,944	2,353
Total number of Specific Acute elective day case spells in the period Actual	2,226											
Total number of Specific Acute elective ordinary spells in the period Plan	179	220	216	323	261	245	335	341	281	378	297	221
Total number of Specific Acute elective ordinary spells in the period Actual	160											

RTT

Number of Completed Admitted RTT Pathways Plan	694	818	749	984	950	895	1,002	976	825	972	888	677
Number of Completed Admitted RTT Pathways Actual	832											
Number of Completed Non-Admitted RTT Pathways Plan	4,442	4,661	4,481	6,099	5,282	5,624	6,604	6,017	5,288	6,317	5,474	4,962
Number of Completed Non-Admitted RTT Pathways Actual	3,558											
Number of New RTT Pathways (Clockstarts) Plan	5,330	5,594	5,378	7,319	6,338	6,749	7,925	7,220	6,346	7,580	6,568	5,954
Number of New RTT Pathways (Clockstarts) Actual	6,403											
The number of incomplete RTT pathways waiting 52+weeks Plan	1,181	1,197	1,195	1,180	1,197	1,195	1,150	1,157	1,150	1,147	1,149	1,130
The number of incomplete RTT pathways waiting 52+weeks Actual	1,187											
The number of incomplete RTT pathways waiting 78+weeks Plan	229	235	237	229	220	210	215	195	199	150	80	0
The number of incomplete RTT pathways waiting 78+weeks Actual	205											
The number of incomplete RTT pathways waiting 104+weeks Plan	5	5	0	0	0	0	0	0	0	0	0	0
The number of incomplete RTT pathways waiting 104+weeks Actual	11											
The total number of incomplete RTT pathways Plan	24,000	23,800	23,600	23,400	23,200	23,000	22,800	22,700	22,600	22,500	22,400	22,300
The total number of incomplete RTT pathways Actual	24,714											

Cancer

The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Plan	47	46	45	44	43	42	41	40	39	35	30	20
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Actual	46											

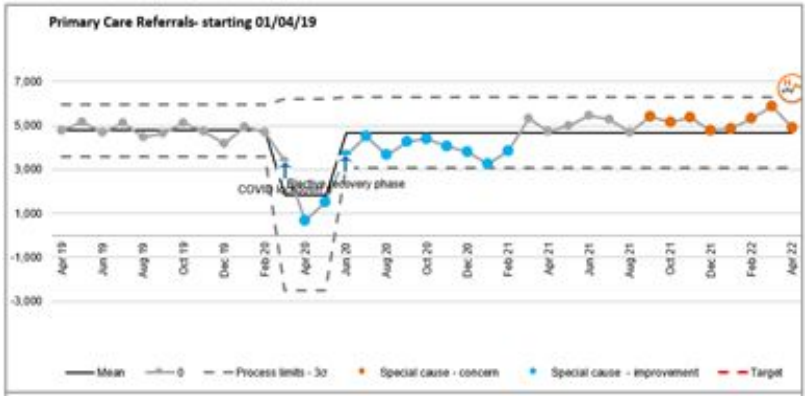
Increasing elective admissions to reduce gap to 19/20 continues to be the focus. Dedicated project support continues in theatres to aid recovery.

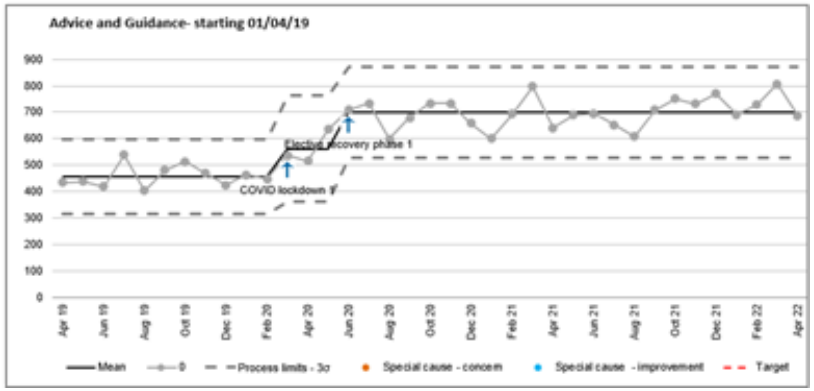
To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered.

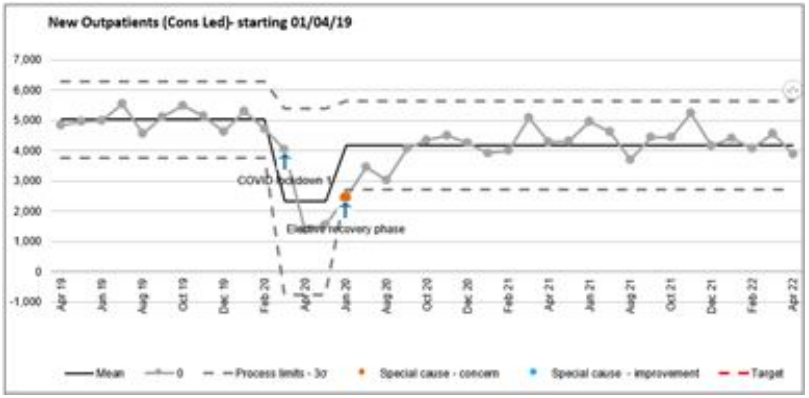
The Trust increased non elective beds on the Elective Surgical Unit, these remain in place to help mitigate increased non elective activity levels. Winter plan with additional capacity still being utilised to release more beds back to elective care.

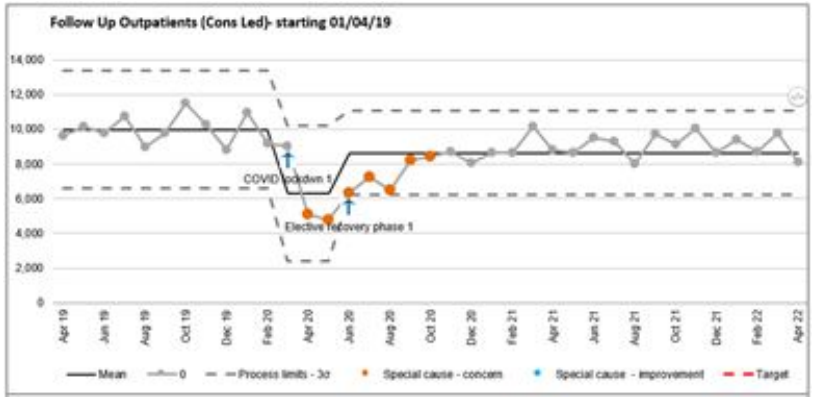
The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, there is currently a reduction in demand for Endoscopy, so HDFT continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels.

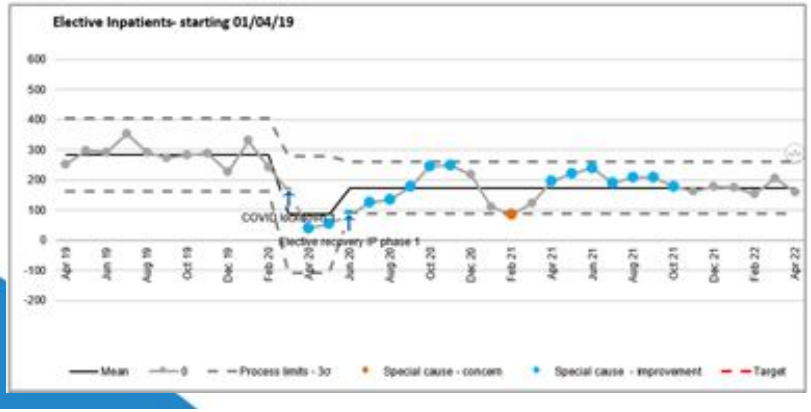
Elective Recovery

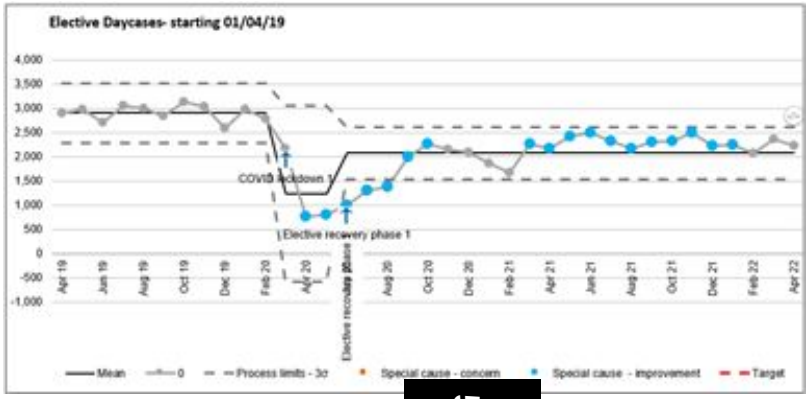






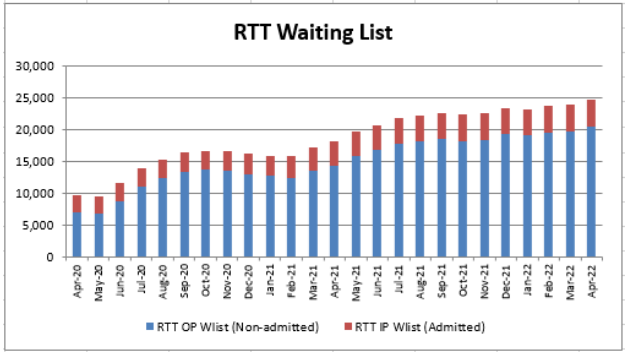


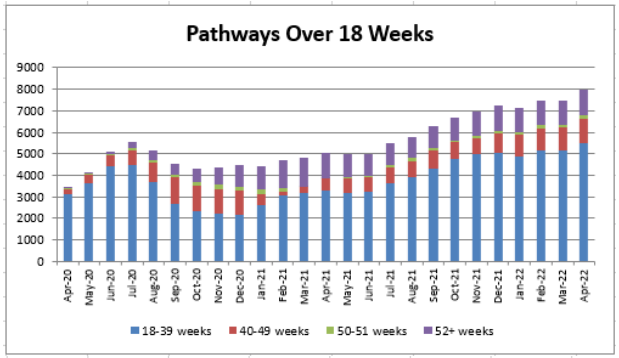




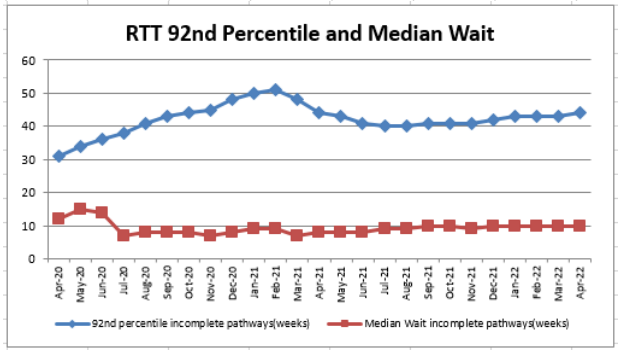
Referral to Treatment (RTT)

