Board of Directors Meeting (Public)
To be held on Wednesday 25th January 2023 12.45 – 3.45pm
Venue: Cedar Court Hotel, Harrogate

AGENDA

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
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs	Discuss	Verbal
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chair	Note	Attached
1.4	**Minutes of the Previous Board of Directors meeting held on 30th November 2022**	Chair	Approve	Attached
1.5	**Matters Arising and Action Log**	Chair	Discuss	Attached
1.6	**Overview by the Chair**	Chair	Note	Verbal
SECTION 2: CEO Updates				
2.1	**Chief Executive Report**	Chief Executive	Note	Attached
2.2	**Corporate Risk Register**	-	Note	Supp. pack
SECTION 3: Ambition: Best Quality, Safest Care				
3.1	**Board Assurance Framework: Best Quality, Safest Care**	Director of Nursing, Midwifery and AHPs	Discuss	Attached
3.2a	**Quality Committee Chair**	Quality Committee Chair	Note	Verbal
3.2b	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Quality Committee Chair	Note	Supp. Pack
3.3	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.4	**Medical Director Report**	Medical Director	Note	Attached

SECTION 4: Ambition: Great Start in Life				
4.1	**Board Assurance Framework: Great Start in Life**	Director of Strategy	Discuss	Attached
4.2	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Note	Attached
4.3	**Maternity Incentive Scheme**	Director of Nursing, Midwifery and AHPs	Note	Attached
SECTION 5: Ambition: Person Centred; Integrated Care; Strong Partnerships				
5.1	**Board Assurance Framework: Person Centred; Integrated Care; Strong Partnerships**	Chief Operating Officer	Discuss	Attached
5.2	**Resource Committee Chair's Reports**	Resource Committee Chair	Note	Verbal
5.3	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	-	Note	Supp. pack
5.4	**Chief Operating Officer's Report**	Chief Operating Officer	Note	Attached
5.5	**Director of Finance Report**	Finance Director	Note	Attached
SECTION 6: Ambition: At Our Best: Making HDFT the Best Place to Work				
6.1	**Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work**	Director of People & Culture	Note	Attached
6.2	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	Verbal
6.3	**Integrated Board Report –** Indicators from Workforce Domains	-	Note	Supp. pack
6.4	**Director of People & Culture Report**	Director of People & Culture	Note	Attached
SECTION 7 Ambition: Enabling Ambitions				
7.1	**Board Assurance Framework: At Our Best: Enabling Ambitions**	Director of Strategy/Medical Director	Discuss	Attached (As per Items 7.3, 7.4, 7.5)
7.2	**Innovation Committee – Chair's Report**	Innovation Committee Chair	Note	Verbal

7.3	**Environment – update**	Director of Strategy	Note	Attached
7.4	**Digital – update**	Medical Director	Note	Attached
7.5	**Innovation - update**	Medical Director	Note	Attached
7.6	**Director of Strategy's Report**	Director of Strategy	Note	Attached
SECTION 8: Governance Arrangements				
8.1	**Audit Committee Chair's Reports**	Committee Chair	Note	Attached
8.2	**Use of the Trust Seal**	-	Note	Supp.Pack
8.3	**WYAAT Programme Executive minutes**	-	Note	Supp. Pack
8.4	**Collaboration of Acute Providers minutes**	-	Note	Supp. Pack
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Public Board meeting:** Wednesday, 29th March 2023 12:45-15:45			
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.*				

NOTE: The agenda and papers for this meeting will be made available our website. Minutes of this meeting will also be published in due course on our website.

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interests
As at 30th November 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
Azlina Bulmer	Non-executive Director	November 2022	Date	1. Executive Director for the Chartered Insurance Institute, 2. Familial relationship for Health Education England
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	No interests declared	
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Tipton 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
Chiara De Biase	Non-Executive Director	November 2022	Date	1. Director of Support and Influencing for Prostate Cancer UK
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. 7. Familial relationship with Harrogate GP Vocational Training Scheme 8. Familial relationship within Harrogate & District NHS Foundation Trust
Jordan Mckie	Acting Director of Finance (From March 2022)	August 2022	Date	1. Chair of Internal Audit Provider Audit Yorkshire
Kama Melly	Non-executive Director	November 2022	Date	1. Kings Council Barrister
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	Group Director, Cost and Productivity Insight at Lloyds Banking Group
Laura Robson	Non-executive Director	No interests declared		

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) 8. Member of Challenge Board for Northumberland County Council.
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) 8. Member of the Corporation of the Heart of Yorkshire Education Group
Julia Weldon	Non-Executive Director	November 2022	Date	1. Director of Public Health / Deputy Chief Executive at Hull City Council and Co-chair of the population health committee for the Humber and North Yorkshire Integrated Care Board.

Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	1. Director of ILS and IPS Pathology Joint Venture 2. Familial relationship within Harrogate & District NHS Foundation Trust

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
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
Maureen Taylor	Non- Executive Director		September 2022	No Interest declared0
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared		

Board of Directors Meeting - Public
Wednesday, 30th November 2022, 1.00 – 4.00pm
Held at Crown Plaza, Harrogate

Present
Sarah Armstrong, Chair
Jonathan Coulter, Chief Executive
Jeremy Cross, Non-executive Director (JC)
Chiara Debiase, Non-executive Director (CD)
Andy Papworth, Non-executive Director (AP)
Laura Robson, Non-executive Director/Senior Independent Director (LR)
Wallace Sampson OBE, Non-executive Director (WS)
Richard Stiff, Non-executive Director (RS)
Julia Weldon, Non-executive Director (JW)
Kama Melly, Associate Non-executive Director (KM)
Azlina Bulmer, Associate Non-executive Director (AB)
Jacqueline Andrews, Executive Medical Director
Matthew Graham, Director of Strategy
Jordan McKie, Acting Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Executive 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
Amanda Russell, Lead Nurse for Intensive Care Unit *for Item 2 – Patient Story*

Observing
3 observers were present at the meeting.

Item No.	Item
BD/11/30/1	**Welcome and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting including new Non-Executive Directors, Associate Non-Executive Directors and those observing the meeting.
1.2	No apologies for absence were received.
BD/11/30/2	**Patient Story**
2.1	Amanda Russell, Intensive Care Unit (ICU) Lead Nurse was in attendance to update the Board on this months patient story, Tom. Tom is 19 and he has muscular-dystrophy. He was a patient in ICU for 10 weeks in the summer of 2022. He was admitted to hospital with a chest infection and was transferred to ICU due to a deterioration in his respiratory function. Here it deteriorated further. He required intubation and a range of interventions, that proved more complicated due to his condition. This was an extremely difficult time for the family, who had never left Tom with anyone caring for him other than themselves. The team developed a strong relationship with Tom and his family during this time. The family contacted the patient experience team to thank the team for the care and support given to Tom and the family.
2.2	The Non-executive Director (LR) noted how important it is to support and care for the whole family and not only an individual patient.

2.3	The Non-executive Director (WS) queried the support available for staff. It was confirmed that there is a network of support available and a range of tools to access.
2.4	**Resolved:** Amanda Russell was thanked for providing the Board with this patient story. The patient story was noted.
2.5	*Kat Johnson, Clinical Director left the meeting. Amanda Russell, ICU Lead Nurse left the meeting.*
BD/11/30/3 **3.1**	**Declarations of Interest and Register of Interests** The register of interests was received and noted.
3.2	New declarations were noted as follows: • Julia Weldon, Non-Executive Director declared that she was Director of Public Health / Deputy Chief Executive at Hull City Council and Co-chair of the population health committee for the Humber and North Yorkshire Integrated Care Board. • Chiara Debiase – Director of Support and Influencing for Prostate Cancer UK • Kama Melly – Kings Council Barrister • Azlina Bulmer – Executive Director for the Chartered Insurance Institute, familial relationship for Health Education England
3.3	**Resolved:** The declarations were noted.
BD/11/30/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 28th September 2022** **Resolved:** The minutes of the meeting on the 28th September 2022 were approved as a correct record.
BD/11/30/5 **5.1**	**Matters Arising and Action Log** The actions were noted as follows: • 7.12 – Winter Plan – Completed • 9.7 – Governor Allocation – Completed • 12.8 – Maternity attendance – Completed • 16.16 – Guardian of Safe Working - Completed • 16.6 – Risk Registers – Completed • 23.8 – Management Restructure – January 2023 • 25.3 - WRES and WDES Reports – Completed • 24.6 – Chair Reports – Completed • 262 – BAF – Completed
5.2	**Resolved:** All actions were agreed as above.
BD/11/30/6 **6.1**	**Overview by the Chair** The Chair noted that Steve Russell, Chief Executive Officer (substantive) would be leaving the organisation to continue his post at NHS England. Thanks were expressed to him for his commitment and dedication at HDFT. The current arrangements would remain and further information would be shared in due course.
6.2	Thanks were expressed to all for trialling the new governance arrangements whereby Sub-Committees of the Board were taking place on the same day as the Board.
6.3	The KITE awards ceremony were noted as taking place the previous week. Thanks were expressed to all involved.
6.4	North Yorkshire County Council Area Committee had been attended by the Chair and Chief Executive Officer.
6.5	

6.6	All Non-executive Director appraisals had been completed, as well as Executive Directors. The Chair also received her 6 month appraisal. It was noted that the Annual Members Meeting is due to take place on Monday 5th December 2022.
6.7	**Resolved:** The Chair's report was noted.
BD/11/30/7	**Chief Executive Report**
7.1	The Chief Executive presented his report as read.
7.2	He highlighted the recent Autumn Statement from the government and the implications for the NHS. This was linked to a focus on improving ambulance response times, improving against the 4 hour emergency care standard and improving access to primary care.
7.3	Since the last meeting of the Board, the CQC had visited to inspect maternity services. Thanks were expressed to all of those involved with the visit. The formal feedback was awaited.
7.4	The Board were updated on the current position with industrial action. It was noted that the strikes planned in December 2022, would not include HDFT.
7.5	Financial hardship was also highlighted and the Board noted the continued options for support that HDFT had available for colleagues.
7.6	The KITE award ceremony was noted and it was highlighted that Theatres had received the award for Team of the Year. The Board noted the significant improvements that had been made by this team in the last 12 months. Thanks were expressed to the team for their hard work and dedication.
7.7	The Non-executive Director (LR) queried when the Hewitt report would be available. The Chief Executive noted that this was expected before the end of the financial year.
7.8	The Non-executive Director (LR) noted that Julian Hartley, Chief Executive was leaving Leeds Teaching Hospital NHS Trust and it was noted that thanks from the Board should be expressed.
7.9	The Non-executive Director (LR) queried the impact of local Trust's strike action. The Chief Executive confirmed that all organisations would be considering the impact this will have on their own organisations and ways to ensure patient safety.
7.10	The Non-executive Director (LR) noted that Claire Hutton, Matron for Theatres had been to the Quality Committee to deliver an update in previous months. It was noted the significant leadership and influence she had on the culture of the team.
7.11	The Non-executive Director (AP) noted the volume of patients that do not attend appointments. The Chief Executive confirmed that this was approximately 5% of clinic appointments. The Director of Strategy made reference to the impact of levels of deprivation on patients who do not attend. Further work was being undertaken on this.
7.12	The Non-executive Director (AP) noted the levels of flu vaccination uptake. Whilst HDFTs vaccination numbers were above levels as compared to other local providers, it was still lower than previous years.
7.13	The Non-executive Director (AP) noted how positive the KITE awards had been. Reflections were made on the long service awards and the impact these individuals have on the organisation.

7.14	The Non-executive Director (JW) noted the potential that cost of living crisis may be having an impact on those patient who do not attend appointments.
7.15	The Non-executive Director (JW) noted that there would be examples of colleagues who had begun as junior workers in the organisation and had progressed to senior management roles and these such be celebrated.
7.16	The Non-executive Director (JW) queried the funding for the system as described in the Chief Executives update. The Chief Executive provided further detail on the amounts being received and confirmed that Plans were being developed at a Place level.
7.17	The Non-executive Director (JW) queried the Opel 3 level in 0-19 services. The Chief Executive confirmed that this was in general related to staffing. The Clinical Director for Children and Community confirmed that significant mitigation was in place to reduce the risk in this area. This include recruitment to different types of roles.
7.18	**Action:** • The Board agreed to formally write to Julian Hartley, Chief Executive at Leeds Teaching NHS Hospital Trust to express HDFTs thanks. • The Board agreed to hold a future workshop within the Wakefield area • The Board agreed that the Resource Committee would review in further detail the Do Not Attend appointment figures.
7.19	**Resolved:** The Chief Executive's Report was noted.
BD/11/30/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/11/30/9 **9.1**	**Board Assurance Framework (BAF)** The Chief Executive provided the Board with an update on the production of the new Board Assurance Framework. It was noted that this was linked to the revised Trust Strategy.
9.2	The Non-executive Director (AP) noted that the BAF focuses on strategic assurance against delivery of the Trust Strategy and the Integrated Board Report (IBR) focused on the current operational position. The Chief Executive and the Director of Strategy confirmed that this was the case and metrics were being reviewed.
9.3	The Non-executive Director (AP) flagged the RAG rating for the Metric / Outcome RAG and the Delivery RAG. The Chief Executive confirmed that the Metric / Outcome RAG links to if the plan in place, if delivered, will meet the overall outcome or ambition. The Delivery RAG links to if the delivery of the plan itself and whether it is on or off track.
9.4	**Resolved:** The revised Board Assurance Framework was noted and it was agreed that formal approval would be consider once further discussions had taken place during the course of the meeting.
BD/11/30/10 **10.1**	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an overall update on the ambition and goals for this area of the BAF. It was noted that this focuses on key quality priorities linked to: • Theatres which was on track to deliver • Falls was rated as Amber due to a delay in commencement against elements of this work stream, mitigation is in place and will be brought back on track in the coming months

	• Pressure Ulcers was rated as Amber due to a delay in commencement against elements of this work stream, mitigation is in place and will be brought back on track in the coming months • Missed Results was rated as Amber due to the action plan requiring development following the recent Rapid Improvement Project • Medication Errors was rated as Green with increased focus on incidents related to insulin errors • Patient Experience was rated as Amber due to current compliance with the NHSE Patient Experience Framework
10.2	Assurance was given against the progress overall of this element of the BAF. It was confirmed that delivery of these projects would meet the overall ambition.
10.3	The Non-executive Director (CB) queried the links between complaints and recruitment and retention. The Executive Director of Nursing, Midwifery and AHPs confirmed that moving forward further triangulation would be utilised.
10.4	**Resolved:** The update on Best Quality, Safest Care was noted.
BD/11/30/11 **11.1**	**Quality Committee Chair's Report** The Chair of the Committee noted the content of her report from the October 2022 meeting. It was highlighted that the Committee had discussed in detail the access to Stroke pathways. The Executive Medical Director had confirmed at the November 2022 Committee that no further concerns had been raised.
11.2	The Committee had discussed the impact on patients who remained in hospital but were medically fit for discharge.
11.3	The Committee had received a presentation at the November 2022 meeting on the Patient Experience Framework as part of the ongoing updates on the Quality Priorities.
11.4	The Committee received an update against key quality metrics. Discussions had been held on Duty of Candour, Concise Serious Incident numbers, Policy and Guidelines, Friends and Family response rates, Health and Safety, Ligature Risks and Tracheostomy Patients and where they are cared for.
11.5	The Committee had received the Quality Governance Management Group (QGMG) November 2022 minutes and discussed the topics that had been reviewed at the meeting.
11.6	The Committee had approved the Infection Prevention and Control Policy.
11.7	The Non-executive Director (CD) queried the initiatives that were in place in relation to prevention of harm to patients who are fit for discharge. The Executive Medical Director updated the Board on the system wide project that was in place.
11.8	**Resolved:** The Board noted the content of the report.
BD/11/30/12 **12**.1	**Integrated Board Report -** Indicators from Safe, Caring and Effective domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
12.2	**Resolved:** The Board noted the content of the report.
BD/11/30/13 **13.1**	**Executive Director of Nursing, Midwifery and AHPs Report** The Director of Nursing report was received and taken as read.

13.2	Nurse staffing was highlighted to the Board in relation to the challenges that remain for fill rates. Mitigation was noted as being in place. Ongoing recruitment plans were noted including the successful bid for international recruitment.
13.3	The recent CQC maternity inspection was highlighted and thanks were expressed to all involved. The draft report was awaited.
13.4	The Non-executive Director (WS) queried if the safeguarding roles that were being recruited to, if they would be like for like. The Executive Director of Nursing, Midwifery and AHPs confirmed that additional roles to strengthen the team would be recruited to as well as like for like posts.
13.5	**Resolved:** The Board noted the content of the report.
BD/11/30/14	**Executive Medical Director**
14.1	The Director of Nursing report was received and taken as read. It was highlighted that the National Medical Director, Professor Sir Stephen Powis would be visiting HDFT on the 2nd December 2022.
14.2	There had been successful recruitment to the SAS (Speciality and Specialist) Doctors Advocate.
14.3	It was noted that the new Innovation Committee had been held in November 2022 and an update was provided on the broader research and innovation programme. A monthly Mortality Committee had also been established.
14.4	An update was provided on the potential £30m for the digital transformation project and noted that the funding had not been received as yet.
14.5	The Non-executive Director (AP) queried where the Clinical Strategy would be signed off. The Chief Executive confirmed that it would be approved by the Board.
14.6	The Non-executive Director (RS) queried the location of the Innovation Team not being on-site at HDFT and if this would impact on visibility. The Executive Medical Director confirmed that a presence would be maintain on and off site, however the remote working would also assist in supporting community services.
14.7	**Resolved:** The Board noted the content of the report.
BD/11/30/15	**Learning from Deaths Quarter 2 Report**
15.1	The Executive Medical Director noted that the full report would be circulated. It was noted that in previous Board meetings discussions had been held on the internal deep dives to the rise in mortality figures.
15.2	It was noted that HDFT had request an independent review and this had been completed. The initial findings have indicated that there is nothing further to note and it was confirmed that the most likely reason for the changes in the figures was in relation to Covid and a change in demographic for the local population.
15.3	The Non-executive Director (AP) queried if the Deputy Medical Director was also the Medical Examiner and that all deaths were being reviewed. The Executive Medical Director confirmed that this was the case.
15.4	**Resolved:** The Board noted the content of the report.
BD/11/30/16	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships**

16.1	The Chief Operating Officer provided the Board with an overall update on the ambition and goals for this area of the BAF. It was noted that there were 13 key areas of focus, of which 3 are rated as green, 9 are rated as amber and 1 is red.
16.2	**Resolved:** The update on person centred, integrated care, strong partnerships was noted.
BD/11/30/17	**Resource Committee Chair Report**
17.1	The Chair of the Committee confirmed the purpose of the Committee was a focus on finance, operational standards and workforce.
17.2	It was confirmed that the Trust would see a breakeven position for 2022-23, but this would be a non-recurrent situation. Discussions had been held on the cost of living crisis, agency costs and cost improvement programmes.
17.3	*Kat Johnson, Clinical Director returned to the meeting.*
17.4	In addition, discussions on the performance against constitutional standards had taken place with a focus on ambulance handovers, cancer 62 week and 2 week waits, urgent care 4 hour target and Referral To Treatment (RTT) target. The successful improvement in Children's Services was also noted.
17.5	The Committee had discussed the recent transfer of Wakefield children's service and the impact that this had on workforce including vacancy rates.
17.6	It was confirmed that Selby Urgent Treatment Centre (UTC) would remain with the Trust for a further 18 months.
17.7	Two key risks were noted in relation to Capital Spend and the 2023-24 financial position.
17.8	The Non-executive Director (RS) queried the funding available to Selby UTC and the impact this would have on staffing. The Chief Operating Officer confirmed that the funding would supporting staffing during this period.
17.9	**Resolved:** The Board noted the content of the report.
BD/11/30/18	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains
18.1	The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
18.2	**Resolved:** The Board noted the content of the report.
BD/11/30/19	**Chief Operating Officers Report**
19.1	The Chief Operating Officer presented the report as read. It was highlighted that there had been an 11% increase on Diagnostic Waiting Times (DM01) performance.
19.2	The Trust continued to support the system with ambulance diverts from other local trusts.
19.3	The Non-executive Director (LR) noted the improved position for dermatology.
19.4	The Non-executive Director (LR) queried the frequency of the Perfect Week. The Chief Operating Officer confirmed that HDFT were following the model implemented by other trusts and the focus was on flow.
19.5	The Non-executive Director (LR) queried how long patients were waiting outside the two week wait for breast patients. The Clinical Director for Planned and Surgical Care

	confirmed that the number of patients that required treatment within 62 days were receiving it. There are short delays in patients receiving their reviews within two weeks.
19.6	**Resolved:** The Board noted the content of the report.
BD/11/30/20	**Director of Finance Report**
20.1	The Director of Finance presented his report as read. It was highlighted that the 2023-24 financial year would be challenging. The Board noted the introduction of the NHS England forecast changes protocol and noted that this had been discussed at Resource Committee.
20.2	The Non-executive Director (RS) queried the costs and funding for the cost of living initiatives at HDFT. The Director of Workforce provided information on the elements that contributed to this.
20.3	**Resolved:** The Board noted the content of the report.
BD/11/30/21	**Board Assurance Framework – Great Start in Life**
21.1	The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on this element of the BAF.
21.2	The Non-executive Director (JW) queried the position on autism assessments. The Executive Director of Nursing, Midwifery and AHPs provided an update which included the changes to commissioning of the models of care.
21.2	The Non-executive Director (RS) noted the Hopes for Healthcare aspirations pre-Covid. It was queried what work would be continued post Covid. The Clinical Director for Children and Community confirmed that work was ongoing and that this would be overseen by the 0-19 Committee.
21.3	**Resolved:** The update on Great Start in Life was noted
BD/11/30/22	**Strengthening Maternity and Neonatal Safety**
22.1	The Executive Director of Nursing, Midwifery and AHPs took the report as read. It was highlighted that the Qualified in Speciality (QIS) had previously been noted at Board as a risk. It was confirmed that recruitment was ongoing and the risk would reduce once those people were in position.
22.2	Historically risks had been reported on vacancies for Delivery Suite Coordinators, it was confirmed that individuals were now recruited to and had commenced in post. The positive impact of the individuals was already being seen in the department.
22.3	A new Healthcare Safety Investigation Branch incident was noted.
22.4	It was noted that at Quality Committee, a discussion had been held on the difficulties for the Maternity Voice Partnership funding.
22.5	The Non-executive Director (AP) confirmed that he had undertaken a 15 steps observation with the Maternity Voices Partnership Chair for community services.
22.6	The Non-executive Director (KM) queried when face to face antenatal classes would recommence. The Executive Director of Nursing, Midwifery, AHPs confirmed that these would recommence at the start of 2023.
22.7	**Resolved:** The report was noted.

