Harrogate and District NHS Foundation Trust

**Board of Directors Meeting (to be held in Public)**
**will be held on Wednesday, 26 May 2021 from 9.00am**
**at the Pavilions, Great Yorkshire Show Ground,**
**Harrogate North Yorkshire, HG2 8QZ**

**AGENDA**

| Item No. | Item | Lead | Action | Paper | Time |
|---|---|---|---|---|---|
| **1.0** | **Welcome and Apologies for Absence** | Chairman | Note | Verbal | 9.00 |
| **2.0** | **Patient Story** | Deputy Chief Nurse | Note/ Discuss | Verbal | |
| **3.0** | **Declarations of Interest and Register of Interests**<br>*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 31 March 2021** | Chairman | **Approve** | **Attached** | |
| **5.0** | **Matters Arising and Action Log** | Chairman | Discuss/ Note/ Approve | Verbal **Attached** | |
| **6.0** | **Overview by the Chairman** | Chairman | Discuss/ Note | Verbal | 9.40 |
| **6.1** | **Chairman's Annual Declaration against Fit and Proper Regulations** | | Note | **Attached** | |
| **7.0** | **Chief Executive Report**<br>**Appendix A Modern Slavery Act Statement**<br>**Appendix B. Corporate Risk Register** | Chief Executive | Discuss/ Note | **Attached To Follow** | 9.50 |
| **7.1** | **Integrated Board Report** | Executive Directors | Note/ Discuss | **Attached** | |
| **7.2** | **Senior Management Team Chair's Report** | Chief Executive | Note | **Attached** | |
| **7.3** | **Board Assurance Framework** | Chief Executive | Note/Approve | **Attached** | |
| **8.0** | **Quality Committee Chair's Reports** | Quality Committee Chair | Note | **Attached** | 10.15 |
| **8.1**<br>**8.1.1**<br>**8.1.2**<br>**8.1.3** | **Medical Director Report**<br>**Guardian of Safe Working Q4 Report**<br>**Learning from Deaths Q4 Report**<br>**Data Protection Officer Report** | Executive Medical Director | Note/Approve<br>Note/Discuss<br>Note/Discuss<br>Note/Discuss/ Approve | **Attached**<br>**Attached**<br>**Attached**<br>**Attached** | 10.20 |

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| | **Comfort Break 10.50-11.00** | | | | |
| **8.2**<br>**8.2.1** | **Director of Nursing Report**<br>**Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report** | Interim Director of Nursing, Midwifery & AHP | Note/ Discuss | **Attached**<br>**Attached** | 10.55 |
| **9.0** | **People and Culture Committee Chair's Report** | People and Culture Committee Chair | Note | **Attached** | 11.20 |
| **9.1** | **Director of Workforce and Organisational Development Report** | Director of Workforce and Organisational Development | Note | **Attached** | 11.25 |
| **9.2** | **'Caring At Our Best' Update** | Executive Medical Director/Interim Director of Nursing, Midwifery & AHP | Note | **Attached** | 11.35 |
| **9.3** | **Proposal to Become an Anti-racist Organisation** | Chief Executive | Approve | **Attached** | 11.45 |
| **10.0** | **Audit Committee Chair's Report** | Audit Committee Chair | Note | **Attached** | 11.55 |
| **10.1** | **Resource Committee Chair's Report** | Resource Committee Chair | Note | **To Follow** | 12.00 |
| **10.2** | **Operational Report including Recovery Plan** | Chief Operating Officer | Note/ Discuss | **Attached** | 12.05 |
| **10.3**<br>**10.3.1** | **Finance Report**<br>**2021/22 Annual Plan** | Deputy Chief Executive/ Director of Finance | Note/ Discuss/ Approve | **Attached**<br>**Attached** | 12.15 |
| **10.4** | **Self-certification against Provider Licence** | Chief Executive | Note/ Approve | **Attached** | 12.25 |
| **11.0** | **Any Other Business**<br>*By permission of the Chairman* | Chairman | Note/ Discuss/ Approve | Verbal | 12.30 |
| **12.0** | **Risks** | Chairman | Discuss/ | Verbal | 12.35 |

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| | *Any risks highlighted during the course of the meeting for consideration of adding to the Risk Register/Board Assurance Framework* | | Approve | | |
| **13.0** | **Board Evaluation** | Chairman | Discuss | Verbal | 12.40 |
| **14.0** | **Date and Time of next meeting**<br>Wednesday, 28 July 2021 at 9.00am | | | | |
| **Confidential Motion – the Chairman to move:**<br>*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.* | | | | | |

Harrogate and District NHS Foundation Trust

## Board of Directors Register of Interest
## As at 20 May 2021

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Angela Schofield | Chairman | 2018 | Date | 1. Member of WYAAT Committee in Common<br>2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership<br>3. Volunteer with Supporting Older People (charity).<br>4. Chair of NHSE Northern Region Talent Board<br>5. Member of Humber Coast and Vale ICS Partnership |
| Jacqueline Andrews | Medical Director | June 2020 | Date | Familial relationship with managing partner 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)<br>2. Company director for the flat management company of current residence<br>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<br>2. Chairman, Headrow Money Line Ltd<br>3. Director and Shareholder, Cross Consulting Ltd (dormant)<br>4. Chairman – Forget Me Not Children's hospice, Huddersfield<br>5. Governor – Grammar School at Leeds<br>6. Director, GSAL Transport Ltd<br>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.<br>2. Chair of the Safeguarding Practice Review Group.<br>3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network.<br>4. Member of the North Yorkshire and York Safeguarding Health Professionals Network.<br>5. Member of the national network of Designated Health Professionals.<br>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<br>2. Member of NHS England and Improvement North East and Yorkshire Regional People Board<br>3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS |

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Wallace Sampson OBE | Non-executive Director | March 2020 | Date | 1. Chief Executive of Harrogate Borough Council<br>2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company.<br>3. Chair of Harrogate Public Services Leadership Board<br>4. Member of North Yorkshire Safeguarding Children Partnership Executive<br>5. Member of Society of Local Authority Chief Executives<br>6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. |
| Mrs Laura Angus | NExT Non-executive Director | January 2021 | Date | 1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG<br>2. Chair of York and Scarborough Medicines Commissioning Committee<br>3. Interim Chief Pharmacist at Humber, Coast and Vale ICS<br>4. MTech Associate; Council Member PrescQIPP<br>5. Chair of Governors at Kirby Hill Church of England Primary School |
| 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<br>2. Director of NCER CIC (Chair of the Board from April 2019)<br>3. Director and Trustee of TCV (The Conservation Volunteers)<br>4. Chair of the Corporation of Selby College<br>5. Member of the Association of Directors of Children's Services<br>6. Member of Society of Local Authority Chief Executives<br>7. Local Government Information Unit Associate<br>8. Local Government Information Unit (Scotland) Associate<br>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<br>2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice |
| 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 |
| Lynn Hughes | Interim Company Secretary | Familial relationship with KLS Martin Ltd, a company providing services to the NHS |

Harrogate and District NHS Foundation Trust

**Board of Directors Meeting (held Public)**

**31 March 2021 at 9.00am**

**In the Calderdale Room, the Pavilions, Great Yorkshire Showground, Harrogate**



**Present**
Mrs Angela Schofield, Chairman
Ms Sarah Armstrong, Non-executive Director
Mr Jeremy Cross, Non-executive Director
Mr Andy Papworth, 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
Dr Jacqueline Andrews, Executive Medical Director
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Dr Matt Shepherd, Action Chief Operating Officer/Clinical Director for Long Term Conditions and Unscheduled Care Directorate
Ms Angela Wilkinson, Director of Workforce and Organisational Development

**In attendance**
Mrs Laura Angus, NExT Non-executive Director
Mrs Kath Banfield, Matron and Interim Freedom to Speak Up Guardian
*(for items BoD/03/21/18-21 only)*
Ms Lynn Hughes, Interim Company Secretary
Dr Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
*(to item BoD/03/18 to 21 only)*
Miss Nosheen Kauser, Early Intervention and Resilience Nurse (0-19 Service at Stockton on Tees), via MS Teams (*item BoD/03/21/02 only*)
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Directorate
Mr Simon Riley-Fuller, Deputy Chief Nurse

**Observing**
Mr D Masterton, Elected Public Governor
Mr S Wilsdon, Business Development Manager, Philips Healthcare

**BoD/03/21/01 Welcome and Apologies for Absence**

1.1 The Chairman welcomed everyone to the meeting.

1.2 Apologies for absence were received from Mrs Jill Foster, Chief Nurse. Simon Riley-Fuller, Deputy Chief Nurse, was welcomed to the meeting..

**BoD/03/21/02 Patient Story**

2.1 Nosheen Kauser, Early Intervention and Resilience Nurse from the 0-19 service in Stockton on Tees joined the meeting virtually and presented the experiences of a young service user. She explained that a pilot Outreach

scheme had been a great success. Referrals to the service are received from partnership organisations such as Social Workers, Accident and Emergency departments, by parents or in circumstances when one of the team observe vulnerable children.

2.2 The Board noted the excellent work that had taken place across health and social care with the aim of providing the best possible support to vulnerable young people in the community. Nosheen explained that she had managed to build up a relationship with the young person which had turned a difficult situation into a positive one.

2.3 Board members had many questions and were grateful for the opportunity to gain an insight into this service. The Chairman thanked Nosheen for sharing the story and for extremely valuable contribution.

**BoD/03/21/3 Declarations of Interest and Register of Interest**

3.1 The register of interests were received and noted.

3.2 It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong and Jill Foster are Directors of Harrogate Integrated Facilities (HIF). Angela Wilkinson is Director of the ILS and IPS Pathology Joint Venture and Wallace Sampson is Chief Executive of Harrogate Borough Council.

**BoD/03/21/4 Minutes of the Meeting held on 27 January 2021**

4.1 **Resolved:** the minutes of the last meeting held on 27 January 2021 were accepted as an accurate record.

**BoD/03/21/5 Matters Arising and Action Log**

5.1 There were no matters arising from the previous meeting in addition to those included on the agenda.

5.2 **The Action Log**

The completed actions were agreed to be closed. Open actions were all on target to be completed by the deadline dates.

**BoD6/03/21/6 Overview by the Chairman**

6.1 The Chairman was pleased the Board had managed to meet face to face within social distancing requirements for the first time for over a year.