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
No. of pathways 18-39 weeks	3,310	3,168	3,255	3,657	3,922	4,336	4,787	4,989	5,035	4,900	5,140	5,156	5,472
No. of pathways 40-49 weeks	521	666	644	735	748	820	743	748	925	978	1,041	1,064	1,164
No. of pathways 50-51 weeks	21	62	91	90	127	133	104	119	103	127	135	139	163
No. of pathways 52+ weeks	1,201	1,087	1,006	988	955	1,008	1,070	1,097	1,177	1,138	1,157	1,140	1,187
Total >18weeks	5,053	4,983	4,996	5,470	5,752	6,297	6,704	6,953	7,240	7,143	7,473	7,499	7,986
Total RTT List	18,182	19,746	20,631	21,785	22,168	22,648	22,423	22,714	23,464	23,323	23,900	23,931	24,714



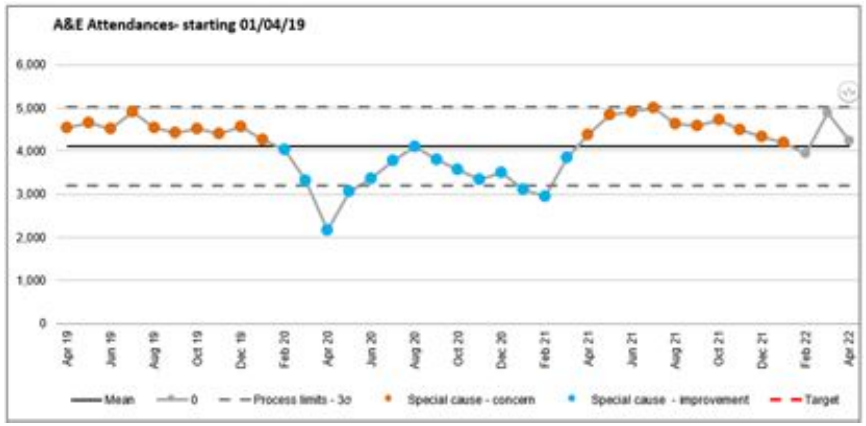


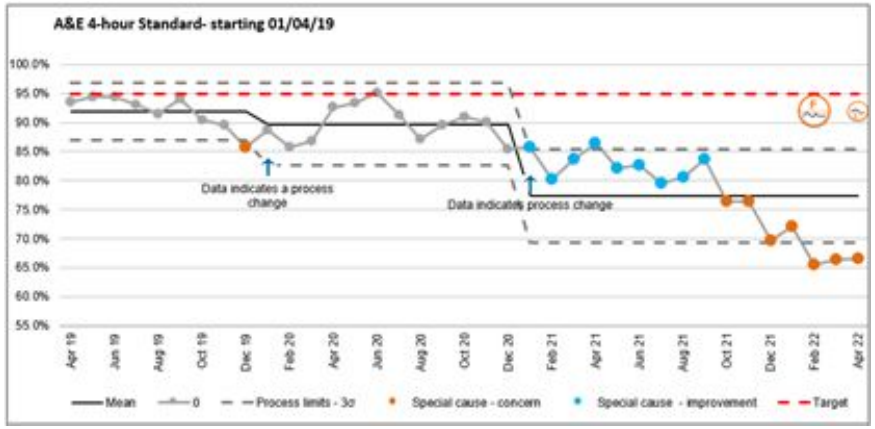
Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	54	0	0	294	319	239	0	22	**928**
3-4	14	0	0	57	129	139	0	4	**343**
5-6	8	0	0	23	85	181	0	3	**300**
7-8	1	0	0	18	72	178	0	4	**273**
9-10	6	0	0	10	46	138	0	8	**208**
11-12	1	0	0	4	45	126	0	2	**178**
13-14	2	0	0	2	32	146	0	5	**187**
15+	5	0	0	16	345	2,167	0	33	**2,566**
Total	**91**	**0**	**0**	**424**	**1,073**	**3,314**	**0**	**81**	**4,983**

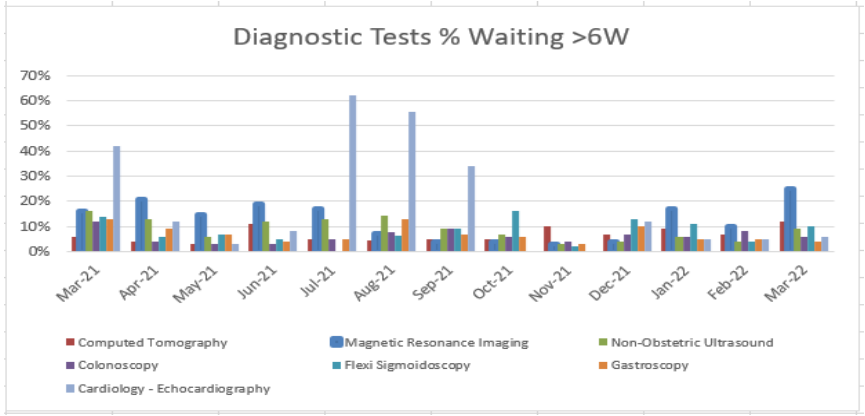


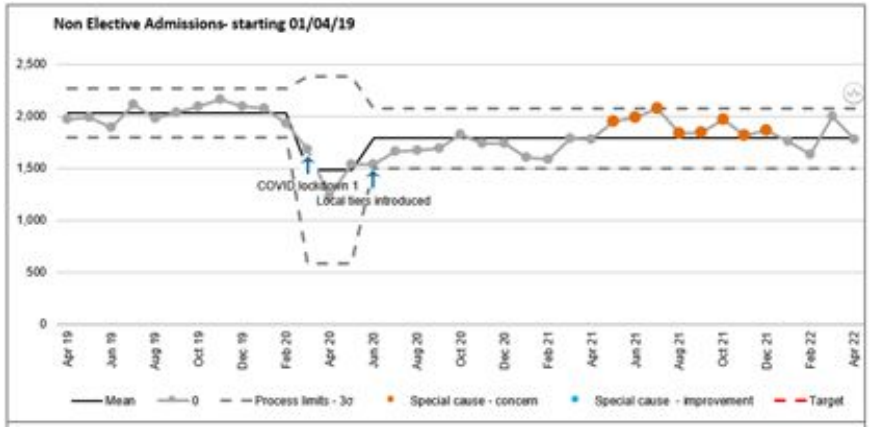
RTT - The Trust had 24,714 patients waiting at the end of April, this is an increase of 783 patients on the March position.
There are 1,187 patients waiting over 52 weeks, this is a 4% increase on the March position.
The 92nd centile remains at 44-weeks in March and the median wait is at 10-weeks.
Of the 4,983 patients waiting for a procedure, 39% are Orthopaedics, 17% General Surgery and 12% Ophthalmology.
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.1% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (54/91) have been waiting <=2 weeks and work continues to ensure these are rapidly coded. 83% of P2 patients have been waiting less than 28-days and there is still an element of patient choice. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

