Board of Directors Meeting (Public)
will be held on Wednesday 27th July 2022 from 9.00am – 1.00pm
To Be Held at the Pavilions, Harrogate

AGENDA

The agenda and papers are made available on our website and in due course the minutes of this meeting will be published.

All items listed in blue text (throughout the agenda), are to be received for information/ assurance and no discussion time has been allocated within the agenda. These papers can be found in the supplementary pack.

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 25th May 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	Verbal	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	Supplementary pack	
SECTION 3: Strategy & Partnerships					
3.1	**Board Assurance Framework**	Chair	Note	Supplementary pack	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 – 27th June 22 and 25th July 2022***	Quality Committee Chair	Note	Verbal	10.00
4.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Discuss/ Note	Supplementary pack	

4.3a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	
4.3b	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	
Comfort Break (10.45 – 11.00)					
4.4a	**Medical Director Report**	Medical Director	Note	**Attached**	11.00
4.5	**Infection, Prevention & Control BAF and Work Plan**	Medical Director	Note	**Attached**	
SECTION 5: Use of Resources and Operational Performance					
5.1	**Resource Committee Chair's Reports – 27th June 22 and 25th July 2022***	Resource Committee Chair	Discuss/ Note	Verbal	11.25
5.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	Supplementary pack	
5.3	**Director of Finance Report**	Finance Director	Discuss	**Attached**	
5.4	**Chief Operating Officer's Report**	Chief Operating Officer	Discuss	**Attached**	
5.5	**Workforce Report and Organisational Development Report**	Director of Workforce and Organisational Development	Discuss	**Attached**	
SECTION 6: People and Culture					
6.1	**People and Culture Committee Chair's Report – 11th July 2022**	Committee Chair	Note	**Attached**	12.20
6.2	**Integrated Board Report –** Indicators from Workforce Domains	Executive Directors	Note	Supplementary pack	
SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Reports – 31st May 2022**	Committee Chair	Note	**Attached**	12.30
7.2	**Annual Governance Timetable**	Finance Director	Note	Verbal	
7.3	**Use of Trust Seal**	Associate Director Quality & Corporate Affairs	Note	Supplementary pack	
8.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/	Verbal	12.50

			Approve		
9.0	**Board Evaluation**	Chair	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 28th September 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 27th July 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
Emma Edgar	Clinical Director (Long term & Unscheduled Care)	No interests declared		
Matt Graham	Director of Strategy	September 2021 April 2022	Date Date	1. Director Governor (Chair of Finance & Premises Committee) – Malton School 2. Stakeholder Non-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)
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	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	March 2022	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018 January 2022 April 2022	Date Date Date	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Member of the Association of Directors of Children's Services 4. Member of Society of Local Authority Chief Executives 5. Local Government Information Unit Associate 6. Fellow of the Royal Society of Arts 7. Stakeholder Non-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)
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	Associate Director, Quality & Corporate Affairs	Familial relationship with Director in NHS England

Directors and Attendees
Previously recorded Interests – For the 12 months period pre July 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)
Jordan McKie	Deputy Director of Finance (Until March 2022)	No interests declared		
Richard Stiff	Non-Executive Director		December 2021 February 2022 February 2022	1. Director and Trustee of TCV (The Conservation Volunteers) – ceased December 2021 2. Local Government Information Unit (Scotland) Associate – LGIU has now fully merged with LGIU listed as current interest 3. Chair of the Corporation of Selby College – dissolved 28 February 2022 when it became part of the Heart of Yorkshire Group.
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	April 2017	March 2022	Director of Shepherd Property Ltd

Board of Directors Meeting - Public
Wednesday, 25th May 2022 from 9.00am – 1.30pm
At the Pavilions, Harrogate

Present
Sarah Armstrong, Chair
Jonathan Coulter, Chief Executive
Russell Nightingale, Chief Operating Officer
Matt Shepherd, Chief Clinical Digital Information Officer (CCDIO), Deputy Chief Operating Officer
Jeremy Cross, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Wallace Sampson OBE, Non-executive Director
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Jacqueline Andrews, Executive Medical Director
Matthew Graham, Director of Strategy
Jordan McKie, Acting Director of Finance
Emma Nunez, Director of Nursing, Midwifery and Allied Health Professionals and Acting Deputy Chief Executive
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Emma Edgar, Clinical Director for Long Term and Unscheduled Care Directorate (LTUC)
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate (PSC)
Natalie Lyth, Clinical Director for Community and Children's Directorate (CC)
Kate Southgate, Associate Director of Quality and Corporate Affairs
Louisa Bollon, Corporate Governance Officer (minutes)

Observing
Four observers were present at the meeting: 1 Public Governor, 1 journalist and 2 members of the public, both from recruitment agencies.

Item No.	Item
BD/05/25/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting.
1.2	Apologies were received from: Charly Gill, Head of Nursing Long Term and Unscheduled Care Directorate.
1.3	Sarah welcomed all Board members, including for her first meeting, Emma Edgar, and all guests.
BD/05/25/2	**Patient Story**
2.1	Heather Stuart joined the Board to present a Patient Story with permission from the family. The story related to a complaint around End of Life Care, and the reporting of the time of death and the certification of this, which can be confusing for families.
2.2	It was agreed by the Board that a Family's grieving goes beyond their experience in Hospital and the Trust should support families through the process. It was confirmed that Charlotte Rock and her team offer support to grieving families. It was noted that 60% of complaints relate to communications, and lessons learnt include keeping the family updated at all times and being honest, open and communicative in a compassionate way, recognising that there will be occasion when we could perhaps have done things better or handled things in a better way.

2.3	The Chair asked for thanks to be passed on to the family for allowing us to share their story.
BD/05/25/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	Updates to the Register of Interests were noted: Jonathan Coulter was no longer Interim Chief Executive of Harrogate Integrated Facilities (HIF); Sarah Armstrong is no longer a Director of (HIF) and has been appointed as HDFT Chair. Wallace Sampson is Chief Executive of Harrogate Borough Council, and Angela Wilkinson and Russell Nightingale are Directors of the Pathology Joint Venture.
3.3	It was further noted that Matt Graham is a Stakeholder Director for HIF, whilst three of Richard Stiff's declarations (The Conservation Volunteers, Local Government Information Unit and Corporation of Selby College) are ended.
3.4	Emma Edgar will be added to the register.
3.5	**Resolved:** The declarations were noted.
BD/05/25/4	**Minutes of the Previous Board of Directors meeting held on 30th March 2022**
4.1	A correction on Page 1 was noted - Long Term and *Urgent* Care, should read Long Term and *Unscheduled* Care.
4.2	**Resolved:** Subject to the above correction, the minutes of the last meeting held on 30th March 2022 were agreed as an accurate record.
BD/05/25/5	**Matters Arising and Action Log**
5.1	No open actions.
5.2	No matters arising.
BD/05/25/6	**Overview by the Chair**
6.1	The Chair thanked members of the Board, Governors and other colleagues who had taken part in the recruitment process to appoint her as Chair, with a special thanks to the previous Chairman for taking the time to spend with her giving an excellent handover.
6.2	The Chair noted she had attended 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'.
6.3	During the Chair's first few weeks in the role, the focus has been on the recruitment process for new Non-Executive Directors, and an associate Non-Executive Director. Interviews will take place in July.
6.4	The Chair is very much looking forward to working with our Council of Governors with a development session booked in early June. A recruitment process is under way for new Governors, with the hope to welcome new members later in the year.
6.5	The Chair also welcomed a newly appointed Stakeholder Non–Executive for HDFT and a new HIF Non-Executive Director.

6.6	**Resolved:** The Chair's report was noted.
BD/05/25/7	**Chief Executive Report**
7.1	The Chief Executive presented his report as read.
7.2	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. The current position in relation to Covid patients is that we have a much improved position. In addition, staff absence as a result of Covid has dropped from over 200 colleagues to the current position of around 70.
7.3	Ambulance handover pressures continue to be of concern across the system, with our handover performance being very good. Whilst there are a number of causes of the current pressures, it should be noted that this is not caused by a significant increase in people presenting at the Emergency Department, but is more a reflection of organisation of care throughout the departments and patient flow both into and, more crucially, out of hospital. In terms of actions within the organisation, we have approved and committed funding to a new ED streaming model, we are progressing with the recruitment plans, and we have recently undertaken a weeklong improvement event to improve flow through the hospital.
7.4	There is significant focus both regionally and nationally on the delivery of elective recovery, including the expectation of national and regional colleagues that the Collaborative of Acute Providers (CAP) is the vehicle through which elective care recovery will be delivered and overseen. The Board is aware, as part of our planning for 2022/23 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.
7.5	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. 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. We are in discussion with Darlington in respect of the future provision of services and how we work together to strengthen our partnership arrangements in that area.
7.6	A new process for SI (Serious Incidents) investigations is being introduced, including colleagues interested in taking on roles as lead investigators, with training offered. Additionally, we have introduced an internal SI committee to review SIs.
7.7	An initial report from our Health and Safety consultant has been received, with actions in a number of areas, including access to the Goods Yard, a review of our ligature assessment process, and use of Sharps bins. Advertising is currently underway for the necessary people to manage the service going forward.
7.8	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. In addition, we responded to the fuel cost increase by temporarily increasing the mileage rate for colleagues who travel as part of undertaking their work.

7.9	The Trust has received the national staff survey and our latest quarterly Inpulse survey that provides feedback about how our colleagues are feeling. 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.
7.10	Laura Robson asked whether any data is collected on the deterioration of patients while waiting for an ambulance, then also waiting in the ambulance outside the hospital to present in ED. The Chief Executive responded we do not currently collect any data of this kind and confirmed that Yorkshire Ambulance Service (YAS) are currently reviewing their working processes and we are looking at ways the Patient Transport Service (PTS) could provide additional support.
7.11	Wallace Sampson asked if we use surrounding Hospitals to help take patients if we have long wait times to offload in ED. The Chief Executive confirmed that we do work with other surrounding Hospitals and we have no restrictions on geographical areas, indeed we often take diverts from other Hospitals when they are busy. We will then repatriate patients back to their local Hospital as soon as fit to do so.
7.12	The Board has approved the Modern Slavery Statement.
7.13	**Resolved:** The Chief Executive's Report was noted.
BD/05/25/8	**Corporate Risk Register**
8.1	The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks.
8.2	It was noted that there is an increased risk around colleague wellbeing.
8.3	In relation to Autism assessments, which is still a risk, Maureen Taylor queried if other Trusts are feeling this same risk, and how long the waiting lists are. Natalie Lyth confirmed that other Trusts are feeling the same concerns around waiting times and that the service is commissioned at a set number a month of how many assessments take place. Some people are on the list for some time and currently the longest wait is 71 weeks.
8.4	**Resolved:** The updates were noted.
BD/05/25/9	**Board Assurance Framework**
9.1	The Chief Executive noted that with the development of the new Trust Strategy, a revised Board Assurance Framework (BAF) would be developed. The Chair also noted that from July 2022 the Sub-Committees of the Board would receive their relevant section of the BAF.
9.2	**Resolved:** The updates were noted.
BD/05/25/10	**Director of Strategy Report**
10.1	The Director of Strategy noted the final draft of the Trust Strategy has been agreed by the Directors team, with wider engagement with colleagues, Governors and external stakeholders is underway. It was noted that the completion of the Clinical Strategy will be delayed to align with management restructures.
10.2	HDFT have held a positive meeting with Harrogate primary care leads with agreed work streams on health inequalities and the care sector. Projects including Urgent and Emergency Care (UEC) and Elective work have been prioritised, plans to develop and embed continuous improvement are noted.

10.3	Anchor Institution is developing approaches to identifying patients and staff in the Armed Forces in the community. This is planned to coincide with a launch in June when Armed Forces Day takes place. In relation to Project SEARCH, Internships will be taking place from Sept 2022, a full update will be provided to the People & Culture Committee.
10.4	Wallace Sampson commented on the ambitions detailed on the Trust Strategy Framework, 'Person centred, integrated care strong partnerships' and felt this could be unnecessarily restrictive stating 'partnerships between local health and care organisations', suggesting that we should include partnerships in the wider community i.e. Police, Fire Brigade.
10.5	On reading through the report, Andy Papworth commented that he felt the wording around 'following recent revelations' on the 'Great Start in Life' slide could give the incorrect impression, particularly as Maternity services at Harrogate Hospital has a good reputation in the local community. As the slide refers to HDFT, it could potentially make people question what these 'recent revelations' were.
10.6	The Board granted the approval to share this Strategy.
10.7	**Resolved:** The Director of Strategy Report was noted.
BD/05/25/11 **11.1**	**Quality Committee Chair's Report** The Chair reports for the April and May 2022 meetings were noted and taken as read.
11.2	The committee had been assured that the whole discharge process is the focus of considerable work. Examples of integrated working were discussed alongside the recently published discharge policy. The philosophy of Home First and Right to Reside were discussed. Pressure on clinical services continues, and delays in discharge resulting in long stays for frail elderly people resulting in concerns for their clinical safety.
11.3	The ED improvement plan was detailed with the ongoing work in the department to address patient safety, Colleague wellbeing, complaints, culture and flow. The Department is under tremendous pressure largely because of flow throughout the hospital but work to bring about improvement in the department and to ensure the best possible care for patients is the focus of the improvement plan. The committee was assured that there is a good improvement focus and there is evidence of changes being made.
11.4	CCs directorate had highlighted some excellent news regarding the Podiatry service. They have been innovative in a number of areas particularly with regard to remote consultation and its use as an education tool. The Team have managed to recruit 5 new podiatrists when others are struggling to recruit. The team has also been requested to write some podiatry related guidelines for the Royal College.
11.5	Additionally, the Trust Home Environment Assessment Tool has been used by North Yorkshire Council to assess homes that are being made available for Ukrainian citizens coming to the county.
11.6	**Resolved:** The Board noted the content of the report.
BD/05/25/12	**Integrated Board Report**
12.1	**Resolved:** The Board noted the content of the report.
BD/05/25/13 **13.1**	**Director of Nursing** The Director of Nursing report was received and taken as read.

13.2	Expressions of interest had been received for the roles of Patient Safety Investigators and Team Leaders, training will commence at the end of May.
13.3	An Interim Health and Safety Manager has been appointed whilst the substantive recruitment process takes place.
13.4	The First Serious Incident Committee took place in early May.
13.5	The Peer Review Well Led Assurance programme received a positive initial evaluation.
13.6	Nurse Staffing fill rates were noted as having 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.
13.7	An increase had been seen in Pressure Ulcers across inpatient and community services. This correlates with reduced fill rates and care hours per patient day (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. Further detailed analysis of Pressure Ulcer and Falls incidents is underway understand the impact on those patients with a longer length of stay.
13.8	Following completion of the second Safer Nursing Care Tool (SNCT) data, it was noted that the next collection date will be September / October and the Board agreed for this to be assessed quarterly, with regular reports received by Board.
13.9	**Resolved:** The Board noted the content of the report.
BD/05/25/14 **14.1**	**Ockenden Report** The Director of Nursing presented the final report from the Ockenden review of maternity service at Shrewsbury and Telford Hospital NHS Trust (SaTH) which had been published on the 30th March 2022.It was noted that 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. The final report identifies several new themes to be shared across all maternity services in England with a further 15 immediate and essential actions.
14.2	**Resolved:** The Board noted the content of the report.
BD/05/25/15 **15.1**	**Strengthening Maternity and Neonatal Safety** The Director of Nursing presented the report, which was taken as read.
15.2	It was noted that 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.
15.3	**Resolved:** The Board noted the content of the report.