6.2 The Chairman reported on a number of changes to the Board. It was Jill Foster, Chief Nurse's last day at the Trust and she thanked her for her contributions over the last eight years. She reported that Emma Nunez was joining the Trust as Interim Director of Nursing, Midwifery and AHPs from 1 April 2021.

6.2.1 Tim Gold, Interim Chief Operating Officer who joined the Trust on secondment from Bradford Teaching Hospitals NHS Foundation Trust had returned to his substantive position at Bradford, and the Chairman thanked Tim for his work over the last six months. Matt Shepherd had covered the Chief Operating Officer's role during March until Russell Nightingale commences in post on 1 April 2021.

6.2.2 The Chairman expressed thanks and best wishes to Sylvia Wood, Deputy Director of Governance who was leaving the Trust having worked for the

Trust for many years. She particularly expressed appreciation for her support to the Quality Committee and Audit Committee.

6.3 Colleague Recognition Awards – were noted to have been a huge success with 342 nominations received. The Chairman thanked everyone who had been involved in making the process a huge success and particularly to colleagues who had taken the time to make nominations.

6.4 Listening Events – the Chairman was pleased to report that Listening Events had been arranged to take place throughout the year with colleagues and Non-executive Directors. The recent events had been held via MS Teams but face to face visits were planned to commence from 12 April 2021 within social distance requirements.

6.5 Digital Board Workshop, 30 March 2021 – the Board had attended a Digital Board Workshop, which was hosted by NHS Digital and NHS Providers. The Workshop had been most valuable and the knowledge gained would help to take the Trust's Digital Strategy forward with further discussion planned to take place at the Board Workshop in June 2021.

6.6 Board Workshop, 24 February 2021 – the Board received an update on the scope of Harrogate Integrated Facilities (HIF); breakout sessions were held on Your Voice, Your Vision, Your Values work, development of the Board Assurance Framework; and development of a Serious Incident Action Plan.

6.7 Corporate Trustee meeting, 31 March 2021 - a Corporate Trust meeting was scheduled to take place later that day.

6.8 The Chairman thanked all Board and Governor colleagues for their support and attendance over the past year with meetings held via virtual arrangement during the pandemic. Meetings with Governors included the formal Council meetings with additional informal meetings to provide updates on key issues and to ensure there was continuous communication and engagement throughout this unprecedented time.

6.9 **Resolved:** the Chairman's update was noted.

**BoD/03/21/7 Chief Executive Report**

7.1 The Chief Executive's report was received and noted.

7.2 The Chief Executive highlighted the one year anniversary of the first COVID admission was marked with a poem for all colleagues "*You're incredible to me*". At that time, the hospital COVID inpatients had now reduced to single digit numbers; and the COVID vaccination programme had been most successful with 89% patient facing colleagues immunised with first vaccination and half of colleagues received their second vaccination. He was pleased to report that most recently Critical Care had moved into its upgraded unit following £1m of investment, which had been most welcomed by the Critical Care team.

7.3 The Chief Executive highlighted matters of concern as routine elective surgery and diagnostic activity, which had been reduced over the pandemic to support COVID demand, with pressures on the 0-19 services showing higher demand with an increase in safeguarding concerns. It was noted that

there is a possibility these could increase further as COVID restrictions are relaxed.

7.3.1 He explained that the Freedom to Speak Up Guardian appointment process had been delayed and arrangements were in place for the Freedom to Speak Up Guardian and a three Associate Guardians to be in post by the end of April 2021.

7.4 He drew reference to the following, which were noted:

- Planning for 2021/22 was underway with additional work taking place to provide assurance on activity;
- A bed configuration review was underway, which is planned to be supported by a Nurse Staffing Review in April 2021;
- Options to support 0-19 teams had been commissioned from the Directorate with a review of demand and capacity in each area, which were supported by the Senior Management Team;
- "*Caring at our best"*, programme continued to take forward improvements aligned to fundamentals of care;
- The values work programme, was in the final stages, with colleagues, including Board's contributions being taken into account to support the review of governance arrangements;
- Work to further develop the health and wellbeing offer for Trust colleagues was being taken forward and Trust colleagues were now being encouraged to take annual leave;
- Discussions had taken place between the Trust and PCNs to develop a stronger, joint "*Harrogate PLACE*" to focus on recovering together.
- Recovery plans were continuing with partnership organisations across HCV and WYAAT.

7.5 Andy Papworth queried the recovery required within the 0-19 service specifically the safeguarding service. In response, the Chief Executive explained that the team were working to support the increase in demand but there are vacancies within the safeguarding team and nationally it is known these positions can be difficult to fill.

7.6 Laura Robson complimented the work of the ARCH team, which she found impressive with the team working on admission avoidance. Laura Robson queried if the temporary arrangement for the scheme would continue or if an alternative arrangement was planned in future. In response, the Chief Executive explained that the service provided was currently planned to continue.

7.7 **Resolved:** the Chief Executive's report was noted.

**BoD/03/21/8 Corporate Risk Register and Board Assurance Framework**

8.1 Corporate Risk Register - The summary Corporate Risk Register was received and noted. The Chief Executive explained that work would continue to develop and embed the management of risks. The risks that had target dates set for March/April 2021 were planned to be discussed at the Corporate Risk Review Group. There were no material changes noted.

8.1.2 Jeremy Cross queried the reason for the reduction in the RTT risk score. In response, Jonathan Coulter explained that the risk had been reviewed through the validation process and the Corporate Risk Review Group had

determined that the risk is still high but due to the recovery plans underway they recommended the risk should be reduced.

8.1.3 Maureen Taylor referred to the IT attributable risks such as Cancer IT system and queried if these areas were aligned to the Digital Strategy. In response, Matthew Shepherd explained that work is underway to align with the Trust's Digital Strategy.

8.1.4 In response to Sarah Armstrong's query on patients' falls, the Chief Executive explained that nationally there had been an increase in pressure ulcers and falls during COVID due to the number of complex frail and elderly patients being cared for in the hospital. Sarah Armstrong queried if there is a backlog of cancer referrals. In response, the Chief Executive explained that the cancer waiting list had reduced significantly and was much lower in comparison to Trusts nationally. Matthew Shepherd explained that an increase in referrals of 15-20% to the breast services had been noted and Kat Johnson explained that there are known risks with the waiting lists, which they were working through, to mitigate risks, to minimise harm to patients.

8.2 Board Assurance Framework (BAF) – it was noted that the Board had discussed at its Workshop on 24 February 2021 risks that threatened the achievement of strategic objectives. Work was now underway to update the BAF with Executive Director leads to incorporate the areas identified by Board members, which will be presented to the Board at its May meeting.

8.3 **Resolved:** i) the Corporate Risk Register and plans in place to develop this were noted; and
ii) the Board Assurance Framework was received and noted, including plans in place to incorporate the additional areas identified by Board members at its February 2021 Workshop.

**BoD/03/21/9 Integrated Board Report**

9.1 The Integrated Board Report (IBR) as at 28 February 2021 was noted. Attention was drawn to the 62 day cancer standard, which was marginally below trajectory in December at 84.5%; and the 14 day performance for suspected cancer and non-cancer related breast symptoms with performance deteriorating during November and December 2020 due to the increase of referrals received. It was noted that there had been one serious incident reported during February 2021, which was in relation to a retained swab and this incident was under internal review.

9.2 The Board noted the work taking place to develop the IBR to include 0-19 services key performance indicators.

9.3 Richard Stiff queried the reason supervision data had been excluded in the IBR. In response, the Chief Executive confirmed that supervision continued to be monitored within the service and would be included in the refreshed IBR.

9.4 Wallace Sampson queried the risks in relation to staff absence. In response, Jonathan Coulter explained that the financial risks in association with staff absence were included on the Corporate Risk Register and there are additional risks on the risk register in relation to staff health and wellbeing.

9.5 **Resolved:** the IBR as at 28 February 2021 was received and noted.

**BoD/03/21/10 Senior Management Team Chair's Report**

10.1 **Resolved:** the Senior Management Team Chair's Report from the meeting held on 24 March 2021 was received and it was noted that there had been great focus on the 0-19 services during that meeting.

**BoD/03/21/11 Integrated Care Update Report**

11.1 The Chief Executive provided an updated on the Integrated Care legislative changes. It was noted that in February 2021, NHS England and NHS Improvement published their recommendations to Government on "*Integrating Care"*, and the Government published their response "*Integration and Innovation: working together to improve health and social care for al*l" which sets out legislative proposals. The intention of the legislation is to promote integration within the NHS, supporting collaboration between providers, and greater collaboration between the NHS and Local Government in order to improve health and wellbeing.

11.2 He drew reference to the key components and the implications for the Trust, specifically:

- The importance of being present and prominent within the Humber, Coast and Vale ICS;
- The importance of remaining a strong partner in other ICS' where we provide children's services;
- The place of the Trust in provider collaboratives;
- The need to develop a strong local community partnership for the Harrogate & District area, to work closely with primary care and local government; and
- The implications of local government reform.

11.3 Wallace Sampson highlighted that different providers had a different understanding of Place.

11.4 It was noted that the plans in place to recruit a Director of Strategy will support this work and that further discussions on system working were planned to take place at a Board Workshop.

11.5 **Resolved:** the Integrated Care Update Report was received and noted.

**BoD/03/21/12 Primary Care Networks/HARA Update Report**

12.1 Jackie Andrews presented a report on the Primary Care Networks (PCNs) and the Harrogate and Rural Alliance (HARA). This provided insight into the establishment of the new Primary Care Networks (PCNs) nationally and in the local setting of primary care partnerships at HDFT. It also provided and update on Harrogate and Rural Alliance (HARA), which was launched in 2019 with the aim of creating an integrated health and social care model in Harrogate and district.

12.2 Wallace Sampson queried the governance arrangements in place for approvals through the work of HARA. In response the Chief Executive confirmed this was through the HARA Board on which the Trust was represented.

12.3 **Resolved:** the Primary Care Networks/HARA Update Report was noted.

**BoD/03/21/13 People and Culture Committee Chair's Report**

13.1 The People and Culture Committee Chair's Report was received and noted from the meeting held on 15 March 2021. The Board noted the significant progress the Committee had made since its formation in 2020. Jeremy Cross highlighted the Non-executive Director Listening Events. At a recent Event attended by Jeremy Cross, Andy Papworth and Trust colleagues they heard that colleagues felt safe, that the PPE team had been excellent and that they felt communications had been very good throughout the pandemic. The only negative responses raised were in relation to the IT provision and the availability of suitable equipment.