Urgent Care and Diagnostics



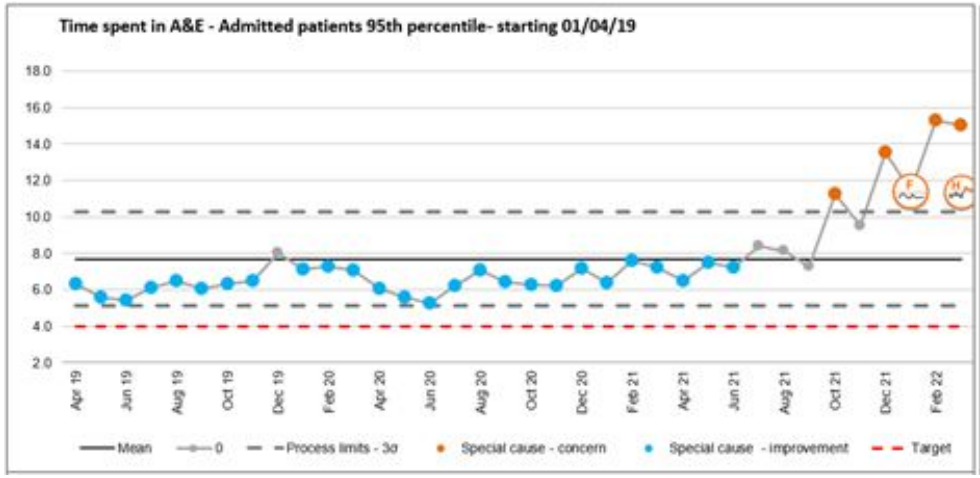


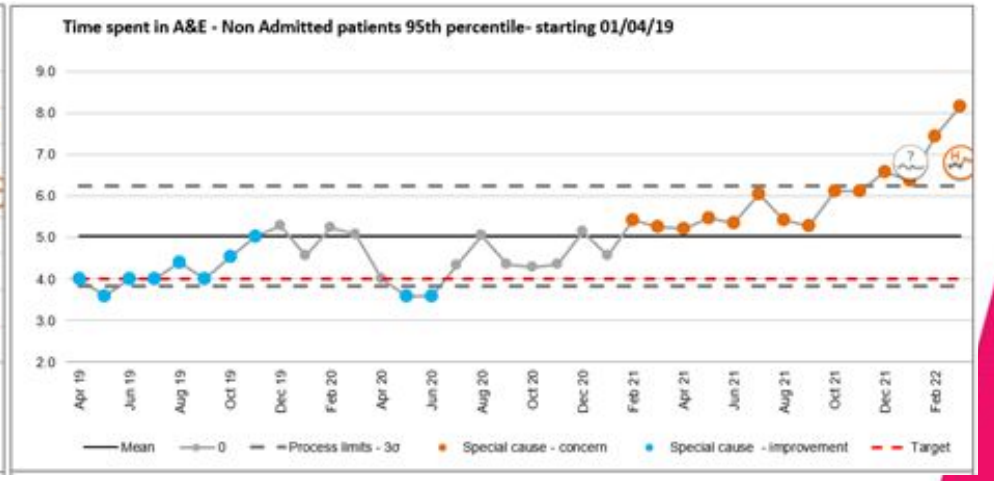


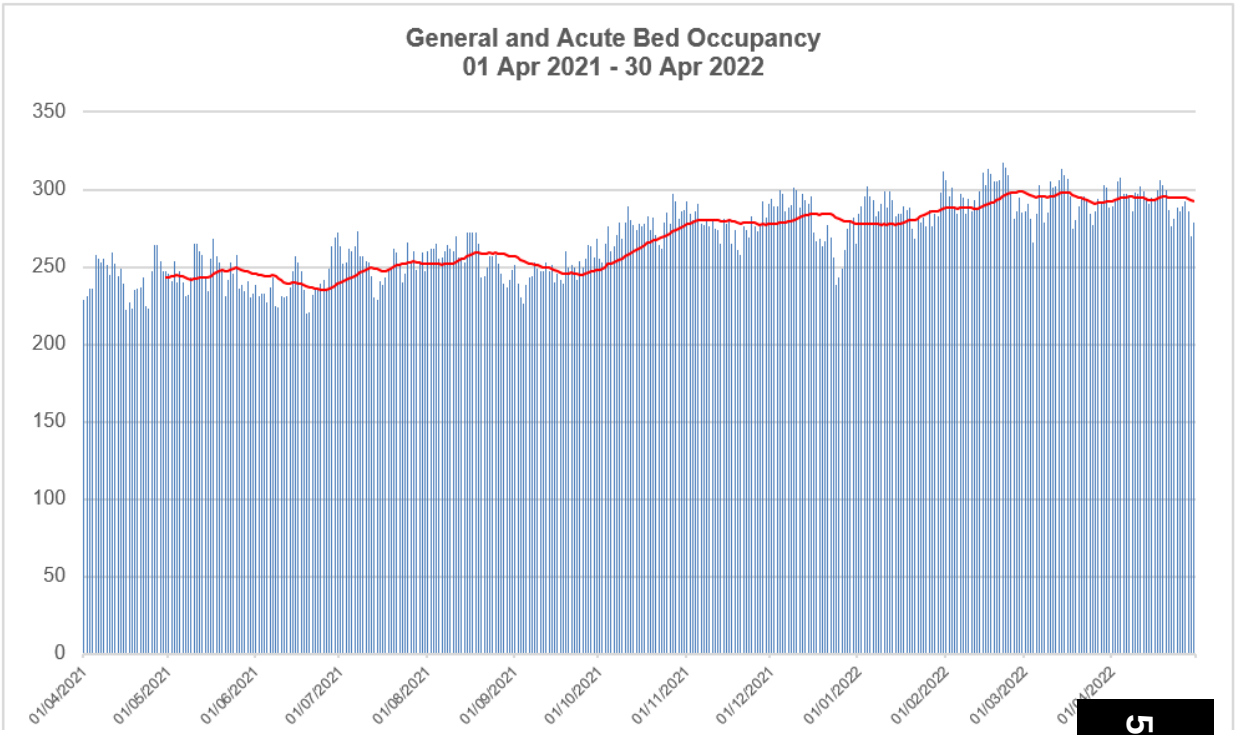


- Performance against the A&E 4-hour standard remained below 95% in April at 66.6%. The 95th percentile wait was 11-hours 31-minutes.
- There were forty-three12-hour breaches in April.
- There were 15 x 30-minute handover breaches and 0 x 60-minute ambulance handover breaches in April.
- ED attendances are now back in line with 2019/20 levels, this combined with the high occupancy levels in the hospital makes flow through the department a significant challenge.
- A UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- A live ED dashboard is now in place with screens visible in a number of hospital operational areas.
- Diagnostic waits beyond 6-weeks continue to decrease with focus maintained on reducing the backlog.

Accident and Emergency







A&E Streaming

4/4/22 - Streaming in place 07:00 - 18:00					28/3/22 No streaming				
Non-Admitted Patients Only									
00:37:00 Home	09:46:00 Home	11:46:00 Home	15:04:00 Home	18:42:00 Home	00:32:00 Home	10:11:00 Home	13:13:00 Home	17:32:00 Home	22:22:00 Home
01:22:00 Home	09:47:00 Home	11:52:00 Home	15:08:00 Home	18:44:00 Home	00:39:00 Home	10:14:00 Home	13:19:00 Home	17:35:00 Home	22:27:00 Home
01:34:00 Home	09:49:00 Home	11:59:00 Home	15:27:00 Home	18:46:00 Home	00:54:00 Home	10:16:00 Home	13:27:00 Home	17:48:00 Home	22:34:00 Home
02:06:00 Home	09:58:00 Home	11:59:00 Home	15:37:00 Home	19:04:00 Home	01:14:00 Home	10:29:00 Home	13:36:00 Home	17:53:00 Home	23:08:00 Home
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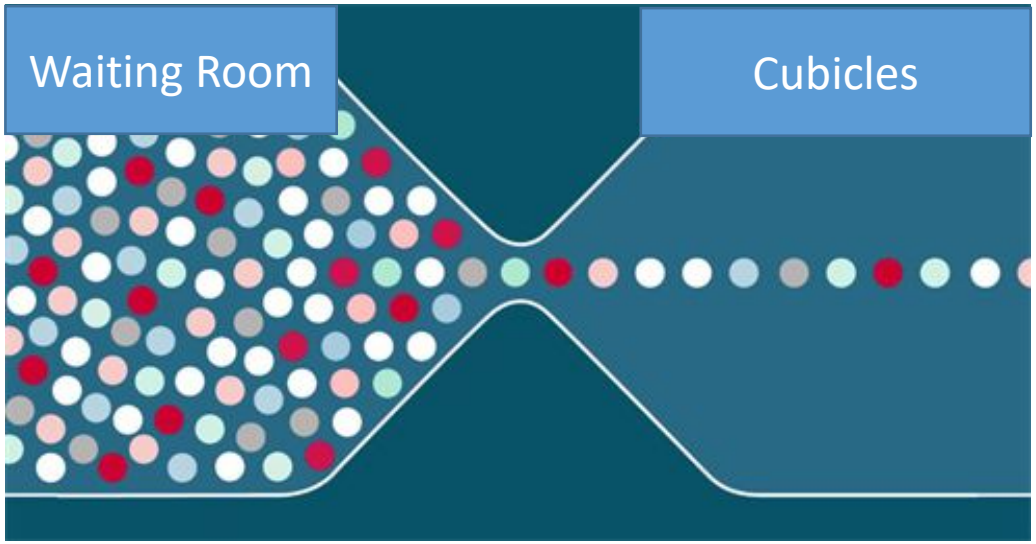
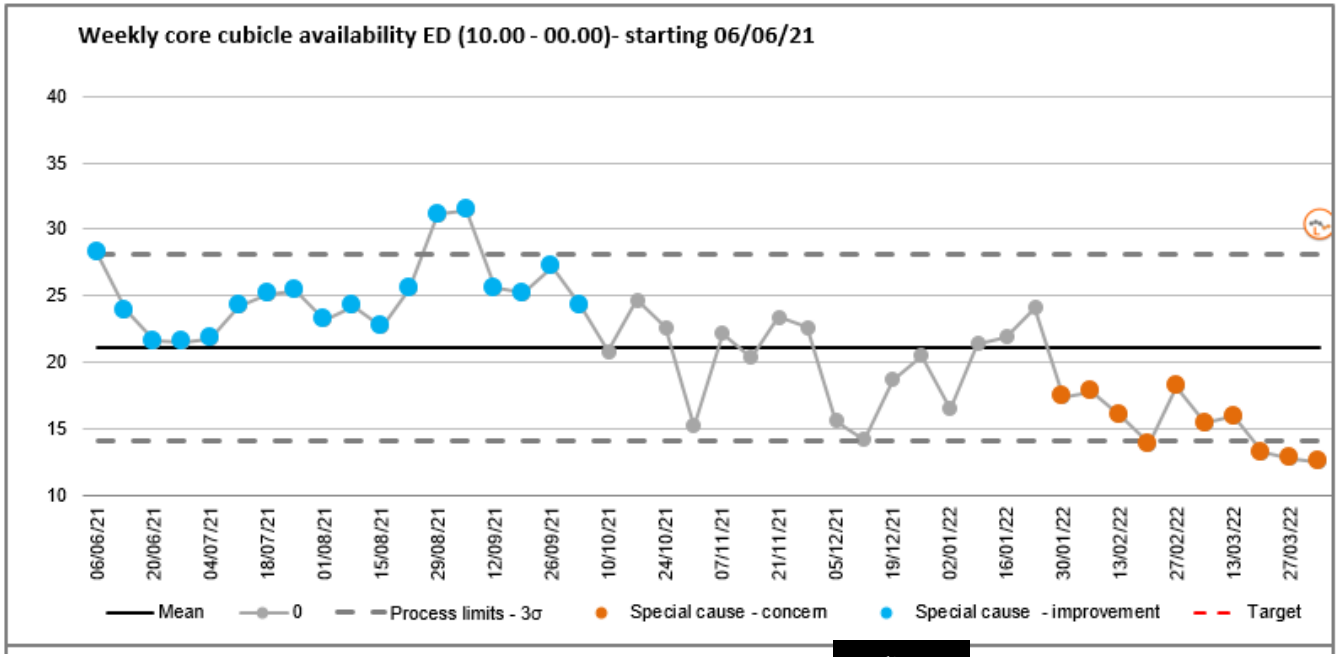
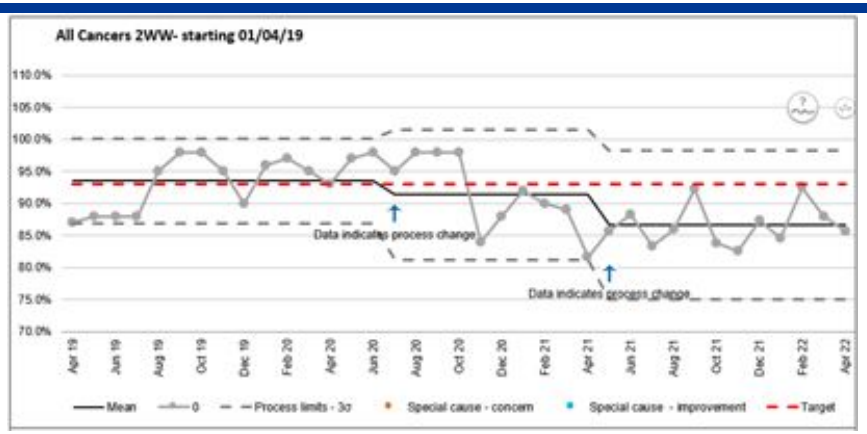
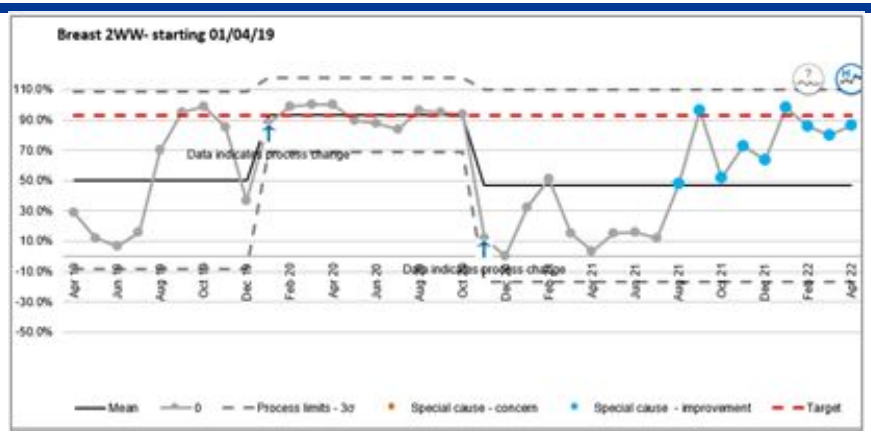
ED Cubicle Capacity