BD/05/25/16	**Continuity of Care Plan**
16.1	The Director of Nursing presented the report which was taken as read.
16.2	The national ambition is for Midwifery Continuity of Carer (MCoC) 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.
16.3	**Resolved:** The Board noted the content of the report.
BD/05/25/17	**Freedom to Speak Up (FTSU) update**
17.1	The FTSU update report had been received and was taken as read.
17.2	The Board noted that the interim FTSU Guardian is Charly Gill, who is covering maternity leave of the substantive post holder. Leza Layton is the Associate Guardian and there is currently a vacancy for a second Associate Guardian.
17.3	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.
17.4	A relaunch and rebrand of FTSU at HDFT is underway, to include the FTSU role in the current work on the organisational culture, values and behaviours. A project plan is in place, and progress will continue to be reported to the Board.
17.5	A concern was raised about the rebranding of Freedom to Speak Up (FTSU) to become 'Listening at Our Best', as this is a well-established and known slogan and changing it may cause confusion and hesitation in colleagues to use this service.
17.6	**Resolved:** The Board noted the content of the report.
BD/05/25/18	**Safer Nursing Care Tool**
18.1	The organisation undertook its second adult inpatient safer staffing review using the licenced Safer Nursing Care Tool (SNCT) over a four-week period crossing February and March 2022.
18.2	**Resolved:** The Board noted the content of the report.
BD/05/25/19	**Guardian of Safe Working (GoSW)**
19.1	The quarterly report from the GoSW had been circulated and taken as read. Dr Matthew Milsom attended to present the information. .
19.2	Issues around persistent overworking of juniors outlined in this report were noted, as was the pressure on staffing across the organisation. The GoSW asked the Board to consider whether medical workforce sustainability should be included on the Trust Risk Register.
19.3	It was noted that Health Education England are undertaking a "deanery visit" on 24th May, to assess the trust, triggered by the exception reports submitted previously and feedback through alternative mechanisms (GMC survey/BMA). It was further noted that issues in Same Day Emergency Care must be addressed prior to the next cohort on 1st August 2022.

19.4	Dr Milsom reported that feedback from the Junior colleagues shows that all other aspects of the training is good.
19.5	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.
19.6	A concern was raised that Datix is being used as a threat to the juniors, who are being told a Datix will be put in if they do not come and see a patient. In response, Emma Nunez commented that though there had been no noticeable rise in Datix's received, Executives do have this in mind, and this is not an appropriate use of the Datix system.
19.7	Jackie Andrews highlighted the need to let Juniors know they can tell us these things, we cannot act upon things that have not come to our attention.
19.8	The Chair thanked Dr Matthew Milsom for undertaking this role.
19.9	**Resolved:** The Board noted the content of the report.
BD/05/25/20 **20.1**	**Medical Director Report** The Executive Medical Director noted the content of her report.
20.2	The Board noted that a Showcase event is planned for June 8th, which will celebrate the work of junior doctors and dentists, doctors and dentists in training, Specialty and Associate Specialist (SAS) doctors and dentists, Advanced Clinical Practitioners (ACPs) and Physicians Associates (PAs). It was highlighted that HDFT had been the top recruiting site for NIHR IMID BioResource research study last month with 100 patients.
20.3	It was reported that systems are now in place for electronic appraisal, job planning and annual leave management. Market testing for the medical E-rostering system and the Digital Aspirant Programme for Electronic Health Records is being undertaken.
20.4	The Board noted that Cybersecurity threats remain at high level.
20.5	It was confirmed that Yorkshire and Humber (Y&H) Health Education England (HEE) are to visit Surgical SDEC following surgical trainee feedback.
20.6	Thanks were noted to Julia Roper, Consultant Quality Governance Manager for all her support over the last 6 months.
20.7	**Resolved:** The Board noted the content of the report.
BD/05/25/21 **21.1**	**Learning from Deaths Quarterly Report** The Executive Medical Director noted the content of the report. Laura Robson further confirmed that the report had also been discussed at Quality Committee.
21.2	Standardised mortality rates continue to be rising since mid-2021. No immediate cause has been identified but further investigation is continuing.
21.3	It was noted that fourteen structured judgement reviews have been undertaken since the last report.
21.4	The Board noted that 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.

21.5	The HDFT Medical Examiner team continues to perform well when benchmarked against regional data.
21.6	Laura Robson queried if we have 'hospice at home' care? The Executive Medical Director confirmed this, but commented that the Trust could be better connected to Hospice Care.
21.7	It was noted that a business case throughout North Yorkshire, "Gold Line", which provides 24 hour support for the terminally is being supported by the CCG.
21.8	**Resolved:** The Board noted the content of the report.
BD/05/25/22	**Resource Committee Chair Report**
22.1	The Chair of the Committee noted his report, which was taken as read.
22.2	The Committee had received comprehensive updates to the financial position at the end of the year, and noted the proposed appointment of the external auditors. The capital plan and Salix work were also highlighted, as were vacancy levels, and the performance issues for ED.
22.3	**Resolved:** The Board noted the content of the report.
BD/05/25/23	**Integrated Board Report**
23.1	**Resolved:** The Board noted the content of the report.
BD/05/25/24	**Director of Finance Report**
24.1	The Director of Finance presented his report as read.
24.2	The Board's attention was drawn to two areas: the levels of Agency spend in a number of areas; and that the Trust's cash position remains positive.
24.3	It was further noted that the Trust Accounts had been submitted to NHSE/I within national timescales, new external auditors are in the process of been appointed.
24.3	**Resolved:** The Board noted the content of the report.
BD/05/25/25	**Chief Operating Officers Report**
25.1	The Chief Operating Officer presented the report as read.
25.2	The Board's attention was drawn to the ambulance handover information, particularly that the Trust had no 60-minute ambulance handover breaches in April, and that 96% of ambulances were offloaded in under 15 minutes, which put us in the top 10 nationwide. The Trust has also continued to support York District Hospital with acute patient diverts when required.
25.3	Adult Community service continues to be very pressured due to increased complexity of caseloads and high vacancy rate, sickness and COVID challenges.
25.4	It was reported that the 0-19 Service is in line with OPEL 2/3 level.
25.5	The Board noted that demand for safeguarding remains high within 0-19 and specialist safeguarding teams, capacity is being impacted due to staff absence, whilst statutory responsibilities are being delivered.
25.6	A proposal has been agreed to utilise Duchy Hospital to deliver further treatment capacity across 2022/23.

25.7	**Resolved:** The Board noted the content of the report.
BD/05/25/26 **26.1**	**Statement – eliminating mixed sex accommodation** The Chief Operating Officer gave a verbal update, and confirmed that there had been no breaches since 2018.
26.2	**Resolved:** The Board noted the update.
BD/05/25/27 **27.1**	**Workforce Report** The Director of Workforce and OD presented her report as read.
27.2	In relation to 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 the community.
27.3	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%.
27.4	Low appraisal rates were noted, and it was confirmed that though appraisals were halted during the pandemic, the process has now been reinstated.
27.5	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, Forces, and Families to advertise vacancies within the Trust.
27.6	A Local Agreement is now in place detailing that the Trust's mileage rates be increased by 10p per mile with effect from 1st March to 31st May 2022. It was noted that the Director Team would consider a number of options to confirm rates beyond May 2022.
27.7	It was confirmed that the Trust will operate services during the Jubilee Bank Holidays on2nd and 3rd June 2022, as it does on all public holidays.
27.8	**Resolved:** The Board noted the content of the report.
BD/05/25/28 **28.1**	**People and Culture (PCC) Chair's Report – 16th May 2022** The Committee Chair for PCC presented his report as read.
28.2	The Board noted that an action plan is in place to improve training rates, which are currently running at compliance of 77% (85% mandatory and 72% role specific) versus a 95% target. This information will also be shared with the Quality Committee.
28.3	An update had been received on ED (Emergency Department) security, which is part of a broader package of measures including de-escalation training
28.4	In relation to 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 had felt it was important to encourage declaration.
28.5	The Board noted that the Inpulse survey results and analysis were discussed.
28.6	**Resolved:** The Board noted the content of the report.
BD/05/25/29	**Integrated Board Report**
29.1	**Resolved:** The Board noted the content of the report.

BD/05/25/30	**Organisational Development Report**
30.1	The Director of Workforce and OD presented her report as read.
30.2	It was confirmed that that all Directorates had received the data from the National staff survey, and had been asked to review and develop local actions. Feedback will then be presented to the Board of Directors at their Workshop on 29th June.
30.3	The results for the Integrity Survey are now available and line managers are reviewing their feedback.
30.4	NICE guidelines on Mental Health at Work have been reviewed, an assessment of the Trust services will be finalised in June.
30.5	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.
30.6	Face to Face Induction has been re-launched in April 2022 for all colleagues and managers across HDFT and HIF. The local induction checklist (LIC) has been updated to include a THRIVE conversation as part of induction to ensure all support is in place.
30.7	The newly launched Pathway to Management 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.
30.8	A new in-house Employee Assistance Programme (EAP) has replaced the previous provider Workplace Options. The service provided by "Vivup" commenced on the 1st April 2022 with a formal launch 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.
30.9	**Resolved:** The Board noted the content of the report.
BD/05/25/31	**Audit Committee Chair's Report**
31.1	The Chair of the Committee presented his report from meetings held on 25th April and 4th May as read. A verbal update was provided by the Chair from the meeting held on 18th May 2022 with a written update to be provided at the next Board meeting.
31.2	The Committee had noted the risks connected with the appointment of the external auditors and the limited progress made with delivery of the HIF audit plan.
31.3	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.
31.4	**Resolved:** The Board noted the content of the report.
BD/05/25/32	**Senior Management Team Report**
32.1	**Resolved:** The Board received a verbal update from the Chief Executive, and noted that all key points had been included during the Board meeting.
BD/05/25/33	**Any Other Business**
33.1	None.

BD/05/25/34	**Board Evaluation**
34.1	The Chief Executive noted the meeting had been productive with openness to discussions, and thanked colleagues for responding to difficult discussions with a professional attitude.
BD/05/25/35	**Date and Time of the Next Meeting**
35.1	The next meeting will be held on Wednesday, 27th July 2022.
BD/05/25/36	**Confidential Motion**
36.1	**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)
27th July 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 in May 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)
JULY 2022

CHIEF EXECUTIVE'S REPORT

Introduction

1. The health and care system continues to operate under enormous pressure, and HDFT is not immune to the challenges that all our facing at the moment. We are now in mid-July, and the acute pressures, the bed occupancy, the community services workload are all greater than you would often experience in mid-January.

2. I will outline some of the key issues through this report, and colleagues will have further detail within individual reports, but I must start by simply expressing my thanks to all colleagues for continuing to deliver care and support to our patients and population in difficult times. It is important to recognise the brilliant things that many are doing to improve services, and support colleagues.

3. During the month of June and into July, we have experienced a significant spike in people in hospital who are CoVid positive. We have currently over 35 people in hospital with CoVid, and whilst the severity of the illness is reduced due to vaccine uptake, the infection control measures that we have had in place result in flow through the hospital being more difficult. We have recently, therefore, amended our approach to managing patients with CoVid, and following risk assessment and input from IPC, we are managing patients within base wards so that patients can receive more appropriate care.

4. The increase in CoVid within the community has also had an impact upon staffing levels. We currently have around 80 colleagues off work, and this peaked in June at over 130, putting additional pressure on staff at a time of increased workload.

5. The guidance in respect of sick pay for people off with CoVid has now changed, and CoVid sickness is now treated and managed in the same way as any other sickness. This will have an impact upon a small number of colleagues who continue to suffer with long CoVid, and who will now move into our usual sickness management arrangements with the risk that after a defined period of time, their pay is reduced or ultimately ceases altogether. We are in dialogue with all colleagues affected by this change, but we need to recognise that this will be a difficult time for some.

6. Finally in respect of CoVid, we are now planning for our autumn CoVid booster and Flu vaccination campaign that will run from September.

7. There have been some communications from the national team in respect of ongoing priorities for the NHS. The focus continues to be on what are described as the "four R's", namely recovery (of elective and cancer care), resilience (of our urgent care system), respect (for our staff, our patients, and the taxpayer who funds the service), and reform (with new ways of working enhanced by digital developments). It is helpful to remember the focus of our services in this way, and reassuring that these are all areas that we spend our time on.

Urgent and Emergency Care

8. Urgent and emergency care provision continued to challenge ourselves and the system during June. Our 4 hour performance has continued to improve, and whilst it still remains below the standard we would want, it is now at 72%.

9. Despite the pressures locally, we continue to offer significant support to colleagues in other parts of our system, in particular York Trust. During June, in line with previous months, we had numerous ambulances diverted to the Harrogate site, which resulted in on average around 15 additional beds occupied by patients admitted as a result. This is absolutely the right response to system support, but we need to recognise the impact upon our colleagues who have to organise and arrange this care. Given the regularity of the divert requests, we are discussing a more planned response that doesn't rely upon out of hours daily calls.

10. Ambulance handovers across the system continue to be a risk. We though, have very few ambulance handover delays, which is a credit to how we operate as an organisation.

11. As I have reported previously, 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.

12. We continue to 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. A system summit is being arranged for September to agree actions before the winter.

13. We are in regular dialogue with the York system and commissioners within that system in respect of the service provided through Selby Urgent Treatment Centre. This service supports the York urgent care system, and is of high quality, but the significant increase in the demand for the service has not yet been matched with sufficient resources to make our current provision sustainable in the medium term. All the necessary parties are engaged in this discussion as we seek a positive solution.

14. We have now agreed the business case and investment into our 'virtual ward' model of care to increase out of hospital capacity. This will now begin to roll out, and we will be assessing the impact of this service alongside other out of hospital capacity to maximise the benefits for our population.

15. We have submitted a bid for additional funding to increase capacity over the winter, and we should hear the outcome of this very soon.

Planned care

16. 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.

17. In respect of our plan to deliver additional elective activity, we are continuing to meet 12 out of 13 measures in our plan. We are reducing our longest waiters, and the HNY system has also managed to significantly reduce those waiting over 104 weeks which is excellent.

18. Despite the pressures on non-elective flow through the hospital, we have not cancelled any elective work throughout June. This is different from many organisations and the teams have worked well to maintain our activity levels.

19. Within the papers for today's private meeting, there is a paper in respect of the TIF2 scheme to increase our elective capacity on the hospital site. This has been developed very quickly in line with regional and national timescales, and will enable us to access c£14m of capital funding to develop our capacity and ability to increase elective work over the next few years.

0-19 services

20. We continue to experience pressure across our 0-19 services, with OPEL levels being 3 for most of the month of June in five of our service areas. We continue to support areas where it is difficult (largely caused by staffing challenges) by moving people from other areas within our catchment. The number of safeguarding strategies continues to be higher than in previous years.

21. As part of our integration of Northumberland services into HDFT we have now concluded our consultation with staff about the future service model and resulting staffing structure. We have now begun the implementation phase.

22. We continue to mobilise the transfer of the Wakefield service into HDFT. Informal greeting sessions have been held, welcome meetings with staff arranged, and discussions with Commissioners continues with a view to agreeing the contract and beginning the provision of the service from October. A significant amount of work is being undertaken by the team in order to ensure that we transfer the services safely and that we can provide the service to the families of Wakefield from October.

Quality and Safety

23. Three serious incidents have been declared in June and arrangements for investigation are in place in line with our process. The new approach to quality governance is being embedded, with weekly summits and a month SI committee in place to understand themes and encourage learning. Key messages are fed back to the whole organisation through Teamtalk each week.

24. Since our last meeting in May, we had a further two incidents within theatres. The response of the theatre team and Directorate colleagues was excellent, and we 'stopped the line' for

an afternoon to ensure that the whole theatre team could learn about the incidents and agree immediate changes to improve safety within the theatre service.

25. The Board will be aware of our risk in relation to Health and Safety. As we described at the last meeting, we received an initial report from our Health and Safety consultant and are taking action in a number of areas. We have now recruited to a Health and Safety manager - who previously worked with the Health & Safety Executive - who will be starting with us soon.

26. On the 7th June we had an Ockenden assurance visit to our maternity services. This visit went very well, and the external team were assured about the progress we have made (and continue to make) in respect of meeting the recommendations of the initial Ockenden report. The Board will be kept aware through this meeting about our maternity services and specifically our actions in respect of the final Ockenden report.

Finance

27. The system has submitted a balanced financial plan for the year, with all organisations planning to reach a break-even position. We have supported the system non-recurrently for this year, which has increased the challenge for ourselves, but we have not changed any operational budgets with Directorates.