BD/30/11/23	**Board Assurance Framework – At Our Best Place to Work**
23.1	The Director of Workforce and Organisational Development updated the Board on this element of the BAF and confirmed that it would be fully populated for the next meeting.
23.2	**Resolved:** The update on the at our best, making HDFT the best place to work was noted.
BD/30/11/24	**People and Culture Committee Chair's Report**
24.1	The Chair of the Committee provided an update on the meeting that had taken place. The Committee had discussed the purpose of the committee and the focus on the People Strategy and Plan.
24.2	It was noted that Wellbeing, Belonging, New Ways of Working and Growth for the Future would be the four pillars for the people governance structure.
24.3	The Health Education England Assessment had been discussed at the Committee. The self-assessment had been positive.
24.4	The gender and ethnicity pay reports had been reviewed at the Committee. A discussion had been held of the potential to review for other areas such as LGTBQ+.
24.5	The Equality Delivery System 2022 assessment had been received. Areas for improvement were noted as undertaking Equality Impact Assessment and the capturing of patient feedback to develop pathways.
24.6	It was noted that the Freedom to Speak Up Guardian had been unable to attend the Committee, but would attend to provide a thematic update at the January 2023 meeting.
24.7	A discussion had been held on the links between HDFT and HIF. It was confirmed that informal issues would be reviewed via the Executive Director links as well as formal updates through the HIF Managing Director reports to the Private Board.
24.8	**Resolved:** The Chair's update was noted.
BD/30/11/25	**Workforce Report and Organisational Development Report**
25.1	The Director of Workforce and OD presented her report as read. The potential industrial action was highlighted and it was noted that contingency plans were being reviewed.
25.2	The Board noted that the Head of Occupational Health was retiring and that the recruitment process had commenced.
25.3	Pension recycling was highlighted as an area of focus that would be reviewed in the coming months by the People and Culture Committee.
25.4	A just a learning approach to employee relation matters was being commenced and would mirror the approach that was undertaken when investigating a Serious Incident. This was a joint project with Unison, HR team and Quality Team.
25.5	It was noted that a new Men's Health Staff Network had been launched.
25.6	The Non-executive Director (WS) queried the programmes of work to increase appraisal rates. The Clinical Directors noted that the position needed to be improved and each directorate were providing additional support to the areas where compliance needed to be increased the most.
25.7	The Non-executive Director (RS) noted mandatory training linked to safeguarding training where there are elements of low compliance. The Chief Executive noted that

	there required further work. The Executive Director of Nursing, Midwifery and AHPs confirmed that some elements of role specific training in relation to safeguarding was received additional focus. Quality Governance Management Group was focusing on the elements where there was a potential clinical risk.
25.8	**Action:** Training and Appraisal Compliance to be reviewed as part of a deep dive at the People and Culture Committee in January 2023.
25.9	**Resolved:** The Board noted the content of the report.
BD/11/30/26	**Board Assurance Framework – Enabling Ambitions**
26.1	The Director of Strategy updated the Board on the environment enabling ambitions. The Executive Medical Director update the Board on the Digital Transformation and Healthcare Innovation enabling ambitions.
26.2	The Non-executive Director (LR) noted the Wensleydale refurbishment would not be completed until the end of 2023. The Clinical Director for LTUC confirmed that the High Dependency Unit would, during that time period, be held on Bolton Ward.
26.3	The Non-executive Director (WS) queried the outcome of the Green Plan. The Director Strategy confirmed that the Plan had been developed. The Travel Plan had been written and was progressing through the sign off process. The BAF would be updated to indicate the plans that would be put in place.
26.4	**Action:** The Executive Medical Director to provide a Grid regarding Innovation to future meetings.
26.5	**Resolved:** The update on the Enabling Ambitions was noted.
BD/11/30/27	**Innovation Committee Chair's Report**
27.1	The Chair of the Committee updated the Board on the development of the new Committee. The inaugural meeting had been held on the 30th November 2022. The meeting was focused on procedural matters in relation to the development of the Terms of Reference and the supporting governance structures. The three primary stands would be in relation to Research & Innovation, Digital Transformation and Continuous Improvement.
27.2	The Committee had noted the scale and breadth of the digital transformation work stream including the capacity to delivery, risks and mitigation. An area of risk was noted to be escalated to the Board on the Electronic Patient Record (EPR).
27.3	The Committee had discussed the development of a partnership with Leeds Teaching NHS Trust in relation to Research and Innovation.
27.4	It had been noted at the Committee that the Board would undertake a workshop at a future date on Continuous Improvement.
27.5	**Resolved:** The Chair's update was noted and reference was made to the escalation of risk to the Board on the Electronic Patient Record.
BD/11/30/28	**Director of Strategy Report**
28.1	The Director of Strategy presented his report as read. It was highlighted that there was a risk in relation to a reduce level of capacity in the Project Management Office.
28.2	A business case for TIF2 had been approved and confirmation of funding had been received.
28.3	**Resolved:** The Director of Strategy Report was noted.

28.4	**Resolved:** The Board confirmed that the Board Assurance Framework was approved in its entirety following full review during the meeting.
BD/11/30/29 **29.1**	**Audit Committee Chair's Report** The Chair noted that no meeting had been held in the time period.
BD/11/30/30 **30.1**	**WYAAT Programme Executive Minutes** **Resolved:** The WYAAT Programme Executive Minutes were noted.
BD/11/30/31 **31.1**	**Collaboration of Acute Providers Minutes** **Resolved:** The Collaboration of Acute Providers Minutes were noted.
BD/11/30/32 **32.1**	**Any Other Business** No further business was received.
BD/11/30/33 **33.1**	**Board Evaluation** Any comments to be submitted to the Chair.
BD/11/30/34 **34.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 25th January 2023.
BD/11/30/35 **35.1**	**Confidential Motion** **Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Board of Directors (held in Public) Action Log for January 2023 Board Meeting							
Minute Number	**Date of Meeting**	Subject	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BD/09/28/23.8	28 September 2022	Management Restructure	An update on the Management Restructure to be provided at the People and Culture Committee in January 2023.	Director of Workforce and OD	25 January 2023	**Update January 2023** To be noted following People and Culture Committee on 25th January 2023	Ongoing
BD/11/30/25.8	30 November 2022	Training and Appraisals	Training and Appraisal Compliance to be reviewed as part of a deep dive at the People and Culture Committee in January 2023.	Director of Workforce and OD	25 January 2023	**Update January 2023** To be noted following People and Culture Committee on 25th January 2023	Ongoing
BD/11/30/26.4	30 November 2022	Innovation	The Executive Medical Director to provide a Grid regarding Innovation to future meetings.	Executive Medical Director	25 January 2023	**Update January 2023** Closed - on the agenda	Closed

Board of Directors (Public)
25th January 2023

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. 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)
JANUARY 2023

CHIEF EXECUTIVE'S REPORT

National and system issues

1. There have been a number of significant communications from NHS England over the last month or so, including the planning guidance for 2023/24, announcement of further financial support by way of a discharge fund, and a reminder and a challenge to systems in respect of delivering the target of having no patients waiting over 78 weeks by the end of March.

2. In terms of the planning guidance, the three key tasks identified are to recover our core services and productivity, progress in delivery of the long-term plan ambitions, and to transform the NHS for the future.

3. In more specific terms, there is a requirement to reduce ambulance handover times, improve A&E wait times, reduce elective waiting lists, improve diagnostic access, and improve access to primary care. There are targets in respect of A&E waiting times (76% to achieve the 4 hour standard) as well as reducing maximum waiting times down to 65 weeks.

4. As part of this guidance, which we will go through later in the agenda, there is a commitment to produce a national workforce plan, independently assessed, as well as a consolidated maternity improvement plan, which will combine a number of recent reports and recommendations.

5. NHS England have been true to their promise to reduce the scale of the planning guidance and to focus on a smaller number of priorities, and this is welcomed, and to be fair there is nothing in the guidance that we wouldn't wish to be delivering for our patients and wider population.

6. Financially, the commitment is for each system to have at least the same amount of funding available as 2022/23, adjusted for expected inflation, but there is a recognition that this funding may need to be deployed in different areas. There is also a move back to an element of tariff-based payment for elective activity, which we will need to work through when the guidance is clearer.

7. We are in the middle of our planning process, and there will be opportunity for full Board engagement over the next couple of months. The expectation is that we develop plans as integrated care systems (ie across HNY ICB), and this will require work from the team to ensure that we manage this both collectively and also organisationally.

8. In respect of the in-year pressure to make sure no patients wait longer than 78 weeks by the end of March, there has been significant discussion across the system. In terms of risk, two of the four hospital trusts in HNY have significant risk to the delivery of this position, and there is therefore understandable interest and scrutiny on the HNY system. There is a request for further mutual aid to support the system, and we have therefore

agreed further support to York in terms of transferring 100 patients across to HDFT for us to see in March.

9. This will necessarily put pressure on our position as an organisation, but is the right thing to do for patients. We have also offered further diagnostic access to help the system performance.

10. It is helpful for the Board to be aware of the mutual aid that we have appropriately supported over the year, and to give assurance that we are a strong system partner whilst also delivering for our usual catchment population. Our mutual aid includes the 100 patients and diagnostic access recently discussed, provision of nurse endoscopist support which has enabled 160 patients to be seen, support for some orthopaedic long wait patients, provision of some Breast cancer capacity to West Yorkshire, and the admission of around 600 acute patients as a result of over 1000 ambulance diverts into Harrogate this year. It should be noted that we have received some support for our oncology service from Leeds which is welcome.

11. Working with our system partners is completely appropriate, and as part of planning for next year we need to ensure that the resource required to deliver this support is recognised and part of the financial allocation to HDFT from the ICB.

12. In terms of our provider collaboratives, we continue to develop a governance model across the HNY acute collaborative that includes a Committee in Common approach that we are familiar with through our WYAAT collaborative. We are almost in a place now whereby agreements are drafted for each Board of the members of the Collaborative to consider and sign up to.

13. HNY ICB have been successful in becoming one of the national front runner systems in respect of improving discharge. The particular area that was part of the proposal was to develop a digital tool that supports an overview of community capacity (including social care) to support and enable speedier discharge. We are awaiting more details in terms of implementation and resource, but this will be a helpful programme across the ICB.

14. In terms of WYAAT, we discussed the aseptic services collaboration at the last Board meeting. A short form business case is being developed which will be discussed at the Committee in Common next week, with the expectation that the national funding will follow reasonably quickly to allow implementation. We continue to work with LTHT in respect of developing theatre capacity at the Wharfedale Hospital site in Otley.

HDFT issues

Introduction

15. The last month has been by necessity very focused on the operational pressures experienced by the Trust in particular and the NHS in general. It should be noted however, that despite the immediate pressures, colleagues have managed and reacted well to the situation, and have worked together to maintain delivery of our services.

16. Whilst the focus has been particularly operational this month, we have still progressed with a number of improvements and delivered services well. We have reconfigured our wards, created an acute frailty unit, continued to deliver elective care as planned (very different to many other Trusts) and continued to deliver strong performance across our 0-19 services.

17. Credit is due to all colleagues who have stepped up as they always do during the recent period.

18. At all times we re-emphasise to our colleagues that whilst there are challenges, there are things that we all can do to improve services, and that we must not 'normalise' some of the difficulties we deal with and accept standards that are not as good as we would want.

19. Also, that what is vitally important is that 'how' we deliver our services – reflecting our values – is a focus that we don't lose.

Our people

20. The Royal College of Nurses voted to take industrial action during a window of November 2022 through to May 2023. HDFT is an organisation where staff have elected to take action, and whilst we were not included in the industrial action that took place in December, we have been a part of the action on 18th and 19th of January.

21. We have engaged positively with both our trade union colleagues and staff RCN members to ensure that we support our colleagues to participate in the strike action whilst maintaining safe levels of service.

22. As I write this report, we are on Day One of the action, and the arrangements have gone very well. Colleagues have felt supported in the action being taken and services have been safely provided.

23. Further dates for action have been announced by the RCN for action if the dispute with the government is not resolved. These dates are the 6th and 7th of February. The 6th of February is also the date of further action by ambulance staff. We will ensure that we have plans in place to manage any impact and support any staff involved.

24. We are awaiting the outcome of ballots by other unions to see whether any further unions might be involved in industrial action in the future.

25. The national staff survey results have now been received into the Trust. This survey took place in the autumn of 2022. The results are currently embargoed, but we will have a session at the February workshop to understand the results in more detail.

26. As the Board are aware, we had our KITE and long service awards at the end of November. I just wanted to put on record how impressive the evening was, both in terms of the people collecting awards for brilliant work, and the organisation of the event itself. It was great to celebrate with colleagues all of the contributions that people make each day for the benefit of our patients.

Our Quality

27. We have now received the draft report from the CQC who assessed our maternity services in November. There are a number of areas in the report that we are responding to the CQC about as part of the factual accuracy process that is a part of any CQC inspection. Whilst it is at the moment a draft report, it should be noted that the leadership and the culture of the department has been viewed positively. We would expect to get a final report from the CQC before the end of the financial year.

28. There is some learning that we will take from the CQC experience in maternity, in particular about the information that we provide to support the CQC in their inspection. We are ensuring that our processes are robust in terms of the reporting and recording of areas such as mandatory training and appraisals, and we recognise that the way in which we have been able to respond in relation to our maternity services might be more difficult when managing the response about the whole Trust. This is helpful to recognise in advance of any future visits.

29. Additionally in relation to maternity services, there are two further things to mention. Firstly, we have on the agenda later the maternity incentive scheme compliance report, and it is pleasing to be able to recommend full compliance with this safety initiative. Secondly, the staffing position in the service is very positive, with no midwifery vacancies currently.

30. We have had to manage pressures on our mortuary capacity recently. This has been a regional issue as well. We have mitigated the risk through additional leased capacity.

31. We have also had to manage a significant increase in patients with respiratory virus. Our infection control arrangements have been well managed by our clinical teams.

32. Positively, we have had no new SIs in the last month and we have also achieved 100% compliance in respect of timely complaint response. This is a significant improvement from twelve months ago.

Our Services

33. As referenced earlier, our 0-19 services continue to deliver very strong performance across all of our geographic footprint. This is despite the operational and staffing challenges that we have been managing over the winter.

34. We continued to struggle to deliver the standards we would want to deliver across the urgent care pathway in December, which is illustrated by our performance against the 4 hour Emergency Department standard. This is indicative of concerns across the whole pathway, but for HDFT the key constraint continues to be the number of patients who remain in our hospital beds due to packages of care not being readily available.

35. It should be noted however, that our ED performance has improved significantly in January. Our ED streaming model is in place, and we have completed the initial capital works within the department, and both of these have resulted in shorter waiting times and therefore better quality and experience for our patients.

36. We have now a Registered Manager in place for our Domiciliary Care service, and we are now on with the CQC registration process.

37. Our cancer service standards remains below where we would like to see it, but the impact of the improvement plans is being felt and the position has improved. We are in dialogue with system partners in West Yorkshire in respect of mutual aid (given and received) to ensure resilience of services.

38. We continue to deliver our elective recovery plan, and the number of people waiting over 78 weeks and over 52 weeks continues to fall. We expect to meet the target of having no over 78 week waiters by the end of the financial year, notwithstanding the risk that might materialise as we appropriately offer further system support to the HNY system.

Our money

39. As I referenced at the last Board meeting, the financial position for the year continues to be a deficit, which reflects the underlying runrate concerns. The expectation is that for 2022/23 the financial plan will be delivered, but with some non-recurrent contributions, so the planning for 2023/24 which I mentioned earlier in the report is the important activity to complete across the Trust and across the ICB.

40. Our agency costs continue to be a key driver, with some additional usage combined with increasing rates resulting in our agency ceiling being breached. Work continues with Directorates to reduce demand and improve controls. Linking this with Our People, having people in post and rostered effectively will be the most material financial improvement we can deliver, along with it improving colleagues well-being and improving quality. This will be the priority in our plan for 2023/24.

Other

41. We have recently submitted tenders for a number of childhood vaccination and immunisation services across the North East and Yorkshire region. We await the outcome, but I would like to thank the Directorate team and the Business Development team for their efforts to produce these high quality proposals.

42. In respect of the Electronic Patient Record programme, we have received and signed the Investment Agreement. This is a significant step in terms of certainty of funding, and as we have discussed last month and through the Innovation Committee, we are now in the process of delivering the initial stages of this improvement and digital project.

43. Whilst there are a number of challenges across the health and care system, and areas of service provision where we know we would want to deliver better care, we continue to engage with and listen to colleagues about what is important to them and how we can collectively create a positive environment within which to work.

44. I referenced the survey results earlier, but we need to maintain the work we have already highlighted from feedback consistently received from colleagues that the most important

thing we can do is have sufficient and appropriately trained people in roles, working in an environment that is supportive of their work, and where their contribution is valued and appreciated.

45. NHS and care services are delivered to people, by people, and therefore this will continue be our key focus across the organisation.

Jonathan Coulter
Chief Executive
January 2023

AMBITION: BEST QUALITY, SAFEST CARE

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

GOALS:

- **Safety: Ever safer care through continuous learning and improvement**
- **Effectiveness: Excellent outcomes through effective, best practice care**
- **Patient Experience: A positive experience for every patient by listening and acting on their feedback**

Governance:

- **Board Assurance:** Quality Committee
- **Programme Board:** Quality Governance Management Group
- **SRO:** Director of Nursing, Midwifery and AHPs, Medical Director

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Metrics		
Safety	Number of Theatre Serious Incidents and Never Events	Number of hospital acquired category 3 and above pressure ulcers with omissions in care	Number of inpatient falls moderate and above with omissions in care
Effectiveness	Number of Moderate and Above incidents for Missed results	Number of medication errors	
Patient Experience	Number of complaints		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR5	Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	4x4=16	4x2=8 (Dec 23)	Clinical Workforce	Averse
CRR73	Insufficient Staffing for Special Care Baby Unit (SCBU)	Risk to continuity of SCBU service, with consequent risk to provision of maternity service, due to inability to provide one "Qualified in Specialty" staff member on every shift due to high vacancy rate.	4x3=12	4x2=8 (Mar 23)	Clinical Workforce	Averse

GOAL: BEST QUALITY, SAFEST CARE: Ever safer care through continuous learning and improvement

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Theatres Safety To improve the safety culture in theatres	Reduction in SIs in theatres		• Cultural review in Theatres (B3Sixty) • Implementation of the revised WHO Checklist • Cleanliness: revised IPC and Cleaning audits implemented • Safety Dashboard implemented • Implementation of revised Stop Before you Block SOP • Implementation of revised Swab Count SOP	• Completed – Action Plan in progress • Completed – Implemented, embedding ongoing • Partially Completed – embedding required • Partially Completed – trial in place • Partially Completed – action plan outstanding • Partially Completed – audit to be undertaken	
Falls To reduce the number of falls in the acute setting rated moderate and above.	Reduction in Falls rated moderate and above per 1,000 bed days		• Older people routinely risk assessed at all appointments • Those at risk of falls have an individualised multifactorial intervention • Older people who fall during admission are checked for injury • Older people in the community with a known history of recurrent falls are referred for strength and balance training • Older people who are admitted after a fall in the community offered a home assessment and safety interventions	• Partially completed – documentation in place in the community, further work required in Acute • Partially completed – available on WebV, compliance to be assessed • Partially completed – post fall initial assessment available, compliance to be assessed • Not completed – gap analysis to be undertaken and referral process developed • Partially completed – environmental assessments available, however process needs to be created for referral	
Pressure Ulcers To reduce the number of pressure ulcers in the acute setting rated moderate and above.	Reduction in pressure ulcers rated moderate and above per 1,000 bed days		• Pressure Ulcer Improvement Plan developed • PURPOSE T risk assessment tool used on all patients • Reassessment of patients as per revised SOP • All at risk patients to have a pressure ulcer management plan in place • Patients with MASD to have joint assessment with continence nurse and TVN • Clinical staff to have Preventing Pressure Ulcer training • Patients who develop Cat 3, 4 and Unstable pressure ulcer, DTI and device related pressure damage to be reviewed by a TVN	• Completed • Partially completed – assessment tool available, training continuing, compliance to be confirmed • Partially completed – reassessment tool available, compliance to be confirmed • Partially completed – tool in place, compliance to be confirmed • Not completed – review and relaunch of MASD pathway to be undertaken • Partially completed – training in place, compliance needs to be improved • Completed	

GOAL: BEST QUALITY, SAFEST CARE: Excellent outcomes through effective, best practice care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Missed Results To reduce diagnostic results not acted upon	Reduction in number of diagnostics results not acted upon		• Digital workstream to be considered • Trust wide policy on requesting clinical investigations	• Non compliant – further work required to scope • Non compliant – on hold until a digital solution explored	
Medication Errors To reduce medication errors and provide assurance against CQC, RPS and HTM standards	Reduction in missed doses Reduction in safety incidents rated moderate and above		• Lead Pharmacist – Medicines Quality and Safety in post • Develop Medicines Quality and Safety Group work plan • Update all medicine safety policies • Develop and implement insulin safety initiatives • Develop and implement oxygen prescribing initiatives • Embed high risk medicines and allergy status dashboards • Complete fridge temperature monitoring actions • Develop e-learning/e-assessment for medicines management	• Completed • Completed • Partially completed – Medicine Policy Updated • Not Complete – Action Plan to be developed • Partially completed – further work to embed • Partially completed – further work to embed • Partially completed – further work to ensure full compliance • Partially completed – tool developed, compliance to be assessed	

GOAL: BEST QUALITY, SAFEST CARE: A positive experience for every patient by listening and acting on their feedback

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Patient Experience To improve patient experience by using patient feedback to drive quality improvement and learning. This will be achieved by full compliance with the 6 principles of patient experience.	Reduction in the number of complaints when compared to the previous year Improved completion time of complaint response		• Principle 1: Leadership – Patient experience manager in post. • Principle 2: Organisation Culture: revised complaints process implemented • Principle 3: Capacity and Capability to effectively collect feedback: patient experience surveys piloted in acute paediatrics • Principle 4: Analysis and Triangulation: quality analyst in post • Principle 5: Using patient feedback to drive quality improvement and learning: Learning Summit implemented • Principle 6: Reporting and Publication: PE section of the Quality Report to move beyond complaints and PALs	• Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance) • Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance) • Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance)	

Trust Board Report January 2023

Report: Executive Director of Nursing, Midwifery and AHPs

Author: Emma Nunez

NHS Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Friends and Family Test (Community) – (*IBR 2.1.2*) – note a deterioration in FFT data in the Adult Community Services. This deterioration relates to a number of negative responses regarding the GP Out of Hours service in Harrogate and further work is ongoing in relation to learning and improving this.

