Harrogate and District NHS Foundation Trust

Board of Directors Meeting (to be held in Public)
will be held on Wednesday, 27 January 2021 from 9.00am
in the Boardroom, Trust Headquarters, Harrogate District Hospital, Harrogate
via virtual arrangement

AGENDA

Item No.	Item	Lead	Action	Paper	Time
1.0	**Welcome and Apologies for Absence**	Chairman	Note	Verbal	9.00
2.0	**Patient Story**	To Be Added	Note	Verbal	
3.0	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**	
4.0	**Minutes of the Previous Board of Directors meeting held on 27 November 2020**	Chairman	**Approve**	**Attached**	
5.0	**Matters Arising and Action Log**	Chairman	Discuss	Verbal **Attached**	
6.0	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.45
7.0	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.55
7.1	**Corporate Risk Register/Board Assurance Framework**	Executive Directors	Note/ Discuss/	**Attached**	
7.2	**Integrated Board Report**	Chief Executive	Discuss/ Note/ **Approve**	**Attached**	
7.3	**Senior Management Team Chair's Report**	Chief Executive	Note	**Attached**	
7.4 **7.4.1**	**North Yorkshire 0-19 Healthy Child Programme** **Section 75 Agreement**	Deputy Chief Executive/ Director of Finance	Note/ **Approve**	**Attached**	
8.0	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	10.15
8.1 **8.1.1** **8.1.2**	**Medical Director Report** **Learning from Deaths Q2 Report** **Guardian of Safe Working Q2 Report**	Executive Medical Director	Discuss/ Note	**Attached**	10.20
8.2 **8.2.1** **8.2.2**	**Chief Nurse Report** **Infection Prevention Control Board Assurance Report** **Healthworker Flu Vaccination Self-assessment Checklist**	Chief Nurse	Note/ Discuss/ Approve	**Attached**	10.40

8.2.3	**Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety**				
9.0	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Discuss/ Note	**Attached**	11.05
9.1	**Director of Workforce and Organisational Development Report**	Director of Workforce and Organisational Development	Note	**Attached**	11.10
10.0	**Audit Committee Chair's Report**	Audit Committee Chair	Note/ Discuss	**Attached**	11.25
10.0.1	**Resource Committee Chair's Report**	Resource Committee Chair	Note/ Discuss	**To Follow**	11.30
10.1	**Operational Report including RTT Recovery Plan**	Chief Operating Officer	Note/ Discuss	**Attached**	11.35
10.2 **10.2.1**	**Finance Report** **Approach to 2021/22 Annual Planning**	Deputy Chief Executive/ Director of Finance	Note/ Discuss	**Attached**	11.50
11.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ **Approve**	Verbal	12.00
12.0	**Board Evaluation**	Chairman	Discuss	Verbal	
13.0	**Date and Time of next meeting** Wednesday, 31 March 2021 at 9.00am				
Confidential Motion – the Chairman 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.*					

In light of the Government's guidelines in relation to COVID-19, Harrogate and District NHS Foundation Trust has taken a decision to not hold meetings of the Board of Directors in Public whilst the guidance on social distancing is in place. A small representative from the Trust's Council of Governors will have the opportunity to observe this meeting if they wish to do so.

The minutes and papers will continue to be published on the Trust website. This decision will be reviewed as the guidance evolves with further communication published on the Trust's website in due course.

Details of the Government response can be found at: https://www.gov.uk/government/topical-evetns/cooronavirus-cofid-19-uk-government-response

Harrogate and District NHS Foundation Trust

Board of Directors Register of Interest

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	Date	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Volunteer with Supporting Older People (charity). 4. Chair of NHSE Northern Region Talent Board 5. Member of Humber Coast and Vale ICS Partnership
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing parterner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director	October 2018	Date	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) 2. Company director for the flat management company of current residence 3. Chief Executive of the Ewing Foundation
Jonathan Coulter	Deputy Chief Executive/ Finance Director	November 2017	Date	(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)
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd 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
Jill Foster	Chief Nurse	July 2020	Date	Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Tim Gold	Interim Chief Operating Officer	August 2020	Date	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)			No interests declared
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)			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.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society
Steve Russell	Chief Executive	March 2020	Date	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber 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
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. Chief Executive of Harrogate Borough Council

				4. Chair of Harrogate Public Services Leadership Board 5. Member of North Yorkshire Safeguarding Children Partnership Executive 6. Member of Society of Local Authority Chief Executives
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care)	April 2017	Date	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018	Date	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

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

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Dr Clare Hall	Deputy Medical Director	1. HDFT representative on WYAAT Pathology group 2. HDFT representative on WYAAT Non-Surgical Oncology group 3. Member, HDFT Transfusion Committee 4. Principal Investigator for haematology trials at HDFT
Jordan McKie	Deputy Director of Finance	No interests declared
Paul Nicholls	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Dr Sylvia Wood	Deputy Director of Governance	Familial relationship with Consultant Radiologist
Lynn Hughes	Interim Company Secretary	Familial relationship with KLS Martin Ltd, a company providing services to the NHS

Board of Directors Meeting (held in Public)

25 November 2020 at 9am

in the Boardroom, Trust Headquarters, Harrogate District Hospital

In order to comply with the restrictions on social distancing due to the Coronavirus COVID pandemic, the meeting was held by video conference.

Present
Mrs Angela Schofield, Chairman
Dr Jacqueline Andrews, Executive Medical Director
Ms Sarah Armstrong, Non-executive Director
Mr Jeremy Cross, Non-executive Director
Ms Laura Robson, Non-executive Director/Senior Independent Director
Mr Richard Stiff, Non-executive Director
Mrs Maureen Taylor, Non-executive Director
Mr Wallace Sampson OBE, Non-executive Director
Mr Steve Russell, Chief Executive
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Mrs Jill Foster, Chief Nurse
Mr Tim Gold, Interim Chief Operating Officer
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Ms Lynn Hughes, Interim Company Secretary
Dr Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Directorate
Dr Matt Shepherd, Clinical Director for Long Term Conditions and Unscheduled Care Directorate

Observing
Mrs Laura Angus, Head of Prescribing, NHS Vale of York CCG/Interim Chief Pharmacist at Humber, Coast and Vale ICS
Ms Clare Cressey, Stakeholder Governor for HIF and Lead Governor
Mr Doug Masterton, Elected Public Governor (Wetherby and Harewood and surrounding areas
Ms Lesley Danby, Ward Matron
Mr Steve Treece, Elected Public Governor (Wetherby and Harewood)
Ms Julie Walker, Deputy Clinical Director for Children's and County Wide Community Services Directorate

BoD/11/20/01 **Welcome and Apologies for Absence**

1.1 The Chairman welcomed everyone to the meeting. She welcomed Laura Angus who was part of the NHS England and Improvement (NHSE/I) NExT Directors Scheme. Julie Walker had recently been appointed as Deputy Clinical Director for Children's and County Wide

Community Services Directorate; and Clare Cressey, Doug Masterton and Steve Treece were observing the meeting.

1.2 It was noted that the meeting was being held by video conferencing facility to comply with the restrictions on social distancing due to the Coronavirus COVID pandemic. The papers are shared with Governors and made available to members of the public via the Trust's website and Governors are able to observe the meeting by video conferencing or the teleconference facility.

1.3 There were no apologies for absence.

BoD/11/20/02 Declarations of Interest and Register of Interests

2.1 Jeremy Cross reported changes to his declarations, which were noted to be recorded in the Register. He had been made Chairman of Forget Me Not Children's Hospice and he had an additional interest as a Member of Kirby Overblow Parish Council.

2.2 It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong and Jill Foster are Directors of Harrogate Integrated Facilities (HIF). Mr Sampson is Chief Executive of Harrogate Borough Council.

2.3 There were no interests declared in relation to open agenda items.

BoD/11/20/3 Minutes of the Meeting held on 30 September 2020

3.1 **Resolved:** the minutes of the last meeting held on 30 September 2020 were accepted as an accurate record.

BoD/11/20/4 Matters Arising and Action Log

4.1 **Matters Arising**

There were no matters arising in addition to those included on the agenda.

4.2 **The Action Log**

The completed actions were agreed to be closed. The open outstanding actions were discussed in turn.

148 Learning Disabilities Policies and Processes. It was agreed to remain open until delivered.

BoD/07/20/17.7 Medical Director's Report. It was noted that the QI methodology and process used at the Trust would be covered at a Board Workshop in 2021. It was agreed this action would remain open until delivered.

BoD/07/20/12 Audit Committee Chair's Report. It was noted that plans are in place to discuss the process to appoint the Trust's External Auditors at the Council of Governors meeting on 14 December 2020. It was agreed to remain open until delivered.

BoD/07/20/14 Recovery Plan Update. Tim Gold provided a verbal update on the review of the quality and patient safety measures at the Duchy. It was noted that all patients are screened before entering the Duchy building. The Trust has weekly meetings at the Duchy and has

a risk sharing arrangement in place, which ensures any risks raised in relation to quality and patient safety at the Duchy are included on the Trust's risk registers.

BoD/11/20/5 **Patient Story**

5.1 The Chairman welcomed Lesley Danby. Lesley delivered a story of a patient who had suffered bowel cancer at the beginning of the COVID pandemic, which resulted in a bowel removal. She also described the experience of the patient's spouse who felt the patient was discharged from hospital too soon. The patient became unwell shortly after discharge and was re-admitted to hospital and tested positive for COVID, sadly passing away in hospital. The patient's spouse expressed concern with the leadership on Nidderdale and Swaledale wards. Lesley explained the lessons learned from the experiences during the first wave of COVID. Changes had been made for some nursing staff to be relocated to care for patients on the end of life pathway, which resulted in them working in a different ward environment. The leadership on the ward had also changed to manage the pathway of patients during the COVID pandemic.

5.2 Laura Robson thanked Lesley for sharing the patient's story and queried the leadership in place on the Swaledale ward. Lesley explained that Harlow and Swaledale wards were merged to support the admission of COVID patient admissions. The decision was made to provide additional nursing support on the ward from other areas in the Trust, which was understood to be the most appropriate support needed at that time. Lessons learned identified that this is a specialist area, requiring a different area of expertise to care for patients on an end of life ward. The increase to the general staffing establishment in such circumstances had not been the solution that was required. It was acknowledged that the COVID pandemic had resulted in a huge learning curve across the NHS.

5.3 The Board thanked Lesley for sharing the patient story and for her leadership shown during this unprecedented time, they also commended all colleagues for the care provided during the COVID pandemic to date.

5.4 **Resolved:** the Patient Story was noted.

BoD/11/20/6 **Overview by the Chairman**

6.1 The Chairman reported that the Council of Governors at their meeting on 29 September 2020 had endorsed the decision of the Remuneration, Nomination and Conduct Committee, approving a second term of three years for Laura Robson; approving a second term of office for the Chairman; and approving an additional one year term for Maureen Taylor.

6.2 As a result of the COVID pandemic the Governor Elections have been postponed until Spring 2021. This affected one Governor, Cath Clelland with a term of office due to end on 31 December 2020. The Council of Governors and the Board supported Cath attending Governor meetings as an observer until the Elections take place in 2021.

6.3 The Chairman reported that Clare Hall had covered the positon of Deputy Medical Director for eight years and had decided to stand down from this position.

6.4 The Chairman thanked Andy Papworth for arranging a workshop to share the experiences at Lloyds Bank. It was noted that Angela Wilkinson planned to update on the success of the workshop within her report later in the meeting.

6.5 Harrogate Hospital and Community Charity had received a £25,000 grant to support Volunteers to work with patients and families during the end of life. It was noted that this will make a huge difference in the future.

6.6 The Chairman explained that the Board Assurance Framework had been paused during COVID with the Board's main focus on operational risks, which are discussed in detail at each Board meeting as part of the Corporate Risk Register. The BAF was redeveloped with the first draft presented to the Board in September. The Chief Executive planned to update the Board later in the meeting on changes that had been made to the draft BAF with the aim of this being approved by the Board.

6.7 **Resolved:** the Chairman's Overview was noted.

BoD/11/20/7 **Chief Executive's Report**

7.1 The Chief Executive's report was noted. He drew reference to the proposed changes to the way additional activity is remunerated with the aim of promoting a fairer approach for all medics, to reduce non-contractual (waiting list initiative) activity, which had been high at the Trust in previous years. The Board would continue to be updated on progress with regards to this area of work.

7.2 It was noted that waiting times for routine care continue to be affected by the COVID pandemic. Despite the lower activity in the emergency pathway, operational performance against the four-hour standard has been lower than expected. He was disappointed to report on an avoidable 12-hour breach, which occurred earlier in November 2020. A root cause analysis was taking place to understand the lessons learned.

7.3 The Chief Executive explained that the Trust had received fewer admissions to hospital in comparison to other Trusts in the West Yorkshire Association of Acute Trusts (WYAAT). As a result, the Trust had offered and provided mutual aid to partner Trusts. This arrangement will continue, whilst ensuring sufficient capacity is in place at the Trust to deal with any increase in activity.

7.4 The Humber Coast and Vale (HCV) Partnership has focused on collaborative planning for the second wave of COVID and the preparation for a possible vaccine. It was noted that the HCV partnership had received £0.5m of funding to support health and wellbeing. A Partnership People Board has been developed to oversee the deployment of the funding.

7.5 Virtual your voice, your vision, your values' workshops held during November were a huge success with over 1,000 colleagues attending. This work is the first stage of the overarching '*At our best'* work programme. A final workshop will take place on 18 December for colleagues that have been unable to attend workshops during November.

7.6 The Chief Executive provided an update on the COVID vaccination plans. NHS organisations had been asked to prepare a vaccination plan to vaccinate patient facing staff and vulnerable patient groups in advance of the vaccination being approved for use in the UK.

7.7 He highlighted that NHSE/I are seeking views on the possible changes to Integrated Care Systems.

7.8 The Chief Executive reported on the Board Development, which had taken place in October.

7.9 It was noted that work continues to reflect and refine risk management arrangements to enable Executive colleagues to have greater oversight and involvement in the management of risk. The Chief Executive drew reference to the draft BAF. Since the last Board meeting the draft BAF has been reviewed by the Corporate Risk Review Group (CRRG) on 13 November 2020 and reviewed and updated by Executive Director leads. He drew referenced to BAF#4.2 and the additional controls that had been put in place to oversee capital spend with the establishment of a Capital Oversight Group. The Board were asked to consider and approve the BAF and note that it is planned to be further developed by regularly reviews by Executive Director Leads, reported and overseen by relevant Board Committees, and by the Board. Any changes to the BAF would be highlighted and brought to the attention of Board Committees/Board meetings in future, which the Board supported.

7.9.1 The Chief Executive drew attention to the Corporate Risk Register (CRR) summary, which had been discussed in detail at the Corporate Risk Review Group on 13 November 2020.

7.9.2 He drew reference to the five risks that had been added to the CRR since it was last reviewed by the Board: CR59 Cancer IT Services; CR2 Rota Gaps in Medical Staffing; CR5 Nursing Shortage; CR61 ED 4 hour standard; CR62 Special School Nursing.

7.9.2.1 He explained that CR2 Rota Gaps in Medical Staffing and CR5 Nursing Shortage had been discussed at the CRRG in July as new risks but due to the gaps on controls and mitigations, further work had been requested before they were added as new risks on the CRR. Work continues to develop the controls and mitigations for CR2 and CR5. It was noted that Angela Wilkinson would provide an additional update on nurse recruitment during her report later in the meeting.

7.9.2.2 CR61 ED 4 hour standard, actions in place to mitigate the risk were noted with the target risk score set at April 2021.

7.9.2.3 CR62 Special School Nursing risk had been discussed in detail at the CRRG and it was noted that an additional school had recently opened,

which had put additional pressure on the service. An increase to the staff establishment has been approved with vacancies currently advertised. Jonathan Coulter and Jill Foster had been in discussion with the CCG who commission this service.

7.9.3 In response to Wallace Sampson's query, it was agreed that an additional risk would be added to the BAF to reflect the changes to the local government and the risks around the Trust being part of two ICS's. **ACTION** (**S Russell, L Hughes)**

7.9.4 Richard Stiff explained that there were plans to build an additional school in Selby and if this would increase CR62 Special School risk. In response, Natalie Lyth explained that the Trust did not provide Special School nursing to Selby, that service is provided by York Teaching Hospital NHS Foundation Trust.

7.9.5 Jeremy Cross highlighted the increased risk with regards to RTT and queried the current risk score of 12. In response, the Chief Executive explained that discussion had taken place at the CRRG around RTT and due to the increased governance processes in place it was agreed to remain as 12 with a further review taking place at the next CRR on 11 December. **ACTION (T Gold)**

7.9.6 Laura Robson drew reference to the CR58 Respiratory Service risk, which had been downgraded and removed from the CRR. She queried the plans in place for non-invasive ventilation (NIV). In response, the Chief Executive explained that there were plans in place to train additional clinical colleagues on NIV as part of the surge arrangements, and that a medium term plan needed to be developed for post-COVID.

7.10 In response to Laura Robson's query it was noted that the Cancer tracking risk required updating and further discussion would take place at the next Corporate Review meeting. **ACTION (T Gold)**

7.11 Maureen Taylor queried if the Flutrack system is used nationally across the NHS and if it could be used to support the roll-out of the COVID vaccination. In response, the Chief Executive explained that this was currently being explored with the supplier.

7.12 In response to the Chairman's request, it was agreed that the North Yorkshire 0-19 Service Consultation document would be shared with members of the Board. **ACTION (L Hughes)**

7.13 **Resolved:** the Chief Executive report, including the detailed update on the corporate risks rated 12 and above; and the BAF were noted.

BoD/11/20/8 **Senior Management Team Chair's Report**

8.1 **Resolved:** the Senior Management Team Chair's report from meetings held on 21 October and 18 November 2020 were noted.

BoD/11/20/9 **Resource Committee Chair's Report**

9.1 The Resource Committee Chair's Report including updates from the Extra Ordinary meeting held on 19 October and meetings held on 26 October and 23 November 2020 were noted.

9.2 Maureen Taylor, Resource Committee Chair explained that the Extra Ordinary meeting focussed on the financial plan for months 7-12. The Committee supported the Trust's plan of a £5.4m deficit. It was noted that an efficiency programme of £2.1m has been developed for delivery across the Trust.

9.2.1 The Committee approved the establishment of a Capital Oversight Group. A capital plan had been developed for the remainder of the financial year with resources of £13m available to support the schemes developed which totalled £15.8m. As a result of over commitment to the programme, £2.68m had been deferred. It was noted that the capital programme has no contingency and there is a small element of slippage to manage throughout the year.

9.3 The 26 October meeting included a review of the quarter two financial positon. It was noted that after COVID cost adjustments and material underspends, all directorates are underspent or at a break-even position.

9.3.1 The consolidated cash position (*Trust and Harrogate Integrated Facilities*) was reported positive at the end of September with a balance in excess of £25m (*excluding top-ups and payments in advance, the underlying cash position is estimated to stand at £6.2m*.) It was noted that retrospective top-ups were running one month in arrears.

9.3.2 The Committee approved two applications for grant funding for a reduction carbon, energy and backlog maintenance scheme.

9.3.3 A letter of support provided by the Trust to Harrogate Healthcare Facilities Management Ltd (t/a Harrogate Integrated Facilities (HIF)) was approved to enable HIF to provide assurance to its auditors in relation to going concern.

9.3.4 The Committee also agreed that Post Project Evaluation would be carried out on all business cases 12 months following their approval.

9.4 The 23 November meeting received an update on month seven, the first month of the new financial regime. The Trust had achieved its plan for October, reporting a deficit position of £340,000 against a planned deficit of £346,000.

9.4.1 There was concern raised with regards to waiting lists and the Committee noted that work was underway to address this.

9.4.2 A loan agreement in relation to funding made available to HIF for capital schemes; and a business case for the introduction of a new Rostering and Job Planning system were approved.

9.5 The Chairman highlighted the amount of oversight and scrutiny the Resource Committee had in fulfilling its role.

9.6 **Resolved:** the Resource Committee Chair's report was noted.

BoD/11/20/10 **Operational Update**

10.1 Tim Gold presented the Operational Update report and drew reference to the key areas of focus for November and December 2020.

10.2 As a result of the significant planning work that had taken place with the COVID Surge Plan and Planned Care Recovery, overall operational performance had improved from the previous period. The Medinet insourcing contract had helped to increase the endoscopy capacity. There was an increase in COVID cases since October but despite that the Trust remained within the first stages of its COVID Surge Plan. Tim Gold explained that the Trust continued to have the Command and Control process in place and it had accepted patient transfers from other WYAAT Trusts during the week commencing 2 November 2020.

10.3 The challenges with long term waits were noted in the context of the COVID surge. The cancer position continued to improve but increased clinic capacity is required to maintain the two week wait performance in November and December for breast cases.

10.4 Performance against the Accident and Emergency 4-hour standard was below 95% in October 2020, which had marginally improved from the previous month. A 12 Hour Trolley Breach had occurred on 4 November with a root cause analysis (RCA) carried out and a workshop held on the lessons learned. Matthew Shepherd and his team are progressing an action plan, which is planned to be discussed with the Emergency Care Improvement Support Team (ECIST).

10.5 It was noted that there has been significant focus on the Children's and County Wide Services Directorate specifically around staff engagement and new ways of working. The Community Dental recovery programme continues to focus on reducing waiting times for first appointments and community dental treatment.

10.6 In response to Andy Papworth's query with regards to Planned Care, Tim Gold explained that clinics need additional time for some procedures in the current working arrangements to comply with infection prevention and control and including social distancing requirements. The Hospital had reduced its capacity but had additional capacity available at the Duchy. The Trust, however, was unable to replace capacity on a like for like arrangement and there had been a reliance on waiting list initiatives in previous years to support the reduction of waiting lists.

10.6.1 Discussion took place around the management of waiting lists. In response to the Chairman's query with regards to the plans in place to manage waiting times, the Chief Executive and Jackie Andrews explained that a whole system review was taking place, this included a review of consultant sessions and job plans. It was agreed that further discussion would take place at the Board Workshop in December.

ACTION (T Gold/J Andrews)

10.7 Following the Trust inviting ECIST to assist with work to improve flow across the Urgent Emergency Care system it was noted that a group has been formed to oversee this work. The ECIST update report was noted, which the Chairman explained had been discussed in detail at the Resource Committee meeting held earlier that week.

10.8 **Resolved:** the Operational update including the ECIST report was noted.

BoD/11/20/11 Finance Report

11.1 The Finance Report as of 31 October 2020 was received and noted. Mr Coulter reminded the Board that the financial position had been discussed in detail during the Resource Committee Chair's report earlier in the meeting. It was noted that the Trust's deficit position at 31 October is aligned to the plan submitted to NHSE/I.

11.2 Further discussions continue with the ICS and NHSE/I with regards to the historical capital loans.

11.3 **Resolved:** the finance report as at 31 October 2020 was noted.

BoD/11/20/12 Treasury Management Policy

12.1 **Resolved:** the Treasury Management Policy was received and supported by the Audit Committee at its 1 September 2020 meeting, which the Board agreed to endorse.

BoD/11/20/13 Integrated Board Report

13.1 The Integrated Board Report (IBR) as at 31 October 2020 was received and noted.

13.2 Mr Papworth drew reference to Staff Appraisals and queried if these would take longer to complete in some directorates as result of the additional pressures of the second phase of COVID. In response, Angela Wilkinson explained that at the beginning of the financial year NHSE/I wrote to NHS provider organisations informing of changes in response to the COVID pandemic, which included Appraisals being paused and excluded from reporting requirements. The Trust has since recommenced Appraisals from July 2020 and Angela Wilkinson noted that some directorates might find it more difficult to complete due to the additional performance pressures. Following discussion, it was agreed that the IBR would be updated to accurately reflect Appraisal reporting requirements. **ACTION (J Coulter/A Wilkinson)**

13.3 It was noted that a review of the format and content of the IBR was taking place. The Chairman confirmed that Non-executive Directors are happy to contribute to the review. **ACTION (J Coulter)**

13.4 **Resolved:** the Integrated Performance Report as at 31 October 2020 was noted.

BoD/11/20/14 Quality Committee Chair's Report

14.1 Laura Robson, Chair of the Quality Committee presented the Quality Committee Chair's Report from the meetings held on 7 October 2020 and 4 November.

14.2 At the 7 October 2020 meeting Clare Cressey and Dave Stott, Governors had observed the meeting. The meeting commenced with a presentation on care after death, which was presented by Charlotte Rock, Lead McMillan Nurse. Following an RPIW a number of changes have been made to standardise processes, training and communication. The Quality Committee were impressed by the changes made and asked Charlotte to report back in 12 months on feedback from patients and progress made with training. The Committee received the Clinical Advisory Group (CAG) minutes from meetings held in August and September 2020 and it was agreed that the monthly cycle of meetings of CAG would cease and meetings would be called as and when required in future.

14.2.1 Laura Robson escalated to the Board the management of policies and guidelines on the intranet, which had previously received a limited assurance report following an Internal Audit. The Committee raised concern with the progress made to update policies and guidelines. Jackie Andrews explained that a project manager had been assigned to oversee the policy review work. Following consideration it was agreed the Audit Committee would be asked to oversee this.

ACTION (J Andrews/L Hughes)

14.3 At the 4 November 2020 meeting Dave Stott, Governor observed the meeting. The meeting commenced with a presentation on the changes to continuous heart monitoring, which was presented by Jude Burden, Lead Cardiac Physiologist. The system is less invasive and better for patients, faster to implement and more cost effective. The Planned and Surgical Directorate Quarter 2 report was received which included some positive comments from patients. This report also highlighted a number of returning complaints to the Directorate and it was agreed a quarterly update would be provided on progress in future. The Board were pleased to note the scrutiny and oversight of the Quality Committee with regards to quality and patient safety.

14.3.1 Laura Robson explained that Jackie Andrews updated the Committee on the work to date that had taken place on the Clinical Governance review and the Board welcomed the outcome of the review in the near future.

14.4 **Resolved:** the Quality Committee Chair's Reports from the meetings held on 7 October and 4 November 2020 were noted.

BoD/11/20/15 Medical Director's Report

15.1 The Medical Director's Report was received and noted. Jackie Andrews drew attention to the national focus on the development of the COVID vaccine, the testing of asymptomatic NHS staff and ensuring that urgent and elective NHS care is provided as much as possible. She highlighted the launch of a new programme of care for patients who are experiencing "Long COVID" with clinics available nationally. Further work is taking place to monitor patients with COVID outside the hospital setting, using pulse oximetry and other remote monitoring packages.

15.2 She updated on the Medical appraisal plans to ensure fitness to practice requirements are met. She explained that an internal audit on medical

appraisals is due to be carried out in Q3/4 and there are ambitions to develop the link between annual job planning and appraisals.

15.3 With regards to patient safety, the Trust's Deputy Medical Director (Quality and Safety), Deputy Chief Nurse, and Head of Risk Management have accepted the role of Patient Safety Specialists (PSS), which has been reported to NHSE/I. They will provide senior leadership and support the development of a patient safety culture, safety systems and improvement activity in the Trust and will work with colleagues from other organisations to share good practice and learning.

15.4 With regards to Research and Development, the results of a survey carried out by Jackie Andrews found that there are a number of medical colleagues from the Trust with higher research degrees and/or have acted as a Principal Investigator for a research study. A similar survey is currently being carried out for nursing and Allied Health Professionals colleagues.

15.5 The Board were pleased to note that the Trust's bid to host its first Health Education England Clinical Leadership Fellow was successful. The Future Leaders Programme offers opportunities for Health Education England Yorkshire and the Humber medical and dental trainees to undertake a one year "out of programme experience" Leadership Fellowship to help grow and develop their personal leadership skills. The Trust's Fellowship is open to all professions and will commence in August 2021.

15.6 Wallace Sampson drew reference to the Research and Development network that exists locally with expertise from a wide variety of businesses and queried if the Trust would be interested in joining discussions with this network. In response, Jackie Andrews agreed further discussions would be welcomed with Mr Sampson outside the meeting.

ACTION (J Andrews)

15.7 Jackie Andrews explained that following Carl Grey standing down from the role of the Trust's Guardian of Safe Working Lead, Dr Matt Wilson, Specialty doctor in Anaesthesia had been appointed to the role.

15.8 **Resolved:** the Medical Director's Report was noted.

BoD/11/20/16 **Learning from Deaths Quarter 1 Report**

16.1 The Learning from Deaths Quarter 1 Report was received and noted. Jackie Andrews explained that COVID deaths are included for Quarter 1 and it is anticipated that an additional report may be required to include COVID information in the future. In total, 65 patients died in hospital within 30 days of a positive COVID test, with a further five dying following discharge.

16.2 No change to mortality incidences was reported. The role of the Medical Examiner, Dr Dave Earl was discussed and noted and it was agreed that a future Board Workshop would enable greater discussion and understanding on the Learning from Deaths process. The Chairman

explained arrangements would be made for this to be included at a Board Workshop in 2021/22. **ACTION (J Andrews/L Hughes)**

16.3 Laura Robson queried the information included in figure 5, 'number of days from admission to cardiac arrests attended by the team'. In response, Jackie Andrews agreed to arrange for further clarification and historical information to be provided in future reports.
ACTION (J Andrews)

16.4 Laura Robson queried when the RESPECT system would launched. In response, Matt Shepherd explained that the system is anticipated to be in place from January 2021 with information included in Q4 report.

16.5 The Chairman thanked Jackie Andrews and Dave Earl for the informative report.

16.6 **Resolved:** the Learning from Deaths Quarter 1 report and the processes for ensuring learning from deaths was noted.

BoD/11/20/17 **Chief Nurse Report**

17.1 The Chief Nurse Report was received and noted. Jill Foster explained that since the report had been written there had been two outbreaks of COVID on the Trust's Granby and Oakdale wards with a number of staff testing positive. Infection control measures resulted in Oakdale ward currently being closed to admissions.

17.2 Jill Foster reported that the Trust was in receipt of a letter from NHSE/I, which included the top 10 tips to reducing COVID infections. She explained that the Trust had taken forward the majority of measures prior to receiving the letter with evidence included in the Infection Prevention and Control Board Assurance Report presented to the Board at its last meeting in September.

17.3 It was noted that ward staffing establishments are adjusted in accordance with need. Laura Robson queried the number of beds and the changes made to bed numbers in response to COVID. In response, Jill Foster agreed to update the report to include bed numbers and circulate outside of the meeting and ensure bed numbers are included in future reports. **ACTION (J Foster)**

17.4 Laura Robson queried the number of midwives currently excluded as a result of COVID related issues. In response, Jill Foster explained there were currently no midwives absent with COVID related issues, however, there were 11 midwives on maternity leave with recruitment plans in place to cover these.

17.5 Jeremy Cross drew reference to the 15% turnover rate for wards, which was referenced in the report and queried if the Trust carried out exit interviews. In response, Jill Foster explained that exit interviews are carried out routinely. Following discussion, it was agreed that the People and Culture Committee would oversee the exit interview process and receive updates on outcomes, themes in future.
ACTION (A Wilkinson)

17.6 It was noted that the Trust aimed to conclude the Flu Campaign by 4 December 2020. There had been 64.85% front line staff to date vaccinated. The Chairman sought Clinical Directors views on the uptake to date. In response Matt Shepherd, Kat Johnson and Natalie Lyth explained that despite the increased communication the uptake from front line staff was disappointing. Staff were encouraged to have vaccine in advance of the COVID vaccination becoming available.

17.7 Sarah Armstrong queried if there were any known risks as result of some colleagues not having the flu vaccination. In response, Jill explained that other parts of the world had seen low cases of flu but colleagues will continued to be encouraged to have the vaccine during the winter.

17.8 It was noted that 38 expressions of interest for the Lead Freedom to Speak Up Guardian (FTSUG) role had been received from most staff groups inclusive of colleagues who identify themselves from a Black, Asian or Minority Background. Interest had also been received for the Associate FTSUG role. All colleagues, who have expressed an interest for the Lead or Associate FTSUG roles and are not appointed to the positions, will be asked offered the opportunity of becoming a Fairness Champion.

17.9 Jill Foster reported that in addition to her role as Chief Nurse, she is now the Trust's Senior Information Risk Owner (SIRO). As the SIRO she will take overall ownership of the Trust's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control for information risk. She will implement and lead the NHS Information Governance risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management.

17.10 Finally, she provided an update on the Cyber Operational Readiness Support (CORS) Programme report. The quarterly remediation progress report highlighted good progress against recommendations with further work required in procurement and to achieve the Cyber Essentials+ accreditation. In response to Richard Stiff query, Jill Foster confirmed that Cyber Essentials+ accreditation is the national benchmark.

17.11 **Resolved:** the Chief Nurse Report was noted and supported.

BoD/11/20/18 **People and Culture Committee Chair's Report**

18.1 Jeremy Cross, Chair of the People and Culture Committee provided a summary from the meeting held on 16 November 2020. The Chair of the BME Network and the FTSUG attended the meeting with plans in place for a Governor to attend future meetings. He explained work is progressing on the People Plan, including the Disciplinary Process, Welfare Conversations, and Leadership Support Circles. Updates were provided on the First Line Leaders Programme by a participant; and on the "At our best" Cultural improvement plan. Board members who had attended the Workshops reported that they had found them to be excellent.

18.2 The Committee received a recruitment report from the Chief Executive, which showed a significant difference in outcomes between white candidates and BAME candidates during the recruitment process and concern was raised with regards to the implications for the Trust. It was agreed that a Deep Dive would be carried out at the next meeting to gain a greater understanding on this area with the aim of this supporting the Trust's work to become an Anti-Racist organisation. Jeremy Cross queried if the WRES risk required adding to the CRR and/or the BAF. In response the Chief Executive explained this would be discussed at the next Corporate Risk Review Group. **ACTION (A Wilkinson)**

18.3 The Chief Executive explained that Shadow SMT suggested two areas for consideration: i) should EDI be included on everything presented to the Board; and ii) should the Trust consider signing up to the Standard Race at Work Charter. The Board recognised the tasks were considerably large and it is essential that all Board members are involved and sighted on this area of work.

18.4 Discussion took place around the items for the next meeting, which included: Deep Dive on Race Equality/Plan; Non-executive Director Drop in Sessions; Selection of Leaders; Integration of Lloyds work. Jeremy Cross explained that these items would be considered in conjunction with the workplan. **ACTION (A Wilkinson, J Cross)**

18.5 The Chairman highlighted the importance of this area of work and the role of the People and Culture Committee having such focus.

18.6 **Resolved:** the People and Culture Committee Chair's report from the 16 November 2020 meeting was noted.

BoD/11/20/19 **Workforce and Organisational Development Report**

19.1 The Workforce and Organisational Development Report was received and noted. Angela Wilkinson thanked Andy Papworth for hosting the workshop at Lloyds for the Trust. The Workshop was very well attended and proved most valuable, drawing parallels with a number of areas that the Trust is working to improve, specifically the traditional appraisal process, which Lloyds moved away from with the introduction of coaching and check-in points. The Trust plans to develop its appraisal process in the New Year and the lessons learned from the Workshop are valuable to inform this area of work.

19.2 It was noted that the Government announced new guidance on the 4 November 2020 in preparation for the second lockdown and the Workforce team had reviewed the Trust's processes to ensure continued compliance.

19.3 Following the implementation of the updated Disciplinary Policy, the Trust, in partnership with Hempson's is providing a number of Workshops throughout November to support managers. In addition to this members of the Board will receive training at its Workshop in December.

19.4 The Trust (including HIF) employ approximately 126 EU citizens and some of these are required to apply to the EU Settlement Scheme by

30 June 2021 to continue living and working within the UK following Brexit. It was noted that Human Resources are reminding colleagues to apply over the next two months due to applications taking longer during COVID.

19.5 Angela Wilkinson explained that the updated Conflict of Interest Policy had been approved and plans were in place to communicate and engage with colleagues, reminding them of their responsibilities during December and going forward.

19.6 **Resolved:** the Workforce and Organisational Development report was noted.

BoD/11/20/20 Any Other Business

20.1 The Chairman congratulated Wallace Sampson on his recent achievement as joint winner of the Public Sector Director of the Year Award from the Institute of Directors Yorkshire and North East region. The ceremony was delivered as a virtual event on 18 November 2020.

20.2 December Board Workshop agenda
It was noted that the Chairman and Chief Executive would consider topics for inclusion on the agenda: HARA/Place; Mortality/Learning from Deaths Training; RTT 20/21 Plan to achieve trajectory; NHSE/I top 10 tips to reducing COVID infection; and the Board Development Plan.
ACTION (L Hughes)

BoD/11/20/21 Evaluation of Meeting

21.1 It was noted that the meeting had enabled open discussion and debate on the key operational pressures, operational and strategic risks, and governance.

BoD/11/20/22 Date and Time of Next Meeting

22.1 The next meeting is scheduled to take place on Wednesday, 27 January 2021 at 9am via virtual arrangement.

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							
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.
148	25 September 2019	Overview of Trust Learning Disabilities policies and application	Agreed would be discussed at a Board workshop by the end of year. At the 25 November 2020 Board further discussion took place and it was agreed an assurance paper would now be provided replacing the need to discuss at a Board Workshop	Chief Nurse	31 March 2021	Paper planned to be provided to note at the February 2021 Board workshop	Open
BoD/07/20/17.7	29 July 2020	Medical Director Report	Agreed QI methodology would be covered at a future workshop. It was agreed this would be arranged and added to the workshop workplan	Medical Director/Interim Company Secretary	30 June 2021	Added to Board Workshop workplan for June 2021	Open
BoD/07/20/12	30 September 2020	Audit Committee Chair's Report	Appointment Process for External Auditors. Noted process needs to be completed before Summer 2021	Deputy Chief Executive/Finance Director	14 December 2020	Process approved by the Council of Governors meeting at its 14 December 2020	Completed
BoD/11/20/7.9.3	25 November 2020	Chief Executive Report - Board Assurance Framework	Update BAF to include entries for: local government changes; and ICS's statutory function change	Chief Executive/Interim Company Secretary	27 January 2021	Included within the BAF	Completed
BoD/11/20/10.7.9.5	25 November 2020	Chief Executive Report - Corporate Risk Register	Noted that discussion had taken place at the CRRG around RTT and due to the increased governance processes in place it was agreed to remain as 12 with a further review taking place at the next CRR meeting	Interim Chief Operating Officer	11 December 2020	Completed. Discussed at December 2020 and January 2021 CRRG meetings. Risk included within the BAF	Completed
BoD/11/20/7.10	25 November 2020	Chief Executive Report - Corporate Risk Register	Cancer tracking entry is inaccurate, agreed further discussion required at Corporate Risk Review Group on 11 December 2020	Interim Chief Operating Officer	11 December 2020	Completed. Discussed at CRRG in January and risk updated.	Completed
BoD/11/20/7.12	25 November 2020	Chief Executive's Report	Agreed the North Yorkshire Consultation Document would be shared with the Board	Interim Company Secretary	04 December 2020	Completed, circulated link via email	Completed
BoD/11/20/10.7.1	25 November 2020	Operational Update	Agreed further discussion would take place at the Board Workshop in December to gain a greater understanding on waiting lists; and a paper would be provided to the Board at its January 2021 meeting on historical waiting lists and plans in place to manage waiting lists going forward	Medical Director/Interim Chief Operating Officer	27 January 2021	Covered at 16 December Board Workshop; and further update included in Board papers	Completed
BoD/11/20/13.2	25 November 2020	IBR	IBR to be updated to accurately reflect Appraisal reporting requirements	Deputy Chief Executive/ Finance Director/ Director of Workforce and OD	25 January 2021	Completed. IBR updated	Completed

BoD/11/20/13.3	25 November 2020	IBR	Non-executive Directors to be contacted to provide feedback on the format and content of the IBR to include within the current review	Deputy Chief Executive/Finance Director	31 March 2021	Updated IBR to be presented at the 31 March 2020 Board meeting. Work in progress	Open
BoD/11/20/14.2.1	25 November 2020	Quality Committee Chair's Report	Audit Committee will be asked to oversee the Policy Review/Management Process. Audit Committee Chair and administration support to be informed	Medical Director/Interim Company Secretary	03 December 2020	Completed. Notified Chair of Audit Committee and Internal Audit who provide admin support to the Committee	Completed
BoD/11/20/15.6	25 November 2020	Medical Director Report	J Andrews to discuss outside of the meeting opportunities to widen local research and development networks	Medical Director	31 March 2021	Work in progress	Open
BoD/11/20/16.2	25 November 2020	Medical Director Report - Learning from Deaths Quarter 1 Report	Future Board Workshop topic in 2021 to include Learning from Deaths in order to gain greater understanding on the process	Medical Director/ Interim Company Secretary	30 June 2021	Planned to present at June 2021 Board Workshop	Open
BoD/11/20/16.3	25 November 2020	Medical Director Report - Learning from Deaths Quarter 1 Report	Agreed to arrange for further clarification and historical information to be provided in future reports re figure 5, 'number of days from admission to cardiac arrests attended by the team'	Medical Director	27 January 2021	Update to be provided at meeting	Open
BoD/11/20/17.3	25 November 2020	Chief Nurse Report	Safe Staffing Report to include bed numbers going forward. Report provided to November Board to be updated to include bed numbers and shared with Non-executive Directors	Chief Nurse	27 January 2021	Update to be provided at meeting	Open
BoD/11/20/17.5	25 November 2020	Chief Nurse Report	Exit interview process to be overseen by the People and Culture Committee going forward	Director of Workforce and OD	30 June 2021	Work in progress	Open
BoD/11/20/18.2	25 November 2020	Chief Executive Report - Corporate Risk Register	WRES risk, further discussion agreed to take place at the CRRG on 11 December if requires including on CRR and/or BAF	Director of Workforce and OD	27 January 2021	Completed, discussed at CRRG on 11 December 2020. Included within the BAF	Completed
BoD/11/20/18.4	25 November 2020	People and Culture Committee Chair's Report	Next meeting of the People and Culture Committee to include: Deep Dive on Race Equality/Plan; Non-executive Director Drop in Sessions; Selection of Leaders; Integration of Lloyds work.	Director of Workforce and OD	18 January 2021	Agenda setting considered the items to agree agenda for the 18 January 2021 meeting	Completed
BoD/11/20/20.2	25 November 2020	Any Other Business	December Board Workshop items to be considered by the Chairman and Chief Executive: items for consideration include HARA/Place (J Andrews) Mortality/Learning from Deaths Training (J Andrews) RTT 20/21 Plan to achieve trajectory (T Gold); NHSE/I top 10 tips to reducing COVID infection (J Foster); Board Development Plan	Interim Company Secretary	02 December 2020	Completed. Chairman and Chief Executive considered items on 2 December when updated agenda was agreed for the 16 December 2020 workshop	Completed

Harrogate and District NHS Foundation Trust

Board of Directors
27 January 2021
Report of the Chief Executive

Agenda Item Number:	**7.0**
Presented for:	Note/Discuss
Report of:	Chief Executive
Author (s):	Chief Executive
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to note this report.

Board of Directors

27 January 2021

Report of the Chief Executive

1.0 Executive Summary

1.1 Since the last Board meeting in November there have been a number of significant changes that have arisen as a consequence of the impact of COVID-19, which has switched the immediate focus on further recovery of elective activity to ensuring there is sufficient capacity for cancer and urgent patients (known as P2) whilst additional critical care demand is managed.

1.2 Services that are not reduced in order to support COVID surge remain in operation although there has been a rise in patient cancellations following the national lockdown.

1.3 Staff absence for COVID related reasons have also risen, which has placed further pressure on teams. The majority of COVID absence is in colleagues who do not have a positive test result themselves.

1.4 The Trust took delivery of the first batch of the Pfizer-BionTech COVID19 vaccine on 4 January 2021 and started our vaccination programme. To date, overall staff uptake 69% and 72% of those in the at risk groups have been vaccinated. The hospital hub is now offering capacity to wider health and social care colleagues.

1.5 Wellbeing support continues to be a major priority for colleagues given the pressures that they are facing.

1.6 The timescale for the planning round for 2021/22 has been extended, and the current financial framework has been rolled over for the first quarter of 2021/22.

1.7 Harrogate Hospital and Community Charity provided 1,800 mince pies in cheer boxes to adults who are looked after by our community services and who were spending Christmas alone, and in partnership with Queen Ethelburga's over 1,000 gifts for children and young people.

1.7.1 And, the resource we usually spend on Christmas meals for colleagues was instead used to provide Christmas hampers for families across North Yorkshire and the North East who are supported by our 0-19 services. With further support from local businesses over 48,000 items were packed into over 1,000 hampers by our Charity team, and players from Harrogate Railway AFC – who also kindly allowed us to use their facility to assemble all of the hampers. Our colleagues in HIF and the Charity travelled over 1,000 miles in total delivering them to our community sites, from where they were taken to children and families by our 0-19 colleagues.

1.8 Finally, we are coming to the deadline for the HDFT and HIF colleague awards and have over 200 nominations!

2.0 COVID 19

2.1 As critical care pressure rose in WYAAT Trusts, whilst HDFT remained relatively less impacted we made the decision to pause some elective activity in order to increase our critical care capacity to provide mutual.

2.2 COVID case in the Harrogate area rose sharply from the end of December in a short space of time meaning we had to implement the next stage of our surge plan. The support of community services, and the ARCHS service has been critical in enabling us to continue to maintain flow. A number of colleagues have been redeployed into the ARCHS service and we are very grateful to them for their support.

2.3 In comparison to other Trusts locally, critical care has come under, and continues to be under relative pressure to what would usually be experienced over Winter due to additional demands arising from COVID. The Trust has implemented further cancellation of elective work in order to release colleagues to support additional critical care capacity, and the Trust is now working to the COVID19 nursing ratios.