28. As you will read within the finance report, the financial challenge is increasing (as it is across the NHS) and we are working collectively internally and externally to manage financial risk.

29. Work is beginning in respect of financial plans for 2023/24, with the expectation that this will be a more difficult year across the NHS in terms of resources. We will schedule some Board discussion in the early autumn to discuss our approach to future planning.

Workforce and wellbeing

30. As we are all aware, the biggest challenge facing the Trust and the NHS currently relates to people. Having enough skilled and motivated people is the key to providing services to our patients and population. As you will have heard from me before the key three things that would improve morale, wellbeing and reduce workplace stress are:

    - 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

31. These continue to be 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.

32. Following our Board workshop last month, we have taken the discussion in relation to ambition further, and have an SMT workshop on 21st July to explore further detail in respect of seven areas of work

    a. Widening access to our jobs

b. The supporting infrastructure for colleagues
c. Approach to recruitment controls
d. Workforce planning and establishments
e. Our training and development offer
f. Our approach to 'over recruiting'
g. Our flexible working offer

33. We will feed back to the Board through the People and Culture Committee the actions that we will put in place to deliver across these areas and increase the workforce supply to the Trust. This will help to address the issue of having people here as referenced above.

34. In terms of the environment for colleagues, we have agreed a series of schemes across the Trust that will improve the environment. These will be delivered over the next six months.

35. In terms of appreciation, a key element relates to pay and conditions, and in particular the impact of the cost of living crisis on colleagues. We have agreed a package of measures to support colleagues that we have discussed across the organisation and with Trade Union partners. This package includes continuing to support mileage costs for the rest of the year, not changing our current approach to parking, providing financial advice and access to discounts, reintroducing the staff shop, an option to exchange annual leave for pay, and confidential support for people in difficulty alongside availability of hardship grants in particular circumstances. Discussion with colleagues will continue to see whether there is any further support that we can reasonably offer to help people in difficult times.

36. The national pay award has been announced with the implementation of the new pay scales due in September. We await any formal response from Trade Unions. Alongside the announcement, guidance in respect of greater controls on agency rates was shared. We will assess the requirements, which includes greater regulatory scrutiny, and respond accordingly.

Other

37. There has been significant announcements in respect of funding to develop our EPR, and the EPRs of other trusts across the system. We will have a discussion later today about the opportunity that this presents and the arrangements that we will need to potentially put in place to oversee and deliver this.

Jonathan Coulter
Chief Executive
July 2022

Director of Strategy

Matters of concern & risks to escalate

PMO
- Elective: Leadership of Outpatient Transformation Project

QI
- New governance for culture improvement (At Our Best) not yet in place

Planning
- Awaiting outcome of RAAC survey of potential risks on HDH site.
- Re-start Wensleydale project group to develop BC (including clinical model, workforce; any work to vacated areas) for approval in Sep 22.

Major actions commissioned & work underway

Strategy
- Final design of Trust Strategy; 22/23 priorities identified

PMO
- **Caring at Out Best (Quality):** planning of Falls Prevention project commenced; following RPIW, pilots underway of digital and process solutions for follow up of clinical results
- **Elective:** TIF2 BC for approval at July SMT (on agenda)

QI
- Teamwork Inpulse Survey: 971 responses by 19 Jul (1080 in Apr survey)
- QI Programme: Theatre Productivity (planning)
- Development of a Leadership Forum

Planning
- ED Fit to Sit and Majors: layout, phasing agreed; tenders Aug, build Sep
- Gamma Camera: tender underway
- Wellbeing Works: working with HIF to deliver agreed works
- Wensleydale (23/24): design work progressing
- CT (23/24): feasibility study for radiology works to support new CT scanner

Business Development
- Planning for HHCC Christmas events: market & hampers
- Volunteer Thank You Events: Morpeth 5 Aug; HDH 11 Aug
- Planning for “KITE Awards” (colleague recognition awards & event)
- Wakefield 0-19 & Tees CIC mobilisations ongoing
- Northumberland 0-19 contract: 30 day consultation closed on 6 Jul; estates strategy roll-out

Positive news & assurance

Strategy
- Harrogate & District CDC workshop on 6 Jul

PMO
- TIF1: Good engagement with LTHT; joint workshop planned for Sep 22
- TIF2: Positive initial meeting with HBC planners

QI
- QI Events: Results of Clinical Investigations QI workshop completed
- New QI Team Accreditations authorised; 21 new Bronze QI Champions

Planning
- Dexa scanner installation completed

Business Development
- HHCC & HIF Newsletters published
- 3 volunteering pathways launched: standard, career enhancement, enhanced support

Decisions made & decisions required

Business Cases
- School Age Immunisations Service eConsent approved
- Virtual Ward: recommended for approval by Resources Committee
- Prioritisation of BC vs funding available (SMT Workshop)

Trust Board Report
Date: July 2022
Report: Executive Director of Nursing, Midwifery and AHP's
Author: Emma Nunez

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Nurse Staffing – (IBR 1.8.1 & 1.8.2) Staffing Fill Rates have seen a significant increase in the month of June as covid absences began to reduce, it is anticipated that this will reduce slightly in July due to most recent covid surge. Care Hours Per Patient Day has not increased at the same level as fill rates so work has commenced on accuracy of reporting however the occupancy/bed number position has required additional staffing from existing workforce and agency. • Pressure Ulcers – (IBR 1.1 & 1.2) have seen a decrease across inpatient services for June, however community have reported an increased number. This increase correlates with community services being at OPEL 4 with staffing sickness and vacancies, with reduced workforce across Social Care. • Falls – (IBR 1.3) slight increase in falls for the month of June. Falls nurse commences post in July to support areas of greatest need. Long length of stay is increasing falls risk, particularly for those patients awaiting ongoing community care packages.	Safer Nursing Care Tool - Preparatory work on 2 data collections for Safer Nursing Care Tool to understand overall impact of current calculations and additional roles Review of NMAHP competency frameworks to ensure sufficient training capacity to meet demand Bid submitted for International Recruitment of 60 nurses, also exploring international recruitment of AHPs Work ongoing to build 'escalation team' to stand up during times of extremis
Positive news & assurance	**Decisions made & decisions required of the Board**
• Incident Reporting – (IBR 1.6 & 1.7) continue to see increase in reporting with variations in types of incidents, however seen a decrease in Serious Incidents for the month of June. Serious Incident Committee running well, shared and thematic learning feeding into Learning Summit. Exec Safety Huddles commenced and Lessons Learned on Team Talk • Sepsis screening – (IBR 1.14 & 1.15)improvement in inpatient and emergency department position, continued focus for Matrons and Nursing Leadership Team • Complaints – (IBR 2.2.1 & 2.2.2) 70% performance against 95% standard. Have seen a reduction in number of complaints received which coincides with an increased quality of responses and also early engagement with patients and families under revised processes • Health and Safety Team recruited • Nurse staffing Agency cascade now in place • Increased student clinical placement capacity	

Harrogate and District NHS Foundation Trust

4.3

Strengthening Maternity and Neonatal Safety Report

Board of Directors

July 2022

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Danielle Bhanvra (Acting HOM), Andy Brown (Risk management Midwife), Kat Johnson (Clinical Director), Vicky Lister (Woodlands and SCBU Manager)

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 May 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 has improved following the successful recruitment of two specialty doctors, neither are entrustable at present and training continues for them both. The three entrustable middle grade doctors are covering nights and weekends with agency cover. A locum middle grade post has been advertised for six months.

6.2 Band 7 coordinators continue to be a concern as three coordinators are currently not working clinically. Recruitment for these posts continues

7.0 Recommendation

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

Maternity

Matters of concern & risks to escalate

- Preconception advice regarding folic acid and vitamin D
- Ascom devices not being used in Maternity and Paediatrics so not receiving automated Patientrack alerts and relying on bleep system
- Concern about legal position when supporting women choosing to give birth outside of guidance
- CO filter supply issues likely to be long term and IPC have not approved 'reusable filter' which is affecting CO compliance
- Growth Assessment Protocol training rates & lower rates of detection of the small-for-gestational age fetus compared with national average
- Safeguarding level 3 rates remain low

Major actions commissioned & work underway

- CQC preparations ongoing
- Working towards MIS4 requirements
- Work continuing with implementation of Badgernet EPR system and interfacing with Trust systems

Positive news & assurance

- Making A Difference award presented to Band 7 for personal actions to cover staffing gaps
- Further Making A Difference award in progress
- Additional midwifery staff started in post
- Positive CQC preparation walk around and additional actions in progress
- New CTG machines have arrived and being rolled out
- Partnership work with Airedale for Perinatal Mortality reviews commenced
- Excellent PROMPT/fetal monitoring training rates – 99% PROMPT , 92% fetal monitoring.
- Community midwifery – 100% safeguarding supervision

Decisions made & decisions required of the Board

Narrative in support of the Provider Board Level Measures – June 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 rota

The middle grade rota remains a challenge as only three doctors are able to work without a consultant on site alongside them. 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. However, the longer term solution to this is more promising. There are four 'non-entrustable' doctors, who cannot work without an onsite consultant - these doctors are covering 08:00 - 20:30h Monday - Friday with an onsite consultant. There is a plan for them to start to work outside of these hours with a senior specialty doctor. This will be an important transition towards becoming entrustable out of hours. In addition, a recruitment process is underway for a further entrustable specialty doctor to support the out of hours work. The Ockenden assurance visit noted that the twice daily consultant led ward round is well embedded.

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 Consultants covering shortfall	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover overnight/ weekend 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.

SICKNESS

Delivery suite Midwives

Long term Sickness (more than 28 days)	1 midwives (1 x anxiety 150 hours)
Short Term Sickness	5 midwives (total 222 hours) • 1- 34.5 hours covid • 2- 84 hours Bell's palsy • 3- 4- 34.5 hours covid • 4- 46 hours covid • 5- 23 hours migraine Excluding covid 107 hours (2 midwives)
Maternity Leave	2 midwives (1.5 WTE)
Paid Absence/Unpaid Absence	5 midwives (351.5 hours) • 1- 140.5 redeployment due to clinical incident • 2- 26.5 hours phased return • 3- 23 hours carers leave • 4- 11.5 hours carers leave • 5- 150 hours anxiety
Non patient facing	0 midwives
Medical Isolation (Covid)	3 midwives (115) 3 x covid pos
Common Sickness Themes	Covid 19

MSW's

Long term Sickness (more than 28 days)	1 MSW (97.5 hours stress not work related)
Short Term Sickness	0
Maternity Leave	1 MSW (0.5 WTE)
Paid Absence/Unpaid Absence	1 MSW 15hours 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	4 episodes (161 hours) – 3 episodes of COVID 19 1 episode gastro
Maternity Leave	2 midwives totalling 240 hours
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)	0-
Short Term Sickness	1 episode- 46 hours
Maternity Leave	1 maternity support worker (135 hours)
Paid Absence	1 episode (11.5 hours) Carer's leave
Non patient facing	None

Unpaid absence	None
Household isolation	None
Common sickness themes	respiratory

Staffing and vacancies

May 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
Band 8	2.00	1.00	0	1	
Band 7	17.10	15.12	1.00	1.7	
Band 6	46.07	45.36	2.5 (includes 1.4 WTE returning from mat leave in July)	0.84	8.31
Band 5	9.00	7.62	4.4	1.38	
Band 3	8.00	6.25	0	1.75	
Band 2	10.24	7.30	2.94	0	
Clinical midwifery vacancies			10.74	4.94 (band 5-7)	13.25 (band 5-7) Includes current vacancies

Vacancies, retirements and resignations – in the month of June

Our staffing levels have improved and we have recruited:

- 5 new midwives have started in June and 4 more are due to start in July.
- We have MSW vacancies and have successfully recruited 3 band 2 MSW's and are currently shortlisting for band 3 MSW's for clinic and Maternity Assessment
- We have recruited 1 WTE band 7 coordinator who will start working for us in July , 1 WTE fixed term band 7 has started in June. We are currently shortlisting for 1 WTE permanent band 7 and awaiting a start date for another fixed term band 7, 0.7 WTE to cover maternity leave.

Use of NHSP and agency for June

DELIVERY SUITE

Midwifery

- From 1st- 30th June 2022, a total of 3105 hours were required to safely staff Delivery Suite and Maternity Assessment Center. During this period, 11% of hours were covered by NHSP (201.5hours). 174hours (17%) were left uncovered meaning that 82% of the midwifery hours were covered by contractual hours.

MSW's

- Between 1st- 30th June 2022, 1035 maternity support worker hours were required for the unit to be fully staffed. During this period, 201.5hours (19%) were covered by NHSP and 174 hours were left uncovered (17%).

PANNAL

Midwifery

- Day shifts- During June there were 180 shifts (1350 hours) to cover including both Early and Lates – 15 (112.5 hours) remained without cover meaning 89% were covered. For staff covering c-section lists there were 16 shifts (120 hours) to cover and 1 remained vacant totaling 94% covered. 89% of shifts were covered by contracted hours and 3% (5 shifts= 37.5 hours) were covered by NHSP.

- Night Shifts- During March there were 60 night shifts (690 hours) requiring staffing. 5 (57.5 hours) of these remained uncovered. 91% of shifts were covered. 99% of shifts were covered with contracted hours and 1% (11.5 hours) covered by NHSP.

MSW's

- For the same period, there were 60 day shifts (450 hours) and 30 nightshifts (345 hours) maternity support worker shifts to cover. 75% of day shifts and 70% of night shifts were covered by contractual hours.7% (52.5 hours) of day shifts and 10% (34.5 hours) of night shifts were covered by NHSP. 30% of shifts remained uncovered.

Staffing summary

Recruitment continues and we are currently shortlisting for 1 WTE Band 7 and Band 3 MSW's WTE 2.4.

We have just interviewed and appointed 3 Band 2 MSW's

We continue to have had an increase in number of elective caesarean sections performed and we continue to be in communication with theatres to discuss creating an additional theatre list to prevent this in future.

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 November – May 22

	November 2021	December 2021	January 2022	February 2022	March 2022	April 2022	May 2022	June
No. of times maternity unit closed to admissions	6	1	5	3	8	0	0	0
Reason Increased activity Staffing below minimum levels	4 2	1 1	4 4	3 0	7 1	N/A	N/A	N/A
No. of women diverted to other maternity units	10	0	5	5	3	0	0	0

The changes to the maternity escalation guideline are now in place including Opel criteria level and discussion with and final decision made to close/divert with the Director on call.

June data – BR+ acuity tool

137 women delivered, 138 babies born

1 BBA's – investigated through Datix

1:1 care in labour - 99.2% 1 to 1 care for women birthed (100% for those born within unit at HDFT)

Labour ward coordinator supernumerary - 99%

Midwife: birth ratio - 27.41 % (gold standard 1:26)

Percentage of specialist midwives in post - 7.2 WTE

Red Flag events (Birthrate +)

Delivery Suite

There were 0 red flags identified from the Birth Rate Plus Data

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 (2 occasion)**
- **Delay in providing pain relief (1 occasion)**

Neonatal services

Safer staffing

Staffing levels, vacancies

1.0WTE recruited into, starts September.

1.69 WTE Vacancy at present (Inc 1.0 WTE above). 0.69WTE currently out to advert (previous month – no candidates). Backword re B5 resigning – VC inputted immediately (0.61WTE QIS)

In June there was a 3.14 WTE deficit due to vacancy and sickness.

1.45 WTE of our workforce in June was covered by agency/NHSP, this was due to vacancy, LTS and short term sickness. There was also use of Woodlands staff to cover some deficits.