13.2 He escalated the following to the Board from the Committee: for the Board to oversee the Trust's journey to become an Anti-racist organisation; and Non-executive Director support to attend future Drop In Listening Events with colleagues.

13.3 **Resolved:** the People and Culture Committee Chair's Report was noted.

**BoD/03/21/14 Director of Workforce and Organisational Development Report**

14.1 The Director of Workforce and Organisational Development report was received and noted.

14.2 It was noted that the WRES and DES paper and the Staff Survey appendices were excluded from the Board pack but it was noted that these had been discussed in detailed at the People and Culture Committee.

14.3 Angela Wilkinson drew attention to the following:

- The Staff Survey response rate had been lower than previous years with focus on the "*At Our Best*" programme. Responses from the Staff Survey showed a deteriorated position in relation to Equality, Diversity and Inclusion. This work was being taken very seriously and scrutinised by the People and Culture Committee;
- A new Speciality Doctor grade and introduction of a new Specialist Grade had been negotiated and agreed nationally with introduction from 1 April 2021;
- Mental Wellbeing, HDFT supporting our people 2021 and beyond. Anxiety, fear and exhaustion among staff had increased during the pandemic, affecting a range of staff groups and in response to this, plans are in place across the two ICS areas. A review of occupational health support is taking place at the Trust with the support of a clinical psychologist from 1 February 2021. Support also continues to be provided by Tees Esk and Wear Valley NHS Foundation Trust's psychology service.

14.3 Andy Papworth refered to the Pulse Survey, which the Trust plans to use going forward. He highlighted the positive use of the survey and the opportunity to triangulate information with the "*At Our Best*" programme and Listening Events. It was noted that this work aligned to the People and Culture Committee.

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

**BoD/03/21/15 Quality Committee Chair's Reports**

15.1 The Quality Committee Chair's reports from the meetings held on 3 February and 3 March 2021 were noted.

15.2 Laura Robson drew attention to the significant risks raised during the 3 February meeting, which included: Outstanding actions on the CQC action plan; Limited assurance regarding transfer of histology specimens; the number of reported incidents regarding inappropriate comments to staff from patients and visitors; and the lack of older person's physician input to emergency surgery patients.

15.2.1 Actions escalated from this meeting included the Quality Dashboard, which was covered in the Chief Nurse report later on the agenda.

15.3 From the 3 March meeting, Laura Robson drew attention to the following: a number of external reports had been received where there is no assessment of compliance against standards and therefore we lack quality assurance about services.

15.3.1 Actions escalated from this meeting included the Youth Forum and implementation of Hopes for Health Care, which was paused during COVID with plans to reinstate this; the work to improve pressure ulcer reporting in the community and the proposed changes to the Tissue Viability service.

15.4 The Chairman queried how the risks escalated from the Quality Committee meetings were taken forward. In response, the Chief Executive explained that arrangements would be made for risks raised to be included within the Executive Medical Director and the Chief Nurse reports together with mitigation actions in place.

**ACTION (Medical Director/Director of Nursing)**

15.5 **Resolved:** the Quality Committee Chair's reports from the meetings held on 3 February and 3 March 2021 and the escalated risks were noted.

**BoD/03/21/16 Medical Director Report**

16.1 The Medical Director's report was received and noted. This provided updates on the Clinical Services Review Surgical Pathways Innovation and Improvement Programme), Medical Appraisals and new appointments with a summary of findings planned to be included in the next report to the Board at its May 2021 meeting; the work to improve the Serious Incidents process; research and development including COVID studies; medical education; and Digital and IT progress against the Trust's Digital enabling strategy.

16.2 Laura Robson referred to foetal monitoring and queried if this was a high level risk. In response, Jackie Andrews explained that this is a mandatory training requirement to ensure compliance and an internal audit was taking place... It was agreed that an update on the outcome of the mandatory training internal audit would be provided to the Board.

**ACTION (Medical Director)**

16.3 **Resolved:** the Medical Director's report was noted.

**BoD/03/21/17 Chief Nurse Report**

17.1 Simon Riley-Fuller presented the Chief Nurse report, which was noted. He drew attention to the nurse staffing and nurse support worker current staffing establishment and the plans in place to commence a full review of nursing establishments in April 2021.

17.2 He provided an update on the infection, prevention and control position and reassured the Board that all healthcare acquired infections would continue to be monitored and reported upon. It was noted that all outbreaks during the reporting period had been in relation to COVID.

17.3 The Board were pleased to note that staff COVID vaccinations were progressing well for both the first and second dose of the vaccination; and there had been no further COVID outbreaks with only one official outbreak open, which was expected to be closed in early April.

17.4 It was noted that in response to a request from HDFT for a review of the tissue viability arrangements it had been identified that the Trust is an outlier for reported community acquired pressure ulcers.. Simon Riley-Fuller confirmed that the Trust had established a new reporting arrangement, with the Tissue Viability now reporting into Corporate Nursing. Following discussion, it was agreed that benchmark information would be included within future report to identify how the Trust compares against neighbouring Trusts. **ACTION (Director of Nursing)**

17.5 Laura Robson queried the vacancy figures included in the report. In response, Simon Riley-Fuller explained that the vacancy information excluded the 0-19 service and midwives. Following discussion it was agreed that vacancy information for midwives and students and school nurses and health visitors would be included in future reports.
**ACTION (Director of Nursing)**

17.6 **Resolved:** the Chief Nurse report was noted, including the nurse staffing current position; the IPC update, the COVID vaccination update; and the Quality update.

**BoD/03/21/18 Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report**

18.1 Kat Johnson thanked Andy Papworth for his support as the Non-executive Director lead for this work.

18.2 Kat Johnson drew attention to the report presented to the Board at its January 2021 meeting, which included the mandated Trust actions in response to the first Ockenden Report. One of the actions included the implementation of the perinatal surveillance model.

18.3 The measures mandated as part of the perinatal surveillance model for February 2021 were reviewed and noted.

18.4 Kat Johnson drew reference to the following of note:

- The CQC peer review process was being scoped;
- The Maternity Voice Partnership had completed a survey of women's experiences during the pandemic;

- Work is ongoing towards completion of the 10 safety actions of the maternity incentive scheme, including training a midwifery sonographer and procuring a scan machine for the Maternity Assessment Centre;
- The third continuity of the carer team 'the Wren team' had been launched;
- All midwifery staffing posts had been filled;
- Middle grade staffing gaps presented a risk to the quality of care due to fatigue in this staff group and the risk had been added to the departmental risk register with mitigating plans in place;
- Safe medical staffing levels had been maintained at all times through contingency planning;
- Maintaining competencies in management of obstetric emergencies through multi-professional training had been compromised by the inability to hold face to face sessions and to mitigate against this risk an online training package was under development;
- Compliance in foetal monitoring training, which is a mandatory requirement by 31 May 2021, had been low for midwifery and medical staff to date. In response to that work was being taken forward to ensure all staff are compliant by 31 May 2021.

18.5 The Chairman queried how the risk register would be used to take forward the known risks. In response, Kat Johnson and the Chief Executive explained that the risks were reviewed by the Maternity Risk Management Group and the risk register was reviewed by the Directorate prior to further review by the Corporate Risk Review Group on a monthly basis.

18.6 The Board noted the format of the report and considered if it was easy to understand and scrutinise. Andy Papworth queried if the metrics could be incorporated into the IBR. In response, it was agreed that Andy Papworth and Emma Nunez would consider maternity metrics for inclusion in the IBR and would review the risk management process with escalation of risks up to the Corporate Risk Register, which would be discussed further at a future Board Workshop. **ACTION (A Papworth and Director of Nursing)**

18.7 **Resolved:** i) the Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report was noted; and
ii) the plans in place to develop the reporting requirements to the Board were planned to be discussed at a future Board Workshop.

*K Johnson left the meeting.*

**BoD/03/21/19 Trust's Learning Disabilities, Policy and Application Update**

19.1 The Trust's Learning Disabilities, Policy and Application update was noted. The principal aim of the Learning Disabilities Liaison Service was to: Ensure HDFT has the structures in place to meet the needs of learning disabilities patients; to provide support and advice to staff; to provide reasonable adjustments to support patients with learning disabilities; and to ensure appropriate training is available. The Learning Disability action plan is overseen by the Supporting Vulnerable People Steering Group and is updated in response to contemporary and emerging reports and recommendations.

19.2 **Resolved:** the Trust's Learning Disabilities, Policy and Application update was noted.

**BoD/03/21/20 Freedom to Speak Up Bi-annual Report**

Kath Banfield, Interim Freedom to Speak Up Guardian attended to speak to this item.

20.1 It was noted that the two interim Freedom to Speak Up Guardians (FTSUG's) were appointed in June 2020 to support the other permanent FTSUG. Speak Up Core Training is now available for managers at all levels, which focuses on listening and understanding the barriers to speaking up. A final module, Follow Up, which is aimed at senior leaders including executive and Non-executive Directors, lay members and governors is planned to be launched later in the year.

20.2 Kath Banfield highlighted that the substantive recruitment of a permanent FTSUG is still outstanding but was planned to be completed before the next Board meeting in May 2021. It was noted that despite the the pandemic, the current FTSUG's had met on a regular basis to offer support to each other and to offer advice on specific cases. All regional FTSUG meetings had been attended throughout the pandemic.

20.3 Sarah Armstrong highlighted the improvements that had been made to support colleagues to speak up. She drew specific attention to the "At Our Best" work, which was helping to encourage colleague to speaking up. Discussion took place around the formal mechanisms to raise concerns and when colleagues feel they have experienced barriers, in such circumstances this is when the FTSUG role is crucial to support colleagues to speak up.

20.4 **Resolved:** i) the Bi-annual Freedom to Speak Up report (July – December 2020) was noted; and
ii) the process to recruit a permanent Freedom to Speak Up Lead Guardian and Associate role(s) to support the Lead and Fairness Champions was noted to be taking place before the next Board meeting in May 2021.