2.4 Community case rates (per 100k) rose from 130 on 26th December 2020, to 460 on 4th January, peaking at 497 on 7th January and since then declining to the latest position of 320 per 100k as at 15th January.

2.5 Engagement with lateral flow testing continues to be good, and overall the number of positive cases detected has been low at around 0.04%.

3.0 Leadership and Culture

3.1 The analysis following on from the Your Voice, Your Vision, Your Values workshops is being undertaken by April Strategy and the feedback is due to be shared in early February and the next sessions to build this into our colleague 'lifecycle' and to train leaders are being scheduled.

3.2 The review of recruitment processes has made great progress with an initial RPIW (Rapid Process Improvement Workshop) and a further workshop is scheduled to develop the initial ideas.

3.3 The People and Culture Committee is strengthening the focus on Equality and Diversity with three key areas agreed as priorities (i) recruitment and career progression (ii) behaviour towards BAME staff from patients and visitors, and (iii) leadership and governance. This is part of the holistic approach we are trying to take to becoming an anti-racist organisation.

4.0 Partnerships

4.1 The North Yorkshire 0-19 Service consultation ended on Monday, 4 January 2021. The responses received during this public consultation are planned to be considered by North Yorkshire County Council's Executive, as well as its Scrutiny of Health Committee, and by Harrogate and District NHS Foundation Trust Board, before the final decision is made. Subject to the outcome of the consultation, it is anticipated the new service will be in place on 1 April 2021. A Further update on this is provided later on the agenda.

5.0 Corporate Risk Register and Development of Board Assurance Framework

5.1 **Corporate Risk Register -** The full Corporate Risk Register (CRR) has been reviewed by the Corporate Risk Review Group and Senior Management Team since the last Board meeting held in November 2020 and a summary is attached at Appendix A. The CRR records the most serious operational risks, these risks are scored by consequence x likelihood of 12 to 25.

5.2 **Board Assurance Framework -**The Board Assurance Framework (BAF) aims to record risks that threatens the achievement of the Trust's long term (strategic

objectives) together with the controls and actions in place to mitigate these risks. The BAF is supported by the CRR.

5.2.1 The BAF was paused during the first phase of the COVID-19 pandemic with focus on operational risk management. Following the Board Workshop in July 2020 work commenced to revise the BAF, which has been presented to the Board since its 30 September 2020 meeting, noting that this is work in progress.

5.2.2 Since the last Board meeting the draft BAF has been reviewed by the Corporate Risk Review Group and reviewed and updated by Executive Director leads. Any changes to the BAF are highlighted to coloured font.

5.2.3 The Board is asked to consider and approve the BAF (Appendix B); note that this is planned to be further reviewed and developed at the Board Workshop on 24 February 2021; and to consider which risks will be allocated to which Board Committee for oversight.

6.0 Recommendation

6.1 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.

7.0 Supporting Information

7.1 The following papers make up this report:
Appendix A –Corporate Risk Register
Appendix B - Board Assurance Framework

Summary of Corporate Risk Register (Risks Rated 12-25 as at January 2021)

Ref	Description	Date added to CRR	Risk score January 2021	Risk score December 2020	Target risk score (date aimed to be achieved)	Risk movement	Current status	Gaps in controls	Lead Executive Director
CR34	**Autism Assessment Service.** Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.	Dec-18	12	12	9 (March 2021)	↔	Risk position remains unchanged from previous period - waiting list reducing, however if referrals continue to increase backlog clearance will remain challenging.	• Lack of commissioned capacity and resources to deliver additional capacity	Chief Operating Officer
CR41	**Summary RTT** Risk to patient safety, performance, financial performance and reputation due to increasing waiting times across a number of specialties, including as a result of the impact Link to BAF January 2021	Aug-19	15	12	6 (March 2021)	↑	* Risk likelihood increased to five to reflect the increase in waiting list size, long waiters and 52 WB that will continue into next year * Only P4 and P3 surgery cancelled to date - this position may change if further levels of covid surge are required * Significant work undertaken with Trust Board in December to communicate the RTT position and risks and current plans for mitigation * Combination of rapid remediation to improve booking and scheduling position and longer term solutions for social distancing, AGPs and outpatient transformation will be required to stop waiting list growth and reduce backlog in 21/22 * Planned Care Recovery Programme being re-scoped and launched in January 21 to increase delivery effectiveness and performance	1. Requirement for social distancing in recovery and ward areas is limiting pace of recovery 2. Ongoing gap to plan for endoscopy and outpatients	Chief Operating Officer
CR49	**ED Imaging** Risk to patients and service when ED X-ray room fails due to age, breakdown or failure to get parts. Equipment now 12 years old and the supplier cannot guarantee parts. Risk to staff due to handling difficulties with aged equipment	Feb-20	12	12	4 (April 2021)	↔	* Risk position unchanged and scheme in development.	• Completion of works approved in ED	Chief Operating Officer

CR52	**Patients, delayed cancer diagnostics, treatment and care** Risk to patient safety, quality of care and psychological impact of delays in diagnostics, treatment plans and surveillance on patients and families Link to BCS14 BCSP - Risk of not achieving national standards due to presure on service at Leeds re CTC scans added January 2021	Apr-20	16	16	8 (April 2021)	↔	* CT activity is at appropriate levels. MRI capacity has improved in October. * Additional endoscopy capacity has been being introduced from December through Medinet * Opening 5th room remains priority and delays concerning - to be tracked through Planned Care Recovery * The number of cases waiting over 62 days for treatment is now reducing * Mammography machine breakdown pre-xmas has added to already challenged breast 2WW position. Task & Finish Group meeting regularly (see below) to resolve and Plan in place to install new Mammo by end of February and the Trust will have a mobile Mammo van in situ in January. * All patients continue to be clinically triaged.	1. triaging and prioritising based on clinical condition 2. addressing long waits continues to be a priority area	Chief Operating Officer
CR54	**Staff well-being and morale** Risk to staff wellbeing and morale in the context of the Covid pandemic.	Apr-20	12	12	9 (April 2021)	↔	Clinical Psychology support for staff from early February from psychologist within the Chronic Pain team Work is continuing to appoint a designated staff psychologist. Additional resources in place including Start Well – End Well, and rapid de-escalation tool for stressful situations.	• Uncertainty associated with the potential impact of a second peak. • National guidance on isolation may result in an increase in the number of staff isolating. • More intensive mental health support (i.e. management time to support colleagues and ways of working and financial support for external psychologists)	Director of Workforce and OD
CR57	**Risk to patient safety, quality of care and staff welfare** Risk due to increased levels of domestic abuse and children's safeguarding - increased presentation at ED with unintentional injuries, increased opportunities for online abuse, decreased opportunity for monitoring and observation of children and young people by professionals, increased demand on social care and other community services for safeguarding work, shielding and vulnerabilities	Apr-20	12	12	8 (January 2021)	↔	Action plans remain in both Sunderland and Middlesbrough - monitored through Bronze Other areas do not need additional safeguarding action plans as yet but will need to review impact of most recent lockdown over the forthcoming months. Middlesbrough has as part of its action plan built in a further 0.4 band 7 specialist nurse, interim. Additional investment in Middlesbrough through applications of the PH COVID grants, approved for 3 years but recruitment has yet to take place so risk remains the same.	• Availability of specialist expertise	Chief Nurse

CR59	**Cancer IT Services** Risk to patient safety due to lack of automated system for tracking Risk to patient safety from missing relevant / important information due to difficulties with multiple electronic record systems. The inability to scan patients records on to WebV	Jul-20	12	12	6 (April 2021)	↔	Agreed to progress the procurement of an 'off the shelf' cancer system and meetings currently taking place to evaluated options, costs and timescales. 6.1.21: Scoping sessions for systems set up for 13th and 18th January 2021. 6.1.21: Business Case to be completed by Feb 21.	Lack of automated system for MDT tracking highlighted in several incidents	Chief Operating Officer
CR2	**Rota gaps in Medical Staffing** Risk to the quality of service delivery in Medicine due to unfilled and vacant rota gaps across grades; reduction in trainee numbers; agency cap rate; variable allocation from deanery; medium term sickness; availability and quality of locums; no-deal EU Exit (added 08/03/2019; impact of Covid-19 (added 13/03/2020).	Jul-20	12	12	9 (April 2021)	↔	Interviews set up for cardiology consultant - not appointed Revised rotas for middle grades & tier 2s in medicine - completed Additional ED junior doctor on nights - completed ED Current advert for 1.7 wte consultants - appointed Recruited 3rd Respiratory Consultant - starts April Recruited Acute Med Consultant - starts April	1. Lack of availability of alternative workforce. 2. Development of alternative acute care model. 3. Ability to fill in line with current Agency Cap rate. 4. Respiratory consultant vacancies & LTS cover 5. Recruitment of substantive Acute Oncology, Respiratory, Acute Medicine, Cardiology Consultants 6. Consultant capacity for acute services	Medical Director
CR5	**Nursing shortage** Risk to the quality of service delivery and patient care due to failure to fill registered nurse and health visitor vacancies due to the national labour market shortage and local shortages in some areas e.g. Stockton, and impact of Covid-19 (added 13/03/2020)	Jul-20	12	12	9 (February 2021)	↔	Senior Nursing Team considering current nursing vacancies and known workforce pipeline to determine if this risk can be decreased.	1. Current vacant Registered Nurse posts across the in-patient ward areas. 2. Inability to fill Registered Nurse and Health Visitor posts in a timely way due to national (and local in some areas e.g. Stockton) labour market conditions. 3. Trust inpatient ward turnover of registered nurses 15% 4. Lack of available alternative workforce 5. Increased gaps at CSW level 6. 10% staffing (RN &CSW) uplift required for seasonal escalation beds 7. Increase in sickness due to Covid	Chief Nurse

CR61	**ED 4 hour standard** Risk of failure to meet 4 hour ED standard with resultant risk to patient experience and increased concerns and complaints associated with long waits	Aug-20	12	12	8 (April 2021)	↔	* Performance stabilised after challenging first half of December, although likely to remain challenging in January and February due to bed occupancy levels and Covid wave 3 * Attendance dropping significantly as a result of lockdown * Additional controls introduced to manage long waiters following 12HB review * Improved governance processes & Emergency Care Recovery Plan in place: 1. Urgent Care Improvement Board established 2. Updated action plan reflecting pressures within ED and covering gaps in control 3. ECIST review completed 4. New weekly breach meeting established to review breaches/ lengths of wait/any extended waits (beyond 6 hours). Meeting will look to triangulate risk of long waits with any harm.	1. Uncertainty on activity levels post CV19 and associated staffing requirements 1. ED staffing levels return to pre CV19 levels April 21 1. Challenges planning staffing based on unknowns in relation to continued impact of CV19 on workload post April 21. 2. Limited access to mental health & inpatient mental health beds 3. Limited support from specialities 4. Lack of timely acceptance by specialities 5. Limited omission avoidance options available overnight 10. COVID impact: access to testing impacting on flow: social distancing & use of PPE; cubicle cleaning between positive patients; side room capacity whilst awaiting results	Chief Operating Officer
CR62	**Special School Nursing** Risk to quality of care and patient safety for Special School nursing patients due to increased demand on provision.	Nov-20	16	20	6 (January 2021)	↓	Staff have been recruited. Recent conversations (7.1.20) with commissioners is that they will not fund the additional BC staffing until a complexity tool is introduced to measure the "need", this will then be linked to a demand and capacity tool (which has not be agreed) to identify WTE and skills mix. Expectation is service will lead this so a project plan will be written - but this will be discussed with HDFT Executive on approach to take. A draft Service Specification has been written but much more work needed on this.	Limited communication from Local Authority around Special School planning.	Chief Nurse
CR63	**Security, Violence & Aggression** Risk to patient / staff safety, patient experience, reputation and trust property due to violence and aggression from patient, relatives and others in the Emergency Department	Jan-21	12		4 (April 2021)	New risk added January 2021	Working with Local Security Support Manager Incidents captured on ED report Attendance at Secrity Group Forum	1. Available Breakaway training 2. Security staff 3. Facilities not conducive to managing a violent episode (lock down) 5. Extended stays in unit 6. Training for caring for patients who are violent / aggressive	tbc

Board Assurance Framework

1. STRATEGIC OBJECTIVE: PEOPLE (description to be determined)

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed
			Likelihood	Conseq	Rating					Internal	External					
BAF#1	To be an outstanding place to work	There is a risk that individual staff engagement and high performing team cultures are compromised **because** there is an insufficient focus on the culture of the Trust and the health and wellbeing of staff which will **impact** on the Trust's ambition to be an outstanding place to work and in turn will impact on the quality of patient experience.	3	4	12	2x2=4	Apr-22	No change	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme	Board of Directors SMT People and Culture Committee	ICS metrics (TBC) Staff Survey	Currently no oversight arrangements in place by regulators	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	People and Culture Committee	A Wilkinson, Director of Workforce and OD	22.09.20 21.01.21
BAF#2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that individual staff engagement and high performing team cultures are compromised **because** there is lack of diversity of thinking due to recruitment and promotion practices that make if more difficult for colleagues with protected characteristics to flourish in the organisation.	3	4	12	2x2=4	Apr-22	New risk	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme	Board of Directors SMT People and Culture Committee	ICS metrics (TBC) Staff Survey	Currently no oversight arrangements in place by regulators	new risk added following request made by Board at the November 2020 meeting. Discussion took place at CRRG prior to risk developed and added.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	21.01.21

2. STRATEGIC OBJECTIVE: WORKING WITH PARTNERS TO DELIVER INTEGRATED CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed
			Likelihood	Conseq	Rating					Internal	External					
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities **because** of a lack of strategic relationships with primary care and local authorities and an internal focus which will **impact** on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	2x2=4	Apr-23		Medical Director attendance at LMC and HARA	MD Board Report SMT Medical Directorate Team meeting	HARA Yorkshire Health Network LMC	Distributed portfolio across Executive Directors for partnerships This risk could exasperate due to the potential local government and NHS (integrating care) re-organisation	risk, controls, assurances updated to include risks agreed to be added for local government and NHS (integrating care) re-organisation; and shared Executive lead between the Chief Executive and Executive Medical Director	SMT	S Russell, Chief Executive/ J Andrews, Executive Medical Director	22.09.20 21.01.21
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	There is a risk that the Trust's population is not able to fully benefit from being part of an integrated care system **because** our secondary care patient flows are to West Yorkshire and our place based population health activities sit within North Yorkshire which are in two different ICSs and there is insufficient management bandwith to participate in both. This will **impact** on our ambition to be an active partner in population health and the transformation of health inequalities.	3	3	9	2x2=4	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members			Duplication of effort and lack of leadership capacity	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	SMT	J Andrews, Executive Medical Director	22.09.20 21.01.21

3. STRATEGIC OBJECTIVE: DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed
			Likelihood	Conseq	Rating					Internal	External					
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding service quality and patient experience **because** there is insufficient focus on an systematic organisation-wide approach to and culture of quality improvement which will **impact** on the Trust's ambition to continuously address the underlying barriers to excellence every time and to provide outstanding care.	3	4	12	3x3=9	Apr-22		Quality Assurance reports Quality Committee Workplan	CQC Action Plan Quality Account	CQC Inspections Bi-monthly Assurance meetings with CCG	Do not have consistent quality control in place	no further changes made since last reported to the Board in November 2020	Quality Committee	J Foster, Chief Nurse	22.09.20 21.01.21
BAF#3.2	To provide a high quality service	There is a risk that some of our secondary care based services are not clinically and financially sustainable **because** of the size of population we serve and our ability to respond to sub-specialisation and to recruit and retain staff which will **impact** on our ambition to provide high quality services.	4	4	16	3x3=9	Apr-23		**External:** Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common	No Project Management Support for clinical review and support to draft strategy	no further changes made since last reported to the Board in November 2020	Quality Committee	J Andrews, Executive Medical Director	22.09.20 21.01.21

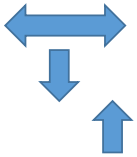
4. STRATEGIC OBJECTIVE: ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed
			Likelihood	Conseq	Rating					Internal	External					
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	3	12	2x3=6	Mar-22		Current financial regime; national framework, ICS discussions; engagement in regional and local service transforation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation **External:** no governance structure or programme of work with Leeds regarding transformation	no further updates made since last presented to the Board in November 2020	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	22.09.20 13.11.20 21.01.21
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	4x2=8	Mar-23		Captial asset register and planning process; financial plan; currrent financial regimeto	Capital Oversight Group formed f		**Internal:** No Capital Programme group in place No efficiency programme for 2020/21 **External:** Currently no ICS Strategy or process in place Currently no commitment by the ICS/NHSI to address the gap	no further updates made since last presented to the Board in November 2020	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	22.09.20 13.11.20 21.01.21

Risk Matrix

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

Changes in Ratings



No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

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

Board of Directors Meeting
27 January 2021
Integrated Board Report - December 2020

Agenda Item Number:	**7.2**
Presented for:	Information
Report of:	Executive Directors
Author (s):	Head of Performance & Analysis
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	✓
To ensure clinical and financial sustainability	✓

Recommendation:
The Board is asked to note and discuss the items contained within this report.

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Integrated board report - December 2020

Key points this month

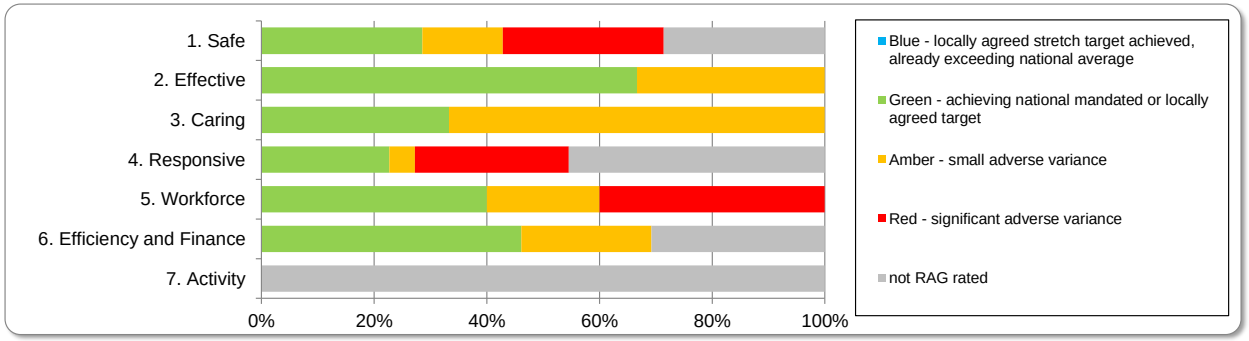
1. The Trust reported a deficit position in month 9 of £528k, significantly favourable to the month 9 plan by £698k. This is the second month where the Trust has reported a favourable variance to plan, with the year to date position now a deficit of £1,559k, £905k favourable to plan.

2. HDFT's performance against the A&E 4-hour standard remained below 95% in December (85.4%). This is a decrease on last month. The year to date position for 2020/21 now stands at 90.6%.

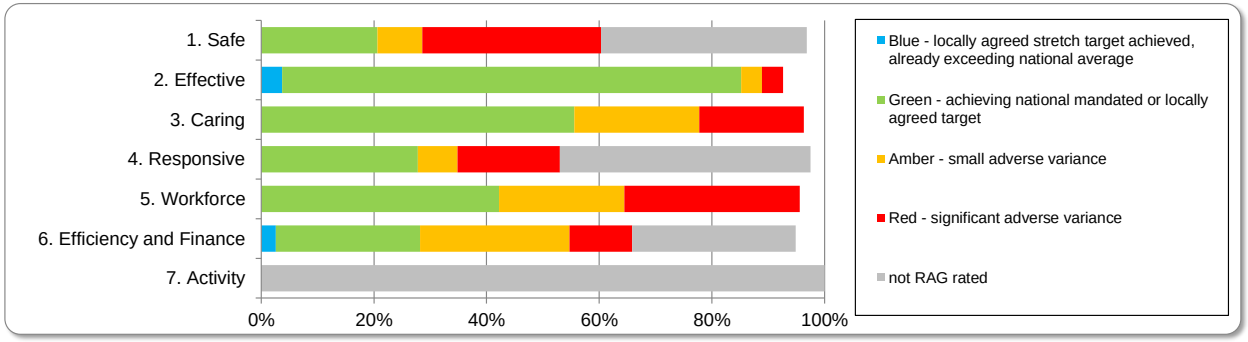
3. Provisional data indicates that 3 of the 7 applicable cancer waiting times standards were achieved in December. The 62 day cancer standard was not delivered in December with provisional performance at 84.5%.

4. 14 day performance for suspected cancer and non-cancer related breast symptoms has deteriorated significantly in November and December due to a surge in breast referrals. Performance for both 14 day standards was below 93% in December (further details contained in this report).

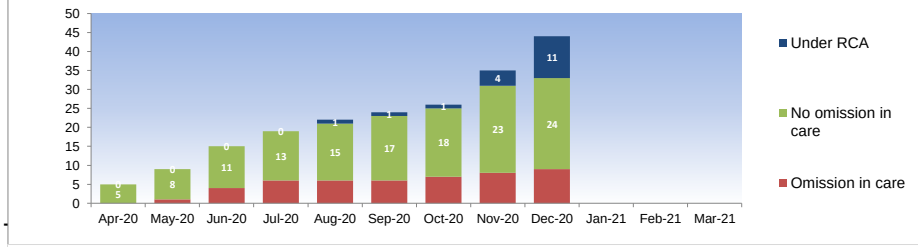
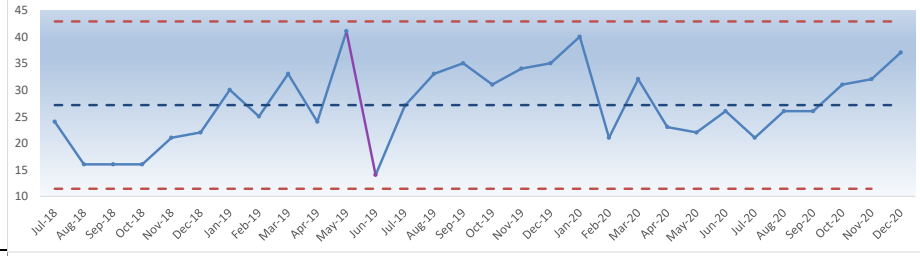
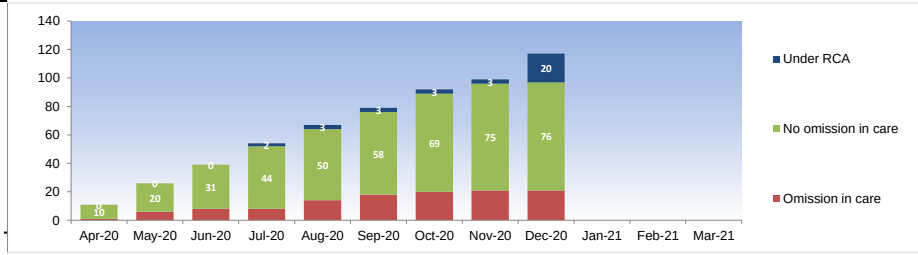
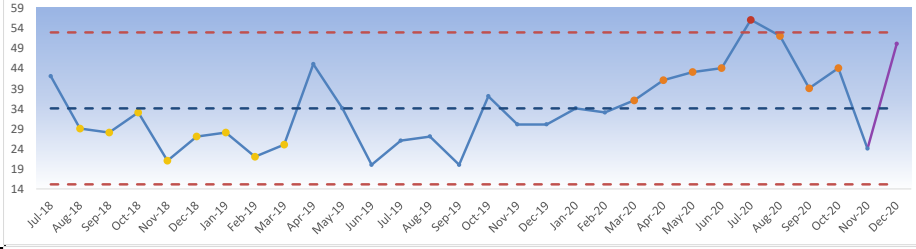
Summary of indicators - current month



Summary of indicators - year to date



Section 1 - Safe - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired		There were 13 hospital acquired category 3 and above pressure ulcers reported in December (including device related and device related mucosal). This is higher than last year with an average of 8 per month reported in 2019/20. 9 of these require RCA, taking the total requiring RCA YTD to 44. Of the 13* reported, there was 1 omission in care, 1 no omission in care and 7 under RCA. *from 01/01/2020 DTI subcategories are reported as LOW harm, no RCA required
1.1b			The number of hospital acquired category 2 and above pressure ulcers reported in December was 37. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired		There were 36 community acquired category 3 and above pressure ulcers reported in December (including device related and device related mucosal). 18 of these require RCA, taking the total requiring RCA YTD to 117. The average per month reported in 2019/20 was 14. Of the 36* reported, there was 1 no omission in care and 17 under RCA. *from 01/01/2020 DTI subcategories are reported as LOW harm, no RCA required.
1.2b			The number of community acquired category 2 and above pressure ulcers reported in December was 50. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

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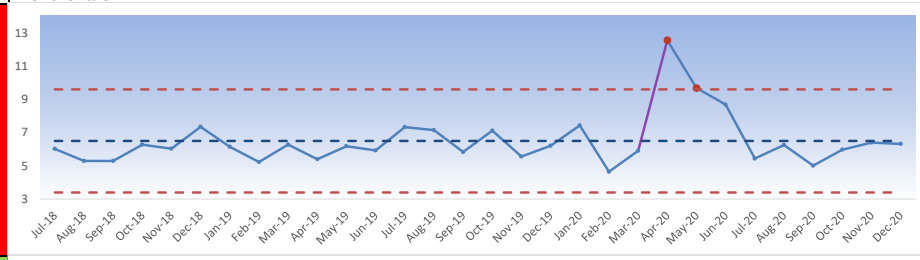
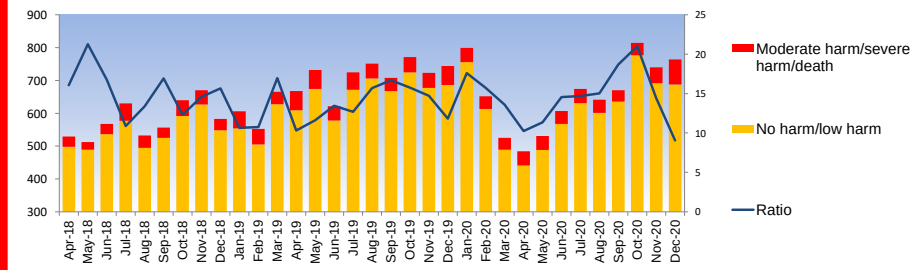
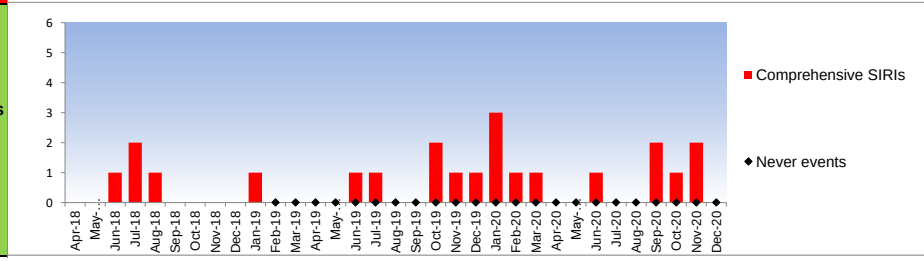
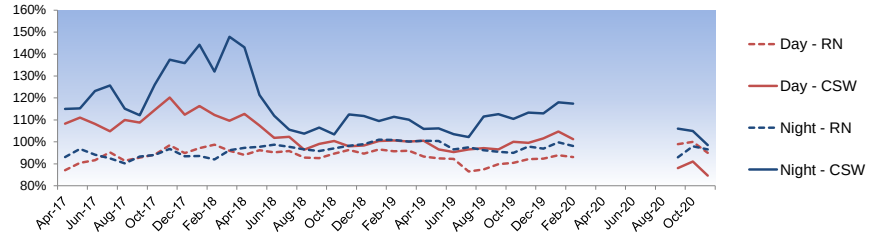
Section 1 - Safe - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls		The rate of inpatient falls was 6.3 per 1,000 bed days in December. This is a slight decrease on recent months and higher than the average HDFT rate for 2019/20 (6.2).
1.4	Infection control		There were 2 cases of hospital apportioned C. difficile reported in December bringing the year to date total to 14 cases. No MRSA cases have been reported in 2019/20 or 2020/21 to date. The annual maximum threshold for lapses in care cases for 2020/21 is 19. This data is yet to be finalised by Infection Control. This graph shows cumulative data YTD.
1.5	Incidents - all		The latest published national data (for the period Apr 19 - Sep 19) shows that Acute Trusts reported an average ratio of 46.6 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's published ratio was 13.1, a reduction on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for December gives a ratio of 9.1.
1.6	Incidents - SIRIs and never events		No SIRIs were reported in December, with the YTD position now at 6 reported cases. No Never Events have been reported YTD. No Never Events were reported in 2017/18, 2018/19 or 2019/20.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	**Safer staffing levels**		After being suspended due to Covid-19, this indicator has now resumed. In November, staff fill rates were reported as follows: - Registered Nurses Day 95% and Night 97% - Care Staff Day 85% and Night 99% December data is being finalised and will be reported in next month's report.

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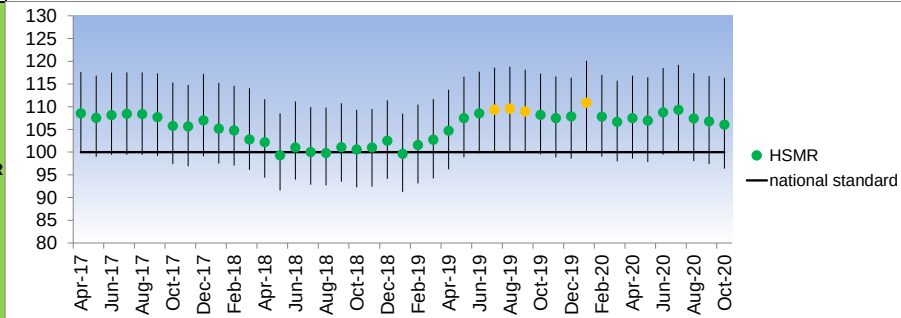
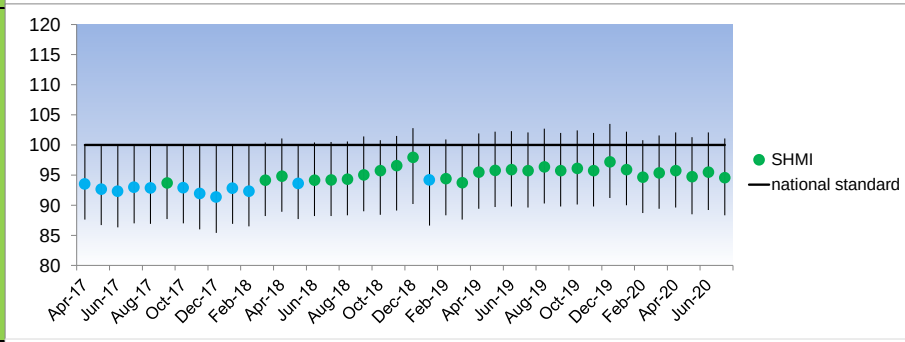
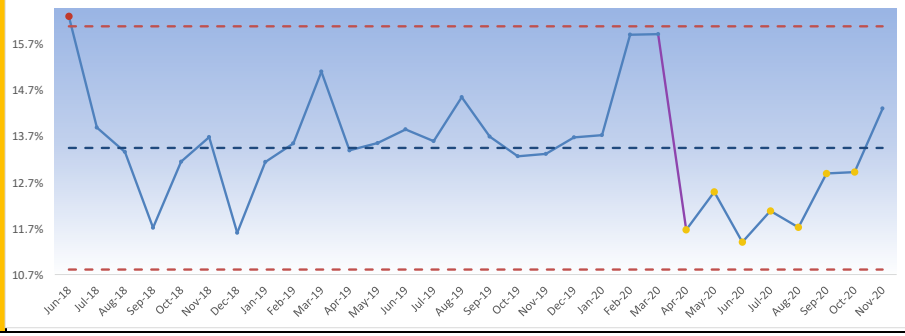
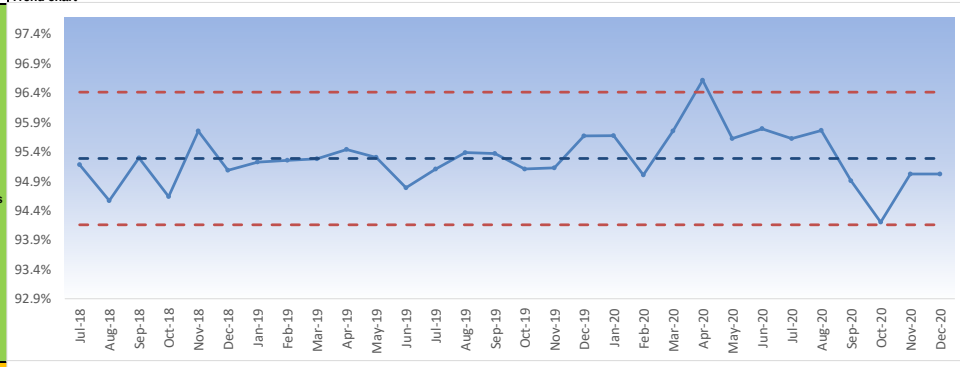
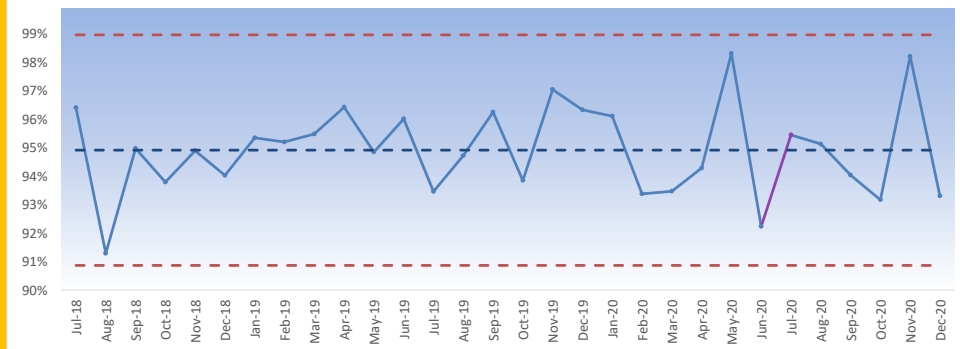
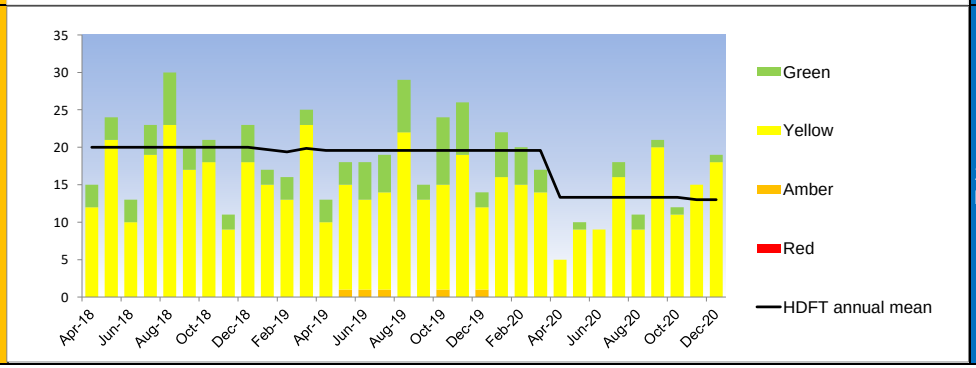
Section 2 - Effective - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR		HDFT's HSMR has decreased to 106.2 for the rolling 12 months ending October 2020, remaining within expected levels. At specialty level, two specialties (Gastroenterology and T&O) have a standardised mortality rate above expected levels. *The delay in calculating and publishing is linked to the requirement that all episodes are clinically coded and therefore there is at least a 2 month delay before they can start to look at the data.
2.2	Mortality - SHMI		HDFT's SHMI for the rolling 12 months ending July 2020 is 94.56, remaining within expected levels. At specialty level, two specialties (Gastroenterology and T&O) have a standardised mortality rate above expected levels. NHS Digital have advised that Covid-19 related activity and deaths is now excluded from the SHMI. They advised that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. *The delay in calculating and publishing is linked to the requirement that all episodes are clinically coded and therefore there is at least a 2 month delay before they can start to look at the data. SHMI is slightly later than HSMR as it includes deaths within 30-days of discharge from hospital that will cause a further delay to the publication
2.3	Readmissions		Emergency readmissions increased to 14.3% in November. This is above the 2019/20 average of 14.0%.

Section 3 - Caring - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients		95.0% of patients surveyed in December would recommend our services remaining above the latest published national average (93.3%, February 2020). 3,187 patients responded to the survey this month, of which 3,029 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services		93.2% of patients surveyed in December would recommend our services, a decrease on last month (98.1%). The latest published national data (February 2020) shows 95.6% of patients surveyed would recommend the services. 103 patients from our community services responded to the survey this month, of which 96 would recommend our services.
3.3	Complaints		19 complaints were received in December (18 yellow, 1 green) which is 4 more than November and higher than the average for 2019/20 of 13 per month.

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Section 4 - Responsive - December 2020

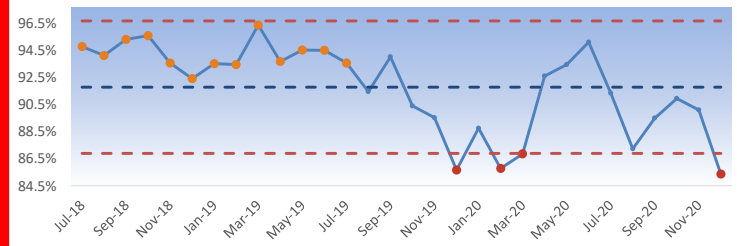
NHS Improvement Single Oversight Framework

4.1 NHS Improvement Single Oversight Framework

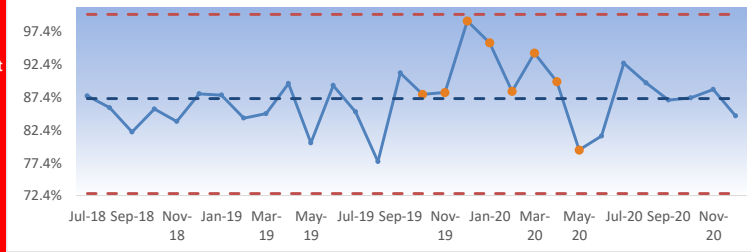
Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways					
A&E 4-hour standard	93.9%	89.3%	88.8%		90.4%
Cancer - 62 days	83.7%	89.6%	87.0%		87.0%
Diagnostic waits	55.5%	74.39%	77.17%		72.0%
Dementia screening - Step 1	92.2%	96.1%	93.3%		94.0%
Dementia screening - Step 2	80.0%	84.6%	75.8%		79.4%
Dementia screening - Step 3	87.0%	90.9%	78.8%		84.6%

4.2 RTT Incomplete pathways performance

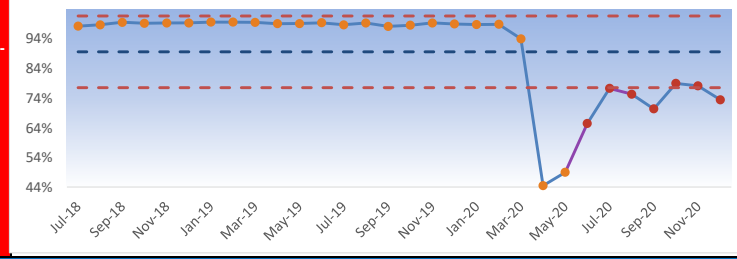
4.3 A&E 4 hour standard



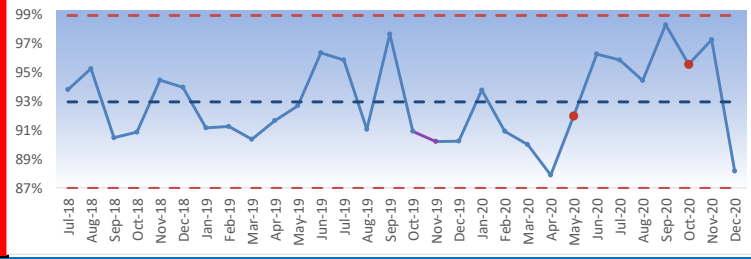
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment



4.5 Diagnostic waiting times - 6-week standard



4.6 Dementia screening



Narrative

Performance against the A&E 4-hour standard was below 95% in December (85.4%), a decrease on last month.

Provisional data shows that performance against the 62 day cancer standard was not delivered in December with performance at 84.5%. As highlighted in last month's report, a surge in 2WW breast referrals has led to a deterioration in 14 day performance in November and December. All other cancer standards were achieved with the exception of 62 day Screening and 31 day surgical subsequent treatments (see a more detailed summary below).

Data shows the performance on diagnostic waiting times decreased with 73.7% waiting less than 6 weeks at the end of December, remaining below the performance standard of 99%. The increase in patients waiting beyond 6 weeks are a result of the appointments being deferred following the stepping down of elective services in response to Covid-19.

Dementia Screening - provisional data suggests that Steps 1-3 were not achieved in December.

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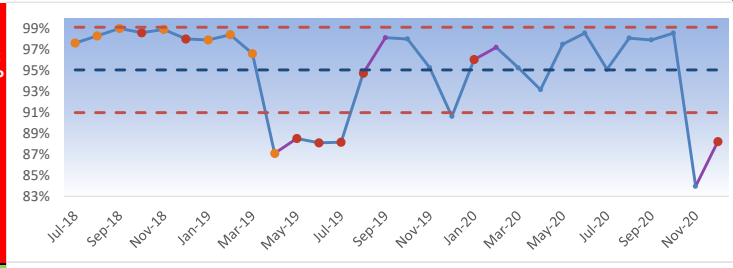
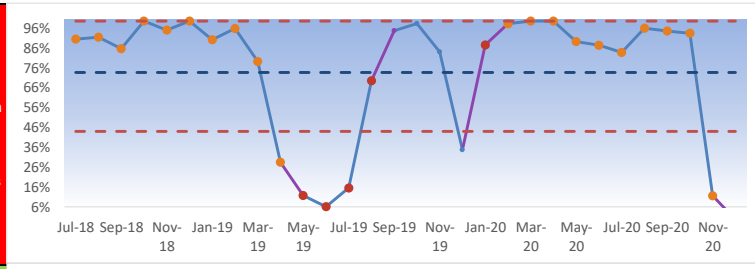
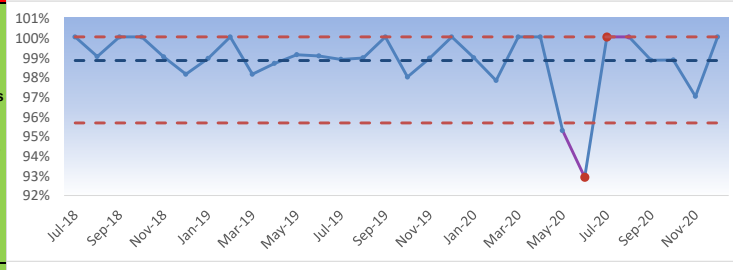
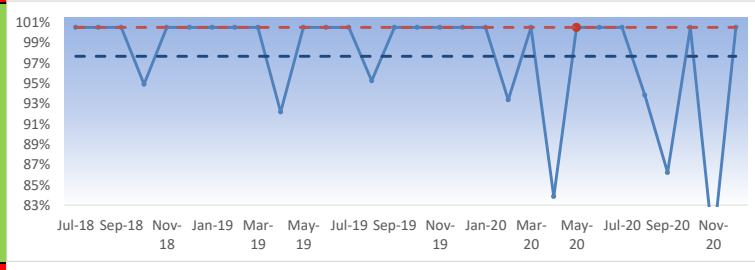
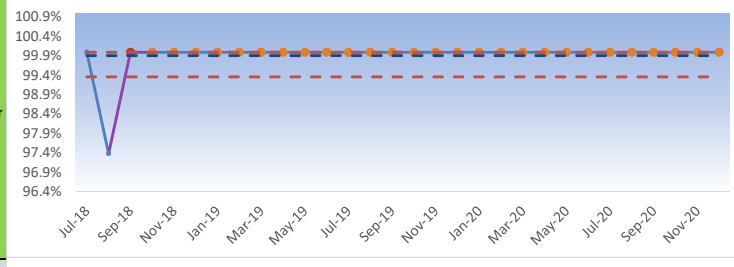
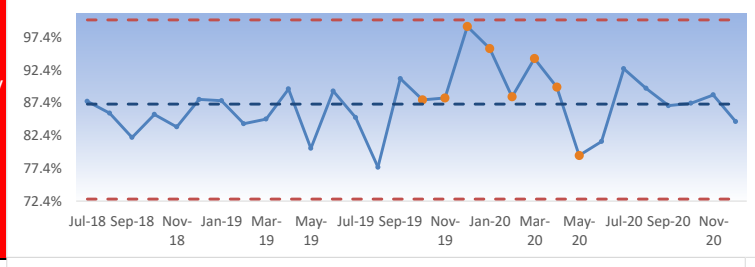
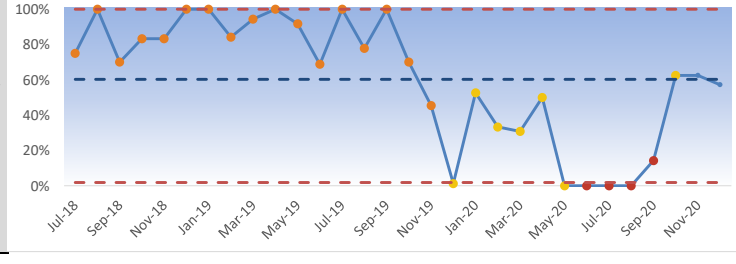
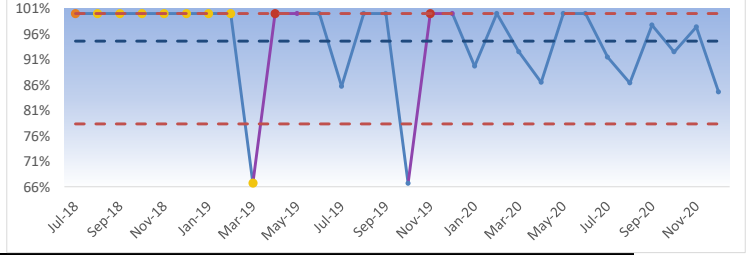
Section 4 - Responsive - December 2020

Cancer waiting times standards

4.70	Cancer - 14 days max wait from urgent GP referral for suspected cancer	
4.80	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	
4.9	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	
4.10	Cancer - 31 day wait for second or subsequent treatment: Surgery	
4.11	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	
4.12	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	
4.13	Cancer - 62 day wait for first treatment from screening service	
4.14	Cancer - 62 day wait for first treatment from consultant upgrade	

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Section 4 - Responsive - December 2020

Narrative

Provisional data indicates that 3 of the 7 applicable cancer waiting times standards were achieved in December.