Qualified in Speciality (QIS) – 81% (aim for above 70%)

Sickness

SCBU	**Nurses**	**Nursery Nurse**
Short Term	Sickness – equivalent of 0.72	0.1WTE
Long Term	0.61 WTE	None
Maternity leave	None	None
Medical Isolation Overall absence –	None	None

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 2021	90%	38 /42	93%	72/77
March 2022	78%	33/42	90%	69/77
April 2022	78%	33/42	87%	67/77
May 2022	76%	32/42	88%	68/77
June 2022	94%	45/48	99%	79/80

Numbers of staff attended face to face Prompt training since October 2021

Midwives	**77/ 80**	**(3 online course)**

MSW's	**8/ 11**
Obstetric staff	**23/ 25**
Anaesthetic staff	**20 / 22 (2 online course)**

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Fetal surveillance training (K2 online training package)

Fetal surveillance training (K2 online training package evidence of Training and competency in past 12 months)

	Obstetric staff	**Midwives**
February 2022	9% (1/11)	8% (11/77)
March 2022	9% (1/11)	8% (11/77)
April 2022	15% (2/13)	14 % (18/77)
May 2022	61% (8/13)	84 % (65/77)
June 2022	75% (12/16)	92 % (74/80)

Safeguarding children's' level 3 (midwives) – 58% - 46/79
Safeguarding children's' level 3 – Obstetrics – 26% 6/23
MSW's – 92% 11/12
Safeguarding Adults – Midwives 77% (61/79) Obstetrics – 61% (14/23) and MSW's – 86% (12/14)

Neonatal resuscitation

	Midwives
January 2022	92%
February 2022	84%
March 2022	91%
April 2022	90%
May 2022	94%
June 2022	95%

SCBU

Training Compliance

Overall learning lab training compliance for SCBU staff is 82.3% (Email sent to staff who are on a lower compliance %)

Risk and Safety

Risk register summary

Risk Register was last formally reviewed with PSC Quality Assurance Lead on 23rd Nov 2021, but updated 6th July 2022. Currently 10 open risks. No new risks. 3 downgraded and 1 risk closed in this period.

- **Risk to patient safety, and staff morale due to pressures in Band 7 Delivery Suite co-ordinator staffing (Score 12).** Band 7 shortlisted, and awaiting references for further

applicant to fixed term post. Gaps being covered by Delivery Suite Managers and significant pressures remain. No change in present risk, but anticipated improvement in coming weeks.

- **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. Interface work commencing with EPMA, Patientrack, ICE, CRIS. Still working to planned rollout at end of year. Additional network points planned for installation.
- **Risk to patient safety and experience from GP surgeries removing support for midwifery clinics (Score 10).** Meeting planned to discuss finance issues with paying for GP Antenatal clinics. No change at present
- **Failure to meet national targets in relation to Continuity of Carer (Score 10).** Suspension of planned continuity rollout plans. For discussion about whether this remains a risk. No change at present
- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 9).** Middle Grade staff in post, but continued issue with entrustibility. Situation improved but pressures remain. Risk downgraded.
- **Risk to patient care due to current lack of Perinatal Mental Health Midwife role (Score 8).** Planned advert for Band 6 Perinatal Mental Health Midwife in preparation. Risk currently remains the same.
- **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. No change
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 6).** Staffing almost to full establishment. 1 Band 6 still to recruit. Awaiting 8 new starters to commence in post over coming weeks. Staffing improved and downgraded. To close once new starters in post.
- **Delay in review of clinical guidelines (Score 6).** Significant improvement in situation and now only 5 guidelines out of date and currently being reviewed. However, some additional patient information leaflets remain out of date. Consultant appointment to shared Obstetric Governance lead post with oversight of clinical guidelines. Continuing work to maintain timely review. Risk downgraded but remains in place.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance rates continue to improve. Plan in place. Risk level currently remains unchanged.

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

In June 2022 there were 45 total incidents reported through Datix. Of these, there was one incident recorded as Moderate Harm.

.Issues include

- Availability of CTG machines for antenatal fetal monitoring due to 2 old machines being ‘condemned’ by medical engineering. New machines were on order and have arrived.
- Issue noted that ASCOM devices not being used within maternity/paediatrics so not receiving automated Patientrack alerts. Some reassurance that there is close contact of Obstetric/Paediatric staff with ward areas so not felt to have affected patient safety. Actions ongoing to address issue.

SCBU
SCBU Incidents
No moderate harm.

Risk Register
One new risk – re lack of annual fire drill due to no fire officer within Trust, none removed for SCBU

Cot occupancy (Cots available on the unit = 7).
Remain at open with 7 cots, 3 babies at present. 11 admission, 2 repatriation back to us (1 was an in utero transfer)

ATAIN
1 x ATAIN – Required catheter
1 x ATAIN – Inc WOB, grunting
1 x ATAIN – Grunting

Babies transferred out.

1 baby transferred out

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

Perinatal Monitoring Review Tool Report:

Joint review with Leeds:

The panel concluded that:

Grading of care of the mother and baby up to the point of birth of the baby: The review group identified care issues which they considered may have made a difference to the outcome for the baby.

Grading of care of the baby from birth up to the death of the baby: The review group identified care issues which they considered would have made no difference to the outcome for the baby.

Grading of care of the mother following confirmation of the death of her baby: The review group identified care issues which they considered would have made no difference to the outcome for the mother.

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. The chair meets regularly with service users and midwives and is currently planning work streams for the next year. The chair also attends MRMG and MSF as per Maternity Incentive Scheme guidance.

Complaints / concerns to PET / compliments

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 June, we had one new complaint and one new concern.

Parents feedback received by SCBU
User feedback

SCBU continues to receive excellent feedback

Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in June 2022.

Request for action from external bodies – NHS Resolution, HSIB

No concerns or requests for action from HSIB/NHSR/CQC have been made directly to the Trust in June 2022

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

Continuity of Carer

Data for June

Requirement (NHS Resolution, safety standard 9)

- Evidence that the Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue to resume CofC models so that this model is available to all women by March 2023 (women booking for maternity care are being placed onto continuity of carer pathways). In light of the increased risk facing black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced CofC models primarily targeting these groups. Consider our vulnerable groups of women – perinatal mental health

Evidence of Board level oversight and discussion of progress in meeting the revised CofC action plan

Provider Board level measure	Information for report	
Continuity of carer action plan – progress	**Continue to Report 0% of women on pathway due to staffing levels**	
Narrative around successes, challenges and plans	**Safe Staffing**	2 new staff B5 (1.8 WTE) started in post, however remains overall shortfall for clinical staff and therefore staffing not safe to proceed. Staffing particularly challenging in community area and further staff leaving over coming months. 5 NQM have been recruited for autumn start, 1 further post will be advertised shortly. New starters have joined inpatient areas, planned for rotation through ante/postnatal and labour ward then community rotation and integrated working
	Planning	Planning spreadsheet completed with National Lead, reviewed with interim HoM regarding deployment of staff. For audit of Pannal ward activity to see if continuity has expected impact on IOL/ PN stays and if safe to reduced staffing as suggested by National Lead. Plan not to rotate new B5 to community/ continuity until have worked in inpatient areas for 12 months as per Ockenden recommendations.
	Communication and engagement	Integrated staff acting as positive role models wit this way of working. Some staff in inpatient areas keen to try integrated working and this will be facilitated as staffing improves and able to back fill.
	Skills Mix	5 midwives continue to work in integrated pattern across IP an community areas. 2 further midwives will rotate to community - 1 B5 will work integrated and 1 B5 will work full time in community. When new midwives feel sufficiently embedded in clinical areas will commence working in integrated way. Community staffing currently does not allow opportunities for staff to be released for upskilling/ time on Labour Ward. 1 new midwife as commenced integrated working on phased return with planned period of supernumerary working support by RA/ CTW
	Training	Developing induction plan with Community Manager to ensure staff rotating out to community feel well supported, have regular opportunities to review progress and training needs utilising TNA and skills matrix
	Team Building	Team Charter framework and Insight Discovery have been identified as useful tools to support team working when staff have been identified for 1st Team
	Link Obstetrician	Link obstetrician identified for first team and communication and referral pathways in place

	SOP	SOP for Integrated Teams written. SOP for Birth Availability teams to be developed as co-production with staff from all areas with aim of increasing staff engagement and ownership and also with MVP involvement.
	Pay	Pay protection arrangements have been agreed for previous team that can be replicated if required for future teams. Awaiting LMS wide discussions regarding uplift and consultation with Unions if this is to be implemented.
	Estates	Continues to be significant barrier to implementation of Continuity and also to necessary restructuring of community. Senior management now supporting with identifying and securing appropriate accommodation and linking with NHS Property Service to progress accommodation options in Ripon. RA linking made with NHS Estates to support this.
	MSDS Reporting	New digital system being built for rollout in December and will support MSDS and MCofC reporting. Project lead will be super user to ensure staff awareness and compliance with MCofC reporting requirements

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 live v

Outstanding actions from the action plan:

- An audit schedule has been completed for the next year 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 – audit
- Audits have commenced with plans to disseminate the learning and action plans

Progress

- Work continues with the MVP group to 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

Regional data received for Quarter 4 shown below. Next update 16th August Q1.

In summary for Quarter 4:

- *Bookings less than 10 weeks are 78.9%, a good improvement from Q3 (74.0%). Rates are the highest in the region (range 58.1-78.9%), and well above the Y&H average (68.2%). No Y&H Trust has met the 90% target.*
- *1:1 care in labour was 98.8%. This is comparable with other Trusts in the region (regional average 98.2%).*
- *Normal delivery rate was 55.6% (no change from Q3), against a regional average of 56.8%.*
- *Total Caesarean section rate was lower than the regional average 27.8% in this quarter (compared with the regional average of 33.0%). Of these, there were 15.1% elective Caesarean sections (compared with 14.3% regional average)*.
- *Induction rate (31.5%) was again lower than the Y&H average (35.8%), with the highest induction rate in the region being 47.3%.*
- *Significant PPH rate was again lower in this quarter (2.7%), and is now well below the regional average (3.8%).*
- *There were 2 stillbirths at HDFT in Q4. Rolling annual antenatal stillbirth rate is currently 2.2 per 1000 births compared with the Y&H average of 3.8 per 1000.*
- *Breastfeeding initiation rates remain very high at 84.8% compared with the regional average of 65.3%, and remains the highest in the region.*
- *Smoking rates at booking and time of birth are amongst the lowest in the region (5.7% and 5.5% respectively), compared with Y&H average of 12.9% and 12.3% respectively.*
- *Carbon monoxide testing at booking and 36 weeks remains a challenge, though have improved and CO testing at 36 weeks (18.1%) is above the regional average in this quarter (15.2%). Some issues have been experienced with supply of Covid-safe CO filters.*

Local HDFT dashboard information

For month of June:

- 136 mothers delivered (and 137 babies born)
- Elective Caesarean section rate 14.7% (decrease since May, 15.6%)
- 18.4% emergency Caesarean section (no change since May, 18.4%)
- 55.1% normal delivery rate (increase from May, 51.8%)
- 11.8% instrumental delivery rate (decrease from May, 14.2%)
- 44.1% induction rate (significant increase from May, 33.3%)
- 1.5% significant PPH ≥1500ml rate (significant decrease compared to May [3.5%]; 2 patients)
- No 3rd degree tears
- 81.8% breastfeeding initiation rate
- 3.7% smoking rate at time of delivery [6.4% in May]
- One Term stillbirth
- One preterm birth <32 weeks

ATAIN (admissions)

Four Term Admissions to SCBU (in addition to skull fracture above):

- One not passed urine for 47 hours since birth
- One admission with increased work of breathing and grunting

- Two admitted following conversion to general anaesthetic at elective caesarean section requiring respiratory support/monitoring

ATAIN actions

Actions identified from recent ATAIN reviews of Term babies admitted to SCBU:

Issue	Action	Status
Delayed admission for baby with high respiratory rate over 21 hours	Review NEWTTs notifications. Identified Ascoms not being used and plan devised to address	In progress
Issue with newborn oxygen facemask require additional inflation to obtain good seal	New facemasks ordered to bring into line with SCBU	Complete
Baby transferred to SCBU too early with low saturations	Disseminate management of respiratory distress flow chart in attempt to keep mum and baby together	In progress
For Registrar to always review baby prior to bloods been taken on D/S	Discuss with neonatal lead	Complete
Respiratory issues at elective LSCS and could have considered maternal steroids prior to surgery	Feedback to Consultant about ensuring individualised discussion of risks/benefits of steroid administration at 37-38^{+6} weeks	Complete
Issues with cold baby on transfer to SCBU	Staff to follow thermal regulation policy correctly and use resuscitaire to actively warm baby. Communication to staff to educate, information added to handover sheets	Complete
Issue with baby requiring resuscitation in PACU	For consideration of resuscitation area for main theatres. Contact Clare Hutton to ascertain if possible	Complete
Incorrect base excess measurement used resulting in unnecessary hypoglycaemia monitoring	Communication to be sent to staff for reminder and learning	Complete
Insufficient heat output with new resuscitaires	Disseminate to nursing & midwifery staff how to correctly use resuscitaire so that overhead heat does not turn off	Complete
Not to administer high levels of non-humidified low flow oxygen to newborn infants	Educate nursing staff about guideline	In progress
Issue with babies becoming cold in main theatres following elective caesarean section	Contact Clare Hutton to ascertain if possible to maintain increased temperature in main theatre	In progress

Saving Babies Lives' v2 metrics for Board oversight (MIS requirement)

	Quarter 1 (April-March 2022)
Small-for-gestational age/Fetal growth restriction detection rates	Q1: 34.7% detection (<10th centile)* (National average 40.6%, Top 10 average 56.8%) Q1: 61.1% detection (<3rd centile) (National average 59.4%, Top 10 average 74.5%)
Percentage of babies <3rd centile >37^{+6} weeks' gestation	2.38% (10/420)
Percentage of babies <10th centile >39^{+6} weeks' gestation	4.52% (19/420)
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth:	
• In late second trimester (16^{+0}-23^{+6} weeks)	0 (No babies born 16-24 weeks in this period)
• Preterm (24^{+0}-36^{+6} weeks)	2.93% (12/410)

*Work ongoing to investigate low SGA detection rates compared with national average, as HDFT has been below national average for last 3 quarters. Possibly may reflect issues with

accuracy of data entry, fundal height measurement or ultrasound scan accuracy. Training in GAP (Growth Assessment Protocol) being prioritised.

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.

<u>The key building blocks:</u>

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

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

<u>Hubs</u> – 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 was released in March 2022 – awaiting national work streams

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.

Medical Director Report
Date: July 2022
Report: Public Board
Author: Dr Jacqueline Andrews

Matters of concern & risks to escalate

- Mortality indicators - HSMR/SHMI currently above expected range- deep dive completed, no quality concerns identified, likely related to change in demographic of inpatients
- Inability to appoint a Chief Registrar for 22/23- local options for a Chief Leadership Fellow being explored
- A number of fragile clinical services at HDFT identified, particularly with provision of out of hours services- working with WYAAT and wider system colleagues to agree regional approach and standards where possible
- Lack of clinical estate for research continues to create reputational, quality and financial risks- options continue to be explored

Major actions commissioned & work underway

- Electronic job planning- systems and processes implementation and training sessions underway
- Market testing of e-rostering systems ahead of business case underway
- New Compliance manager commenced and supporting MD team with review of HDFT compliance with national clinical standards/best practice
- Harrogate and District roundtable and collaborative working to create an Innovation Hub, to facilitate better join up between healthcare, local govt, industry and academia.
- RPIW held to standardise and improve processes for review of clinical results – a number of immediate and longer term actions being taken forward

Positive news & assurance

- A number of successful Consultant recruitment campaigns in recent months-some for previously hard to fill specialties
- New consultants network re-established and mentoring programme expanded
- SAS Doctor advocate role out to advert
- NHSE/I financial allocation for new Electronic Patient Record communicated- major transformational programme now underway, working with HNY ICS colleagues to maximise return for investment

Decisions made & decisions required of the Board

- Governance of Digital Transformation Programme – whether to consider stand alone board sub committee/task and finish group

Board of Directors (Public)
July 2022

Title:	**Infection, Prevention & Control BAF and Work Plan**
Responsible Director:	Medical Director
Author:	Medical Director

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions.	
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.	