**BoD/03/21/21 Audit Committee Chair's Report**

21.1 The Audit Committee Chair's Report from the meetings held on 29 January and 3 March 2021 were noted. Richard Stiff drew attention to the risks raised at both meetings, which included the agreed "must do" list of internal audits includes work essential for effective risk management to be facilitated by relevant managers during quarter four.

21.2 He recommended to the Board following Audit Committee approval that the temporary changes to delegated spending limits agreed in 2020 should be made permanent, which the Board considered and agreed to support. The delegated spending limits were agreed as the following:

- Up to £500,000 – Executive/SMT approval
- From £500,000 to £1m – Resources Committee approval
- Over £1m – Board of Directors approval

21.3 **Resolved:** i) the Audit Committee Chair's reports including the risks from the meetings held on 29 January and 3 March 2021 were noted; and
ii) the delegated spending limits approved by the Audit Committee were supported and approved by the Board.

**BoD/03/21/22 Terms of Reference of Audit Committee**

22.1 **Resolved:** the changes to the Audit Committee Terms of Reference, which had been agreed by the Audit Committee were noted and approved.

**BoD/03/21/23 Resource Committee Chair's Reports**

23.1 The Resource Committee Chair's reports from the meetings held on 22 February and 29 March 2021 were noted. Maureen Taylor explained that the Trust had achieved its plan for February 2021, reporting a surplus position of £3,154,000 against a planned deficit of £1,221,000 and the position reflected funding of £3.7m received to offset lost income.

23.2 The cumulative position was noted as a surplus of £1,174,000 against a planned deficit of £4.6m and the Trust forecasted a break-even position at year-end. The consolidated cash position (Trust and HIF) as at 28 February 2021 reported a balance in excess of £43m.

23.3 She highlighted the funding that had been secured to review the Trust's Digital Strategy and an update was provided on the Salix Carbon Reduction Project.

23.4 **Resolved:** the Resource Committee Chair's reports from the meetings held on 22 February and 29 March 2021 were noted.

**BoD/03/21/24 Operational Report**

24.1 The Operational Report was received and noted. Matt Shepherd drew attention to:

- Cancer performance, high levels of demand noted for breast services with an additional breast clinic planned to take place during April;
- RTT Waiting list continued to increase with longer waiting lists in Trauma and Orthopaedics, Ophthalmology, Gynaecology, General Surgery, Urology and Dental;
- 4 hour performance had seen a recovery to mid eighty percent performance and it would be difficult to exceed 90-95% performance whilst COVID testing, cleaning and social distancing are in place;
- Safeguarding pressures with workforce concerns in the CC's Directorate;
- Plans in place for the fifth Endoscopy room to cover capsule endoscopy from May 2021.

24.2 He was pleased to report that Beth Barron had been appointed as the Operations Director for PSC and plans were in place to re-advertise the Operations Director position for LTUC.

24.3 The Chief Executive thanked Matt Shepherd for his leadership whilst covering the Chief Operating Officer position during March until Russell Nightingale commences in post on 1 April 2021.

24.4 **Resolved:** the Operational Report was noted.

**BoD/03/21/25 Finance Report**

25.1 The Finance Report as at 28 February 2021 was noted. The Board were pleased to note that the Trust's financial performance was in line with plan with a forecast to deliver a breakeven position at the end of the year. The necessary level of efficiency had been delivered across the Trust during the

second half of the year; and the cash position was positive, with capital funding received with improved debtor/creditor management.

25.2 **Resolved:** the Finance Report as at 28 February 2021 was noted.

**BoD/03/21/26 2021/22 Annual Plan**

26.1 The 2021/22 Annual Plan in relation to financial planning for 2021/22 was noted.



26.2 The Board considered and approved the proposed internal budgets and financial plan for Q1 2021/22 and noted that further updates would be provided to the Resource Committee at its April 2021 meeting.

26.3 The capital planning process that had taken place to date was noted with the £30m Capital Programme for the Trust for 2021/22 considered and approved.

26.4 Jeremy Cross queried what the £1.2m related to within the report. In response, Jonathan Coulter explained that the £1.2m had been identified for the replacement of medical equipment and it was agreed this would be reported back to Resource Committee to note. **ACTION (Finance Director)**

26.5 **Resolved:** i) the current position in relation to financial planning for 2021/22 was noted:
ii) the proposed internal budgets and financial plan for Q1 2021/22 were approved;
iii) further updates were planned to be provided to the Resource Committee including the allocation of system financial resources, in advance of submitting the financial plan to external partners and Regulators
iv) the capital planning process to date was noted, including the discussion at Resource Committee; and
v) the Trust's 2021/22 capital programme was approved.

**BoD/03/21/27 Any Other Business**

27.1 There was no other business.

**BoD/03/21/28 Risks**

28.1 It was noted that there were no additional risks agreed for inclusion on risk registers or the Board Assurance Framework.

**BoD/03/21/29 Board Evaluation**

29.1 It was noted that the meeting had enabled discussion on key strategic and operational issues.

**BoD/03/21/30 Date and Time of Next Meeting**

30.1 The next meeting will be held on Wednesday, 26 May 2021 at 9am.

**Confidential Motion**

**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7 Section 18(E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

| Board of Directors (held in Public) Action Log for 26 May 2021 Board Meeting | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Minute Number** | **Date of Meeting** | **Subject** | **Action Description** | **Responsible Officer** | **Due Date** | **Comments** | **Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory. |
| 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/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.<br><br>Draft content for the IBR to be discussed at April Workshop and reported to May Board meeting | Deputy Chief Executive/Finance Director | 28/04/2021<br><br>31 May 2021 | Update to be provided at the meeting | 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 | Work in progress towards June Board Workshop | Open |
| BoD/11/20/17.5 | 25 November 2020 | Workforce and OD Report | Exit interview process to be overseen by the People and Culture Committee going forward | Director of Workforce and OD | 30 June 2021 | Included on People and Culture Committee workplan | **Completed** |
| BoD/01/21/11.10 | 27 January 2021 | North Yorkshire 0-19 Healthy Child Programme | Monitoring of contract outcomes/outputs to be factored into the updated IBR. J Coulter and N Lyth to discuss and agree content for IBR prior to this being shared with the Board for consideration | Finance Director/Deputy Chief Executive and CD for CCCC Directorate | 28/04/2021<br>26 May 2021 | Update to be provided at the meeting | Open |
| BoD/01/21/15.4 | 27 January 2021 | Guardian of Safe Working Quarter 3 Report | Jackie Andrews agreed that she would request that a collection of verbatim comments is included in future reports | Medical Director | 26 May 2021 | Update to be provided at the meeting | Open |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| BoD/01/21/17.9 | 27 January 2021 | Strengthening and Optimising Board Oversight for Maternity and Neonatal Safety | The CQC KLOE framework and this Action Plan would be added to the agenda for the April Board Workshop | A Papworth, Non Executive Director/Chief Nurse and CD PSC | DTBA | When the items for the Board Workshop were agreed it was agreed to defer this to a future Workshop. Date to be agreed for a future Board Workshop | Open |
| BoD/03/21/15.4 | 31 March 2021 | Quality Committee Chair's Report | Risks/issues/areas of concern esclated to the Board by the Quality Committee were agreed would be included in the Medical Director and Director of Nursing future Board reports, together with required actions/mitigations. | Medical Director/ Director of Nursing | 26 May 2021 | Noted, update to be provided at the meeting | **Completed** |
| BoD/03/21/16.2 | 31 March 2021 | Medical Director Report | Medical Appraisals - outcome of Internal Audit and remedial actions to be reported to the Board | Medical Director | 29 September 2021 | Internal Audit outcome to be reported to Audit Committee in June. Plans in place to provide update to the Board at its December meeting on progress made against required actions | Open |
| BoD/03/21/17.4 | 31 March 2021 | Chief Nurse Report | Pressure Ulcers - benchmark information to be included within future report to identify how the Trust compares against neighbouring Trusts | Director of Nursing | 26 May 2021 | Current challenges in availabilitiy of data outside own provider organisation. Work ongoing to look at developing this routinely across the system. | Open |
| BoD/03/21/17.5 | 31 March 2021 | Chief Nurse Report | Breakdown of vacancies to cover Nurses and Midwives inclusive of the 0-19 service to be included in future reports | Director of Nursing | 26 May 2021 | Included in Director of Nursing, Midwifery and AHP report | **Completed** |
| BoD/03/21/18.6 | 31 March 2021 | Maternity Incentive Scheme - Mandatory Training | A Papworth and E Nunez to consider metrics for inclusion in IBR to cover maternity and look at the risk management process with escalation of risks up to the Corporate Risk Register for further discussion at a future Board Workshop | A Papworth, Non Executive Director/Direcror of Nursing | DTBA | Work in progress. Update to be provided at the meeting | Open |
| BoD/03/21/21.2 | 31 March 2021 | Audit Committee Chair's Report | Financial limits approved by the Audit Committee and ratified by Board to be included within the Board minutes | Interim Company Secretary | 26 May 2021 | Included in draft minutes | **Completed** |
| BoD/03/21/26.4 | 31 March 2021 | 2021/22 Annual Plan | Breakdown of medical equipment replacement costs to be provided to the Resource Committee at its next meeting as part of the Capital Programme update report | Deputy Chief Executive/Finance Director | 24 May 2021 | Planned to be covered at the Resource Committee meeting on 24 May 2021.<br><br>Update to be provided at the meeting | Open |

Harrogate and District NHS Foundation Trust

**Board of Directors (held in Public)**
**26 May 2021**

# Fit and Proper Person Compliance for year ending 31 March 2021

## Chairman's Annual Declaration



| | |
|---|---|
| **Agenda Item Number:** | **6.1** |
| **Presented for:** | Information |
| **Report of:** | Chairman |
| **Author (s):** | Interim Company Secretary<br>Head of Resourcing |
| **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 receive assurance that Harrogate and District NHS Foundation Trust is fully compliant with Regulation 5 and the associated requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

# Board of Directors (held in Public)

## 26 May 2021

## Fit and Proper Person Compliance for year ending 31 March 2021

## Chairman's Annual Declaration



**Fit and Proper Persons Update**
The Care Quality Commission (CQC) Regulation 5: Fit and proper person director's test came into effect in November 2014. Regulation 5, recognises that individuals who hold authority in organisations that deliver care and responsible for overall quality and safety of that care. The regulation ensures that registered providers have individuals who are fit and proper to carry out the important role of director ensuring that the provider is also able to meet the existing requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Work has been undertaken in order to provide assurance to the Board of Directors that the Trust's annual Fit and Proper Persons process and checks have been carried out confirming compliance with Regulation 5.