14 day performance for suspected cancer and non-cancer related breast symptoms was below the operational standard in December - all 70 non-cancer related breast referrals were first seen in the month after day 14 (0%) and 88% of suspected cancer referrals seen by day 14, below the expected standard but a small improvement on last month – a total of 104 patients were first seen after day 14, 95 of which were breast referrals. The current average wait for a 2WW breast appointment is 24 days. Referrals are currently being triaged in order to ensure patients with a higher level of urgency are prioritised, and work is also being done to manage the impact of these delays on delivery of treatment for those patients diagnosed with cancer.

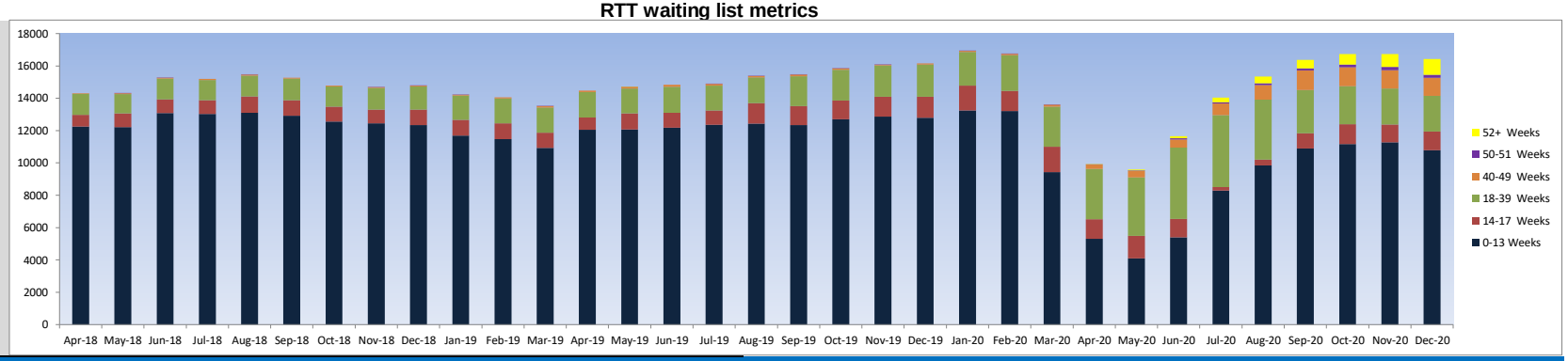
62 day standard performance is expected to be below 85% in December at 84.5%. Provisionally there were 55.0 accountable treatments in December with 8.5 over 62 days. Of the 11 tumour sites treated in December, performance was above 85% for all but 3 (Colorectal, Head and Neck, and Lung). Forecasting based on confirmed/scheduled treatments indicates that current performance is also below the 85% standard in January. 3 patients waited over 104 days for treatment in December – these delays were due to a combination of medical/diagnostic complexity and patient choice. All pathway delays will be reviewed by the breach panel at the end of January.

Provisional data indicates that 66.7% (10/15) of patients treated at tertiary centres in December were transferred by day 38.

62 day Screening performance was below the standard of 90% with 4 patients treated after 62 days (57.1%). Activity levels were below the de minimus for the month with 7 patients attributable to HDFT (equivalent to 3.5 accountable treatments).

Section 4 - Responsive - December 2020

RTT waiting list metrics

4.15	RTT waiting list split by weeks	

Narrative

Provisional data shows that there were a total of 16,421 patients on the RTT waiting list at the end of December. There were 973 patients waiting over 52 weeks at the end of the month. Extra capacity at The BMI Duchy continues to support the reduction of long-waiting orthopaedic patients who make up around 40% of the 52W total.

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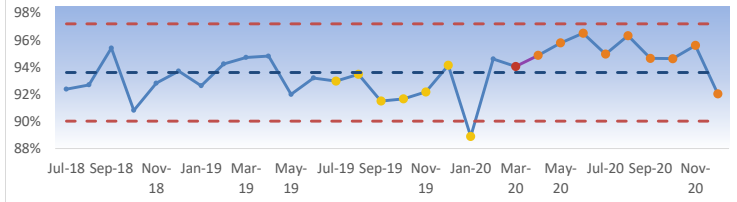
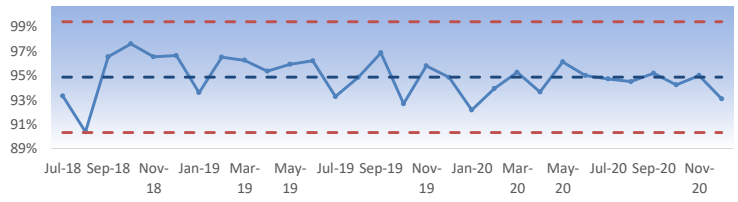
Section 4 - Responsive - December 2020

Children's Services metrics

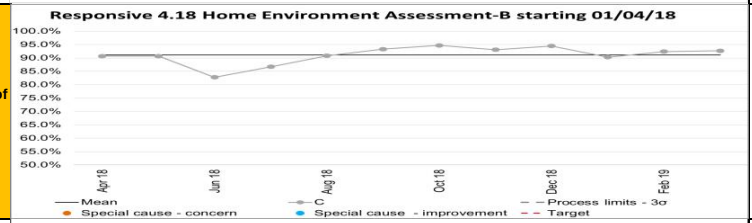
4.16 Children's Services - 10-14 day new birth visit



4.17 Children's Services - 2.5 year review

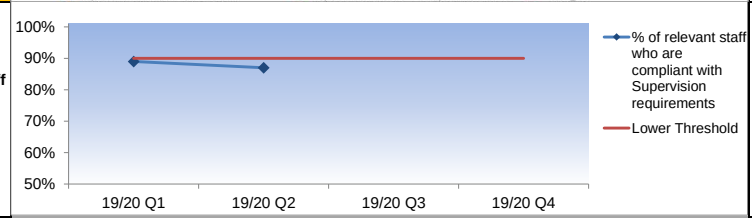


4.18 Children's Services - Use of the Home Environment Assessment Tool

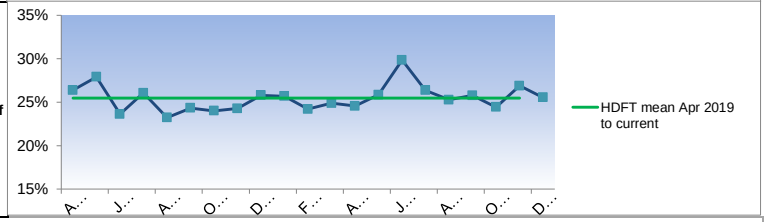


4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences

4.20 Children's Services - Staff compliance with Safeguarding Supervision.

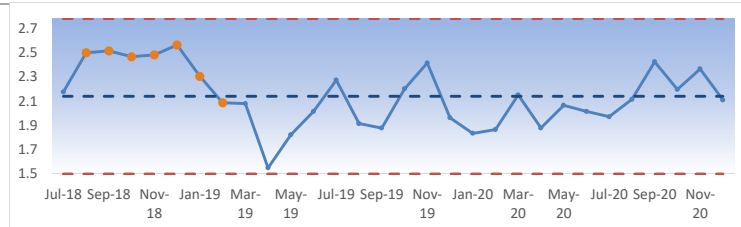


4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence.

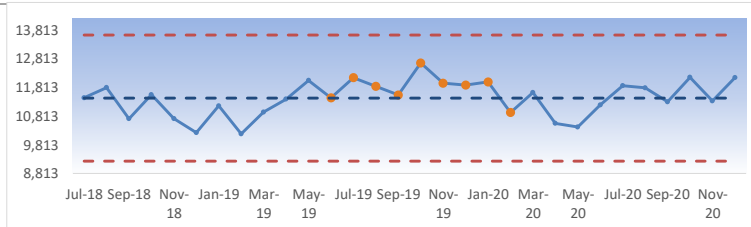


Adult Community Services metrics

4.22 OPEL level - Community Care Teams



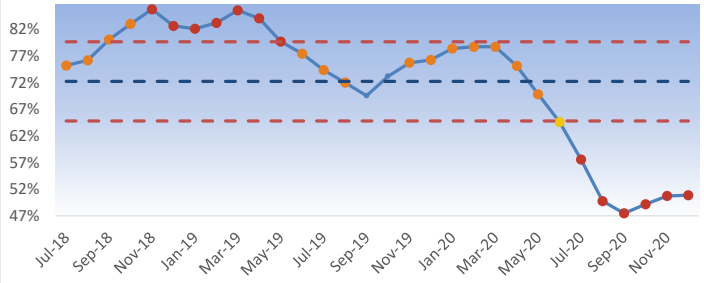
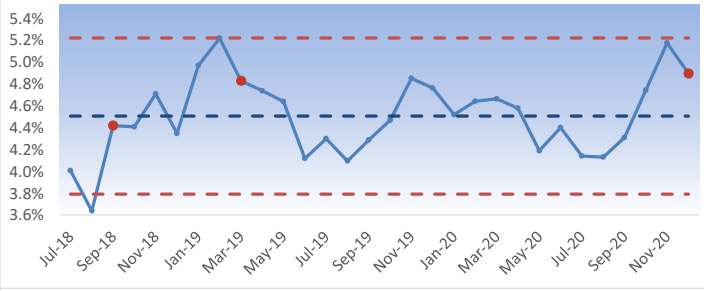
4.23 Community Care Teams - patient contacts



Narrative

The Children's Services and Adult Community Services metrics are currently showing no adverse variance. Following discussions at the Quality Committee, the Trust has increased the standard for the Safeguarding Supervision indicator to 90%, previously 75%.

Section 5 - Workforce - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates		Although appraisals were put on hold during the peak of Covid-19, our current completion rate stands at 50.4%.
5.2	Mandatory training rates		The data shown is for the end of December. Mandatory and Essential Training is currently being reintroduced and full MEST reporting has now resumed. The overall training rate for mandatory elements for substantive staff is 92% and has not changed since the last reporting cycle.
5.3	Sickness rates		Non-Covid-19 related sickness has increased in December 2020 to 4.9% and is higher than November 2019.

Competence Name	Renewal Period	Required	Achieved	Compliance %
Information Governance and Data Security	Annual	3956	3425	87%
Equality, Diversity and Human Rights	3 Yearly	3956	3742	95%
Fire Safety	Annual	3956	3458	87%
Health, Safety and Welfare	5 Yearly	3956	3830	97%
Infection Control	Once Only	3956	3876	98%
Safeguarding Children	3 Yearly	3956	3693	93%
Safer Manual Handling	3 Yearly	3956	3627	92%
Risk Awareness	Once Only	3956	3842	97%
Fire Safety Facilitator Led Training	2 Yeary	3956	3314	84%

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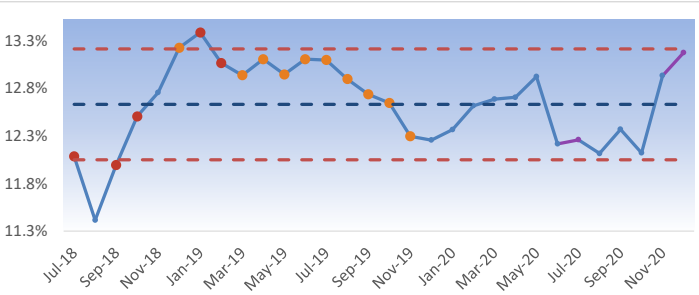
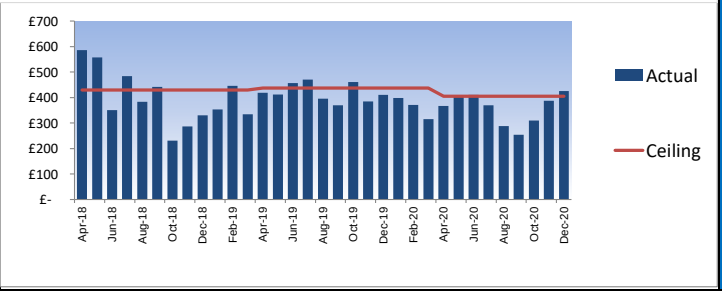
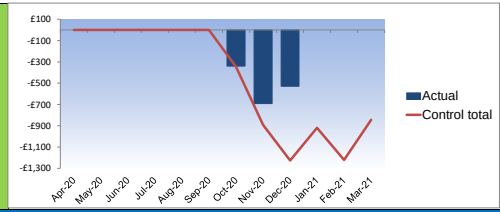
Section 5 - Workforce - December 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate		Staff turnover, both voluntary and involuntary, increased this month.
5.5	Agency spend in relation to pay spend		Month 9 agency spend increased to £425k. This is a consolidated position and represents a spike in expenditure which is under review.

Section 6 - Efficiency and Finance - December 2020

Finance

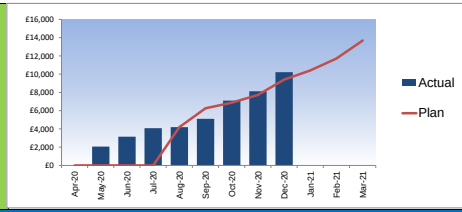
6.1 **Surplus / deficit and variance to plan**



6.2 **NHS Improvement Single Oversight Framework - Use of Resource Metric**

Element	Plan	Actual
Capital Service Cover	2	2
Liquidity	1	1
I&E Margin	1	1
I&E Variance From Plan		1
Agency	1	1
UoR Rating	1	1

6.3 **Capital spend**



Narrative

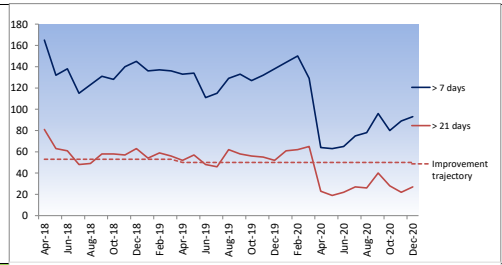
The Trust reported a deficit position in month 9 of £528k, significantly favourable to the month 9 plan by £698k. This is the second month where the Trust has reported a favourable variance to plan, with the year to date position now a deficit of £1,559k, £905k favourable to plan.

Currently reported as a 1. It should be noted that this rating is currently not being formally reported to NHSEI.

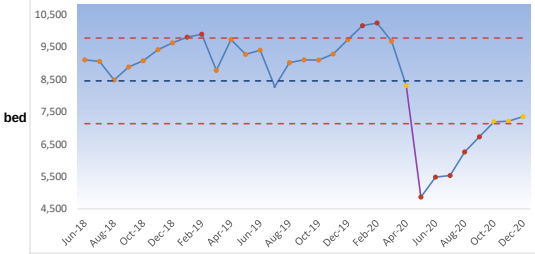
Trust spend is outlined in the graph, with a forecast position of approx. £14m dependant on approvals. It should be noted that the funding position of Covid wave 1 schemes is still to be finalised.

Inpatient efficiency metrics

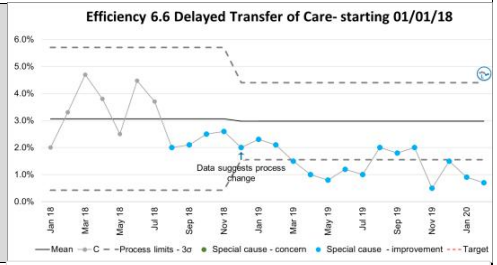
6.4 **Long stay patients**



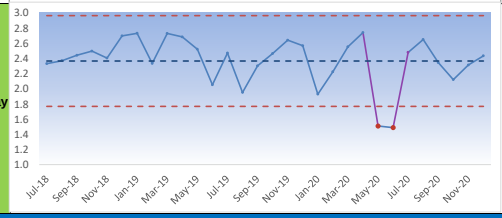
6.5 **Occupied bed days**



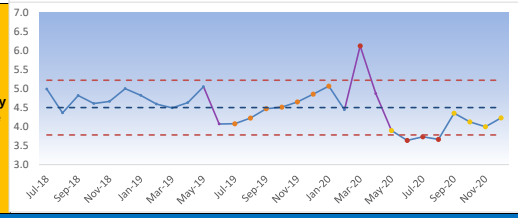
6.6 **Delayed transfers of care**



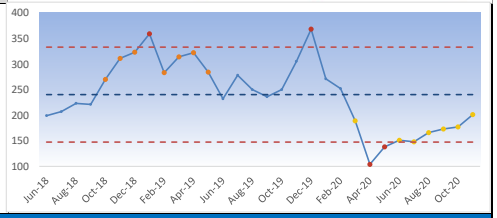
6.7 **Length of stay - elective**



6.8 **Length of stay - non-elective**



6.9 **Avoidable admissions**



Narrative

In December, long stay patient numbers and occupied bed days remained stable. Elective and non-elective length of stay increased, but with both remaining below the Trust mean. Avoidable admissions are increasing but remain below the Trust mean.

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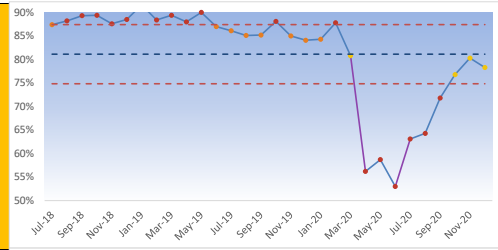
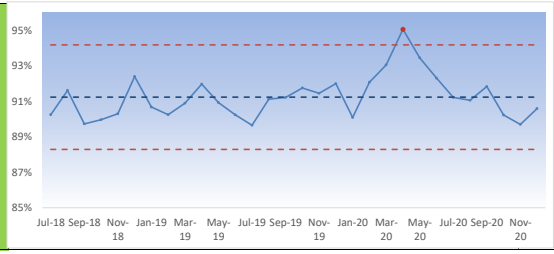
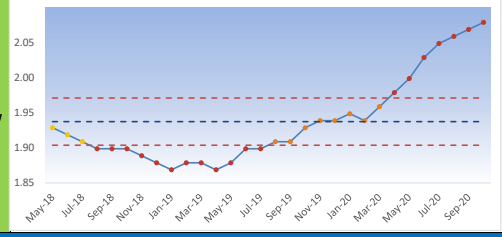
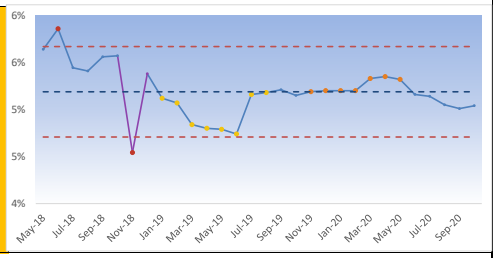
Section 6 - Efficiency and Finance - December 2020

6.10	Theatre utilisation		6.11	Day case rate	
6.13	Outpatient new to follow up ratio				



Narrative

Theatre utilisation decreased in December and remains below the target and Trust mean position.

Outpatient DNA rates increased and the new to follow up ratio continued to increase.

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Section 7 - Activity - December 2020

Narrative

The tables below show activity by Point of Delivery by Contract Type: North Yorkshire AIC; All Other CCGs (PbR); NHSE, Yorkshire Hub Cost per Case.

All activity types are below the levels experienced in 2019/20 as a result of Covid-19. The Trust has now submitted the acute recovery plan base case and step up activity profiles to NHSE/I as detailed in this month's Operational Performance Report to board.

North Yorkshire CCG AIC

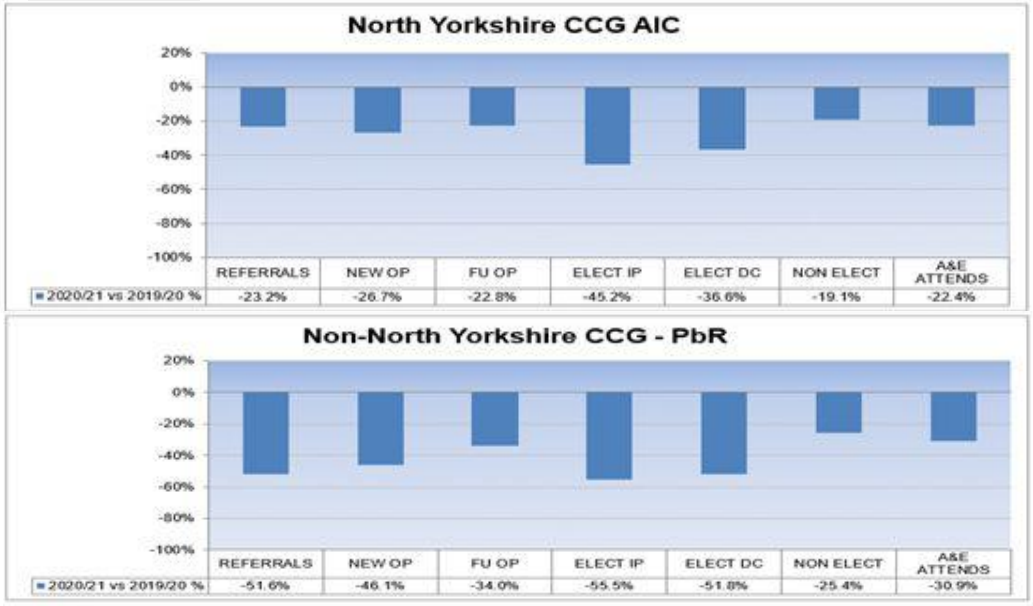
GROUP	2019/20 DEC	2020/21 DEC	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	2,825	2,715	29,201	22,413	-6,788	-23.2%
NEW OP	5,235	5,126	51,058	37,444	-13,614	-26.7%
FU OP	10,323	10,577	102,211	78,920	-23,291	-22.8%
ELECT IP	137	139	1,605	880	-725	-45.2%
ELECT DC	1,711	1,549	16,639	10,554	-6,085	-36.6%
NON ELECT	1,626	1,391	14,082	11,390	-2,692	-19.1%
A&E ATTENDS	3,281	2,695	29,709	23,050	-6,659	-22.4%

Non-North Yorkshire CCG - PbR*

GROUP	2019/20 DEC	2020/21 DEC	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	1,322	904	13,794	6,683	-7,111	-51.6%
NEW OP	2,103	1,581	20,511	11,060	-9,451	-46.1%
FU OP	3,501	3,096	36,337	24,000	-12,337	-34.0%
ELECT IP	95	78	973	433	-540	-55.5%
ELECT DC	617	529	6,521	3,142	-3,379	-51.8%
NON ELECT	490	352	4,342	3,238	-1,104	-25.4%
A&E ATTENDS	1,247	782	10,803	7,470	-3,333	-30.9%

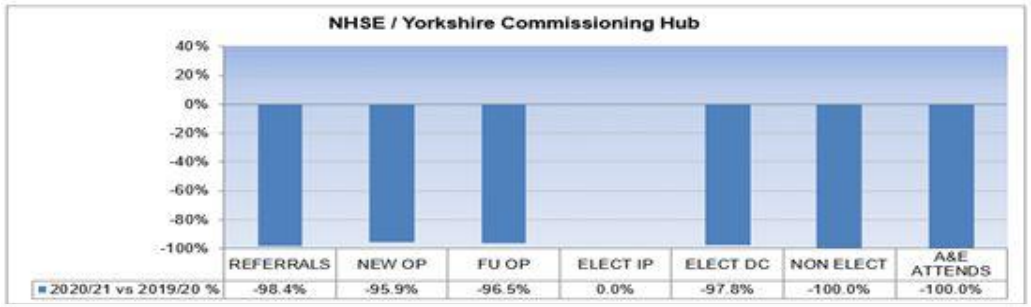
*Non-HaRD CCGs: Leeds CCG, Vale of York CCG, All Other CCGs

Activity Summary



NHSE / Yorkshire Commissioning Hub

GROUP	2019/20 DEC	2020/21 DEC	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	17	0	188	3	**-185**	**-98.4%**
NEW OP	144	14	1,913	79	**-1,834**	**-95.9%**
FU OP	379	15	4,180	146	**-4,034**	**-96.5%**
ELECT IP	1	0	12	12	**0**	**0.0%**
ELECT DC	312	10	3,416	74	**-3,342**	**-97.8%**
NON ELECT	2	0	50	0	**-50**	**-100.0%**
A&E ATTENDS	17	0	182	0	**-182**	**-100.0%**



Trust Total

GROUP	2019/20 DEC	2020/21 DEC	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	4,164	3,619	43,183	29,099	**-14,084**	**-32.6%**
NEW OP	7,482	6,721	73,482	48,583	**-24,899**	**-33.9%**
FU OP	14,203	13,688	142,728	103,066	**-39,662**	**-27.8%**
ELECT IP	233	217	2,590	1,325	**-1,265**	**-48.8%**
ELECT DC	2,640	2,088	26,576	13,770	**-12,806**	**-48.2%**
NON ELECT	2,118	1,743	18,474	14,628	**-3,846**	**-20.8%**
A&E ATTENDS	4,545	3,477	40,694	30,520	**-10,174**	**-25.0%**

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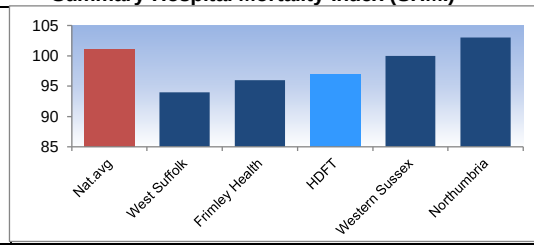
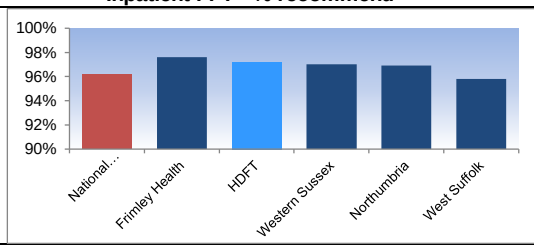
Section 8 - Benchmarking - December 2020

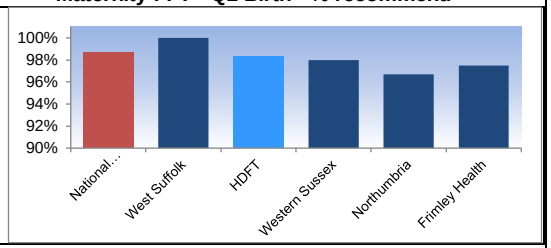
8.1 Summary Hospital Mortality Index (SHMI)



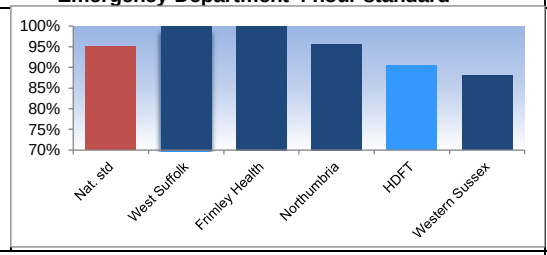
8.2 Inpatient FFT - % recommend



8.3 Maternity FFT - Q2 Birth - % recommend

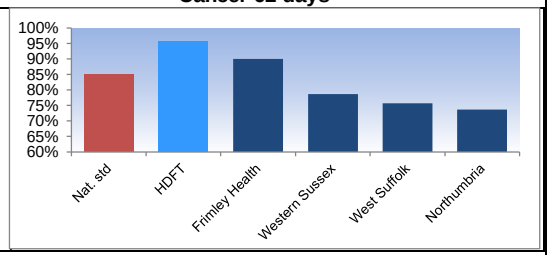


8.4 Emergency Department 4 hour standard

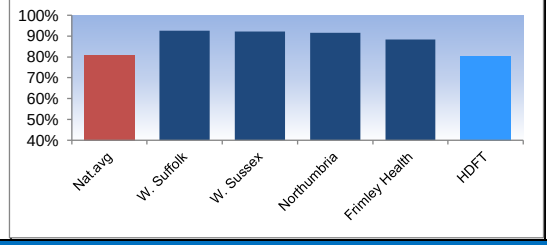


8.5 RTT incomplete pathways

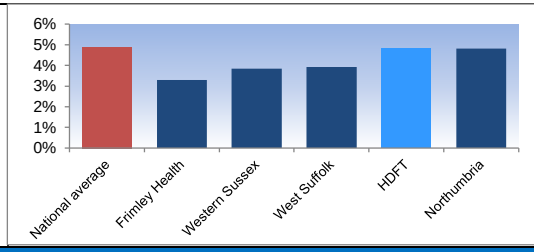
8.6 Cancer 62 days



8.7 Staff FFT - % recommend (place to work)



8.8 Sickness absence



8.9 Proportion of temporary staff

Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of metrics, the data has been sourced from NHSE Website, Data Statistics.

Harrogate and District NHS Foundation Trust

Integrated board report - October 2020

Key for SPC charts

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)

Icon	Description
	Special cause variation - improvement (indicator where low is good)
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

Harrogate and District NHS Foundation Trust

Data Quality - Exception Report

Domain	Indicator	Data quality rating	Further information
Safe	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber** 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Caring	Friends & Family Test (FFT) - Adult Community Services	**Amber** 	The number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year.
Efficiency and Finance	Theatre utilisation	**Amber** 	This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.
Responsive	OPEL level - Community Care Teams	**Amber** 	This indicator is in development.
Activity	Community Care Teams - patient contacts	**Amber** 	During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time.

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Indicator traffic light criteria

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.	tbc	tbc
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI hospital acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes hospital teams only.		
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI community acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes community teams only.		
1.3	Safe	Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.	Blue if YTD position is a reduction of >=50% of HDFT average for 2019/20, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2019/20, Amber if YTD position is a reduction of up to 20% of HDFT average for 2019/20, Red if YTD position is on or above HDFT average for 2019/20.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.4	Safe	Infection control	HDFT's C. difficile trajectory for 2019/20 is 19 cases, an increase of 8 on last year's trajectory. This increase takes into account the new case assignment definitions. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2019/20. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
1.5	Safe	Incidents - all	The number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
1.6	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.7	Safe	Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		
2.2	Effective	Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2019/20, Amber if latest month rate > HDFT average for 2019/20 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
3.1	Caring	Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.	Green if latest month >= national average % recommended, Amber if latest month <= 5 percentage points below national average, Red if latest month greater than 5 percentage points below national average.	Comparison with national average performance.
3.2	Caring	Friends & Family Test (FFT) - Adult Community Services	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.		
3.3	Caring	Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2019/20, Amber if on or above HDFT average for 2019/20, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
4.1	Responsive	NHS Improvement governance rating	NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. From 1st April 2018, dementia screening perfromance forms part of this assessment.	As per defined governance rating	
4.2	Responsive	RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.	Green if latest month >=92%, Red if latest month <92%.	NHS England
4.3	Responsive	A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.	Blue if latest month >=97%, Green if >=95% but <97%, amber if >= 90% but <95%, red if <90%.	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
4.4	Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.5	Responsive	Diagnostic waiting times - 6-week standard	Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%. A high percentage is good.	Green if latest month >=99%, Red if latest month <99%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	Dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	RTT waiting list split by weeks	Number of referred patients waiting for treatment broken down into weeks.	tbc	tbc
4.16	Responsive	Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Target to be reviewed by CCC Directorate	tbc
4.17	Responsive	Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.18	Responsive	Children's Services - Use of the Home Environment Assessment Tool	The % of eligible children in Durham who had a HEAT assessment. The performance target is 95%.	Green if latest month >=95%, Amber if between 90% and 94%, Red if <90%.	Contractual requirement
4.19	Responsive	Children's Services - Reports for Initial and Review Child Protection Case Conferences	The % of reports submitted prior to Case Conferences (where reports are reqeusted earlier than 48 hours before Case Conference.)	Green if latest month >=95%, Red if <95%.	Contractual requirement
4.20	Responsive	Children's Services - staff compliance with Safeguarding Supervision.	% of community staff achieving 80% compliance for Safeguarding Supervision.	Green if latest month >=90%, Red if <90%.	tbc
4.21	Responsive	Children's Services - % achievement against KPI for Breast Feeding Prevalence at 6-8 weeks.	% of children breast fed at the 6-8 week review. Charted against Prevalence targets for all 0-5 services.	Target to be reviewed by CCC Directorate	tbc
4.22	Responsive	OPEL level - Community Care Teams	The OPEL (Operational Pressures Escalation Level) is a measure of operational pressure being experienced by the community care teams. A value of 1 to 4 is agreed each day, with 1 denoted the lowest level of operational pressure and 4 denoting the highest. The chart will show the average level reported by adult community services during the month.	tbc	Locally agreed metric
4.23	Responsive	Community Care Teams - patient contacts	The number of face to face patient contacts for the community care teams.	tbc	Locally agreed metric
5.1	Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
5.2	Workforce	Mandatory training rate	Latest position on the % substantive staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
5.3	Workforce	Staff sickness rate	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
5.4	Workforce	Staff turnover	The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
5.5	Workforce	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
6.1	Efficiency and Finance	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
6.2	Efficiency and Finance	NHS Improvement Financial Performance Assessment	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
6.3	Efficiency and Finance	Capital spend	Cumulative Capital Expenditure by month (£'000s)	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
6.4	Efficiency and Finance	Long stay patients	This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement) or over 21 days (previously super-stranded patients). The data excludes children, as per the NHS Improvement definition. A low number is good.	tbc	as defined by NHS Improvement
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	Delayed transfers of care	The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.8	Efficiency and Finance	Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		
6.9	Efficiency and Finance	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.	tbc	tbc
6.10	Efficiency and Finance	Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.12	Efficiency and Finance	Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		
6.13	Efficiency and Finance	Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.		Locally agreed targets.

Data quality assessment

Green		No known issues of data quality - High confidence in data
Amber		On-going minor data quality issue identified - improvements being made/ no major quality issues
Red		New data quality issue/on-going major data quality issue with no improvement as yet/ data confidence low/ figures not reportable

Harrogate and District NHS Foundation Trust

Board of Directors Meeting
27 January 2021

Committee Name:	Senior Managers Team Chair's Report
Committee Chair:	Chief Executive
Date of meeting:	20 January 2021
Date of Board meeting this report is to be presented	27 January 2021

Summary of key issues

There was no SMT meeting in December 2020. Shadow SMT met on 19 January 2021 and provided comments, advice and their recommended decisions on the items SMT considered at its 27 January 2021 meeting. Shadow SMT's feedback is greatly appreciated; it provides a very important broader voice into decision making.

Key issues discussed were as follows:

- *Operational Performance* was discussed and noted that:
  - The Winter plan has been implemented and actioned with increased bed capacity.
  - Recent increase in COVID 19 inpatients and critical care has triggered the next phases of the Covid Surge Plan.
  - Silver and Gold meetings have been increased to reflect the escalation
  - Recognition that staffing remains a challenge with recent increases in COVID related absence increasing the impact.
  - Planned care recovery programme continues to ensure urgent electives continue to be seen in an appropriate timescale.
  - Focus continues on the 14 day cancer performance and 62 day and 104 day backlogs

- Medical Staff Additional Payment Recommendations were approved.

- Ockenden Independent Review Action Plan and Maternity Review Process was prepared in response to NHS England and NHS Improvement challenge to NHS providers, commissioners and local maternity systems to reflect on whether existing assurance mechanisms for maternity services are effective and ensure that poor care and avoidable deaths with no visibility or learning cannot happen in their organisations. The action plans was supported.

- Serious Incidents process and lessons learned were discussed in detail.

- Radiology Investigation update was noted to have also been reported to the Radiology department who are working on a proposed action plan.

- North Yorkshire 0-19 Service update was discussed and noted.

- Outcome of North Yorkshire County Council 0-19 Service Consultation was received

with plans in place to provide the Section 75 to the Board.

- CQC Action Plan and Process for Peer Review was received and actions were agreed to continue to take this forward.

- SMT supported the submission of the Emergency Department/Mammography Business Case to Resource Committee for approval.

The following were received and noted:

- Integrated Board Report
- Chief Nurse Report Infection, including IPC, COVID and Flu vaccination update
- Quality Performance
- Team HDFT *At out best*
- Workforce & Organisational Development Report
- Financial Performance
- Planning Process 2021/22
- Corporate Risk Register
- Corporate Risk Review Meeting Minutes
- Children's and Countywide Care Chair's Report
- Long Term and Unscheduled Care Chair's Report

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

There were no risks raised in addition to those included on the risk registers.

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

Nothing was raised.

Harrogate and District NHS Foundation Trust

Board of Directors
27 January 2021
North Yorkshire 0-19 Healthy Child Programme

Agenda Item Number:	**7.4**
Presented for:	Note/Approve
Report of:	Deputy Chief Executive/Finance Director
Author (s):	Head of Charity and Business Development Project Manager
Report History:	Senior Management Team, 21 January 2021
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives

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

Recommendation:

The Board of Directors is asked to:

- Note the outcome of the public consultation
- Note the discussions that will continue in relation to any changes to the future service delivery specification issues that have emerged and continue to be discussed in relation to the future service delivery specification
- Note the Commencement of the workforce consultation on 1 February 2021
- Note the development of the draft S75 agreement with NYCC
- Approve the publishing by NYCC and HDFT for Joint public technical consultation of the Draft S75 agreement starting on 2 February 2021 for a period of 30 days finishing on 3 March 2021

Board of Directors Meeting

27 January 2021

North Yorkshire 0-19 Healthy Child Programme

Deputy Chief Executive/Finance Director

1.0 Background

1.1 HDFT and North Yorkshire County Council (NYCC) have agreed in principle to work together in partnership via a Section 75 (S75) Agreement to facilitate the delivery of the North Yorkshire 0-19 Healthy Child Programme. By pursuing a S75 approach rather than a more traditional contracting model HDFT and NYCC will be able to develop a long-term partnership that continuously evolves and develops the service.

1.2 HDFT and NYCC have developed a new service model which both parties believe can safely and effectively meet the needs of the target population. A public consultation ran for a period of ten weeks on the proposed changes which commenced on 26 October 2020 and finished on 4 January 2021.

1.3 Due to Covid-19, the majority of the consultation was completed online via surveys and publically advertised virtual events, however all electronic publicity also featured contact phone numbers via which physical copies of the consultation pack could be accessed.

1.4 The purpose of this report is to update the Board of Directors on the progress in relation to the:

- Outcome of the Public Consultation
- Commencement of the Workforce Consultation
- Development of the S75 Partnership Agreement

1.5 The Board is also asked to approve the draft S75 agreement for joint technical public consultation with NYCC in February 2021.

2.0 Public Consultation Update

2.1 Attached is the NYCC HCP Consultation Executive Report detailing the outcome of the public consultation on the changes identified to the 0-19 Healthy Child Programme. This report also seeks approval from the NYCC Executive to implement the proposed service model, pending the outcome of the public technical consultation on the section 75 agreement.

2.2 There are some issues which have been identified as part of the consultation process. These are:

- Sexual Health Advice
- NHS involvement in Safeguarding meetings for 5-19
- Vision Screening and Continence
- Schools advice

2.3 The Trust are working with NYCC to work through the issues identified, which aren't significant in relation to the revised service model and the Trust are continuing with the workforce consultation. Any amendments to the service model that are proposed following agreement with NYCC will be brought back to the Board for approval in March 2021.

3.0 Workforce Consultation

3.1 Colleagues working in the service have had regular staff briefings about the potential service changes.

3.2 Now that the service model as proposed is materially agreed with NYCC the workforce consultation can continue as planned.

3.3 The consultation with the 0-5 and 5-19 HDFT workforce is scheduled to commence on 1 February 2021 on the new model required to deliver the new service specification.

3.4 This consultation is for a period of 30 days working with the senior management team and HR to outline the changes to current working arrangements and provide the support over the consultation period to the workforce.

4.0 Development of the S75 Partnership Agreement

4.1 Following negotiation and deliberation between Partners, it is proposed that from April 2021 the service will be delivered via a Section 75 Agreement to allow for increased partnership working, shared oversight and delivery and a phased approach to integration and joint working.

4.2 HDFT and NYCC share a view that coordinating and integrating planning and delivery activities will help facilitate the best use of resources to support the population of North Yorkshire and deliver high quality outcomes.

4.3 The strategic objectives of the Partnership are:

1. To ensure the effective and efficient management and delivery of the Service;
2. Through sharing resources and working in collaboration, to improve service, performance, quality and outcomes for children, young people and families;
3. To ensure that services are children, young people and family focused, and responsive to identified needs;
4. To deliver seamless services through effective multi-agency and multi-disciplinary planning, communication and processes;
5. To ensure value for money and efficient use of resources, maximising income where at all possible and avoiding duplication;
6. To respond to gaps in service delivery through improved service design, and inform commissioning intentions; and
7. To increase the range of skills, professional and organisational, available for the provision of services and provide a diverse range of learning and development opportunities for staff.

4.4 The Partners agree to adopt the following principles when carrying out this Section 75 agreement:

1. To be openly accountable for performance of the Partners' respective roles and responsibilities set out in this Section 75;
2. To communicate openly and transparently about major concerns, issues or opportunities relating to the delivery of this Section 75;
3. To commit to learn, develop and seek to achieve full potential from the Service. To share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4. To adopt a positive outlook and behave in a positive, proactive manner;
5. To act in the best interests of Service Users and their families and to ensure that they are always at the forefront of decision making;
6. To adhere to statutory requirements and evidence based best practice, complying with applicable laws and standards, data protection and freedom of information legislation;
7. To act in a timely manner, recognising the time-critical nature of the project and to respond accordingly to requests for support;
8. To act in good faith to support achievement of the key objectives and compliance with these principles; and
9. To provide coherent, timely and efficient decision-making.

4.5 Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 ("Regulations") enable NHS bodies to exercise prescribed local authority health-related functions in conjunction with their own NHS functions. The power to enter into section 75 agreements is conditional on the following:

1. The arrangements are likely to lead to an improvement in the way in which those functions are exercised; and;
2. The partners have jointly consulted people likely to be affected by such arrangements.

4.6 The purpose of the agreement is to put in place the arrangements required to govern and manage shared planning and delivery of integrated services. The Healthy Child Programme Board will be established as the vehicle through which the parties will discharge their responsibilities in respect of working together within the defined financial and operational schedules. The Agreement applies to the defined health, public health and social care services supplied to the residents of North Yorkshire County Council.

4.7 The Draft S75 Agreement, which is attached, covers a range of matters; of particular note to the Board of Directors are the following:

- Unlike some previously agreed S75 agreements (e.g. HARA) it is not the intention of the Partners through this S75 Agreement to establish a Pooled Fund, although there is nothing in this Agreement that precludes the Partners from doing so if subsequently agreed;
- Operational staff will remain fully employed within the Trust on current terms and conditions;
- The partners will continue to explore any opportunities for children's services integration, wider partnership working, and integrated provider management approaches that will improve the outcomes for children, young people and families across North Yorkshire;
- Quarterly performance monitoring will be undertaken in line with the performance framework and reporting to the HCP Board. A Service Transformation and Improvement Plan will be jointly developed to drive forward areas of development, reporting to the HCP Board;
- Service overspends and underspends will be considered jointly with the intention to reinvest any underspend back into the service; any underspend remaining at the end of the term will be returned to NYCC
- Where the Public Health Grant does not rise in line with additional costs incurred (e.g. the issues arising which we have experienced from Staff pay awards), the partners will meet at the earliest opportunity to understand the full extent and of any shortfall and mutually agree a way forward;

4.8 The agreement covers the period from 01/04/2021 – 31/03/2031, subject to break clauses at five years, and eight years.

4.9 The schedules associated with the S75 Agreement are not subject to public technical consultation and therefore are not included within the attached draft S75 agreement. A full contractual document will be presented to the Trust Board in March 2021 for approval.

4.10 Performance implications

4.10.1 There will be an agreed set of metrics for the HCP. The performance metrics in the first year have been developed from the existing performance requirements of each organisation who is party to the Section 75.

4.11 Partnership Working

4.11.1 HCP is an example of integrated working across the NHS, Public Health and social care. Working with our local authority partners is a key Trust priority as well as an ambition outlined in the NHS Long Term Plan, published in January 2019.

4.11.2 HCP forms one part of a wider system of support for children, young people and families across North Yorkshire.

4.12 Financial implications

4.12.1 The draft Section 75 agreement is explicit in the financial resources covered in the draft agreements and will be detailed in Schedule 3 of the draft Agreement. The financial resources agreed reflect the discussions that we have had through the Trust Board over the last 12 months. Each party will maintain its existing financial accountability and internal and external audit arrangements and bear its own risk in relation to service planning and delivery.