Infection Prevention and Control Board Assurance Framework – 2022-2023

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

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

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

Abbreviations:

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

Version 1.0 (IPCC approved 30/6/22)

Compliance Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessment and consider the susceptibility of service users and any risks that their environment and other users may pose to them.		
Sub-duties	**Evidence/Assurance**	**Gaps/Action**
The organisation outlines its collective responsibility for keeping to a minimum the risks of infection and the means by which the trust will prevent and control such risks	HDFT IPC Policy – Section 001. This policy describes the management and organisation of HCAI prevention and control at HDFT.	Policy- Section 001 is beyond review date. **Planned Action:** Review of this policy is an action on the IPC annual work plan.
The organisation has a clear governance structure and accountability that identifies a single lead for infection and cleanliness and be accountable directly to the head of the registered provider	Single lead for infection and cleanliness accountable to the Chief Executive is the Director of Infection Prevention and Control (DIPC) Dr Jacqueline Andrews (Medical Director). The DIPC has direct access to the Board of Directors (BoD) Supported by a Deputy DIPC – Jenny Nolan (Deputy Chief Nurse) Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and reports to Quality Governance Management Group (QGMG) and Quality Committee (QC).	Current governance structure not described in the HDFT IPC Policy – Section 001. **Planned Action:** Review of this policy is an action on the IPC annual work plan.
The organisation has comprehensive policies in place for the prevention of infection.	The trust has 35 evidence based policies which cover all aspects of prevention of infection. Policies are available on the Trust Intranet page and reviewed every three years (sooner if new guidance is published). New policies/policy reviews are presented to the IPCC. The IPCC makes a recommendation to the Senior Management Team (SMT) in accordance with the Trust "policy on policies" document.	Due to the pandemic the routine review of policies has been suspended. 27 of the 35 policies are beyond their review date. **Planned Action:** Overdue policy reviews are captured on the IPC risk register. Policy review plan is included in the IPC annual work plan.
The organisation has a clear process for detecting and reporting HCAI	The Trust has a surveillance system in place to routinely detect and report HCAI. It includes both mandatory and locally agreed surveillance.	Current HCAI reporting arrangements not described in the IPC policy – Section 001.

Version 1.0 (IPCC approved 30/6/22)

	MB – BSOP-140 describes how organisms causing HCAI are communicated to the Clinical microbiologists and IPC Team. Microbiology T-card system ensures HCAI alert emails are sent. The IPC Tracker is the central document for the recording of all HCAI data. The IPC team are responsible for mandatory reporting on HCAI in accordance with UKSHA criteria and do this via the UKSHA Data Capture System (DCS) The IPC team produce a monthly IPC report of HCAI infections and provide analysis/interpretation of this data.	**Planned Action:** Review of this policy is included on the IPC annual work plan.
The organisation has mechanisms in place to provide assurance that IPC policy is implemented and adhered to	Assurance of adherence to IPC Policy is obtained via regular audit, post infection review and matron inspections. Each ward/department completes a monthly General IPC Inspection audit. The results are collated by the IPC team and analysed at both the IPC Team meeting and IPCC. The IPC team also conduct monthly commode and cannula insertion audits. The results are analysed at both the IPC Team meeting and IPCC. The IPC team have a process in place for the routine review of HCAI's – The Post-infection review (PIR) which is an additional mechanism to assess compliance with IPC Policy. Completion of PIR's is one of the IPC KPI's. Zero avoidable HCAI's is another Trust KPI. Performance against the KPI's is included in the monthly IPC report. Matron "walk-arounds" take place in order to directly observe compliance with IPC policy.	Disruption to monthly General IPC Inspection audit with the move to the Tendable system. **Planned Action:** IPCT to undertake General IPC Inspection audits via Tendable for first 6 months of this year. Wards to take over this process thereafter with a peer-to-peer assessment model. Ward to continue to submit monthly paper based IPC General Inspection Audit until Tendable system is fully implemented. Matron "walk arounds" have not taken place or been re-established during the pandemic. **Planned Action:** Re-establishment of the Matron walk around is included on the IPC annual work plan.

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

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

The organisation should have an antimicrobial stewardship committee responsible for the organisations stewardship programme.	Antimicrobial Prescribing and Stewardship Group (APSG) established. The group meets bi-monthly and is Chaired by the Trust Lead for Antimicrobial Stewardship. This group reports to the Area Prescribing Committee (APC) which in turn reports into the Trust's Clinical Effectiveness Forum (CEF). The Trusts Stewardship Program is described in the Antimicrobial Medicines Code and is overseen by APSG.	None.
The organisation should have in place an antimicrobial stewardship policy. Adherence to prescribing guidance and compliance with post-prescribing review should be monitored and audited on a regular basis.	The Antimicrobial Medicines Code (review date December 2022) describes the Trusts policy for antimicrobial stewardship. APSG has responsibility for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews.	IPCC currently does not receive assurance from APSG regarding compliance with prescribing guidelines and post-prescribing reviews. **Planned Action:** IPCC to receive a bi-annual report from APSG with audit results.
The organisation should have access to timely microbiological diagnosis, susceptibility testing and reporting of results. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.	Microbiological diagnosis and susceptibility testing is available on-site 7 days per week in a UKAS accredited laboratory. Advice regarding the prescription of antimicrobial therapy is available 24 hours per day, 7 days per week and 365 days per year from both a pharmacist and Clinical Microbiologist.	None.
The organisation should report local antimicrobial susceptibility data and information on antimicrobial consumption to the national surveillance body. This information should be communicated back to prescribers in primary and secondary care to improve prescribing quality.	Susceptibility data reported to the national surveillance body (SGSS) via electronic link directly from the Laboratory information management system (LIMS). Annual susceptibility report is produced and presented to APSG. Antimicrobial consumption data is collected by the Antimicrobial Pharmacist and presented to APSG. The Antimicrobial Stewardship Team undertake the annual mandatory point-prevalence audit of antibiotic use. Results are presented to APSG.	IPCC currently does not receive reports from APSG with information regarding antibiotic susceptibility and consumptions. **Planned Action:** IPCC to receive a bi-annual report from APSG covering antibiotic consumption and surveillance.

	Core membership for APSG includes representatives from Secondary care Directorates and the Community. They are responsible for the cascade of antimicrobial consumption and surveillance data in order to improve prescribing quality.	
Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use.	The trust has a mandatory induction session on Antimicrobial prescribing which is given by one of the Consultant Microbiologists. An e-learning module regarding the appropriate use of antimicrobials is required by all prescribers every 3 years.	IPCC does not currently receive assurance of compliance with 3 yearly antimicrobial prescribing training. **Planned Action:** IPCC to receive a bi-annual report from APSG covering compliance with 3 yearly training module.
Criterion 4: Provide suitable accurate information on infections to service users, visitors and any person concerned with providing further support or nursing / medical care in a timely fashion		
Produce and provide accurate information for patients, service users and providers	IPC information on Trust Internet IPC information displayed on posters within the Trust Patient advice leaflets (PILS) – provided to all patients with alert organisms (CDI, CPE, MRSA, VRE). Discharge documentation includes information in relation to infection status and treatment. Transfer checklist includes information in relation to infection status and treatment.	Review of IPC information on internet and within the trust is reviewed on an ad-hoc basis. **Planned Action:** Review of IPC information on internet and within the trust to be included in the annual IPC work plan. PILS have not been reviewed and updated throughout the pandemic. **Planned Action:** Review of PIL's to be included on the annual IPC work plan. No audit in place to assess the compliance with including IPC information on discharge documentation and transfer checklists.

		Planned Action: Annual audit of IPC information on discharge and transfer documentation to be included on the annual IPC work plan.
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people		
Identification of people who have or are at risk of developing infection.	IPC requirements for the isolation of patients is described in Section 002 Isolation Policy and Section 003 Procedures for Individual Diseases. Patients who have a history of an alert organism are flagged on iCS and the IPC team is notified electronically when they are admitted. Patients who require isolation have appropriate signage on single room doors to advise staff and visitors of the precautions in place. IPC team audit compliance with isolation precautions on a quarterly basis and report the results to the IPCC. Instances where isolation is required but cannot be fulfilled (lack of single room beds) must be reported via Datix. IPC team review the Datix events quarterly and report them to the IPCC. IPC Nurses attend the daily bed meetings to support and advise the clinical site managers on the appropriate placement of patients.	Section 002 and 003 are beyond the review date. **Planned Action:** Policy review program is included in the IPC annual plan. No SOP for how an alert organism flag is applied to a patient. **Planned Action:** SOP for adding an organism flag to be included on the annual IPC work plan. Audit of compliance with isolation policy is not currently being performed. **Planned Action:** Quarterly audit of compliance with isolation policy to be included on the annual IPC work plan. Datix records of failure to isolate are not currently reviewed by the IPC team. **Planned Action**: Quarterly review of isolation Datix to be performed by the IPC team and presented at the IPCC.
Criterion 6:Systems to ensure all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection:		

The organization shall ensure that its staff are equipped with the necessary knowledge and skills to be fully involved in the process of prevention and controlling infection	Staff induction – IPC session is included in the mandatory staff induction package. Staff are not permitted to start work until this package has been completed. Mandatory IPC Training – National IPC Training modules are used via e-learning. Level 1 is for non-clinical staff and should be completed every 3 years. Level 2 is for clinical staff and should be completed annually. Compliance with Mandatory Training is one of the local IPC KPI's and is reported via the monthly IPC report. Trust volunteers have a bespoke IPC training package which is undertaken at induction. Non-mandatory IPC training: - Care support worker fundamentals of care training - Monthly IPC newsletters - Toolbox talks	IPCC does not currently receive assurance that Trust Volunteers are complaint with IPC training. There is no IPC training renewal agreement in place for volunteers. **Planned Action:** Matron for IPC to work with Volunteer coordinator and develop a mechanism for IPCC to receive assurance regarding training compliance. To agree that volunteers complete IPC training on an annual basis. Non-mandatory IPC training is provided in an ad-hoc manner and attendance is not recorded. **Planned Action**: Matron for IPC to develop a non-mandatory IPC training schedule and develop a mechanism to record attendance.
Infection prevention needs to be included in the job descriptions for staff and contractors working in service user areas need to be aware of any issues with regard to infection prevention and obtain "permission to work"	Infection prevention responsibilities is included as standard in the Trust Job Description Template. HiF have responsibility for making contractors aware of any issues with regards to infection prevention and control and grant "permission to work".	None.
Where staff undertake procedures which require skills such as aseptic technique staff must be trained and demonstrate proficiency before being allowed to undertake the procedures independently.	Asepsis training and assurance: Nursing Staff – Line manager required to complete competency assessment every three years and upload the evidence to ESR. FY1 Doctors – Trust Clinical Educators train and assess at induction. Evidence if uploaded on ESR. Doctors have to be re-assessed every 3 years.	IPCC does not currently receive assurance of compliance with asepsis training. Asepsis training is not included in Mandatory training, there is no system to remind staff when it is due. No process for training and assessing Allied health professionals who undertake aseptic procedures is in place.

		No process for training and assessing Doctors (beyond Fy1) in aseptic procedures. **Planned Action:** Lack of asepsis assurance to go on to the IPC risk register. Proposal for asepsis training and assurance to become part of mandatory training to be made via the IPCC. This could be delivered along the same model as resuscitation training.
Criterion 7:Provide or secure adequate isolation facilities		
The organization should ensure it is able to provide adequate isolation precautions and facilities to prevent or minimise the spread of infection.	Isolation facilities are available in the Emergency Department including two negative pressure isolation rooms in resus. Every in-patient ward has a number of single rooms which are neutral pressure and available for the isolation of patients with infection. Some of these rooms are en-suite. The Intensive Care Unit has three negative pressure single rooms and a further two neutral pressure single rooms. Two single en-suite rooms are available in the Sir Robert Ogden Macmillan Centre.	A description of the number of single rooms, their ventilation status and location is not included in any of the IPC policies. **Planned Action**: IPC in collaboration with Estates to assess the number and status of single rooms within the inpatient setting and include this within the IPC Policy, Section 002.This will be captured on the IPC annual work plan.
Criterion 8:Secure adequate access to the laboratory support as appropriate		
The organisation should ensure that the laboratory used to provide a microbiology service have in place appropriate protocols and operates to the standards required by the relevant national accreditation bodies.	The Trust Microbiology Laboratory is accredited to UKAS ISO 15189. The work of the Laboratory is governed by a comprehensive set of Standard Operating Procedures (SOP's) for the examination of specimens. The Laboratory uses an	None.

	electronic document management system (Q Pulse) for storage of all its procedures. Timeliness of reporting is regularly audited and results are presented at the Monthly Senior Laboratory Meetings.	
Criterion 9: Have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections		
The organization should have in place appropriate policies covering the following matters. All policies should be clearly marked with a review date and the review date adhered to. Each policy should indicate ownership, authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be a rolling programme of audit. • Standard infection prevention and control precautions • Aseptic technique • Outbreaks of communicable infection • Isolation of service users with infection • Safe handling and disposal of sharps • Prevention of occupational exposure to blood borne viruses (BBV's) and management should exposure occur • Closure of rooms, wards, departments and premises to new admissions • Disinfection • Decontamination of reusable medical devices • Single use medical devices • Antimicrobial prescribing • Reporting of infection to local health protection team and mandatory reporting to UKSHA • Control of outbreaks and infections associated with specific alert organisms	The Trust has the following policies in place which cover the matters described in criterion 9 - Section 014 Standard precautions including hand hygiene and PPE - Section 031 Principles of asepsis - Section 027 Hospital outbreak policy - Section 002 Isolation of patients policy and principles of notification - Section 004 BBV and inoculation incident policy - Section 019 Decontamination and body fluid spillage - Section 020 Decontamination policy, procedures for items in general use - Antimicrobial medicines code - Section 001 Management and organization of the prevention and control of HCAI - Section 024 CPE Policy - Section 003 Procedures for individual diseases - Section 012 MRSA Policy - Section 010 Respiratory Virus Policy	Majority of these policies are beyond their review date. **Planned Action:** Overdue policy reviews is captured on the IPC risk register. Policy review program is included in the IPC annual work plan.

(MRSA, C.difficile, GRE, CPE, VHF, CJD, TB, Respiratory viruses, Diarrhoeal infection) • CJD/vCJD • Safe handling and disposal of waste • Packaging, handling and delivery of laboratory specimens • Care of deceased persons • Use and care of invasive devices • Purchase, cleaning, decontamination,maintanence and disposal of equipment • Surveillance and data collection • Dissemination of information • Isolation facilities • Uniform and dress code • Immunisation of service users	- Section 039 VHF Policy - Section 009 C.difficile policy - Section 013 CJD Policy - Section 023 Healthcare Waste Disposal Policy - BS-COSHH-001- Handling blood, blood products, urine and faeces - Section 029 Handling of bodies after death - Section 044 Prevention of infection in the mortuary - Section 015 Infection control in IV procedures - MB-LP-BSOP-140 – Communication of results from the microbiology department - Trust Dress Code Policy - SOP for School based immunization programme management - Antibiotic and immunization advice for patients with absent/dysfunctional spleen.	
Criterion 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection		
All staff can access Occupational Health Services and Occupational Health Advice	The Trust commissions an Occupational Health Service for staff. Staff can access the service via their line manager or self-referral.	None.

The organisation has an Occupational Health Policy on the prevention and management of communicable infections in care workers	The Occupational Health Department have responsibility for the Staff Communicable Diseases and Immunisation Policy. The Occupational Health Department and IPC team have shared responsibility for the Communicable Disease in Staff and Exclusion Policy. Section 017. The IPC team have responsibility for the Policy on prevention and management of occupational exposure to blood and body fluids. Section 004.	Occupational Health Team do not provide assurance to the IPCC regarding the compliance with the Staff Communicable diseases and Immunisation Policy. **Planned Action:** IPCD to investigate how the Occupational Health Department currently fit into the Trusts Governance structure. IPC Policies 017 and 004 are beyond the review date. **Planned Action:** Policy review program is included in the IPC annual work plan.