Major actions commissioned & work underway

- Draft CQC Maternity Inspection Report has been received and factual accuracy response submitted
- Patient Experience – work underway to improve the patient experience/feedback mechanisms, including the voice of the child and patient and public engagement.
- Pressure Ulcers – (*IBR 1.1 & 1.2*) – Both inpatient and community services have seen increased reporting of Pressure Ulcer incidence annually however both have seen reductions in prevalence in December 2022 when compared with December 2021 which is a reflection of the diagnostic and associated improvement work undertaken across the previous year. As a quality priority the pressure ulcer improvement work planning has continued with further engagement at Board and Quality Committee being scheduled.
- Falls – (*IBR 1.3*) – as a quality priority ongoing work related to the trustwide improvement plan for falls continues which is underpinned by NICE Clinical Standards. This work was presented to Quality Committee in November 2022 and will continue to be developed and reported in line with our Quality Governance.

Positive news & assurance

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Overall Nurse staffing fill rates are on an upward trend despite a slight decrease in December 2022 following seasonal sickness. Internationally recruited nurses are progressing through training processes and will be deployed onto Wards every other month. A further funding bid has been submitted to NHSE to continue International Recruitment plans and the business case to recruit 100 nurses has been agreed. CHPPD has stabilised in line with fill rate increase.
- Incidents – ratio of low harm incidents/Serious Incidents and Never Events – (*IBR 1.6 & IBR 1.7*) - Reporting of low harm incidents has more than doubled in the last 6 months which reflects a positive shift in reporting culture across the organisation. This coincides with a reduction of the number of serious incidents and never events which provides a level of assurance of the effectiveness of our incident reporting systems and associated governance.
- Complaints – (*IBR 2.2.1 & IBR 2.2.2)* – 8th consecutive month where the number of complaints received by the Trust has fallen below the mean. This correlates with a 100% response rate for complaints in December providing a good level of assurance of our complaints processes and proactive engagement with patient and family concerns early.

Decisions made & decisions required of Board

Medical Director Report for Public Board
Date: January 2023
Author: Dr Jacqueline Andrews

Matters of concern & risks to escalate

- **Digital:**
- Ongoing challenge of delivering 22/23 spend, as yet no central decision about possible carry forward into a 4th year for EPR programme
- WYAAT LIMS (laboratory digital management system) programme experiencing delays. HDFT 3rd on deployment (Nov 23) if further slippage risks overlap with EPR implementation
- **Quality:**
- Mortuary capacity under pressure locally and nationally
- National alert for knee implant (NewGen) 900 HDFT patients affected. Quality team and orthopaedics co-ordinating actions, reporting and patient comms
- Clinical research estate solution being reworked- further risk to NIHR CRN funding if unable to increase commercial clinical research portfolio

Major actions commissioned & work underway

- Medical mandatory training- review of role based training needs underway
- Good progress being made with policy reviews and best practice guidance- Policy Governance Officer now in post and implementing Policy Stat
- Inaugural Mortality Committee meeting Dec 2022- decision made to extend scope to include end of life and organ/tissue donation- pathway mapping to be undertaken to better describe bereavement function requirements
- WYAAT Non Surgical Oncology (NSO)- agreed model not yet implemented due to concerns from partner Trusts about loss of inpatient oncology. MDs now inputting, no substantial change to HDFT service planned

Positive news & assurance

- Single Sign On solution (Imprivata) procured – launch meeting Jan 23
- Lead Healthcare Scientist role advertised for HDFT (new role to add to medical/dental/MAAP/pharmacist leadership roles)
- Innovation Manager appointed- Clinical Lead for Innovation about to be advertised
- X 7 Digital Clinical Leads appointed- leadership areas being allocated
- New Clinical Guidelines Group and New Interventional Procedures Groups ready to launch.
- Medical appraisal rates >90% in Dec 22
- SHMI mortality indicator now within normal limit for 3 months
- Surgical SDEC relocating to surgical ward area- HEE Y&H aware and no further actions planned

Decisions made & decisions required of the Board

AMBITION: GREAT START IN LIFE

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

GOALS:

- **The national leader for children and young people's public health services.**
- **Hopes for Healthcare: services which meet the needs of children and young people.**
- **High quality maternity services with the confidence of women and families**

Governance:

- **Board Assurance:** Resources Committee; Quality Committee
- **Programme Board:** Great Start in Life Programme Board; Quality Governance Management Group
- **SRO:** Director of Strategy; Director of Nursing, Midwifery and AHPs

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Indicators		
C&YP PH Services			
Hopes for Healthcare			
Maternity Services			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	3x4=12	3x2=6 (Mar 26)	Clinical Operational	Cautious

GOAL: GREAT START IN LIFE: The national leader for children and young people's public health services

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Children's Public Health (PH) Services Growth Strategy	More integrated services for children Securing long-term partnerships		• Children's PH Strategy Workshop – Oct 22 • Draft Growth Strategy supported by Children's PH Services Board Working Group (WG) – Jan 23 • Growth Strategy approved by Trust Board – Mar 23	• Complete • On Track • On Track	
Increasing the profile and influence of our Children's PH Services	Sharing evidence and learning for Children's PH Services Influencing regional/national policy Increased staff engagement		• Children's PH Strategy Workshop – Oct 22 • Draft Engagement Plan supported by Children's PH Services Board WG – Jan 23 • Children's PH Services Conference – TBC	• Complete • On Track • TBC	
Improving strategic relationship management with system partners	Improved outcomes for children Securing long-term partnerships		• Children's PH Strategy Workshop – Oct 22 • Review existing strategic relationships – Dec 22 • Stakeholder Management Plan supported by Children's PH Services Board WG – Jan 23	• Complete • On Track • On Track	
An operating model to support & enable services outside Harrogate	Improved outcomes for children Improved service delivery Increased staff engagement		• Children's PH Strategy Workshop – Oct 22 • Review of corporate support – Jan 23 • Review of community estate and processes – Mar 23 • Proposal for "Northern Hub" – Mar 23 • Draft Operating Model supported by Children's PH Services Board – Apr 23	• Complete • At risk • Delayed – lack of capacity delayed to end Q1 23/24 • Delayed – lack of capacity delayed to end Q1 23/24 • At risk	

GOAL: GREAT START IN LIFE: Hopes for Healthcare – services which meet the needs of children and young people

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To embed the "Hopes for Healthcare" principles in all HDFT services	Better patient experience for children Improved safety for children		• Establish Great Start in Life Programme Board – Jan 23 • Further actions to be determined through programme board – TBC	• Delayed – stocktake meeting on 24 Jan; first board set up for 21 Feb • TBC – this objective likely to continue into 23/24	

GOAL: GREAT START IN LIFE: High quality maternity services with the confidence of women and families

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Ockenden Safety Action 1 – Enhanced Safety	Robust governance of maternity services at service and trust board level Improved safety and outcomes through learning from incidents		• Maternity dashboard on LMNS agenda quarterly • Maternity Triumvirate working in place • Ockenden Action Plan discussed at Board • Triangulation of incidents/complaints, claims • External clinical specialist opinion for mandated incidents • Maternity SI reports and key issues summary to Trust Board and LMNS quarterly • PMRT cases reviewed to required standard • Data submitted to the Maternity Services Dataset • All HSIB cases reported • Perinatal clinical quality surveillance model implemented	• Compliant • Compliant • Compliant • Compliant • Compliant • Compliant • Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 2 – Listening to women and families	Improved patient experience for women and families Improved safety and outcomes through learning from incidents		• Non-Executive lead for maternity, collaborative working with Exec lead and maternity team safety champions • Involvement of women and families in using PMRT tool to review perinatal deaths • Robust mechanism for service user feedback through Maternity Voices Partnership • Maternity team safety champions meet bimonthly with board safety champions	• Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 3 – Staff training and working together	Improved teamworking in general and, particularly, in response to maternity emergencies		• Maternity multi-disciplinary team (MDT) training • Day and night consultant led ward round on labour ward • Dedicated obstetric governance lead • External training funding ringfenced for maternity • 90% attendance at multi-professional maternity emergencies training since Dec 19 • Schedule for MDT training in place	• Compliant • Compliant • Compliant • Partially compliant • Compliant • Compliant	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Ockenden Safety Action 4 – Managing complex pregnancy	Improved safety and outcomes for women with complex pregnancies and their babies		• Agreement on criteria for referral to tertiary maternal medicine centre • Named consultant lead for women with complex pregnancies, and mechanism to audit compliance • Early intervention for women with complex pregnancies • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • Agreed maternal medicine centre	• Compliant • Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 5 – Risk assessment through pregnancy	Improved safety and outcomes for women and their babies		• Ongoing review of place of birth as part of antenatal risk assessment and developing clinical picture • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • Risk assessment review and place of birth discussion recorded at every contact with Personalised Care Plan	• Compliant • Compliant • Compliant	
Ockenden Safety Action 6 – Monitoring fetal wellbeing	Improved safety and outcomes for women and their babies		• Lead midwife and obstetrician for fetal wellbeing, with sufficient seniority and expertise, appointed • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • 90% attendance at multi-professional maternity emergencies training since Dec 19	• Compliant • Compliant • Compliant	
Ockenden Safety Action 7 – Informed Consent	Improved patient experience for women		• Accessible information available to enable informed choice of place and mode of birth • Accessible, evidence based information on antenatal, intrapartum and postnatal care • Equal participation and informed choices by women in decision making processes • Respect for women's choices following informed discussion and decision making • Robust mechanism for service user feedback through Maternity Voices Partnership • Clear, written information on care pathways, compliant with NHS policy, available on trust website	• Compliant • Compliant • Compliant • Compliant • Compliant • Compliant	

Harrogate and District NHS Foundation Trust

4.2

Strengthening Maternity and Neonatal Safety Report

SMT

December 2022

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), Andy Brown (Risk management Midwife), Kat Johnson (Clinical Director), Vicky Lister (Paediatric Matron)

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 September 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 Risk Management Group Maternity Services Forum	
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 December 2022 as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

The 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. 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 also 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 an update 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

4.1 Not applicable

5.0 Risks and Mitigating Actions

5.1 Safeguarding training, supervision and guidelines
5.2 Homebirth service provision
5.3 Maternity Assessment Centre risk assessment and documentation
5.4 Mandatory training figures in Learning Lab database

6.0 Recommendation

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

Maternity – December 2022

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Mandatory training compliance • CQC Maternity Inspection draft report received • Homebirth service provision added to risk register • Safeguarding risk continues – action plan in place and 8A Named Midwife role out to recruitment.	• Improvements to Maternity Assessment Centre processes underway • Safeguarding training plan agreed • Badgernet preparation continues • Plans to re-start antenatal classes from April 2023 progressing (delayed due to Badgernet delay)
Positive news & assurance	**Decisions made & decisions required of the Board**
• Agreement to join in regional Ask a Midwife service. • 4.6WTE MSW recruited • Perinatal Mental Health Midwife 0.8WTE recruited	• Maternity Incentive Scheme – paper attached. Board to decide if meets the criteria for compliance.

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

1.0 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.

2.0 Obstetric cover on the delivery suite, gaps in rota

RCOG has recognised the challenges with middle grade staffing and published guidance (August 2022) on covering gaps and the process for ensuring any external locums have the appropriate skills and competencies. The maternity unit has been staffed to minimum safe staffing standards at all times during December 2022. There remains one vacant slot on the middle grade night and weekend rota. This slot is vacant pending appropriate sign off of competency to work with a consultant off site. In addition there are vacant shifts on the first on call rota due to maternity and a doctor working less than full time. There have also been issues of short term sickness at all levels which have also needed covering, often at short notice. The vacant shifts have all been covered by a combination of doctors undertaking additional adhoc sessions (including consultants acting down) or agency locums. The unit has been safely staffed at all times during the reporting period.

3.0 Midwifery safe staffing, vacancies and recruitment update

Birthrate plus recommended a total clinical, specialist & management maternity staffing of 76.21WTE for HDFT. The current budget is 73.39 WTE for midwifery staffing band 5-7 and 13.44 WTE for Band 2 and 3 support staff.

3.1 December Absence position

Midwifery hours lost across Pannal, Delivery Suite and Community –
2.1 WTE sickness absence
4.6 WTE maternity leave

Maternity support worker hours lost across Pannal, Delivery Suite and Community –
1.5 WTE sickness absence
0.6 WTE maternity leave

3.2 Vacancy position

0 WTE Midwifery vacancy (Band 5-7).
5.4 WTE Maternity support worker vacancy (Band 2-3) – 4.6 WTE have been recruited and are awaiting start dates.

No Maternity Assessment Centre MSW band 3 cover at present. Recruited band 2 MSW's following review. Awaiting start dates. There has not been available staffing to consistently add the third midwife to night shifts on Pannal in this period.

3.3 Use of NHSP

2.82 WTE NHSP midwifery staffing across Pannal and Delivery Suite.
1.8 WTE NHSP maternity support worker staffing across Pannal and Delivery Suite

3.4 Homebirth provision

Home birth provision is covered by a first and second on-call midwife every night between 17:00 – 08:00.

Two homebirths were booked at beginning of December for birth in this month. One homebirth was attended and birthed, and one woman birthed in hospital following induction of labour due to being postdates.

In the period 01/12/2022 – 31/12/2022, the home birth provision was not allocated or suspended due to staffing on twelve occasions (38.7%). The service was suspended due to:

- Sickness and unable to find cover
- Staffing/ clinic cover issues next working day
- Ongoing weekend cover issues
- Ambulance services strike

A review of the organisation of on call cover is on-going.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Absence position

Current mat leave – 0.69 WTE B6
0.30WTE nurse short term absence
0.92 WTE long term absence

4.2 Vacancy

1.22 WTE remaining vacancy to be recruited into

4.3 Recruitment

- 0.77 WTE QIS – Start date 12.12.22
- 0.92 WTE - Neonatal experience but non QIS. Start Feb '23
- 1 WTE Start date TBC (QIS)

- Remaining 1.22 WTE out to advert

4.4 Qualified in Speciality (QIS)

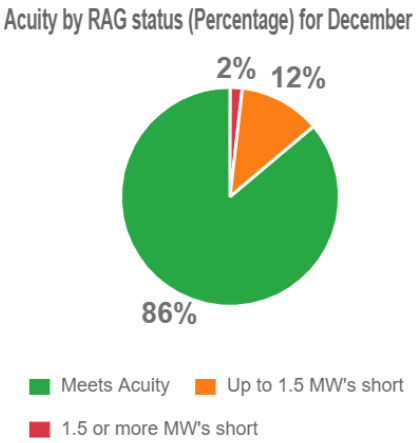
SCBU budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS = 8.274 WTE. The ODN have clarified that the QIS compliance is based on staff in post excluding any vacancy.
85% compliance (7.07WTE QIS/8.29WTE overall = 85%)

5.0 Birthrate Plus Acuity Staffing Data

Delivery Suite
The following graph highlights that the provision of staff during December 2022 on Delivery Suite has met the acuity 86% of the time. 87% of the time no clinical actions were required. 13% of the occasions clinical actions were required, these included:

- Delay in commencing induction of labour - 12 occasions (44%)
- Delay in continuing induction of labour - 7 occasions (26%)
- Postponed induction of labour - 3 occasions (11%)
- Coordinator not supernumerary – 5 occasions (19%)

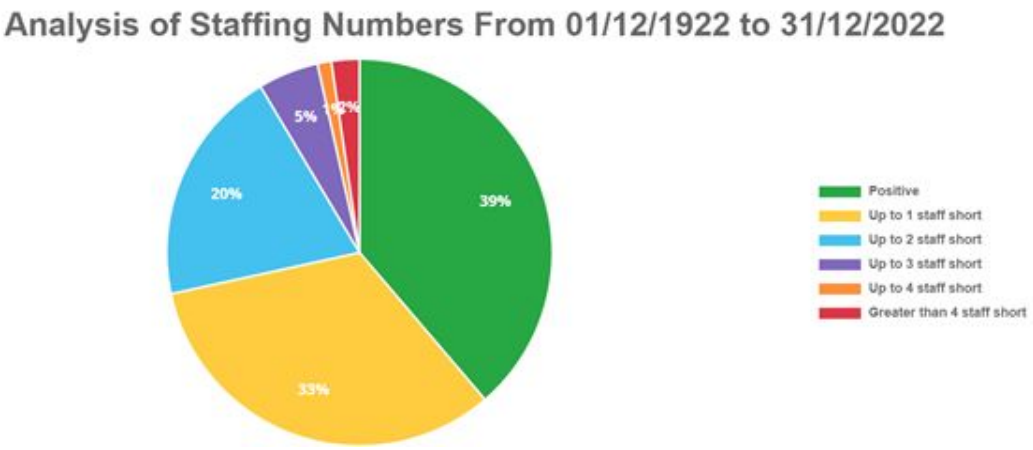
These percentages do not add to 100% as more than 1 action could have been taken at any one time.



99.2 % of women received1 to 1 care in labour for women birthing at HDFT (excluding BBA in line with new reporting criteria for Y&H Dashboard). There was one unexpected delivery on Pannal Ward following induction of labour and two BBAs.

Pannal Ward
Staffing on the antenatal/postnatal ward meets the acuity 64% of the time. There were 93 scheduled assessment periods on Birthrate plus during December 2022, of these 80 were completed, giving a confidence factor of 86%. During the month the data reports that 36% of shifts being at least a midwife short or staff being redeployed.

31% of shifts recorded a relevant staffing factor
- Unexpected MW absence- 10 occasions
- MW redeployed elsewhere- 8 occasions
- Unable to fill MW shift – 5 occasions
- Unexpected support worker absence – 1 occasion
- Unable to fill vacant support staff shift – 6 occasions
- Admin staff less than rostered numbers – 2 occasions



6.0 Red Flag events recorded on Birthrate Plus

Delivery Suite

There were 3 Red Flag identified from the Birthrate Plus Data which were

- Missed or delayed care - one occasion
- Delay between admission for induction and beginning of process – two occasions

Pannal Ward

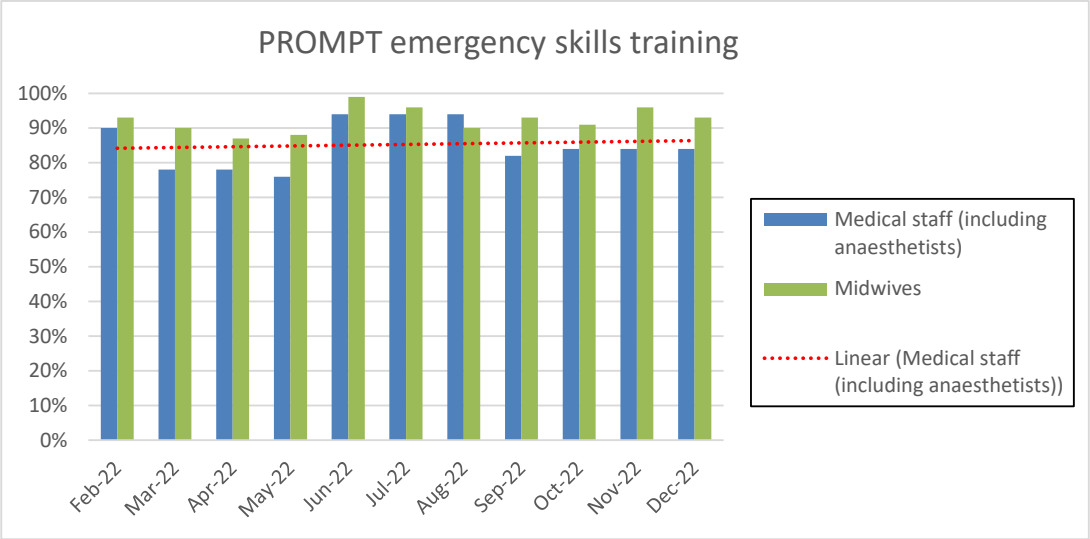
There were 9 occasions where Red Flags identified from the Birth rate Plus Data which were:

- Delay between admission for induction and starting the process – five occasions
- Missed or delayed care >60 mins – two occasions
- Delay in providing pain relief – one occasion
- Delay between presentation and triage – one occasion
  Any occasion when a midwife is not able to provide one-to-one care to a woman in established labour – one occasion

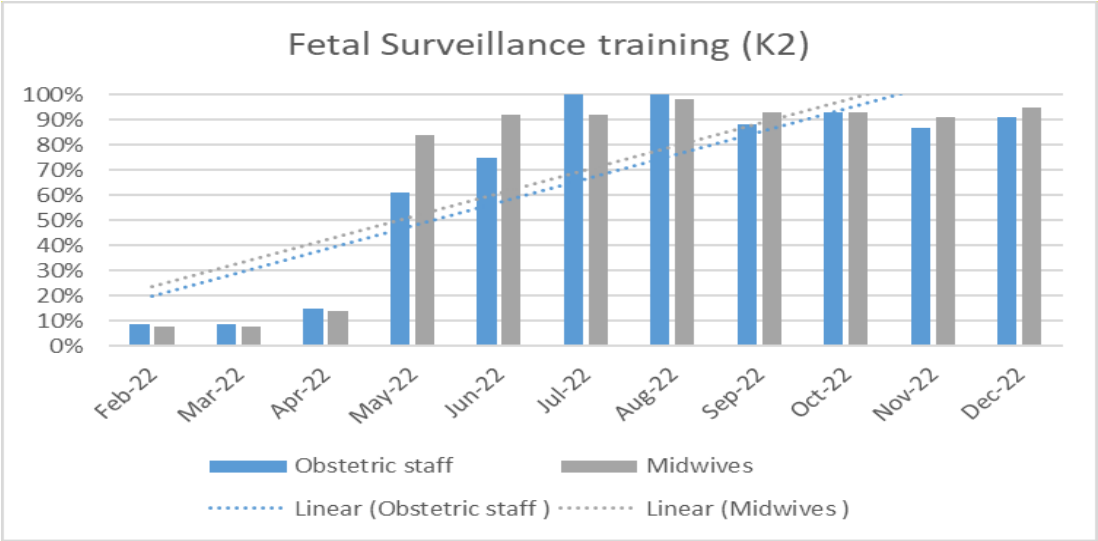
7.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

7.1 Prompt emergency skills training

Training figures for PROMPT include those who have completed training in the last 12 months.