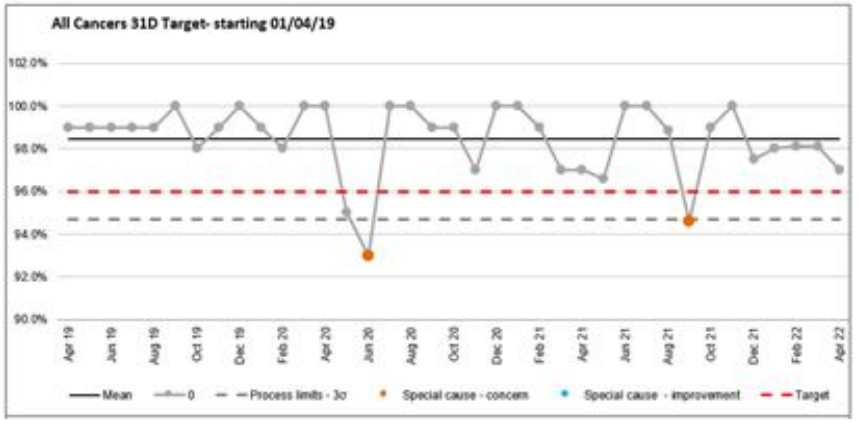


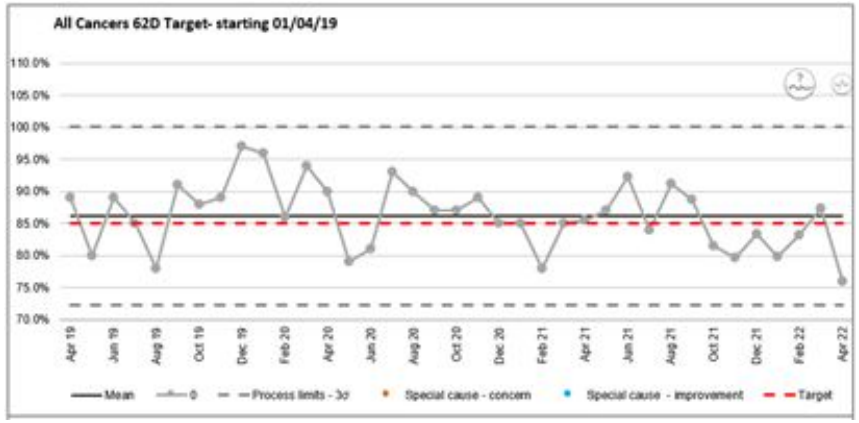


Cancer Performance









- The 62-day standard was not met in April with a performance of 75.9%
- The 31-day standard was met in April with a performance of 97.0%
- The 2-week wait standard was not met in April with a performance of 85.7%
- The 2-week wait breast symptomatic standard was not met in April with a performance of 86.2%
- At the end of March 46 patients remain on an open cancer pathway over 62 days with 11 of these over 104 days. This remains a key focus, it is also one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis has been completed and actions being taken to address the shortfall. The colorectal pathway has now resumed 'straight to test'.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics in place.