Infection Prevention and Control Team – Work Plan 2022-2023

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

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

Abbreviations:

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

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Work Plan Item Number	Task	Task Lead	Target Date	Progress
1	IPC Policy – Section 001 • Content reviewed and updated • Transferred to the new trust policy template • Approved at IPCC and then ratified at SMT	LH	Aug-22	
2	Review and update IPC Policies which are beyond their routine review date • Refer to detailed policy review plan (appendix 1)	SA	Mar-23	
3	Transfer the monthly IPC general inspection audit to Tendable	SA	Jun-22	23.6.22: General IPC inspection on Tendable. Not all wards have access. Aim for all August inspections to be done via Tendable. Scoring issue raised with Tendable team.
4	Hand back the responsibility for completion of the monthly IPC general inspection audit to ward managers with a peer-to-peer assessment model	SA	Sept-22	
5	Establish monthly IPC audits at Ripon and Selby MIU	SA	Aug-22	
6	Re-establish a programme of Matron “walk arounds”	SA	Jul-22	
7	IPCC to receive assurance report from Decontamination Committee at an agreed frequency	LH	Jul-22	
8	IPCC to receive assurance report from Water Safety Group at an agreed frequency	LH	Aug-22	
9	IPCC to receive quarterly cleaning assurance report from HiF	LH	Jun-22	23.6.22: Andy Colwell informed the IPCC that cleaning assurance would be provided monthly.
10	IPCC to receive bi-annual assurance report from APSG	LH	Sept-22	
11	Review of IPC information on Trust Website	SA	Oct-22	
12	Review of IPC information displayed within the trust	SA	Jun-22	23.6.22: Review of signage in progress (IG) IPC noticeboards on wards to be tackled after the signage.
13	Review and update Patient information leaflets for alert organisms (CDI,CPE, MRSA and VRE)	SA	Nov-22	
14	Develop an annual audit programme of IPC information on discharge and transfer documentation	SA	Nov-22	
15	Produce an SOP for adding an iCS flag to a patient with an alert organism	AG	Jun-22	Complete
16	Develop a quarterly audit programme for compliance with isolation policy	SA	Oct-22	
17	Develop a quarterly programme for the review of Datix incidents at IPCC	AG/IG	Jul-22	
18	Develop an assurance process for volunteers and compliance with IPC training	SA	Dec-22	
19	Produce a non-mandatory IPC training package and assurance framework	SA	Aug-22	
20	Proposal for asepsis training to be included in Mandatory training	LH	Jun-22	23.6.22: not started
21	Produce a document describing the number and status of single rooms within the inpatient setting for inclusion in IPC Policy-Section 002.	LH	Jul-22	
22	IPCC to receive assurance report from Occupational Health at an agreed frequency	LH	Sep-22	
23	Complete annual mandatory SSI surveillance audit	IG	Dec-22	
24	Re-establish the IPC Link person programme	JC	Mar-23	

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Appendix 1: IPC Policy Review Plan

Policy number	Policy Title	Review date	Priority for review
001	Management and organisation of the prevention and control of HCAI	30/4/22	23.6.22: not started
002	Isolation of patients policy, principles and notification of infectious diseases	30/4/22	
003	Procedures for individual diseases	30/4/22	
004	Blood borne virus and inoculation incident	30/4/22	
005	Tuberculosis	29/2/24	
006	Meningococcal disease	30/04/22	
007	Haemophilus influenze Type b (Hib) Disease	30/04/22	
008	Chickenpox and Shingles (VZV)	30/04/22	23.6.22: changed to red priority
009	Clostridium difficile	30/04/22	23.6.22: in-progress
010	Respiratory virus guidelines	30/04/22	23.6.22: Trust respiratory tract guidance (including COVID-19) remains in use.
011	Scabies and other ectoparasites	30/04/22	
012	MRSA	31/01/26	
013	CJD	31/10/22	
014	Standard precautions including hand hygiene and PPE	30/4/22	23.6.22 in-progress
015	Infection Control in Intravenous Procedures	30/09/24	
017	Communicable diseases in staff and exclusion policy	30/04/22	
018	MRGNB	30/04/22	23.6.22: in-progress
019	Decontamination, antiseptic disinfectant and body fluid spillage	30/04/22	
020	Decontamination policy – procedures for items in general use	30/04/22	
021	Bed management and movement of patients	30/04/22	
022	Laundry	30/04/22	
023	Healthcare waste disposal	30/04/22	
024	CPE	30/04/22	23.6.22: in-progress
025	Pest Control	30/04/22	
026	Animals and pets in hospital and community settings	31/10/22	
027	Hospital outbreak	31/11/22	
029	Handling of bodies after death	31/10/21	
030	Infection control and Legionellosis	30/04/22	
031	Principles of asepsis	30/04/22	
032	Prevention of infection for Visitors, visiting staff, volunteers and work experience students	30/04/22	
037	Prevention of surgical site infections	30/11/22	
038	Prevention of CAUTI	30/04/22	23.6.22: not started
039	VHF	30/04/22	
042	RCA of hospital acquired infection	30/04/22	23.6.22: not started
043	HCAI Data Sheets for patient information	30/04/22	
044	Prevention of infection in the mortuary and post-mortem room	30/04/22	

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Finance
Board of Directors
27/07/22

Matters of concern & risks to escalate

- Month 3 position is reported as a deficit, reflecting a number of the underlying pressures faced in the Trust.
- Key Drivers include performance against Savings programme, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity and escalation.
- Agency expenditure continues to increase month to month.
- Engagement of budget holders has been raised as a concern, with mixed but generally low uptake of meetings with finance colleagues.
- The wider Humber and North Yorkshire ICS plan is a stretching position with a number of risks which are impacting the Trust.

Major actions commissioned & work underway

- Renewed focus on delivering plan, identifying efficiencies and recovering position. Action plan developed with directorates and SMT.
- Triumvirate and Budget Holder training and requirments to be re-emphasised.
- Working through risks associated with ERSF achievement – monthly monitoring group set up.
- Capital Programme outline for 2023/24 – 2024/25 being developed and will be presented at some point during Q2.
- Audit Programme being agreed with external audit firm likely sign off 7th October.

Positive news & assurance

- Ongoing work to support BPPC, additional payment run being trialled and key companies being targeted.
- Non PO No Pay, all suppliers to be contacted next week.
- Excellent attendance at the Quarterly Finance Team session. Subjects covered included Finance Strategy, Inclusion and Communication.
- Further £9m allocated for EPR development.

Decisions made & decisions required of the Board

- Approval of in year ERF expenditure linked to capital programme.

Operational Update

July 2022

Russell Nightingale
Chief Operating Officer

Operational Update July 2022 (June Performance)

Matters of concern & risks to escalate

- COVID admissions and occupancy increased in June following the current growth in cases in the community, reaching the same levels as the last surge.
- Cancer 62-day wait target not achieved at 78.0% (5.9.1)
- Cancer 2WW performance was below the 93% target at 73.5% (5.10)
- Cancer (Breast) 2WW target not achieved at73.3%
- Non-Elective demand remains a challenge and the Trust continues at full capacity (100+% bed occupancy)
- A&E 4-hour performance in June remains below the standard at 71.6%, significant bed pressures impacting on flow, continued increase in presentations and divert support provided to York FT. (5.6)
- The Trust had two 60-minute ambulance handover breach in June
- 15 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- TIF2 delivery timescales and concern regarding planning approval/ required and electrical infrastructure works

Major actions commissioned & work underway

- TIF2 short form business case nearing completion (c.£15m) to increase on site theatre provision, positive discussions regarding planning approval continue.
- Reset for Outpatient Transformation Board, now clinically led with active positive discussions across specialties, actions and work progressing
- C2-Ai Risk Stratification software implementation starting with IPDC elective waiting list patients, senior team in PSC actively involved, AHSN supporting benefits realisation analysis
- LUNA product with AI to support RTT validation to allow easier focus on our waiting lists (12-16 week implementation continues)
- Submitted bid for national additional capacity funding to support opening of acute frailty unit and frailty SDEC in autumn/winter

Positive news & assurance

- Referral to treatment total waiting list reduced in June, (5.1.3)
- Cancer 31-day wait target achieved at 96.2% (5.1.2)
- Cancer 28 days faster diagnosis 80.4%, above the 75% standard (5.11)
- A&E 4-hour performance has now improved for 4-months in a row
- YOS LLP trial signed off and first list 11th June 2022
- 184 elective theatres lists were undertaken out of a possible 227 (86%)
- Continued reduction in >78-week waiters for surgery
- M03 plan met 11 of 13 measures for June, number of patients transferred to a PIFU pathway and the number of patients waiting 63+ days on a cancer pathway were below plan
- RTT 92nd percentile at 44 weeks (5.1.3)
- Top quartile national performance for Ambulance handover delays
- Continued to support York District Hospital with acute patient diverts when required and able to support
- Agreed proposal to utilise Duchy Hospital to deliver further treatment capacity across 2022/23.

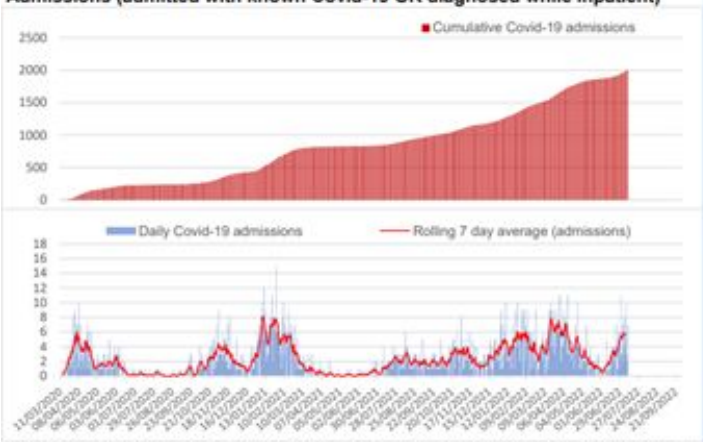
Decisions made & decisions required

- Change of clinical pathway for COVID+ patients – stepping down cohorting of patients and moving to patients remaining on appropriate ward for care required
- Solution implemented to create ring fenced orthopaedic capacity on Fountains ward with non-orthopaedic electives being safely placed in other surgical wards
- Continue to maintain escalation capacity open to support 40-45 patients per day in hospital not meeting criteria to reside

COVID-19 Management Report

Inpatients with confirmed Covid-19 (NHSE Daily Sit Rep)

Admissions (admitted with known Covid-19 OR diagnosed while inpatient)



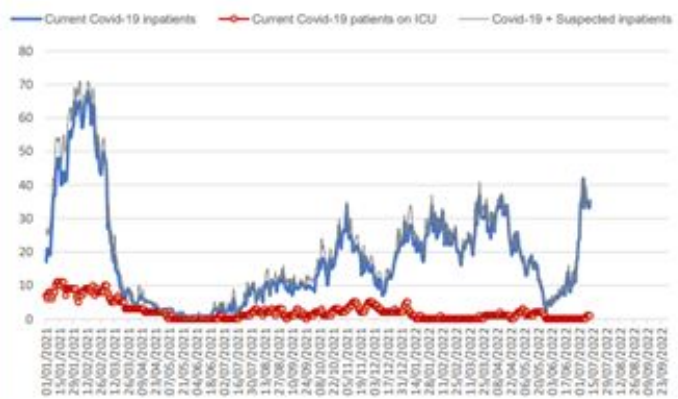
Yesterday **7**

To date **2002**

Last 7 days **40**

8-14 days ago **38**

Current Covid-19 inpatients



Today **35**

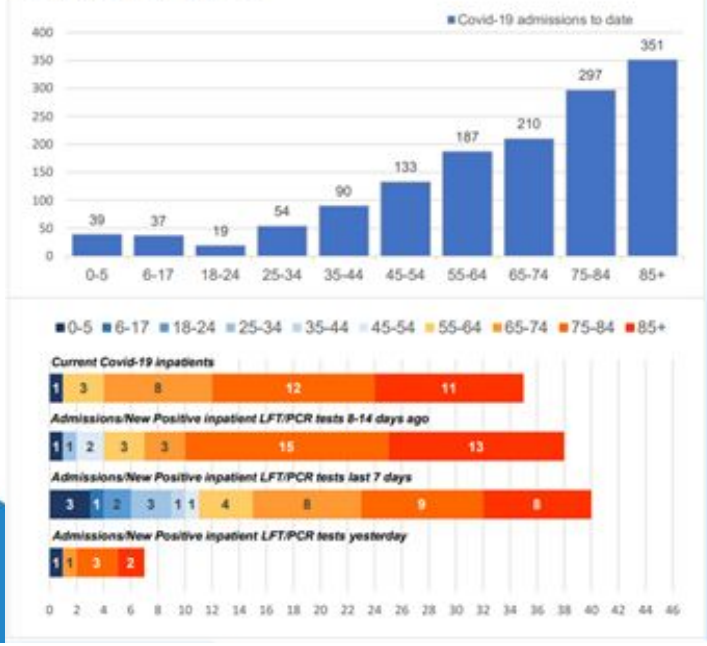
Yesterday **33**

7 days ago **42**

14 days ago **17**

Note: *Admission data* ***excludes*** *inpatients whose first positive swab was reported after discharge, and* ***includes*** *patients with a positive result who died in hospital before the result was known*

Covid-19 admissions by age



Today

0-5 **1**

6-17 **0**

18-24 **0**

25-34 **0**

35-44 **0**

45-54 **0**

55-64 **3**

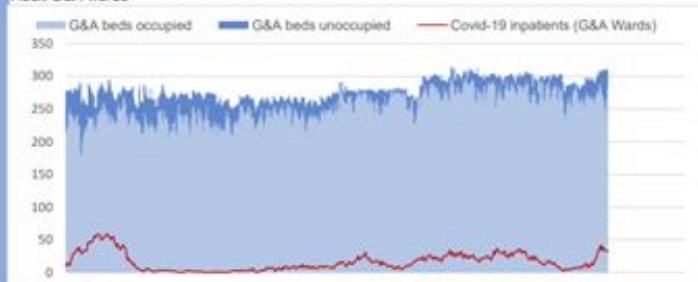
65-74 **8**

75-84 **12**

85+ **11**

Bed occupancy

Adult G&A wards



Intensive Care Unit

G&A (Adult)
% occupied **90.7%**
% Covid-19 **12.1%**

ICU
% occupied **87.5%**
% Covid-19 **14.3%**

% Covid
(Adult G&A + ICU) **11.8%**

5.4

Children's and Community

Performance Indicator Description	Apr	May
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	90.8%	91.3%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.0%	93.6%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	93.3%	100.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	95.4%	90.2%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	93.0%	91.8%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	97.9%	95.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Sunderland**	98.4%	99.5%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Northumberland**	96.7%	95.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	85.5%	86.7%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.4%	93.0%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	99.2%	84.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	89.1%	91.1%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	96.0%	95.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	95.7%	96.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**	96.6%	90.4%

June – OPEL Level 3

Adult Community

Service continues to be very pressured due to increased complexity of caseloads and high vacancy rate and sickness – OPEL level increased to 4 for two-days in June.

Task and finish group continues to meet to agree approaches to address the vacancy challenges. This includes approval of skill mix changes, virtual recruitment campaigns, career fairs and rolling adverts. Enhanced NSHP rates are being continued in the service to support the ongoing pressures.

Appointments have been made to the new Senior Community Nurse role, rotational nurse posts through ARCH and CCT's but Band 5 nursing continues to be the most significant challenge.

.

0-19 Service

Durham, Sunderland, Middlesbrough Gateshead, Northumberland all still at OPEL 3 with support being provided across patch from Darlington, Stockton, North Yorkshire who are at OPEL 1/2 and the Safeguarding Central Team. In OPEL 3 areas actions involve:

Flexible approach to timelines for mandated contacts introduced

Face to face or virtual contacts based on risk assessment, family health needs assessment and cumulative risk.

Safeguarding

Continued high levels of Safeguarding activity.

Floating Safeguarding strategy Nurses continue to support most pressured 0-19 contact areas.

Statutory responsibilities still being delivered.

Community Dental

Service has plan to achieve trajectory to see longest waiters in line with Trust recovery plan. WLI sessions to target longer waiters, Key risk are those patients that require GA and external anaesthetic support has been commissioned to support additional sessions.