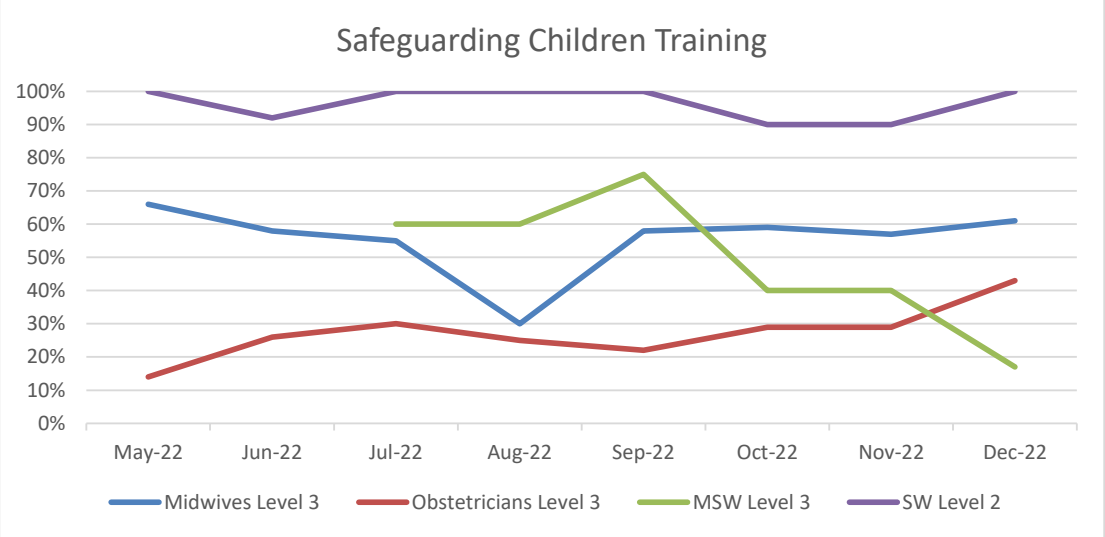
7.2 Fetal surveillance training (K2 online training package)

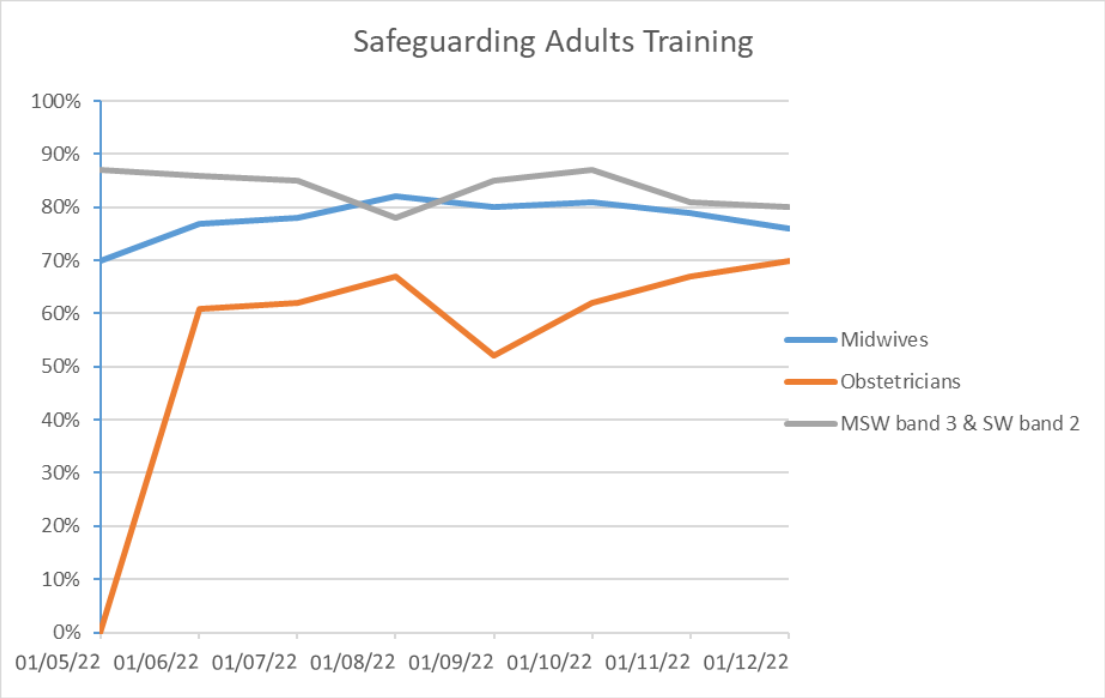


7.3 Safeguarding Children and Adults training

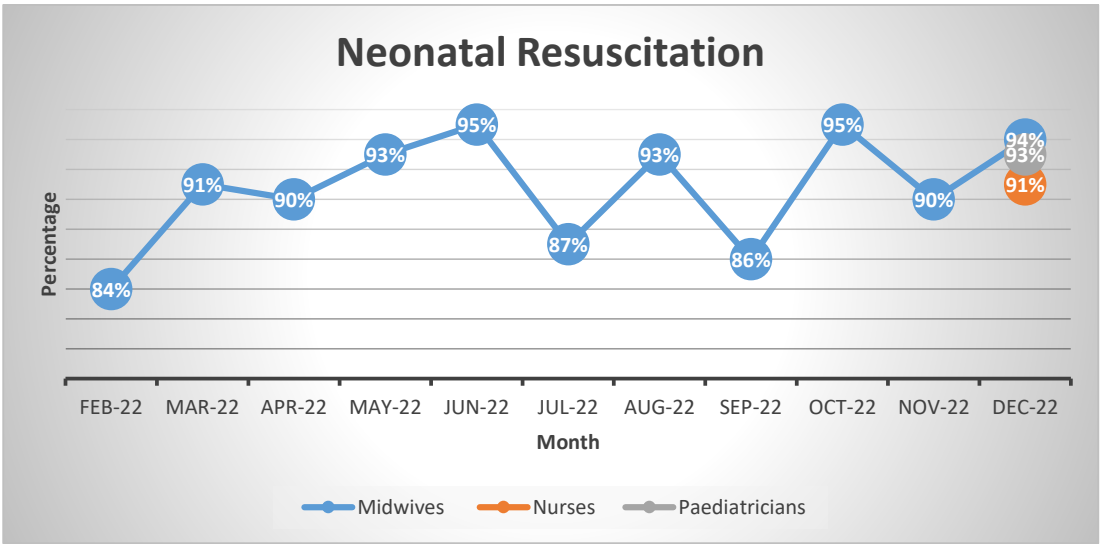
It is recognised that the staff compliance with Safeguarding Children training is not meeting the required standards. This has been added to the Risk Register and an action plan has been created. A Band 8A Named Midwife for Safeguarding job is being advertised and interviews are planned for February 2023. Work is underway to improve compliance with training between January and March 2023. A new package of Safeguarding training will be in place from April 2023. Staff will be prioritised for attendance based on their current compliance. Consideration of multi-agency training is also in progress.

Work is also on-going to improve compliance of Adult Safeguarding training and supervision.





7.4 Neonatal resuscitation – Midwives, Neonatal Nurses and Paediatricians



7.5 SCBU Training Compliance

Overall Learning Lab training compliance for SCBU staff is 90.6%.

8.0 Risk and Safety

8.1 Maternity Risk register summary

Risk Register has now been transferred to PSC Core Group.

One new risk added:

- **Risk to service provision for homebirths due to unreliable homebirth cover (Score 8).** Difficulties experienced in providing cover for homebirths due to staffing model and sickness issues. Resulting in inability to provide consistent homebirth service and cancellation resulting in need to transfer into hospital.

8 current risks:

- **Risk to patient safety, and lack of compliance with national recommendations due to inadequate provision of Named Midwife: Safeguarding oversight (Score 12).** Plan agreed for enhanced role of Named Midwife: Safeguarding to ensure effective safeguarding oversight. Awaiting interviews for role. No current change.
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 9).** Go-live date deferred to March 2023. No further change in risk level at present.
- **Risk to patient care due to current lack of Perinatal Mental Health Midwife role (Score 8).** Interviews completed for role. Risk currently remains the same.
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 4).** Commissioning of service has been approved. Still awaiting implementation arrangements for the service with Service Manager. No change
- **Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 6).** Action plan in place and updates being completed by Named Midwife for Safeguarding. No current change.

- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 6).** Difficulties experienced by cross-boundary working, and different IT systems in community and inpatient areas means that relevant information not being shared effectively. Digital Midwife continuing to work on appropriate solution with Badgernet implementation. No current change.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance improving and action plan in place. Risk level currently remains unchanged.
  Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 6). Pressures remain within the service. No change

8.2 Maternity Incidents

In December 2022 there were 64 total incidents reported through Datix (but two rejected as duplicates). Of these, there were 4 incidents recorded as Moderate Harm. These related to:

- Transfer to HDU with hyponatraemia following excessive fluid intake. A Duty of Candour letter has been completed and a Quality Improvement plan is being implemented relating to improvements in fluid balance.
- Transfer of baby for brain cooling following a difficult emergency caesarean section. On review at tertiary unit the baby was considered to be neurological stable and did not require cooling. Duty of Candour has been completed in view of the difficult caesarean section and temporary separation from baby.
- Bladder injury at elective caesarean section, as a result of adhesion from two previous caesarean sections. Some additional issues related to catheter care follow up
- Admission to unit with severe pre-eclampsia and subsequent transfer to HDU following delivery for ongoing care. 48h report completed and for review and round table debrief.

Additional incidents of note include:

- Six readmissions of baby (with jaundice/weight loss/feeding issues)
- Four 3rd degree tears (3 at normal delivery, one at forceps)
- Three incidents of Suspension of maternity services due to activity (including one incident relating to 40 minute closure due to ODP being on a transfer). 3 patients diverted.
- Three incidents related to failure to action low ferritin levels
  Two incidents of severe pre-eclampsia requiring magnesium sulphate
- One Datix for elective caesarean undertaken on Delivery Suite due to list overrun
- One issue relating to resuscitaire oxygen level or connection problem
- One knee injury following collapse of a lithotomy stirrup on Delivery bed
- An incident of malicious damage to ANC toilets resulting in flooding and water damage.

8.3 SCBU Incidents

No moderate harm incidents.

8.4 SCBU Risk Register

One new risk added, not yet ratified, around the increase chance of requests to take off pathway neonates due to increased OPEL levels of Neonates across the region.

QIS staffing remains on risk register, scored at a 12 currently.

8.5 Babies transferred out

Two transfers out - one for prematurity, one for cooling

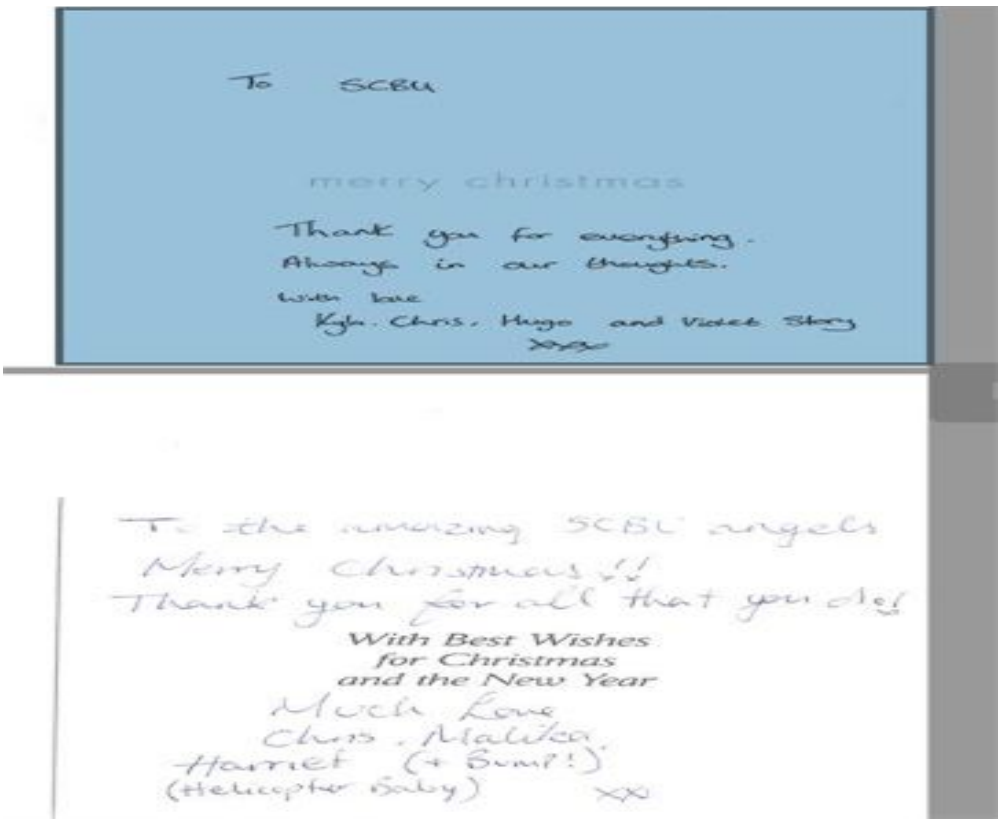
9.0 Perinatal Mortality Review Tool (PMRT)

One PMRT review (joint with James Cook) completed in relation to maternal death/stillbirth. No new reportable cases in December.

Findings from PMRT include:
- Lack of CO monitoring at booking due to inconsistent supply of covid-safe filtered mouthpieces (new CO monitors purchased).
- Lack of routine follow up questioning about domestic abuse (woman was accompanied at booking, but not revisited at subsequent appointments).

Action plan to be developed looking at themes from last few years.

10.0 Service User feedback



11.0 Complaints

- One formal complaint in relation to management of miscarriage on Wensleydale Ward
- One formal complaint ongoing relating to computation of NIPE check under incorrect patient details and communication in relation to discharge against medical advice
- One concern relating to receipt of incorrect appointment letter (relating to 20 week scan not nuchal scan)
- Claim relating to labial tear not identified/repaired at delivery
- Follow up patient meeting in relation to not wanting forceps delivery and lack of antenatal planning to avoid

12.0 Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received

13.0 Request for action from external bodies – NHS Resolution, HSIB, CQC

CQC visit in November 2022. Initial feedback highlighted some concerns in relation to Maternity Assessment Centre (MAC) oversight and equipment checking. Draft report received highlighting concerns regarding mandatory training, audit, risk assessment in MAC. Work is in progress on an implementation plan and action plan for the specific areas.

HSIB request for additional information in relation to current investigation has made reference to the referral process from Ripon Minor Injuries Unit. A patient attended MIU and was sent directly to Ripon ANC with no documentation or record of triage.

14.0 Healthcare Safety Investigation Branch (HSIB)

No new incidents notified to HSIB. One active case from October relating to Maternal Death and Stillbirth following a maternal collapse at home. HSIB and Coroner investigation ongoing.

15.0 Maternity incentive scheme – year 4 (NHS Resolution)

See separate report. The report provides information on position and progress in relation to compliance with the ten maternity safety actions.

Risks and Mitigating Actions

15.1 One case where closure of the perinatal mortality review tool (PMRT) surveillance data was four days outside of the required one month deadline for completion. The late submission of the surveillance data represents a non-compliance with the required timescale for Safety Action One.

15.2 There wasn't at least 70% of records submitted to NHS Digital via maternity services data submission (MSDS) in July 2022 that had a valid 'Care Professional Local Identifier' recorded. This represents non-compliance with the requirement for Safety Action Two. The implementation of Badgernet will resolve the issue.

This report provides the information required to demonstrate HDFT's level of compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year four. The Trust Board need to be satisfied that the evidence within this report satisfies these requirements prior to final sign off by the Chief Executive by February 2023.

16.0 National priorities

16.1 Continuity of Carer – National targets paused by NHS England as of 21st September 2022. **Work that is ongoing in preparation for a relaunch includes:**

- mapping and planning provision that is needed within current provision and how this will align with future continuity teams to enable a smooth transition as and when teams roll out.

- Supporting junior staff with community rotation to facilitate skills and confidence building so they will be able to work in continuity teams as they roll out.
- Audit of Homebirth to see how this could fit in a continuity team/ possible case loading team.
- Analysis of needs of our deprived areas to plan enhanced MCoC offer to women and families in these areas.

16.2 Reading the signals. Maternity and neonatal services in East Kent - the Report of the Independent Investigation October 2022

NHS England plan to release an action plan further to the final Ockenden Report (2022) and East Kent report in early 2023. Benchmarking of East Kent report against HDFT is currently underway.

16.3 Update on Ockenden (December, 2020) action plan

- Work continues with the Maternity Voices Partnership (MVP) group to review and update patient information leaflets and the HDFT maternity webpage
- HDFT are to be part of the pilot for the Advocacy roles.

17.0 Clinical Indicators – Yorkshire and Humber Regional Dashboard

Quarter 3 data available 14th February 2023.

18.0 Local HDFT dashboard information

For month of December:

- 135 mothers delivered (and 138 babies born)
- 15.6% elective Caesarean section rate (decrease from Nov, 19.7%)
- 16.3% emergency Caesarean section (decrease from Nov, 21.8%)
- 57.8% normal delivery rate (significant increase from Nov, 44.3%)
- 10.4% instrumental delivery rate (decrease from Nov, 14.1%)
- 35.6% induction rate (significant increase from Nov, 24.6%)
- 2.2% significant PPH ≥1500ml rate (decrease from Nov [3.5%];
- Four 3rd degree tears (three at normal delivery, one at forceps)
- 82.6% breastfeeding initiation rate (decrease since Nov, 90.8%)
- 5.2% smoking rate at time of delivery [3.5% in Nov; 7 patients]
- No stillbirths in December recorded

19.0 Avoiding Term Admissions in Neonatal Units (ATAIN)

Two Term newborn admission to SCBU which are being reviewed at ATAIN case review meeting (one related to transfer out for cooling, discussed above).

19.1 ATAIN actions

Current open actions identified from recent ATAIN reviews of Term babies admitted to SCBU:

Issue	Action	Status

ASCOM devices not being utilised routinely by maternity/paediatric staff	Work ongoing to increase use of ASCOM amongst ward staff and by paediatric doctors	In progress
Short admission to SCBU but no documentation by paediatric/SCBU staff in notes or Badgernet	Reminder to staff. Datix when no notes are documented	In progress
Baby came to SCBU for cannulation/IV drug administration, which could have been done on Pannal Ward with mum	Communicate to medical & nursing staff need to try to keep mum and baby together	In progress
Vapotherm commenced without Consultant approval (off-pathway)	Check guidelines and ensure this is outlined within these. Communicate to medical & nursing staff	In progress
Try to monitor babies for longer on CLWS with borderline sats/work of breathing before admitting	Continue to encourage staff to stay with baby for ≈30 mins if conditions allow	In progress
No documentation of communication by paediatric staff with mother in relation to resuscitation (subsequent complaint)	Discuss with neonatal lead and ensure yellow liaison sheet completed	In progress
No consultant involvement in decision to transfer baby for cooling (decision made by Embrace Team)	Discuss with neonatal lead	In progress

20.0 Saving Babies Lives' v2 metrics for Board oversight

	Quarter 2 (July-Sept 2022); Q3 not yet available	
Small-for-gestational age/Fetal growth restriction detection rates	Q2: 41.3% detection (<10th centile; 19 cases) (National average 42.8%, Top 10 average 59.2%) Q2: 71.4% detection (<3rd centile; 10 cases) (National average 61.7%, Top 10 average 78.9%)	
	Quarter 3 (Oct-Dec 2022)	December 2022
Percentage of babies <3rd centile >37+6 weeks' gestation	3.1% (13/417)	4.3% (6/138)
Percentage of babies <10th centile >39+6 weeks' gestation	6.0% (25/417)	5.8% (8/138)
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	0 babies born 16-24 weeks in this period (0/407)	0 babies born 16-24 weeks in this period (0/132)
• Preterm (24+0-36+6 weeks)	4.9% (live, 20/407) 0.2% (stillborn, 1/407)	3.0% (live, 4/132)

21.0 Conclusion and recommendation

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

Harrogate and District NHS Foundation Trust

4.3

Final Report for the Maternity Incentive Scheme – Year 4

Trust Board

January 2023

Title:	Final Report for the Maternity Incentive Scheme – Year 4
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), James Wright (Operations Director), Kat Johnson (Clinical Director),

Purpose of the report and summary of key issues:	The purpose of this report is to detail compliance against the ten Maternity Incentive Scheme safety actions and to highlight areas of potential non-compliance.	
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:	Senior Management Team Maternity Risk Management Group	
Recommendation:	Board are asked to note the compliance position against each of the standards and agree declaration of compliance.	

Final Report for the Maternity Incentive Scheme – Year 4

1.0 Executive Summary

This report details the standards required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year four.

2.0 Introduction

Year four of the Maternity Incentive Scheme was launched on 9 August 2021. The scheme supports the delivery of safer maternity care through an incentive element to Trust contributions to the Clinical Negligence Scheme for Trusts (CNST).

Provision for the maternity incentive scheme has been built into NHS Resolution CNST maternity pricing for 2022/23. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved. Such a payment would be at a much lower level their original ten per cent contribution.

Obstetric incidents can be catastrophic and life-changing, with related claims representing the CNSTs biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2020/21, obstetrics claims represented 11 per cent (1,190) of clinical claims by number, but accounted for 59 per cent of the total value of new claims; almost £4.2 billion.

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

This report provides detail of position and progress with compliance with the ten maternity safety actions, drawing the attention of the Board to the areas at risk of non-compliance.

3.0 Proposal

Trust Board is asked to note the information provided in the report and discuss if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year four.

Trusts that have not achieved all ten safety actions must submit an action plan together with the Board declaration form. The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form.

4.0 Quality Implications and Clinical Input

4.1 This report provides information on position and progress with compliance with the ten maternity safety actions.

5.0 Equality Analysis

5.1 An equality analysis has not been undertaken

6.0 Risks and Mitigating Actions

6.1 One case where closure of the perinatal mortality review tool (PMRT) surveillance data was four days outside of the required one month deadline for completion. There were mitigating reasons for this delay and improved processes have been put in place to avoid a recurrence. The late submission of the surveillance data represents a non-compliance with the required timescale for Safety Action One which will be externally verified via MBRRACE-UK data.