Children's and Community 1

Metrics	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Q1	Q2	Q3	Q4	YTD 2021-2022
% of antenatal contacts																	
Darlington	95.8%	92.5%	97.4%	97.2%	100.0%	97.6%	86.4%	90.4%	82.9%	87.3%	98.1%	95.9%	95.2%	98.3%	86.6%	93.8%	**93.5%**
Durham	89.3%	91.1%	91.4%	94.3%	89.6%	85.5%	80.6%	72.2%	70.2%	67.2%	69.8%	70.4%	90.6%	89.8%	74.3%	69.1%	81.0%
Gateshead	90.2%	95.0%	97.0%	93.0%	96.9%	97.5%	92.5%	89.6%	89.0%	87.4%	82.8%	85.9%	94.1%	95.8%	90.4%	85.4%	**91.4%**
Middlesbrough	92.9%	94.1%	93.9%	99.2%	95.9%	94.5%	69.4%	41.0%	36.4%	31.9%	32.6%	41.1%	93.6%	96.5%	48.9%	35.2%	**68.6%**
North Yorkshire	68.9%	72.2%	78.2%	74.4%	81.2%	84.6%	82.8%	78.2%	76.5%	76.0%	82.0%	78.0%	73.1%	80.1%	79.2%	78.7%	**77.8%**
Northumberland							97.3%	99.1%	99.0%	98.4%	100.0%				98.5%	99.2%	**98.8%**
Stockton	88.5%	86.2%	90.4%	91.6%	84.0%	90.7%	94.3%	88.6%	83.2%	75.0%	75.6%	75.2%	88.6%	88.8%	88.7%	75.3%	85.3%
Sunderland	98.0%	93.0%	94.1%	90.8%	89.5%	87.7%	85.3%	87.7%	94.7%	92.9%	88.9%	87.6%	95.0%	89.3%	89.2%	89.8%	**90.9%**
% New Birth Visits completed by 14 days																	
Darlington	91.1%	97.6%	97.2%	93.8%	98.9%	96.2%	96.2%	97.4%	95.3%	100.0%	100.0%	91.5%	95.3%	96.3%	96.3%	97.2%	96.3%
Durham	96.1%	96.0%	96.3%	97.6%	96.3%	94.3%	97.0%	95.0%	95.9%	95.1%	96.0%	92.9%	96.1%	96.1%	96.0%	94.7%	95.7%
Gateshead	96.5%	96.2%	97.9%	98.8%	99.3%	98.7%	92.5%	96.4%	98.8%	98.0%	97.7%	98.2%	96.9%	98.9%	95.9%	98.0%	97.4%
Middlesbrough	96.4%	97.4%	92.7%	95.8%	94.3%	92.4%	86.7%	96.6%	94.8%	92.6%	94.7%	93.8%	95.5%	94.2%	92.7%	93.7%	94.0%
North Yorkshire	92.6%	90.3%	92.3%	94.0%	92.5%	89.1%	91.6%	81.6%	93.5%	92.0%	91.2%	92.0%	91.7%	91.9%	88.9%	91.7%	91.1%
Northumberland							91.7%	93.1%	92.4%	91.9%	91.0%				92.4%	91.5%	92.0%
Stockton	89.4%	89.7%	92.4%	93.3%	90.5%	86.4%	93.1%	89.4%	94.2%	88.5%	93.9%	91.8%	90.5%	90.1%	92.2%	91.4%	91.1%
Sunderland	98.9%	99.6%	98.3%	96.2%	99.6%	99.5%	98.6%	99.6%	100.0%	98.3%	99.0%	96.5%	98.9%	98.4%	99.4%	97.9%	98.7%
% Infants Breastfeeding at 10-14 days																	
Darlington	51.3%	52.9%	46.5%	43.3%	40.4%	43.6%	52.4%	44.9%	50.0%	43.0%	53.4%	46.3%	50.2%	42.4%	49.1%	47.6%	47.3%
Durham	41.6%	40.2%	40.7%	42.9%	39.8%	39.9%	46.2%	42.8%	46.0%	41.4%	41.8%	41.5%	40.8%	40.9%	45.0%	41.6%	42.1%
Gateshead	54.1%	47.4%	53.6%	57.7%	52.9%	51.0%	47.2%	54.5%	51.2%	52.7%	50.8%	56.7%	52.5%	53.9%	51.0%	53.4%	52.5%
Middlesbrough	46.4%	48.2%	43.9%	51.0%	46.3%	55.3%	40.6%	43.5%	42.5%	47.8%	56.1%	48.4%	47.5%	50.9%	42.2%	50.8%	47.5%
North Yorkshire	63.5%	65.1%	66.4%	67.7%	62.5%	66.0%	58.5%	61.5%	65.4%	68.2%	67.4%	59.7%	64.7%	65.4%	61.8%	65.1%	64.3%
Northumberland							80.8%	75.5%	75.0%	74.4%	76.0%				77.1%	75.2%	76.3%
Stockton	44.2%	47.9%	46.8%	46.0%	46.5%	43.0%	46.8%	51.6%	48.4%	51.6%	47.3%	48.9%	46.2%	45.2%	48.9%	49.3%	47.4%
Sunderland	37.7%	39.3%	45.0%	44.4%	40.7%	40.5%	41.8%	45.7%	41.1%	36.5%	40.8%	47.9%	41.8%	41.9%	42.9%	41.7%	41.8%
% infants breastfeeding at 6-8 weeks																	
Darlington	47.8%	34.7%	33.7%	31.7%	25.3%	34.8%	35.0%	36.1%	40.0%	34.9%	32.1%	40.0%	38.7%	30.6%	37.0%	35.7%	35.5%
Durham	33.7%	28.3%	28.0%	32.0%	29.5%	26.6%	27.4%	34.9%	29.5%	36.7%	32.8%	33.0%	31.0%	29.4%	30.6%	34.2%	31.0%
Gateshead	36.2%	41.6%	39.7%	44.5%	45.3%	42.5%	35.2%	41.9%	42.6%	38.9%	41.7%	40.4%	40.9%	44.1%	39.9%	40.3%	40.9%
Middlesbrough	38.1%	37.7%	37.4%	34.2%	32.7%	40.1%	37.3%	29.2%	34.3%	28.9%	37.8%	39.8%	35.2%	35.7%	33.6%	35.5%	35.6%
North Yorkshire	56.1%	51.4%	55.5%	54.3%	54.7%	49.0%	51.0%	49.8%	50.0%	55.8%	58.4%	54.0%	53.3%	52.7%	50.3%	56.1%	53.3%
Northumberland							46.4%	43.6%	45.8%	39.4%	45.1%				45.3%	42.3%	44.1%
Stockton	39.6%	35.1%	36.0%	39.3%	34.0%	36.2%	30.6%	35.5%	36.2%	33.3%	35.7%	36.5%	36.9%	36.5%	34.1%	35.2%	35.7%
Sunderland	26.8%	25.3%	32.3%	30.6%	29.7%	27.1%	31.3%	28.2%	35.5%	27.0%	23.4%	28.9%	28.8%	29.1%	31.7%	26.4%	28.8%

Children's and Community 2

Metrics	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Q1	Q2	Q3	Q4	YTD 2021-2022
% of 6-8 week reviews completed by the time the infant is 8 weeks old																	
Darlington	92.5%	100.0%	97.8%	96.3%	94.9%	93.5%	88.8%	97.0%	95.3%	97.6%	95.1%	90.6%	96.8%	94.9%	93.7%	94.4%	95.0%
Durham	88.6%	92.2%	91.5%	92.3%	90.5%	88.5%	90.9%	91.0%	92.0%	86.6%	91.3%	86.4%	90.8%	90.4%	91.3%	88.1%	90.2%
Gateshead	96.6%	91.3%	97.1%	95.5%	96.9%	95.6%	95.0%	93.1%	98.2%	98.3%	98.4%	98.0%	95.5%	96.0%	95.4%	98.2%	96.2%
Middlesbrough	87.1%	85.2%	91.3%	91.6%	89.6%	73.2%	70.3%	57.7%	62.4%	80.9%	92.1%	94.7%	87.9%	84.8%	63.5%	89.2%	81.3%
North Yorkshire	92.0%	89.4%	92.4%	90.7%	94.2%	93.9%	86.9%	88.0%	89.9%	91.3%	92.6%	95.7%	91.3%	92.9%	88.3%	93.2%	91.4%
Northumberland							93.0%	95.2%	93.7%	90.9%	89.9%				94.0%	90.4%	92.5%
Stockton	89.7%	93.5%	91.5%	92.5%	86.8%	87.9%	92.7%	92.0%	90.4%	89.4%	90.7%	93.4%	91.6%	89.1%	91.7%	91.2%	90.9%
Sunderland	96.3%	97.8%	94.3%	95.7%	95.4%	93.4%	93.8%	95.9%	96.5%	95.8%	96.0%	97.7%	95.7%	94.8%	95.4%	96.5%	95.7%
% of 12 month reviews completed by the time the child is 15 months old																	
Darlington	95.1%	96.8%	96.1%	96.9%	96.8%	91.3%	91.8%	95.9%	95.8%	96.7%	97.4%	98.9%	96.0%	95.0%	94.5%	97.7%	**95.8%**
Durham	83.4%	80.2%	82.7%	87.1%	87.3%	84.1%	88.3%	85.0%	79.5%	76.4%	73.0%	71.8%	82.1%	86.2%	84.3%	73.7%	81.6%
Gateshead	97.2%	99.3%	97.2%	98.5%	97.9%	97.1%	98.1%	97.4%	97.7%	99.4%	93.5%	95.4%	97.4%	97.8%	97.7%	96.1%	**97.4%**
Middlesbrough	97.8%	97.8%	97.8%	100.0%	96.9%	98.5%	99.3%	95.7%	97.4%	98.6%	99.1%	98.6%	97.8%	98.5%	97.5%	98.8%	**98.1%**
North Yorkshire	96.9%	90.5%	95.3%	93.9%	98.5%	95.7%	98.1%	98.1%	97.9%	97.6%	98.0%	96.4%	94.2%	96.0%	98.0%	97.3%	**96.4%**
Northumberland							93.3%	91.5%	92.8%	82.4%	94.2%				92.5%	88.3%	**90.8%**
Stockton	95.7%	94.4%	94.3%	95.7%	95.9%	97.1%	96.3%	98.1%	92.0%	97.2%	98.1%	97.2%	94.8%	96.2%	95.5%	97.5%	**96.0%**
Sunderland	94.2%	96.0%	93.9%	96.5%	96.5%	98.6%	96.8%	94.8%	96.9%	93.8%	96.2%	97.6%	96.0%	97.2%	96.2%	95.9%	**96.0%**
% of 2-2.5 year reviews completed by the time the child is 2.5 years old																	
Darlington	97.8%	98.9%	98.8%	94.9%	97.7%	98.8%	97.3%	95.1%	95.3%	95.2%	100.0%	97.9%	98.5%	97.1%	95.9%	97.7%	**97.3%**
Durham	90.1%	87.6%	90.4%	89.8%	90.0%	87.8%	89.5%	89.9%	88.1%	88.0%	89.8%	90.9%	89.4%	89.2%	89.2%	89.6%	89.3%
Gateshead	95.0%	97.1%	97.2%	95.5%	98.6%	97.2%	95.4%	95.5%	93.2%	95.9%	95.1%	94.0%	96.4%	97.1%	94.7%	95.0%	**95.8%**
Middlesbrough	97.3%	94.9%	94.1%	94.2%	96.8%	98.2%	97.3%	93.8%	95.3%	96.9%	98.3%	98.6%	95.4%	96.4%	95.5%	97.9%	**96.3%**
North Yorkshire	82.6%	85.6%	91.9%	90.9%	90.1%	90.2%	84.2%	88.3%	92.0%	87.0%	86.8%	88.5%	86.7%	90.4%	88.2%	87.4%	**88.2%**
Northumberland							90.6%	87.6%	90.7%	89.8%	88.9%				89.6%	89.4%	**89.5%**
Stockton	92.9%	94.4%	91.8%	90.5%	91.9%	93.1%	87.5%	94.2%	89.1%	87.5%	85.0%	87.4%	93.0%	91.8%	90.3%	86.6%	**90.4%**
Sunderland	97.8%	97.7%	94.5%	95.9%	97.5%	92.4%	94.4%	95.9%	94.6%	96.8%	91.9%	94.6%	96.7%	95.3%	95.0%	94.4%	**95.3%**
% of 2 to 2.5 year reviews completed in the month with a completed ASQ3																	
Darlington	100.0%	99.0%	98.2%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	98.9%	99.1%	100.0%	99.6%	99.6%	**99.6%**
Durham	90.1%	87.6%	90.4%	89.8%	90.0%	87.8%	89.5%	89.9%	88.1%	88.0%	89.8%	90.9%	89.4%	89.2%	89.2%	89.6%	**89.3%**
Gateshead	97.2%	97.2%	96.4%	97.3%	94.7%	92.3%	96.3%	96.4%	90.0%	92.9%	96.0%	92.5%	95.3%	94.8%	94.2%	93.8%	**94.9%**
Middlesbrough	99.2%	96.4%	100.0%	99.3%	100.0%	96.0%	100.0%	98.7%	98.4%	97.7%	100.0%	99.4%	98.5%	98.4%	99.0%	99.0%	**98.8%**
North Yorkshire	99.7%	100.0%	98.3%	98.7%	100.0%	98.8%	99.0%	98.4%	99.1%	100.0%	99.2%	100.0%	99.3%	99.2%	98.8%	99.7%	**99.3%**
Northumberland							95.4%	98.0%	99.0%	94.8%	95.8%				97.5%	95.3%	**96.6%**
Stockton	95.0%	96.4%	96.8%	93.3%	88.0%	94.5%	89.7%	95.1%	90.0%	92.2%	92.7%	91.9%	96.1%	91.9%	91.6%	92.3%	**93.0%**
Sunderland	96.5%	99.5%	98.8%	95.8%	98.1%	98.5%	97.6%	97.3%	95.2%	98.6%	92.9%	99.0%	98.3%	97.5%	96.7%	96.8%	**97.3%**