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	425	451	438									
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	4,367	4,151									
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	9,495	8,630									

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	2,598	2,352									
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	2,411	2,144									
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	187	208									

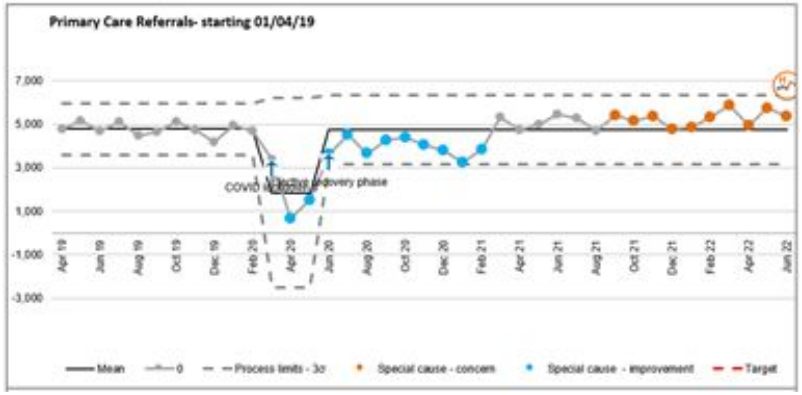
RTT

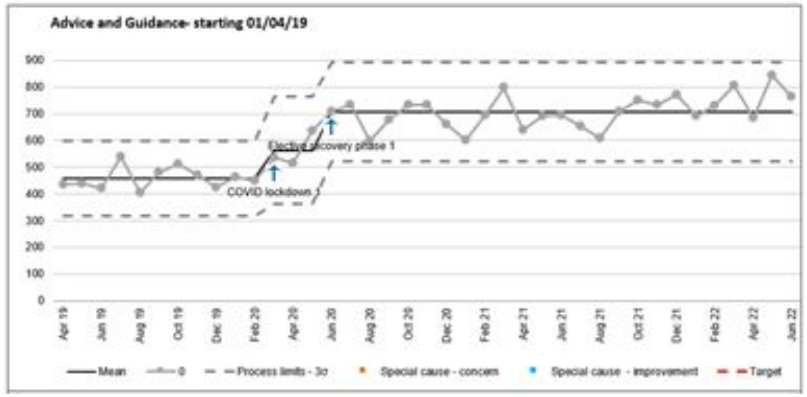
Number of Completed Admitted RTT Pathways Plan	694	818	749	984	950	895	1,002	976	825	972	888	677
Number of Completed Admitted RTT Pathways Actual	832	1,057	886									
Number of Completed Non-Admitted RTT Pathways Plan	4,442	4,661	4,481	6,099	5,282	5,624	6,604	6,017	5,288	6,317	5,474	4,962
Number of Completed Non-Admitted RTT Pathways Actual	3,558	4,079	4,233									
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	7,219	6,382									
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	1,196	1,261									
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	184	169									
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	3	1									
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	25,384	25,184									

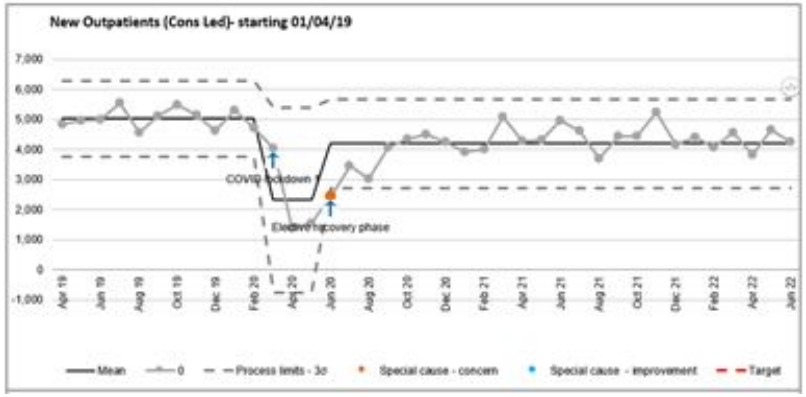
Cancer

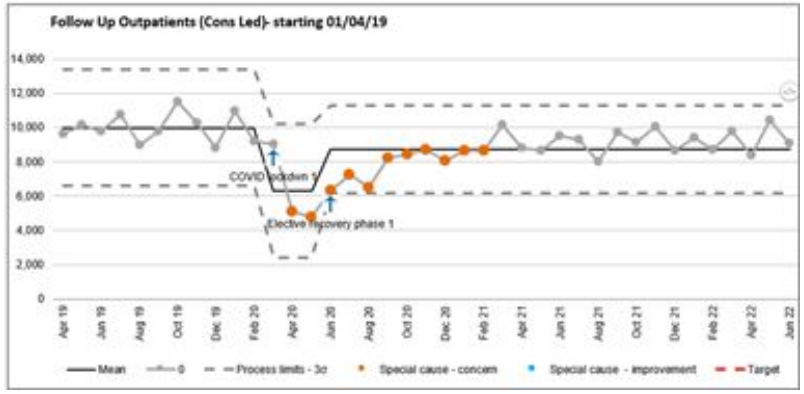
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Plan	47	46	45	44	43	42	41	40	39	35	30	20
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Actual	46	39	48									

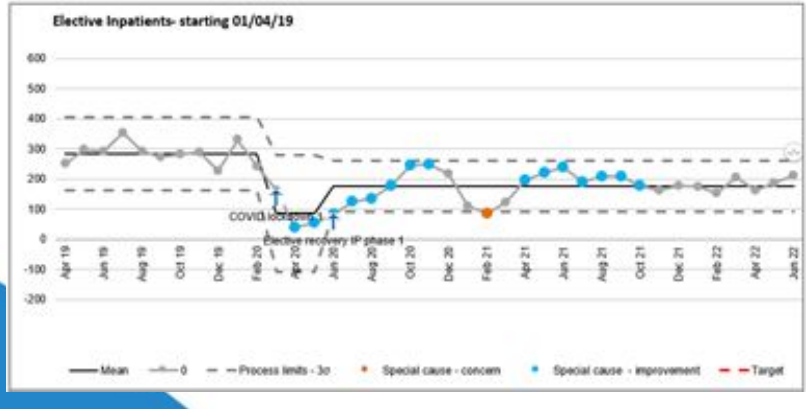
Elective Recovery

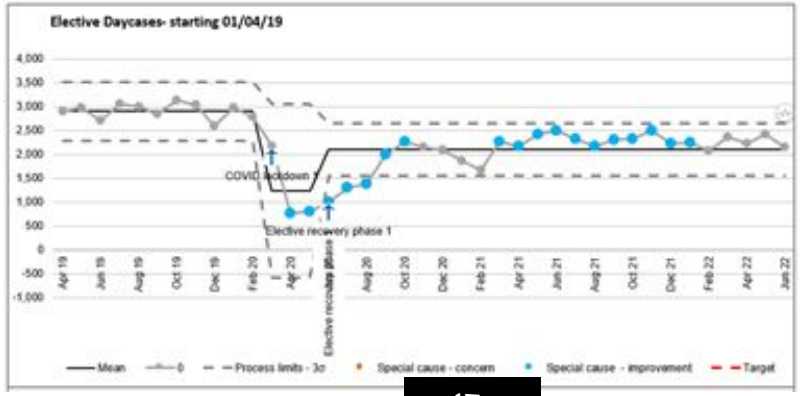








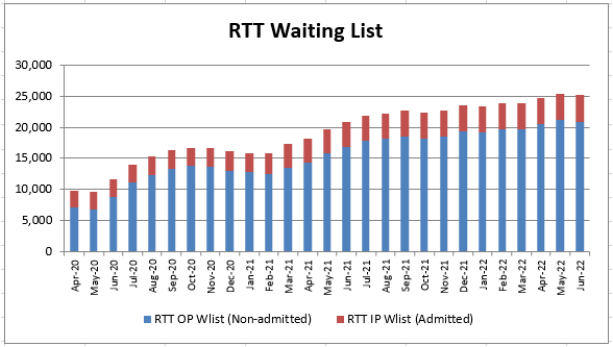


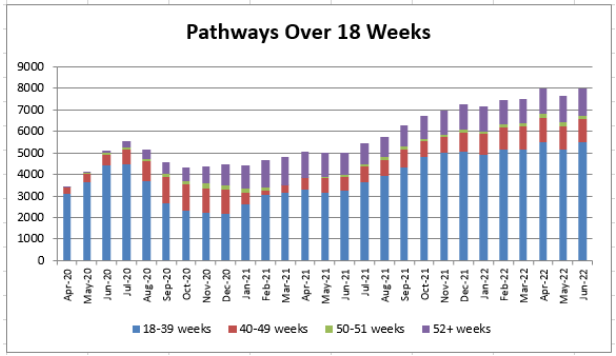


5.4

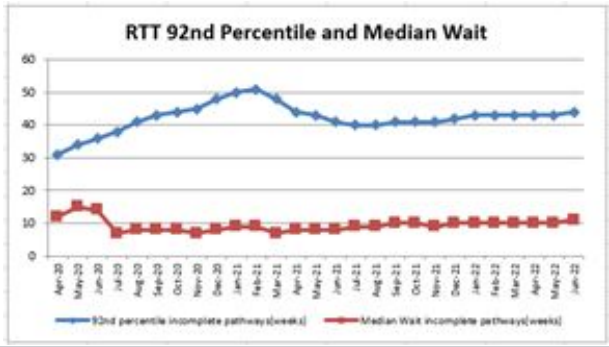
Referral to Treatment (RTT)

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
No. of pathways 18-39 weeks	3,657	3,922	4,336	4,787	4,989	5,035	4,900	5,140	5,156	5,472	5,131	5,487
No. of pathways 40-49 weeks	735	748	820	743	748	925	978	1,041	1,064	1,164	1,121	1,063
No. of pathways 50-51 weeks	90	127	133	104	119	103	127	135	139	163	181	188
No. of pathways 52+ weeks	988	955	1,008	1,070	1,097	1,177	1,138	1,157	1,140	1,187	1,196	1,261
Total >18weeks	5,470	5,752	6,297	6,704	6,953	7,240	7,143	7,473	7,499	7,986	7,629	7,999
Total RTT List	21,785	22,168	22,648	22,423	22,714	23,464	23,323	23,900	23,931	24,714	25,384	25,134



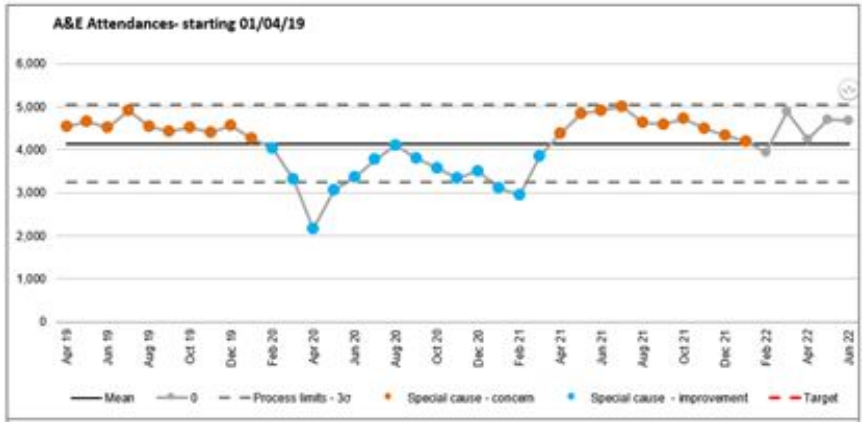


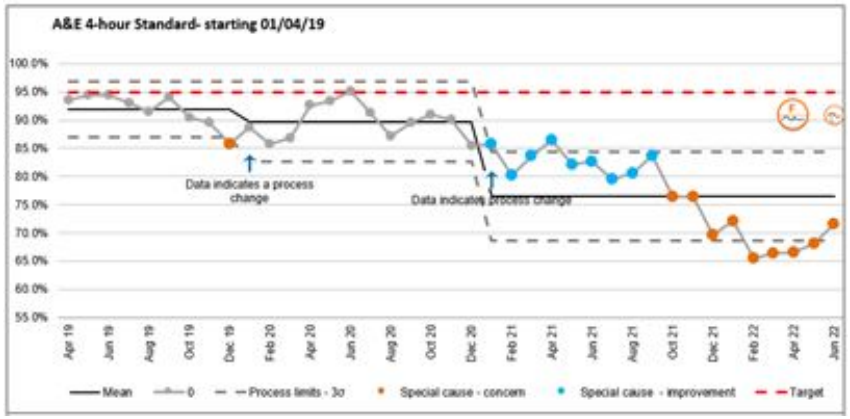
Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	82	0	0	346	303	308	0	24	**1,063**
3-4	11	0	0	35	115	150	0	3	**314**
5-6	8	0	0	26	163	186	0	6	**389**
7-8	4	0	0	9	62	169	0	5	**249**
9-10	2	0	0	6	63	134	0	4	**209**
11-12	1	0	0	5	29	126	0	4	**165**
13-14	2	0	0	2	26	151	0	1	**182**
15+	6	0	0	11	310	2,088	0	31	**2,446**
Total	**116**	**0**	**0**	**440**	**1,071**	**3,312**	**0**	**78**	**5,017**

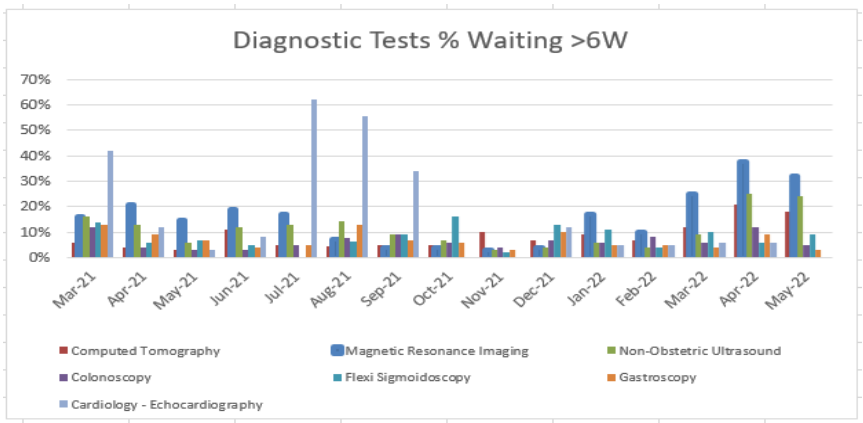


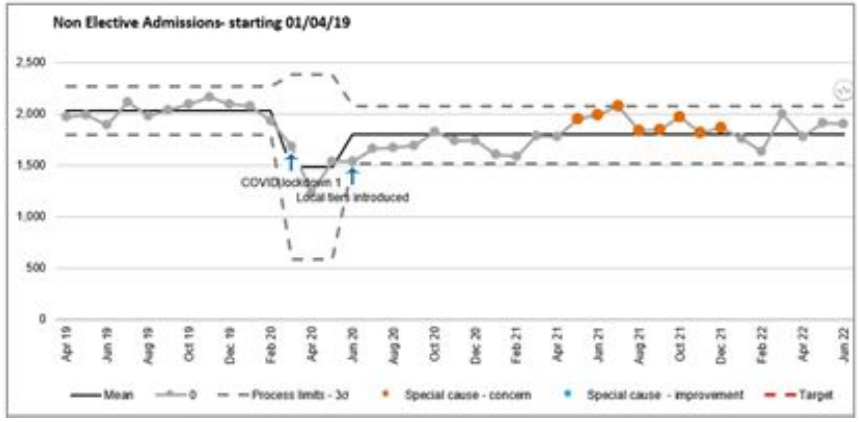
RTT - The Trust had 25,134 patients waiting at the end of June, this is a reduction of 250 patients on the May position. There are 1,261 patients waiting over 52 weeks, this is a 5% increase on the May position. The number of patients waiting longer than 18 weeks has increased compared to last month. The 92nd centile is 44-weeks and the median wait is at 11-weeks.
Of the 5,017 patients waiting for a procedure, 38% are Orthopaedics, 17% General Surgery and 12% Ophthalmology.
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (82/116 have been waiting <=2 weeks and work continues to ensure these are rapidly coded. 87% 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