6.2 There wasn't at least 70% of records submitted to NHS Digital via maternity services data submission (MSDS) in July 2022 that had a valid 'Care Professional Local Identifier' recorded. This information is available in PCS however is not pulling through to the MSDS submission. The implementation of Badgernet will resolve the issue. This represents non-compliance with the requirement for Safety Action Two which will be externally verified via NHS England & Improvement regarding submission to the Maternity Services Data Set.

7.0 Recommendation

7.1 The Board is recommended to declare compliance with the Maternity Incentive Scheme Year Four Standards whilst recognising the two minor data capture issues which will be available to NHS Resolution on external verification.

7.2 The Board is required to give their permission to the CEO to sign the Board declaration form, and action plan if required, prior to submission to NHS Resolution.

7.3 The CEO of the Trust will ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is apprised of the MIS safety actions' evidence, action plan if required, and declaration form.

7.4 The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.


teamHDFT
At our best
HIF
HARROGATE INTEGRATED FACILITIES
NHS
Harrogate and District
NHS Foundation Trust
Maternity Incentive Scheme
Matters of concern & risks to escalate
• Safety Action (SA) 1 – One late surveillance case – 4 days late submission
• SA 2 – Care Professional Local Identifier not recorded for 70% of MSDS submission.
Major actions commissioned & work underway
• Badgernet EPR system Go Live date 20th March. Will enable appropriate reporting to Maternity Services Data Set.
• SA6 - Action plan regarding Uterine Artery Doppler training and roll out on-going.
Positive news & assurance
SA 4 and 5 - Appropriate workforce planning for maternity services
SA 7 – Effective Maternity Voices Partnership in place enabling the service user voice to be heard and services to be co-produced.
SA 8 – Local training plan in place which meets all six core modules of the core competency framework. Over 90% of each maternity unit staff group have attended multi-professional training in maternity emergencies, fetal surveillance and newborn life support.
Decisions made & decisions required of the Board
• Given the information provided Board to decide if satisfied that the requirements of the maternity incentive scheme are being met.

Maternity Incentive Scheme – Year Four.

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) 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 previous years, 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 as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Trust submissions will be subject to a range of external verification checking points, these include cross checking with:

- MBRRACE-UK data (safety action 1 standard a, b and c),
- NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive),
- National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a).
- Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

The evidence for each Safety Action can be found in the following location - W:\Labour\Maternity Incentive Scheme

Safety Action One

1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		***Required standard –*** ***Pages 8 – 16 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

All perinatal deaths have been notified as required from the 6th May 2022 (MIS stated timescale) and surveillance forms have been completed using the MBRRACE – UK reporting website. Within the period 6th May 2022 to current, there have been 9 cases reported to MBRRACE for fetal deaths over 22+0 weeks where the baby died under the care of Harrogate & District NHS Foundation Trust. Of these, 4 were terminations of pregnancy due to fetal abnormality and consequently are excluded from PMRT review. For one case closure of surveillance data was four days outside of the required one month deadline for completion. This was due to a failure to correctly complete the closure process whilst awaiting post-mortem results. This was due to a gap in Bereavement Lead cover whilst awaiting a start date and the previous Bereavement Lead who had agreed to cover the gap in lead role by bank shifts suffering a family bereavement of her own. The new Bereavement Lead Midwife is now in place and there are robust plans in place to ensure cover in her absence. The late submission of the surveillance data represents a non-compliance with the required timescale for this metric. The late submission of this data does not pose a risk to patient safety. The remainder of the cases had surveillance data completed within the timescale.

The multi-disciplinary review team review the care uses the perinatal mortality review tool (PMRT), and draft reports are generated via the PMRT within the required timescale. Parents are informed of the PMRT and their perspectives about their care and that of their baby are sought. Monthly reports on MBRRACE notification and PMRT reports are submitted to the Trust Board, within the Strengthening Maternity and Neonatal Safety Board Report.

Safety Action Two

2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		***Required standard –*** ***Pages 17 – 24 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

A Digital Strategy is in place and has been shared with the LMNS and ICB as required. The Digital Midwife engages with the Digital Child Health and Maternity Programme by their engagement with the Digital Midwives Expert Reference Group. The July 2022 (MIS stated timescale) submission met the Clinical Quality Improvement Metrics (CQIMs) for this safety action.

There wasn't at least 70% of records submitted in July 2022 that had a valid Care Professional Local Identifier recorded. This represents non-compliance with the requirement for this metric.

There has been difficulty in understanding where this metric is being pulled from the HDFT system (PCS) for the MSDS submission. The information regarding Lead Care Provider is reliably submitted in to PCS. Further adaptions of the PCS system to improve this data point is not financially viable due to the move to Badgernet as the Maternity electronic patient record from 20th March 2023. The implementation of Badgernet will resolve the issue.

Safety Action Three

3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?		***Required standard –*** ***Pages 25 – 34 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Transitional Care is in place on Pannal Ward to reduce separation of mums and babies. Babies admitted to Transitional care are reviewed on a daily basis by a paediatrician as required and the care of babies admitted to Transitional Care are reviewed following the care provision. The data capture of babies admitted to Transitional care will improve with the implementation of Badgernet electronic patient record. Audits are in place and information regarding ATAIN is shared with the maternity, neonatal and Board level safety champions. A report is available in the evidence folder which demonstrates the details of compliance with this safety standard.

Safety action 4

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		***Required standard –*** ***Pages 35 – 43 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Obstetric attendance in line with the Royal College of Obstetricians and gynaecologists (RCOG) workforce document is audited and shows good compliance. The Anaesthetic medical workforce provide appropriate availability to the obstetric unit at all times. British Association of Perinatal Medicine (BAPM) standards are met for neonatal medical and neonatal nurse staffing. The report available in the evidence folder demonstrates full compliance with this safety standard for obstetric, anaesthetic, neonatal medical and nursing staff.

Safety action 5

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		***Required standard –*** ***Pages 44 – 47 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

Midwifery staffing establishment is calculated using BirthRate+ and the maternity budget is allocated in line with this. The Labour Ward Co-ordinator is supernumerary the majority of the time and all women receive one to one care in active labour. The bi-annual midwifery staffing report demonstrating compliance (Mar 2022 – Oct 2022) was submitted to the Board in Dec 2022 and is available in the evidence folder.

Safety action 6

6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?		***Required standard –*** ***Pages 48 – 55 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The report in the evidence folder provides more detailed information to support compliance with this safety standard. All recommendations of the Saving Babies Lives care bundle version two have been implemented as required apart from Element Two. Quarterly care bundle surveys are submitted to the clinical network as required. Women who at high risk of placental dysfunction and fetal growth restriction (FGR) should receive uterine artery Doppler measurement at 24 weeks' gestation (a normal result could reduce the need for increased ultrasound surveillance in the 3rd trimester). Radiology capacity and training has resulted in an inability to provide this service until recently. However, as mitigation of possible risk it was agreed locally to undertake continuing serial ultrasound growth scans at 4 weekly intervals from 28 weeks for women with high risk factors. This action results in increased care for a larger group of women than would be identified by Uterine Artery Doppler measurement. Training has now taken place and Uterine artery Doppler measurements will be in place by 2nd February 2023.

Safety action 7

7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?		***Required standard –*** ***Pages 56 – 58 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The Maternity Voices Partnership works closely with maternity service leaders and service users to co-produce services and review service provision. Evidence is available in the evidence folder which demonstrates compliance with each requirement of this standard.

Safety action 8

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 that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal		***Required standard –*** ***Pages 59 – 65 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

	and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?		

A training plan has been developed to ensure that all six core modules of the Core Competency Framework are included the training programme. Over 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies. Over 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring. Over 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course.

Safety action 9

9	Demonstration that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues.		***Required standard*** ***Pages 66 –73 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**
	Progress in meeting the revised Continuity of Carer action plan is overseen by the board on a minimum of a quarterly basis commencing January 2022		

The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk). The revised pathway formalises how Trust-level intelligence is shared with LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.

Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-about; minimum staffing in maternity services; and training compliance.

Trust Board has reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board that rollout should be suspended at present.

Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

Safety action 10

10	Reporting 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme		***Required standard –*** ***Pages 74 – 78 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

All eligible cases fitting the reporting criteria have been notified to HSIB and NHS Resolution (where applicable). All patients where incidents have occurred which may require notification to HSIB, a Duty of Candour letter is completed. Within this, information is provided about the role of HSIB and potential future involvement of NHS Resolution.

Conclusion

This report provides the information required to demonstrate HDFT's level of compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year four.

The Trust Board need to be satisfied that the information within this report and evidence folder satisfies these requirements prior to final sign off by the Chief Executive and submission to NHS Resolution by 12 noon Thursday 2nd February 2023.

AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS

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

GOALS:

- **The best place for person centred, integrated care**
- **An exemplar system for the care of the elderly and people living with frailty**
- **Equitable, timely access to best quality planned care**

Governance:

- **Board Assurance:** Resources Committee
- **Programme Board:** Elective Programme Board, Urgent & Emergency Care Programme Board
- **SRO:** Chief Operating Officer

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Indicators		
Person Centred, Integrated Care			
Care of the Elderly			
Planned Care			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR41	Referral To Treatment (RTT)	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties as a result of the impact of Covid 19	3x4=12	3x2=6 (Mar 24)	Clinical Operational	Cautious
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4 hour standard.	3x5=15	3x2=6 (Aug 23)	Clinical Operational	Cautious

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: The best place for person centred, integrated care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Streaming	Improved ED 4 Hour Performance Improved flow through ED Improved patient experience		• Staff Recruitment – Sep 22 • Staff in post – Oct 22 • E-streaming in place – Oct 22 • Staff training complete – Jan 23	• Complete • Complete • Missed • Complete	
ED Reconfiguration: Fit to Sit, Majors Area	Improved ED 4 Hour Performance Improved flow through ED		See "Enabling Ambition: An environment that promotes wellbeing" for details	Stage1/3 complete. Stage 2/3 underway.	
ED/Acute Flow – Acute Referral Triage	Reduction in ED attendances Improved satisfaction from referrers Patients referred to the right service first time		• Workforce & data review – Sep 22 • User feedback analysed – Sep 22 • Pathways written – Nov 22 • Single point of access for acute and community services in place - TBC	• Complete • Complete • Complete • Decision required on whether to progress with single point of access for acute and community	
ED/Acute Flow – Consultant Allocation	Reduce delays in medical review Reduce number of outliers Improved clinical experience Improved consultant working		• Centralised ward clerk management – Nov 22 • Standard ward clerk training programme – Nov 22 • Future ward reconfiguration agreed – Nov 22 • SOP agreed – Dec 22 • Future ward reconfiguration implemented – Dec 22	• Complete • Complete • Complete • Complete • Complete	
ED/Acute Flow – Acute Medicine Model	Reduced LoS for acute medicine patients Compliant with 14hr senior review standard Extended SDEC opening hours, increased SDEC capacity		• Acute Assessment Team & SDEC specification – Jul 22 • Acute Medicine staffing review – Aug 22 • Acute Medicine matron in post – Aug 22 • Training programme in place – Dec 22 • Staff investment (business case) – Mar 23 • Increased consultant team in place – Aug 23	• Complete • Complete • Complete • Complete • To be considered as part of 22/23 planning • Dependent on 22/23 planning outcome	
ED/Acute Flow – Internal Referrals	Reduced time to request inpatient specialty review Standardising process Improving patient flow Reduce 24 hr maximum time to accept inpatient specialty review		• Design SDEC and Elderly Med referral forms – Oct 22 • SDEC & Elderly Med referral forms in WebV – Dec 22 • Train users – TBC • WebV referral forms testing – TBC • Go Live - TBC	• Complete • Delayed – Jan 23 • TBC • TBC • TBC	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Urgent Care Response (UCR)	Admission avoidance Reduced delayed discharges		• UCR pathways approved – Sep 22 • UCR clinical gov agreed with Pri Care – Oct 22 • UCR practitioners recruited – Oct 22 • Systm1 updated with pathways – Oct 22 • UCR team completed training – Oct 22 • All UCR pathways live – Oct 22 • Update DoS with UCR service – Oct 22 • Additional support workers recruited – Dec 22	• Complete • Complete • Complete • At Risk (2 pathways to complete) • Complete • Complete (2 pathways not yet on Systm1) • Complete • On Track	
Virtual Ward (VW)	Increased virtual ward capacity for a larger cohort of patients Reduced delayed discharges		• Elderly medicine consultant capacity in place – Nov 22 • Night staff recruitment – Dec 22 • IT solution to manage VW in place – Dec 22 • Identify first cohort of VW patients – Dec 22 • VW beds implemented on Systm1 – Dec 22 • Initial Hospital at Home capacity live – Dec 22 • Full additional Virtual Ward capacity live – Dec 23	• Complete • At Risk (Nursing recruited; HCA re-advertised) • At Risk (ICB solution not delivered; Trust solution now requested leading to delay) • Complete • Complete • Complete • On Track	

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: An exemplar system for the care of the elderly and people living with frailty

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
No strategic objectives for 22/23 identified for this goal – focus in 22/23 on urgent and emergency care flow through ED, hospital and community services.					

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: Equitable, timely access to best quality planned care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Wharfedale Theatres (TIF1)	• Additional activity (estimated 282 General Surgery Day Case, 1017 Urology Day Case, 535 Gynaecology Day Case per annum) • Improved waiting time performance		• NHSE Business Case (BC) approval – Nov 22 • Internal BC approval – Jan 23 • MOU signed – Feb 23 • Proposal operationalised - Nov 23 • Contract signed – Feb 24 • Recruitment complete – Feb 24 • Construction complete – Mar 24 • Go Live – May 24	• On Track • On Track • On Track • On Track • On Track • On Track • On Track • On Track	
HDH Additional Theatres (TIF2)	• Additional activity (General Surgery 750 day case/inpatient, Urology 1300 day case/inpatient, Gynaecology 60 day case/inpatient, Breast 250 day case/inpatient per annum) • Improved waiting time performance		• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Planning permission awarded – Jan 23 • Complete tender, appoint contractor – Jun 23 • Recruitment complete – May 24 • Construction complete – Jul 24 • Go Live – Aug 24	• Complete • On Track • On Track • On Track • On Track • On Track • On Track • On Track	

Outpatient Transformation	• Reduce Follow Ups by 25% (compared to 19/20)
	• Expand uptake of Patient Initiated Follow Up (PIFU) to all major outpatient specialties
	• 2% of all outpatient attendances to PIFU pathway
	• Deliver 16 speciality advice requests, including A&G, per 100 outpatient 1st attendances
	• At least 25% of outpatient appointments to take place via telephone or video
	• Improved waiting time performance
			• PIFU rolled out to Rheumatology, Orthopaedics, Ophthalmology, Gastro
			• PIFU rolled out in:
			  ○ Gastro, Neurology, ENT, Physiotherapy – Dec 22
			  ○ Dermatology , Cancer – Jan 23
			• Waiting List validation – Jan 23
			• Orthopaedic Pathway Re-design complete (Hip and Knee 12mth FU) – Apr 23
				• Complete
				• On Track
				• On Track
				• On Track
				• On Track	

Theatres Productivity	• Increased activity through theatres • More specific metrics to be agreed through RPIW		• Priority specialties agreed – GRIFT HVLC 6 Specs • Improvement events delivered – TBC • Further actions dependent on outcome of improvement events.	• Complete • At risk	

Operational Update

January 2023

Russell Nightingale
Chief Operating Officer

Operational Update January 2023 (December Performance)

Matters of concern & risks to escalate

- Cancer 62-day wait target not achieved at 79.6% (5.9.1) up from 75.3%
- Cancer 2WW performance was below the 93% target at 74.9% (5.10) but improved from 57% Nov 22.
- Cancer (Breast) 2WW target not achieved at 9%, the service are focussed on improving the position.
- Non-Elective demand remains a challenge and the Trust continues at full capacity and hence occupancy remains a challenge with numbers higher than expected or planned
- Further escalation of system pressures relating to non-elective care and ambulance handovers
- Significant levels of COVID up to 25 inpatients with significant rise in other respiratory virus (RSV/Influenza) – up to 40 inpatients
- A&E 4-hour performance in December remains below the standard at 63%, significant bed pressures impacting on flow, continued increase in presentations and divert support provided to York FT. (5.6)
- The Trust had 94 over 60-minute ambulance handover breach in December
- 153 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)

Major actions commissioned & work underway

- TIF2 internal business case being prepared.
- LUNA product with AI to support RTT validation in place now plus additional manual validation of RTT commissioned alongside LUNA project-
- Recruitment underway to domiciliary care project with aim to be delivering packages of care by February 2023
- Full ED streaming model due to commence 5th January 2023
- Operational Restructure running to plan with development program also underway, 1 x GCL and 1 x SM left to recruit
- Focus on GIRFT productivity in surgical specialties.
- Review and trial of amended flow meetings to support discharges
- Planned roll out of red to green methodology to wards from beginning of January
- Contingency planning underway for industrial action from ambulance service and royal college of nursing.

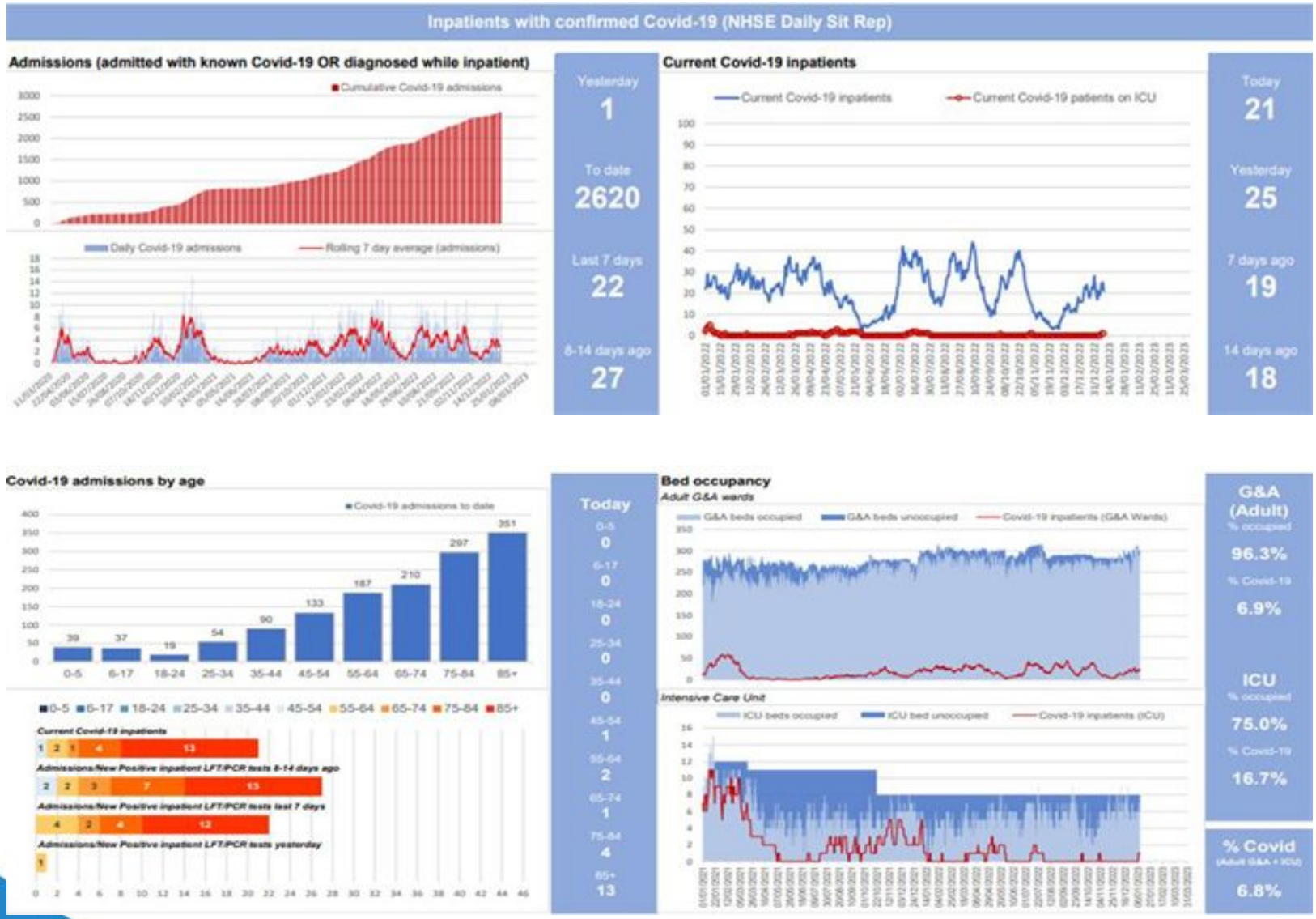
Positive news & assurance

- LLP continues with lists into December
- 199 elective theatres lists were undertaken out of a possible 218 despite challenging circumstances, 91% (88% last month)
- Cancer 31-day wait target achieved at 98% (5.1.2)
- Continued reduction in >78-week RTT waiters for surgery ahead of plan
- RTT 92nd percentile at 45 weeks (5.1.3)
- Top quartile national performance for Ambulance handover delays
- Continued to support York District Hospital with acute patient diverts
- Sufficient bed capacity for Christmas Bank holidays and despite difficult week entered New Year weekend with capacity.
- Dermatology responded and resolved 2WW issue- now back under 2WW.
- Frailty Unit moved to larger footprint with capacity to take same day emergency care for frailty.
- Major ED reconfiguration works – fit to sit area now completed

Decisions made & decisions required of the Board

- Continue to maintain escalation capacity open to support 60+ patients per day in hospital not meeting criteria to reside
- Maintained ring fenced orthopaedic elective capacity despite significant non-elective pressures

COVID-19 Management Report



Children's and Community

Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	90.8%	91.3%	93.6%	**91.9%**	94.2%	95.0%	93.8%	**94.3%**	94.3%	91.4%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.0%	93.6%	94.7%	**94.8%**	96.3%	96.8%	95.0%	**96.0%**	96.8%	95.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	93.3%	100.0%	100.0%	**97.8%**	100.0%	97.5%	100.0%	**99.2%**	98.9%	100.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	95.4%	90.2%	88.9%	**91.5%**	97.8%	97.7%	95.2%	**96.9%**	90.2%	91.4%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	93.0%	91.8%	95.3%	**93.4%**	97.8%	93.8%	97.5%	**96.4%**	88.9%	95.9%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	97.9%	95.7%	98.5%	**97.4%**	98.8%	97.1%	96.9%	**97.6%**	97.0%	100.0%
Health Visiting - % of children receiving a 12 month review by 15 months - **North Yorkshire**	98.0%	97.2%	97.6%	**97.6%**	98.3%	99.0%	97.0%	**98.1%**	97.6%	97.9%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Northumberland**	96.7%	95.8%	97.6%	**96.7%**	95.3%	96.4%	95.1%	**95.6%**	94.3%	92.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	85.5%	86.7%	92.0%	**88.1%**	94.1%	91.8%	94.7%	**93.5%**	98.0%	95.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.4%	93.0%	92.8%	**92.1%**	93.3%	90.1%	91.1%	**91.5%**	91.8%	92.4%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.8%	98.8%	**98.5%**	96.7%	100.0%	93.9%	**96.9%**	98.9%	98.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	99.2%	84.5%	96.5%	**93.4%**	96.4%	98.5%	93.0%	**96.0%**	96.9%	96.6%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	89.1%	91.1%	93.2%	**91.1%**	97.5%	97.6%	95.7%	**96.9%**	94.0%	95.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	96.0%	95.5%	90.0%	**93.8%**	98.1%	97.3%	93.8%	**96.4%**	92.1%	94.6%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	95.7%	96.5%	93.8%	**95.3%**	97.0%	95.3%	94.9%	**95.7%**	97.3%	97.2%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**	96.6%	90.4%	94.6%	**93.9%**	93.7%	93.6%	91.6%	**93.0%**	91.0%	90.4%

Safeguarding
Continued high levels of Safeguarding activity. There are particularly high levels of Safeguarding strategies in Middlesbrough. Following Audit it appears the threshold for instigating a strategy is in line with other contact areas so the decision has been made to try and recruit to two new Safeguarding roles to support 0-5 services in this area.
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.