4.13 Legal implications

4.13.1 Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 ("**Regulations**") enable NHS bodies to exercise prescribed local authority health-related functions in conjunction with NHS functions.

4.13.2 Under the Public Contracts Regulations 2015 (PCRs) two contracting authorities can enter into a collaboration agreement (co-operation) subject to meeting the tests of Regulation 12 (7) PCRs (known as Hamburg). It is considered that the partnership arrangement through a S75 Agreement between HDFT and NYCC satisfies this test.

4.13.3 The Trust has appointed Hempsons who are working alongside the Trust to work through any legal implications as part of this agreement.

5.0 Next Steps

5.1 Over the coming weeks work will continue in order to:-

- Work through the issues identified through the consultation process to refine the service delivery model
- Commence the Workforce consultation on 1 February and align the workforce to the new model
- Continue to develop and agree the details for the S75 agreement in readiness for consultation in February 2021

6.0 Recommendation

6.1 The Board of Directors is asked to:

- Note the outcome of the public consultation
- Note the discussions that will continue in relation to any changes to the future service delivery specification issues that have emerged and continue to be discussed in relation to the future service delivery specification
- Note the Commencement of the workforce consultation on 1 February 2021
- Note the development of the draft S75 agreement with NYCC
- Approve the publishing by NYCC and HDFT for Joint public technical consultation of the Draft S75 agreement starting on 2 February 2021 for a period of 30 days finishing on 3 March 2021

7.0 Supporting Information

7.1 The following papers make up this report:

- NYCC HCP Consultation Executive Report
- S75 Draft Agreement

Dated **2021**

NORTH YORKSHIRE COUNTY COUNCIL

and

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

SECTION 75 PARTNERSHIP AGREEMENT

This Document is a working draft, negotiations between NYCC and HDFT are ongoing to finalise the content in accordance with the requirements of each organisation.

Contents

THIS DEED IS MADE ON

BETWEEN

(1) **North Yorkshire County Council** of County Hall, Racecourse Lane, Northallerton, DL7 8AD (the "**Council**")

(2) **Harrogate and District NHS Foundation Trust** of Lancaster Park Road, Harrogate, North Yorkshire, HG2 7SX (the "**Trust").**

WHEREAS

(A) The Council is a Local Authority established under the Local Government Act 1972 (as amended) and by virtue of Part 1 of the Care Act 2014 the Council is responsible for ensuring access to, commissioning and/or providing Early Year's and Health Services on behalf of the population of North Yorkshire.

(B) The Trust is an NHS Foundation Trust established under Section 35 of the National Health Service Act 2006 ("**2006 Act**").

(C) Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 ("**Regulations**") enable NHS bodies to exercise prescribed local authority health-related functions and for local authorities to exercise various prescribed NHS functions. The power to enter into section 75 agreements is conditional on the following:

- The arrangements are likely to lead to an improvement in the way in which those functions are exercised.
- The partners have jointly consulted people likely to be affected by such arrangements.

(D) The health-related functions that could be exercised by an NHS body on behalf of the Council under a Section 75 agreement include health visiting and school nursing.

(E) The Partners enter into this Agreement in exercise of the powers in Section 75 of the 2006 Act and the Regulations in order to establish a framework for the exercise of provision of health related functions, and the integrated provision of the 0-19 Healthy Child Service to eligible people within the Council's administrative area in accordance with the terms of this Agreement. The delivery of the service is managed through joint governance mechanisms in which both the Trust and Council participate through a process of co-operation and joint working.

(F) The objective of this Agreement is to improve outcomes for children aged 0 to 19 and their families, through the provision of an integrated service. The service will be known as the 0-19 Healthy Child Service ("**the Service**"). This will be achieved through close working between the NHS and Local Government and which is pursuant to the obligations for the Partners to co-operate with each other in providing such services in accordance with Section 82 of the 2006 Act

(G) The Agreement promotes and implements the joint delivery and support of the Service by bringing together Public Health, Children's Social Care and NHS services. The Partnership Arrangements will allow for more coordinated approaches to the delivery of the Service, leading through shared objectives, coordinated support and joined up oversight. This will enable improved efficiency within the system and better experience and outcomes for people accessing services. The aims and outcomes of the Partners are set out in Clause 3.

(H) The Partners intend to develop their partnership over time and move towards further integration in respect of service provision. Key work streams including looking at further integration of working practices and pathways, co-location of services, integrated data and information systems. The ongoing aim is to ensure that needs and issues are identified early, and the right interventions and support by the right practitioner at the right time and place are implemented. During the Agreement the Partner's

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will continually pursue opportunities for children's services integration, wider partnership working, and integrated provider management approaches.

(I) This Agreement follows consultation jointly by the Partners with such persons as appear to the Partners to be affected by these arrangements and these arrangements contribute to the fulfilment of the objectives set out in the Health Improvement Plan as required under the Regulations.

(J) The Partners are satisfied that the arrangements contemplated by this Agreement are likely to lead to an improvement in the way that their funds and services for children and young people aged 0-19 and their families are managed and delivered.

(K) The Council and the Trust have approved the terms and conditions of this Agreement.

(L) The Partners are entering into this Agreement in exercise of powers referred to in Section 75 of the 2006 Act.

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1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, except where the context otherwise requires, the following expressions shall have the meanings respectively ascribed to them:-

"2000 Act" means the Freedom of Information Act, 2000;

"2006 Act" means the National Health Service Act, 2006;

"Additional Services" means any services that are not included in the Services on the Commencement Date but are subsequently included within the scope of this Agreement by agreement between the Partners in accordance with Clause 35;

"Agreement" means this Agreement, Schedules and Annexes and any variation of it from time to time agreed by the Partners;

"Aims and objectives" means as described in Clause 3 of this Agreement;

"Annual Review" means a review undertaken by the Partners to demonstrate the extent to which the Aims and Objectives have been delivered for each year of the Agreement;

"Authorised Officers" means the person notified by each of the Partners to the other from time to time as authorised to act on behalf of that Partner (which person shall until further notice be for the Council its Commissioning Manager Health and Inclusion and for the Trust its General Manager for North Yorkshire);

"Change in Law" means a change in Law that impacts on the Partnership Arrangements, which comes into force after the Commencement Date;

"Commencement Date" means 1 April 2021;

"Council" means North Yorkshire County Council (and any successor to its statutory function);

"Council Health Related Functions" means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the provision of the Services as further set out in Schedule 2 including in particular the functions under Section 2B and 6C (1) of the 2006 Act;

"Data Controller" has the meaning set out in the Data Protection Legislation;

"Data Protection Legislation" means, for the periods in which they are in force in the United Kingdom, the GDPR, the Data Protection Act 2018, the Electronic Communications Data Protection Directive 2002/58/EC, the Privacy and Electronic Communications (EC Directive) Regulations 2003 and all applicable laws and regulations relating to Processing of Personal Data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner's Office, in each case as amended or substituted from time to time;

"Exit Strategy" means an exit strategy agreed between the Partners within six (6) months of the Commencement of this Agreement;

"Expiry Date" means 31 March 2026;

"Financial Contributions" means the financial contributions of the Partners as set out in Schedule 3;

"Financial Year" means the financial year from 1st April in any year to 31st March in the following calendar year;

"GDPR" means (a) the General Data Protection Regulation (Regulation (EU) 2016/679); and (b) any equivalent legislation amending or replacing the General Data Protection Regulation;

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“Health Improvement Plan” means the local NHS health improvement and modernisation plan which applies to the Trust and any other plan known to incorporate the Aims and Outcomes;

"Healthy Child Programme Board" means the Healthy Child Programme Board (previously named the Shadow Board) which shall be the joint officer group responsible for the review of performance and oversight of this Agreement as set out in the governance arrangements in Schedule 4;

"Information Commissioner’s Office" means the UK's supervisory authority based at Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF;

"Law" means any applicable law (including but not limited to decisions of the European Court of Justice) provision of the EC Treaty, legislation of the European Union, statute, bye-law, regulation, order, regulatory policy, guidance or code of practice (to the extent that such policy, guidance or code is legally binding) rule of court or directions or requirements of any Regulatory Body, delegated or subordinate legislation or notice of any Regulatory Body;

"NHS Functions" means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the Trust as are relevant to the provision of the Services, including in particular those set out in Schedule 2;

"Partners" means the parties to this Agreement and the term “Partner” shall mean either one of them; the term “Partnership” shall be construed accordingly;

“**Partnership Arrangements**” means the arrangements made between the Partners under this Agreement;

"Personal Data" shall have the meaning set out in the Data Protection Legislation;

"Pooled Fund" means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations;

“Public Health Grant” means the ring fenced grant amount determined and paid to the Council by or on behalf of the Secretary of State pursuant to Section 31 of the Local Government Act 2003;

“Quarter” means one of the following periods in each Financial Year:

(a) 1 April to 30 June (quarter one);

(b) 1 July to 30 September (quarter two);

(c) 1 October to 31 December (quarter three); and

(d) 1 January to 31 March (quarter four);

"Regulations" means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 as amended by the Care Act 2014 (Consequential Amendments) (Secondary Legislation) Order, 2015 and other amendments as may be made from time to time;

"Regulatory Body" means a government department and regulatory, statutory and other entities committees and bodies which whether under statute, rules and regulations, codes of practice or otherwise are entitled to regulate or investigate the matters dealt with in this Agreement or any other affairs of either of the Partners;

"Service" means the 0-19 Healthy Child Service as set out in in **Schedule 1** (Service Specification);

“Service Transformation and Improvement Plan” has the meaning set out in Clause 8;

"Service User" means any eligible person receiving or entitled to receive the benefit of the Service;

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"Trust" means the Harrogate and District NHS Foundation Trust (and any successor to its statutory function);

"TUPE" means the Transfer of Undertakings (Protection of Employment Regulations) 2006.

"VAT Guidance" means the guidance published by the Department of Health entitled "VAT arrangements for Joint NHS and Local Authority Initiatives including Disability Equipment Stores and Welfare- Section 31 Health Act 1999" as amended or replaced from time to time.

"**Working Day**" means any day other than Saturday, Sunday, a public or bank holiday in England.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 COMMENCEMENT AND DURATION

2.1 This Agreement will come into force on the Commencement Date.

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2.2 Unless terminated earlier in accordance with Clause 30 or other prior lawful termination and subject to Clauses 2.3 and 2.4, the Agreement will terminate on the Expiry Date.

2.3 The Partners may extend this Agreement for a period of 3 years after the Expiry Date by agreement in writing, subject to approval of the Partners' boards ("**the First Extension**"). Such extension will commence on the day after the Expiry Date.

2.4 The Partners may extend this Agreement for further period of 2 years beyond the First Extension, ("**the Second Extension")** by agreement in written subject to the approval of the Partners' Board. Such extension will commence on the day after the expiry of the First Extension.

2.5 The Partners will aim to enter into discussions 18 months prior to the Expiry of the Agreement and of the First Extension. Any agreement to extend will be formally agreed in writing by the Partners 12 months prior to the Expiry Date or expiry of the First Extension unless otherwise agreed by the Partners.

3 AIMS AND OBJECTIVES

3.1 The Partners have agreed to enter into partnership arrangements as described in this Agreement for the purpose of developing and providing the Service as set out in **Schedule 1**.

3.2 The overall strategic aim of the Service will be to ensure the delivery of high quality services for children and families through joint working across the health and social care system.

3.3 The strategic objectives of the Partnership are:

3.3.1 To ensure the effective and efficient management and delivery of the Service;

3.3.2 Through sharing resources and working in collaboration, to improve service, performance, quality and outcomes for families and children and young people;

3.3.3 To ensure that services are children, young people and family focused, and responsive to identified needs;

3.3.4 To deliver seamless services through effective multi-agency and multi-disciplinary planning, communication and processes;

3.3.5 To ensure value for money and efficient use of resources, maximising income where at all possible and avoiding duplication;

3.3.6 To respond to gaps in service delivery through improved service design, and inform commissioning intentions;

3.3.7 To increase the range of skills, professional and organisational, available for the provision of services and provide a diverse range of learning and development opportunities for staff.

4 PRINCIPLES

4.1 The Partners agree to adopt the following principles when carrying out this Section 75 agreement:

4.1.1 To be openly accountable for performance of the Partners' respective roles and responsibilities set out in this Section 75;

4.1.2 To communicate openly and transparently about major concerns, issues or opportunities relating to the delivery of this Section 75;

4.1.3 To commit to learn, develop and seek to achieve full potential from the Service;

4.1.4 To share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.5 To adopt a positive outlook and behave in a positive, proactive manner;

4.1.6 To act in the best interests of Service Users and their families and to ensure that they are always at the forefront of decision making;

4.1.7 To adhere to statutory requirements and evidence based best practice, complying with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation;

4.1.8 To act in a timely manner, recognising the time-critical nature of the project and to respond accordingly to requests for support;

4.1.9 To act in good faith to support achievement of the key objectives and compliance with these principles; and

4.1.10 To provide coherent, timely and efficient decision-making.

4.2 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of the Services in accordance with the terms of this Agreement.

5.2 The Council agrees that the Trust will exercise the Council's Health Related Functions to the extent necessary for the purposes of performing its obligations under this Agreement in conjunction with the NHS Functions.

5.3 The Councils Health Related Functions that are being exercised under the Agreement by the Trust are further set out in Schedule 2 of this Agreement. The NHS services which the Trust will provide in conjunction with the Council Health Related Functions are set out in Schedule 2 of this Agreement.

6 SERVICES

6.1 The Trust agree to provide the Service in accordance with the Service specification in Schedule 1 and subject to the governance arrangements set out in Schedule 4. The Trust will be responsible for the management and the delivery of the Services under this Agreement.

6.2 The Trust shall ensure that all relevant legislation and statutory guidance in relation to delivery of the Service are complied with and shall manage their staff and the Service in accordance with all such legislation and statutory guidance.

6.3 Other services may be included in the Agreement if they are intended to meet the needs of the Service Users, and where those other services meet the agreed joint Aims and Objectives of the Partners as described in Clause 3, and the Healthy Child Programme Board so determines and any such services which the Partners agree are to be included with the scope of this Section 75 Agreement will require a formal variation to this Agreement in accordance with Clause 35.

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7 STAFFING

7.1 The Trust shall ensure that adequate staff are allocated to the provision of the Service, and that those staff members are competent and able to carry out their duties, including but not limited to, having the appropriate and up-to-date qualifications where applicable to that role.

7.2 Staff remain subject to their respective employer's terms and conditions and employment policies.

7.3 Each Partner will bear responsibility for all costs associated with their directly employed staff, including basic costs of employment and associated non- pay costs including professional indemnity, and costs associated with development and training.

7.4 The Partners may wish to develop/create integrated service functions in the future.

8 SERVICE TRANSFORMATION AND IMPROVEMENT PLAN

8.1 The Partners shall prepare a Service Transformation and Improvement Plan for the Service for the entirety of this Agreement. The Service Transformation and Improvement Plan shall:

8.1.1 set out the agreed Aims and Outcomes for each specific Service and any Additional Services;

8.1.2 describe any changes or development required for the specific Service; and

8.1.3 provide information on how changes in funding or resources may impact the specific Service.

8.2 The Service Transformation and Improvement Plan shall be developed by the Partners within the first six (6) months from the Commencement Date and shall continually be developed throughout the Agreement.

8.3 The Service Transformation and Improvement Plan will be led by the Trust and will involve a collaborative approach with both Partners working together to agree the contents. The Service Transformation and Improvement Plan will be developed with the operational working group and approved by the Healthy Child Programme Board.

8.4 In the event that any agreed changes to the Service Transformation and Improvement Plan results in any increases or reductions in the level of services in the scope of the Agreement, the partners shall vary the Agreement in accordance with Clause 35, and which may require the Partners to make corresponding adjustments to the financial arrangements as set out in Schedule 3 of this Agreement.

8.5 If the Partners cannot agree the contents of the Service Transformation and Improvement Plan, the matter shall be dealt with in accordance with Clauses 29.1 and 29.2. Pending the outcome of the dispute resolution process (without for the avoidance of doubt does not include the mediation process set out in Clauses 29.3 to 29.7 or termination of the Agreement under Clause 31), the Partners shall continue to provide the Service on the same basis as the Services were provided as at the Commencement of this Agreement.

9 PERFORMANCE MANAGEMENT

9.1 The Partners shall adhere to the performance management framework set out in Schedule 5.

10 FINANCIAL ARRANGEMENTS

10.1 The financial arrangements in respect of the delivery of this Agreement shall be as described in Schedule 3, which may be amended from time to time in accordance with Clause 35.

10.2 Each Partner shall pay its own costs and expenses incurred from time to time in the negotiation and management of this Agreement, save as expressly otherwise provided in this Agreement.

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10.3 For the avoidance of doubt, it is not the intention of the Partners through this Agreement to establish a Pooled Fund, although there is nothing in this Agreement that precludes the Partners from doing so if subsequently agreed in accordance with Clause 36. If the Partners do agree to establish a Pooled Fund, the Parties recognise that this Agreement will require amendments to ensure compliance with the Regulations.

11 RISK SHARE, OVERSPENDS AND UNDERSPENDS

Risk Share

11.1 No risk share arrangements shall apply to this Agreement unless otherwise agreed in accordance with Clause 36. For the avoidance of doubt, each Partner shall manage their own risks in respect of their respective financial and resource contribution to the Service as set out in Schedule 3.

11.2 The Partners have agreed that if the Council does not receive an appropriate inflationary increase in its Public Health Grant allocation and therefore is unable to pass such an increase across to the Trust, the position would be managed through dialogue between both Partners, based on the principles of partnership as set out in Clause 4 of this Agreement. An example of where this might arise is the nationally agreed pay award. Any agreement in this regard that require changes to this S75 Agreement will be agreed in in accordance with Clause 36.

Overspends

11.3 Liability for any overspends shall sit with the Trust unless approved in writing by the Council prior to the overspend occurring.

11.4 Notwithstanding the position as set out in Clause 11.1 and 11.3 above, where there is a financial pressure for either Partner, both Partners commit to working collaboratively to discuss how this might be addressed. Partners will work together and flexibly with respect to any overspends and underspends that arise. This could, for example, look at phasing any overspends where appropriate and also balancing off any underspends against non-funded pay costs.

11.5 The Trust shall make the Council aware of any potential overspend as soon as it becomes aware of this possibility. The Trust will confirm reasons for the overspend, both current and projected, and in conjunction with the Council, agree recommendations for action to bring the budget back into balance.

Underspends

11.6 The Trust shall make the Council aware of any potential underspends prior to the end of the Financial Year.

11.7 The benefit of any underspend at the end of the Financial Year will be agreed between the Partners with the intention to reinvest in the Service.

11.8 The benefit of any not already committed underspend (including any redundancy costs) on termination or expiry of this Agreement (whichever is appropriate) shall be repaid in full to the Council.

12 CAPITAL EXPENDITURE

12.1 The Financial Contributions shall be directed exclusively to revenue expenditure. Any arrangements for the sharing of capital expenditure shall be made separately and in accordance with section 256 (or section 76) of the NHS Act 2006 and Directions made thereunder.

13 SET UP COSTS

13.1 Each Partner shall bear its own costs of the establishment of the Partnership Arrangements under this Agreement.

14 PREMISES/NON-FINANCIAL CONTRIBUTIONS

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14.1 As at the Commencement Date the list of the premises owned by the Council from which parts of the Service will be delivered from (the "**Council Premises**") are:

14.1.1 [Please insert]

14.2 The Partners acknowledge that the Council Premises named in Clause 14.1.1 may change by agreement in writing between the Partners.

14.3 The Council will make the Council Premises available to the Trust for the delivery of the Services only. For the avoidance of doubt, the Council Premises cannot be used by the Trust for any other reason other than to deliver the Services as specified in this Agreement.

14.4 The Council will grant a license for the Trust to enter the Council Premises on a non-exclusive basis for the delivery of the Service. Such license will terminate automatically on the termination of this Agreement for any reason. The costs associated with the license fall outside of this Agreement.

14.5 There are no other non-financial contributions by the Partners.

15 GOVERNANCE

15.1 The governance arrangements in respect of this Agreement are as set out in Schedule 4.

15.2 The Trust shall nominate its Authorised Officer, who shall be the main point of contact for the Council and shall be responsible for representing the Trust and liaising with the Council's Authorised Officer in connection with the Partnership Arrangements.

15.3 The Council shall nominate the Council's Authorised Officer, who shall be the main point of contact for the Trust and shall be responsible for representing the Council and liaising with the Trust's Authorised Officer in connection with the Partnership Arrangements.

15.4 The Authorised Officers shall be responsible for taking decisions concerning the Partnership Arrangements on behalf of their respective organisations, unless they indicate that the decision is one that must be referred to their respective boards or Committees. All decisions in respect of this Agreement shall be made by each respective Partner in line with its own Standing Orders and Scheme of Delegation.

15.5 The Partners shall each nominate officers to the Healthy Child Programme Board in accordance with Schedule 4. The Terms of Reference of the Healthy Child Programme Board are set out in Schedule 4 (as amended from time to time by agreement between the Partners).

15.6 The Partners shall each nominate officers to the Healthy Child Programme Operational Group. The terms of reference of the Healthy Child Programme Operational Group are set out in Schedule 4 (as amended from time to time by agreement between the Partners).

16 QUARTERLY REVIEW AND REPORTING

16.1 The Partners shall carry out a quarterly review of the Partnership Arrangements within 30 days of the end of each Quarter. The aim of the review is to identify and consider new issues as have arisen during the Quarter and to address/confirm progress in respect of previously agreed actions.

16.2 The Trust shall submit a quarterly report to the Healthy Child Programme Board setting out:

16.2.1 A summary of new issues/actions arising during the Quarter and a summary of progress against previously agreed actions;

16.2.2 the Service delivery against the agreed outcomes and performance as set out in Schedule 5; and

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16.2.3 an update on the workforce position including key risk and mitigations to the partnership such as staffing capacity, sickness absence and recruitment.

17 ANNUAL REVIEW

17.1 The Partners agree to carry out a review of the Partnership Arrangements within three months of the end of each Financial Year (**Annual Review**), including:

17.1.1 the performance of the Partnership Arrangements against the Aims and Objectives set out in Clause 3 of this Agreement;

17.1.2 the performance of the individual Service against the service levels and other targets contained in the relevant contracts;

17.1.3 plans to address any underperformance in the Services;

17.1.4 actual expenditure compared with agreed budgets, and reasons for and plans to address any actual or potential underspends or overspends;

17.1.5 review of plans and performance levels for the following year; and

17.1.6 plans to respond to any changes in policy or legislation applicable to the Services or the Partnership Arrangements.

17.2 The Trust shall prepare an annual report with input from the Council following the Annual Review for submission to the Trust's board and for Council approval.

18 STANDARDS

18.1 The Partners shall collaborate to ensure that the Partnership Arrangements are discharged in accordance with:

18.1.1 the service standards set out in Schedule 1 and Schedule 6;

18.1.2 the prevailing standards of clinical governance;

18.1.3 the requirements specified by the Care Quality Commission and any other relevant external regulator.

18.2 The Trust shall ensure its operational guidance and procedures reflect compliance with this Clause 18. In particular the Trust shall comply with the North Yorkshire Safeguarding Policy.

18.3 The Trust shall ensure that each employee is appropriately managed and supervised in accordance with all relevant prevailing standards of professional accountability.

19 HEALTH AND SAFETY

19.1 The Trust shall (and shall use reasonable endeavours to ensure its Representatives) comply with the requirements of the Health and Safety at Work etc Act 1974 and any other legislation, orders, regulations and codes of practice relating to health and safety, which may apply to the Service and persons working on the Service.

19.2 The Trust shall ensure that its health and safety policy statement (as required by the Health and Safety at Work etc Act 1974), together with related policies and procedures, are made available to the Council on request.

19.3 The Trust shall notify the Council if any incident occurs in the performance of the Service, where that incident causes any personal injury or damage to property that could give rise to personal injury.

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20 EQUALITY DUTIES

20.1 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance equality of opportunity and foster good relations between different groups.

20.2 The Trust agrees to adopt and apply policies in its carrying out of the Council's Health-Related Functions, to ensure compliance with their equality duties.

20.3 The Trust shall take all reasonable steps to secure the observance of this Clause 20 by all servants, employees or agents of the Trust employed in delivering the Service described in this Agreement.

21 DATA PROTECTION

21.1 The Partners acknowledge that for the purpose of this Agreement, they are each Data Controllers and agree to comply with their obligations under the Data Protection Legislation and abide by Schedule 6 (Information Sharing Agreement).

22 FREEDOM OF INFORMATION ACT AND ENVIRONMENTAL PROTECTION REGULATIONS

22.1 The Partners acknowledge that each of them is subject to obligations under the 2000 Act ("**FOIA**") and the 2004 Regulations.

22.2 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request in relation to this Agreement under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include (but not be limited to) finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any reasonable requests by the Partner receiving a request for comments or other assistance.

22.3 Any and all agreements between the Partners as to confidentiality shall be subject to duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of this Clause 22 if it makes disclosures in accordance with the 2000 Act and/or the 2004 Regulations.

23 CONFIDENTIALITY

23.1 The Partners shall ensure that confidentiality is maintained at all times in all matters relating to the services provided under this Agreement.

23.2 In this Agreement "**Confidential Information**" shall mean any information or data (of whatever nature and however recorded or preserved) of a confidential nature relating to either Partner or its activities or the activities and affairs of its employees, agents, Service Users or relatives, under this Agreement. Save that Confidential Information shall not include information or data that is or becomes:-

23.2.1 generally available to the public otherwise than by reason of breach of the provisions of this Clause;

23.2.2 known to the other Partner and is at its free disposal (having been generated independently by the other Partner or a third party) and not derived directly or indirectly from the Partner's Confidential Information prior to its receipt from the Partner;

23.2.3 subsequently disclosed to the other Partner without obligations of confidence by a third party owing no such obligations to the Partner in respect of that Confidential Information;

23.2.4 required by law to be disclosed;

23.2.5 required by the Local Government Commissioner for England.

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23.3 The Partners agree at all times during the continuance of this Agreement to keep confidential all the other Partner's Confidential Information, and only to share such information to the extent permitted by Law. For avoidance of doubt, this Clause shall not affect the rights of any workers under Section 43 A-L of the Employment Rights Act 1996.

23.4 The Partners hereby warrant that in respect of the Confidential Information of the other Partner (including any person employed or engaged by them in connection with this Agreement) they shall:

23.4.1 only use the other Partner's Confidential Information for the performance of their obligations under this Agreement;

23.4.2 not disclose any of the other Partner's Confidential Information to any third party without the prior written consent of the other Partner;

23.4.3 take all necessary precautions to ensure that all the other Partner's Confidential Information is treated as confidential and not disclosed (save as aforesaid) or used other than for the performance of their obligations under this Agreement by their employees, servants, agents or sub-contractors;

23.5 Nothing in this Clause 23 shall be deemed or construed to prevent either Partner from disclosing any Confidential Information obtained from the other to any employee, consultant, contractor or other person engaged by them in connection herewith, provided that they shall have obtained from the employee, consultant, contractor or other person a signed confidentiality undertaking on substantially the same terms as are contained in this Clause.

23.6 Upon termination or expiry of this Agreement, howsoever occurring, the Partners shall return or destroy at the direction and request of the other Partner all Confidential Information and all notes and memoranda prepared in relation to the Confidential Information, of the other Partner.

23.7 The Partners must ensure that all matters relating to the individual Service User's circumstances are treated as confidential. When information is to be shared with other agencies a Service User consent form will be signed, the form of which shall be agreed between the Partners.

23.8 The provisions of this Clause 23 shall continue to apply notwithstanding termination of this Agreement.

24 OMBUDSMEN AND INVESTIGATIONS BY REGULATORY BODIES

24.1 The Partners shall co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) or any other Regulatory Body in connection with this Agreement.

25 AUDIT

25.1 The Trust shall provide to the Council any reports reasonably required concerning the Health-Related Functions for the purposes of their audit on reasonable notice. The Partners shall agree an annual audit schedule pertaining to elements of the Health Related Functions to determine compliance and quality.

25.2 The Partners shall co-operate in the provision of Information, and access to premises and staff, to ensure compliance with any statutory inspection requirements, or other monitoring or scrutiny functions. The Partners shall implement recommendations arising from these inspections, where appropriate.

26 INDEMNITY AND INSURANCE

26.1 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by National Health Service Resolution) in respect of all potential liabilities arising from this Agreement. Both Partners will seek to recover any losses incurred as a result of the arrangements set out in this Agreement through the insurance arrangements set out in this Clause

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26.1. Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

26.2 Each Partner shall provide to the other upon request such evidence as may reasonably be required to confirm that the insurance arrangements are satisfactory and are in force at all times.

26.3 Except insofar as such loss, damage or injury has been caused by any act or omission by on the part of, or in accordance with the instructions of, the Council, its employees and agents, the Trust (the "**Indemnifying Partner**") shall indemnify the Council, its officers, employees and agents against any damage, cost, liability, loss, claim or proceedings whatsoever arising in respect of:

26.3.1 any damage to property real or personal, including any infringement of third party patents, copyrights and registered designs;

26.3.2 any personal injury including injury resulting in death;

26.3.3 any award or recommendation of compensation payable to a Service User following complaint or investigation by the Health Service Commissioner or Local Government Commissioner for England or any similar entity;

arising following the commencement date of this Agreement out of or in connection with the Service, to the extent such damage, cost, liability, loss, claim or proceedings shall be due directly to any negligent act or omission, fraud or a breach of contract in relation to this Agreement, by the Indemnifying Partner, its officers or employees, any fraudulent or dishonest act of any of its officers, employees or contractors or any breach of statutory or common law duty,

26.4 Under this Agreement neither Party shall be liable to the other for any indirect loss of profit, loss of use, loss of production, loss of business, loss of business opportunity, loss of business revenue, loss of goodwill or any claim for consequential loss or for indirect loss of any nature.

26.5 The indemnity shall not apply to any such claim or proceeding:

26.5.1 unless as soon as reasonably practicable following receipt of notice of such claim or proceeding, the Partner in receipt of that notice shall have notified the other Partner in writing of it and shall, upon the latter's request and at the latter's cost, have permitted the latter to have full care and control of the claim or proceeding, using legal representation approved by the Partner in receipt of that notice, such approval not to be unreasonably withheld or delayed; or

26.5.2 if the Partner in receipt of the notice the claim or proceeding, its employees or agents shall have made any admission in respect of such claim or proceeding or taken any action related to such claim or proceeding prejudicial to the defence of it without the written consent of the other Partner (such consent not to be unreasonably withheld or delayed), provided that this condition shall not be treated as breached by any statement properly made by the former Partner, its employees or agents in connection with the operation of its internal complaints procedures, accident reporting procedures or disciplinary procedures or where such statement is required by Law.

26.6 Each Partner shall keep the other Partner and its legal advisers fully informed of the progress of any such claim or proceeding, will consult fully with the other Partner on the nature of any defence to be advanced and will not settle any such claim or proceeding without the prior written approval of the other Partner (such approval not to be unreasonably withheld).

26.7 The Partners shall use their reasonable endeavours to inform each other promptly of any circumstances reasonably thought likely to give rise to any such claim or proceedings of which they are directly aware and shall keep each other reasonably informed of developments in relation to any such claim or proceeding even where they decide not to make a claim under this Clause 26.

26.8 The Partners shall each give to the other such help as may reasonably be required for the efficient conduct and prompt handling of any claim or proceeding.

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26.9 No Council staff will be transferring to the Trust under the terms of this Agreement. The Council therefore warrants that there are no individuals presently employed by the Council (including, for the avoidance of doubt, the Council's Staff) whose contracts of employment will, by virtue of TUPE, would or could be deemed as employees of the Trust after the Commencement Date.

26.10 No Trust staff will be transferring to the Council under the terms of this Agreement. The Trust therefore warrants that there are no individuals presently employed by the Trust (including, for the avoidance of doubt, the Trust's staff) whose contract of employment will, by virtue to TUPE, would or could be deemed as employees of the Council after the Commencement Date.

26.11 Nothing in this Agreement shall absolve the Council or the Trust of their statutory duties to Service Users or others.

27 LIABILITIES

27.1 Subject to Clauses 27.2 and 27.3, neither Partner shall be liable to the other Partner for claims by third parties arising from any acts or omissions of the other Partner in connection with the Services before the Commencement Date.

27.2 As the Trust is currently providing the Service under separate service agreements (which will terminate prior to the commencement of this Agreement), all rights and liabilities under these existing agreements are preserved.

27.3 Each Partner shall, at all times, take all reasonable steps to minimise and mitigate any loss or damage for which the relevant Partner is entitled to bring a claim against the other Partner under this Agreement.

28 COMPLAINTS

28.1 Complaints, incidents and serious incidents related to the Service will be managed by the organisation from which they originate. If there is a complaint in relation to the provision of the Services, the Trust will investigate and respond to the complaint. If there is a perceived benefit in shared accountability the Partners will together take a decision on which Partner is best placed to lead the appropriate process to investigate and respond.

28.2 Where a complaint cannot be handled in the way described above or relates to the operation of the arrangements made pursuant to this Agreement or the content of this Agreement, then the Authorised Officers, or their nominated deputies will set up a complaints subgroup to examine the complaint and recommend remedies.

28.3 Any dispute or uncertainty about which procedure to follow should be resolved jointly by the Patient Experience Team (Trust) and the Complaints Manager (Council).

28.4 Where the complaint is being brought against both the Trust and the Council, it will be managed within the shortest timeframe of whichever Partner.

28.5 Both parties shall co-operate in the investigation of all complaints and will participate in the complaints resolution process as required.

28.6 Both parties shall co-operate in the investigation of enquiries from elected members of the Council.

28.7 The Trust shall ensure that all Services provided and arrangements for complaints are in accordance with its policy and that of the Equality and Human Rights Commission and all or any policies and procedures approved by the Trust as available through its web site under the 2000 Act.

28.8 During the term of the Agreement, the Partners shall work together to develop closer integration on a range of issues including complaints management.

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28.9 Each Partner shall use their reasonable endeavours to inform the other Partner of any circumstance reasonably thought likely to give rise to a complaint or in which a complaint has been made.

29 DISPUTE RESOLUTION

29.1 The Partners will use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement.

29.2 In the event of a dispute over the application or interpretation of this Agreement, the dispute may be referred by the Partners in writing as follows:

29.2.1 in the first instance to the Authorised Officers or their nominated deputy to resolve through ordinary negotiations within ten (10) days;

29.2.2 in the second instance (if resolution by the Authorised Officers cannot be reached in line with Clause 29.2.1) to, the Healthy Child Programme Board. The members of the Healthy Child Programme Board shall use their best endeavours to resolve such disputes through ordinary negotiations within sixty (60) days;

29.2.3 in the third instance (if resolution by the Healthy Child Programme Board cannot be reached in line with Clause 29.2.2) to, the Chief Executives or relevant Director within each organisation who shall co-operate in good faith to resolve the dispute as amicably as possible within 30 days of service of the notice.

29.3 If the Dispute is not resolved within thirty (30) days following a referral under clause 29.2.3, the Partners shall attempt in good faith to resolve the dispute through the model mediation procedure of the Centre for Effective Dispute Resolution (CEDR).

29.4 If the Partners are unable to agree on the joint appointment of a mediator within five (5) days, they shall make a joint application to CEDR to nominate the mediator.

29.5 The mediator, after consultation with the Partners where appropriate, will:

29.5.1 attend any meetings with either or both of the Partners preceding the mediation, if requested or if the mediator decides this is appropriate and the Partners agree;

29.5.2 read before the mediation each case summary and all the documents sent to him;

29.5.3 chair, and determine the procedure for the mediation;

29.5.4 assist the Partners in drawing up any written settlement agreement; and

29.5.5 abide by the terms of CEDR's model mediation procedure and CEDR's code of conduct for mediators.

29.6 The mediator (and any member of the mediator's firm or company) will not act for either of the Partners individually in connection with the dispute in any capacity during the Term. The Partners accept that in relation to the dispute neither the mediator nor CEDR is an agent of, or acting in any capacity for, either of the Partners. Furthermore, the Partners and the mediator accept that the mediator (unless an employee of CEDR) is acting as an independent contractor and not as an agent or employee of CEDR.

29.7 CEDR, in conjunction with the mediator, will make the necessary arrangements for the mediation including, as necessary:

29.7.1 nominating, and obtaining the agreement of the Partners to, the mediator;

29.7.2 organising a suitable venue and dates;

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29.7.3 organising exchange of the case summaries and documents;

29.7.4 meeting with either or both of the Partners (and the mediator if appointed), either together or separately, to discuss any matters or concerns relating to the mediation; and

29.7.5 general administration in relation to the mediation.

29.8 If there is any issue about the conduct of the mediation upon which the Partners cannot agree within a reasonable time, CEDR will, at the request of either Partner, decide the issue for the Partners, having consulted with them.

29.9 The Partners agree to notify the mediator of any of the relevant timescales which they wish to observe.

29.10 Each Partner will state the names of:

29.10.1 the person(s) who will be the lead negotiator(s) for that Partner, who must have full authority to settle the dispute; and

29.10.2 any other person(s) (such as professional advisers, colleagues or sub-contractors) who will also be present at, and/or participating in, the mediation on that Partner's behalf.

29.11 Each Partner will send to CEDR at least 2 (two) weeks before the mediation, or such other date as may be agreed between the Partners and CEDR, sufficient copies of:

29.11.1 its case summary; and

29.11.2 all the documents to which the case summary refers and any others to which it may want to refer in the mediation.

29.12 In addition, each Partner may send to the mediator (through CEDR) and/or bring to the mediation further documentation which it wishes to disclose in confidence to the mediator but not to the other Partner, clearly stating in writing that such documentation is confidential to the mediator and CEDR.

29.13 The mediator will be responsible for sending a copy of each Partner's case summary and supporting documents (pursuant to clause 23.10) to the other simultaneously.

29.14 The Partners should try to agree:

29.14.1 the maximum number of pages of each case summary; and

29.14.2 a joint set of supporting documents or the maximum length of each set of supporting documents.

29.15 The mediation will take place at the time and place arranged by CEDR.

29.16 The mediator will chair, and determine the procedure at, the mediation.

29.17 No recording or transcript of the mediation will be made.

29.18 If the Partners are unable to reach a settlement in the negotiations at the mediation, and only if both the Partners so request and the mediator agrees, the mediator will produce for the Partners a non-binding recommendation on terms of settlement. This will not attempt to anticipate what a court might order but will set out what the mediator suggest are appropriate settlement terms in all of the circumstances.

29.19 Any settlement reached in the mediation will not be legally binding until it has been reduced to writing and signed by, or on behalf of, the Partners. The mediator will assist the Partners in recording the outcome of the mediation.

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29.20 The mediation will terminate when:

29.20.1 a Partner withdraws from the mediation;

29.20.2 a written settlement agreement is concluded;

29.20.3 the mediator decides that continuing the mediation is unlikely to result in a settlement; or

29.20.4 the mediator decides he should retire for any of the reasons in CEDR's code of conduct.

29.21 Every person involved in the mediation will keep confidential and not use for any collateral or ulterior purpose:

29.21.1 information that the mediation is to take place or has taken place, other than to inform a court dealing with any litigation relating to the dispute of that information; and

29.21.2 all information (whether given orally, in writing or otherwise) arising out of, or in connection with, the mediation including the fact of any settlement and its terms.

29.22 All information (whether oral or documentary and on any media) arising out of, or in connection with, the mediation will be without prejudice, privileged and not admissible as evidence or disclosed in any current or subsequent litigation or other proceedings whatsoever. This does not apply to any information, which would in any event have been admissible or disclosed in any such proceedings.

29.23 Clauses 29.21 and 29.22 shall not apply insofar as any such information is necessary to implement and enforce any settlement agreement arising out of the mediation.

29.24 None of the Partners will call the mediator or CEDR (or any employee, consultant, officer or representative of CEDR) as a witness, consultant, arbitrator or expert in any litigation or other proceedings whatsoever. The mediator and CEDR will not voluntarily act in any such capacity without the written agreement of both the Partners.

29.25 CEDR's fees (which include the mediator's fees) and the other expenses of the mediation will be borne equally by the Partners. Payment of these fees and expenses will be made to CEDR in accordance with its fee schedule and terms and conditions of business.

29.26 Each Partner will bear its own costs and expenses of its participation in the mediation.

29.27 Neither the mediator nor CEDR shall be liable to the Partners for any act or omission in connection with the services provided by them in, or in relation to, the mediation, unless the act or omission is shown to have been in bad faith.

30 TERMINATION

30.1 Without prejudice to other rights and remedies at law, and unless terminated under clause 30.3, either Partner may terminate this Agreement at any time by giving 18 months' written notice to the other Partner.

30.2 The Partners may, without prejudice to any other provision of this Agreement, agree in writing to terminate the Agreement, and if the Partners so agree, they must agree the date upon which termination takes effect.

30.3 Either Partner (for the purposes of this clause 30.2, the **First Partner**) may terminate this Agreement in whole or part with immediate effect by the service of written notice on the other Partner (for the purposes of this clause 30.2, the **Second Partner**) in the following circumstances:

30.3.1 if the Second Partner is in breach of any material obligation under this Agreement, provided that, if the breach is capable of remedy, the First Partner may only terminate this Agreement

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under clause 30.3, if the Second Partner has failed to remedy the breach within 28 days of receipt of notice from the First Partner (**Remediation Notice**) to do so;

30.4 Either Partner may terminate this Agreement in whole or part upon a minimum of 12 months' written notice following a failure to resolve a dispute under Clause 29.

30.5 If there is a Change in Law that prevents either Partner from complying with its obligations under this Agreement or a Change in Law makes provision substantially more onerous, the Partners will discuss the impact on the Services (including any financial impact) and agree a way forward, including whether termination under Clause 30.2 is required.

30.6 The provisions of clause 31 shall apply on termination of this Agreement.

31 CONSEQUENCES OF TERMINATION

31.1 On the termination or expiry of this Agreement, howsoever occurring:

31.1.1 the Partners shall co-operate in good faith in order to terminate this Agreement with as little adverse impact on Services Users and staff as reasonably possible;

31.1.2 the Partners will comply with the Exit Strategy;

31.1.3 premises and assets shall be returned to the contributing Partner in accordance with the terms of their leases, licences or agreed schedule of condition;

31.1.4 any assets purchased in connection with this Agreement/the Services shall be returned to the Partner from whose Financial Contribution the purchase was made;

31.1.5 The Trust shall, at the request of the Council, assign any contracts or parts thereof, which relate to services it performs on behalf of the Council under this Agreement; and

31.1.6 the Trust shall transfer to the Council all records in its possession relating to the Health-Related Functions in accordance with the Data Sharing Agreement at Schedule .

31.2 Overspends on termination of the Agreement shall be dealt with in accordance with Clause 11.2.

31.3 Subject to clause 31.4, underspends on termination of the Agreement shall be dealt with in accordance with Clause 11.5.

31.4 The Trust shall be entitled to direct any underspends to the following purposes:

31.4.1 to meet obligations under existing contracts;

31.4.2 to defray the costs of making any alternative arrangements for Service Users; and

31.4.3 to meet the costs of any redundancies arising from the termination of the Partnership Arrangements.

31.5 The provisions of the following clauses shall survive termination or expiry of this Agreement:

31.5.1 Clause 21;

31.5.2 Clause 22

31.5.3 Clause 23;

31.5.4 Clause 26;

31.5.5 Clause 27;

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31.5.6 Clause 28;

31.5.7 Clause 34; and

31.5.8 Clause 40.

32 PUBLICITY

32.1 No Partner shall issue any press release or any statement containing information relating to or connected with or arising out of this Agreement or the matters contained in it, including information relating to the business or affairs of any other Partner, without obtaining the previous approval of the other Partner such approval to be in relation to its contents and the manner of its presentation and publication or disclosure (such approval not to be unreasonably withheld or delayed).

33 EXCLUSION OF PARTNERSHIP, JOINT VENTURE OR AGENCY

33.1 Nothing in this Agreement shall create a legal partnership as defined under the Partnership Act, 1890 or joint venture between the partners or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

33.2 Neither Partner nor any of its employees or agents will in any circumstances hold itself out to be the servant or agent of the other Partner, except where expressly permitted by this Agreement.

33.3 Save as expressly provided otherwise in the Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner shall in any way whatsoever have authority to, or hold itself out as having authority to:

33.3.1 act as an agent of the other;

33.3.2 make any representations or give any warranties to third parties on behalf of or in respect of the other;

33.3.3 bind the other in any way; or

33.3.4 vary, amend revoke or create any byelaw.

34 PROTECTING CHILDREN AT RISK

34.1 The Partners shall at all times act to safeguard and promote the wellbeing of the Service Users. The protection of children at risk and safeguarding is a priority. A new service safeguarding model, agreed with the North Yorkshire Children Safeguarding Partnership, is in place which describes clearly the role of the Heathy Child Programme within the system in North Yorkshire. There is a dedicated safeguarding team to work across the system, but the Partners recognise that all practitioners have a role to play in protecting children and keeping them safe.

34.2 The Partners shall maintain comprehensive procedures that:

34.2.1 promote the safety and welfare of children and adults at risk; and,

34.2.2 comply with any statutory requirements.

34.3 The Trust shall provide training on safeguarding matters to all Service staff, and they shall require all staff to undertake such training, ensuring they have an understanding of their safeguarding roles and responsibilities to a level that is commensurate with their duties to safeguard adults and children and to meet the competencies outlined in any national framework for safeguarding in accordance with the statutory requirements and government guidance relating to safeguarding adults and children.