Children's and Community 3

April OPEL Level – 3
Adult Community
Service continues to be very pressured due to increased complexity of caseloads and high vacancy rate, sickness and COVID challenges
Task and finish group established to progress skill mix review, updated recruitment campaign.
Work progressing on skill mix review, with new Senior Community Nurse job description developed to support pressures in District Nursing and retention of Band 5 community Nurses. Recruitment for these new roles have commenced.

0-19 Service
In line with OPEL 2/3 level the following actions are being taken:
• Non urgent activity paused, cancelled or re-arranged.
• Flexible approach to timelines for mandated contacts introduced.
• Face to face or virtual contacts based on COVID risk assessment, family health needs assessment and cumulative risk.
• Support required from outside of contract area.

Safeguarding
Staff absence from work within the safeguarding specialist team is impacting on capacity within the team.
Demand for safeguarding remains high within
0-19 and specialist safeguarding teams.
Statutory responsibilities still being delivered

Community Dental
Plans in place to link with clinical teams across HCV to embed best practise and teams have scheduled WLI sessions to target long waiters to ensure all dated, small number of long waits at end of April owing to patients not attending. All day Saturday lists have commenced. Key risk are those patients that require GA and external anaesthetic support has been commissioned to support additional sessions.

BOARD SUMMARY
WORKFORCE MATTERS – MAY 2022

Matters of concern & risks to escalate

- Complex ER casework continues to increase with a number of Employment Tribunal cases, ACAS conciliations, Disciplinary, Grievance, Capability and Organisational Change cases being managed by the team

Sickness

- Sickness remains high in April and has seen an increase this month to 5.90%
- Excluding Covid related sickness, the Trust's sickness rate is 3.75% which is below the Trust's threshold of 3.90%.
- An increase in both short term and long term sickness rates in April has contributed to the overall rise in the sickness rate this month. Short term sickness has increased from 2.89% last month to 3.04% and long term sickness has increased from 2.64% to 2.86%.
- "S15 Chest & respiratory problems" continues to be the top reason for sickness in April and this reason equates to 39.9% of the overall sickness in the month. This is the sickness reason used for recording Covid related sickness.

Turnover

- The Trust has seen an increasing trend in turnover rates since December, however rates have remained relatively steady in April and turnover for the month is 15.67%

Major actions commissioned & work underway

- Terms of Reference developed for Cultural Review in ED. LTUC management team to send comms notifying staff about the review. B3sixty to commentce review once staff notified.
- HR policies being updated. Action plan in place for all policies past review dates to be reviewed by July 2022. ER Policies (Disciplinary, Attendance Management, Capability, Grievance) being revised.

e-Rostering

- A business case is in the process of being drawn up to commence phase 2 rollout. This will require the system to be rolled out to approximately 2000 further employees across the HDFT patch with a large proportion of the employees being based in community.

ESR MSS

- The second phase of the implementation will begin in May 2022 and will see the system rolled out to the remaining departments in the Trust.

NED and Associate NED

- Recruitment programme underway

BOARD SUMMARY
WORKFORCE MATTERS – MAY 2022

Matters of concern & risks to escalate

- Turnover figures from April 2022 will now be reported by FTE (not by headcount), following the alignment of Trust-wide reporting via the Manager Self Service system. This will a minimal impact on turnover comparison to previous months.
- The breakdown of turnover in April is 3.71% due to involuntary terminations and 11.97% due to voluntary terminations.
- LTUC and PSC Directorates have seen a decrease in turnover in comparison to the previous month
- The 'Additional Clinical Services' staff group has seen a further increase to turnover this month and remains the staff group with the highest turnover rate, which is 18.07% in April.

Appraisals

- The appraisal rate in April is 56.93% which has reduced from previous month of 63.92%.
- Non-Medical appraisal % = 55.99% (previous month 63.48%)
- Medical appraisal % = 68.00% (previous month 68.24%)

Major actions commissioned & work underway

Clinical Excellence Awards (CEAs)

- The 2018 – 2021 agreement relating to CEAs have concluded. The lack of agreement from BMA and NHSE has resulted in Employers having the flexibility of how the process will run for the 2022/2023 round. A task and finish group will be set up to work through this process which will then require JLNC approval and Board signoff

BOARD SUMMARY
WORKFORCE MATTERS – MAY 2022

Positive news & assurance

- Recruitment to HRBP and HR Advisor roles taking place during May
- HDFT and HIF have signed the Veterans Covenant and achieved the Defence Employer Recognition Scheme Silver award. In addition HDFT and HIF have registered with the Career Transition Programme and Forces and Families to advertise vacancies.
- Local Agreement is now in place detailing the Trust's mileage rates be increased by 10p per mile with effect from 1st March to 31st May 2022. Director team are due to consider a number of options to confirm rates beyond May 2022.
- Local Agreement developed to confirm the Trust will operate services on 2nd and 3rd June as it does on all public holidays

Decisions made & decisions required of the Board

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Andy Papworth
Date of meeting:	16th May 2022
Date of Board meeting this report is to be presented	25th May 2022

Summary of key issues

- We always start People and Culture Committee with a colleague update/story. Liza Layton joined to share her experience of working and applying for promotion in Theatres. She contrasted previous experience of applying for multiple positions without success and poor feedback, with more recent experience where feedback has been constructive with good support. Liza also shared positive views on the reciprocal mentoring programme and a much better "vibe" generally across the Theatres department.

- Helen Laird, Colleague Wellbeing Lead, updated on the approach to wellbeing support, which is a key part of the Trust strategy. We have recently changed EAP (Employee Assistance Programme) provider and would like to see better take-up rate by colleagues. Take-up will therefore be monitored via the committee, including quantitative and qualitative assessment, plus a lens on diversity.

- We received an update on ED (Emergency Department) security, where we have listened to colleague feedback and put in place dedicated security staff. This is part of a broader package of measures including de-escalation training which we are monitoring. Colleagues are also being reminded to record incidents via Datix so that themes and trends can be tracked.

- The Chief Operating Officer updated verbally on the output from the culture review in Theatres. A comprehensive list of recommendations is being taken forward and we discussed lessons learnt. The output and actions will be shared with colleagues in Theatres.

- Following up on an action from the last meeting, we discussed Trust data on disability disclosure. It was identified that a proportion of colleagues (13.5%) do not currently declare whether or not they have a disability. The committee felt it was important to get underneath this and to encourage declaration. We also discussed the importance of having a workforce representative of the communities we serve and some benchmarking will be done on this to enable us to assess the right ambition.

- We received an update from Charly Gill, our Freedom to Speak Up Guardian. The speak up policy has been relaunched and there are now 43 FTSU Champions. The

committee asked about coverage of the champions across the service and in terms of diversity, and this will be brought back to the next meeting.

- We covered another comprehensive update on the People Plan, including:
    - Staff survey (which had also been covered at the recent Board meeting). Our discussion focused on assurance that actions are being followed up, both locally and Trust-wide, whilst also avoiding action "overload". There had also been a discussion at SMT on this.
    - Exit interviews and the recent launch of a new, simpler approach with 'Great with Talent'. Thus far, 16 out of 83 leavers had responded. We will receive a further update on this at our next meeting.
    - Line manager webinars, which are proving popular.
    - Training, where the current compliance is 77% (85% mandatory and 72% role specific) versus a 95% target. An action plan is in place to improve this but we will also raise the issue with Quality Committee for awareness.
- Krishna Kaur, our Equality, Diversion and Inclusion lead, gave an update on the staff networks. The main focus is on recruitment, with a number of gaps in chair, secretary and treasurer roles. The team would also like to have Executive sponsors for each network - this will be discussed at SMT.
- Finally, we received and discussed the latest Inpulse survey results and analysis, which is proving hugely useful as a feedback tool. Key highlights from this survey which focused on Integrity are:
    - Response from 1080 colleagues (last time 1029).
    - 56 teams received team level data enabling local insight and action (last time 53 teams).
    - Segmentation is now available by professional role.
    - A more positive culture (37% positive vs 31% last time and 24% first survey); and a less negative culture (40% vs 45% last time and 52% first time). These are encouraging signs which would not have been visible without Inpulse.
    - Key priority areas from improvement are: 1. Workload, 2. Resources, 3. Working Environment, and 4. Wellbeing support. This triangulates with feedback from the staff survey, verbatim comments and other feedback (e.g. Non Exec Director visits).
    - There will a further discussion on this with the Board in the June workshop.
- Ian Barlow observed the meeting and fed back on the quality and usefulness of discussion.

Any significant risks for noting by Board? (list if appropriate)

- Quality Committee to be sighted on the position with mandatory and role based training, given below target.