Adult Community
Service still running at OPEL3 due to a 27% vacancy rate in adult community nursing.
A number of initiatives continue to be undertaken to support recruitment including an Adult Community Recruitment Event on the 1st December.
Discussions taking place to review current RCA process for reviewing community pressure ulcers to reduce time required of clinical staff. Jenny Nolan is supporting the service with this review.

0-19
SCPHN vacancy rates have improved to 11.68% (excluding the new Wakefield that is currently being mobilised). This is an improvement from 18.6% in Sept and is due to the SCPHN qualifying and going into substantive posts. Durham, Northumberland and Middlesbrough have the highest vacancy rates at 16.7%, 18.9% and 18.3% these services remain at OPEL 3 along with Sunderland and Gateshead. Safeguarding activity remains high but there is a month on month improvement in the delivery of the universal visits in 0-5 services and new skill mix is supporting a targeted approach to 5-19 services.

Workforce Group
We have previously run separate groups to progress workforce strategy's for Adult Community Nursing and 0-19 Services. The group has now agreed to have a CC Directorate wide Workforce group with updated membership, TOR and action plan. This will be chaired by the new Head of Nursing Emma Anderson who came into post on 4th December.

Community Dental
No patients breeched 104 weeks RTT wait at the end of December. Ability to have zero 78 weeks wait by end March 22 is a risk due to the unknown impact of any strikes and paediatric capacity due to consultant maternity leave from Jan 23. Discussions taking place with Leeds around support for MDTs and virtual consultations.

Planned Care Recovery

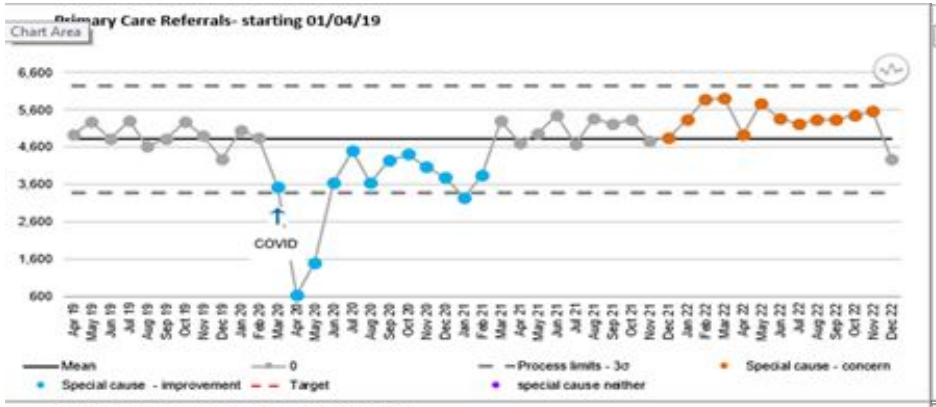
Outpatients	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	450	500	550	600	675	750	825	875	925	1,000	1,050	1,100
Actual	425	451	438	575	677	682	700	766	676			
Consultant-led 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	3,829	4,663	4,291	3,906	4,120	4,427	4,578	5,248	3,684			
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	8,375	10,432	9,324	8,540	8,675	9,375	9,383	10,647	8,107			
Elective Admissions												
Total number of specific acute elective spells in period -Plan	2,429	2,645	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 period -Actual	2,400	2,613	2,352	2,402	2,483	2,656	2,607	2,814	2,438			
Total number of specific acute elective day case spells in period -Plan	2,250	2,425	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 period -Actual	2,239	2,426	2,141	2,231	2,282	2,469	2,384	2,585	2,261			
Total number of specific acute elective ordinary spells in period -Plan	179	220	216	323	261	245	335	341	281	378	297	221
Total number of specific acute elective ordinary spells in period -Actual	161	187	211	171	201	187	223	229	177			
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	1,011	999	1,083	1,198	1,287				
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	3,458	4,079	4,233	3,879	4,517	4,207	4,456	4,711				
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	6,817	6,917	6,669	6,727	6,869				
Number of RTT incomplete 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
Number of RTT incomplete pathways waiting +52 weeks - Actual	1,187	1,196	1,261	1,297	1,297	1,350	1,285	1,201				
Number of RTT incomplete pathways waiting +78 weeks - Plan	229	235	237	229	220	210	215	195	199	150	80	0
Number of RTT incomplete pathways waiting +78 weeks - Actual	205	184	169	155	144	133	112	100				
Number of RTT incomplete pathways waiting +104 weeks - Plan	5	5	0	0	0	0	0	0	0	0	0	0
Number of RTT incomplete pathways waiting +104 weeks - Actual	11	3	1	0	0	0	0	0				
Cancer												
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
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Actual	46	39	52	57	76	67	51	58	56			

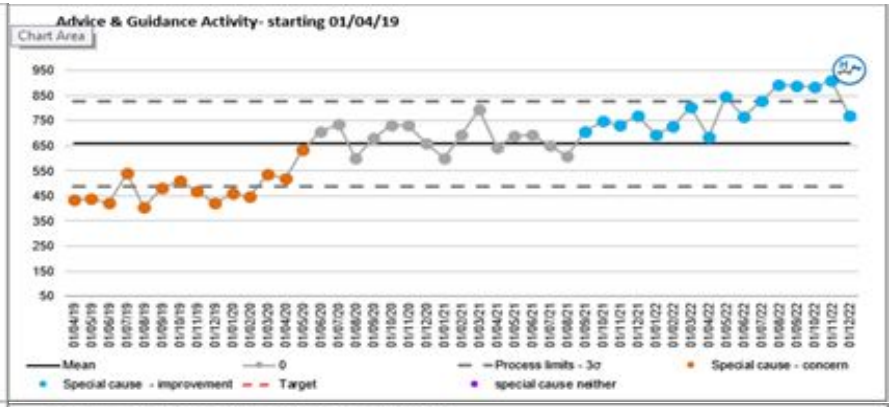
Increasing elective capacity to 2019/20 levels continues to be the key focus. 12% of 2019/20 was delivered through premium out of core sessions. Sickness absence, vacancies and some estates issues closing a theatre have caused challenge this month. Activity has grown however we remain below plan.

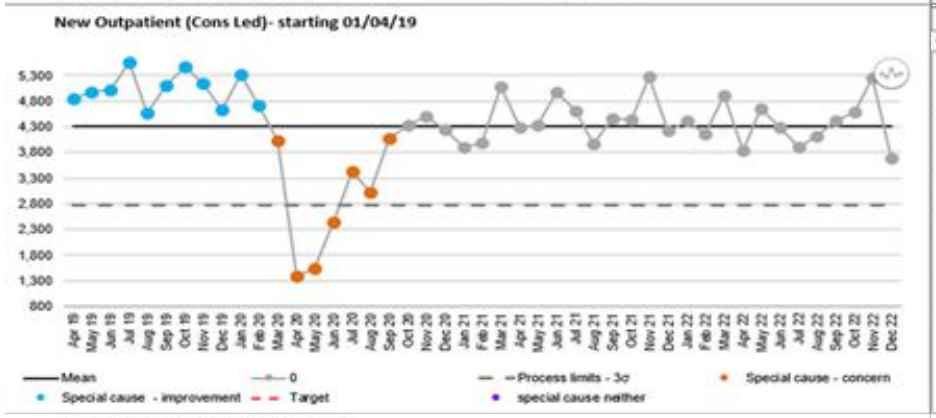
Outpatient clinic templates now returned to pre-covid levels to support an improvement to our current position. LLP process now in place with additional theatre session taking place. PIFU activity as a percentage of activity has reached 3%. Further work ongoing to switch f/u to new activity. Significant increases in advice and guidance activity from 2019/20 which do not get reflected in above figures (baseline of 450/month now up to 825/month)

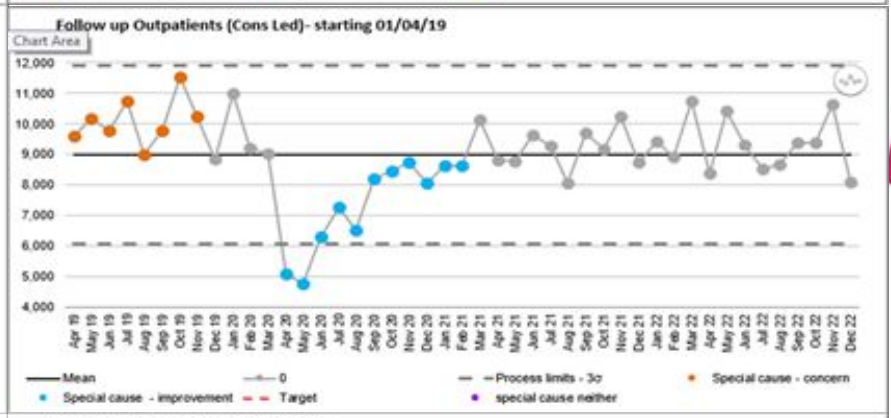
The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, we continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels.

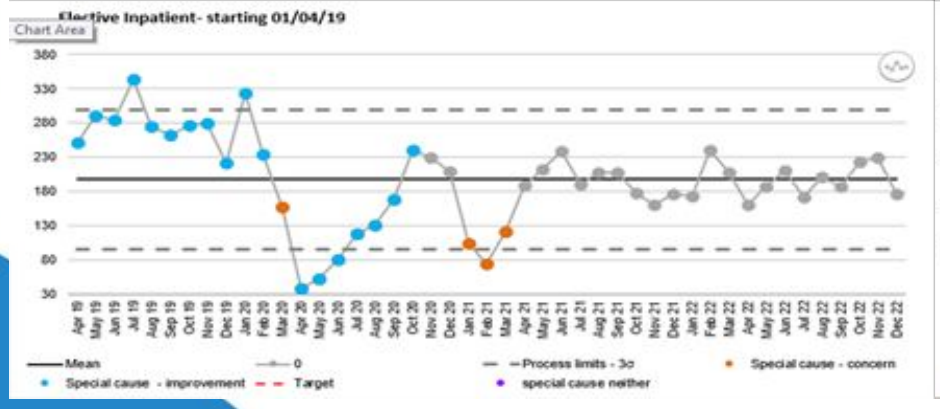
Elective Recovery

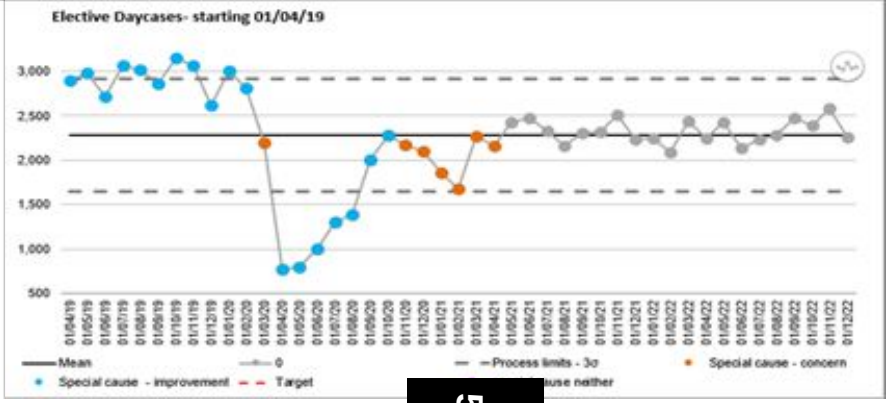












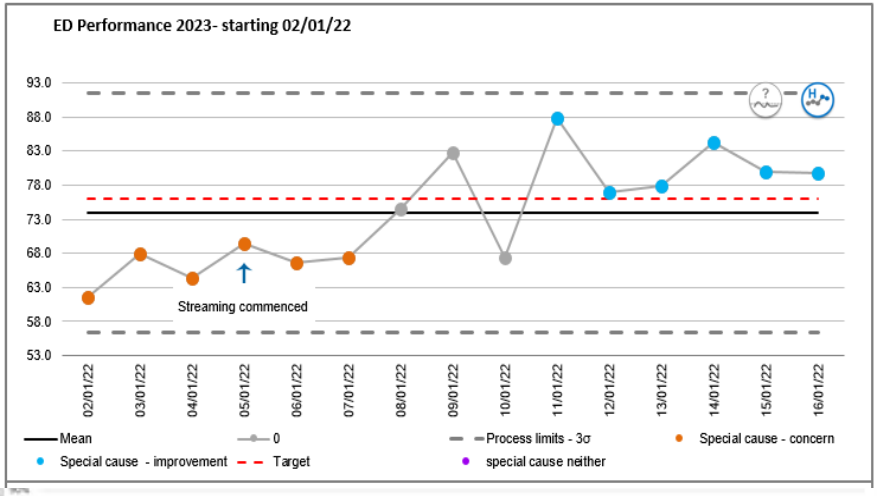
5.4

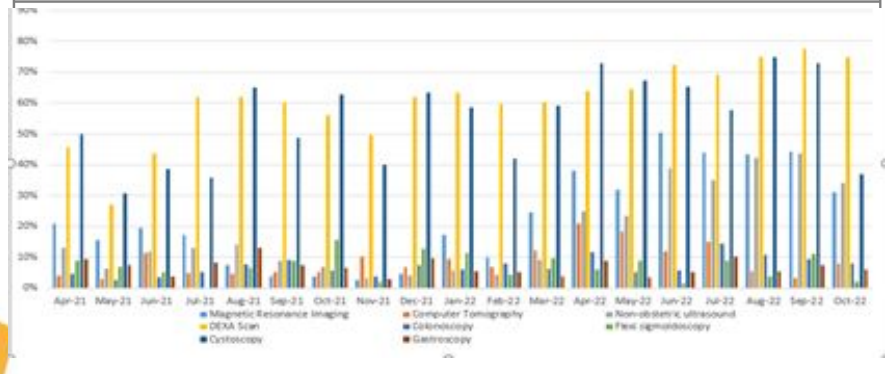
Referral to Treatment (RTT)

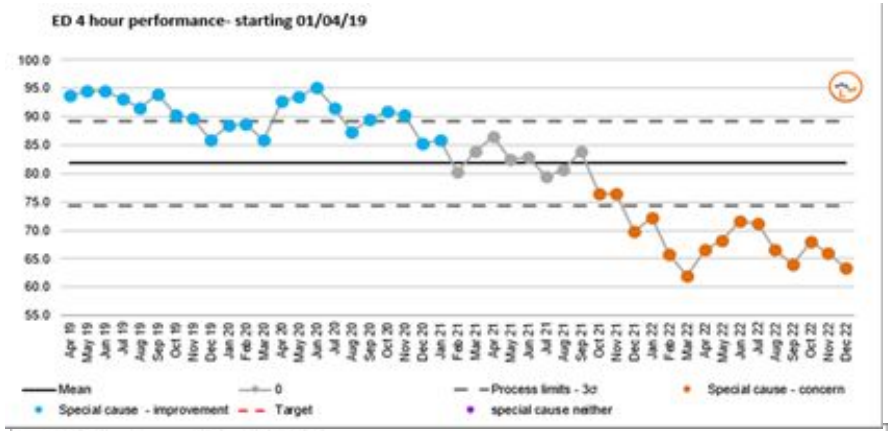
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	*Dec-22*
Total incomplete RTT pathways	24,714	25,384	25,134	25,629	25,564	25,490	25,437	25,388	*24,961*
Pathways under 52 weeks	23,311	24,001	23,703	24,177	24,123	24,007	24,040	24,087	23,542
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350	1,285	1,201	*1,299*
> 78 weeks	205	184	169	155	144	133	112	100	*120*
> 104 weeks	11	3	1	0	0	0	0	0	*0*

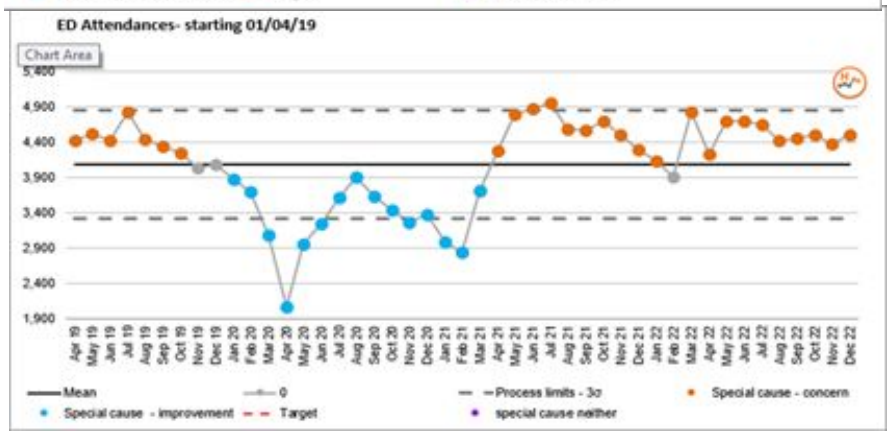
RTT - The Trust had 25388 patients waiting at the end of November, this continues the decreasing trend in RT pathways. There are 1,201 patients waiting over 52 weeks, this is also a decrease. The AI solution for RTT validation is in place with some snagging work ongoing, additionally we are buying in some time to support more rapid validation over the next 2 months.
The number of patients waiting 78+ weeks continues to reduce ahead of plan.
Of the 4,714 patients waiting for a procedure on our waiting list, 36% are Orthopaedics, 17% General Surgery and 11% Ophthalmology.
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.3% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (45/84) have been waiting <=2 weeks and work continues to ensure these are rapidly coded. 82.7% 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



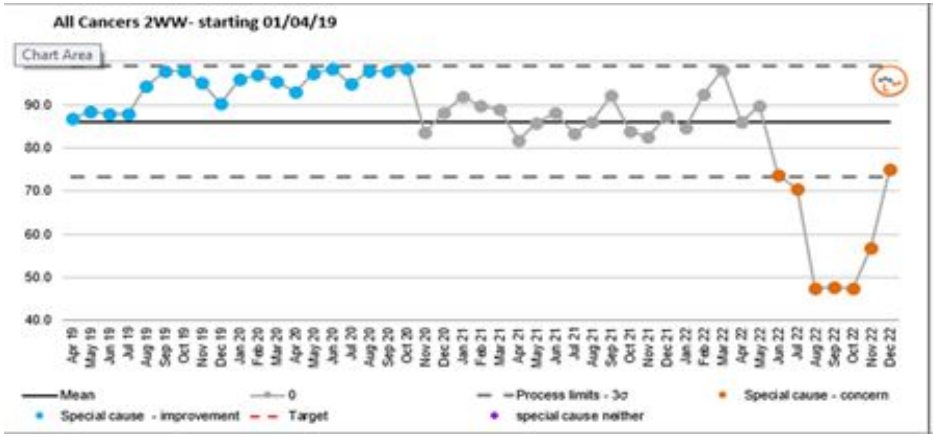


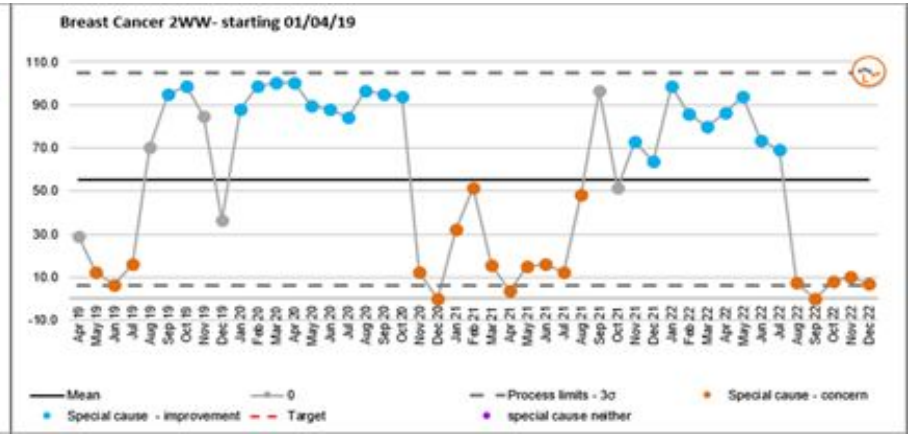


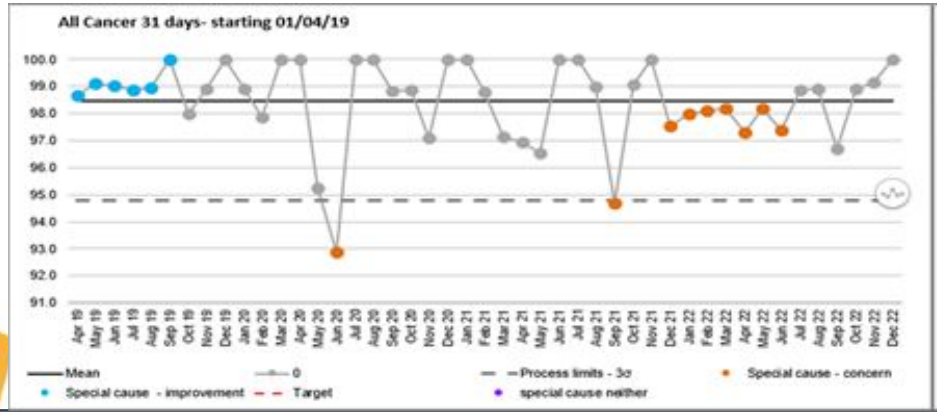


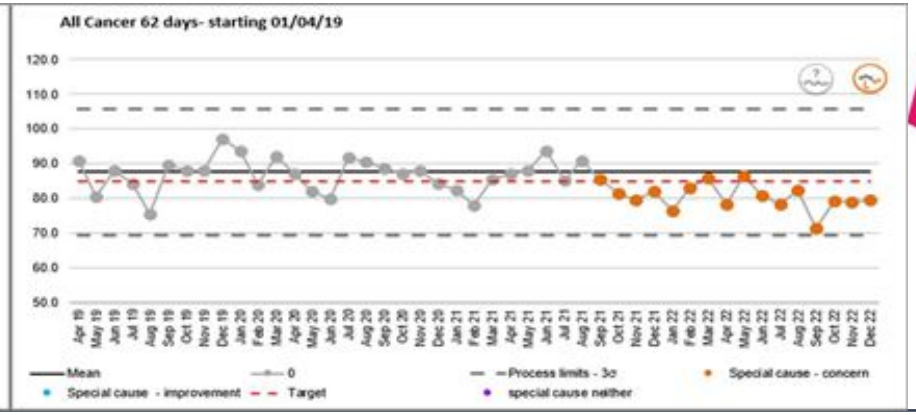
- Performance against the A&E 4-hour standard remained below 95% in De ember at 63.4%. ED performance since streaming model commenced has shown a step change. This is also linked to an improved period of bed availabiltity.
- There were 153 x 12-hour breaches in December.
- There were 183 x 30-minute ambulance handover breaches and 94 x 60-minute ambulance handover breaches in December.
- 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 continues to be maintained despite vacancies and sickness, diagnostic waits reducing or stable in most areas. Significant activity above 2019 baseline is being achieved in CT, MRI & US to reduce waiting times. All modalities are on a trajectory.