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34.4 The Trust shall maintain and keep training records of all such training undertaken by Service staff so as to evidence the staff's attendance and the level of training undertaken. This training should include active encouragement to staff in respect of whistle blowing if they become aware of suspected abuse.

34.5 The Trust shall ensure that the issue of safeguarding of adults and children is included in its induction procedures for all service staff.

34.6 The Trust must ensure that professional boundaries are maintained between service staff and Service Users so that Service Users are safeguarded from any form of abuse or exploitation including physical, financial, psychological and sexual abuse, neglect, discriminatory abuse or self-harm or inhuman or degrading treatment through deliberate intent, negligent acts or omissions or ignorance by the Service staff in accordance with written policies and procedures.

35 VARIATION

35.1 The Partners anticipate that over the lifetime of this Agreement the provisions may need to change in order to support the delivery of the Aims and Objectives and the Service Specification in Schedule 1, which may themselves change from time to time (as agreed between the Partners) to reflect national and local priorities. This Agreement shall not be varied or amended unless such variation or amendment has been agreed in writing and signed by the Partners.

36 ASSIGNMENTS AND SUB-AGREEMENT

36.1 Subject to Clause 36.2 and other than as required by Law, neither Partner shall:

36.1.1 assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partner, which shall not be unreasonably withheld or delayed.

36.1.2 create any interest, charge or security over or deal in any other manner with this Agreement or part of it without the prior written consent of the other and for the avoidance of doubt, a partner shall be absolutely entitled to withhold such consent;

36.1.3 only sub-contract the performance of this Agreement or any part thereof with the prior written consent of the other partner, which consent the other partner shall be absolutely entitled to withhold;

36.1.4 cease to sub-contract if the other Partner in writing withdraws such consent, save that in such event the partner who has so sub-contracted shall be allowed a reasonable period in which to rearrange its affairs of not less than three months; and

36.1.5 consent to sub-contract (if given) shall not relieve the sub-contracting partner from any liability or obligation under this Agreement.

36.2 The Council may assign, novate, or otherwise dispose of its rights and obligations under this Agreement without the consent of the Trust, provided that such assignment, novation or disposal shall not increase the burden of the Trust's obligations under this Agreement and such assignment, novation or disposal is limited to any legal entity with which the Council merges or which is a successor body of the Council by reason of statutory or voluntary reorganisation.

37 INTELLECTUAL PROPERTY

37.1 In this Clause 37 "**Intellectual Property**" shall mean all copyright, patents trademarks, service marks, database rights, design rights (whether registered or unregistered) and all other similar proprietary rights as may exist anywhere in the world.

37.2 The Partners hereby grant each other a royalty free licence with the right to sub-license to use any of existing Intellectual Property of either Partner required for the performance of the other's obligations under this Agreement in accordance with the provisions of this Agreement. Such license and any sub-licence to expire when this Agreement is terminated or expires howsoever occurring. Upon termination

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of the licence each Partner shall return or destroy and procure the return or destruction by any sub-licensee at the direction and request of the other Partner all the other Partner's Intellectual Property.

37.3 Any Intellectual Property that arises solely as a result of this Agreement shall be assigned as follows:

37.3.1 If the Intellectual Property relates to the NHS Functions the rights shall be vested in the Trust;

37.3.2 If the Intellectual Property relates to the Council's Health Related Functions the rights shall be vested in the Trust;

37.3.3 Where any Intellectual Property cannot be so determined as being created either in the exercise of NHS Functions or Health Related Functions ("**Joint Intellectual Property**") then the Joint Intellectual Property shall vest in the Partner in the best position to exploit the Intellectual Property as determined by the Healthy Child Programme Board. The other Partner shall be entitled to be paid royalties at a reasonable rate to be determined by the Healthy Child Programme Board on any commercial exploitation of the Joint Intellectual Property.

37.4 Each Partner hereby grants to the other Partner an irrevocable royalty free license of all Intellectual Property arising in the course of this Agreement, with the right to sub license, to use such Intellectual Property for any purposes the other Partner sees fit, save that where a Partner is receiving royalties from the exploitation of Joint Intellectual Property from the other Partner it shall be entitled to sub-license such Joint Intellectual Property on a commercial basis with the prior consent of the other Partner, such consent not to be unreasonably withheld or delayed.

38 EVIDENCE IN LEGAL PROCEEDINGS

38.1 Each Partner shall if required to do so by the other provide any relevant information in connection with any legal proceedings, internal disciplinary hearing or other hearing arising in connection with this Agreement, save in connection with any proceedings or potential proceedings between the Partners.

38.2 Each Partner shall immediately on becoming aware of any accident, damage or breach of any statutory provision relating to or connected in any way with the Partnership arrangements under this Agreement, notify the other of the said accident, damage or breach.

38.3 Any information or assistance provided by either Partner to the other in accordance with this Clause 38 shall be provided free of charge unless the subject of the proceedings or hearing arose prior to the Commencement Date of this Agreement.

39 ENTIRE AGREEMENT

39.1 The terms herein contained together with the contents of the Schedules and Annexes constitute the complete agreement and understanding between the Partners and supersede all previous communications representations understandings and agreements with respect to the subject matter hereof, and any representation promise or condition not incorporated herein shall not be binding on either Partner.

39.2 Each of the Partners acknowledges and agrees that in entering into this Agreement, and the documents referred to in it, it does not rely on, and shall have no remedy in respect of, any statement, representation, warranty or understanding (whether negligently or innocently made) of any person (whether party to this Agreement or not) other than as expressly set out in this Agreement, excluding fraudulent misrepresentation.

40 FORCE MAJEURE

40.1 In this Agreement, "**Force Majeure**" shall mean any cause preventing either Partner from performing any or all of its obligations which arises from or are attributable to either acts, events, omissions or accidents beyond the reasonable control of the Partner so prevented including act of God, war, riot,

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civil commotion, malicious damage, compliance with any law or governmental order, rule, regulation or direction, accident, breakdown of plant or machinery, fire, flood or storm or war, civil war, armed conflict or terrorist attack, nuclear, chemical or biological contamination or sonic boom.

40.2 If either Partner is prevented or delayed in the performance of any of its obligations under this Agreement by force majeure, that Partner shall forthwith serve notice in writing on the other Partner specifying the nature and extent of the circumstances giving rise to force majeure, and shall, subject to service of such notice and having taken all reasonable steps to avoid such prevention or delay and have no liability in respect of the performance of such of its obligations as are prevented by the force majeure events during the continuation of such events, and for such time after they cease as is necessary for that Partner, using all reasonable endeavours, to recommence its affected operations in order for it to perform its obligations.

40.3 If either Partner is prevented from performance of its obligations, by reason of force majeure, for a continuous period in excess of three months, the other Partner may terminate this Agreement forthwith on service of written notice upon the Partner so prevented, in which case neither Partner shall have any liability to the other except that rights and liabilities which accrued prior to such termination shall continue to subsist.

41 OBSERVANCE OF STATUTORY REQUIREMENTS

41.1 The Partners shall comply and ensure that their employees, agents and sub-contractors shall comply with all the relevant legal provisions, whether in the form of orders, regulations, statutes, statutory instruments, codes of practice, bye laws, directions or governmental guidance or the like, to be performed in connection with this Partnership arrangements under this Agreement.

42 THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT, 1999

42.1 The Contracts (Rights of Third Parties) Act, 1999 shall not apply to this Agreement.

43 WAIVERS

43.1 The failure or delay of either Partner to exercise a right or remedy provided by this Agreement or by law shall not be construed to be a waiver of the right or remedy. A waiver of a breach of any provision of this Agreement or of a default under this Agreement shall not be construed to be a waiver of any other breach or default and shall not affect the terms of this Agreement.

43.2 A waiver of a breach of any terms of this Agreement or a default under this Agreement will not prevent a Partner from subsequently requiring compliance with the waived obligation. The rights and remedies provided by this Agreement are cumulative and (subject as otherwise provided in this Agreement) are not exclusive of any rights or remedies provided by law.

44 NOTICES

44.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 45.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

44.1.1 personally delivered, at the time of delivery;

44.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

44.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

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44.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

44.3 The address for service of notices as referred to in Clause 44.1 shall be as follows unless otherwise notified to the other Partner in writing:

44.3.1 if to the Council, addressed to the Authorised Officer; and

44.3.2 if to the Trust, addressed to the General Manager for North Yorkshire 0-19 Services.

45 SEVERANCE

45.1 If any provision of this Agreement shall be found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this Agreement, which shall remain in full force and effect.

45.2 If any provision of this Agreement is so found to be invalid or unenforceable but would be valid or enforceable if some part of the provision were deleted, the provision in question shall apply with such modifications as may be necessary to make it valid or enforceable.

46 GOVERNING LAW

46.1 This Agreement shall be governed by and construed in all respects in accordance with the laws of England and the Partners submit to the exclusive jurisdiction of the Courts of England.

47 COUNTERPARTS

47.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Parties shall constitute a full original Agreement for all purposes.

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IN WITNESS whereof the Partners Authorised Officers have signed and executed as a Deed and delivered this Agreement on the day and year first before written.

EXECUTION OF AGREEMENT BY THE TRUST
THE COMMON SEAL of Harrogate and District NHS Foundation Trust
Was hereunto affixed in the presence of:

Authorised Signature……..

Name (print)…….

Position……

Date……

Authorised Signature……..

Name (print)…….

Position……

Date……

EXECUTION OF AGREEMENT BY THE COUNCIL

THE COMMON SEAL of North Yorkshire County Council
Was hereunto affixed in the presence of:

Authorised Signature……..

Name (print)…….

Position……

Date……

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SCHEDULE 1– SERVICE SPECIFICATION

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SCHEDULE 2– FUNCTIONS

1 INTRODUCTION

1.1 This Schedule details the Council Health Related Functions and NHS services that are delivered under this Partnership Agreement. This Schedule may be subject to amendment from time to time.

2 COUNCIL HEALTH RELATED CARE FUNCTIONS – 0-5 SERVICE

2.1 The Council delegates its Health Related Functions to the Trust under The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, as amended.

2.2 The Regulations described in paragraph 2.1 above require local authorities to carry out five mandated child development reviews, providing a national, standardised format to ensure universal coverage and ongoing improvements in public health (as set out in Regulation 5A(2) of the Regulations referenced in paragraph 2,1 of this Schedule 2).

2.3 the five mandated reviews are:

2.3.1 the antenatal health promoting visit;

2.3.2 the new baby review;

2.3.3 the six to eight week assessment;

2.3.4 the one year assessment; and

2.3.5 the two to two-and-a-half year review.

3 COUNCIL HEALTH RELATED CARE FUNCTIONS – 6-19 SERVICE

3.1 The Council delegates its Health Related Functions to the Trust under 2006 Act, specifically Schedule 1, paragraph 1 which require local authorities to

"*provide for the medical inspection at appropriate intervals of pupils in attendance at schools maintained by [the local authority] and for the medical treatment of such pupils.*"

4 TRUST NHS FUNCTIONS - 0-5 SERVICE

4.1 The NHS services which the Trust will provide in conjunction with the Council Health Related Functions are:

4.1.1 Specialist children's services (complex health needs and disabilities);

4.1.2 Speech and language therapy;

4.1.3 Acute and community paediatrics;

4.1.4 Specialist safeguarding service for children;

4.1.5 Elective children's surgery; and

4.1.6 Childhood immunisations.

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SCHEDULE 3– FINANCIAL CONTRIBUTIONS

1 FINANCIAL CONTRIBUTIONS

1.1 This Agreement is proposed to continue in force for a period of five years with two potential extensions of three and two years respectively, totalling a maximum of ten years.

1.2 The Council agrees to pay the Financial Contributions to the Trust in respect of the delivery of the Council's Health Related Functions as follows:

	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 - 10
Financial Years	**2021-22 £**	**2022-23 £**	**2023-24 £**	**2024-25 £**	**2025-26 £**	**Years 2026-31 £**
Revised service 0 - 19 after savings applied	**7,611,500**	**7,394,500**	**7,154,500**	**6,884,500**	**6,884,500**	**34,422,500**

1.3 The Financial Contribution for each Financial Year will be paid quarterly in advance. The Trust is not required to issue an invoice.

1.4 Where a change in cost base is outlined within NHS guidance and where this matches the additional allocation provided to the Local Authority in the Public Health Grant, this will be passed on to the Trust in a full and timely manner. Where this causes a financial pressure for either Partner, further discussions will need to occur as set out in Clause 11.4 of this Agreement.

1.5 If the process outlined in paragraph 1.4 above introduces a level of risk to the service, or a financial risk to either or both Partners, the Partners agree to act at the earliest opportunity to understand the potential scale of any shortfall and develop options for how this could be managed. Jointly-developed proposals will be shared with the Healthy Child Programme Board for further development or approval. The Partners agree to use reasonable endeavours to work together to reach a position where there is a good outcome for both Partners, and importantly the children and families this service serves.

2 PREMISES

2.1 Any costs arising out of the Trust's use of Council Premises to provide the Services will be addressed in a separate licence agreement.

3 VAT

3.1 As at the Commencement Date, the Services are exempt from VAT and VAT is therefore not payable in additional to the Financial Contributions.

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SCHEDULE 4– GOVERNANCE STRUCTURE

1 INTRODUCTION

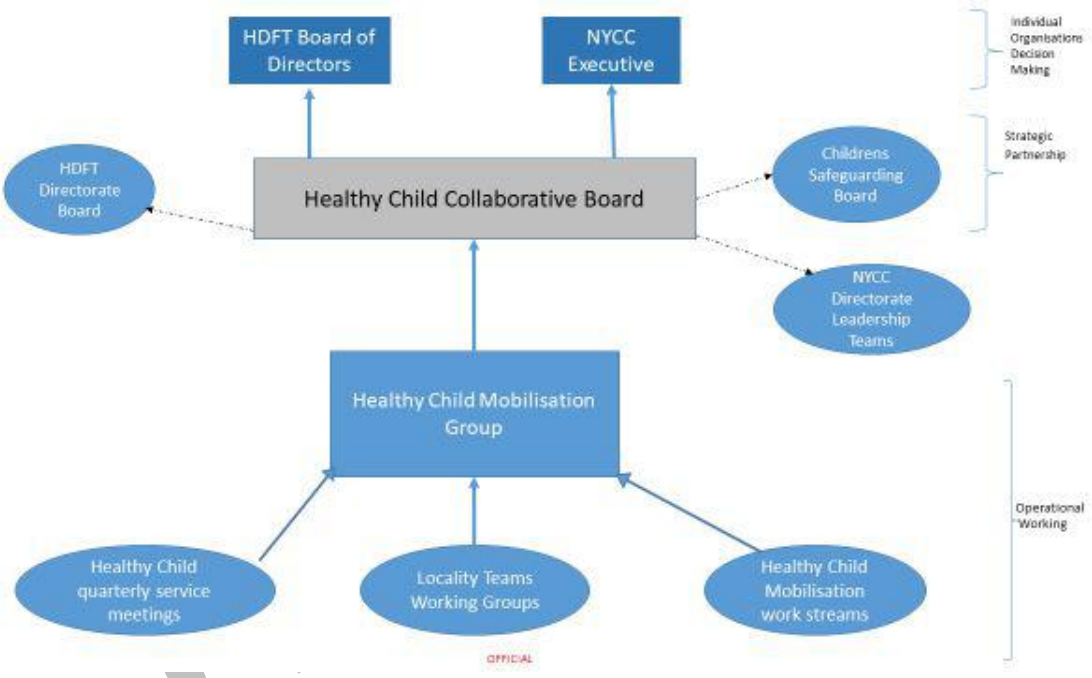
1.1 The purpose of this Schedule 4 is to set out the governance structure for the Partnership Arrangements under this Agreement.

1.2 This Schedule includes the terms of reference of the groups directly involved in the governance of this Agreement and describes those of relevance to it.

2 GOVERNANCE STRUCTURE CHART

2.1 The diagram below illustrates the governance arrangements agreed between the Partners.

PARTNERSHIP GOVERNANCE FRAMEWORK FOR INTEGRATED 0-19 HEALTHY CHILD SERVICE



2.2 Where members of the Healthy Child Programme Board do not have requisite authority to make decisions, they must escalate to the relevant authority holder in line with its own constitution and governance arrangements.

3 TERMS OF REFERENCE

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SCHEDULE 5– PERFORMANCE MANAGEMENT FRAMEWORK

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SCHEDULE 6– INFORMATION SHARING AGREEMENT

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Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	2 December 2020
Date of Board meeting this report is to be presented	27 January 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Dave Stott, Public Governor.
- The Quality Committee has had NIV as an outstanding action since April 2020. This item was a concern about the management of NIV patients in the hospital before COVID. Alternative arrangements were made to manage the patients as a result of COVID and the item was no longer relevant. We will receive more information regarding the management of these patients when normal activity is resumed. The QC is assured that the management of NIV patients has greatly improved and that improvement will be sustained going forward.
- The analysis of complaints had been raised at a previous meeting. The concern was to ensure that all people who used our services had opportunity to raise concerns if it were necessary. We do not currently analyse complaint information by age, gender, disability, ethnicity, or any protected characteristics. The committee agreed that at the present there was no need to do this and therefore have agreed not to request this analysis.
- The committee received a briefing on COVID 19 related issues including the rollout of the vaccine. The Board has been updated on all the issues since the meeting
- The remainder of the meeting was devoted to a new Clinical Governance and Safety framework for the future. This piece of work is being developed by the Medical Director and the Chief Nurse, a wide ranging consultation is taking place. The QC had opportunity to help shape the ideas that will be presented to the board in a future meeting.

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

None to note.

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

No matters for escalation.

Harrogate and District NHS Foundation Trust

Board of Directors Meeting

27 January 2021

Medical Director Report

Agenda Item Number:	**8.1**
Presented for:	Discuss/Note
Report of:	Executive Medical Director
Author (s):	Executive Medical Director
Report History:	none
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to note the contents of this paper.

Board of Directors Meeting

27 January 2021

Medical Director Report

Dr Jacqueline Andrews

1. Executive Summary

This report provides an overview of the work of the Medical Directorate portfolio, identifying current challenges, opportunities and priorities under the following headings:

- *Clinical operations, professional standards and workforce development*
- *Quality Governance (Patient Safety, Clinical Effectiveness and Patient Experience)*
- *Research and Development*
- *Quality Improvement and transformation*
- *Medical Education*
- *Digital and IT Services, including Information Governance*

2. Clinical operations, professional standards and workforce development

I am delighted to confirm that Dr Sarah Sherliker (Consultant Anaesthetist) has been appointed to the role of Deputy Medical Director (Clinical Operations and Workforce) from February 2021. She will play a lead role in working with the Chief Operating Officer and Directorate Teams to perform a review of our clinical services at HDFT to enable us to develop our new clinical services strategy. Key enabling workstreams for this is a number of cross cutting reviews including our medical workforce and job planning models and a review of our acute services pathways and configuration and hospital at night ambition.

3. Quality Governance

Medical Examiner Office HDFT
Following the appointment of Dr Dave Earl, Lead Medical Examiner, we have now also successfully appointed 3 Medical Examiners and a Medical Examiner Officer. These new posts will all be active by March 2021. As well as reviewing our mortality systems and processes, Dr Earl now also leads on the publication of our quarterly Learning from Deaths report, his Q3 report is attached to this paper.

Patient Safety

The team continue to explore options for triangulation of quality governance data and have looked at external packages such as InPhase and Datix as part of the scoping for this work. Future needs are to be considered as part of the quality governance refresh. Alongside this, work is being done to review the Serious Incident process and the standard Terms of Reference have been amended for clarity and ease of use. Data has recently been shared with Directorate colleagues in relation to incident reporting on Datix to help identify ways that learning is shared as close as possible to the event being reported.

Clinical Effectiveness

The current priorities for the Clinical Effectiveness team are: supporting the 80 National and 28 local priority projects on the 2020/21 annual programme, ensuring compliance with the mandatory national audits which form part of the NCAPOP/Quality Accounts, and completing as many local priority projects as possible before the end of Q4. Due to the COVID-19 pandemic, it is likely that a significant number of the 75 local projects from this year's plan will not be completed in year. Planning will soon be underway for the 2021/22 annual programme and we will review with directorate teams what the priorities will be, in view of another year with likely significant disruption due to the continuing COVID pandemic.

The Clinical Effectiveness team are to be congratulated as they are due to receive their silver team accreditation through the HDFT Quality Improvement Academy later this month. They completed a significant package of work to achieve their accreditation, including developing a monthly training and development plan for the team, creating a training package for trainee doctors and other clinical staff and developing products such as a simple Excel Guide. Work has also been undertaken on streamlining various documents to encourage more staff to complete the audit registration, reporting and action planning process. A communication strategy has been developed and various steps taken to raise the profile of the department as well as forge links with external Audit and Improvement Organisations.

4. Research and Development

Urgent public health (UPH) studies for COVID remain a priority and the team are currently recruiting into seven urgent public health studies. This includes the RECOVERY study, which identified the positive impact of dexamethasone on COVID. Treatment with dexamethasone is now firmly embedded in clinical practice within the Trust, ensuring outcomes for patients with COVID are improved. RECOVERY is now examining the impact of convalescent plasma and monoclonal antibodies in 2 of the arms of the study and despite the current pressures, research staff, clinical teams and support services have worked collaboratively to ensure this important study is accommodated within every day clinical practice. The R&I team have also worked with the Y&H Clinical Research Network to secure some additional funds to help support the medical teams with recruitment.

Other COVID research studies being delivered at HDFT include observational studies collecting demographic and outcome data for all COVID positive patients as well as specific subgroups of positive patients including those with a respiratory infection which started in the previous 24hrs, pregnant women, ventilated patients and those with an existing cancer diagnosis. 735 patients have been recruited to date at HDFT into national COVID-19 urgent public health studies, capturing all patients admitted to HDFT with a positive diagnosis.

Staff continued to support a number of non-COVID clinical trials throughout the year to ensure treatment options for HDFT patients was delivered. These included several cancer studies, studies of biological therapies in Rheumatology and Dermatology and also a number of therapeutic studies for diabetic patients. However, the number of commercially funded studies available to recruit into has been significantly lower this year with a resulting negative impact on commercial research income for the Trust.

A number of active research studies have had to be paused due to the COVID pandemic. The national target is to reinstate 80% of the studies previously being delivered. This has been achieved within the Trust. There are now a total of 59 studies

open and recruiting or with participants in follow up. This amounts to 1230 participants supported by research staff.

Skills of the research nursing staff have and are being utilised to support clinical care on the wards whilst also supporting recruitment into UPH studies. Furthermore, research staff with appropriate skills have been identified to support the vaccination programme at HDFT as required.

5. Quality Improvement and Transformation

The co-ordination and delivery of the HDFT cultural programme "At Our Best" continues to be a priority programme for the QI/Transformation team, with a number of colleague panel workshops due to be held later this month and next month as part of the clinical governance workstream. QI training is continuing where it can, with focus being given to those colleagues approaching platinum accreditation, to enable a wider pool of highly trained QI leaders able to function at an independent level throughout the organisation.

I reported in my previous Board paper that HDFT's bid to host our first HEE (Health Education England) Clinical Leadership Fellow was successful. The Future Leaders Programme offers opportunities for Health Education England Yorkshire and the Humber clinical staff to perform a one year Leadership Fellowship to help grow and develop their personal leadership skills. Following competitive interview, I am pleased to report that Darran Miller, Advanced Care Practitioner in Emergency Medicine at HDFT has been successfully appointed into the role. Darran will commence in the role in August 2021 and will join the QI Team in delivering a number of innovation and improvement projects, including a project targeting clinical recruitment processes and culture.

6. Medical Education

In view of the unprecedented strain on the NHS arising from the COVID-19 pandemic NHS England and HEE have stated in a recent letter to Trusts and medical schools that medical students, currently on clinical placements in Acute Trusts, can do paid voluntary work caring for patients whilst on these placements. The letter states that in addition to the time spent in clinical placements, in agreement with the local medical school, medical students can sign up for paid work for up to 12 hours per week to support clinical services. The University of Leeds has asked host Trusts to express interest in this scheme which HDFT has done. We await confirmation if we have been matched with any final year medical students who have signed up to the scheme.
Junior doctors in training continue to play a large role in the care of patients during the COVID pandemic. The Yorkshire and Humber Deanery has stated that Trust Directors of Medical Education can oversee any short term but necessary changes to junior doctor job plans due to the pressures currently being faced by the NHS. At the time of writing, junior doctors at HDFT have not had to alter their out of hours rotas since the 1st wave in March 2020.

7. Digital and IT Services

HDFT have been invited to submit an application to be part of the **Digital Aspirants Programme (DAP)** for 21/22, which if successful, will provide up to £250K of revenue funding to advance the digital maturity of the organisation. The DAP has been established to meet the following national investment objectives:

· Advance the digital maturity of secondary care providers

· Allow Integrated Care Systems (ICS's) to harness technology to help realise their transformation goals

· Enable information to be shared across local healthcare systems, laying the foundations for integrated care

· Catalyse ICS level leadership of the digital agenda at a local level

Investment for Digital Aspirants has been further enhanced by a targeted investment category to support development of provider and ICS strategic digital Business Cases in preparation for applications to a new Frontline Digitisation investment programme. HDFT will hear the outcome of our application shortly.

8. Recommendation

The Board is recommended to approve the contents of the Medical Director report.

Supporting Information

1. Learning from Deaths Report Q3 20/21
2. Guardian of Safe Working Report Q3 20/21

Board of Directors Meeting
27 January 2021
Learning from Deaths Quarterly Report Q3

Agenda Item Number:	**8.1.1**
Presented for:	Discuss/Note
Report of:	Medical Director
Author (s):	Deputy Medical Director
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

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

Board of Directors Meeting

27 January 2021

Learning from Deaths

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the Trust continue to track the national trends

Standardised mortality rates are relatively stable, with the HSMR above average but within the normal range and the SHMI below average (although on an individual month basis, both fall in predicted ranges)

14 Structured judgement reviews have been undertaken since the last LFD report. 12 cases had overall care described as good or excellent. 2 cases related to patients with Learning Difficulties, and an external second review (LeDeR) of these is underway.

Overall Covid-19 death rates in the second wave appear improved from the first, although there are a number of reasons why this may have occurred.

Mortality from patients admitted to Critical Care is in the expected range.

A review into death of patients with Chronic Obstructive Pulmonary Disease (COPD) was undertaken following a previous SHMI alert. This has highlighted a number of learning points but did not find any significant lapses in care.

2.0 Introduction

Covid-19 continues to impact on this reporting period. Not only has the disease itself caused significant mortality in its own right, the necessary modifications in working practices and limitations placed on standard operating and reporting procedures has meant that the content of this report remains reduced compared to pre-pandemic reports. In addition, the date range of some of information provided does not fit easily into standard quarterly reporting. We will continue to review the format of the report to ensure we are providing information is the most meaningful format for all stakeholders.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a longer-term view of Trust mortality rates. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line on the Figure 1). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level, although it would expected that this may change due to the more significant regional variations with the second and third waves of the pandemic.

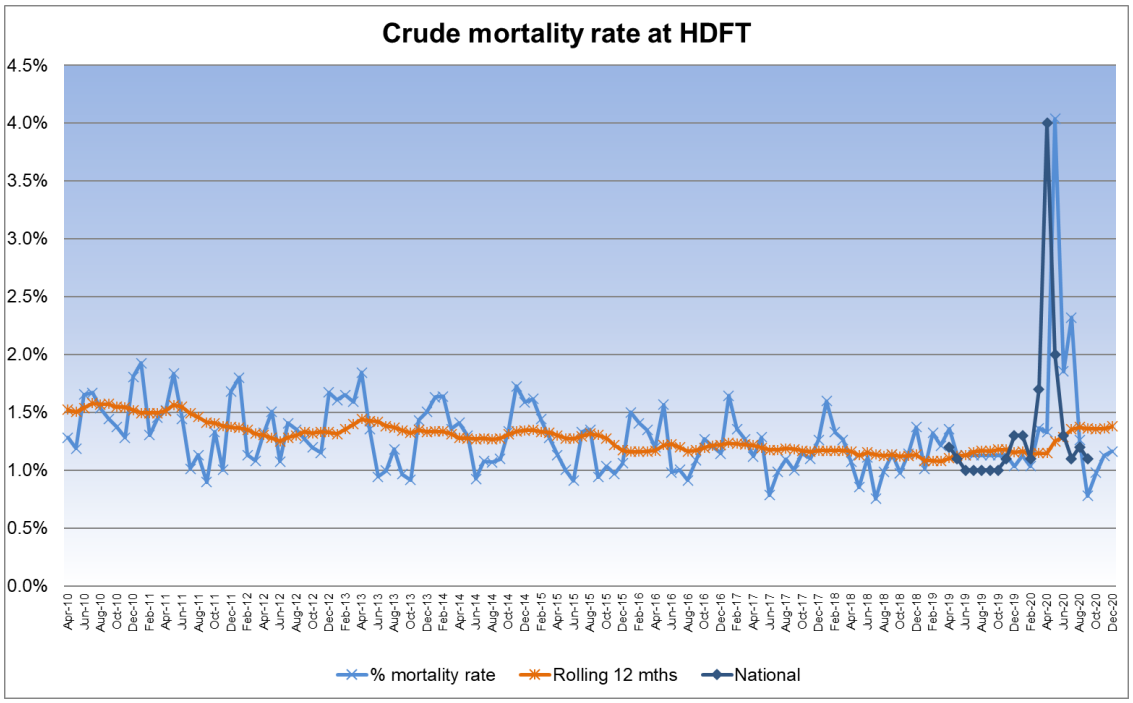


Figure 1: Crude mortality rates over the last 10 years (%deaths per hospital admission)

Standardised Mortality Rates (HSMR and SHMI)

The HSMR (Figure 2) has remained relatively constant for the last 16 months and although at a level of around 105-110% predicted does fall within predicted levels each month. Two specialities have been identified as having a mortality rate above expected levels – Trauma & Orthopaedics and Gastroenterology. Individual case reviews are being undertaken to identify any concerns and future learning opportunities in these specialties, together with 3 deaths from Acute Cerebrovascular Disease (stroke) noted in October as an amber alert (less than 1 was expected). Findings will be provided in the Q4 Learning from Deaths report.

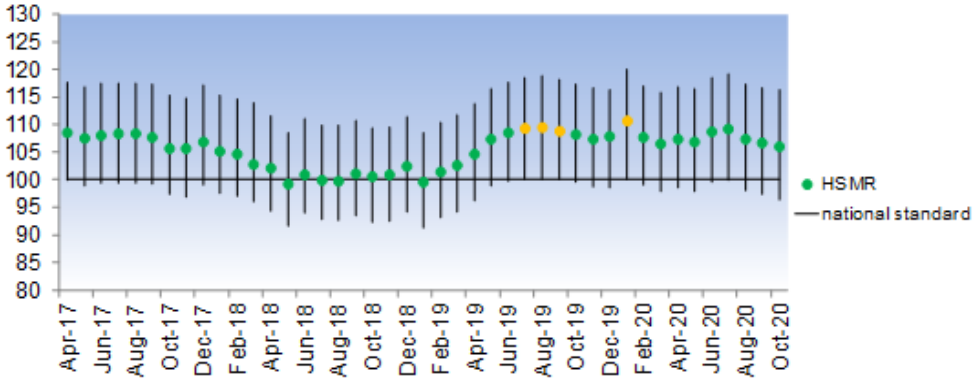


Figure 2: HSMR. Dots show the recorded values with error bars showing possible range of true values. Yellow dots indicate a deteriorating trend which is likely to be significant

The SHMI rates (Figure 3) are also stable, and although consistently below 100% on a monthly analysis they are still within the expected range. Please note that due to modelling difficulties, all Covid-19 related deaths are excluded in the SHMI reporting by NHS Digital.

There have been no highlighted alerts for SHMI between October 2019 and September 2020.

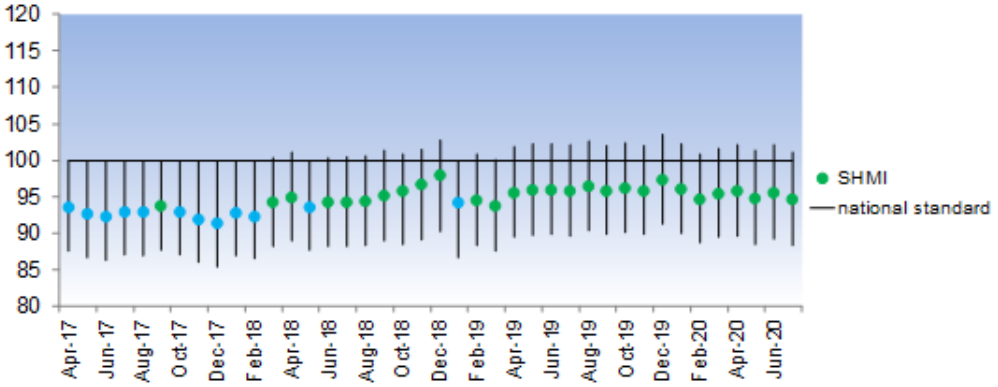


Figure 3: SHMI Dots show the recorded values with error bars showing possible range of true values. Blue dots indicate an improving trend which is likely to be significant

3.2 Structured case reviews

14 cases have been reviewed in this quarter, although it should be noted that a number of the deaths were from the preceding year 19/20. These include 11 in-hospital deaths related to COPD (Chronic Obstructive Pulmonary Disease) which were highlighted in a previous SHMI alert and discussed later in this report.

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

Case ID	Evidence of Learning Difficulties?	Evidence of Serious Mental Health Issue?	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	N	N	4	4	4	4	5
2	Y	N	4	-	3	4	4
3	N	N	5	5	5	5	5
4	N	N	4	4	4	4	5
5	N	N	4	4	5	3	4
6	N	N	3	4	4	4	4
7	N	N	5	4	4	4	4
8	N	N	3	4	5	4	4
9	N	N	5	5	4	4	4
10	N	N	3	5	4	4	4
11	N	N	4	-	4	3	4
12	N	N	5	4	4	5	4
13	N	N	4	4	4	4	4
14	Y	N	5	5	4	5	5
Median Score	-	-	4	4	4	4	4

Table 1: Structured Judgemental Reviews (SJR) conducted in 2020

2 patients were identified as having learning difficulties. They will have a second review conducted as part of the external LeDeR process and their findings reported when available.

3.3 Covid-19 Deaths

Tables below show the hospital's Covid-19 mortality for Q1, 2 and 3 (Q1 was shown in the last report but is reposted in line with the 28 day reporting standard). Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion. The data in the 1st column titled "Total" represents all inpatients with a positive PCR test. The 2nd column "Death within 28 days" refers to deaths that occurred after hospital discharge and is therefore in addition to the in hospital deaths shown in column 3.

Note that the in-hospital mortality in Q1 was 34.9%, as compared to 12.1% and 13.2% in Q2 and Q3 respectively. It would be premature to comment on the exact reasons for this, as a number of factors have changed over this period including earlier referral to hospital services, earlier access to testing in and new therapeutic interventions such as dexamethasone. In addition, there appears to be a slight shift in the age distribution of admissions, with a more even spread from those age 55 and over.

Confirmed Covid-19 inpatient discharges (Apr-Jun 2020)				% (of patients)		% (of deaths)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital	% Death within 28 days	% Death in hospital
6-17	1	0	0	0.0%	0.0%	0.0%	0.0%
18-24	2	0	0	0.0%	0.0%	0.0%	0.0%
25-34	3	0	0	0.0%	0.0%	0.0%	0.0%
35-44	4	0	0	0.0%	0.0%	0.0%	0.0%
45-54	15	0	1	0.0%	6.7%	0.0%	1.4%
55-64	18	0	4	0.0%	22.2%	0.0%	5.4%
65-74	33	0	8	0.0%	24.2%	0.0%	10.8%
75-84	63	4	27	6.3%	42.9%	66.7%	36.5%
85+	73	2	34	2.7%	46.6%	33.3%	45.9%
Total	212	6	74	2.8%	34.9%		

Confirmed Covid-19 inpatient discharges (Jul-Sept 2020)				% (of patients)		% (of deaths)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital	% Death within 28 days	% Death in hospital
6-17	1	0	0	0.0%	0.0%	0.0%	0.0%
18-24	1	0	0	0.0%	0.0%	0.0%	0.0%
25-34	0	0	0			0.0%	0.0%
35-44	1	0	0	0.0%	0.0%	0.0%	0.0%
45-54	2	0	0	0.0%	0.0%	0.0%	0.0%
55-64	3	0	0	0.0%	0.0%	0.0%	0.0%
65-74	2	0	1	0.0%	50.0%	0.0%	25.0%
75-84	14	0	2	0.0%	14.3%	0.0%	50.0%
85+	9	1	1	11.1%	11.1%	100.0%	25.0%
Total	33	1	4	3.0%	12.1%		

Confirmed Covid-19 inpatient discharges (Oct-Dec 2020)				% (of patients)		% (of deaths)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital	% Death within 28 days	% Death in hospital
6-17	1	0	0	0.0%	0.0%	0.0%	0.0%
18-24	3	0	0	0.0%	0.0%	0.0%	0.0%
25-34	10	0	0	0.0%	0.0%	0.0%	0.0%
35-44	9	0	1	0.0%	11.1%	0.0%	3.8%
45-54	24	0	1	0.0%	4.2%	0.0%	3.8%
55-64	38	0	0	0.0%	0.0%	0.0%	0.0%
65-74	31	0	4	0.0%	12.9%	0.0%	15.4%
75-84	42	0	9	0.0%	21.4%	0.0%	34.6%
85+	39	1	11	2.6%	28.2%	100.0%	42.3%
Total	197	1	26	0.5%	13.2%		

Table 2: Covid19 deaths for admissions, either whilst still an inpatient or within 28 days of positive test. Note that "Confirmed Covid-19" relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

3.4 Mortality after Critical Care Admission

Figure 4 shows the risk adjusted hospital mortality for all patients admitted to Critical since 2016 and includes data up to the end of Q2 this year. As the last year only includes 6 months data, the confidence intervals are wider than in previous years. Direct comparisons with other units will be more difficult this year, as in many centres data collection was suspended during surge periods (not the case at HDFT). In addition, some units which opened additional CPAP/NIV areas did not include these patients in their data, whereas the majority of HDFT patients requiring CPAP/NIV have been admitted to Critical Care areas and therefore included in our report.

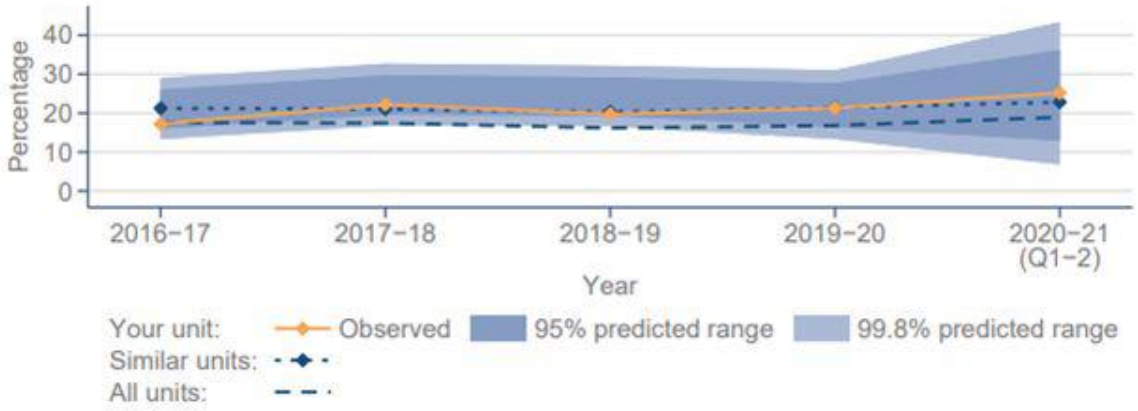


Figure 4: In hospital mortality for all patients admitted to HDFT Critical Care Unit since April 2016. "Similar units" are defined as ones with a similar size and case-mix to ourselves. "All units" will include more specialist units which often have a lower mortality rate (eg. dedicated cardiac surgery units with a predominantly elective caseload)

3.5 Excess Death in Patients with Chronic Obstructive Pulmonary Disease (COPD)

A previous SHMI alert related to excess deaths in patients with COPD, where HDFT had 35 deaths over a 12 month period compared to a predicted 23. 14 casenotes (selected as those with the lowest predicted mortality) were reviewed. A summary of the findings is:

- 3 patients died after discharge. All had severe disease and were on long-term home oxygen
- 5 patient died "with" COPD rather than "of" COPD. These include deaths from unrelated cancer, bowel perforation, sepsis and myocardial infarction
- No cases of poor care were identified, and in all cases death was judged to be unpreventable
- Specific learning points are that although COPD is a common cause for admission, patients with it may still have other pathologies and recognising that when they are short of breath, other conditions need to be considered.

4.0 Future Plans and Learning

Since the last report, the new HDFT Medical Examiner service has begun to review hospital deaths, with a plan to scrutinise all deaths in hospital by the end of January. This should enable earlier, more robust identification of cases for learning and also improve the accuracy of recording cause of death. Additional cases for review will still be identified by HMSR/SHMI triggered alerts and incident reports. Lessons learned and dissemination will be a significant tenet of the proposed continuous learning and improvement system underpinning the Trust's governance structures.

5.0 Recommendation

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

Harrogate and District NHS Foundation Trust

Board of Directors Meeting

27 January 2021

Guardian of Safe Working Hours Report Q2 and Q3 2020/21

Agenda Item Number:	**8.1.2**
Presented for:	Discuss/Note
Report of:	Executive Medical Director
Author (s):	Guardian of Safe Working Hours
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	

Recommendation:
The Board of Directors is asked to receive and note the content of the report.

Board of Directors Meeting

27 January 2021

Guardian of Safe Working Hours Report (Q2/3 2020/21)

1.0 Executive Summary

This is the Thirteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st July to 31st December 2020, which covers two quarters [Q2 and Q3 of 2020/21]. The period of the COVID-19 emergency from 1st April 2020 greatly affects this report.

The orderly stream of quarterly reports was interrupted by the Board's instruction to change the periodicity of written reports to four-monthly intervals. This is out of synchronization with the regional quarterly reporting pattern. The Trust's reports were following alternately in and out of phase with the quarters.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all trainee doctors employed on the 2016 Terms and Conditions of Service (TCS) contract. These have moved to Version 5 of the contract.

46 exception reports have been received from trainees in Q2 (7 in Q1) and 52 in Q3. This is an increase to usual numbers with an increasing trend. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters in General Medicine. There were no reduced educational opportunity exception reports in Q2 but there were 3 in Q3. Exception reporting remains comparatively low in this Trust although highly variable across the region.

There having been no breach of the European Working Time Directive, no fine has yet been levied. National trends in medical post-graduate training and indeed medical workforce numbers overall continue to be adverse.

There has been no regional or national meeting for guardians in the last quarters. Trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue monthly.

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. Trainees were redeployed to medicine and the COVID wards on new 'COVID rotas'. They have responded positively to the experience. Remarkably, no exception reports had been received from 17th March 2020, and in the months of April and May 2020. However, exceptions reports have returned and are increasing in Q2 and Q3.

This is the key quality assurance statement for the Board:

'*The Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates*.'

This statement is qualified by an on-going issue in General Medicine – discussed below.

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce department. There has been no progress with this implementation.

The Guardian has resigned his office from 31st December 2020. The Trust has re-appointed to this role. The post-holder can hold no other managerial office in the Trust and should be independent of management.

2.0 Introduction

This is the thirteenth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data are held in the DRS computer system and are available on request. The DRS application happens to be malfunctioning currently and support has been requested.

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. The quarterly report is a contractual duty upon the employer under the 2016 TCS.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

3.0 High level data

In January 2021

Trainee posts: the position is similar to previous reports. At any time there are rota gaps around 5% in established NHS training posts. These from time to time include maternity and other leave, resigners and vacant posts not filled. The Medical Workforce Department continuously seeks recruitment to vacant posts.

The current position is six gaps (4.9%) of which three posts are in recruitment, two have locum appointments being extended and one has a departmental decision not to fill currently.

Pertinently to issues discussed below, the Foundation Year posts are all recruited and filled.

4.0 Exception reports

Exception reports are individual notifications to the DRS system by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota by more than ½ hour. Exception reports have a time-limited process for response by the Trust. At any one time there may be a few reports awaiting attention by individual clinical supervisors.

Clinical supervisors are in most cases poor at responding to exception reports. This task was dropped on consultants without their agreement by the 2018 Trainees new contract and has never had an enthusiastic response. The Guardian has to review and agree outstanding reports. This role change has been agreed in the V5 Terms and Conditions.

This report presents Quarter 2 & 3: 2020/21

Q2: 1.7.2020-30.9.2020 Exception reports by department: hours/rest				
Specialty[five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	39	39	0
General Surgery	0	7	7	0
TOTAL	0	46	46	0
Q3: 1.10.2020-31.12.2020 Exception reports by department: hours/rest				
Specialty[five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	44	44	0
Trauma & Ortho	0	4	4	0
General Surgery	0	3	3	0
Emergency Medicine	0	1	1	0
TOTAL	0	52	52	0

There were 3 ‘Education’ exception reports in Q3 but none in Q2. Reports are greatly increased on Q1 (7) on the resumption of normal rotas after the initial COVID-19 pandemic emergency.

Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine. [Exception reports are known generally to under-report over-working].

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgment. Clinical supervisors are expected to guide their trainees in efficient working, prioritising clinical activities and making timely hand-overs to over-night teams. The Trust will incur a small cost each month in some hours’ over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is usually over-spent on medical locum costs for consultants and trainees.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees’ employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. Clinical supervisors are intended to respond to each exception report. Despite repeated advice some never do and the report has to be managed by the Guardian. The Guardian has no actual managerial power over individuals in directorates.