The Trust Fit and Proper Persons Test process was carried out in February 2021 in accordance with the Trust FPPT Guidance, the following roles have been subject to the Fit and Proper Person's tests:

- Board of Directors (including Non-executive Directors)
- Deputy Directors
- Clinical Directors
- Harrogate Integrated Facilities Board of Directors

The results of the checks have been summarised in the table below. Overall, this demonstrates that reasonable checks have been undertaken to ensure full compliance against CQC Regulation 5.

| Fit and Proper Person Test | Outcome |
|---|---|
| Insolvency check | No issues found |
| Disqualified director check | No issues found |
| Professional body checks | No issues found |
| Annual FPPR Declaration forms completed | Full compliance |
| Board of Directors Register of Interests | Register provided at every Board meeting, any conflicts reported are managed as appropriate |

**Supplementary Information:**
Appendix A - the Board's Register of Interest as at 31 March 2021;
Appendix B - the Annual Chairman's Declaration, Fit and Proper Test.

Harrogate and District NHS Foundation Trust

## Board of Directors Register of Interest
## As at 31 March 2021

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Angela Schofield | Chairman | 2018 | Date | 1. Member of WYAAT Committee in Common<br>2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership<br>3. Volunteer with Supporting Older People (charity).<br>4. Chair of NHSE Northern Region Talent Board<br>5. Member of Humber Coast and Vale ICS Partnership |
| Jacqueline Andrews | Medical Director | June 2020 | Date | Familial relationship with managing partner 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)<br>2. Company Director for the flat management company of current residence<br>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<br>2. Chairman, Headrow Money Line Ltd<br>3. Director and Shareholder, Cross Consulting Ltd (dormant)<br>4. Chairman – Forget Me Not Children's hospice, Huddersfield<br>5. Governor – Grammar School at Leeds<br>6. Director, GSAL Transport Ltd<br>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.<br>2. Chair of the Safeguarding Practice Review Group.<br>3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network.<br>4. Member of the North Yorkshire and York Safeguarding Health Professionals Network.<br>5. Member of the national network of Designated Health Professionals.<br>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<br>2. Member of NHS England and Improvement North East and Yorkshire Regional People Board<br>3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS |

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Wallace Sampson OBE | Non-executive Director | March 2020 | Date | 1. Chief Executive of Harrogate Borough Council<br>2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company.<br>3. Chair of Harrogate Public Services Leadership Board<br>4. Member of North Yorkshire Safeguarding Children Partnership Executive<br>5. Member of Society of Local Authority Chief Executives<br>6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. |
| Mrs Laura Angus | NExT Non-executive Director | January 2021 | Date | 1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG<br>2. Chair of York and Scarborough Medicines Commissioning Committee<br>3. Interim Chief Pharmacist at Humber, Coast and Vale ICS<br>4. MTech Associate; Council Member PrescQIPP<br>5. Chair of Governors at Kirby Hill Church of England Primary School |
| 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<br>2. Director of NCER CIC (Chair of the Board from April 2019)<br>3. Director and Trustee of TCV (The Conservation Volunteers)<br>4. Chair of the Corporation of Selby College<br>5. Member of the Association of Directors of Children's Services<br>6. Member of Society of Local Authority Chief Executives<br>7. Local Government Information Unit Associate<br>8. Local Government Information Unit (Scotland) Associate<br>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<br>2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice |
| 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 |

**Appendix B**

## Fit and Proper Person Test

## Chairman's Annual Declaration

As Chairman of Harrogate and District NHS Foundation Trust, I confirm that all Executive Directors, Directors and Non-executive Directors comply with the Care Quality Commission Regulation 5 and existing requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following completion of all appropriate Fit and Proper Person Test checks all Executive Directors, Directors and Non-executive Directors are considered to be of good character, and mentally fit. There has been no evidence of misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity.



My declaration has been informed by:

Completion of the annual Fit and Proper Persons Test self-declaration;
My knowledge of the Trust recruitment process for new appointments at Director level, which includes the application and interview process; reference checks and other pre-employment checks; a review of the Boards Register of Interests;
A review of the GMC and NMC register to ascertain whether such registration was valid for the role covered by a Director;
A review of DBS checks; and
A review of the individual insolvency register and directors disqualification register for the individuals agreed as meeting the definition of a Director undertaken by the Head of Recourcing in February 2021.

**Recommendation**

The Board of Directors is asked to note the contents of this report and receive assurance that Harrogate and District NHS Foundation Trust is fully compliant with Regulation 5 and the associated requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

**Angela Schofield**
**Chairman**

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 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. |

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# Board of Directors Meeting (held in Public)

## 26 May 2021

## Report of the Chief Executive



### 1.0 Introduction

1.1 Since the last Board meeting in March we have welcomed Russell Nightingale as our Chief Operating Officer and Emma Nunez as our Interim Executive Director of Nursing, Bidwifery & AHPs. Both have taken forward with pace, enthusiasm and drive their respective priorities – Russell on operational recovery, and service delivery and improvement, and Emma on Quality, Safety and professional leadership. Along with Jackie Andrews, our Medical Director they are working together to ensure there is clarity of roles and responsibilities, cohesive triumvirate leadership at a service level, ensuring that directorates have the right capacity and capabilities and that the corporate teams are aligned in a way that supports delivery of our key priorities.

1.2 The Director of Strategy role has been advertised and will help the Trust take forward the transformation and integration of services, as well as helping ready the Trust for the changes in the NHS landscape arising from 'Integrating Care'. The substantive Director of Nursing, Midwifery and AHP's is also currently advertised.

1.3 Our Board workshop took place on 28th April 2020, and focused on Board development, Board reporting and the Board Assurance Framework and then with BAME colleagues who joined and challenged us, we together considered our role, and the steps that should be taken to move towards being an anti-racist organisation. This built on the proposals from workshops that had previously taken place as part of our response to the staff survey, the workplace race equality standard (WRES) and our priority on valuing difference, ensuring all colleagues fell a sense of belonging, and are treated fairly.

1.4 We marked Ramadan in a very different way this year with Hussain, one of our colleagues in Harrogate Integrated Facilities, sharing what Ramadan meant to him to all colleagues on Team Talk, with spaces for colleagues to pray, grab bags for colleagues outside of the fasting period, and guidance to managers on how to support colleagues during Ramadan. Our catering colleagues introduced a Halal menu to celebrate Eid and particular thanks goes to them for their thoughtful and careful consideration of this.

1.5 A bid for resources to meet the Ockenden actions has been submitted, with the support of the Local Maternity System (LMS).

1.6 To mark the contribution of colleagues during an extra-ordinary year, and having reflected on feedback we have given every colleague in HDFT and HIF a 'Thank you #teamHDFT day' which is an additional day of annual leave for colleagues to take before 31st March 2022.

### 2.0 Recovery of services

2.1 Referrals for planned care were at 95% of pre-pandemic levels (2019) in April 2021, and attendances at the Emergency Department were at 99%. Despite this, emergency admissions to hospital have remained slightly below previous levels (90%). During May attendances have increased, and are now higher than pre-pandemic levels which is placing strain on the emergency pathway, and the team.

2.2 For elective activity all types of treatment for patients (outpatients, day cases and inpatients) were above the nationally expected threshold – but below the same level in 2019/20 which means the waiting list continues to grow and waiting times continue to increase in some specialities.

2.3 The Trust is working collaboratively with Trusts in the West Yorkshire Association of Acute Trusts (WYAAT) through the elective co-ordination hub to ensure that waiting times are not disproportionately different in different Trusts. Targeted collaboration is also taking place with Trusts in the Humber, Coast and Vale (HCV) Integrated Care System.

2.4 One of the priorities is to recover services in a way which is considerate of inequalities, and although only one way to consider this, we have examined waiting times. This shows that there are some differences in waiting times between patients from more deprived areas and patients in more affluent areas. The average waiting time for patients in the most deprived areas (measured through the Index of Multiple Deprivation) of Harrogate was 113 days, and 95 days for patients in the least deprived areas. Waiting times for patients from an ethnic minority were slightly lower than others in both urgent and routine care. This requires further, and more detailed examination to understand the causes of these differences, and may in the case of ethnicity be affected by the sample size. We also need to explore other inequality lenses such as patients with a learning disability, and whether there are any differences in access to healthcare for different groups of patients.

2.5 Our 0-19 services continue to face pressure, with a surge in demand and an increased vacancy rate (9%) and we have approved further resources for safeguarding to try and support teams. Whilst mandated contacts as part of the Healthy Child Programme continue to take place, some are being conducted virtually based on a risk assessment and because of the increase in safeguarding the preventative work that health visitors and school nurses would ordinarily undertake has been compromised.

## 3.0 'At our best' – the HDFT way

3.1 "At our best" describes our ambition to achieve consistently high standards in everything that we do, across our key priority areas.

3.2 As part of this, we have agreed four behaviours that we value, and which represent how HDFT and HIF colleagues can consistently be at our best. They are – Kindness, Integrity, Teamwork and Equality.

3.3 A behaviour framework has been designed, and over 700 leaders have participated in two workshops to support colleagues to adopt a set of tools and practices that will help embed these behaviours into our daily working lives, through recruitment, induction, a strengths based appraisal process, wellbeing conversations, a structured feedback model and a pathway for resolution of conflict.

3.4 Feedback on the tools from the workshops has been very positive and the 'alignment' work has been intensive but very worthwhile. It is planned to 'launch' these tools, along with the values in June, and to ensure that all colleagues are able to access shorter 'learning' on the tools and the behaviour framework.

3.5 A colleague app is in development to improve communication and to allow colleagues to more easily access resources and is planned to go live in June. In July the Inpulse app (which will be integrated into the colleague app) will go live and is a way of testing sentiment more regularly, as well as supporting teams to solve challenges. Inpulse is an online platform for colleague engagement, framed around workplace satisfaction

surveys and sentiment analysis. A comprehensive package of "wrap around" support has been developed to support first line leaders who will be responsible for making changes to support improved workforce experience scores. This will include action learning sets, coaching resources, webinars and technical training, as well as access to nationally available NHS resources. Training will take place in June, with a July launch. In addition to a core set of questions, we will focus on one of the behaviours each quarter. Our reward and recognition schemes will also be aligned to this.