Any matters of escalation to Board for decision or noting (list if appropriate)

None

Integrated Board Report - April 2022

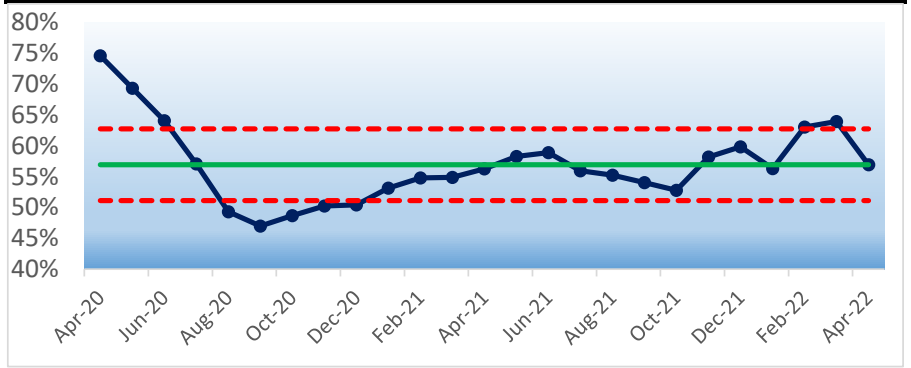
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-22
Value / RAG rating	56.9%

Indicator description

The number of staff who had an appraisal within the last 12 months. The Trust aims to have 90% of staff appraised.

SPC chart



Narrative

The appraisal rate in April is 56.9% which has reduced from the previous month of 63.9%.

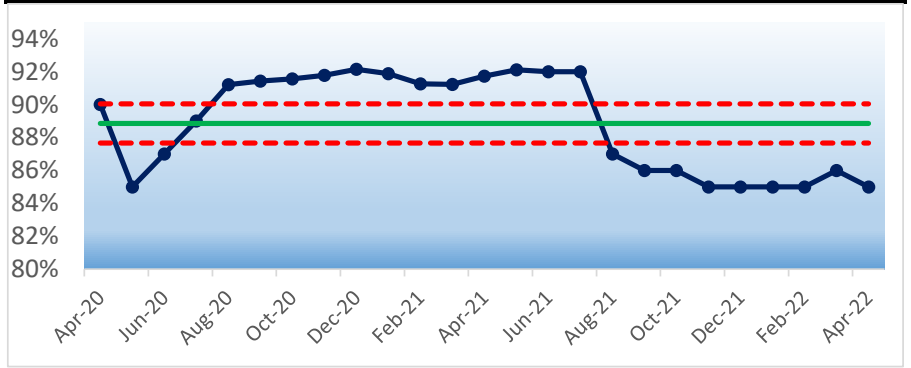
- Non-Medical appraisal % = 56.0% (previous month 63.5%)
- Medical appraisal % = 68.0% (previous month 68.2%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-22
Value / RAG rating	85.0%

Indicator description

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

SPC chart



Narrative

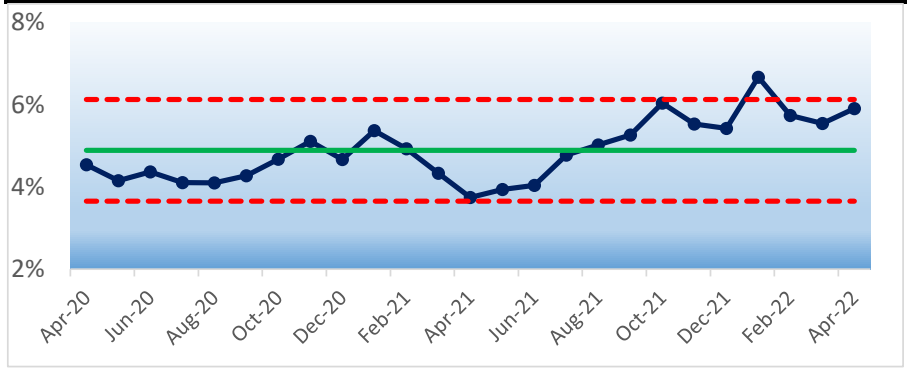
The data shown is for the end of April for the Mandatory Core elements of training. The overall training rate for substantive staff is 85% and has decreased by 1% since the previous month. The overall compliance for Mandatory core and mandatory role based training is currently 77% and has remained the same since the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-22
Value / RAG rating	5.9%

Indicator description

Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%.

SPC chart



Narrative

Sickness remains high in April and has seen an increase this month to 5.9%. Excluding Covid related sickness, the Trust's sickness rate is 3.8% which is below the Trust's threshold of 3.9%.

An increase in both short term and long term sickness rates in April has contributed to the overall rise in the sickness rate this month. Short term sickness has increased from 2.9% last month to 3.0% and long term sickness has increased from 2.6% to 2.9%.

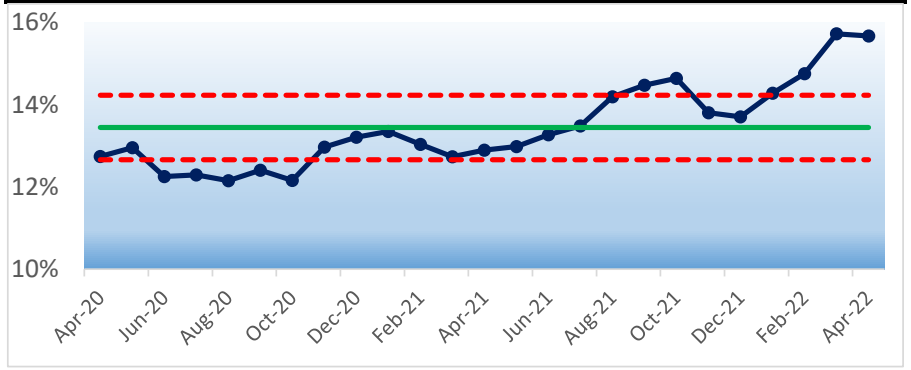
"S15 Chest & respiratory problems" continues to be the top reason for sickness in April and this reason equates to 39.9% of the overall sickness in the month. This is the sickness reason used for recording Covid related sickness.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-22
Value / RAG rating	15.7%

Indicator description

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

SPC chart



Narrative

The Trust has seen an increasing trend in turnover rates since December, however rates have remained relatively steady in April and turnover for the month is 15.7%. Turnover figures from April 2022 will now be reported by FTE (not by headcount), following the alignment of Trust-wide reporting via the Manager Self Service system. This will have a minimal impact on turnover comparison to previous months.

The breakdown of turnover in April is 3.7% due to involuntary terminations and 12.0% due to voluntary terminations.

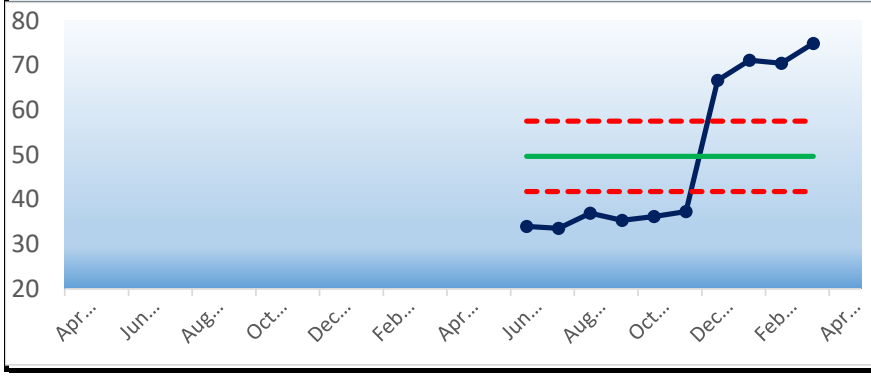
LTUC and PSC Directorates have seen a decrease in turnover in comparison to the previous month. The 'Additional Clinical Services' staff group has seen a further increase to turnover this month and remains the staff group with the highest turnover rate, which is 18.1% in April.

Indicator	**4.5 - Children's Services - 0-19 Services - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Mar-21
Value / RAG rating	74.94

Indicator description

The chart shows the total number of vacancies across all localities of the Trust's 0-19 Children's Services. This data is provided a month in arrears.

SPC chart



Narrative

Vacancies of Health Visitors and School Nurses within the 0-19 Children's service have increased in March. The 0-19 Children's service is holding monthly workforce meetings and has an action plan in place to reduce the number of vacancies and ensure they do not rise. The next targeted campaigns for community will take place in June as well as an event on the 7th July to specifically target the 0-19 service.

Indicator	**4.6 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

Narrative

SPC chart

Indicator	**4.7 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

BOARD SUMMARY
OD MATTERS – MAY 2022

Matters of concern & risks to escalate

Mandatory training compliance:
Mandatory Core 85.59%
Role Specific – 72.19%
Trust Overall 77.21

RPIW action plan.
Compliance recovery plan awaiting approval.
Additional e-learning packages.
Addition of pre-assessments to mandatory roles. Follow up procedures re-introduced "post-COVID"
Additional training sessions are being delivered during out of hours ie evenings and weekends.
E-learning content is being delivered.
Training in using dashboard on Learning Lab to be provided on a regular/weekly basis in short webinar form.
L&D team to provide reporting to line managers until 30 September to allow transition period whilst line managers become familiar with Learning Lab.

Medical Devices post vacant.
Limited training available - Theory compliance 76.5%.
Practice Educators delivering training.
- Remedies

Mandatory Training Lead working with reps o arrange in house training and link trainers. 5 e-learning packages agreed at patient safety forum.
Role to be recruited to.

Major actions commissioned & work underway

- **Equality Impact Assessments** in terms of policy, process and training is nearing completion for launch in June to enable new service/policy/planning developments to be reviewed appropriately around inclusivity in relation to the 9 protected charactertistics.
- **National staff survey** – directorates have received their directorate level data, and are asked to review and develop local actions. Directorate OD/CDs to present their feedback to the Board of Directors at the workshop on 29 June. The communications plan is attached.
- **Inpulse Survey** – the results for the Integrity Survey are now available and line managers are reviewing their feedback and work with their teams to demonstrate listening and you said/we did solutions
- **NICE guideline on Mental Health at Work** – our assessment of our services in this regard is underway, to be finalized during June.
- Work is being carried out by the OH &WB service in partnership with the Operational HR to develop a **mental wellbeing support package for colleagues** undergoing management processes.