Of course, ideal conditions of employment for trainee doctors are one obligation amongst many in the Trust, particularly in periods of winter pressures.

5.0 Work schedule reviews and interventions

5.0a Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No work schedule review has been necessary to date.

5.0b Interventions

There is, however, an increasing trend in exception reports of over-working in Foundation Years 1 and 2 doctors in General Medicine.

The Guardian has raised the issue of over-working in General Medical wards for FY1 and FY2 trainees with the Director of Postgraduate Medical Education. He has raised the issue with consultants in the medical specialties and robust discussions are currently taking place. The consultants rightly say that everyone on medical wards is hard-pressed owing to pressure of work and anxiety arising from the pandemic. However, unlike consultants and nurses, trainee doctors have specific contractual protection against over-working and remedies available to put this right.

The Guardian suggests that isolated cases of over-working are to be expected in emergency conditions. The Trust is grateful for trainees' flexibility on occasion and in ensuring patient safety. However, repeated instances raise the question of whether the rotas and workload are appropriate for the trainees in this specialty. Trainee doctors have responded magnificently to the challenge of COVID – as have all health-care staff – but the Trust is contractually obliged to ensure that the trainees balance their service work with educational opportunity and rest.

The Guardian takes the view that working in a national viral emergency is good professional experience. But the Trust must ensure that the trainees' working hours are not systematically excessive and that health and welfare of trainee doctors is not compromised.

This an on-going problem handed on to the successor Guardian. No sanction is appropriate so far as genuine attempts are made to address over-working.

6.0 Vacancies

The vacancies are not significantly changed at 6 (4.9%) of established training posts. Of six vacancies, three are in recruitment, two have extended locum appointments and one is a 'dormant' post which the Trust has decided not to fill currently.

The Foundation Year posts are fully recruited.

The continual successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but challenged by the availability and willingness of suitable doctors to apply.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

The percentage of vacancies is worse in other Trusts: we are doing relatively well.

The Guardian usually has access to the HR database of trainee doctors which is up-dated monthly.

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. There are about 60 SAS grade doctors in the Trust.

7.0 Fines

The Guardian has the contractual power to penalize departments/directorates for failure to ensure safe working hours and particularly repeated breaches of the Working Time Directive. This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the Guardian of Safe Working Hours' account. A list of items against which the fines have been disbursed should be attached as an appendix.

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive caused by the Trust. Fines have been levied in other trusts in the thousands of pounds.

Working time rules may of course change after BREXIT.

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

8.0 Meetings

The Guardian has had no regional or national meetings to attend in the quarter. There has been a regional meeting of guardians held by MS Teams in September. The general experience across the region has been of trainees rising to the challenge, following the rules for self-isolation and of greatly reduced exception reporting owing to temporary working arrangements.

9.0 Trainees' Forum

Trainees' fora have increased to monthly in the viral pandemic. The importance of exception reporting has been canvassed to the trainees.

It is clear that the COVID-19 emergency has greatly affected post-graduate medical training. Educational opportunities, assessments, course and examinations have been discontinued and the amount of clinical experience in their home specialties has been curtailed. On the other hand, trainees understand that they have participated in front-line service in the national emergency, greatly appreciated by the public at large and educational in its own way. They will each have something impressive to put on application forms and to discuss in future interviews. Some trainees will have delayed completion of examinations and completion of training programmes.

10.0 Disclosure

These regular Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at the regional meeting each time. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. They are sent this whenever they ask.

11.0 Confidentiality

Given that Guardians' reports may be in the public domain, the identities of any sub-specialties, individual doctors and supervisors are concealed in the Guardian's quarterly report. Full data are available to the Board of Directors in private session on request.

12.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in these quarters.

13.0 Inclusion of SAS doctors within the scope of the Guardian

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing responsibility to doctors in training grades, the Guardian will embrace the remaining SAS (non-training, non-consultant grade) doctors within his system and responsibility. Strictly, this has no contractual or statutory basis, but the Trust has agreed – in an exchange of letters with the Medical Director - that it will honour agreements and determinations made by the Guardian as if these doctors were training grade doctors covered by the 2016 TCS V5. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce manager. The workload and IT implications of this change are still to be determined.

14.0 Change of Guardian

The Guardian has resigned his office from 31st December 2020 having taken up a different post in the Trust from 1st January 2021. A new guardian was appointed but has not to date taken up his duties. The out-going Guardian has prepared this expediently report on an acting basis. Naturally, the out-going Guardian will assist in the induction of the new guardian when he takes up his post. All exception reports to date are dealt with.

15.0 Issues arising

a. The Trust continues in comparatively good standing. We had had a below-average rate of exception reporting during the COVID-19 emergency. Exception reports have increased greatly since 1st September 2020.
b. There is an on-going problem of over-working and late finishes for trainee doctors owing to colleagues off sick, rota gaps and pressure of clinical work. This is especially true in General Medicine. The Guardian has raised this formally with the Director of Medical Education who is currently discussing this issue with consultants and managers.
c. Reluctance in trainees to report exceptions exists regionally and nationally.
d. Exception reports are being received and processed.
e. There are gaps in rotas but recruitment is likely for five of six vacancies. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well.
f. No national Guardian meeting has yet been announced for 2021.
g. The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed in principle: the Guardian will discuss implementation of this process with the medical workforce department as becomes possible.
h. The Guardian has resigned his office from 31st December 2020.

16.0 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. One intervention has been necessary this quarter.
c. At the date of reporting, the Board of Directors is assured from the evidence available that:
   i. The exception reporting system is operational for all trainees; they are now all to be converted to 2016 TCS Version 5.

ii. Over-working owing to pressure of work and rota gaps is a chronic problem in General Medicine. This is under active management by the DME and consultants in Medicine.
iii. The Guardian can only intervene on notified problems.
iv. The successor Guardian will continue to attend regional and national meetings.

17.0 Questions for consideration by the Board of Directors

a. The Board is asked to receive the quarterly report of two quarters and to consider the assurances provided by the Guardian.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled. The situation in General Medicine is concerning with the risk of systematic over-working in FY trainees.
c. The Guardian makes no additional request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 4.6 per cent.
e. The Guardian has resigned his office and therefore has been replaced.

Dr Carl Gray
Guardian of Safe Working Hours to 31st December 2020
Report in an acting capacity

Harrogate and District NHS Foundation Trust

Board of Directors Meeting
27 January 2021
Report of the Chief Nurse

Agenda Item Number:	**8.2**
Presented for:	Discuss, Note
Report of:	Chief Nurse
Author (s):	Chief Nurse
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

Recommendation:
The Board is asked to discuss and note this work.

Board of Directors

27 January 2021

Report of the Chief Nurse

1.0 Executive Summary

1.1 The Chief Nurse Portfolio at HDFT includes professional standards and workforce development, clinical governance and risk management (shared with the Medical Director), Director for Infection Prevention and Control, Executive Lead for Adult and Children's Safeguarding, Learning Disabilities and Autism, Executive Lead for Maternity and Children's Services, professional lead for nursing and midwifery education portfolio (from September 2020), Executive Lead for Allied Health Professionals (AHP's), Freedom to Speak Up Lead and Senior Information Risk Owner (SIRO).

1.2 I will be regularly reporting on the following areas of the Chief Nurse portfolio

- Professional standards and workforce development
- Clinical quality and patient safety
    - Infection prevention and control
    - Fundamental care standards
    - Patient Experience
- Adult and Children's Safeguarding
- Nursing, Midwifery and AHP Education

1.3 The other elements of the Chief Nurse portfolio will be reported on as required.

2.0 Introduction

2.1 The Chief Nurse report provides an overview of care quality, activities underpinning care and nursing, midwifery and AHP development. This is particularly important in our continued response to the challenging and evolving COVID -19 pandemic.

2.2 More details of key performance metrics, which are proxy indicators for quality of care, are provided in the Integrated Board report.

2.3 This is a new report style aiming, in conjunction with the Medical Director report, to provide assurance for the quality of care (safety, effectiveness and experience) and professional standards at HDFT.

3.0 Proposal

3.1 To provide a high quality, regular report of the work, performance and strategy of the HDFT Corporate Nursing Directorate, with particular emphasis on the following key areas

- Professional Standards and Workforce Development
- Clinical Quality and Patient Safety
- Adult and Children's Safeguarding
- Nursing, Midwifery and AHP education

4.0 Quality Implications and Clinical Input

4.1 Better clinical engagement within the leadership of HDFT will facilitate our ambition to provide outstanding patient outcomes and experience every time.

5.0 Equality Analysis

5.1 The corporate nursing team are committed to equality, diversity and inclusivity.

6.0 Financial Implications

6.1 The Chief Nurse Directorate has an agreed budget.

7.0 Risks and Mitigating Actions

7.1 There is a robust corporate nursing risk register that feeds into the Corporate Risk Register, monitored by the Corporate Risk Register Group

8.0 Consultation with Partner Organisations

8.1The CN engages with a wide range of internal and external stakeholders to develop work programmes

9.0 Monitoring Performance

9.1 Clinical Quality and Patient Safety

9.1.1 Nursing Workforce Pipeline

9.1.2 Last month the Trust Board received information about substantive nurse staffing levels on the adult in-patient wards as they have been determined to manage the Covid-19 pandemic. Also reported was the number of vacancies for registered nurses (RN) and care support workers (CSW).

9.1.3 As the impact of nursing staff capacity on the quality of care experienced by patients is well documented, it is important for the Board to be informed of the work streams in place to minimise RN vacancies and have zero CSW vacancies.

9.1.4 Currently there are 31 RN's in the pipeline for commencing work in the trust. Of these, there are **9** RN's with agreed start dates before end of March. The remaining **22** RN's are expected to start employment between March and October as they are a combination of students yet to qualify and international recruitments. There are 25.75 CSW's currently in the pipeline to commence work at the Trust.

Current RN vacancies = **35.56 wte**
Current CSW vacancies = **28.22 wte**

9.1.5 Monthly average turnover in WTE is 3 RN's based on information from between January and September 2020. In general, domestic recruitment matches the average monthly turnover.

Adding together the current vacancy rate with an average turnover would suggest that 71 Registered Nurses and Registered Nurse Associates would need to be recruited in 2021 to reach establishment. A range of recruitment methods including local recruitment, Global Learners, UK-based international nurses is essential to reach and maintain establishment.

To note: The NMC is re-opening the temporary register meaning that up to twelve international nurses may fill Registered Nurse vacancies earlier than expected, under supervision.

9.1.6 Local recruitment: Recruitment events continue to take place on a rolling programme (usually monthly) both for the hospital and community. The latest event online on 15th January yielded 14 successful applicants. The event was held on a Saturday and feedback has indicated that this was preferred as opposed to during the week. The next Saturday event is planned for the end of February. The next Community Registered Nurse recruitment event will take place on 9 February

Methods include the use of social media, attendance at university events and a calendar of Trust facilitated recruitment events. The Trust also pays the first year of NMC fees for newly qualified nurses.

9.1.7 Registered Nursing Associates: There are currently two cohorts of Nurse Associates. On successful completion of the programme they are offered a Band 4 Nursing Associate post which replaces a Band 5 RN vacancies on some wards.

9.1.8 Global Learners Programme: Harrogate and District NHS Foundation Trust has worked in partnership with Health Education England's Global Learners Programme (GLP) to develop an effective pathway for internationally qualified RN's to work and complete recognised learning in the NHS in an ethical and sustainable manner.

Since October 2017, the programme has recruited 38 RNs. These nurses have filled 30 vacancies on LTUC and PSC inpatient wards, 6 in theatres and 2 in the Emergency Department. Subsequently two nurses have moved to Endoscopy and one has moved to another Trust. An extended business case for 31 nurses was agreed in January 2019, 27 of these have arrived with 4 nurses due to arrive in 2021.

To note: The NMC is re-opening the temporary register meaning that up to twelve international nurses may fill Registered Nurse vacancies earlier than expected, under supervision.

9.1.9 International Nurse Registration Programme: It is proposed that a new International Nurse Registration Programme (INRP) will support Trust employees who are registered as nurses in another country to gain registration with the NMC. This will enable them to work as band 5 RNs. To gain their Registration, the nurses must complete a process which includes passing an OSCE test. The Trust has already informally helped five international nurses to gain their PIN's and fill band 5 vacancies. The programme continues to demonstrate the Trust's willingness to invest in its employees and allow them to fulfil their potential.

An initial survey of existing HDFT Care Support Workers (CSW) took place in June 2019 and 10 nurses were identified (in addition to the those that have already passed). This programme is a useful recruitment tool as local Trusts do not offer a similar programme.

Unlike, GLP's, many of our CSW have been working in the UK for some time and have their own visa arrangements. International nurses moving from care homes or joining after

university courses may need sponsorship. If sponsorship was required, the directorate would request Vacancy Control to cover the cost.

There will be capacity to provide OSCE training from early 2021 onwards. Over a 12-month period, it is predicted that 10 Registered Nursing vacancies could be filled with INRP's.

9.1.10 Health Education England (HEE) HCSW programme: this is HEE Initiative in partnership with Indeed (. Its aim is to help achieve zero vacancy at health care support worker level. Financial support is being offered to Trust. HDFT has agreed a MoU and the first recruitment webinar hosted by the Trust is planned for 22nd January 2021.

9. 2 Flu Campaign 2020/21

9.2.1 The flu programme planning for 2020/21 aims to achieve 100% (90% for external reporting) for frontline workers and is a 100% offer to all colleagues.

9.2.2 This year's Flu Campaign is expected to be completed nationally by 31st January 2021.

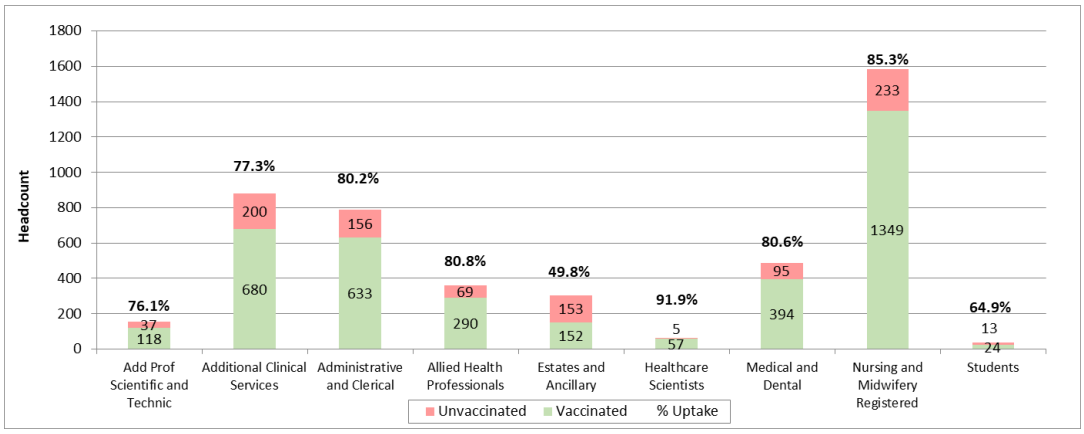
9.2.3 Current position –as 19th January 2021 the number of frontline workers who have received a flu vaccination is 2,973, which is **81.99 %.** The number I reported in November 2020 was 2,083, which was **57.65%.**

9.2.4 Current Position – as of 19th January 2021

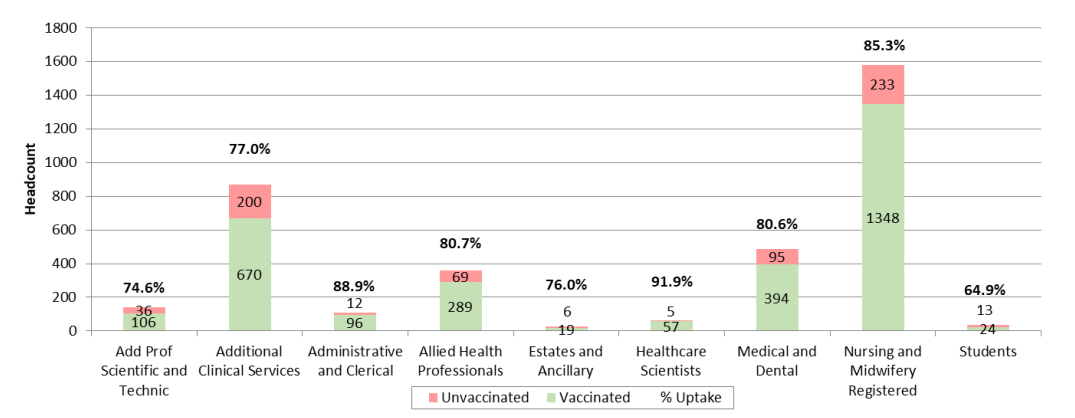
ALL STAFF	**Vaccinated**	**Headcount**	**% Vaccinated**
TRUST TOTAL (Excluding HIF)	3,512	4,322	**81.26%**
TOTAL (Including HIF)	3,697	4,658	**79.37%**

FRONT LINE STAFF	**Vaccinated**	**Headcount**	**% Vaccinated**
TRUST TOTAL (Excluding HIF)	2,973	3,626	**81.99%**
TOTAL (Including HIF)	3,003	3,672	**81.78%**

9.2.5 Flu Vaccination uptake by Staff Group (including HIF)



9.2.6 Flu Vaccination uptake by Staff Group – Frontline Staff (including HIF)



9.2.7 Flu Vaccination uptake by Staff Group (including HIF)

Staff Group	Vaccinated	Unvaccinated	% Uptake	Headcount
Add Prof Scientific and Technic	118	37	76.1%	155
Additional Clinical Services	680	200	77.3%	880
Administrative and Clerical	633	156	80.2%	789
Allied Health Professionals	290	69	80.8%	359
Estates and Ancillary	152	153	49.8%	305
Healthcare Scientists	57	5	91.9%	62
Medical and Dental	394	95	80.6%	489
Nursing and Midwifery Registered	1349	233	85.3%	1582
Students	24	13	64.9%	37

9.2.8 Flu Vaccination uptake by Staff Group – Frontline Staff (including HIF)

Staff Group	Vaccinated	Unvaccinated	% Uptake	Headcount
Add Prof Scientific and Technic	106	36	74.6%	142
Additional Clinical Services	670	200	77.0%	870
Administrative and Clerical	96	12	88.9%	108
Allied Health Professionals	289	69	80.7%	358
Estates and Ancillary	19	6	76.0%	25
Healthcare Scientists	57	5	91.9%	62
Medical and Dental	394	95	80.6%	489
Nursing and Midwifery Registered	1348	233	85.3%	1581
Students	24	13	64.9%	37

9. 2.9 Healthcare Worker Flu Vaccination – Self-Assessment Management Check List. This is a requirement of DHSC, NHSE/I and PHE (letter published 5 August 2020) to be completed and approved by the Trust Board by December 2020. The checklist is live and has been updated throughout the campaign. The Board last saw this checklist in November 2020 when it was almost completed. The checklist is now completed and is a supplementary paper supporting this paper.

9.3 Covid Vaccination Programme

9.3.1 63.58% or 3,106 colleagues have received the first dose of a covid vaccination as of 19th January 2021.

9.3.2 HDH has been declared a hospital hub site and received the first batch of vaccine on 4th January 2021. We are receiving the Pfizer-BioNTec vaccine. We have no ultralow freezer capacity so the vaccine is received in a thawing state. We have five days to use our supply safely.

9.3.3 There are no plans nationally to supply small hospital hub sites with AZ (Oxford) vaccine yet. This vaccine is more transportable and would allow a 'flu vaccination programme' approach to help vaccinate colleagues across the North Yorkshire and North East footprint.

9.3.4 Mutual aid has been sought from hospital hub sites and Primary Care Networks (PCN's) across North Yorkshire and the North East to support colleagues working in these areas to receive the vaccine closer to home. Some colleagues have chosen to attend the hospital site.

9.3.5 Each batch of vaccine can provide between 975 and 1125 doses of vaccines.

9.3.6 As there are a limited number of vaccines per batch, following a discussion at our Ethics Committee and following national guidance at the time, the first batch of vaccine was prioritised. It went to a small number of patients who have been in-patients in the hospital before the PCN's commenced their vaccination programmes and to colleagues, following risk assessment, are deemed to be at a higher risk to the effect of Covid-19 infection.

9.3.7 As we received additional batches of the vaccine and we were confident we had enough clinic spaces, the vaccine has been offered to all colleagues.

9.3.8 In addition, the vaccine has been offered to all non-Electronic Staff Register (ESR) colleagues such as students.

9.3.9 As the national guidance regarding the time elapse between the first and second dose of the vaccine has changed, hospital hubs have been instructed to help vaccinate all health and social care colleagues who do not work in hospital hubs and opportunistically anyone in the national group categories 1 – 4. We are working closely with partners to achieve this.

9.3.10 HDFT Covid Vaccination Campaign as of 19th January 2021

TOTAL COVID VACCINATIONS (OF THOSE IN AT RISK GROUPS)

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	89	160	55.6%
Corporate Services	61	91	67.0%
Long Term and Unscheduled Care	237	350	67.7%
Planned and Surgical Care	196	283	69.3%
Harrogate Healthcare Facilities Management	99	121	81.8%
TOTAL (including HIF)	**682**	**1,005**	**67.9%**

TOTAL COVID VACCINATIONS (OF ALL STAFF)

	# Vaccinated	Headcount of Staff	% Uptake
Childrens and County Wide Community Care	678	1,467	46.2%
Corporate Services	285	431	66.1%
Long Term and Unscheduled Care	1090	1,538	70.9%
Planned and Surgical Care	812	1,096	74.1%
Harrogate Healthcare Facilities Management	241	353	68.3%
TOTAL (including HIF)	**3,106**	**4,885**	**63.6%**

BAME Covid Vaccinations

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	20	43	46.5%
Corporate Services	22	40	55.0%
Long Term and Unscheduled Care	151	227	66.5%
Planned and Surgical Care	117	175	66.9%
Harrogate Healthcare Facilities Management	18	23	78.3%
TOTAL (including HIF)	**328**	**508**	**64.6%**

SHIELDING Covid Vaccinations

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	30	46	65.2%
Corporate Services	10	14	71.4%
Long Term and Unscheduled Care	29	40	72.5%
Planned and Surgical Care	19	28	67.9%
Harrogate Healthcare Facilities Management	8	15	53.3%
TOTAL (including HIF)	**96**	**143**	**67.1%**

AGE Covid Vaccinations (Male 55 and over, Female 65 and over)

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	13	23	56.5%
Corporate Services	27	31	87.1%
Long Term and Unscheduled Care	44	67	65.7%
Planned and Surgical Care	52	65	80.0%
Harrogate Healthcare Facilities Management	78	90	86.7%
TOTAL (including HIF)	**214**	**276**	**77.5%**

PREGNANCY Covid Vaccinations

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	0	7	0
Corporate Services	0	0	#DIV/0!
Long Term and Unscheduled Care	0	7	0
Planned and Surgical Care	0	7	0
Harrogate Healthcare Facilities Management	0	0	#DIV/0!
TOTAL (including HIF)	**0**	**21**	**0**

VULNERABLE Covid Vaccinations (e.g. Diabetic, other conditions)

	# Vaccinated	# At Risk	% Uptake
Childrens and County Wide Community Care	30	50	60.0%
Corporate Services	7	11	63.6%
Long Term and Unscheduled Care	26	27	96.3%
Planned and Surgical Care	18	22	81.8%
Harrogate Healthcare Facilities Management	3	4	75.0%
TOTAL (including HIF)	**84**	**114**	**73.7%**

STAFF GROUPS Covid Vaccinations

	# Vaccinated	Headcount of Staff	% Uptake
Add Prof Scientific and Technic	123	160	76.9%
Additional Clinical Services	572	906	63.1%
Administrative and Clerical	558	836	66.7%
Allied Health Professionals	270	381	70.9%
Estates and Ancillary	213	321	66.4%
Healthcare Scientists	51	63	81.0%
Medical and Dental	309	515	60.0%
Nursing and Midwifery Registered	1002	1666	60.1%
Students	8	37	21.6%
TOTAL (including HIF)	**3,106**	**4,885**	**63.6%**

9.4 Infection Prevention and Control

9.4.1 A zero tolerance approach continues to be taken by the Trust towards all avoidable Healthcare associated infections (HCAIs). We ensure that good IPC practices are applied consistently and are part of our everyday practice meaning that people who use our services receive safe and effective care and the people who work to provide services are safe and protected.

9.4.2 In addition to their usual work the Infection Prevention and Control Team (IPC) are working tirelessly to provide support and advice during the ongoing global pandemic. We have, however, reported a number of outbreaks of Covid -19 infection that are

nosocomial in origin. The number of outbreaks remains small and are well managed by the IPC Team and directorate colleagues

9.4.3 Covid -19 Nosocomial Outbreaks

The only outbreaks the IPCT have identified and managed this year to date are COVID-19 related.

Ward	Date	Status	OCG meetings	Outbreak report
Jervaulx	May	Closed	-	Done
Byland/Jervaulx	July	Closed	-	Done
Granby	November	Closed	23/11/20, 26/11/20	Done
Oakdale	November	Closed	24/11/20, 26/11/20, 7/12/20	Done
Dermatology MDU	December	Closed	7/12/20	Done

9.4.4 In November 2020 NHSE/I issued an Assurance Toolkit for 10 key actions for Infection Prevention and Control Testing and required Trust Board to assure themselves these action were completed and that there is evidence that the actions undertaken are effective.

9.4.5 The small number of covid-19 outbreaks to date is evidence there are good systems of control in place. The completed IPC and Testing Key Action Toolkit is a supplementary paper supporting this report. It is a dynamic toolkit and is reviewed and updated monthly.

9.5 Future Freedom to Speak Up Guardian (FTSUG) Arrangements

9.5.1 The move toward a new model continues to go well. We had 38 expressions of interest, with colleagues from most staff groups represented and a number of colleagues who identify themselves from a Black, Asian or Minority Background. The process of selection has continued with our interim FTSUG's meeting the applicants for a short problem solving exercise to talk through a typical scenario. This part of the selection process has been completed and five colleagues have been recommended by the FTSUG's for consideration as the Lead FTSUG. The interviews for this role is planned for 25th January 2021.

9.5.2 There are a further group of colleagues who wish to be considered for a role as an Associate FTSUG. The selection for these roles will take place after the Lead FTSUG has been appointed.

9.5.3 The interim arrangements continue to work well.

10 Recommendation

10.1 The Board is recommended to approve the content of this report**.**

11 Supporting Information

11.1 The following papers make up and support this report

- IPC and Testing 10 Key Actions Assurance Toolkit
- Healthcare Worker Flu Vaccination – Self Assessment Checklist

Key actions: Infection Prevention and Control Testing: Updated 18/1/21

Organisations

It is the board's responsibility to ensure that:

Key Action	Requirement	Action	Evidence	RAG
1	Staff consistently practice good hand hygiene	Complete	IPCQAT scores	Green
	All high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient	Workstation areas decontamination – instigate "Clinell Clean time" (complete) Non-workstation high touch areas (e.g. door plates/handles). Responsibility of the Domestics team. SOP's have not altered as a result of the pandemic. Adrian Koplinsky to review SOP's and increase the number of times frequently touched surfaces are decontamination (ongoing)	Clinell clean time posters Domestic SOP's when updated	Amber
2	Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.	Complete	Rooms labelled with maximum occupancy Keep left signs in corridors 2m markings in areas where staff need to queue Staggered break times SALUS – non-clinical workplace assessments IPC guidance on intranet HR toolkits / FAQ's on intranet	Green
3	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.	Complete	IPC guidance, Trust COVID-19 page of intranet	Green

			PPE QIP posters IPCQAT scores	
4	Patients are not moved until at least two negative test results are obtained, unless clinically justified.	Not actioned Patients are initially admitted in to a side room. Following clinical assessment and a single SARS-CoV-2 PCR result patients are either managed on a "red" ward if COVID-19 positive or a "yellow" ward if COVID-19 negative. Patients who test negative on admission are then re-screened at day 3 and 5. Patients who test negative on admission but in whom COVID-19 is clinically suspected (NTAP) continue to be managed in a side room and undergo further PCR tests for SARS-CoV-2 before considered suitable for a move to a "Yellow" ward.	IPC guidance, Trust COVID-19 page of intranet.  NTAP LH version 1.docx	Red
5	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.	Set up monthly board assurance review meeting (complete) Daily Siterep sign off process (complete)	Sitrep ICD monthly updates for DIPC	Green
6	Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated.	Purchase of clear plastic curtains for physical segregation in 6 bed patient bays (complete) Ventilation – reliant on maximising fresh air through open windows. Action to have a minimum standard of windows open for 10 minutes every hour (complete)	Curtains in situ Risk assessment for bays increasing from 4 beds to 6 beds. Ventilation – Window opening posters	Green
7	Staff testing: a) Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.	a) complete b) N/A – nosocomial rate is not high.	Data submissions	Green

	b) If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.			
8	Patient testing: a) All patients must be tested at emergency admission, whether or not they have symptoms. B) Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission. c) Those who test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission. d) All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them. e) Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission	a) complete b) complete c) partially complete – awaiting go-live date for ePMA to alert ward staff which patients are due their repeat 3 and 5 day screen. In the meantime the IPC surveillance team continue to manually review inpatient lists and identify those needing repeat screens. However, we know that this process is not robust, only available Monday-Friday and some repeat screens are missed. d) complete NB: PHE guidance changed on 18/12/20 – **5. Discharge to a single occupancy room in a care facility, including nursing homes, residential homes and designated settings:** *"Immunocompetent patients who have tested positive for SARS-CoV-2 by PCR and have already completed their 14-day isolation period, should be exempt from testing prior to hospital discharge within 90 days from their initial illness onset or test, unless they develop new COVID-19 symptoms. In this case, a clinical assessment should be made to determine subsequent onward movement"* https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients#discharge-to-a-single-occupancy-room-in-a-	IPC guidance, Trust COVID-19 page of intranet. ePMA for triggering day 3 and 5 repeat swabs	Amber *Green when ePMA up and running*

		care-facility-including-nursing-homes-residential-homes-and-designated-settings e) complete		

Systems

Local systems must:

9	Assure themselves, with commissioners, that a trusts infection prevention and control interventions (IPC) are optimal, the board assurance is complete and agreed action plans are being delivered	Complete – weekly commissioner led meeting	Minutes of meetings	
10	Review system performance and data, offer peer support and take steps to intervene as required	Complete – weekly commissioner led meeting	Minutes of meetings	

Healthcare Worker Flu Vaccination – Self Assessment Checklist

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Yes
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Completed
A4	Agree on a board champion for flu campaign	Agreed – Jill Foster, Chief Nurse
A5	All board members receive flu vaccination and publicise this	Agreed – almost completed for all Board members
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The Flu team is formed from a multidisciplinary group. It meets daily and the unions receive an update at the partnership meetings
A7	Flu team to meet regularly from September 2020	Flu meetings commence in July meeting weekly. Since the campaign has begun the group has met daily
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Available to all staff vis Trust intranet site
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Will be published via FluTrak system and via Communication Team across all platforms

Healthcare Worker Flu Vaccination – Self Assessment Checklist

B3	Board and senior managers having their vaccinations to be publicised	Will be completed by November 2020
B4	Flu vaccination programme and access to vaccination on induction programmes	Not now necessary. All new colleagues assigned to FluTrak and invited to attend a clinic
B5	Programme to be publicised on screensavers, posters and social media	Flu programme publicised via comms across all platforms.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly feedback to be provided via Flu Trak and disseminated across the organisation
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer Vaccinators identified for each area and have received training materials and are signed off as competent
C2	Schedule for easy access drop in clinics agreed	Complete
C3	Schedule for 24 hour mobile vaccinations to be agreed	Complete
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Complete
D2	Success to be celebrated weekly	Colleagues will be updated on a weekly basis from the end of October – process of obtaining accurate figures of staff groups by wards, departments and teams under discussion – aim to be completed by end of week

Harrogate and District NHS Foundation Trust

Board of Directors Meeting
27 January 2021

Strengthening and Optimising Board Oversight for Maternity and Neonatal Safety

Agenda Item Number:	**8.2.3**
Presented for:	Note/Discuss/Approve
Report of:	Chief Nurse
Author (s):	Clinical Director Planned and Surgical Care, Head of Midwifery, Matron for Maternity Services, Risk Management Midwife
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of nformation Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

Recommendation:

The Board is asked to:

1. discuss and note the contents of this report;
2. approve an internal review of maternity services against the CQC key lines of enquiry; and
3. agree the content/ format of the Board oversight for maternity and neonatal safety as part of the perinatal surveillance model plan.

Strengthening and Optimising Board Oversight for Maternity and Neonatal Safety

CONTENTS

Executive Summary

This report is written in response to the NHS England and NHS Improvement challenge to NHS providers, commissioners and local maternity systems to reflect on whether existing assurance mechanisms for maternity services are effective and ensure that poor care and avoidable deaths with no visibility or learning cannot happen in their organisations.

The report summarises the findings from the Ockenden Review published in 2020 and details the Trust's current position in relation to the immediate and essential actions, compliance with NICE guidance, compliance against the CNST safety actions and a current workforce gap analysis.

The report contains a maternity staffing update in relation to the current challenges to staffing including long term sickness, COVID guidance, vacancies, recruitment and maternity leave.

There is an update on the continuity of carer progress as required by Better Births and this includes a plan to strengthen the home birth service which has been challenged due to staffing issues in recent months.

Information is provided on escalation and diversions in maternity and the plan for review of the process for escalation and its application.

An update on the maternity incentive scheme is provided and it is noted that the submission has been deferred to July 15th 2021.

Information is provided on SIs, HSIB investigations and complaints in maternity over the past two years.

Finally, there is a section on the perinatal surveillance model, which will be the vehicle through which the Board will be asked to strengthen and optimise Board oversight for maternity and neonatal safety.

The Board is asked to approve an internal review of maternity services against the CQC key lines of enquiry and to agree the content/ format of the Board oversight for maternity and neonatal safety as part of the perinatal surveillance model plan.

1. Introduction

Following publication of the Ockenden Review in December 2020, NHS England and NHS Improvement have challenged NHS providers, commissioners and Local Maternity Systems to reflect on whether existing assurance mechanisms for maternity services are effective, and ensure that poor care and avoidable deaths with no visibility or learning cannot happen in their organisations.

The Ockenden Review made seven early recommendations for the wider NHS, labelled 'Immediate and Essential Actions' (IEA) and twelve urgent clinical priorities within these. Trusts have been required to submit compliance with IEA reports to the national maternity team in December 2020 and Boards must implement monthly perinatal quality surveillance against new minimum quality measures and locally collected intelligence from January 2021 (NHS England and NHS Improvement 2020).

This briefing summarises the compliance reporting requirements to the national maternity team (Section 2.2.) and proposed monthly perinatal quality surveillance report and dashboard.

2. Summary of Findings of the Independent Review of Maternity Services at **Shrewsbury and Telford Hospitals NHS Trust**

The independent review of maternity services at Shrewsbury and Telford Hospitals NHS Trust examined maternal and neonatal harm between the years 2000 and 2019. The initial scope of the review focussing on 23 families has been expanded and the experiences of 1,862 families will be included in the final review and report due in 2021. This first report considers the 250 cases reviewed to date.

This initial review included clinical review of 250 cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies

Key Findings:

- Poor governance across a range of areas, leading to a failure to learn from incidents
- Board oversight was compromised by a high turnover of executive leadership impacting organisational knowledge and memory - there was a tendency to regard problems as 'historical' or 'legacy'
- Lack of compassion and kindness by some members of the maternity team
- Poor assessment of risk leading to inappropriate place of birth
- Deficiencies in clinical care and competency in the management of women with complex medical needs
- Failure to recognise the deteriorating woman and appropriately escalate
- Poor fetal monitoring practice and management of labour, especially in respect of oxytocin augmentation; and failure to learn from previous cases

- Use of excessive force during operative vaginal delivery with evidence that obstetricians were not following established local or national guidelines
- Suggestion of reluctance to perform caesarean section and of women's choices in mode of birth not being respected
- Poor bereavement care
- Inadequate obstetric anaesthetic provision – poor obstetric anaesthesia practice, lack of escalation to, and involvement of, senior anaesthetists and limited representation of anaesthetic consultants in incident investigation and MDT meetings after significant incidents

3. NHS England and NHS Improvement Response

Seven early recommendations were made by the Ockenden review team for the wider NHS; these were labelled 'Immediate and Essential Actions' (IEA).

NHS England and NHS Improvement identified 12 urgent clinical priorities from the IEA and set out a reporting schedule for NHS Trusts to confirm compliance with these via the national maternity team.

Table 1 Timescale for Submission of Compliance with IEA to national maternity team

Action	Date	Approval Process/	Status
Submission of compliance with 12 urgent clinical priorities from the IEAs as per letter to Trust Chairs dated 14 December 2020	By 5pm on 21 December 2020	Chief Executive review and sign off	Partial compliance (10 fully compliant and 2 partial)
Complete and take to next public Board an NHS E/I assurance assessment tool which draws together elements including: 1) All 7 'Immediate and Essential Actions' of the Ockenden report, 2)Compliance with NICE guidance 3) Compliance against the CNST safety actions, and 4) A current workforce gap analysis	To be submitted to Regional Maternity Team by 15th February 2021 (moved from 15th January 2021) Next public Board	TBC	In progress
Confirmation that the Trust has a plan in place to meet the Birthrate Plus (BR+) standard including confirming timescales for implementation	Submission to Regional Chief Midwife by 31 January 2021.	Director of Nursing and Quality to review and sign off by 15 January 2021	

3.1 Immediate and Essential Action 1: Enhanced Safety

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

- Clinical change where required must be embedded across Trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

  - ✓ *HDFT bimonthly Maternity Risk Management Group monitor clinical outcomes through incident reporting and review of the local maternity dashboard*
  - ✓ *HDFT's outcomes are recorded on the regional Yorkshire and Humber Dashboard*
  - ✓ *The Y and H dashboard is regularly reviewed at the LMS Board/ clinical expert group*

Further action required:

  - ✓ *Refresh of local maternity dashboard to aid intelligent interpretation of outcomes and direct and monitor quality improvement projects*

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

  - ✓ *Babies meeting the criteria for Each Baby Counts and are referred for investigation by HSIB. These are term babies who sadly die in labour, or suffer a neonatal brain injury or neonatal death*
  - ✓ *Direct and indirect maternal deaths during pregnancy or within 42 days of delivery are referred for investigation by HSIB; other maternal deaths would also be discussed with HSIB (and HSIB investigation undertaken at their discretion)*
  - ✓ *Should HSIB decide not to investigate, internal investigation would be undertaken (SI/SE as required by PESH)*
  - ✓ *All cases referred to HSIB are subject to a local 72-hour report, identifying immediate safety concerns and learning but no further Trust investigation currently occurs for HSIB cases.*
  - ✓ *Pre-term babies who die during, or after, labour or suffer a neonatal brain injury, are not investigated by HSIB - these cases are investigated locally with the level of investigation decided at Trust level*
  - ✓ *There is currently no established system for seeking external clinical specialist opinion within the region (although HDFT has previously engaged external clinical expert opinion on an ad hoc basis at the discretion of the medical director)*

Further Action required:

- ✓ *The Local Maternity System Obstetric clinical leads/ clinical directors are working with the LMS to set up an LMS panel which can support the external clinical specialist opinion mandate*
- ✓ *Given the scope of the recommendation it is likely that additional resource will be required to meet this standard*
- ✓ *It remains unclear whether cases investigated by HSIB also require a full Trust investigation with external specialist opinion – this needs clarification as advice from HSIB has been that the HSIB investigation should be the only investigation undertaken.*

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

- ✓ *All maternity SI reports are seen in full in the private section of the Trust Board meeting.*
- ✓ *Maternity SI reports not routinely shared with the local LMS. However, all HSIB reports have been shared.*

Further Action required:

- ✓ *Process for LMS scrutiny and oversight needs further development and agreement – currently SI reports are not shared.*

3.1.2 Link to maternity safety actions

- Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

- ✓ *All relevant cases are reviewed using the National Perinatal Mortality Review Tool to the required standard. No current cases outstanding.*

Further Action required:

- ✓ *Audit of use of National Perinatal Mortality Review Tool to be undertaken*

- Are you submitting data to the Maternity Services Dataset to the required standard?

  - ✓ *Current CNST Scorecard for submission of MSDS confirms compliance with 11 of 13 criteria (outstanding criteria 3 relates to need to achieve compliance with Information Standards notice by 28th Feb 2021; criteria 4 relates to data submission up to Feb 2021 so will be compliant with this criteria*
  - ✓ *The lack of an up to date maternity information system makes data submission more challenging; data on Personalised Care Plan and Continuity of Carer currently being updated and verified manually*

Further Action required:

- ✓ *Business case for paperless maternity record has been completed and needs approval and implementation*
- ✓ *Trust Board to confirm compliance with the MSDSv2 Information Standards Notice, DCB1513 And 10/2018, by 28 February 2021, or that a locally funded plan is in place to do this, and agreed with the maternity safety champion and the LMS.*

- Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

  - ✓ *Yes, all qualifying cases have been submitted to HSIB.*

3.1.3 Link to urgent clinical priorities

- Develop a plan to implement the Perinatal Clinical Quality Surveillance Model

  - ✓ *The revised perinatal clinical quality surveillance model was published in December 2020 and can be found at: https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf*

Further Action required:

- ✓ *Develop a plan to implement the perinatal clinical quality surveillance model This will be discussed later in this paper in section 3.1.3 and section 10.*

3.2 Immediate and Essential Action 2: Listening to Women and Families

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

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards
- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

✓ *This role does not currently exist*

Further Action required:

✓ *This role needs further definition with roles and responsibilities clearly defined – awaiting further clarification at regional level*

- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

✓ *Andy Papworthm Non-executive Director has been appointed to this role and has attended the first maternity risk management group meeting in January*
✓ *Role descriptor from NHSE/I has been shared with Andy Papworth*

Further action required:

✓ *To agree how the role of non-executive safety champion will work locally and link with the local MVP*

3.2.2 Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard

✓ *Yes.*

Action 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 to coproduce local maternity services?

✓ *Yes*
✓ *Established in 2018 the MVP group consists of a working group of service users, commissioners and providers (midwives and doctors) collaborating to enhance the quality of care within maternity services*

- ✓ *The original service user team have since stepped down from their roles, excluding the chair and new members have recently joined with allocated roles to support the chair*
- ✓ *With terms of reference in place, the Harrogate MVP group have structured quarterly meetings with senior midwives and service providers to co-produce improvements to local maternity service*
- ✓ *Unlike other maternity organisations with a commissioned MVP service, there is no financial remuneration for the MVP chair at Harrogate however; the team do have access to a small fund to use as required, supported by the WY&H LMS*
- ✓ *Throughout 2019 and early 2020 the MVP team visited the maternity unit to complete the '15 steps challenge' and 'walk the patch' to meet with staff in the maternity department to identity improvements to safety, quality and patient experience - the outcome of these visits has been fed back to the relevant departments and teams to implement improvements*
- ✓ *Current work streams for the MVP team include reviewing themes from a recent survey aimed at service user experiences of using maternity services during Covid - this feedback will be used to inform service improvements and developments.*
- ✓ *Other approaches of gathering service user feedback is through different forums such as friends and family, social media, compliments and complaints.*

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

- ✓ *Bimonthly meetings scheduled – and evidenced by TOR and agenda*

3.2.3 Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.

- ✓ *See above under maternity safety action 7*

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

- ✓ *Jill Foster, chief nurse is the Executive Director with specific responsibility for maternity services*
- ✓ *Andy Papworth is the named Non-executive Director*

3.3 Immediate and Essential Action 3: Staff Training and Working Together

3.3.1 Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it
- This evidence must be externally validated through the LMS, 3 times a year

✓ *This is a general principle firmly embedded within the department*
✓ *The approach to multidisciplinary training is described in the maternity training needs analysis and includes all staff groups*
✓ *The pandemic has caused an interruption in the face to face obstetric emergencies training (Prompt) and an online package is now in place with a training schedule in place as specified within the NHS Resolution Maternity Incentive Scheme Covid-amendments.*

Further action required:

✓ *Process for external validation of multidisciplinary training by the WY&H LMS to be developed*

- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward

✓ *Current labour ward consultant sessions run 08:00 – 16:30h Monday to Friday*
✓ *Currently consultant-led and present ward rounds occur Monday – Friday at 08:00h and in the evening prior to the on call consultant leaving the hospital site*
✓ *At the weekend the on call consultant undertakes a ward round at 08:00h and returns to the site in the evening for a second ward round (usually at 20:00h to coincide with the evening handover)*
✓ *The requirement to undertake twice daily ward rounds is detailed in an SOP*

Further action required:

✓ *Although the arrangements above satisfy the requirement for twice daily ward rounds, the evening ward round may occur as early as 16:30h*
✓ *A proposal for lengthening the consultant day time sessions Monday – Friday to 08:00 – 20:30h to provide a ward round at the start of the day and night shift has been agreed by the consultant body – this needs working into a business case*

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only

✓ *To date all external funding for the training of maternity staff has been ring-fenced for maternity services*
✓ *The expectation of the maternity services is that any further funding will be ring-fenced in the same way*

3.3.2 Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

- ✓ *Yes*

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

- ✓ *Not currently as Prompt emergency training has been compromised by COVID-19 pandemic and need for social distancing during training sessions*
- ✓ *Prior to the restrictions of pandemic, this was compliant*
- ✓ *An online training package has been devised and a training schedule written to ensure that at least 90% completion of all staff groups is achieved for compliance with this safety action of the Maternity Incentive Scheme*

3.3.3 Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.