## 4.0 Planning for 2021/22

4.1 Following an SMT workshop, the key trustwide priorities are proposed as follows:

- Recovery of elective services, in a way which does not exacerbate health inequalities
- Recovery of 0-19 services
- Caring at our best including our approach to frailty, right patient right team and Learning at our best
- Health & Wellbeing of colleagues, 'At our best' and equality, diversity and inclusion

## 5.0 Modern Slavery and Human Trafficking Act 2015

5.1 The Trust's annual statement in accordance with the Modern Slavery Act 2015 is provided at Appendix A. The Board is asked to consider and approve this statement to support the legislation requirements, which will be displayed on the Trust's website.

## 6.0 Corporate Risk Register

6.1 The Corporate Risk Register (CRR) has been reviewed by the Corporate Risk Review Group and Senior Management Team since the last Board meeting was held 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.

## 7.0 Board Assurance Framework

7.1 The Board Assurance Framework (BAF) has been reviewed and discussed by the Board at its Workshop since the last meeting and a summary of the updated BAF is attached at Appendix C. The detailed BAF is provided on the agenda today for Board's review.

## 8.0 Recommendation

8.1 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.

## 9.0 Supporting Information

9.1 The following papers make up this report:
Appendix A - the Trust's annual statement in accordance with the Modern Slavery Act 2015
Appendix B –Corporate Risk Register Summary
Appendix C – Board Assurance Framework Summary

**Appendix A**

# Modern Slavery and Human Trafficking Annual Statement

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

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

## Policies relating to Modern Slavery

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

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

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

## Our People

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

## Our Supply Chain

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

## Our Performance

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

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

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

Approval for this statement
*This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2021.*

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

***Steve Russell***
***Chief Executive***

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Chief Executive Report (Corporate Risk Register)

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|---|---|
| **Agenda Item Number:** | **7.0 (Appendix B)** |
| **Presented for:** | Note/Discuss |
| **Report of:** | Chief Executive |
| **Report History:** | Corporate Risk Review Group<br>Senior Management Team |
| **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 Corporate Risk Register and consider whether there are items where further assurance is required.

7

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Chief Executive Report (Corporate Risk Register – Appendix B)

1. The Corporate Risk Register (CRR) consists of operational risks scoring 12 or above. It is reviewed monthly at the Corporate Risk Review Group.

2. Some key changes and issues to highlight are as follows:

3. **CRR34 – Autism Assessment**. The original recovery plan was to reduce waiting times to within three months by September 2021. The original improvement plan increased capacity to 46 per month from 21, and assumed referral rates of 30 per month. This has increased to 46 per month, and consequently limited progress is being made into reducing waiting times. Additional non-recurrent support of £0.3m has been provided for a 12 month period, and the service are recruiting to those posts. This will increase the capacity to 60 per month, but the service have forecast it will take up to 27 months to reduce the waiting times if referrals continue at the current level. Although the target date will not be met, it has not yet been changed whilst further work is undertaken to validate the modelling and to identify options to address the waiting times.

4. **CR41 – RTT**. A broader piece of work has been agreed to consider patients who are not on an RTT pathway, such as those on active monitoring.

   In addition, although embedded within this risk, community dental waits form a significant proportion of long waits. The recovery plan is underway and over 52 week waits have reduced from 705 to 609, and are forecast to reduce to 120 by November 2021, supported by the non-recurrent resource. Without extension of this, the long waits will start to rise. Work is underway to consider how to achieve an RTT complaint pathway on a sustainable basis.

5. **CR52 – Cancer pathways**. This relates primarily to the two week pathway in breast services, and ongoing failure to meet the standard over a number of months. Whilst additional short term actions have been agreed and are likely to support improvement by August, these need to be tested for sustainability (as referred to in paragraph 10).

6. **CR57 – Impact of safeguarding demand**. On review of this risk at Senior Management Team, further scoping is being undertaken to identify options to provide additional shorter term support whilst recruitment to the additional roles agreed takes place.

7. **CR5 – Nursing shortage**. For the 0-19 service the modelling shows that the position is at best stand still. As such additional measures are to be scoped to alongside the demand and capacity review which is taking place.

8. C**R59 – Cancer tracking system**. This has been agreed as part of the 2021/22 capital programme. The revenue consequences will be managed within the collective directorate envelopes. This risk has been rescored to 9, and will remain on the LTUC risk register to ensure continued progress.

9. **CR61 – ED 4 hour standard**. Although the risk has remained as 12, it was noted that activity has increased to above pre-COVID levels which is placing further pressure on performance. An RPIW is planned to explore alternative pathways to reduce pressure, building on the recommendations of the ECIST report because the target date has been passed (as referred to in paragraph 10) and the standard has consistently been failed.

10. The target risk scores have not been met by the planned dates for the following risks – CR52 which relates to resilience in the Breast Cancer pathway, CR54 which relates to Staff wellbeing, CR2 which relates to gaps in medical staffing, CR61 which relates to the ED four hour standard, and CR63 which relates to risks arising from violence and aggression. In order to consider management of these risks in more detail, a detailed review of the action plan will be undertaken to better define new proposed dates along with clarity on what conditions would need to be met to reduce the risk.

11. The risks relating to nursing vacancies are currently aggregated for all nurses. It has been agreed this risk needs to be split to better show the risk relating to acute nursing, community nursing and school nursing and health visiting). This will be completed for the next review of the risk register.

12. The following risks are in the process of being removed from the corporate risk register:

13. **CR49 – ED Imaging**. This has been removed from the corporate risk register as the unit is being commissioned, and the arrangements during the work have been effective. It will remain on LTUC's risk register for a short period of time as it is commissioned.

14. **New risks** which have been added, which are to be developed are as follows:

15. CR66 – Aseptic Unit. This relates to the estate related risks. The required works to manage the immediate risk form part of the 21/22 capital programme, whilst the WYAAT business case is developed further.

16. CR67 – COVID testing platform. This relates to the resilience of the current platform. Additional platforms are being tested and trialled and this will allow the risk to be reduced if these are successful as expected.

17. Anaesthetic workforce gaps which may impact on the elective recovery programme. The target date for resolution is June 2021, and the next review will consider the actions being taken and the likelihood of this being achieved, and the conditions required to reduce the risk.

18. Nursing leadership in planned and surgical care due to three resignations (Head of Nursing and two matrons). Whilst these are out to advert, there are risks arising from the concurrent turnover. The Deputy Director of Nursing will provide direct support to the directorate as part of the mitigation.

19. The following changes are being made with effect from the month of June 2021 to strengthen the process of risk review:

20. Directorate risk registers will be reviewed in broader Directorate performance reviews, to review risk scoring, progress of actions and any themes across directorates which would together warrant a corporate risk.

21. The Corporate Risk Register will be reviewed in an Executive Risk Group, chaired by the Chief Executive, with the Executive Directors prior to review by SMT.

22. It is recommended that the Board discuss and note the Corporate Risk Register and consider whether there are items where further assurance is required.

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

| Ref | Description | Date added to CRR | Risk score May 2021 | Risk score April 2021 | 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 commencement of autism assessment within 3 months of referral.<br><br>Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. | Dec-18 | 12 | 12 | 9 (Sept 2021) | ↔ | **Update May 21**<br>An increase in referral rate means that capacity matches demand (referrals and capacity per month are both 46) and as a result means no reductions are being made to the waiting list which currently stands at 545. The longest wait is currently 71 weeks.<br><br>Recruitment to the staff to support the recovery plan is underway which will support a further 14 assessment per month. This is funded by non-recurrent funding of £278k provided by the CCG.<br><br>Whilst there is non-recurrent support in place for 12 months starting from June (when staff are expected to start) which will increase capacity to 60 per month this will have a more limited impact on the reduction in waiting times. If referral rates remain at the current level without further intervention the service has forecast it would take 27 months to reduce the waiting times to three months.<br><br>**Next steps**<br>Options are being explored to reduce recovery timescales.<br><br>**Mitigation**<br>A formal diagnosis is not required to put in place the strategies required to support the child.<br><br>Part of the non-recurrent funding enables a pilot of the Solihull model with a number of the families which gives access to information/strategies via a virtual platform to support them whilst they await the assessment. | Changes in referral numbers will impact on the recovery timeline<br><br>The funding provided is non recurrent and there will need to be a provision made to allow the funding to bridge more than one financial year.<br><br>Recovery timescales will be impacted by ability to recruit and also any leavers from the service. | Chief Operating Officer |

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|---|---|---|---|---|---|---|---|---|---|
| CR41 | **Summary RTT**<br>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<br><br>Link to BAF January 2021 | Aug-19 | 12 | 12 | 6<br>(May 2021) | ↔ | **May 2021**<br>Safety risk – Clinical Harm Review process should be articulated in management plan re: mitigation of risk.<br><br>**PSC update**<br>Virtual review clinics underway for P4 long waiting patients across specialties.<br><br>Social Distancing in DSU has been reviewed with IPC, trolley capacity can increase from the reduced 10 trollies to 18 trollies (safety measures and guidance is in place and all patients are assessed to determine if they are clinically extremely vulnerable so they can be given a side room)<br><br>Contract continued with Medinet to provide increased capacity for Endoscopy, this is significantly improved the waiting list position and treatment of patients. | 1. Requirement for social distancing in ward areas is limiting pace of recovery<br>2. Ongoing gap to plan for endoscopy and outpatients | Chief Operating Officer |
| CR52 | **Patients, delayed cancer diagnostics, treatment and care.**<br>Risk to patient safety, quality of care and psychological impact of delays in diagnostics, treatment plans and surveillance on patients and families<br><br>Link to BCS14 BCSP - Risk of not achieving national standards due to pressure on service at Leeds re CTC scans added January 2021 | Apr-20 | 12 | 12 | 8<br>(April 2021) | ↔ | **May 2021**<br><br>The current area of risk is predominantly in breast 2 week wait performance and capacity. Patient triage, additional adhoc clinics and engagement of a private provider have added additional capacity in breast with an improving position. Demand in breast remains high but less volatile. Current radiology capacity in CT/MRI above 19/20 levels. Endoscopy activity also recovered. | 1. Streamlined monitoring / tracking requirements<br>2. Psychological support<br>3. Limited diagnostic testing<br>4. Limited theatre capacity<br>5. Limited capacity in Breast one-stop service | Chief Operating Officer |
| CR54 | **Staff well-being and morale**<br>Risk to staff wellbeing and morale in the context of the Covid pandemic. | Apr-20 | 12 | 12 | 9<br>(April 2021) | ↔ | **May 2021**<br>Staff morale is multifaceted following the pandemic and not limited to covid. Large piece of work still ongoing around staff health and wellbeing and morale.<br><br>(We are comfortable with the narrative that PSC have added here) | • Uncertainty associated with the potential impact of a second peak.<br>• National guidance on isolation may result in an increase in the number of staff isolating.<br>• 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 |