Cancer Performance



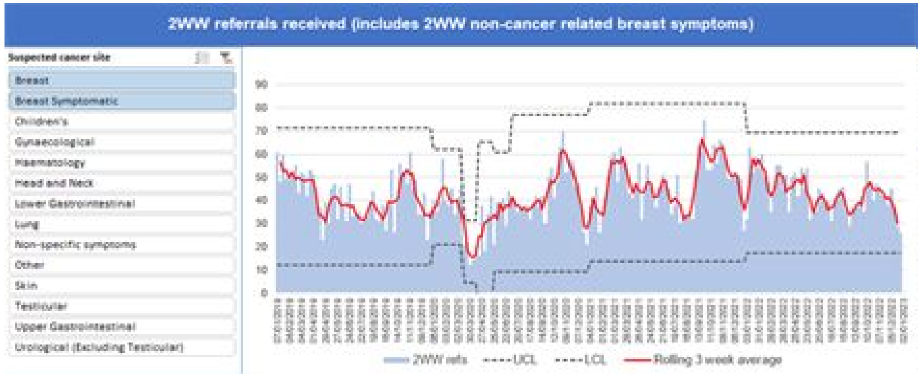


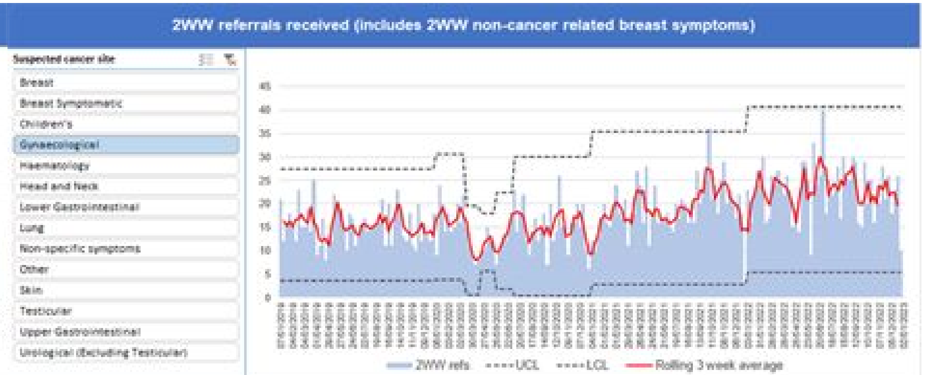


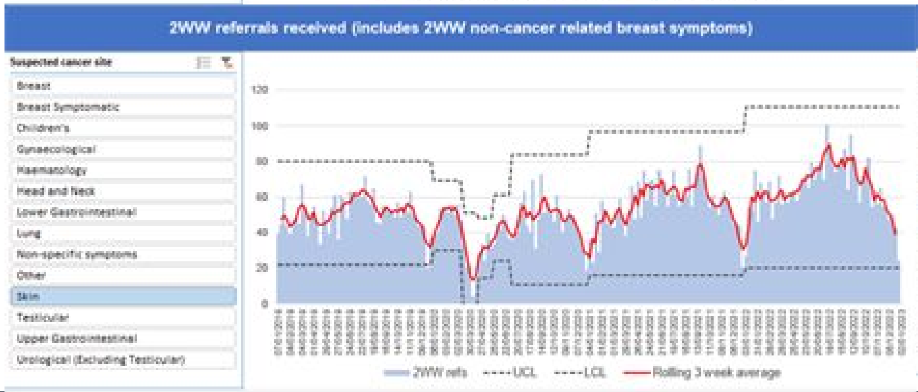


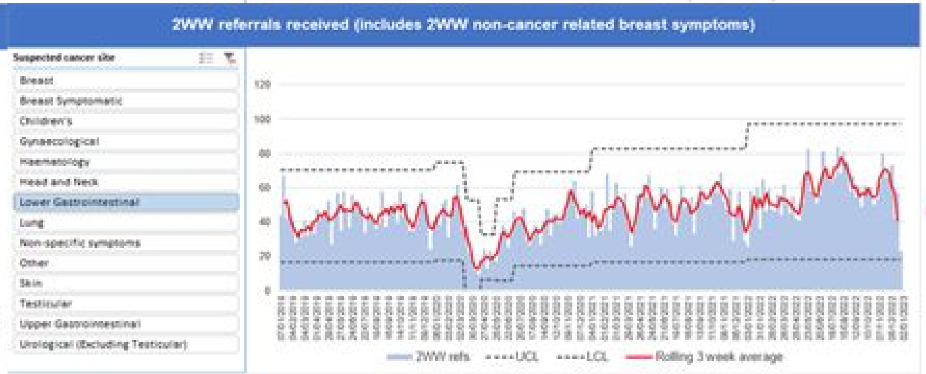
- The 62-day standard was not met in December with a performance of 79.6% against the 85% standard.
- The 31-day standard was met in November with a performance of 100%
- The 2-week wait standard was not met in December with a performance of 74.9%. A significant increase in 2WW referrals has been seen in several challenged services (Breast, Lower GI, Dermatology and Gynaecology).
- The 2-week wait breast symptomatic standard was not met in October with 9% of patients being seen within 2-weeks. Work with York to support on going high demand has started as well as insourcing clinics.
- At the end of December 56 (58 in Nov) patients remain on an open cancer pathway over 62-days with 11 (11 in Nov) of these over 104-days. This remains a key focus, it is also one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis has been completed and actions being taken to address the shortfall. The colorectal pathway has now resumed 'straight to test'.

Cancer Performance









- Performance against the 2WW Cancer standard continues to remain below the standard in December but with an improving position.
- 2WW referrals have seen a sustained increase for a number of the higher volume cancer sites, including Dermatology (skin), Gynaecology and Lower GI, resulting in demand remaining above available capacity and a performance deterioration.
- Gynaecology and post menopausal bleed capacity has been a challenge owing to staff sickness. The successful recruitment of a Nurse Hysteroscopist will improve this position and improve the diagnostic capacity.
- Successful recruitment of a new General Surgeon will improve the Lower GI position from September. A capacity and demand gap does remain as a result of the significant increase resulting from high profile national media coverage, options to reduce this gap continue to be explored.
- 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 provided by the outsourced private provider ceased in August as a result of them being unable to support clinics over the Summer period.. Since then further outsourced capacity has been utilised.Short term consultant sickness (2-weeks) has also impacted on capacity available.
- Work has commenced with York who have a much better position around mutual aid.

Finance Position December 2022

Matters of concern & risks to escalate

- The Trust continues to forecast a breakeven position but is doing so by non recurrent means. The underlying run rate would be a pressure of £12m
- Key Drivers remain performance against Savings programme, Agency expenditure, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity, inflation and escalation
- Planning for 2023/24 – pressures related to Revenue and Capital. Focus on reducing run rates required, as well addressing risks in relation to Activity, Flow and Workforce which create financial pressure
- Work required to ensure delivery of Capital Programme in year

Major actions commissioned & work underway

- Detailed planning process for 2023/24 commenced
- Discussions with ICB on wider planning process and resource availability
- Review of finance structure and processes to support directorate structure
- Understanding workforce and activity movements from 2019/20, with particular focus on the opportunities and risks presented by current planning discussions nationally
- Finalising approach to any changes to the 2022/23 Capital programme

Positive news & assurance

- The Trust continues to forecast achievement of this years plan, albeit with the risks outlined above, as well as the issues for 2023/24
- Flow of funding associated with 2022/23 ERSF confirmed
- Recruitment to vacant posts within the team
- Discussions regarding the Procurement service development moving forward

Decisions made & decisions required of the Board

AMBITION: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. We will offer everyone opportunities to develop their career at HDFT through training and education. We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

Governance:

- **Board Assurance:** People and Culture Committee
- **Programme Board:** People & Culture Programme Board
- **SRO:** Director of People & Culture

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Metrics		
Looking after our people	• **Physical and emotional support to be "At Our Best"**	**Turnover** **Vacancy Factor** **Sickness Absence** **Number of leaders trained** **Appraisal Compliance** **MEST Compliance**	
Belonging	• **Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**	**Staff survey feedback** **Number of ER cases** **WRES data** **WDES data** **Gender Pay Gap** **Ethnicity Pay Gap**	
New ways of working	• **The right people, with the right skills, in the right roles**	**Vacancy Factor** **Agency/locum spend** **Time to Recruit**	
Growing for the future	• **Education, training and career development for everyone**	**Student Feedback** **Number of courses run** **Number of internal promotions**	

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR6	Workforce Risks	Risk to patient care and safety due to potential impacts on staffing levels and increased reliance on agency workers. Potential for lower colleague engagement due to increased workload, post pandemic burn-out and poor working environment. Risk of:	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

		- potential increase in lapses in delivery of safe and effective care to patients and service users. - both short and long term mental and physical health impacts on staff.				

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Looking after our people: physical and emotional support to be "At Our Best"

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To have strong focus on all aspects of health and wellbeing to retain colleagues.	• Increased staff retention. • Reduced vacancy factor. • Reduced sickness absence. • Improved appraisal compliance. • Improved employee engagement via survey scores.		• To work with Health & Safety to deliver a programme to ensure there is a robust model in place to support workplace stress across the organisation. • Continue improve and embed health and wellbeing support to colleagues. • Develop programme to support embedding of KITE behaviours and 'At Our Best' tools to support cultural change. • Run quarterly Inpulse surveys and national staff survey's to gather ongoing feedback on employee experience. • Review National Staff Survey 2022 feedback, develop communications plan and plan to act on feedback. • Plan in place to achieve 90% appraisal compliance across the Trust. • Plan in place to achieve 90% MEST compliance across the Trust. • To work with Trade Union Colleagues to deliver a Fair & Just Culture programme around ER casework management • Review of reasons for people leaving, to ensure any recurrent themes are addressed.	• Managing workplace stress project to be in 3 phases – phase 1 underway. • Health and wellbeing programme in place, more promotion required to ensure all colleagues aware and know 'its ok to not be ok'. • Learning materials and toolkits available across all aspects, KITE included in corporate induction and leadership development programmes – further work required at Directorate and team level. • Quarterly Inpulse surveys embedded and Directorate and team actions taken. • All Directorates working to 90% compliance appraisal – current appraisal 68%. • All Directorates working to 90% MEST compliance – current compliance 87%. • Draft communications plan for National Staff Survey 2022 developed. • Fair & Just Culture work has commenced with Trade Union Colleagues. • Piloting for 12 months with Last Opinion to obtain greater feedback on reasons for leaving.	
To continue to develop employment practices and policies, which support colleague work life balance.	• Improved attraction of staff. • Reduced vacancy factor. • Increased staff retention. • Flexible and agile working environments.		• Review and implement flexible/agile working policy. • Revise and implement Retire and Return policy. • Implement Colleague Wellbeing Passports to support those with caring or disability/long term conditions. • Continue to develop our health and wellbeing services in line with the NHS Health and Wellbeing diagnostic tool.	• Policy review partially completed. • Work to commence on Colleague Wellbeing Passports. • NHS Health & Wellbeing Diagnostic 90% completed.	
To develop our leaders to ensure at compassionate and inclusive leadership is the accepted and expected leadership culture, in line with our KITE values.	• Improvement in responses to question related to leadership in staff survey. • Increased staff retention. • Reduced sickness absence.		• Continue to deliver Pathway to Management and First Line Leader training. • Implement Pathway to Management as a mandatory requirement. • Develop and promote Leadership journey	• Delivery plans in place for both programmes. • Leadership Team discussion required around mandating Pathway to Management.	

	• Improved employee engagement via survey scores.		• Suite of EDI training to be launched. • Access to Coaching and Mentoring Training • Deliver Leading Transformational Triumvirates programme with ILN. • Working with Health & Safety develop models to leaders to manage workplace stress.	• Leadership Journey promotional materials developed and communications plan underway. • EDI training developed and delivery plan being developed. • Leading Transformational Triumvirates programme designed and commissioned with ILN, programme launched 23 November 22 and runs for 12 month period.	

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Belonging: teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To be an organisation where everyone demonstrates KITE behaviours (Kindness, Integrity, Teamwork and Equality), to care for patients, children and communities who are the focus of everything we do.	• Improved scores on related questions from Inpulse and national staff surveys. • Reduction in employee related matters linked to staff behaviours. • Increased staff retention.		• Develop programme to support embedding of KITE behaviours. • Develop programme to support 'At Our Best' tools – ABC of appreciation, Respectful Resolution, 4 S Appraisal and BUILD Feedback tools.	• Programme to be developed and delivered by Senior OD Practitioner who joined on 09.01.23. • Root Out Racism 'app' developed 80% to be joined with FTSU and rolled out.	
To build strong teams who support each other, work collaboratively and with collective goal of delivering excellent care to our patients.	• Improvement in responses to question related to leadership in staff survey. • Increased staff retention. • Reduced sickness absence. • Improved employee engagement via survey scores.		• Cascade of Inpulse survey feedback and team actions to improve team cohesion. • Development of dashboard to highlight teams where KPI's indicate potential challenges within in team environment. • Adhoc OD support to teams highlighted above.	• Quarterly Inpulse surveys now well embedded with a Behaviour added into the questions each quarter to measure how well embedded our KITE behaviours are. January 23 is Kindness, which will allow direct comparison with the January 22 survey, which was also focussed on Kindness.	

To promote equality and diversity so everyone is valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support networks, leadership development and training of all colleagues.	• Improvement in responses to question related to leadership in staff survey.
	• Increase in number of employees with protracted characteristics.
	• Strong and active staff support networks in place across the Trust.
	• Active Diversity Calendar in place with high visibility of events.
	• EDS22 Assessment Rating of Achieving.
	• Increased staff retention.
			• Deliver WRES & WDES action plans to support HDFT being an inclusive and diverse organisation.
			• Grow membership of staff support networks and develop their role in the organisation.
			• Launch of Equality Impact Assessment policy, process and training programme.
			• Launch pilot unconscious bias training
			• Manage programme of events linked to Diversity Calendar.
			• EDS22 workforce domain action plan developed.
				• Additional training and development is being carried out for BAME leadership, cohort I and Reciprocal mentoring, cohort II.
				• Network Chairs invited to PAG
				• Increased numbers in all staff networks since December 23.
				  ○ Menopause 84 members
				  ○ LGBT+ 40+
				  ○ Disability and long term conditions 50+
				  ○ BAME 30+
				  ○ Mens Health 6
				  ○ Neurodiverse Network – Feb 23 launch
				• Network groups using WRES and WDES from 2023 to inform discussions and feedback points to feedback to Board.
				• Equality Impact Assessment new process and associated training - to be launched during January 2023.
				• Training on Unconscious Bias and Neurodiversity will be rolled out as training	

				available to all staff on Learning Lab. Programme written, to be piloted Feb 23. • EDS22 – external submission by 28 Feb 23 following Equality Reference Group agreed on outcomes from the report then action plan will be developed by end of March 23.	
To seek to increase diversity across our decision making forums.	• Increased equality, diversity and inclusion across all areas of Trust employment practices and wider decision making and recruitment. • Increased staff retention. • Improvement in WRES/WDES data.		• Promote HDFT as an inclusive and diverse employer in our recruitment information. • Review participation in key decision making forum/governance forums and recruitment. • Refresh of imagery to be more reflective of the employees that work here on all media platforms and recruitment sites.	• Recruitment pack under development with statements from Network Exec Sponsors, blogs and vlogs from staff to support. • Signposting information to be included in the recruitment pack to encourage recruitment from outside of the locality.	

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: New ways of working: the right people, with the right skills, in the right roles

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To plan and design our workforce as creatively as possible, to have the right number of skilled colleagues in the right roles.	• Resourcing and workforce numbers aligned to service needs and financial position. • Reduced reliance on agency/locum and other temporary workforce solutions.		• Develop integrated Resourcing & Workforce Plan to ensure we have the right numbers of skilled staff at the right time • Explore skills mix review/new role development and new ways of working • Review Core and Role Specific Mandatory training requirements for each role • Support development of Domiciliary Care subsidiary • Support Clinical Education Fellow Posts across the Organisation • Support Less Than Full Team as guided by HEE • Support Medical Trainees to meet curriculum requirements • Escalate exception reports • Organisational Development programme to support Pathology Services Joint Venture • E-job planning	• Workforce planning underway – 2 workshops held – Activity and Workforce with Finance workshop scheduled for early February. • Directors reviewing MEST requirements for each role across the Trust • There is currently 1 50/50 Clinical Education fellow in Frailty, and 2 colleagues supporting 2 education days in Medicine. Awaiting further interest from other specialities with the intention of supporting 6 from Sept 23-24. • E-job planning - project for implementing e-job planning will go to next workforce systems board. Meeting with ODs and CDs to find a solution regarding final sign off of job plans.	
To recruit great colleagues by building a strong employer brand and implementing effective recruitment practices, making the best use of digital solutions.	• Resourcing and workforce numbers aligned to service needs and financial position. • Reduced reliance on agency/locum and other temporary workforce solutions. • Reduced time to recruit. • Increased number of applicants for all roles.		• Achieve Disability Confident Accreditation Level II • Achieve Rainbow Badge Accreditation • Retain Menopause Accreditation • Publicise diversity of workforce on Intranet Careers page and via social media • Review use of social media in recruitment processes to improve reach • Explore opportunities to attract candidates with protected characteristics • Reach out to wider communities e.g., Care Leavers, Project Search • Review job descriptions, person specifications and job adverts to ensure modernized and appropriate	• Working towards level II of Disability Confident Employer scheme – submitting application with evidence end of Feb. Updating policies, additional training developed and signposting materials. • Rainbow Badge Re accreditation submission end of March 23. Additional resources were created, signposting materials and changes to policies to be more inclusive. • Introducing improved access information and guidance for candidates using google translate, contrast colours and video platforms. • Job adverts going out to third sector job boards focusing on disability and LGBT+ • Working with Project Search to provide core skills and work experience for four interns. Increasing numbers to 10 from September.	

To continue with the implementation of e-rostering to ensure that safe staffing levels can be allocated and managed with maximum efficiency.	• Right staff with the right skills in the right place at the right time.		• Embed Healthroster into business as usual • E-rostering for medical staff project established • Develop e-roster KPIs	• Roster review meetings in place to support compliance and KPIs on a monthly basis. 27/10/22 - E-rostering for clinical staff has been rolled out and project is complete. Next step is to embed and ensure good rostering practices are being followed. E-rostering team have ward review meetings on a monthly basis with a number of non-compliant teams to improve performance. Medical e-roster - awaiting procurement to update us on figures in order to update us on business case. Project team currently identifying suppliers to showcase their products.	

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Growing for the future: education, training and career development for everyone

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To develop career pathways and offer development opportunities to enable colleagues to grow their skills and access career progression at teamHDFT.	• Increased staff retention. • Grow our own talent/succession planning.		• Linking with Corporate Nursing/Professional Development - develop career pathways for all professions. • Develop and implement talent management approach. • Training and development opportunities available to support individual growth and progression. • Appraisal discussions held with all colleagues. • Promote Leadership offering - Compassionate and Inclusive Leadership.	• Leadership Pathway for Managers is live – auto enrolment for all new managers since April 2022. • NHS Elect is live and available for colleagues. • Training and Development opportunities added regularly to Learning Lab. • Appraisal updated to values based, training available via Learning Lab.	
To be a collaborative partner to Health Education England and Higher Education Institutions.	• Positive feedback from HEE Provider Self-Assessment. • Positive feedback received from HEIs on student experience. • Positive feedback from undergraduate learners i.e. NETS. • Number of placements increased.		• Live running document HEE Provider Self-Assessment discussed quarterly prior to Q3 submission. • Regular schedule of meetings in place with HEE and HEI's. • Co-Ordinate the annual HEE Senior Leader visit. • Growing for the Future sub-group in place.	• 1st submission of new style self-assessment Dec 2022. Review due 30th Jan 2023 – GFF. • Regular attendance at DEEF, Acute Trust Meeting, Regional MEM meetings etc. • Potential Senior Leader date for 19th October. • Growing for the Future Sub group 2nd meeting Jan 30th.	
To be an excellent place to learn and develop for all colleagues and students from all professions (international and UK based), offering great placements.	• Positive feedback gained from Guardian of Safe Working. • Positive feedback received from medical and non-medical student evaluation of placements - NETS and PARE. • Competent teams with diverse skill mix.		• Target to recruit 31 international nurses • Support Ward Based Tutors to deliver curriculum requirements. • Review internal offering of training to meet organisational need. • Review of Commissioned Training. • Develop Learning Lab to its fullest potential.	• Current exception report escalations and NETS feedback resulted in a triggered visit by HEE. Currently following action plan on SDEC. • Ward-based Tutors continue to evaluate well from UGME. • Learning Lab hosts all Mandatory Training, a robust leadership and wellbeing offering and is continuing to grow.	