- ✓ *See above*

(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime, we are seeking assurance that a MDT training schedule is in place

- ✓ *See above*

3.4 Immediate and Essential Action 4: Managing Complex Pregnancy

3.4.1 There must be robust pathways in place for managing women with complex pregnancies

- Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre

✓ *Local guidelines are in place for the management of women with complex pregnancy and are available on the intranet*
✓ *The tertiary level Maternity Medicine Centre is in development and a first draft service specification has been shared with CDs across the WY&H LMS*

Further Action required:

✓ *Continued engagement with WY&H LMS maternal medicine centre plans*
✓ *Link criteria for referral within local guidance as agreed*

- Women with complex pregnancies must have a named consultant lead

✓ *All women with complex pregnancies are booked under a consultant*
✓ *First audit of compliance 1st January 2020 showed that 100% of women booked under consultant-led care had a named consultant documented on ICS*

- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

✓ *The Antenatal guideline details booking risk assessment and referral for consultant involvement*
✓ *All women have a personalised care plan within their hand held notes which details a management plan for the pregnancy/ postnatal period*

3.4.2 Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

✓ *General compliance with all five elements of Saving Babies' Lives care bundle Version 2, except one aspect of ultrasound scanning within the Fetal Growth Restriction element.*

Further Action required:

✓ *Business case for Increased Ultrasound Scanning capacity has been completed and needs approval and implementation*
✓ *Training and implementation of assessment of uterine artery Dopplers delayed due to Covid*
✓ *CO monitoring suspended due to Covid-19 restrictions*

3.4.3 Link to urgent clinical priorities:

- All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.

✓ *Compliant*

- Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

✓ *See above*

3.5 Immediate and Essential Action 5: Risk Assessment throughout Pregnancy

3.5.1 Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway

- All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional

  ✓ *SOP in place which details the process for formal risk assessment at every antenatal contact*

- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture

  ✓ *SOP includes ongoing review of intended place of birth based on the developing clinical picture*

Further Action required:

✓ *Documentation of risk assessment relies on staff members recording that this has occurred, even where there is no change to the risk or plan of care*
✓ *Electronic records would improve documentation of risk assessment at each contact and simplify audit – to progress business case for electronic record*

3.5.2 Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

✓ *See above section 3.4.2*

3.5.3 Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.

✓ *See above*

3.6 Immediate and Essential Action 6: Monitoring Fetal Wellbeing

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

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines

- ✓ *Fetal monitoring leads are in place – Professional Development Midwife, Kathy McClune and consultant obstetrician, Mike Critchley*
- ✓ *Weekly fetal monitoring training sessions are in place, supported by both the fetal monitoring leads*

Further Action required:

- ✓ *Job descriptions to reflect roles and responsibilities as above*
- ✓ *Remuneration for consultant lead to be agreed*
- ✓ *Schedule of training activities to be published*

3.6.2 Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

- ✓ *See above section 3.4.2. Fetal monitoring lead 0.4 WTE in place.*

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

- ✓ *Not currently as Prompt emergency training has been compromised by COVID-19 pandemic and need for social distancing*
- ✓ *An online training package has been devised and a training schedule written to ensure that at least 90% compliance is achieved for compliance with the Maternity Incentive Scheme*

3.6.2 Link to urgent clinical priorities:

a) Implement the saving babies' lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

✓ *See above*

3.7 Immediate and Essential Action 7: Informed Consent

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

- ✓ *Although place of birth is discussed with women, clear written information beyond that in the hand held notes is not available*
- ✓ *There is a process for women requesting delivery by caesarean section which is clearly described in the caesarean section clinical guideline but clear written information specifically on maternal choice for caesarean section is not available*
- ✓ *Women who have experienced a previous caesarean birth are given evidence based information via the Birth Choices Proforma and face-face counselling*

Further Action required:

- ✓ *Service to identify suitable written information on place of birth; or devise local information leaflet*
- ✓ *Service to identify suitable written information on caesarean section for maternal choice or devise local leaflet*

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

- ✓ *A variety of patient information leaflets are provided – both locally devised (based on current best evidence) and from the RCOG*

Further Action required:

- ✓ *Service to complete a review of patient information provision and produce a gap analysis*
- ✓ *Review to consider equality of information provision e.g. consider how patient information may be provided in a range of languages*
- ✓ *MVP to be involved in new patient information leaflets and to review existing provision*

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

- ✓ *Shared decision making is embedded in patient pathways e.g. birth choice after caesarean section*
- ✓ *Picker CQC Maternity Survey 2019 indicated 99% of respondents felt "Involved in decisions about your care".*

Further Action required:

- ✓ *Service to work with MVP to design and complete an updated survey on shared decision making and informed choice*
- ✓ *Repeat Picker survey 2021*

Women's choices following a shared and informed decision-making process must be respected

- ✓ *Women's choices are respected and they are encouraged to be involved in shared decision-making, this is not always clearly documented*
- ✓ *Women are encouraged to complete birth plans and to discuss their choices with their named midwives*

Further action required:

- ✓ *As we do not have a maternity electronic system, the WY&H LMS have supplied copies of personalised care plans for women. This will encourage more discussion on choices and decision-making*

3.7.2 Link to Maternity Safety actions:

Action 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 to coproduce local maternity services?

- ✓ *Yes - See 3.2.2 above*

3.7.3 Link to urgent clinical priorities:

a) Every Trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the Trust website. An example of good practice is available on the Chelsea and Westminster website.

- ✓ *See 3.7.1*

3.8 Maternity Workforce Planning

3.8.1 Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard

- ✓ *Clinical workforce planning compliant with Maternity Safety Standards*
- ✓ *Described in Medical Staffing on the Delivery Suite guideline*

Further Action required:

- ✓ *Plan and implement extended daytime consultant cover on Delivery Suite (08:00 – 20:30h)*

Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- ✓ *Regular review of midwifery and MSW establishment occurs and is described in the Minimum Staffing Guideline.*
- ✓ *The service monitors staffing via the Birthrate+ Acuity tool.*
- ✓ *A Maternity escalation policy is in place and each diversion is reviewed by the Matron retrospectively*
- ✓ *Maternity staffing update provided in section 4 of this report*

Further Action required:

- ✓ *A prospective review of midwifery and MSW staffing has been agreed using the information in the Birthrate+ tool*

4. Maternity Staffing Update

This section of the report provides additional information that is not included in the 12 essential and immediate actions from the Ockenden report.

4.1 Maternity Staffing (update)

We currently have reduced midwifery staffing numbers due to the following:

- ✓ Long-term sick = 1.5WTE (x 2 midwives)
- ✓ Midwives non-patient facing = 2.5WTE (x 3 midwives)
- ✓ Vacancies = 5.0WTE
- ✓ Midwives who are pregnant or on maternity leave (14)

Recruitment

The maternity staffing levels are very closely monitored by the matron and team leaders, with vacancy control requests completed early. However, as with other vacancies in the organisation, the notice period is much shorter than the time it takes to complete the recruitment process.

As a service we have never previously had issues with recruitment and the maternity department at Harrogate appears to be an appealing place to work. However, the last advert for band 6 midwives (November 2020) there were five shortlisted candidates but only one attended for interview. Having spoken to other staff within the WY&H LMS, this appears to be the same in other units. We have escalated this as an agenda item for the WY&H LMS workforce group this month for further discussion. Similar issues experienced across the region so an LMS Recruitment campaign being developed.

The posts have been re-advertised, including band 5 midwives as well as band 6. Although we are cautious of the number of newly qualified midwives (band 5s) we recruit and want to ensure that these midwives receive the appropriate level of support during their 18-month preceptorship and enable safe skill mix of midwives on the shifts.

Leavers

Eleven midwives left the department between March and December 2020. The majority of leavers were at band 6 and 7.

Band 7 = 3.6 WTE

Band 6 = 4.1 WTE

Band 5 = 0.8 WTE

The reasons for leaving included promotion, retirement, leaving to work in a maternity unit closer to home and emigrating. There were no common themes.

New starters (includes some maternity leave cover) = 13

Plans going forward to address the reduced midwifery staffing levels

This has been discussed and agreed with Jill Foster, Chief Nurse in early January 2021

- For the senior midwifery team to share a positive message with staff and to share the plan going forwards
- Recent shortlisting for Band 5&6 midwives (7 candidates).
- Keep a band 6 midwife advert on NHS jobs
- Midwife currently on secondment to the Y&H Clinical network returning back to HDFT 0.5WTE mid-January to mid-April
- 1.6WTE midwives already recruited (band 6) – to start mid-February
- 1 retired midwife returning back to work 1 day a week until April
- Current advert out for NHSP midwives (midwives interested in working in Harrogate)
- Consider using agency midwives and to block book individual staff if possible.
- Midwifery applications from overseas – to discuss the organisational process in more detail
- Advert for band 2 Maternity support workers (MSW's) being advertised – ensure we are fully established in this role
- Consider a Registered General Nurse (band 5) for recovery on Elective Caesarean section days if unable to recruit enough midwives. This would release some midwifery hours on these days
- We have agreed a prospective review of the midwifery and MSW establishment and the acuity of the women using the Birthrate + tool and company to do this. There has been no such review for a number of years
- To clarify the advice for pregnant workers > 28 weeks pregnant – whether these members of staff are able to provide direct patient care or not after an individual risk assessment. There is a discrepancy in the advice from the RCM and RCOG as well as between occupational health and HR.

5. Continuity of carer Update (C of C) (Better Births, 2016)

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. This has shown to improve outcomes for both mother and baby. We introduced our first C of C team in February 2019 (Ivy) followed by a second team (Willow) in November 2019. This is a very different way of working for midwives and moves away from the traditional model of working in community or the acute hospital setting, midwives are expected to provide antenatal, intrapartum and postnatal care to a caseload of women. National trajectories were set of percentages of women expected to be on the pathway by March 2020 and March 2021. Due to Covid-19 and the challenges this has presented these trajectories are to aim for but no penalty if not achieved.

The first two teams took a while to implement fully but gradually over the months, the midwives could see the benefit of this model and of this way of working. Unfortunately, the midwifery staffing levels reduced in these teams leading to a complete review of our plans. We planned full implementation of the CofC model for all women living in the Harrogate area from January 2021; we have had to defer this plan and will implement one team case loading (on call) (Wren team). This team will provide care to women from Mowbray Square surgery in Harrogate and the women requesting home birth.

As we launch the Wren team, we are in the process of realigning the remaining community midwifery teams and caseloads resulting in a better number of women on the community midwifery caseloads and in line with contracted hours for each individual midwife. This will result in the introduction of 2 further mixed risk geographical rostered teams and finally the Birth after caesarean team by June.

Once all women in the Harrogate area are on a continuity of care pathway the next phase of this model will be discussions with Leeds Teaching Hospital Trust to implement a model for women who live in the Leeds area and who choose to deliver in Harrogate. We have a significant number of women who do not live in the Harrogate area but choose to deliver in Harrogate, approximately one third of our births.

Number of women delivered and babies born

Year	Mothers delivered	Live Babies born
2018	1801	1817
2019	1763	1776
2020	1726	1750

Births per year (2015-2019) by postcode location

	2015	2016	2017	2018	2019	
HG*	1268	1243	1204	1132	1049	**5896**
LS*	535	513	529	518	542	**2637**
YO*	135	153	124	128	136	**676**
DL*	20	20	18	24	20	**102**
BD*	12	24	21	15	15	**87**
WF*	3	5	1	4	4	**17**
Other	2	8	4	4	6	**24**
	1975	**1966**	**1901**	**1825**	**1772**	**9439**

Home birth service

The home birth service was suspended in August and will be re-introduced from the end of January by the Wren team. The second on call for the home birth service will be provided by the wider community midwifery team. The numbers of women requesting home births is small, on average 1-2 a month.

Risks

We fully acknowledge that having no home birth service has reduced the choice of place of birth for a small number of women and is the reason why we plan to introduce a team of midwives who can support this service going forwards. We hope that having a team of midwives who will promote the service may lead to an increase in the number of requests for home birth. The decision to suspend the service has been discussed in detail with the regional midwifery leads and Harrogate CCG.

6. Maternity escalation and diversions

Maternity service provision can be unpredictable and it is therefore necessary to have a contingency plan for those situations where the safety of mothers and babies may be compromised. There is a maternity escalation and a minimum staffing guideline in place. The decision to close the maternity unit to further admissions and/or the diversion of women to another maternity unit in the region is made by the delivery suite coordinator and the Consultant on session/on call (weekends and nights). During office hours there are senior midwives and specialist midwives who can provide clinical care and assist in this decision-making process.

This decision to close to further admissions and/or diversion of women to other units is made due to:

- Increased workload
- Insufficient staff to provide safe care
- Lack of beds.
- Sickness

Number of women delivered and babies born

Year	Mothers delivered	Live Babies born
2018	1801	1817
2019	1763	1776
2020	1726	1750

Incidents Related to Staffing and Escalation

	Reported Datix incidents related to staffing and escalation						
	Community staff brought in to work in maternity unit	Inadequate Staff for workload	Inadequate staff for workload - community	Inadequate staff for workload - hospital	Escalation to hospital on-call midwifery staff	Suspension of maternity services	Number of women diverted
2017	5	37	0	0	0	5	7
2018	3	16	1	4	1	2	2
2019	3	0	3	7	2	13	6
2020	0	0	3	8	11	24	19
TOTALS	**24**	**153**	**7**	**19**	**14**	**47**	**34**

During the day, there are team leaders and specialist midwives at work who can work clinically if required but this is not available during the night or at the weekend. A datix incident form should be completed for the following reasons;

- The maternity unit is closed to admissions
- When a woman is diverted to another hospital – these women are always sent a letter of apology by the HOM with the opportunity to discuss further if required
- When the hospital midwife has attended

We recognise that the number of times the maternity unit has required escalation and the numbers of women diverted to other units has significantly increased in 2020. This may relate to a number of pressures within the unit:

- The requirement of the Maternity Incentive scheme to have the coordinator acting in a supernumerary capacity
- Change in personnel at band 7
- Focus on one to one care in labour and introduction of Birthrate Plus staffing tool
- Concerns about risk and SIs
- Increase in complexity of clinical work
- Effects of COVID on staffing levels

We are currently reviewing the escalation guideline to ensure that it is fit for purpose and that there is consistent application of the process.

7. Maternity incentive scheme (year 3)

NHS Resolution is operating a third year of the CNST maternity incentive scheme to support the delivery of safer maternity care. The scheme incentivises 10 maternity safety actions. Trusts are expected to demonstrate that they have achieved full compliance with all elements of the 10 safety actions and if fully compliant with each safety action they will recover the element of their contribution relating to the CNST maternity incentive fund, and may also share some of the unallocated funds. The Trust Board have to be satisfied that the evidence provided demonstrates full compliance with the 10 maternity safety actions. The safety actions involved in the scheme include:

- The use of the perinatal mortality review tool for all perinatal deaths
- Submission of data to the Maternity Services Data Set (MSDS),
- Demonstration of a transitional care model to reduce term baby admissions into neonatal units
- Effective systems for midwifery and medical workforce (2 safety actions)
- Compliance with Saving babies Lives care bundle (version 2)
- Demonstration of a mechanism for gathering service user feedback and working with a local maternity Voice Partnership (MVP) to coproduce local maternity services
- Demonstration of multi-disciplinary staff training
- Demonstration of a maternity safety champions within the service and at Trust Board level
- Reporting of incidents under NHS Resolutions Early Notification scheme.

HDFT compliance with the 10 maternity safety actions in the last 3 years:

Year 1 (2018/19)	Compliance with 5/10 safety actions
Year 2 (2019/20)	Full compliance with all 10 safety actions
Year 3 (2020/21)	Evidence due for submission 15th July 2021

Due to Covid-19, the submission date for evidence this year has been deferred twice and now is set for July 15th 2021. The maternity team are currently working hard to ensure evidence is collected and ready for submission with staff identified to lead on each of the 10 maternity safety actions and regular meetings planned to discuss progress, evidence and support if required. Our plan is to ensure the Trust Board are regularly updated on progress against the 10 maternity safety actions.

In section 3 above the maternity safety actions that link with the immediate and essential actions are cross referenced as required by the assurance tool.

8. Significant Incidents (SI)

Between 1st January 2019 and 15th December 2020 there have been five incidents reported as SI.

9. HSIB investigations

The Healthcare Safety Investigation Branch (HSIB) conducts independent investigations of patient safety concerns and make independent judgements in NHS-funded care across England. Investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations made aim to improve healthcare systems and processes in order to reduce risk and improve safety. From 1 April 2018, HSIB became responsible for all patient safety investigations of maternity incidents occurring in the NHS, which meet the criteria for the Each Baby Counts programme.

The purpose of this programme is to achieve rapid learning and improvement in maternity services, and to identify common themes that offer opportunity for system-wide change. For these incidents, HSIB's investigation replaces the local investigation, although the NHS Trust remains responsible for Duty of Candour and for referring the incident to HSIB. HSIB work closely with parents and families, healthcare staff and organisations during an investigation.

Between 1st January 2019 and 15th December 2020 there have been six incidents reported to HSIB.

10. Complaints

Between 1st January 2019 and 15th December 2020 there have been 16 complaints (2 green, 14 yellow).

11. NICE Compliance

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the Trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Compliance Documents and Baseline Assessment Tool maintained by Clinical Effectiveness Department. Compliance with NICE guidelines and Quality Standards reviewed and benchmarked. Action plans developed to address any areas of non-compliance, or justification and risk assessment made where compliance is not possible	Formal benchmarking and compliance undertaken at request of Clinical Effectiveness Department, following national guideline updates or issued Quality Standards. Clinical guidelines reviewed against national guidance (both NICE and RCOG), on standard 3 year review schedule or more frequently when new regional or national guidance is issued, new evidence, or in response to clinical findings/incidents.	All guidelines circulated amongst midwifery, obstetric, and neonatal specialist clinicians, and ratified through the Maternity Risk Management Group (MRMG) (governance). Where possible local guidelines are based upon national recommendations or approved pathways. Guidelines reviewed and updated on ongoing basis to maintain compliance with best evidence. Guidelines shared routinely with other Trusts and across the Local Maternity system (LMS) in effort to standardise best care.	Work ongoing to develop regionally applicable guidelines across the Local Maternity System (LMS), to ensure consistent management. LMS-wide guidelines developed through an approved Guideline Development working group. Update of local guidelines to continue according to schedule.	LMS-wide guidelines being continually brought into alignment on ongoing basis. Other local guidelines allocated for review and update by appropriate clinicians	Appropriate time dedicated to guideline review and participation in LMS Guideline working group	Continue to monitor guideline status through MRMG and allocate as priority

12. Perinatal Surveillance Model

The following is taken from 'Implementing a Perinatal Surveillance Model' published by NHSI/E in December 2020 and available at: https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

Principle 1 – Strengthening Trust-level oversight for quality

Since 2017 all Trust Boards have been required to have a Board-level safety champion, whose remit is to bring together a range of internal sources of insight to provide strategic oversight and leadership for perinatal safety. However, insight gathered from a range of system partners suggests that Trust Board oversight of perinatal clinical quality in provider organisations remains variable. Reasons for this include:

- *perinatal clinical quality is not always reviewed regularly and methodically, using a consistent set of data and information*
- *variable understanding of maternity services on the part of Board members*
- *variable effectiveness in different models of safety champion*
- *challenges representing perinatal clinical quality in a context of competing priorities.*

We are therefore setting out six requirements to strengthen and optimise Board oversight for maternity and neonatal safety:

1. To appoint a non-executive director to work alongside the Board-level perinatal safety champion to provide objective, external challenge and enquiry.

2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.

3. That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to HSIB.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.

5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need.

6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

A range of further support measures are under consideration, including safety culture leadership training, access to a Trust-level dashboard and access to an NHS Resolution developed annual maternity Trust claims scorecard to help target interventions aimed at improving patient safety.

The model above challenges Boards to review the perinatal surveillance model in full and to undertake the six requirements.

	Progress	Further action
1. *To appoint a non-executive director to work alongside the Board-level perinatal safety champion to provide objective, external challenge and enquiry.*	Andy Papworth appointed	Agree what responsibilities this will involve at local level
2. *That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.*	This paper serves as the first monthly report (but is much longer than would usually be required	Agree content and process for monthly review by the Trust Board
3. *That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to HSIB.*	All SIs are reviewed at Trust Board	Process for WY&H LMS review to be clarified
4. *To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at Board meetings.*	Appendix 2 shared below	To agree the minimum dataset for perinatal surveillance dashboard
5. *Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need.*		To discuss and agree with the WY&H LMS
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.		To review the role of the safety champion as described

Appendix 2 – Minimum Data Measures for Trust Boards

Select Trust:

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:

Maternity Safety Support Programme	Select Y / N:	If No, enter name of MIA

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data monitoring tool												
Findings of review all cases eligible for referral to HSIB.												
Report on: •The number of incidents logged graded as moderate or above and what actions are being taken •Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training •Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite , gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively.												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	

13. Further Action

The Ockenden Report has put maternity services at the forefront of Trusts' collective minds. However, it should be noted that the immediate and essential actions overlap with the important work of Saving Babies' Lives and the Maternity Incentive Scheme (year 3). In common is the requirement to work with women and families to provide a safe, effective, caring and responsive service. This requires effective leadership at all levels of the organisation and we need to ensure that staff at all levels are supported to lead and provide the level of care our local community deserves.

Suggested actions:

- Internal review of maternity services against CQC Key Lines of Enquiry with process agreed by the Safety Champion and NED and review shared with Trust Board on completion
- Plan for the Perinatal Surveillance Model agreed

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Jeremy Cross, Non-executive Director
Date of meeting:	18 January 2021
Date of Board meeting this report is to be presented	27 January 2021

Summary of key issues

- We received an update on the people plan and a detailed presentation on Health and Well being. It was encouraging both to see the breadth of the offer to colleagues during the Covid crisis, and also the structured approach that has been put in place this time. The committee are keen to understand which of these initiatives has worked best for colleagues
- We received an update on the Culture Programme – it was pleasing to see that momentum was being maintained even in the difficult circumstances that everyone is working under
- Following the worrying data received at the last meeting around the potential issues for BME colleagues in the recruitment process we received an update from Matt Shepherd as to how work was progressing to address this issue – both in terms of ensuring that we are reaching out to all communities, and also in ensuring that the interview and shortlisting process was fair. This will be an important piece of work to stay close to (especially given the later presentation on BME matters)
- We received an update from the Chairs of the BME network and the LGBT+ network. It was encouraging to hear of the surveys completed and there are opportunities to talk to colleagues in the future which will be developed. There are interesting plans to promote LGBT+ awareness month in February
- The hospital chaplain – Darren McLintock – attended the meeting and updated us on his work and team, and some of the challenges he faced. It was good to hear that there are clear lines of communication between the chaplaincy and the rest of the hospital and how they are working together. Darren noted some challenges around the use of the “chapel” space and ensuring that it was used and seen as available to members of all faiths and communities.
- David Plews has an excellent proposal for NED’s to attend drop in sessions with 5-8 colleagues from across the Trust each month to find a way of getting some of the softer intelligence of “what its like to work here” at the moment. No doubt all NED colleagues will wish to take part

- In response to a challenge from the last meeting Steve Russell presented a broad set of data from various sources giving greater insight into the experience of BME colleagues working in the Trust. Some of the presentation was deeply upsetting – especially the verbatim comments reported of members of the public directing abuse to our people. It was noted that in reporting this abuse, there was currently no way of reporting the impact – as the system was designed around Physical abuse as opposed to Racist Verbal abuse. So colleagues were reporting "no harm" – when in reality this is clearly not the case.
- Steve showed a number of metrics – some of which showed BME colleague experiences to be in line with the rest of the Trust, and others where there was a difference. Most notably BME colleagues:

  - have a lower level of sickness incidence to the Trust average
  - are less likely to be looking to leave the Trust
  - do not believe that they are as likely to be promoted as white colleagues
  - are **significantly** more likely to be abused by patients

- The outcome of this work will clearly need some careful consideration, but it proves that our ambition to work towards being a Non Racist organisation has some significant challenges – perhaps more than we realised. Initially the Committee agreed there were two urgent priorities:

1. The recruitment workstream that has already started – but also including the opportunities for promotion being made fair for all
2. The dealing with abuse from the public, and ensuring we are seen as a Zero Tolerance organisation. All agreed this needed more than a mere marketing campaign

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

- The data from the Deep Dive on BME experiences needs acting on – now we know about it, we have to be seen to be addressing it

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

- Board Colleagues will want to stay close to the Anti Racist work outlined above
- NED Board Colleague will want to volunteer to take part in the Drop in Sessions discussed above

Board of Directors Meeting
27 January 2021
Workforce & Organisational Development Report

Agenda Item Number:	**9.1**
Presented for:	Discuss/Note
Report of:	Director of Workforce and Organisational Development
Author (s):	Workforce and OD senior team – various contributors
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to discuss and note the items documented.

Board of Directors Meeting
27 January 2021
Director of Workforce and Organisational Development Report

1.0 Executive Summary

The Workforce & Organisational Development Public Board paper for January 2021 contains several up-dates for information and also papers for review, feedback and action.

Updates include:

- COVID 19 – Vaccination Campaign
- COVID 19 - Lockdown update
- Additional resources to support COVID19 response and winter pressures
- Additional funds to support winter workforce pressures
- Conflict of Interest/relationships at work risk assessments
- HDFT People Plan Up-date

2.0 COVID 19 Workforce response

As this is the first Board meeting since the announcement of the third national lockdown and 3rd wave Covid surge, an update on all workforce actions taken in response to this is included.

2.1 Vaccination Campaign

Our campaign got underway on Monday 4th January 2021 in the Covid Vaccine Clinic (previously the PAU) Abbey Wing 1st Floor Harrogate Hospital.

An electronic booking system Covid Track is in use to allow staff to choose convenient appointment times. Email invitations to book appointments are sent to staff NHS email addresses. Support is being provided to those colleagues who cannot access NHS Mail

At the time of writing over 3000 staff have been vaccinated.

2.2 COVID 19 National Lockdown

On 4 January 2020, the Prime Minister announced a return to national lockdown measures, instructing the public to stay home, protect the NHS and save lives.

Government guidance reinforced the messages to the public to not leave, or be outside of their home except where necessary. This required full review of our workforce guidance and practice which we have done and reissued to managers and staff to ensure we are compliant.

2.3 Shielding/CEV

Government guidance in relation to protecting people at risk of Coronavirus is that those who are clinically extremely vulnerable (CEV) should not attend work, school, college or university, and limit the time they spend outside the home.

Letters have been issued nationally to all those who are Clinically Extremely Vulnerable who are required to shield, however we enacted a clear instruction to those colleagues impacted to work from home immediately. All staff impacted receive full pay.

2.4 Working from Home

Government guidance with regards to going to work requires colleagues who are able to work from home to do so and we have reinstated the instruction for this to be enacted. We have however provided clarity that a leadership presence is expected on site.

3.0 Additional resources to support COVID19 response and winter pressures

Leeds Year 5 medical students - NHS deployment in January 2021. In view of the unprecedented strain on the NHS arising from the COVID-19 pandemic NHS England and HEE have stated in a recent letter to Trusts and medical schools that medical students, currently on clinical placements in Acute Trusts, can do paid voluntary work caring for patients whilst on these placements. The letter states that in addition to the time spent in clinical placements, in agreement with the local medical school, medical students can sign up for paid work for up to 12 hours per week to support clinical services. This is in line with the published volunteering guidance by the Medical Schools Council.

Year 5 consists predominantly of clinical placement experience and teaching with students undertaking 6 clinical placements of varying specialties throughout their final year - 3 from September to December and 3 from January to April. Dr Jackie Andrew, Medical Director is progressing this opportunity.

4.0 Additional Funds to Support Winter Workforce Pressures'

NHS England and NHS Improvement have notified NHS Trusts of £80 million of funding support for recruitment of international nurses, healthcare support workers (HCSWs) and medical support workers (MSWs) in Q4 20/21.

It is anticipated that rapid, large-scale recruitment activity will support Trusts in meeting urgent and emergency care, elective, COVID-19 surge and vaccination requirements in the coming months.

The table below details the funding and next steps for each category of funding:

Staff Group	Funding	Next Steps
International Nurses	Targeted £19.7m funding will be provided to selected trusts to support further international nurse recruitment and facilitate new overseas nurses arriving by April 2021...	HDFT has successfully been allocated a proportion of funding which will be used to create a dedicated OSCE training space for at least 8 nurses and cover increased costs due to Covid, to provide English tuition to nine HDFT CSW's who are registered as nurses in another country.
Heath Care Support Worker (HCSW)	All Trusts employing HCSWs can access external funding to support recruitment into these roles.	The HCSW programme will continue supporting HDFT to reduce vacancies through the national recruitment campaigns, enhanced induction and on-boarding, and sharing good practice; and continue offering targeted support to those trusts with the most vacancies.
Medical Support Workers	NHS England and NHS Improvement are prioritising £15m of national funding to Trusts to	HDFT to establish where MSWs can usefully augment their medical workforce on wards and in theatres.

(MSWs)	provide additional clinical support for the short-term recruitment of up to 1,000 doctors as MSWs.	

5.0 Conflict of Interest – Implementation of the new policy

The Board is aware that we have launched a new policy in relation to the above and the matters within this policy have been an area of concern to the board previously. A new system called 'Declare' will be launched in the first quarter to support implementation primarily of the Gifts, Hospitality and Conflict of Interests. An exercise is now being launched for managers to conduct a risk assessment of all declared relationships at work where there may be an actual or perceived conflict. This will be launched via line manager webinars and through Directorate BPs before an all user email is launched over the next few weeks. A central record will be kept and annual reporting of all data instigated. A copy of the risk assessment can be seen at Appendix A

6.0 HDFT People Plan Update

Progress is being made on the implementation of the People Plan, notable actions that have been taken include the following;

6.1 Looking After Our People

'Develop a graduated range of emotional and psychological wellbeing interventions to support colleagues, e.g. Restorative Supervision across services. Continue to embed and improve the range of Health & Wellbeing Services'

Health & Wellbeing – a revised health and wellbeing plan has been developed and approved by SMT. The presentation was shared with the People N ad Culture Committee. The next step is to develop this into a costed delivery plan over a 2 year roll-out period. Workforce structure discussions are underway within Occupational Health and recruitment for the Clinical Psychology post in progress.

It has been agreed that income received from staff car parking charges will be donated to the Harrogate Hospital and Community Charity and be re-invested in Health & Wellbeing programmes for colleagues. The Colleague Panel will play a key role in determining the priorities for this funding (approx. £72,000).

Start Well/End Well – extreme teaming approaches were launched in December. An HR toolkit has been developed and further work to socialise this approach is taking place.

Leadership Support Circles continue to run successfully

A workshop for line managers on Stress De-escalation and resilience was piloted in December with 17 senior clinical leaders to provide skills and tools in managing highly stressed colleagues. This has evaluated very positively and is being rolled out during January, February and March.

The HR team has been running a series of Line Manager Webinars aimed at giving guidance, support and sharing hot topics to enable them to line manage more effectively and confidently. Rebranding and relaunch of these will take place from January, and we are developing a programme of monthly topical workshops to support our first line leaders.

6.2 New Ways of Working

'We enable all colleagues to reach their full potential through the provision of education, learning and development opportunities. @teamHDFT we have the skills, competencies and leadership qualities to deliver outstanding patient and service user care. We ensure our colleagues are well equipped to meet the service delivery demands of both now and of the future. We understand our workforce diversity and maximise opportunities for all individuals regardless of background and belief. We develop innovative workforce solutions which allow us to make the best use of the talent and skills available to us.'

We have committed to the national Kick-start programme, which is designed to provide a 6 month placement and work experience to 16 to 24 year olds who are Not in Education, Employment or Training (NEET). We are partnering with North Yorkshire County Council and Health Education England on the development of these placements. We are aiming to provide between 10 and 15 placements.

The team are developing a business case for technology enhanced Learning platform which will modernise and transform learning and development across HDFT. 2 suppliers (Synergy and Chambury) have been chosen to demonstrate their products w/c 18th January as part of the tendering process.

E-Rostering - The Trust have made the decision to move away from RosterPro and to introduce new systems for the rostering of staff groups. Colleagues will move to one of two new systems which will be introduced this year, depending on the type of working pattern they have either Allocate for complex rotas or Manager Self Service (MSS) for standard working patterns.

For the teams/departments who will move to Allocate Health Roster, a number of activities will need to take place before implementation which the project team are working on. The kick off meeting is taking place during the first week of February. The team is currently updating the Rostering Policy, reviewing and aligning the shift pattern terminology, review and agreement of rostering 'rules', data gathering for each department and agreeing which departments will be in the pilot group and the subsequent rollout schedule.

Dedicated training for departmental roster managers and colleagues will take place and communication about the project is about to commence in readiness for an implementation from April.

6.3 Growing for the Future

'We plan ahead to anticipate and meet changes in patient and service user needs and demand for our services within the constraints that we face. We have confidence in our data, enabling us to be forward-thinking, evidence based and collaborative. Our workforce is ever more diverse and our talent management processes support the development of emerging and growing talent.'

The TRAC recruitment system is now embedded for vacancy control and recruitment processes and development work regarding the reporting function is underway.

Shadow SMT have now completed their development programme and are now formal part of our corporate governance structure. The team have developed their knowledge and skills over the period of the programme and are contributing effectively to SMT agendas.

Following the successful bid for the Allocate e-rostering system, the team have been working behind the scenes to enable all of the governance, finance and resource to commence mobilisation. A kick off meeting is scheduled for January involving all stakeholders.

6.4 Belonging

'*Through an open-minded culture and practical policy of inclusiveness, we understand and support all colleagues' beliefs and will support them to have a great daily lived experience and to fulfil their career aspirations. @teamHDFT is a place where people are proud to work, and where they feel valued, recognised and supported to develop their true potential. People feel free to speak up, enjoy coming to work, and have a sustainable work life balance* '

The Committee has received information following a deep dive into impact of some processes on BME colleagues and also received updates about the strands of work on the EDI programme separately e.g. anti-racism, reciprocal mentoring, staff networks.

Recruitment Workshop - As part of our ongoing work to improve our recruitment practices in accordance with National People Plan and as part of the Team HDFT At Our Best programme, a recruitment workshop took place in early December 2020.

The purpose of the workshop was to review the perceived and actual variation in recruitment practices and decisions, which are not always as fair, equal and unbiased as they should be.

Data indicated that individuals with certain protected characteristics (particularly BME or disabled people) are less likely to apply for some roles and in the event that they do, less likely to be shortlisted or appointed following interview.

The workshop examined the root cause behind each of these components and aimed to revise practice, processes and culture so that recruitment in HDFT is objective, transparent, fair and non-discriminatory.

The aims of this project are to:

- Increase the percentage of individuals with protected characteristics applicants applying for roles
- Improve education and awareness for recruiting managers in relation to equal opportunities
- Increase the percentage of individuals with protected characteristics being short-listed for roles
- Have more diverse / representative interview panels
- Increase the representation of people with protected characteristics in more senior roles
- Introduce Trust values as part of the ongoing selection process
- Introduce model/standardised recruitment and selection practice where applicable for key decision making roles
- Explore appropriate alternatives to an interview as the selection process and whether this improves equality, diversity and inclusivity.

The two day workshop identified 15 key actions to achieve the aims of the project. These range from creating recruitment packs, guidance and training to panel members, involvement of staff networks to considering generic role recruitment practices.

7.0 Supporting Documentation

Appendix A – Risk Assessment – relationships at work

Employee Declaration Form (Part A)

To be completed by Employee

In accordance with the Conflicts of Interest Policy all employees are required to declare to their line manager any existing or new personal relationships they have with other members of staff, stakeholders or partners, which may give rise to an actual or potential conflict of interest, trust or breach of confidentiality.

What type of relationship at work and/or loyalty interests should be declared:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are related to a Trust member of staff who is classed as a 'Decision maker' as described in this policy.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Name:	:
Position:	
Department:	
Directorate/Hosted Organisation:	
Name of Line Manager:	

Name of person with whom you have a close personal relationship as detailed above

Name:	
Position:	
Department:	
Nature of Personal Relationship:	

Sign and date the section applicable:

a. Is the person named above in the same line management chain as you at either first or second tier?

Yes □ No□

I understand that where a close personal relationship exists between me and another employee in the same line management chain, at first or second tier that alternative line management arrangements must be made and this may result in one or other of us being moved to a different area/department/site after discussion and based on service requirements.

Signed: ..... Dated: .....

b. Do you and the person named above work in the same team/department (i.e. report to the same line manager)? Yes □ No □

I understand that where I work in the same team or department as someone with whom I have a close personal relationship outside of work, a risk assessment must be undertaken to mitigate any possible risk to myself or the service. I understand that if it is not possible to mitigate the risk it may be necessary to consider the transfer of one or other of us to another team/department or location after discussion.

Signed: ..... Dated: .....

c. Is the person named above with whom you have a close personal relationship above classed as a Decision Maker, an Executive or a Director or Senior Management Team member? Yes □ No □

.

I understand this relationship as declared above will be maintained on a register by the Human Resources Department.

Signed: ..... Dated: .....

d. Is the person named above with whom you have a close personal relationship, in an organization in which the Trust does business?

Yes □ No □

Signed: ..... Dated: .....

Risk Assessment (Part B)

To be completed by the line manager in conjunction with Employee by using the scoring matrix below to identify the severity of the risk:

Detail of the named employee's positions in Trusts ie line management report, same team/department or Decision Maker, Executive or a Director or Senior Management member:

Description of Risk	Presence/ Significance of Risk	Options available to control risk	Mitigating actions agreed	Risk Score see guidance below
Line Management e.g. Appraisal, employee relations investigation etc.				
Team working e.g. Allocation of duties /annual leave/rostering				

Recruitment & Selection Are or could be, involved in the recruitment of close family members and relatives, close friends and associates and business partners associates and business partners				
Financial governance e.g. Sign off of expenditure				
External Organization in which the Trust does business e.g. procurement of services				

Other To be specified (e.g. Relationship with Decision Maker/Executive Director/Senior Manager/Recruitment officer)				
Where concerns regarding conflicts of interest arising from a personal relationship are identified, please score the impact below. The scoring methodology is the same used for risk assessments.				Total Score:

A copy of the completed form must be signed by the employee and line manager and retained on their personal file and a copy submitted to the HR Department at hdft.hr@nhs.net

All risk assessments with a score of 12 and above must be recorded on the Directorate and Corporate risk registers.

Signed (Employee)..... Date.....

Print name (Employee).....

Signed (Manager)..... Date.....

Print name (Manager).....

Risk Assessment Scoring Matrix

Likelihood	Consequence				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Likelihood descriptors

Likelihood	Broad descriptor	Probability descriptor	Time-framed descriptor
Rare (1)	This will probably never happen/recur	<0.1%	Not expected to occur for years
Unlikely (2)	Do not expect it to happen/recur but it is possible it may do so	0.1-1%	Expected to occur at least annually
Possible (3)	Might happen or recur occasionally	1-10%	Expected to occur at least monthly
Likely (4)	Will probably happen/recur, but it is not a persisting issue / circumstance	10-50%	Expected to occur at least weekly
Almost certain (5)	Will undoubtedly happen/recur, possibly frequently	>50%	Expected to occur at least daily

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:	2 December 2020
Date of Board meeting this report is to be presented	27 January 2021

Summary of key issues

The Committee met via Microsoft Teams and was well attended. The matters considered included –

- Corporate Risk Review Group - minutes of the Corporate Risk Review Group and the latest version of the Corporate Risk Register were received. The appropriate inclusion of Covid related risk factors was noted as was the level of detail considered at the group's meetings. It was agreed that this provided a good level of assurance in respect of governance arrangements and risk management processes during the pandemic.
- Quality Committee – minutes from recent Quality Committee meetings were received and noted.
- Audit Committee Effectiveness - the Committee received the output from the annual survey of Audit Committee Effectiveness. This was broadly in line with the 2019 output in terms of Committee performance and contribution to Trust governance, although it was noted that the number of "strongly agree" assessments had fallen in some areas while "agree" had increased. Some further analysis of the survey responses was requested along with a review to the approach to the effectiveness survey next year with a view to enabling the survey to be more informative.
- Gifts and Hospitality - progress with the implementation of the revised gifts and hospitality policy and procedure was reported to the Committee.
- Internal Audit Programme – the Committee received details of only one finalised report at this meeting. This was a refection of the slowing of the investigation, reporting and sign-off process during a period when Trust managers had been focused on managing the demands on the organisation of the pandemic. There are signs that the process is now speeding up which is positive from a "good governance" point of view. The Committee was assured by the creation of a list of "must do audits" that had been discussed and agreed between the Head of

Internal Audit and senior management. The Committee was told that the planned number of audit days in 2020/21 would almost certainly be used to the Trust's benefit despite the delays seen in the delivery of the plan to date.

- HIF Internal Audit Programme – the Committee received an update on progress with the HIF internal audit programme, this had been delayed, largely on hold, during the first two quarters of the year. Delivery on the plan was now recovering. Quarters 3 and 4 would see the bulk of HIF related internal audit activity take place. It was reported that the majority of planned audit days would be used as with the Trust audit plan.
- Counter Fraud - the Committee received an update on counter fraud activity. The substantial amount of cyber/IT based fraud impacting on the NHS was noted. This type of activity had increased greatly during the pandemic. It was noted that a number of effective approaches had been developed to deal with this and other forms of fraudulent activity including training and development opportunities for Trust staff enabling them to recognise and respond to fraudulent activity appropriately.
- External Audit – Rashpal Khangura had returned as the Trust's external audit partner from KPMG after a period of secondment. The usual KPMG sector technical update was received along with a confirmation of the fees required to be paid in the current year. Fee expectations have increased, but the committee was assured by management that the payment requested was acceptable and reasonable reflection of the work to be done, which included some new requirements. This matter gave rise to some concerns in relation to the planned external audit procurement to come as noted below.
- Single Tender Actions – none were presented at this meeting of the Audit Committee.

The Committee will meet next on 29th January 2021.

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

Consideration of the 2020/21 fee expectations of the Trust's current external auditor gave rise to discussion of the forthcoming procurement exercise and concerns that in the current external audit market it may be difficult to secure a range of expressions of interest, and that the fee expectations of potential external auditor providers might be significantly above the current levels.

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

None.

Board Committee Report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor, Non-executive Director
Date of last meeting:	21 December 2020 and 25 January 2021
Date of Board meeting for which this report is prepared	27 January 2021

Summary of key issues:

1. **Month 8 – November.** The Committee received information on the financial position for November. The trust achieved its plan for November, reporting a deficit position of £691k against a planned deficit of £892k. The cumulative position is a deficit of £1,031k against a planned deficit of £1,238k, £207k favourable to plan.
2. Covid costs to date total £7.84m. Main cost drivers are high cost and homecare drugs and CNST costs.
3. After adjusting for Covid costs in the year to date, Corporate Directorate has a small overspend with all other Directorates being underspent. There is an efficiency requirement for month 7 to month 12 of £1.8m.
4. Planned care recovery continues. Outpatients remain below plan due to a combination of reduction in referrals, low take-up of Waiting List Initiative sessions and workforce constraints. Day case and endoscopy continue to perform, there is an element of reduced capacity linked to the mutual aid provided to WY&H providers. The fifth endoscopy room has opened with Medinet providing weekend lists. Inpatients continue to deliver above plan.
5. The 62-day cancer standard was on track in November whilst the 14-day performance was below the operational standard in November. Extra 2 week wait Saturday clinics have been scheduled for January to March.
6. ED performance against the 4-hour standard was below 95% in November.
7. There is significant focus to reduce waiting times in community dental.
8. The waiting list at the end of November was 5% down on October.
9. The workforce position in November showed substantive staffing behind plan by 76.65 whole time equivalents (wte) whilst bank and agency staff exceeded plan by 11.55 and 10.60 wte respectively. The trust vacancy rate is 4.38% up from 4.12% in October.
10. The biggest vacancy rate is in Children's and County Wide Care Directorate at 7.26% (73.10 wte variance to plan in November). Vacancies in qualified community nursing is the main gap but also gaps in Health visitors and school nurses. There is a strong pipe-line of staff particularly in nursing and support to clinical staff.
11. The consolidated cash position (Trust and HIF) was very healthy at the end of November with a balance in excess of £29m. Excluding top-ups and payments in advance, the underlying cash position is estimated to stand at £5.1m.

Performance against the Better Payment Practice Code continues to improve.