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|---|---|---|---|---|---|---|---|---|---|
| CR57 | **Risk to patient safety, quality of care and staff welfare 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 (November 2021) | ↔ | **May 2021**<br>A Business Case has been approved to increase Safeguarding resource to reflect the pressures on the specialist team and the 0-19 teams.<br><br>Agreement in place to allow 0-19 service to continue with virtual visits based on the risk assessment of the practitioner (with the exception of the primary visit which has to be done face to face). This is to support the teams with the increased safeguarding work.<br><br>Reviewing at a Trust level what other staff could be freed up to support Safeguarding Strategy Meetings. | • Availability of specialist expertise | Chief Nurse |
| CR59 | **Cancer IT Services**<br>Potential risk to patient safety due to lack of automated system for tracking<br>Risk to patient safety from missing relevant / important information due to difficulties with multiple electronic record systems. | Jul-20 | 12 | 12 | 6 (October 2021) | ↔ | **May 2021**<br>Current legacy system remains in place but is reliant on large amount of manual input and support. Modern systems currently being appraised with 6-week timescale for going to tender.<br><br>We have rescored the risk to be 3x3 = 9 (as no patient harms detected since July 20) | Lack of automated system for MDT tracking highlighted in several incidents | Chief Operating Officer |
| CR2 | **Rota gaps in Medical Staffing**<br>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) | ↔ | **May 2021**<br>Junior doctor rota in medicine currently has 2 gaps which commenced in May 2021, prior to that the rota was full.<br>Consultant vacancies remain in acute medicine, respiratory medicine, haematology and cardiology. Successful recruitment has taken place in acute medicine, respiratory medicine and cardiology with candidates expected to take up post in the next 3 months. Acute oncology support from Leeds and York is ongoing and sufficient but there are pressures on acute oncology across the region. We also have our long-standing locum oncologist. | 1. Lack of availability of alternative workforce.<br>2. Development of alternative acute care model.<br>3. Ability to fill in line with current Agency Cap rate.<br>4. Recruitment of substantive Acute Oncology, Respiratory, Acute Medicine, Cardiology Consultants | Medical Director |

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| CR5 | **Nursing shortage**<br>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 (October 2021) | ↔ | **May 2021**<br>PSC<br>Recruitment process for PSC Wards, Theatres and Endoscopy have and continue to be undertaken to mitigate and fill the gaps.<br><br>Open Days have been undertaken with further scheduled for Theatres.<br><br>Current Vacancies for PSC are::<br>Current RN vacancies for PSC wards: 5 RN<br>Planned new RN starters: 5 RN (over the coming months)<br>Current CSW vacancies for PSC: 8 CSW<br>Planned CSW new starters: 5 CSW<br>Main Theatres<br>Current RPractitioners vacancies for PSC: 5.5 RN<br>SN RPractitioners for PSC: 3.5 RN<br>RPractitioners Mat Leave for PSC: 2 RN<br>RPractitioners LtS for PSC: 1 RN<br>DSU<br>Current RPractitioners vacancies for PSC: 6.73 RN<br>Endoscopy<br>Current RN vacancies: 9 RN<br>Planned new RN starters: 3 RN (over the coming months)<br>Current B6 Vacancies: 1<br><br>**0-19:**<br>Significant vacancy gaps in Band 6 specialist 0-19 roles remain.<br><br>A recruitment and retention group and action plan are in place. This includes looking at skill mix and new roles, sign up to NHSP, rolling recruitment days in line with inpatient nursing and improved use of social media to promote roles.<br><br>Posts have now been offered to all students at the end of their placements.<br>Modelling undertaken to evaluate impact of current turn over and recruitment plans which will be updated | 1. Current vacant Registered Nurse posts across the in-patient ward areas.<br>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.<br>3. Trust inpatient ward turnover of registered nurses 15%<br>4. Lack of available alternative workforce<br>5. Increased gaps at CSW level<br>6. 10% staffing (RN &CSW) uplift required for seasonal escalation beds<br>7. Increase in sickness due to covid | Chief Nurse |

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|---|---|---|---|---|---|---|---|---|---|
| CR61 | **ED 4 hour standard**<br>Risk of failure to meet 4 hour ED standard with resultant risk to patient experience and increased concerns and complaints associated with long waits. Increased morbidity and mortality associated with long stays in the emergency department. | Aug-20 | 12 | 12 | 8<br>(April 2021) | ↔ | **May 2021**<br>Activity has grown to above 19/20 levels over the last few weeks with the restrictions to flow associated with COVID-19 infection control compliance remaining in place resulting in a growth in the patients waiting in the ED for longer than 4/ 6 hours to admission or discharge.<br>To reduce delays more rapid COVID-19 testing is being implemented.<br>Development of a urgent treatment walk in stream in rapidly being progressed to manage circa 30% of attendances in a more efficient manner releasing ED staff to focus on the most sick patients.<br>The same day emergency care unit is taking patients directly from the ambulance service to avoid the emergency department.<br><br>Relaunch of the acute referral line to primary care to better manage acute patient flow. | 1. Uncertainty on activity levels post CV19 and associated staffing requirements<br>1. ED staffing levels return to pre CV19 levels April 21<br>1. Challenges planning staffing based on unknowns in relation to continued impact of CV19 on workload post April 21.<br>2. Limited access to mental health & inpatient mental health beds<br>3. Limited support from specialities<br>4. Lack of timely acceptance by specialities<br>5. Limited omission avoidance options available overnight<br>10. COVID impact: access to testing impacting on flow: social distancing & use of PPE; cubicle cleaning between positive patients; side room capacity whilst a/w results | Chief Operating Officer |
| CR63 | **Security, Violence & Aggression**<br>Increasing number of incidents relating to violence or threat of violence to staff in our acute services with a risk of physical and/or psychological harm to staff or other patients. | Jan-21 | 12 | 12 | 4<br>(April 2021) | ↔ | **May 2021**<br><br>Additional de-escalation training planned for staff, portering staff available to assist.<br>Additional CCTV and body cams are being planned.<br>Remain able to contact the police for support.<br>Responding to patients with unacceptable behaviour with letters to be written to them detailing the incident and any further actions the hospital may take. Security arrangement continue to be reviewed through a re-convened security forum. | 1. Available Breakaway training<br>2. Security staff<br>3. Facilities not conducive to managing a violent episode (lock down)<br>5. Extended stays in unit<br>6. Training for caring for patients who are violent / aggressive<br>7. Police response times | Chief Operating officer |
| CR65 | **Maternity electronic record system**<br>Risk to compliance with national strategy, ease of compliance with MSDS, and patient safety risk due to lack of end-end maternity electronic record system. | Feb-21 | 12 | 12 | 2<br>(December 2021) | ↔ | **May 2021**<br>Currently the Maternity unit are without an end-end maternity electronic record system.<br><br>Funding has been agreed for system and meetings have been initiated starting the discussion around the procurement process. | • Unable to offer patient access to own records which will mean we are not compliant with Digital Maternity Record Standard and risk to Maternity Incentive Scheme<br>• Lack of single system means there may be risks due to lack of effective sharing of information at point of care (and between regional Trusts) resulting in possible omission of important safety information<br>• Inability for on-call Consultant to access system remotely which | Chief Nurse |

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| | | | | | | | | would improve safety and more effective decision-making<br>• Lack of single system makes extraction of data for the Maternity Services Dataset more complex<br>• Significant duplication of clinical information in multiple systems and handwritten patient records leading to significant inefficiencies and time/financial wastage<br>• Lack of pathways embedded in electronic system mean there is lack of prompting about appropriate management and potential for omissions in care<br>• More complexity in provision of community based care due to limited access to electronic records<br>• Potential loss to follow up | |
| CR67 | **Covid test analyser - risk of disruption to flow and elective work**<br>Risk to COVID-19 service provided by Microbiology, HDFT by loss of the single testing platform due to age of analyser or lack of available engineers to fix or maintain analyser. | Mar-21 | 12 | 12 | tbc | ↔ | **May 2021**<br>There is a risk of disruption to flow and elective work due to the risk of the single testing platform failing. The analyser was not designed for the recent workload and it failed x3 last month. There is some resilience and contingencies with neighbouring providers for elective work but there is a risk to acute work. A new platform is being developed and another is being trialled.<br><br>**We now have 4 different platforms capable of delivering COVID-19 testing which would lead to this being re-scored as 9 moving to LTUC risk register.** | No analyser resilience across the three sites in the JV. | tbc |
| NEW | **Anaesthetic gaps**<br><br>**Long term gaps on junior tier rota due to a number of reasons including trainees who are novices and not yet clinically able join the o/c rota in addition to maternity gaps.** | May-21 | 12 | | 2 (June-21) | New | **May**<br><br>**The Anaesthetic team are trying to appoint a locum post but have been unsuccessful to date. The team are working with the Finance manager to look to appoint a consultant post.**<br><br>**The Clinical lead is reviewing Anaesthetic Job plans to review redistribution of PAs where possible to fill gaps on the rota.** | Cancellation of theatre lists to prioritise P1 and P2 theatre lists<br>Patients get cancelled on the day or day before.<br>Poor patient experience<br>Increased length of wait for patients | tbc |

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| NEW | **Nursing leadership within the PSC directorate**<br><br>**Head of Nursing and two Matron leaving.** | May-21 | 12 | | 2 (Oct-21) | New | **May**<br><br>**Currently the 2x Matron posts are out to advert for secondments, the Deputy Head of Nursing post is due to be advertises.**<br><br>**The Deputy Chief nurse is to provide Nursing leadership support to the directorate whilst continuing to recruit into the vacant posts.** | Lack of Matron leadership across:<br>Endoscopy<br>Day surgery<br>Main theatres<br>ITU<br>Senior Nursing leadership around quality standards and complaints<br>Reduced Moral across Nursing teams | |