People & Culture

Matters of concern and risks to escalate

Turnover

Turnover Rate remains has slightly decreased from 15.83% to 15.62%

Sickness

- Sickness has increased from 4.88% in November to 5.65%.

Appraisals

- Appraisal Rate has increased from 65.25% in November to 68.03%.

Carry over annual leave

- A further analysis of balances of annual leave is being undertaken and will be shared with directorates in January. There are still a large number of colleagues who have large numbers of annual leave still to be taken by the end of January

Industrial Action

- The RCN has confirmed that two day's of strike action will occur on the 18th and 19th January from 8am to 8pm each day.

Major actions commissioned and work underway

Industrial action

- A Silver Command Team with responsibility for preparing for the strikes is in operation
- Impact of National derogations on HDFT have been in addition to assessing which local derogations need to be requested
- Communication and engagement plan in place to ensure Staff and managers remain updated on the National position in order to prepare us for the strikes
- rosters and rota's for known strike days are under review and managers are asking staff if they intend to strike to help inform our planning and maintain patient safety

Clinical Excellence Awards 2022/23

- A joint group including LNC colleagues are working through the options for implementation of the CEA award for 2022/2023 (changes following COVID)

National Staff Survey /Inpulse

- National staff survey results received (currently under embargo) communications plan under development
- KINDNESS Inpulse survey planning complete ready for launch 16 to 31 January

Covid/Flu Vaccination Campaign –

- Staff campaign successfully delivered

Managing Workplace Stress project

- Under development in collaboration with Health & Safety Team

Disability and Carers Passports

- under development to ensure consistence of support for colleagues throughout their employment at HDFT.

EDS22

- final self assessment evidence submitted, and External Equality Stakeholder Reference Group to meet in January in readiness for Final submission 28 February

People & Culture

Matters of concern and risks to escalate

Major actions commissioned and work underway

Staff Network Groups:

Increased membership in all and started the Men's Health Network (James Wright supporting as Executive Sponsor – 7 members
BAME - 40 members
Menopause – 80 members
LGBT+ - 30 members
Disability and Long-term conditions – 35 members

EDI

- Equality Impact Assessments and training - all live on the learning lab and documents are on the intranet - Publicity to follow in January
- Review of Reciprocal Mentoring programme complete with proposal for cohort II agreed.
- Submission to be made by 31 Jan for our application to meet the Level II Disability Confident Scheme
- Tackling Racism - working with new FTSU to discuss finalising the on-line app to enable colleagues to confidentially report incidents of racist behaviour.
- Unconscious Bias training pilot [planned - to be delivered as a pilot to 2Cs
- 'Working with Neurodiverse Staff' to be delivered to Phlebotomy as a pilot

. **Pay and Pensions**

- Work continuing on Medical Additional Rates Group and Staff Pensions Impact Group

Just and Learning Culture

- Phase II of the work underway In partnership with the Trade Unions. 5 priority areas/actions agreed;

People & Culture

Positive news and assurance

Recruitment

- 109 candidates has been set start dates which means all checks are complete, candidates may be working notice periods and will be commencing with HDFT shortly.

International Recruitment

- 4 International Nurses arrived in the month of December with 10 further nurses arriving in during the month of January 2023

Occupational Health, Learning & Development

- Interim Head of Occupational Health recruited to be in post from 3 January to 31 March (Tracy Cooke), to cover gap between Suzanne Ford leaving on 13 January, and our substantive Head of Occupational Health, Janette Barnes commencing on 27 March.
- Colleague Wellbeing Programme Lead post recruited to – Mel Kavanagh (previously job sharing the role) successfully appointed to whole time role.
- Clinical Psychologist for the Colleague Wellbeing successfully appointed to (Helen Hardy)
- People & Culture Team Time Out Event held on 16 December enacting feedback and actions form Directorate Inpulse survey

BAME Leadership Course - applications are now closed at 30

Decisions made and decisions required of the Board

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

GOALS:

- **A patient and staff environment that promotes wellbeing.**
- **An environment and equipment that promotes best quality, safest care.**
- **Minimise our impact on the environment.**

Governance:

- **Board Assurance:** Resources Committee
- **Programme Board:** Environment Board
- **SRO:** Director of Strategy

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Metrics		
Environment that promotes wellbeing			
Environment that promotes best quality, safest care			
Minimise our impact on the environment			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks currently					

GOAL: AN ENVIRONMENT THAT PROMOTES WELLBEING: A patient and staff environment that promotes wellbeing.

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Wellbeing Improvements	To improve the working environment for staff		• Minor refurbishments and redecoration • Complex schemes project briefs and designs – Oct 22 • Complex schemes costing and detailed design – Nov 22 • Complex schemes prioritisation – Dec 22 • Prioritised complex schemes completed – Mar 23	• Complete • Complete • On Track • On Track • On Track	

GOAL: AN ENVIRONMENT THAT PROMOTES WELLBEING: An environment and equipment that promotes best quality, safest care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Reconfiguration: Fit to Sit, Majors Area	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete - Jul 22 • Contract award - Aug 22 • Fit to Sit Phase 1 start - Sep 22 • Fit to Sit Phase 1 complete - Dec 22 • Majors Area Phase 2A start - Jan 23 • Majors Area Phase 2A complete - Mar 23 • Majors Area Phase 2B start - Mar 23 • Works complete - Apr 23	• Complete • Complete • Complete • Complete • Complete • On Track • On Track • On Track	
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Design complete – Aug 22 • Tender & Contract award – Mar 23 • Build complete – Jun 23 • Commissioning complete – Aug 23 • In service – Sep 23	• Complete • On Track • On Track • On Track • On Track	
Radiology Reconfiguration Phase 1-2 – XRay & CT	• To improve reliability and capacity of imaging services		• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Tender & Contract award - TBC • Build complete - TBC • Commissioning complete – TBC • In service – TBC	• Complete • Complete • On Track • Further milestones dependent on phasing of overall capital programme for 23/24	
ED2 (UTC) Reconfiguration	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build start – Mar 23 • Build complete – Aug 23 • Commissioning complete – Sep 23 • In service – Sep 23	• Complete • Delayed – now planned for 25 Jan 23 • At risk – timescale is achievable, but pre-tender estimate is above capital allocation so risk that tenders are unaffordable • At risk – target start on site end of Apr 23 • At risk • At risk • At risk	
Wensleydale Ward Refurbishment	• Dedicated cardiology and respiratory ward, including High Observation/Non-invasive Ventilation Beds		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build Start – Apr 23 • Build complete – Oct 23 • Commissioning complete – Nov 23 • In service – Dec 23	• Complete • Delayed – now planned for 25 Jan 23 • At risk – timescale is achievable, but pre-tender estimate is above capital allocation so risk that tenders are unaffordable • At risk – target start on site end of Apr 23 • At risk • At risk • At risk	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
HDH Additional Theatres (TIF2)	• Additional activity (General Surgery 750 day case/inpatient, Urology 1300 day case/inpatient, Gynaecology 60 day case/inpatient, Breast 250 day case/inpatient per annum) • Improved waiting time performance		• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Planning permission awarded – Jan 23 • Complete tender, appoint contractor – Jun 23 • Recruitment complete – May 24 • Construction complete – Jul 24 • Go Live – Aug 24	• Complete • To be completed by end of Jan 2023 • On Track • Delayed – planning process will need to run in parallel to the tender process. • On Track • On Track • On Track • On Track	

GOAL: AN ENVIRONMENT THAT PROMOTES WELLBEING: Minimise our impact on the environment

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Development of the Trust "Green" Plan	A longterm plan and governance structure for the reduction of the Trust's carbon emissions		• Green Plan approved by HDFT and HIF Boards • Governance structure, Sustainability Board, in place reporting to HIF Board	• Complete • Complete	
SALIX Carbon Reduction Programme	To improve the estates infrastructure at Harrogate District Hospital in order to reduce carbon emissions		• Solar panels • Air and ground source heat pumps • Window replacement	• Behind original programme • Current completion planned for Aug 23	
Travel Plan	To develop sustainable models of transport for patients, staff and visitors		• Patient, staff, stakeholder engagement • Travel Plan drafted • Discussed with Environment Board and SMT – Dec 22 • Further actions TBC	• Complete • Complete • Complete	

ENABLING AMBTION: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE

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

GOALS:

- **Systems which enable staff to improve the quality of care**
- **Timely, accurate information to enable continuous learning and improvement**
- **An electronic health record to enable effective collaboration across all care pathways**

Governance:

- **Board Assurance:** Innovation Committee
- **Programme Board:** Digital Board, EPR Programme Board
- **SRO:** Medical Director

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Metrics		
Systems which enable staff to improve the quality of care			
Timely, accurate information to enable continuous learning and improvement			
An electronic health record to enable effective collaboration across all care pathways			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks currently					

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: Systems which enable staff to improve the quality of care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Luna (RTT Tracking)	To improve the quality of waiting list data in order to support timely treatment of patients		• Business Case approved – Jun 22 • Contract signed – Jun 22 • Initial Go Live – Dec 22	• Complete • Complete • On Track	
eRostering	To improve how staff are rostered for shifts in order to provide a better staff experience (better planning and management of shifts) and more efficient and effective utilisation of staff		• Business Case approved – Dec 20 • Contract signed – Dec 20 • Initial Go Live – Jun 21 • Project complete – Dec 22	• Complete • Complete • Complete • On Track	
Datix Cloud	To provide a robust clinical governance and risk management platform for the Trust to underpin our quality learning and improvement system		• Business case approved – Apr 22 • Initial Go Live – Apr 23 • Project complete – Dec 23	• Complete • On Track • On Track	
ASCOM Nurse Call (linked to Wensleydale Digital Exemplar Ward)	To improve quality and staff experience by enabling more effective and efficient response to patient calls		• Business Case approved – Mar 22 • Wensleydale refurbishment starts – Apr 23 • Wensleydale back in service – Dec 23 • Basic nurse call solution live – Dec 23 • Task management live – Mar 24 • Medical device integration – Jun 24	• Complete (implementation delayed due to timescales for Wensleydale refurbishment) • On Track • On Track • On Track • On Track • On Track	

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: Timely, accurate information to enable continuous learning and improvement

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Implement Microsoft Azure/Power BI	To improve decision making by providing more accurate, timely information to clinicians and managers		• Business Case – Oct 22 • Contract signed – Dec 22 • Go Live – Mar 23	• Complete • On Track • On Track	

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: An electronic health record to enable effective collaboration across all care pathways

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
New Electronic Patient Record	To improve the quality of maternity services		• Strategic Outline Case – Aug 22 • Outline Business Case – Jun 23 • Full Business Case – Jan 24 • Contract signed – Jan 24 • EPR delivery project starts – Mar 24 • Initial Go Live – TBC, likely Q2/3 25/26	• Complete • On Track • On Track • On Track • On Track • TBC	
Maternity Electronic Patient Record	To improve quality of maternity services and staff experience through better clinical information, more efficient and effective ways of working.		• Business Case approved – Mar 22 • Contract signed – Mar 22 • Go Live – Mar 23	• Complete • Complete • On Track	
Single Sign On	To improve the security of Trust IT systems, save staff time and implement an enabler for the EPR		• Business Case – Nov 22 • Contract signed – Dec 22 • Initial Go Live – Jun 23	• Complete • On Track • On Track	
Laboratory Information Management System (LIMS)	To provide a single LIMS across all WYAAT pathology services to enable system working and information sharing		• WYAAT Business Case approved – Jan 21 • Contract signed – Jan 21 • Go Live – Dec 23	• Complete • Complete • On Track	
Scan4Safety Medicines Management (Omnicell) (Link to Medicines Safety Quality Priority)	Reduction in medicines safety incidents		• Business Case approved – Jul 21 • Contract signed – May 22 • Initial Go Live – Oct 22 • Project complete – Mar 23	• Complete • Complete • Complete • On Track	
Somerset (Cancer Tracking)	To enable the timely management of cancer referrals and meet mandated cancer reporting requirements		• Business Case approved – Aug 21 • Contract signed – Feb 22 • Initial Go Live – Oct 22	• Complete • Complete • Complete	
Outpatient Flow and eOutcomes	To improve outpatient outcomes data and outpatient productivity by capturing of outcomes at point of care and supporting flow		• Business Case approved – Apr 22 • Contract signed – Dec 22 • Initial Go Live – Sep 23	• Complete • On Track • On Track	
Robotic Process Automation	To release staff time, reduce delays and improve data processing accuracy by using automating information processes		• Business Case approved – Dec 22 • Contract signed – Mar 23 • Initial Go Live – Jun 23	• On Track • On Track • On Track	
Yorkshire & Humber Care Record	To enable sharing of patient information across systems and organisations		• Regional Business Case approved – Jun 20 • Regional contract signed – Jun 20 • Initial Go Live – May 22	• Complete • Complete • Complete	

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY

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

GOALS:

- **To be a leading trust for the testing, adoption and spread of healthcare innovation**
- **To be the leading trust for children's public health services research**
- **To increase access for patients to clinical trials through growth and partnerships**

Governance:

- **Board Assurance:** Innovation Committee
- **Programme Board:** Research and Innovation Board, Quality Improvement Board
- **SRO:** Medical Director

Metrics *(to be developed following review of Integrated Board Report)*

Goal	Metrics		
To be a leading trust for the testing, adoption and spread of healthcare innovation			
To be the leading trust for children's public health services research			
To increase access for patients to clinical trials through growth and partnerships			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related Corporate Risks currently					

GOAL: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY: To be a leading trust for the testing, adoption and spread of healthcare innovation

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Establish Harrogate Innovation Hub	Facilitate and accelerate the growth of innovative healthcare solutions by building partnerships with industry, academia, government and voluntary sector and offering a real world testbed for healthtech and digital innovations		• Harrogate Innovation Hub Launch event – Oct 22 • Identify Innovation Hub location – Oct 22 • Recruit Innovation Manager – Jan 23 • Appoint Clinical Lead for Innovation – Jan 23 • Further actions to be developed	• Complete • Complete • On Track • On Track	
Research, Audit, Innovation and Service Evaluation (RAISE) group	To build collaboration with innovation partners		• Scoping the potential for RAISE with partners such as Academic Health Science Network, Research Design Service – Mar 23 • Further actions TBC following scoping	• On Track	

GOAL: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY: To be the leading trust for children's public health services research

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To understand Children's PH research and identify how we can contribute	Build the evidence base for Children's PH Services Improved outcomes for children		• Children's PH Services Strategy Workshop – Oct 22 • Paper on Children's PH research for Children's PH Services Board WG – Jan 22 • Further actions to be developed	• Complete • On Track • TBC	
To provide opportunities for Children's PH services, and the children and families they support, to be involved in research studies	Build the evidence base for Children's PH Services Improved outcomes for children		• Identify and open research studies into children's public health – Mar 23	• On Track – 3 studies opening	

GOAL: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY: To increase access for patients to clinical trials through growth and partnerships

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Dedicated research clinic space	Retain Clinical Research Network funding		• Identify dedicated clinic space within HDH for research clinics – Sep 22	• Complete	
Increase research workforce capacity	To increase capacity to deliver research in HDFT		• 4 additional research staff • 2 additional clinical fellows to support research in frailty, neurology and rehabilitation – Jan 23 • Education and training of clinical staff on research	• Complete • On Track • Ongoing	
Implement clinical trials in HDFT	To increase the number of clinical trials delivered at HDFT		• Implement a novel pilot mechanism to prioritise and assess feasibility of studies – Feb 23 • Establish partnership with IQVIA (a leading global provider of analytics and clinical research services)	• On Track • Complete	

Director of Strategy

Matters of concern & risks to escalate

Capital Planning
- RAAC. Several areas of RAAC identified requiring immediate action (mitigation plans in place and works will be completed in January to address); ongoing survey and monitoring; need a plan to eradicate by 2030

Major actions commissioned & work underway

PMO
- OP Transformation: expansion of electronic patient comms via Synertec
- UEC: domiciliary care project included as priority project

QI
- Current work supporting: Elective C-Section pathway, Imaging, Discharge Hub, Therapy Services, Antenatal Clinic
- Planning: Early Discharge Event, Equipment Library
- Appointment of external support for a major programme to develop and implement an Improvement Operating Model

Capital Planning
- 22/.23 Programme: Reviewing programme for underspends to allow additional small projects in 22/23
- ED RIAT and Majors Area work underway
- Wensleydale & ED2: out to tender in Jan 23
- TIF2: preparation of P23 tender underway
- Aseptics: contractor appointed, project on track
- Imaging: developing business continuity plan; designer appointed for department reconfiguration plan
- Estates Strategy: mini-tender planned to appoint external consultancy

Positive news & assurance

Strategy
- Integrated planning process underway; draft plan to ICS in mid Feb
- Draft 23/24 Strategic Objectives developed for review at SMT and Board workshops in Feb

PMO
- BCRG: Haematology Nursing, Pharmacy Homecare, SSD Upgrade, 22/23 Nursing International Recruitment BCs approved.
- CDC: approval of NY CDC BC expected which will provide funding to upgrade diagnostics provision at Ripon CH; NHSPS developing refurbishment plans.

Capital Planning.
- 22/23 Programme: Fit to Sit, Omnicell, Gamma Camera, Theatres Beverage Room, Wellbeing, Lascelles will be completed by 31 Mar 23
- Power: Confirmation from Mott McDonald that current electrical infrastructure is sufficient to support TIF2 Theatres

Business Development
- Submission of tenders for Vaccination & Immunisation Services

Decisions made & decisions required

PMO
- BCRG: ED2(UTC), Nursing International Recruitment 23/24-24/25, Robotic Process Automation BCs recommended for approval

QI
- Strong support from Trust Board in December for a trustwide Improvement Operating Model which will support continuous improvement and benefits realisation for the EPR.

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:	7th December 2022
Date of Board meeting this report is to be presented	25th January 2023

Summary of key issues

The meeting was held via Teams and was well attended. Kathy Gargan and Steve Treece observed and contributed to the meeting on behalf of the Council of Governors.

Key items on the agenda included -

- Corporate Risk Register - the Committee considered the regular risk register overview report. It was noted that the report format was a work in progress to an extent and suggestions were made as to how the report might be developed to provide greater visibility of current and emerging issues. It was noted that the December Board Workshop would have a focus on risk related matters. It was asked to what extent HIF risks should be or were included on the corporate register. The HIF MD will attend future meetings to contribute to consideration of HIF internal audit reports and her presence will provide an opportunity to discuss the recognition and mitigation of HIF risks.
- 2022/23 Internal Audit Programme – four final reports had been issued since the last meeting. One had only advisory status and two provided significant assurance. However, a report on pressure ulcers offered only limited assurance. Committee members expressed disappointment with the low numbers of completed risk assessments and varying compliance with Trust processes and documentation

across departments and wards despite the attention given to this issue in a number of places including at the Quality Committee. It was noted that this report would be considered at the next meeting of the Quality Committee were the detail could be examined more closely and further assurances sought. Feedback on the Quality Committee's discussions would be provided to the March Audit Committee meeting. The Committee approved the addition of an audit relating to prescription charges to the annual programme as requested by management.

- Outstanding Internal Audit Recommendations Benchmarking Report – a benchmarking report had been requested at a previous meeting. The report covered performance across Audit Yorkshire's client base. At first sight it appeared that HDFT's performance in implementing internal audit recommendations was not as it might be when compared to others despite actions taken by the Executive Team to improve the responsiveness of the organisation to audit recommendations. On a more positive note it was recognised that HDFT's audit programme was likely to generate a greater number of reports and therefore more recommendations as it included a larger number of audit days than those in some other Trusts. The integrity of HDFT managers in facilitating audits in areas of work where it was felt that attention might be needed could also be a cause a relatively high number of recommendations materialising. It was also noted that some long-standing issues might no longer be relevant but remained on the list of unactioned recommendations. The reliability of updates on the central record also remained uncertain.

- Current Outstanding Internal Audit Recommendations - twenty 2021-22 recommendations remained unactioned at the date of the meeting and progress continued to be made in addressing outstanding recommendations. The equivalent HIF report showed no outstanding recommendations.

- Counter Fraud Report – the Committee received and considered the regular counter fraud progress report. As previously noted cyber threats, phishing and payroll diversion attempts posed significant threats to the NHS as a whole and not just to HDFT. A post Covid evaluation report providing a clean bill of health for HDFT was received. Minor amendments to the Trust's counter fraud policy were agreed giving rise to a question as to where authority to approve

polices of this type should sit in the context of the Trust's 2022 "policy on polices" agreed by the Board earlier in the year.

- External Audit – it was reported that planning for the 2022-23 audit had begun, but no work had been done on the programme itself as yet. The deadline set by NHSE for submission of the 2022-23 final accounts was 31 August 2023. Azets colleagues anticipated that their work would be complete well in advance of this date. An additional Committee meeting would be required as the May Committee meeting would be too early and the September meeting too late to sign off on the annual report and accounts. Compliance with two new audit standards was required in 2022-23, one related to fraud risk were there were no concerns at HDFT at this stage. The second related to general risk issues derived from the need to avoid the failure of external auditors to identify significant and material misstatements seen in other (mainly private sector) organisations in recent years. This standard had the potential to increase the amount of time required to deliver the Trust's audit.

- Post Project Evaluations – there were no reports to receive. It was noted that meetings of the Post Project Evaluation Group had only recently resumed following the transfer of the Chair to a new role in HIF. A flow of evaluations through to future meetings of the committee was now expected.

- Single tender actions – no single tender procurements were reported since the last meeting of the Committee.

The next scheduled meeting of the Committee is on 1st March 2023.

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

None.

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

For noting – the question of approval of governance related polices in the context of the Trust's 2022 "policy on policies".