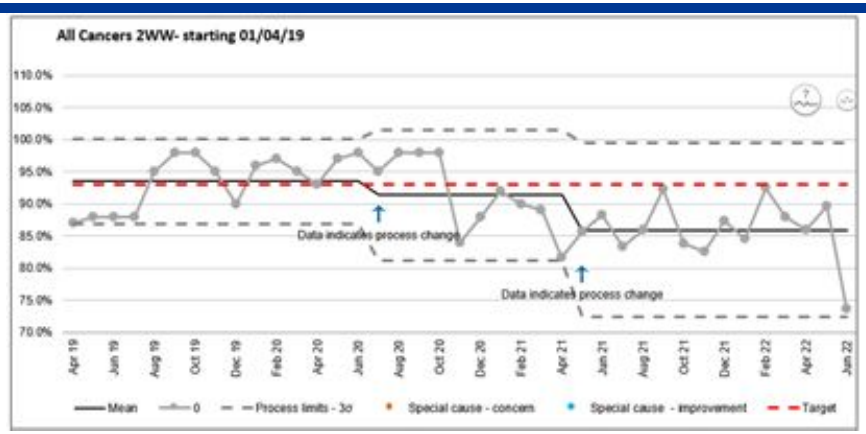


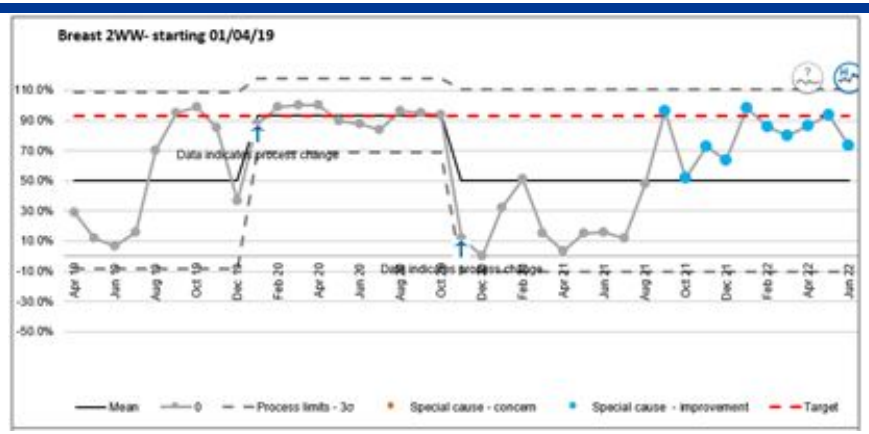


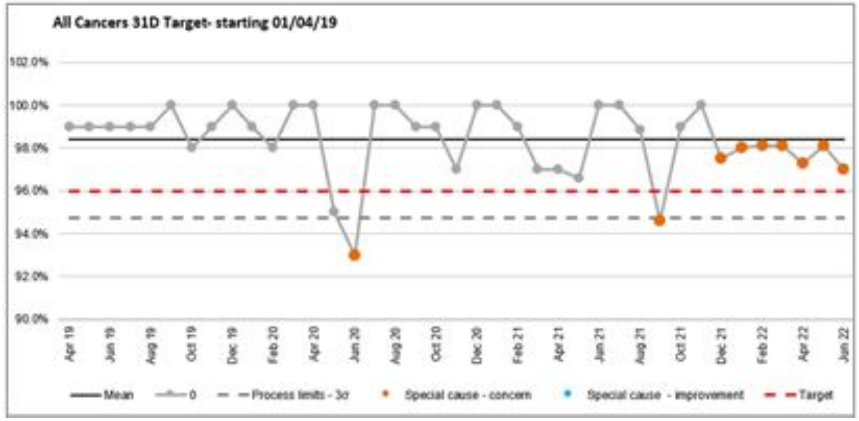


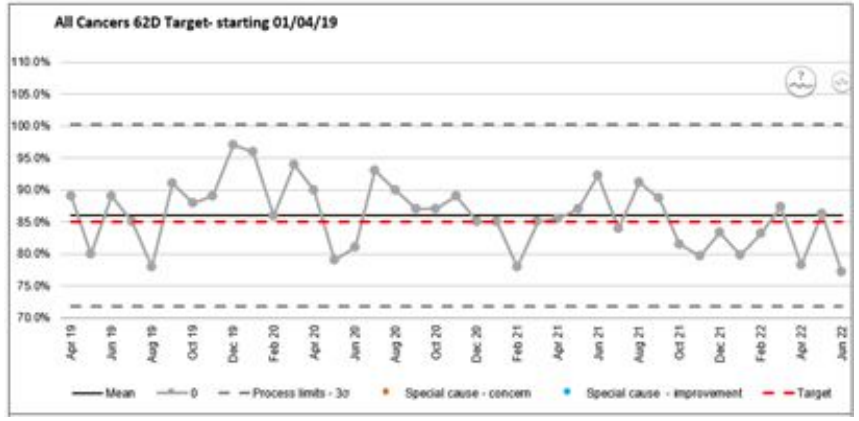
- Performance against the A&E 4-hour standard remained below 95% in June at 71.6%. The 95th percentile wait was 09-hours 59-minutes.
- There were 15 x 12-hour breaches in June.
- There were 32 x 30-minute handover breaches and 2 x 60-minute ambulance handover breach in June.
- ED attendances are now 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.
- Imaging diagnostic activity maintained despite vacancies and sickness, diagnostic waits reducing following last month's increase, this has improved in June following a focus on reducing backlog.

Cancer Performance









- The 62-day standard was not met in June with a performance of 78% against the 85% standard, primarily failings in Colorectal pathway
- The 31-day standard was met in June with a performance of 96.3%
- The 2-week wait standard was not met in June with a performance of 73.5%, Urology performing at 35% due to sickness and annual leave in the month
- The 2-week wait breast symptomatic standard was not met in June with a performance of 73.3%
- At the end of June 52 patients remain on an open cancer pathway over 62-days with 7 of these over 104-days. This remains a key focus, it is also one of
- 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

Workforce & OD

Matters of concern and risks to escalate

- Theatres Investigation – draft report shared with PSC Directorate team to develop action plan – awaiting action plan from Senior PSC team.
- ER casework continues to increase with a number of Disciplinary, Grievance, Capability and Organisational Change cases.

Sickness – 4.96%

Turnover – 16.29%

Appraisals – 60.82%

- Triggered visit by HEE regarding surgical trainees in SDEC following escalation of issues by trainees. Report and conditions placed on us by HEE awaited. Timescale of August to put corrective actions in place.
- Learner Education Report from HEE re triggered visit to SDEC received 8.07. Report is with P&SC to respond to with action plan to remedy issues raised.
- Long term sickness of Education Learning & Development Manager creates risk to service delivery. Interim options being explored as planned return date looking in doubt.
- No training room for Moving & Handling training to take place following refurbishment of Herriotts, alternatives being sought. On HR Risk Register

Major actions commissioned and work underway

- Cultural Review in ED underway.
- Exit Interview pilot extended for 12 months.
- Staff recognition awards & Long Service Event - Working group in place planning event.
- Changes to Covid Sick Pay being implemented
- CEA 2022 was signed off at Director Team and JLNC
- Board Workshop with a focus on workforce issues held on 29 June was very beneficial in terms of informing workforce priorities. SMT workshop to be held on 21 July to progress.
- EDI Lead interviews scheduled for 29 July with a shortlist of 4 strong candidates.
- Leadership forum being developed and scheduled for September 2022 to support line managers with responding to feedback from staff surveys. Aim to create a community of practice/peer support
- Flu/covid vaccine steering group established and meeting regularly. Agreement to purchase Flu/COVID Track. Seeking rooms to host vaccination centre. Recruiting to project management and administrative support roles.
- Doctors in training rotation – 3 August – on-boarding and induction preparations underway
- Survey Monkey developed to capture feedback from out-going doctors in training

Positive news and assurance

- Core Mandatory Training compliance has increased to 90% with combined core and role specific at 81% - significant increases in compliance achieved since RPIW in April 2022.
- Successful MPET review regarding Undergraduate trainee provision with positive feedback received on our trainee experience and HDFT identified as strong educational partner
- **ESRGo went live on the 21st June which was very successful.**
- **Radiology, Microbiology, Diabetes, General Surgery and Acute Frailty were successful consultant recruitment campaigns.**

Decisions made and 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:	11th July 2022
Date of Board meeting this report is to be presented	27th July 2022

6.1

Summary of key issues

- Unfortunately, we were unable to start the meeting this time with our usual colleague story due to Covid absence for the planned presenter. There were also a number of other apologies due to annual leave, absence and clinical priorities. Nonetheless, it was a very useful meeting, covering a number of topics that are really important for colleagues in the Trust and the Board.

- In my Chair report, I referenced the recent Board workshop in June which focused entirely on HDFT colleagues and the Trust People Plan. The Workshop was a really useful session covering insight into the current workforce position and trends, plus a review of plans and priorities. The Executive team have since discussed the workshop output and several key areas of focus are emerging, namely: 1. Widening access (e.g. recruitment adverts); 2. Infrastructure including environment; 3. Recruitment and establishment controls; 4. Learning and development; and 5. Flexible working. This will now be taken forward in an SMT (Senior Management Team) Workshop before coming back to Board.

- We have launched the annual effectiveness review of the People and Culture Committee, and responses were encouraged so we can obtain as much useful feedback as possible.

- We received an update on the site security pilot, under which security colleagues are in place overnight at Harrogate hospital from 6pm. This is receiving good feedback and a full evaluation of the pilot will be done at the end of July.

- The Deputy Director of Workforce and OD gave a comprehensive update on the People Plan, some highlights as follows:
    - The latest Inpulse survey on Teamwork is in progress so we will look at the feedback from this in our next meeting.
    - Feedback from the National staff survey is being taken forward by a cross organisational task and finish group. We are being more specific on the follow up actions, remembering three key themes i.e. resourcing of teams, working environment and appreciation.
    - Excellent work establishing a Menopause staff network with 59 members already.

- Progress on training which is now at 90% completion for core training (85% last meeting) and 81% completion for combined mandatory and role based training (77% last meeting), albeit both remain behind the 95% Trust target.
- Significant activity on Professional Development.
- Preparations to host a number of Interns with autism in September (three confirmed), supported by a coach and tutor.

- We discussed the importance of the right working environment, including facilities such as a suitable staff area. The Trust has created a significant budget (£0.5m) that colleagues can bid for funds from. The importance of empowering colleagues to buy/replace simple things they need quickly within departmental budgets was also discussed.

- Ron Eldridge from Great With Talent joined the meeting to share the latest feedback from Exit Interviews. Take-up has increased to a 26% (49/186) response rate, with ambition and an action plan to get this to the benchmark of around 50-60%. There is a lot of insight to be gained from leavers, e.g. 69% of leavers would return and recommend the Trust and 47% of leavers are 'happy' (versus 40% benchmark), albeit Ron recommends increasing the response rate over the next few months before relying too heavily on these statistics. Further insight and actionable feedback can be gained here, including leaver reason details and free text feedback, and the pilot will be extended for a further 12 months to allow this.

- We received an update on the Employee Assistance Programme (EAP) and the latest usage, given the move of provider to Vivup. Access to self help remains at previous levels, but more people are accessing the new counselling offer which is good to see as it means more people are getting further help where needed. We will continue to monitor the usage of EAP, plus have a look at overall outcomes from the service in our next meeting.

- We also received an update on Occupational Health (OH), which is seeing increased demand. There are two parts to this, firstly, health clearance for new joiners (a 2 day turnaround) and secondly, support for existing colleagues (required within 10 days). Colleagues in the OH team are working really hard to meet the demand but there are vacancies in the team. We will keep an eye on this, including wait times for colleagues, via the Committee.

- There was a deep dive into employee turnover, which remains above target. A retention group has been established and action plans are forming, which we will oversee and support at the Committee. We discussed the need to make it easy for leavers to return (e.g. if new roles outside the Trust don't work out) and the retention group will look at this. The biggest leaver reason is Work-life balance, but we need deeper insight into what this really means - the work on Exit Interviews (as mentioned above) can start to give this insight.

- We discussed the current position with regards to Cost of Living, the impact this is having and the steps the Trust is taking to support colleagues. The Executive Team are focused on this important issue, and the CEO outlined some of the measures that have been taken and some of the further ideas being explored, which the Committee supported.

- The Staff Networks now have Executive sponsors (as follows) and we are looking to establish a Men's Health Network as well:
  - BAME & Ally — Russell Nightingale
  - DLTC — Matthew Graham
  - LGBT+ — Suzanne Lamb
  - Menopause — Angela Wilkinson

- The Deputy Director - Transformation and Improvement provided the usual, excellent update on the Culture Programme. Highlights included Team awards, the launch of a FTSU electronic form and an interesting example on dictation devices, which shows the practical things the Trust is looking at to support equality and diversity.

- On evaluating the meeting, Ian Barlow, observing Governor, commented on the wide range and usefulness of topics discussed and alongside the chair, thanked colleagues for all the effort and input involved.

Any significant risks for noting by Board? (list if appropriate)

There were no new risks or items to escalate this time.

Any matters of escalation to Board for decision or noting (list if appropriate)

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:	31st May 2022
Date of Board meeting this report is to be presented	27th July 2022

Summary of key issues

This was an additional meeting added to the Audit Committee programme to consider matters not ready for earlier Committee meetings. The meeting was attended by representatives of Azets, the Trust's newly appointed external auditors. Tony Doveston and Will Fish observed the meeting on behalf of the Council of Governors.

The Committee met via Microsoft Teams and was well attended. Agenda items included -

- External Audit - Chris Brown and Bethany Hinks from Azets were introduced to the Committee. Chris provided some background information on the creation and growth of Azets over recent years through the acquisition/amalgamation of a relatively large number of small and medium sized firms. Azets' client portfolio already included NHS organisations in England and Scotland. The Azets team providing external audit to another foundation trust would deliver external audit services to HDFT.

- Monitor Provider License – it was noted that the Trust is required to self-certify compliance with a number of licence conditions and that NHS Improvement provided a template to assist the recording of self-certification. The Committee felt that the focus of the certification appeared to be too much on process rather than performance whereas previously there was greater focus on performance alongside process. The Committee suggested that the narrative could be developed to include reference to the steps taken by the Trust to maintain good governance and effective delivery during the pandemic. The Committee noted the Trust's compliance with license conditions.

- NHS Professionals Assurance Statement – the Committee received and noted the assurance statement observing that the assurance was based on a sample of only 16 files over a three-month period. There was some discussion of

mandatory training compliance of bank/agency staff.

- Internal Audit – it was noted that a large volume of work had taken place since the meeting on 18th May to progress the audit plan and follow up on outstanding recommendations. The 2021-22 plan had now been completed with only a few final reports still in draft.

- HIF Internal Audit - the Committee was pleased to note all recommendations had been completed in the weeks leading up to the meeting. An issue relating to problems with the system access required to allow staff to update progress had resulted in Audit Yorkshire staff having to update on behalf of HDFT and HIF colleagues. Steps were in hand to deal with this barrier.

- Internal Audit Annual Report and Head of Internal Audit Opinion – it was reported that increased activity in preceding weeks had moved audit work on sufficiently to allow the preparation of an opinion. The formal opinion would be one of "significant assurance". However, seven reports delivered in 2021-22 providing only limited assurance would be reflected in the opinion narrative.

- There was a discussion of the limited visibility of HIF governance for Governors including the absence of the opportunity for Governors to observe HIF Board meetings. The status of HIF as a limited company separate, but wholly owned by the Trust, was noted. Discussion as to how Governors could be better sighted on HIF work would take place between relevant persons.

- It was noted that a further additional meeting would be required to consider matters related to the 2021-22 financial statements and the Annual Governance Statement in advance of sign-off by the Trust Board.

The next scheduled meeting of the Committee is on 7th September 2022.

Any significant risks for noting by Board? (list if appropriate)

None.

Any matters of escalation to Board for decision or noting (list if appropriate)

None.