BOARD SUMMARY
OD MATTERS – MAY 2022

Matters of concern & risks to escalate

Insufficient Education room capacity to meet organisational need: mandatory training, recruitment education arrangements (ie OSCE for International Nurse Recruitment), medical education

Remedies:

Out of hours use of the education centre (Evenings and weekends), where possible.

Proposal for interviews and meeting bookings to be reduced from 1 month in advance to 1 week.

Funding external space where education quality is not compromised (ie didactic sessions).

Creation of in-house e-learning packages. MS Teams sessions wherever possible.

low compliance with Medicines Management

The actions taken provide:

- More accessible training
- More realistic training time commitment
- More relevant training
- E-assessment provides increased assurance

Major actions commissioned & work underway

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BOARD SUMMARY
OD MATTERS – MAY 2022

Positive news & assurance

Induction:
Induction has been re-launched in April 2022 for all colleagues and managers across HDFT and HIF. All colleagues are enrolled onto a face-to-face values based induction providing new starters with a compassionate and inclusive introduction to the Organisation.

The local induction checklist (LIC) has been updated to include a THRIVE conversation as part of induction to ensure all support is in place to get new starters off to a flying start.

Feedback for the induction has been overwhelmingly positive.

Pathway to Management – the newly launched programme has been run, with positive feedback. This programme delivers tangible manager skills such as HR processes, recruitment, appraisal, THRIVE, Manager self service, effective communication and much more.

A new in-house **Employee Assistance Programme (EAP) provider Vivup** has replaced the previous provider Workplace Options. The service commenced on the 1st April 2022 with a "soft launch". A formal launch of the EAP Vivup is planned to take place in May 2022. The service offers access for all employees to 6 sessions of face to face or remote counselling, 24/7 telephone help and advice, an extensive range of self-help workbooks and resources and staff retail and service savings

Decisions made & decisions required of SMT

2021 National Staff Survey –Communications Plan

Event	Date(s)	Format	Who		Update	Completed
Director Team	03/03	Verbal update	Shirley Silvester			√
People & Culture Committee	14/03	Report of results	Shirley Silvester			√
Embargo lifted	**30/03**					
SMT	21/04	Report of results from QH for review	Quality Health			
Board of Directors	27/04	Report of results from QH for review	Quality Health			
Draft Trust-wide Implementation Plan/You Said We Did	20/05	Draft Trust-wide Implementation Plan/You Said We Did to be developed by Staff Survey Working Group Linkage to Inpulse Survey Results	A Callow NLangdale C Gill Staff Network Chairs OD's	Suzanne Lamb Sharon McKenna HONs Sarah Sherliker Lynda Fussell Krishna Kaur		
Partnership Forum	20/04	Up-date on Staff Survey Results	Shirley Silvester			
LNC	26/04	Update on Staff Survey Results	Angela Wilkinson			
Directorate Level reporting	30/04	Detailed Directorate Departmental breakdown reports produced and issued	Shirley Silvester/Lee-anne Hutchison			
Directorate Level review and You Said/We did	By 31/05	Directorate Implementation Plan/You Said We Did developed and Overall Trust actions aligned	Directorate Teams			
People & Culture Committee	16/05	Review of progress in developing Trust Wide Implementation Plan/You Said We Did	Shirley Silvester			
TeamTalk/Colleague Briefing	May/June	Review of results and Implementation Plan/You Said We Did	Angela Wilkinson			
Board of Directors Workshop	29/06	Review of Implementation Plan/You Said We Did at Directorate and overall Trust levels	Angela Wilkinson			

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	25th April, 4th May, 18th May 2022
Date of Board meeting this report is to be presented	25th May 2022

Summary of key issues

The Committee has met via Microsoft Teams and has been well attended. Steve Treece observed the 4th May meeting on behalf of the Council of Governors. Kim Betts, the new Internal Audit Manager succeeding Tom Watson, attended her first Committee meeting on 25 April.

25th April

This "informal meeting" for NEDs with the Acting Finance Director and colleagues and Internal Audit officers had been scheduled to provide members with a page-by-page briefing and opportunity to review the Trust's draft annual accounts prior to submission to NHSE/I. Members took the opportunity to seek clarification on a number of points, including so called "significant issues" within the draft accounts. Members received assurance on these matters

It was noted that the External Audit commentary on the accounts could not be provided until the current external audit services procurement exercise was complete.

The Committee noted that in a number of areas the accounts had been prepared on the basis of prudence with cautious estimates of income or expenditure being included where a level of doubt remained as to the likely position.

4th May

- **The Corporate Risk Register & Risk Review Meetings -** The Committee received an update on the management of corporate risks together with minutes of the Risk Review Group. It was noted that a number of risks have had the dates for the achievement of target ratings extended. It was reported that the Executive Risk Group is to consider adding new corporate risks in relation to data quality and themes and issues emerging from SI investigations. The receipt of approved minutes meant that the information supplied to the Audit Committee was inevitably dated and it was requested

that consideration is given to providing draft minutes or a summary report on the most recent decisions of the Risk Review Group.

- **Quality Committee Minutes -** The chair of the Quality Committee spoke to the minutes of the most recent meetings. There were no matters arising relevant to the Audit Committee remit.

- **Gifts and Hospitality –** the Committee received a verbal update on queries raised on a previous report. It was apparent that some refinement of the guidance to staff in relation to the position of private limited companies owned or part owned by staff members might be helpful and be mentioned in any training provided.

- **Local Security Management Specialist's (LSMS) Annual Report and 2022/23 Workplan –** the Committee received and considered the LSMS annual report on the 2021/22 year. It was noted that site visits to advise on and assess security issues had now resumed. This was welcomed. There was some discussion of the level of reporting and access to reporting systems in community and 0-19 services where there seemed to be few recorded incidents or concerns in 2021/22. A trial involving the provision of onsite security staff in ED was noted as well as progress with the provision of body worn cameras and additional training for staff. A reference to "absconders" in the report received some attention as did the level of reported incidents of violence and aggression towards staff. The work plan for the year ahead was approved.

- **Audit Committee Annual Report –** the Committee received and considered a draft annual report. The report was approved for submission to the Trust Board.

- **Trust Annual Report and Accounts –** An update was received confirming that matters raised at the accounts review meeting held on 25th April had been incorporated into the latest working draft documents. Draft accounts had been submitted to NHSE/I the day after the meeting achieving the required deadline. External audit work on the accounts was dependent on the appointment of a new provider. Final submission of accounts was anticipated around 22 June and the submission of audited accounts in October in line with an extension in the timeline agreed for the Trust by NHSE/I arising from the delay in appointing an external audit partner. This was an issue impacting on a number of NHS Trusts in the current year and not unique to HDFT. It was also noted that at the time of the meeting the Head of Internal Audit Opinion could not be provided. This was due to the number of incomplete audits and outstanding recommendations. Work was underway with some urgency to reach a position where the Opinion could be completed. An additional Audit Committee meeting was agreed to take place at the end of May or the beginning of June by which time it was anticipated that completed reports and a final Opinion could be provided.

- **Internal Audit Reports –** The Committee received four final reports, two offering significant assurance and two limited assurance. In the case of the limited assurance reports it was confirmed that remedial action was either planned or underway.

- **Implementation of Outstanding Audit Recommendations** - The number of incomplete audit report recommendations was considered. This continued to be a cause for concern. The data presented was felt to be somewhat out of date and a more up to date report would be presented at the next meeting of the Committee.

- **HIF Internal Audit Progress Report –** the Committee noted that there had been limited progress made with delivery of the HIF audit plan. Two reports were currently in draft, but work was being done to accelerate the delivery of expected/essential reports. The issues leading to slow progress in HIF were similar to those which had impeded delivery of the Trust internal audit programme over the last two years.

- **Appointment of External Auditors -** The Committee received an update on the procurement of an external audit services partner. A potential provider has been identified and could be commissioned via a framework arrangement. It was anticipated that an update on this procurement would be provided to the Governors so that a decision to appoint could be considered by the Council of Governors in due course.

- **Staffing –** it was noted that there had been significant staffing changes impacting on the audit function in recent months with an Acting Finance Director in post, a new Head of Internal Audit and a new Internal Audit Manager taking up post and the transfer of secretarial support to the Committee from Audit Yorkshire to the Trust's Executive support team.

- **Post Project Reviews** – the Committee received an update report on progress of the Post Project Evaluation process which did not appear to have been fully restored to the expected level as yet.

- **Single Tender Actions** – the Committee received notice of a small number of single tender actions. Some of these reports related to purchases made in 2020 and 2021 but were only now being reported to the Committee as more normal administrative arrangements interrupted by the pandemic were progressively restored.

- **NHS Resolution Claims** – the Committee was asked by its Governor observer where in the Trust's governance structure NHS Resolution claims were monitored and assessed. It was confirmed that these were recorded and considered within the remit of the Resources Committee (costs) and the Quality Committee (links to SIs and learning). Insurance was provided through national systems.

18th May 2022

This meeting will take place after the deadline for the submission of reports for the May Trust Board Meeting. The Committee Chair will provide a brief verbal report on the meeting to the Board with a written note being included in the papers for the July Board meeting.

The Committee will meet next on 31st May (additional meeting) and 7th September 2022.

Any significant risks for noting by Board? (list if appropriate)

1. Matters related to the appointment of an external audit services provider.
2. Continuing issues and concerns in relation to the delivery of the internal audit programme in both the Trust and HIF.

Any matters of escalation to Board for decision or noting (list if appropriate)

None.