12. The Committee received a presentation on the financial framework for 2021/22. Official planning guidance is still awaited.
13. A baseline plan has been developed, using as a starting point, a merger of the month 7-12 plan and the 2019/20 outturn, giving a baseline plan for 2021/22 of £8.4m deficit.
14. The deficit position is due to depreciation, increased CNST premium, 2019/20 issues and payback to WY&H ICS. The guidance may deal with depreciation and CNST could be commissioner funded reducing the deficit to £5.1m.
15. Issues for discussion include efficiency expectations, influence of commissioner funding in relation to income, whether the Trust should be looking to break-even or make a surplus to service loans and support capital programme.
16. The Committee considered the risks on the Board Assurance Framework relating to strategic objectives assigned to Resources Committee.
17. **Month 9 – December.** The Committee received information on the financial position for December. The Trust achieved its plan for December reporting a deficit of £528k against a planned deficit of £1,226k. The cumulative position is a deficit of £1,559k, £905k favourable to plan.
18. A prudent approach is being taken to the position reported to ensure pressures later in the year can be dealt with.
19. Directorates are mostly living within budgets, any overspends are understood and being mitigated where possible.
20. A simple forecast based on the continuation of months 7 to 9 performance shows the Trust could reduce the deficit, which combined with additional funding to offset any shortfall in non-NHS income could bring the deficit plan closer to balance or achieve a small surplus at year end.
21. Outpatients remain below plan at 86%, challenges being reduction in referrals, low take-up of Waiting List Initiative sessions, workforce constraints and patients cancelling appointments due to the Covid lockdown. Elective day case and endoscopy achieved 103% in December, however, the January forecast is for this to drop to around 68%. Medinet continue to provide week-end lists. Inpatients out-performed plan at 134% but again the forecast is for this to drop significantly in January.
22. There are 972 RTT patients waiting over 52 weeks at the end of December and 2,272 waiting over 40 weeks. Total waiting list was down to 16,289 (from 16,734 in November).
23. ED performance remained below target in December (at 85.4%). The 62-day cancer standard was delivered in December with backlogs in 62 and 104 weeks reducing. The 14-day performance remains below the operational standard. Extra 2 week wait Saturday clinics are scheduled.
24. The recovery in community dental work continues, the waiting list is reducing, however, there were a number of 52-week breaches at the end of December.
25. The workforce position in December showed substantive staffing behind plan by 90.76 whole time equivalents (wte) whilst bank and agency staff exceeded plan by 8.69 and 2.18 wte respectively. The Trust vacancy rate was 4.76% in December, up from 4.38% in November (and 4.12% in October).
26. The biggest vacancy rate remains in Children's and County Wide care Directorate at 8.19% (84.58 wte variance to plan in December). There are 82 vacancies in community nursing of which 60 are currently in the recruitment

process. 35 students in the 2020/21 cohort are due to qualify in October.

27. With regard to vacancies, HDFT benchmarks well against the North East and Yorkshire. Our vacancy benchmarking is skewed by current vacancies within Children's and County Wide services.
28. A forecast of recruitment activity towards full establishment was provided for registered nurses and care support workers. There is a strong position in February and March which needs to be maintained.
29. The consolidated cash position (Trust and HIF) was very healthy at the end of December with a balance of £29m. Aged receivables over 90 days old have reduced by £4m from November and a further £4m improvement is expected in month 10.
30. Capital spend was ahead of plan in December. Additional approvals have increased the plan to £16m with £10.2m spend to date. Covid wave 1 schemes of £5m still await approval. This is now expected in February.
31. NHS England have advised that planning for 2021/22 will be delayed for 3 months. The current regime will extend to cover Q1 2021/22. Revenue funding for Q2 2021/22 onwards will continue to be distributed at a system level, consistent with the Long-Term Plan settlement. Internally, briefings have taken place with Directorates and baseline positions are being established. Activity and performance discussions have commenced. A detailed timetable has been drawn up.
32. A business development update was provided which confirmed:
    - Mobilisation of the County Durham 0-25 Family Health Service contract which commenced in September 2020
    - The Trust has secured the second extension for the 0-19 contract in Gateshead
    - The Trust has agreed in principle to work together in partnership with North Yorkshire County Council to implement a new service model for the NY 0-19 Healthy Child Programme.
33. A business case for the upgrade of Emergency Department X Ray and replacement of mammography equipment was considered and approved. Total capital costs £952k of which £528k is provided by the Humber Coast and Vale Integrated Care System, the balance met by HDFT capital programme. The new facilities should be available for use at the end of March 2021.

Are there any significant risks for noting by Board? (list if appropriate)

- The impact of Covid work on activity recovery and waiting lists

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

None

Harrogate and District NHS Foundation Trust

Board of Directors
27 January 2021
Operational Update

Agenda Item Number:	**10.1**
Presented for:	Discuss/Note
Report of:	Chief Operating Officer
Author (s):	Chief Operating Officer, Deputy Director of Informatics
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to note the status and content of the Operational Update report.

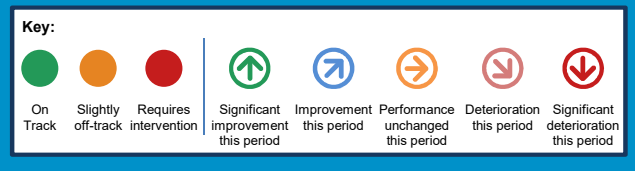
NHS
Harrogate and District
NHS Foundation Trust

Trust Board Operational Update

Tim Gold, Chief Operating Officer
January 2020

Public Board

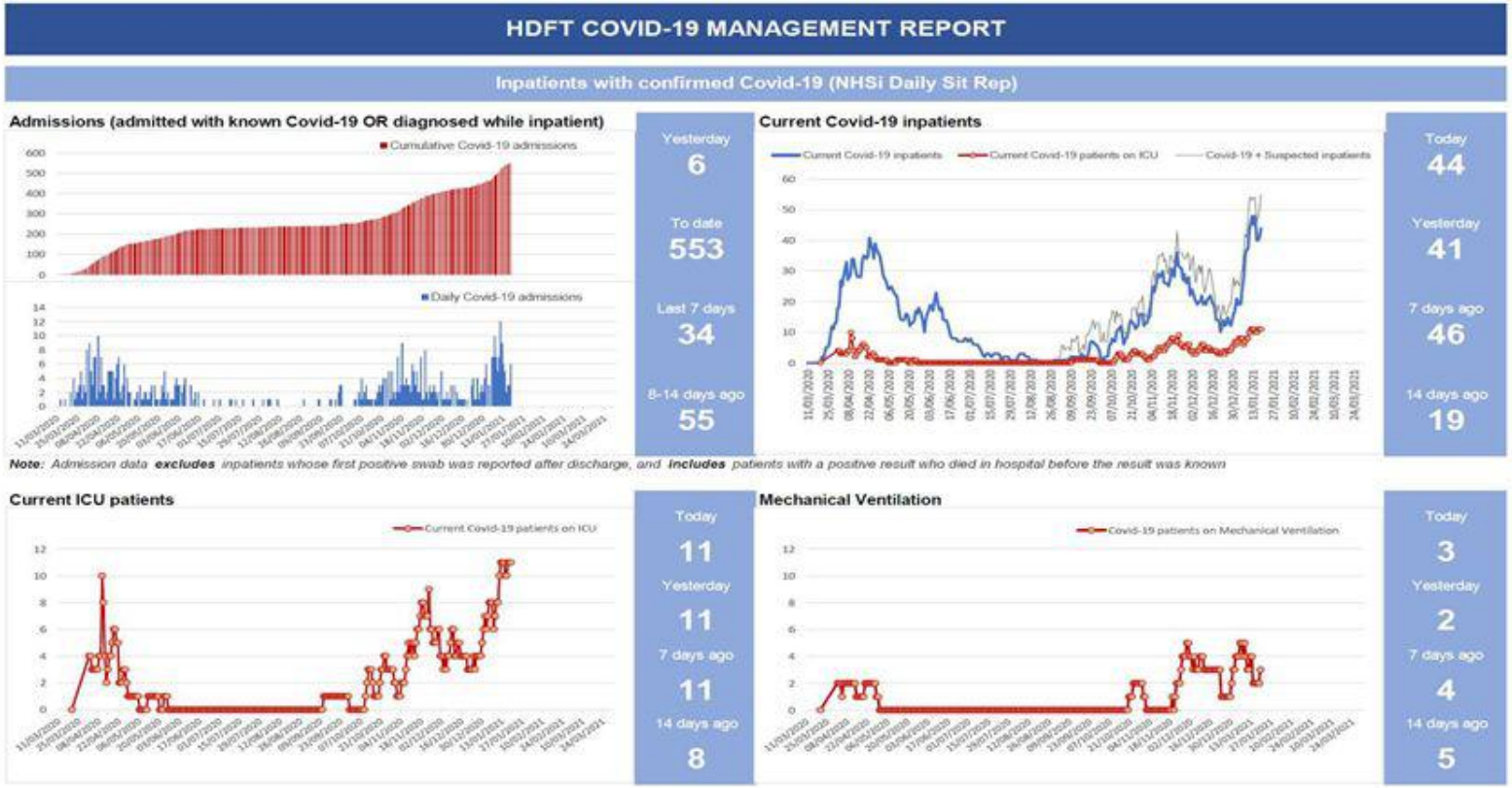
Highlight Report Definitions:
Overall – Overall Programme/workstream delivery status
Performance – performance against key NHS constitutional standards
Actions/Milestones – Programme/workstream delivery trajectory against a clearly defined implementation plan
Issues – Programme/workstream issues that are impacting delivery of the implementation plan and/or performanceTrajectory
Risks – Programme/workstream risks that if not mitigated, could become an issue that could impact the delivery of the implementation plan and/or performance trajectory



Contents

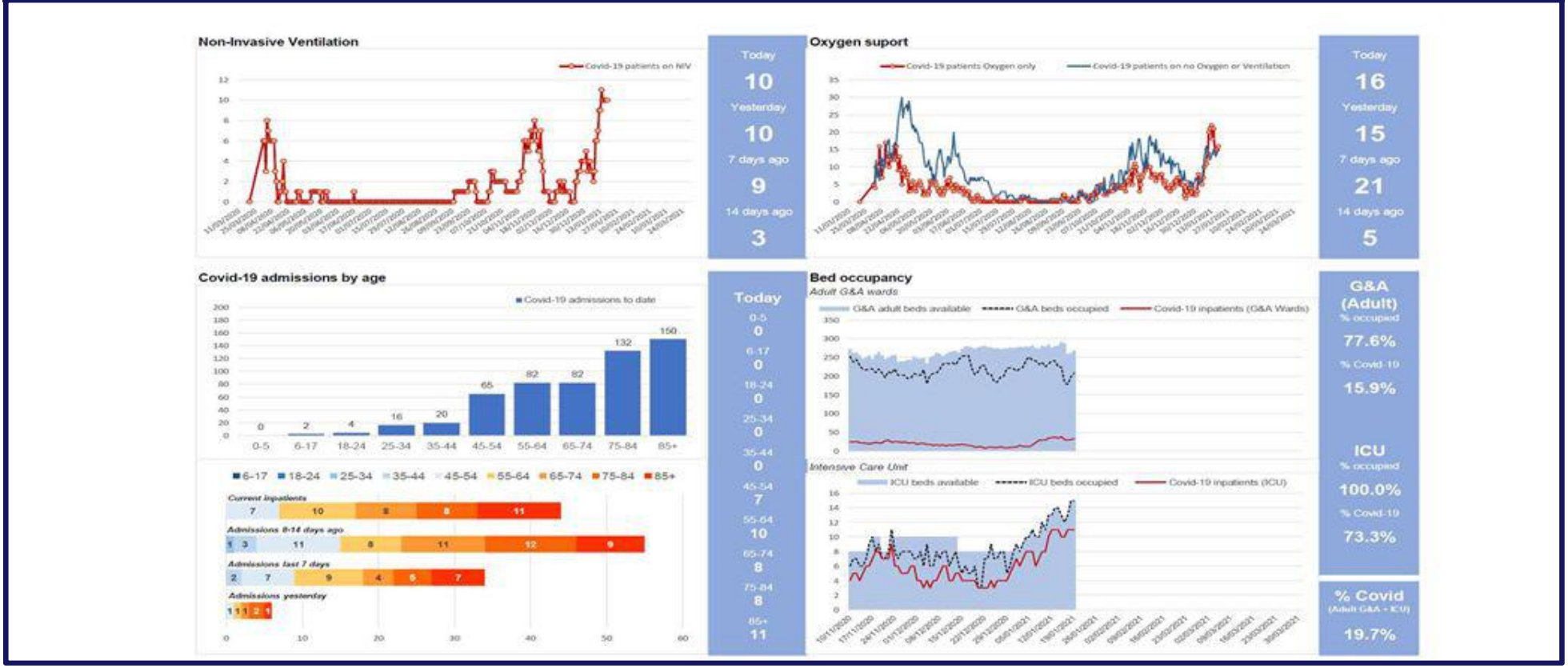
1 COVID Management Report (@19.01.2021)

Covid inpatients and critical care patients have both increased significantly in January. Currently 44 covid inpatients; c. 20% of adult bed base.



1 COVID Management Report (@19.01.2021)

Critical care unit has been running at full capacity with the proportion of covid patients increasing (73%) – additional surge capacity has been opened to address this.



1 COVID Management Report (@19.01.2021)

Whilst overall sickness absence (5.7%) remains lower than regional peers, covid related sickness has risen significantly over the last 14 days and makes up 50% of Trust sickness absence.

1 COVID Surge Plan (@19.01.2021)

Inpatient covid beds and critical care capacity increased to manage covid surge – priority 3 and priority 4 electives postponed to release staff. Daily incident command meetings augmented.

Surge Plan Summary

- We have moved from Surge 2 to Surge 3 of our Ward Surge plan and from Surge 2 to Surge 4 of our critical care surge plan
- Nidderdale has been emptied and cleaned ready to be used as a Covid ward if necessary – current bed occupancy and covid numbers mean Harlow and Wensleydale capacity sufficient. Reviewed daily.
- Nidderdale patients will now be cared for on ESU and DSU will be staffed overnight and be used for green elective patients.
- All electives apart from urgent "Priority 2" surgery and cancer surgery postponed for a month to facilitate critical care surge and staffing of DSU.
- Running additional training sessions on NIV and vent care to support staff moving into critical care.
- Safeguarding activity levels reviewed across all 0-19 services – no plans in place to re-deploy staff to acute
- Incident Command governance increased – Trust Silver and Gold daily meetings in place
- Ethics Committee and Clinical Advisory Group mobilised and ready to meet as required

General & Acute Bed Base Surge Position

Covid Surge Level	Number of Covid Inpatients	Covid Wards Open
1	0-14	End of Harlow
2	15-44	End of Harlow, Wensleydale
3	45-74	All of Harlow, Wensleydale & Nidderdale
4	75+	Harlow, Wensleydale, Nidderdale & Jervaulx

Critical Care Surge Position

Critical Care Surge Beds Open* (Base = 6 Level 3 beds)
Surge 1: Base + 2 beds
Surge 2: Base + 4 beds
Surge 3: Base + 6 beds
Surge 4: Base + 8 beds

*Staff to be used flexibly to create L2, L3 or red NIV beds as required.

Covid-19 Incident Command Structure

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Operations Highlight Report: December - January 2020

Overall Operations Summary

Overall operational performance reported as amber, unchanged from previous period. This reflects the Winter Plan and Covid Surge Plan continuing to support effective flow and site management. Surge levels have been increased to increase red covid ward and critical care capacity in line with increased covid patients. Planned Care Recovery continues however rate of recovery impacted by the need to cancel electives in December and January to re-deploy staff to critical care. Work continues to clinically review and prioritise patients on the waiting list and to increase endoscopy capacity. The long waiting cancer position continues to improve however Breast clinic capacity needs to be increased in Q4 to clear backlog caused by first lockdown and the Mammography machine breaking down in December . A mobile mammo van has been leased to support this and the permanent replacement should be operational by the end of February. ED and Length of Stay performance is stable and the Urgent Care Improvement Programme is now operational. In Children's & County Wide Services, all services continue to be delivered and staff have not been redeployed to support acute service delivery. Additional safeguarding surge plans in place in Sunderland & Middlesbrough, reviewed weekly through demand & capacity modelling.

Key Priorities for Next Period

1. COVID: Maintaining surged critical care capacity and safe staffing levels
2. PLANNED CARE: Developing the 21/22 theatre session plan and implementing actions to increase outpatient capacity, e.g. increasing waiting space, critical care move
3. URGENT CARE: Introduce 111 First into CAT clinic and continue to embed the shared admissions criteria and Long Waiters Escalation Plan into ED team
4. CANCER: Increasing two week wait Breast Cancer clinic capacity
5. CCCC: Maintain trajectory of Community Dental recovery, begin HDFT N Yorkshire staff consultation, recruit into Specialist School Nursing staff vacancies

Programme/Workstream	Overall	Performance	Actions/ Milestones	Issues	Risks
Operations Summary					
Covid Response					
Planned Care Recovery					
Urgent Care & Cancer Improvement					
Children's & County Wide Services					

Key Programme Actions for Next Period

#	Area	Milestone	Due by	Status
1	COVID	Plan & Implement the ICU move	14th March	
2	PLANNED	Agree the 21/22 Theatre Session Plan	31st March	
3	PLANNED	Embed PA Consulting improvements (scheduling tool and 6-4-2)	18th December	
4	URGENT	Introduce 111 First slots from GP direct to CAT clinic	28th February	
5	URGENT	Increase 2 week breast capacity (super clinics, independent sector?, Nightingale?)	28th February	
6	CCCC	Recruit into School Nursing staff vacancies	31st March	

Key Operational Issues

#	Issue	Owner	Rating	Action	Due by
1	Covid numbers increased to above first wave peak	T.Gold	High	Implement Covid Surge Plan to increase covid ward and critical care capacity	15/01/20
2	Breast Cancer 2 Week Wait Backlog	M. Shepherd	High	Increase 2 week breast capacity (super clinics, independent sector?, Nightingale?)	28th February

Key Operational Risks

#	Risk Description	Own.	Score
1	Covid second surge could require the postponement of elective and outpatient activity leading to delays in planned care recovery and inability to provide urgent cancer care	T.Gold	12

Actions from Previous Period

Key Programme Actions for Next Period (from September Board)					
#	Milestone	Due by	Status		Comments
1	Start Medinet contract and open 5th endoscopy room	30th November			Medinet contract operational. Unable to currently resource 5th room – going to use for colon capsule and staff through Medinet.
2	Complete 12HB Review and report back to COO	30th November			Completed – Long Waiters Escalation Plan implemented.
3	Increase urgent breast clinic capacity	18th December			Ongoing – however January clinic unable to run due to Mammography machine breakdown. Sessions planned for February and independent sector also being considered.
4	Sign off scope of Urgent Care Improvement Programme	18th December			Completed

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3 Planned Care Recovery – Activity

Activity run-rate consistent with November, against an increased January target. Inpatients, Day case and endoscopy being impacted by elective postponements for Covid surge.

Planned Care Recovery – Performance Against Submitted NHS E/I Phase 3 Plan

	September			October			November			December			January				
Point of Delivery	Actual 01/09 - 30/09	NHS E/I Phase 3 Plan	% Delivered	Actual 01/10 - 31/10	NHS E/I Phase 3 Plan	% Delivered	Actual 01/11 - 30/11	NHS E/I Phase 3 Plan	% Delivered	Actual 01/12 - 31/12	NHS E/I Phase 3 Plan	% Forecast	Actual 01/01 - 18/01	Booked 19/01 - 31/01	Total Fcst 01/01 - 31/01	NHS E/I Phase 3 Plan	% Delivered
Total Outpatients	**12,262**	**13,243**	**93%**	**12,718**	**16,460**	**77%**	**13,183**	**15,302**	**86%**	**11,949**	**13,830**	**86%**	**5,847**	**6,968**	**12,815**	**17,502**	**73%**
New Outpatients (Cons Led)	4,083	4,464	91%	4,313	5,421	80%	4,488	5,460	82%	4,127	4,985	83%	1,829	2,336	4,165	5,952	70%
Follow Up Outpatients (Cons Led)	8,179	8,779	93%	8,405	11,039	76%	8,695	9,842	88%	7,822	8,845	88%	4,018	4,632	8,650	11,550	75%
Elective Daycases (excl endoscopy)	1,417	1,183	120%	1,477	1,171	126%	1,460	1,341	109%	1,409	1,210	116%	648	458	1,106	1,582	70%
Elective day case endoscopy	572	774	74%	775	864	90%	698	958	73%	673	818	82%	455	213	668	1,041	64%
Elective Daycase Total	**1,989**	**1,957**	**102%**	**2,252**	**2,035**	**111%**	**2,158**	**2,299**	**94%**	**2,082**	**2,028**	**103%**	**1,103**	**671**	**1,774**	**2,623**	**68%**
Elective Inpatients	**177**	**131**	**135%**	**244**	**223**	**109%**	**248**	**221**	**112%**	**216**	**161**	**134%**	**75**	**16**	**91**	**210**	**43%**
% Delivered RAG	>=95%	70-94%	<70%														

Note1: Forecast day case numbers include an estimate for Clinical Haematology and Clinical Oncology
Note2: NHSE/ I Phase 3 Plan reflects confirmed amended Day case target submitted 05.10.2020
Note3: Forecast Outpatient attendances include an estimate for Urgent Clinic attendances

Summary

- Outpatients came in at 86% in December however remain down on plan and are projecting a c. 73% outturn against increased January plan, with attendances forecast to be in line with November outturn. Challenges include reduction in referrals as well as patients cancelling appointments in response to the COVID lockdown.
- Day case and endoscopy cases were at 103% in December, however despite the impact of the COVID surge plan and the standing down of a number of elective lists, the January forecast is at 68% against plan. Medinet continue to provide weekend lists as well as covering a number of lists impacted by staff shielding.
- Inpatients over achieved in December at 134% against plan, however a number of lists have needed to be stood down to support the covid response and is expected to drop to c. 43% in January

3 Planned Care Recovery – Performance

Overall RTT waiting list continues to increase in line with forecast, however Priority 2 patients waiting over four week target is reducing. Clinical prioritisation ongoing across all specialties.

Clinical Prioritisation & Review

- Work continues to clinically review all patients on the inpatient/day case admissions list to allocate a P1-6 national classification for surgery rating – 76% now reviewed with the outstanding patients linked to a small number of specialties/ consultants.
- Clinical leads to agree the maximum length of time a patient should wait before requiring another review to ensure their priority status hasn't changed (specialty dependent).
- Clinical Prioritisation and review to be reviewed through PSC Quality & Safety Governance Meeting.

Waiting List & Referral for Treatment (RTT)

- There were 979 RTT patients waiting over 52 weeks at the end of the month and 2306 waiting over 40 weeks.
- P2 Clinical Priority patients waiting > 8 weeks has reduced from 29 at beginning of December to 12 as at 12 January
- C. 400 orthopaedic joints agreed with BMI to be delivered under the National Contract to support backlog position
- Total patients waiting 16,289
- PA Consulting continue to support Theatres Improvement Programme.

Outpatient clinics

- Reduced in December in line with plan, however came in below P3 plan; current forecast for January in line with previous months – remediation actions continuing as part of Planned Care Recovery Plan
- Loss of capacity continues to be offset by a reduction in primary care referrals in a number of specialties

	Feb 20	Nov 20	Jan 20
RTT %	86%	74%	73%
92nd %	21 weeks	44 weeks	49 weeks
WL Size	16,750	16,730	16,289

Weeks Waiting	P1A	P1B	P2	P3	P4	P5	P6	Not Rec	Total
0-2	1	0	39	86	141	11	0	369	647
3-4	0	0	28	87	163	0	0	119	397
5-6	0	0	13	73	200	0	0	70	356
7-8	0	0	5	62	197	2	0	48	314
9-10	0	0	4	40	141	1	0	46	232
11-12	0	0	2	23	118	0	0	30	173
13-14	0	0	1	21	164	2	0	33	221
15+	0	0	5	124	1279	7	0	233	1648
Total	1	0	97	516	2403	23	0	948	3988

	40-51 Weeks	52-61 Weeks	62-71 Weeks	72-81 Weeks	82-91 Weeks	Grand Total
Breast	6	4	3			13
Cardiology	3	2				5
Community Dental	647	237	25	1		910
Dermatology	8	4	1			13
Diabetic Medicine	2					2
Elderly Medicine	2					2
Endocrinology	3	1				4
ENT	34	8	2	1		45
Gastroenterology	26	3	1	1		31
General Surgery	89	49	37	10	1	186
Gynaecology	50	38	26	21	3	138
Hepatology	10	2				12
Maxfax	13	7			1	21
Neurology	11	1	1			13
Ophthalmology	143	69	4			216
Orthodontics	1					1
Paediatric Endocrinology		1				1
Paediatric T&O	1					1
Paediatrics	8	2	2			12
Respiratory	17	2	1			20
Rheumatology	1					1
Trauma&Orthopaedics	193	162	117	65	7	544
Urology	52	27	16	8	3	106
Vascular	7	2				9
Grand Total	1327	621	236	107	15	2306

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Planned Care Recovery – Programme Delivery – Q4 Actions

NHS Harrogate and District NHS Foundation Trust

Programme governance strengthened to drive planned care recovery across four workstreams. Weekly Planned Care Delivery Group and monthly Planned Care Recovery Board established.

Workstream 1: Outpatients Recovery

#	Milestone	Due by	Status
1	Implement additional Planned Care Recovery Governance (Delivery Group & Recovery Board)	31/01/20	
2	Confirm if independent sector can be used to increase Two Week Wait Breast capacity	19/02/21	
3	Confirm options and approach for increasing outpatient waiting room capacity to facilitate clinic template increase	01/03/21	
4	Recruit additional Gastro Consultant	30/04/21	
5	Increase proportion of telephone/virtual clinics to reduce cancellations and DNAs	28/02/21	
6	Agree approach for expanding glaucoma monitoring clinics for overdue follow up patients and implement	31/01/20	

Workstream 2: Inpatients & Daycase

#	Milestone	Due by	Status
1	Agree and implement 2021/22 theatre schedule from April 21.	31/03/21	
2	Embed PA consultancy scheduling tool and 6-4-2 process to be implemented within the organisation.	28/02/21	
3	Re-establish the evening lists in DSU and Main theatres that were in place prior to Covid-19 (27 sessions in a 4 week period)	30/04/21	
4	Continue to pre assess patients during the current covid surge to establish a pool of patients ready for when theatres recommence.	31/01/21	
5	Review of speciality doctor timetables to enable them to cross cover free lists when consultant on leave.	31/03/21	

Workstream 3: Independent Sector

#	Milestone	Due by	Status
1	Identify and transfer Long waiting T&O patients to BMI – 377 identified to date and shared with BMI	31/01/21	
2	Identify and transfer Long waiting Ophthalmology patients to BMI – 115 identified to date and shared with BMI	31/01/21	
3	Offer local anaesthetic cataract patients opportunity to transfer to NewMedica for their surgery	31/01/21	
4	All independent providers within the region to be contacted re availability and support for HDFT long waiting patients	31/01/21	

Workstream 4: Endoscopy

#	Milestone	Due by	Status
1	Hit and maintain 12 points per list for Medinet weekend lists	31/01/21	
2	Open the 5th room initially using Medinet and colon capsule	25/01/21	
3	Increase internal capacity to 12 points per lists for all service lists.	28/02/21	
4	Re-establishment of Endoscopy pre-assessment service to minimise cancellation and DNAs	31/03/21	
5	Set up colon capsule endoscopy service to increase overall endoscopy capacity.	15/02/21	

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Urgent Care & Cancer Update

NHS Harrogate and District NHS Foundation Trust

ED Performance stable, and up slightly in comparison to same position in 19/20. ECIST recommendations being rolled out through Urgent Care Improvement Programme.

ED Performance

- ED attendances and admissions continue to track c. 20% below pre-Covid levels
- ED performance 90% YTD, up from 89% YTD in 2019/20 and Q3 performance at 89%, up from 87% in in 19/20
- The service continues to progress with the ECIST actions and recommendations (see overleaf)

Urgent Care Recovery Programme

- Minors stream now operational again from January
- Long-waiters escalation plan written and rolled out – includes clear instructions for what to escalate and when – including a 12 hour trolley wait avoidance checklist
- Admission criteria shared and agreed with both medical and surgical leads to reduce "ping-pong" between ED, ward and specialties
- Hours of CAT service to accept surgical patients on weekends with the aim to deliver full 7 day service in Summer (in line with ECIST recommendations)
- 111 First now operational and slots available. Next stage to pilot direct booking into CAT clinic from GPs.
- Nurse to nurse admission protocol being agreed between ED and Admissions Ward to reduce time taken for unnecessary medical review

Cancer

- Provisional data shows that performance against the 62 day cancer standard was delivered in November with performance at 88.3%.
- 14 day performance for suspected cancer and non-cancer related breast symptoms was below the operational standard in December – all 69 non-cancer related breast referrals were seen after day 14 (0%) and 87.9% of suspected cancer referrals seen by day 14
- Referrals continue to be triaged in order to ensure patients with a higher level of urgency are prioritised, and work is also being done to manage the impact of these delays on delivery of treatment for those patients diagnosed with cancer.
- Extra 2WW Saturday clinics have been scheduled in January and February and we are planning to do the same in March – also exploring interim use of the independent sector to clear the backlog
- Cancer surgery being maintained despite increased covid pressures

Long-waiting cancer patients by site

	30/04/2020			31/05/2020			30/06/2020			31/07/2020			31/08/2020			30/09/2020			31/10/2020			30/11/2020			31/12/2020		
Site	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104	Total	>62	>=104
Breast	12	0	3	20	1	3	19	1	3	18	1	2	12	0	2	18	1	1	13	0	1	12	0	0	20	1	0
Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	2	0	0
Colorectal	121	16	1	172	58	10	200	39	40	226	22	41	253	32	39	243	42	16	246	24	11	172	11	6	222	26	2
Gynaecological	30	3	1	36	7	2	32	1	4	30	0	2	35	1	1	42	4	0	40	3	1	36	0	0	66	3	0
Haematological	2	0	0	3	1	0	4	0	0	5	0	0	7	0	0	2	0	0	7	0	0	3	0	0	1	0	0
Head and Neck	12	3	2	17	2	3	23	1	3	22	1	0	23	2	1	36	1	0	21	3	0	20	0	0	39	0	0
Lung	5	0	0	6	0	0	4	1	0	9	0	0	7	1	0	10	0	0	6	0	0	8	1	0	7	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sarcomas	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Skin	22	5	1	21	5	3	38	3	3	46	1	2	59	1	0	78	6	0	72	0	0	49	1	0	79	3	0
Testicular	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	2	0	0
Upper Gastrointestinal	26	1	0	44	9	0	75	11	7	83	13	8	90	18	13	81	11	8	67	8	3	39	1	2	57	3	2
Urological	22	8	3	23	3	7	21	1	5	25	0	1	45	1	1	47	3	1	44	6	0	31	1	2	30	3	0
Total	253	36	11	342	86	28	417	58	65	464	38	56	532	56	57	558	68	26	516	44	16	372	15	10	525	39	4

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Children's & County Wide Services

NHS Harrogate and District NHS Foundation Trust

Children's and County wide services all continue to be provided without redeployment into acute services. Specialist School Nursing staffing remains largest risk for Directorate.

Summary

Covid Wave: Children & County Wide Services continues to deliver all its services without redeployment. NHSI and commissioner expectation is that children's services will remain a priority in light of increased vulnerability. There are additional safeguarding surge plans in Sunderland & Middlesbrough, reviewed weekly through demand & capacity. 4-6 staff with ICU experience identified to the Trust to support.

North Yorkshire 0-19 Service: Public Consultation finished on the 4th January. Clinical model approved 4 areas to consider in terms of mitigations eg vision screening. Draft S75 agreed and all to go to NYCC Executive on the 26th January. The HDFT staff consultation to start on the 1st February as will the technical consultation for the S75. Staff briefing held on the 15th January (65 staff joined the 3 sessions) .

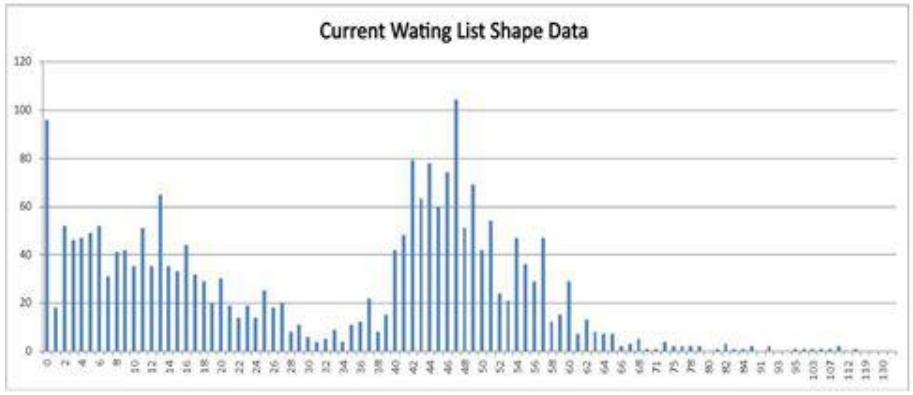
0-19 Staffing – Increasing number of vacancies in these services (84.18wte). Managers reporting low interest in these posts. Number of factors – COVID means staff not wanting to move; increased safeguarding activity means roles are very different (move away from public health); low morale in Durham& North Yorkshire due to service changes. Meeting soon to explore each locality in detail – and recommendations made such as (over) recruiting the current round of students – which was the same approach in 19/20.

Specialist School Nursing – still a 20 on the risk register. Recruitment underway for additional posts but they will need to come into post and be inducted. CCG unwilling to fund the additional £220k, without a full demonstration of activity and demand – and have suggesting a complexity tool on all 550 cases. CCCC pulling together a plan project plan which will outline a process and additional resource and costings required.

Childhood Immunisation – good performance prior to current lockdown. On track to deliver enhanced flu in North Yorkshire & York (72%) and is 63% across DDT. Estimate that it will be 71%, commissioners positive regarding performance but key risk is current lockdown of schools**.**

Community Dental Recovery

- Significant focus continues to be placed on reducing our waiting times for both first appointment and community dental treatment.
- Since the recovery process started the total waiting list size has dropped from 2,587 to 2,235 at the end of December. The number of 52 week breaches at the end of December is 334.
- Acute RTT performance team have been allocated to produce a recovery performance dashboard. This information is being monitored weekly through the Trust Performance & Access Meeting (TPAM).
- Clinic templates continue to be rolled out to all sites to drive improved clinic utilisation. This work will initially focus on the hub sites and then it will be rolled out to the satellite sites. It will also allow us to monitor the clinic fill rates more accurately. Templates have been well received with the clinical teams.



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6 Key January Messages

- *The Winter plan has been implemented and actioned increasing bed capacity*
- *Recent increase in COVID 19 inpatients and critical care has triggered the next phases of the Covid Surge Plan*
- *Trust Silver and Gold meetings have been increased to reflect the escalation*
- *Recognition that staffing remains a challenge with recent increases in COVID related absence increasing the impact*
- *The planned care recovery programme continues although has been impacted by redeploying staff for Covid Surge*
- *Cancer long waiting backlogs continue to decrease, however there remains a need to augment additional 2WW breast clinic capacity to clear 2WW breast clinic backlog*
- *Children's and County wide services all continue to be provided without redeployment into acute services and additional safeguarding surge plans in place for Middlesbrough and Sunderland*

Board of Directors Meeting
27 January 2021
Financial Position

Agenda Item Number:	**10.2**
Presented for:	Discuss/Note
Report of:	2020/21 Financial Position for the year to December 2020
Author (s):	Deputy Chief Executive/Finance Director Deputy Director of Finance
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	✓
To ensure clinical and financial sustainability	✓

Recommendation:
The Board is asked to discuss and note the items contained within this report.

NHS
Harrogate and District
NHS Foundation Trust

Financial Position

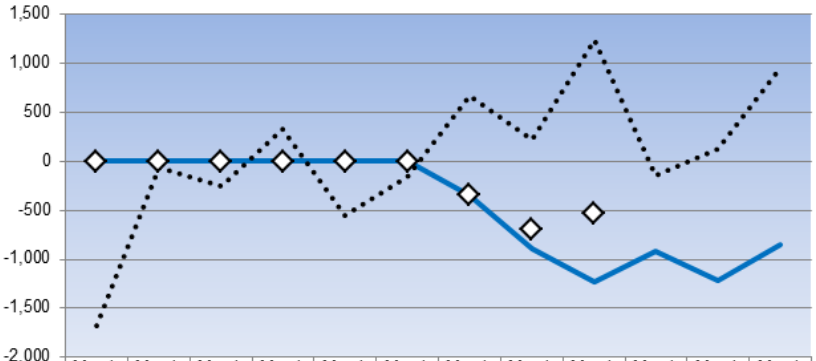
27th January 2021 – Board of Directors

Financial Position

Harrogate and District NHS Foundation Trust

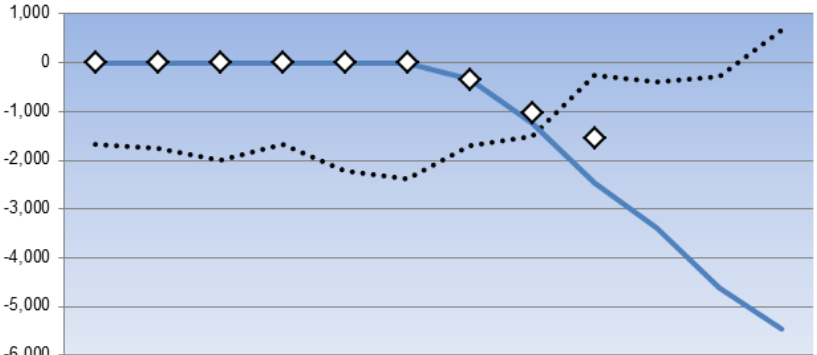
The Trust reported a deficit position in month 9 of £528k, significantly favourable to the month 9 plan by £698k. This is the second month where the Trust has reported a favourable variance to plan, with the year to date position now a deficit of £1,559k, £905k favourable to plan. The graphs below outline this.

HDFT Monthly Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Plan	0	0	0	0	0	0	-346	-892	-1,226	-920	-1,221	-845
Actual	0	0	0	0	0	0	-340	-691	-528			
Prior Year	-1,677	-67	-256	326	-554	-158	674	217	1,241	-150	126	960

HDFT Cumulative Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Prior Year	-1,677	-1,744	-2,000	-1,674	-2,229	-2,387	-1,713	-1,496	-254	-404	-278	682
Plan	0	0	0	0	0	0	-346	-1,238	-2,464	-3,384	-4,605	-5,450
Actual	0	0	0	0	0	0	-340	-1,031	-1,559			

The position reported to NHSI will be £150k better than the above, a result of transactions outside of the control total. The position is currently being finalised and may have some minor changes.

To month 6 the position was supported by £1.9m and £13.0m of prospective and retrospective top up funding respectively. As previously described the funding position for month 7 onwards has moved to a prospective top up and a Covid allocation. For quarter 3 the value of this income support is £6.7m.

Relatively few items are excluded from these allocations for NHS income. The exclusions include Covid Testing, Covid Vaccination programmes, Flu vaccination programmes and Nightingale costs.

Non NHS Income is positive in month, with the year to date favourable variance increasing to £650k. This contributes to the favourable variance above.

At present the Trust is not adjusting the forecast position for external monitoring as there are a number of material factors that could influence this.

Month 9 accounts are currently being prepared, with planning also taking place for 2021/22. This is being done on a Going Concern basis, and will be reviewed through Audit Committee.

Cashflow, Debtors and Creditors

Harrogate and District NHS Foundation Trust

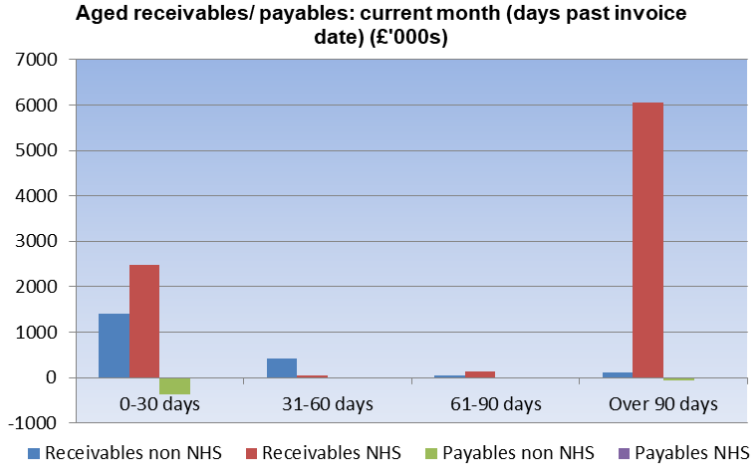
As the graph to the right highlights, the cash position for the Trust remains positive. Removing the benefits of the current cash regime mean caution is still required, and there is still no clear confirmation on if this will continue in March. Forecasting is made more difficult based on the current outstanding Covid capital cases. If the cash regime did not continue, the covid capital is not cash backed and the deficit position continues the forecast balance could **reduce to £4m**.

Better Payment Practice Code performance is positive and improving as outlined in the information below.

Finally the aged debt position has improved by £4m between months, with a further £4m improvement expected in month 10. This is the result of discussions with North Yorkshire CCG in relation to their previous organisations debts.

Other indicators	Year to date			
	Current month %	Previous month %	Movement %	Trend
BPPC % of bills paid in target				
- By number	**75.6%**	**72.7%**	**2.8%**	
- By value	**68.3%**	**64.2%**	**4.1%**	

	Year to date		
	Current month	Previous month	Movement
BPPC % of bills paid in target			
Non NHS			
- By number	**76.4%**	**73.6%**	**2.7%**
- By value	**66.3%**	**62.0%**	**4.3%**
NHS			
- By number	**64.6%**	**60.3%**	**4.2%**
- By value	**74.5%**	**71.0%**	**3.6%**



Board of Directors Meeting
27 January 2021
Approach to 2021/22 Annual Planning

Agenda Item Number:	**10.2.1**
Presented for:	Discuss/Note
Report of:	Approach to Planning for the 2021/22 financial year
Author (s):	Deputy Chief Executive / Finance Director Deputy Director of Finance
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	✓
To ensure clinical and financial sustainability	✓

Recommendation:
The Board is asked to discuss and note the items contained within this report for assurance.

Board of Directors Meeting
27 January 2021
Report of the Deputy Chief Executive/Finance Director

Planning 2021/22

Background

The planning cycle for 2021/22 has started, with a number of workstreams needing to come together by the end of March to produce a Board approved Finance, Workforce and Activity plan for the Trust. This paper aims to outline the approach to this plan, recognising the impacts Covid-19 may have as well as the wider challenges in recovery and sustainability.

We await detailed guidance from a NHS England perspective on the National approach, however, this will not have material impacts on the timelines and work outlined below. The attached letter (APPENDIX 1) from Amanda Pritchard and Julian Kelly contains some of the considerations for 2021/22 from a National perspective.

General Approach

In order to simplify what has been complicated by Covid-19, the approach taken to planning will be to utilise 2019/20 as a baseline for workforce, finance and activity, making adjustments for inflation and other known impacts that are not Covid-19 related. There has been consideration of a number of alternative approaches, however, each introduce a level of complexity and estimation. It has been agreed that because of this the 2019/20 baseline is most reasonable.

This baseline will then be supplemented with adjustments for operational Covid-19 costs and Recovery plans. Covid-19 costs will be reviewed on a rolling basis, reflecting the uncertainty of impacts such as the vaccine rollout. Recovery plans will need to be worked through with specialties and services, however, national guidance will potentially influence the funding flows and baselines for this.

Initial financial position for 2021/22

Initial financial planning assumptions have been shared with the Resources Committee, and internal work continued. However, as noted below in respect of the external process, we have been informed that the current financial regime that is in place for the second half of this year will continue for at least Q1 of 2021/22.

At a summary level the initial financial assessment is

£'000s	19/20 Outturn	NR items	19/20 Normalised	20/21 Impacts	21/22 Planning impacts	21/22 baseline plan
Income	261,578	-10,303	**251,275**	12,964	4,405	**268,644**
Expenditure	260,938	-3,191	**257,747**	10,386	8,944	**277,077**
Surplus	**640**	**-7,112**	**-6,472**	**2,578**	**-4,539**	**-8,432**

This bridge outlines the movement from 2019/20 outturn to a potential 2021/22 baseline plan, and the detail behind this information was discussed at the Resource Committee. The key movements from 2019/20 outturn to 2021/22 baseline relate to

area	£'000
CNST	1361
Depreciation	2000
WY&H	500
2019/20 issues	3212
contingency	2000

Ordinarily, this would result in an efficiency requirement of £8.4m, but there remain a number of key planning assumptions that we are awaiting information in respect of. These include

- Any financial improvement trajectory
- Expectation of delivery of breakeven or surplus
- Any prospective support for recovery/CoVid into 2021/22
- Funding for depreciation in recognition of the increased capital expenditure nationally during 2021/21
- The level of funding to cover the cost pressure in relation to CNST
- The system allocations
- Any alterations to the capital and cash regime

It is anticipated that the clarification on a number of these items would improve the financial baseline as described in the bridge above, with the exception of the system allocation, which is currently more likely to be a risk to system affordability than a benefit.

There is a national briefing this week that I will update the Board and Resources Committee about, which will provide some steer as to the process and assumptions for 2021/22. In the meantime, we will continue with our internal planning process in relation to finance, activity, and workforce, with a view to concluding this by the end of March.

External Process

Aside from Appendix 1, there has been no official timeline published for externals returns. We understand that expected deadlines are –

25th January – Guidance Published
11th March – Draft Submission
25th April – Final Submission

It should be noted that these are subject to change, with recent expectations given that the process will be **delayed by 3 months**.

Internal Process

Internally the development of the constituent parts of the plan has commenced, with the process outlined at SMT and meetings occurring at Directorate level. There has been a small working group established to oversee the plans development, with weekly updates given to the Director Team.

Resource Committee has received the baseline assumptions for the Trust financial plan, as well as more detail on the approach which is being taken to the plans development. The Committee is being updated on progress and will receive more detailed information through February and March. The Board will also be updated in February, although as referred to earlier, the external process and approval is likely to be delayed significantly.

To support the timeline above, as well as ensure budgets, activity plans and workforce plans are in place for 2021/22, the Board will receive the internal plan at the March meeting.

Recommendation

The Board is asked to note the current position in relation to the planning process and note the role of the Resources Committee to provide oversight and assurance to the Board as the plan develops over the next few months.