**Updates in May 2021 are highlighted in blue.**

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

| Ref | Description | Date added to CRR | Risk score May 2021 | Risk score April 2021 | Target risk score (date aimed to be achieved) | Risk movement | Current status | Gaps in controls | Lead Executive Director |
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| CR41 | **Summary RTT**<br>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<br><br>Link to BAF January 2021 | Aug-19 | 12 | 12 | 6<br>(May 2021) | ↔ | **May 2021**<br>Safety risk – Clinical Harm Review process should be articulated in management plan re: mitigation of risk.<br><br>**PSC update**<br>Virtual review clinics underway for P4 long waiting patients across specialties.<br><br>Social Distancing in DSU has been reviewed with IPC, trolley capacity can increase from the reduced 10 trollies to 18 trollies (safety measures and guidance is in place and all patients are assessed to determine if they are clinically extremely vulnerable so they can be given a side room)<br><br>Contract continued with Medinet to provide increased capacity for Endoscopy, this is significantly improved the waiting list position and treatment of patients. | 1. Requirement for social distancing in ward areas is limiting pace of recovery<br>2. Ongoing gap to plan for endoscopy and outpatients | Chief Operating Officer |
| CR52 | **Patients, delayed cancer diagnostics, treatment and care.**<br>Risk to patient safety, quality of care and psychological impact of delays in diagnostics, treatment plans and surveillance on patients and families<br><br>Link to BCS14 BCSP - Risk of not achieving national standards due to pressure on service at Leeds re CTC scans added January 2021 | Apr-20 | 12 | 12 | 8<br>(April 2021) | ↔ | **May 2021**<br><br>The current area of risk is predominantly in breast 2 week wait performance and capacity. Patient triage, additional adhoc clinics and engagement of a private provider have added additional capacity in breast with an improving position. Demand in breast remains high but less volatile. Current radiology capacity in CT/MRI above 19/20 levels. Endoscopy activity also recovered. | 1. Streamlined monitoring / tracking requirements<br>2. Psychological support<br>3. Limited diagnostic testing<br>4. Limited theatre capacity<br>5. Limited capacity in Breast one-stop service | Chief Operating Officer |
| CR54 | **Staff well-being and morale**<br>Risk to staff wellbeing and morale in the context of the Covid pandemic. | Apr-20 | 12 | 12 | 9<br>(April 2021) | ↔ | **May 2021**<br>Staff morale is multifaceted following the pandemic and not limited to covid. Large piece of work still ongoing around staff health and wellbeing and morale.<br><br>(We are comfortable with the narrative that PSC have added here) | • Uncertainty associated with the potential impact of a second peak.<br>• National guidance on isolation may result in an increase in the number of staff isolating.<br>• 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 |

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|---|---|---|---|---|---|---|---|---|---|
| CR57 | **Risk to patient safety, quality of care and staff welfare 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 (November 2021) | ↔ | **May 2021**<br>A Business Case has been approved to increase Safeguarding resource to reflect the pressures on the specialist team and the 0-19 teams.<br><br>Agreement in place to allow 0-19 service to continue with virtual visits based on the risk assessment of the practitioner (with the exception of the primary visit which has to be done face to face). This is to support the teams with the increased safeguarding work.<br><br>Reviewing at a Trust level what other staff could be freed up to support Safeguarding Strategy Meetings. | • Availability of specialist expertise | Chief Nurse |
| CR59 | **Cancer IT Services**<br>Potential risk to patient safety due to lack of automated system for tracking<br>Risk to patient safety from missing relevant / important information due to difficulties with multiple electronic record systems. | Jul-20 | 12 | 12 | 6 (October 2021) | ↔ | **May 2021**<br>Current legacy system remains in place but is reliant on large amount of manual input and support. Modern systems currently being appraised with 6-week timescale for going to tender.<br><br>We have rescored the risk to be 3x3 = 9 (as no patient harms detected since July 20) | Lack of automated system for MDT tracking highlighted in several incidents | Chief Operating Officer |
| CR2 | **Rota gaps in Medical Staffing**<br>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) | ↔ | **May 2021**<br>Junior doctor rota in medicine currently has 2 gaps which commenced in May 2021, prior to that the rota was full.<br>Consultant vacancies remain in acute medicine, respiratory medicine, haematology and cardiology. Successful recruitment has taken place in acute medicine, respiratory medicine and cardiology with candidates expected to take up post in the next 3 months. Acute oncology support from Leeds and York is ongoing and sufficient but there are pressures on acute oncology across the region. We also have our long-standing locum oncologist. | 1. Lack of availability of alternative workforce.<br>2. Development of alternative acute care model.<br>3. Ability to fill in line with current Agency Cap rate.<br>4. Recruitment of substantive Acute Oncology, Respiratory, Acute Medicine, Cardiology Consultants | Medical Director |

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|---|---|---|---|---|---|---|---|---|---|
| CR5 | **Nursing shortage**<br>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 (October 2021) | ↔ | **May 2021**<br>PSC<br>Recruitment process for PSC Wards, Theatres and Endoscopy have and continue to be undertaken to mitigate and fill the gaps.<br><br>Open Days have been undertaken with further scheduled for Theatres.<br><br>Current Vacancies for PSC are::<br>Current RN vacancies for PSC wards: 5 RN<br>Planned new RN starters: 5 RN (over the coming months)<br>Current CSW vacancies for PSC: 8 CSW<br>Planned CSW new starters: 5 CSW<br>Main Theatres<br>Current RPractitioners vacancies for PSC: 5.5 RN<br>SN RPractitioners for PSC: 3.5 RN<br>RPractitioners Mat Leave for PSC: 2 RN<br>RPractitioners LtS for PSC: 1 RN<br>DSU<br>Current RPractitioners vacancies for PSC: 6.73 RN<br>Endoscopy<br>Current RN vacancies: 9 RN<br>Planned new RN starters: 3 RN (over the coming months)<br>Current B6 Vacancies: 1<br><br>**0-19:**<br>Significant vacancy gaps in Band 6 specialist 0-19 roles remain.<br><br>A recruitment and retention group and action plan are in place. This includes looking at skill mix and new roles, sign up to NHSP, rolling recruitment days in line with inpatient nursing and improved use of social media to promote roles.<br><br>Posts have now been offered to all students at the end of their placements.<br>Modelling undertaken to evaluate impact of current turn over and recruitment plans which will be updated | 1. Current vacant Registered Nurse posts across the in-patient ward areas.<br>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.<br>3. Trust inpatient ward turnover of registered nurses 15%<br>4. Lack of available alternative workforce<br>5. Increased gaps at CSW level<br>6. 10% staffing (RN &CSW) uplift required for seasonal escalation beds<br>7. Increase in sickness due to covid | Chief Nurse |

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|---|---|---|---|---|---|---|---|---|---|
| CR61 | **ED 4 hour standard**<br>Risk of failure to meet 4 hour ED standard with resultant risk to patient experience and increased concerns and complaints associated with long waits. Increased morbidity and mortality associated with long stays in the emergency department. | Aug-20 | 12 | 12 | 8<br>(April 2021) | ↔ | **May 2021**<br>Activity has grown to above 19/20 levels over the last few weeks with the restrictions to flow associated with COVID-19 infection control compliance remaining in place resulting in a growth in the patients waiting in the ED for longer than 4/ 6 hours to admission or discharge.<br>To reduce delays more rapid COVID-19 testing is being implemented.<br>Development of a urgent treatment walk in stream in rapidly being progressed to manage circa 30% of attendances in a more efficient manner releasing ED staff to focus on the most sick patients.<br>The same day emergency care unit is taking patients directly from the ambulance service to avoid the emergency department.<br><br>Relaunch of the acute referral line to primary care to better manage acute patient flow. | 1. Uncertainty on activity levels post CV19 and associated staffing requirements<br>1. ED staffing levels return to pre CV19 levels April 21<br>1. Challenges planning staffing based on unknowns in relation to continued impact of CV19 on workload post April 21.<br>2. Limited access to mental health & inpatient mental health beds<br>3. Limited support from specialities<br>4. Lack of timely acceptance by specialities<br>5. Limited omission avoidance options available overnight<br>10. COVID impact: access to testing impacting on flow: social distancing & use of PPE; cubicle cleaning between positive patients; side room capacity whilst a/w results | Chief Operating Officer |
| CR63 | **Security, Violence & Aggression**<br>Increasing number of incidents relating to violence or threat of violence to staff in our acute services with a risk of physical and/or psychological harm to staff or other patients. | Jan-21 | 12 | 12 | 4<br>(April 2021) | ↔ | **May 2021**<br><br>Additional de-escalation training planned for staff, portering staff available to assist.<br>Additional CCTV and body cams are being planned.<br>Remain able to contact the police for support.<br>Responding to patients with unacceptable behaviour with letters to be written to them detailing the incident and any further actions the hospital may take. Security arrangement continue to be reviewed through a re-convened security forum. | 1. Available Breakaway training<br>2. Security staff<br>3. Facilities not conducive to managing a violent episode (lock down)<br>5. Extended stays in unit<br>6. Training for caring for patients who are violent / aggressive<br>7. Police response times | Chief Operating officer |
| CR65 | **Maternity electronic record system**<br>Risk to compliance with national strategy, ease of compliance with MSDS, and patient safety risk due to lack of end-end maternity electronic record system. | Feb-21 | 12 | 12 | 2<br>(December 2021) | ↔ | **May 2021**<br>Currently the Maternity unit are without an end-end maternity electronic record system.<br><br>Funding has been agreed for system and meetings have been initiated starting the discussion around the procurement process. | • Unable to offer patient access to own records which will mean we are not compliant with Digital Maternity Record Standard and risk to Maternity Incentive Scheme<br>• Lack of single system means there may be risks due to lack of effective sharing of information at point of care (and between regional Trusts) resulting in possible omission of important safety information<br>• Inability for on-call Consultant to access system remotely which | Chief Nurse |

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| | | | | | | | | would improve safety and more effective decision-making<br>• Lack of single system makes extraction of data for the Maternity Services Dataset more complex<br>• Significant duplication of clinical information in multiple systems and handwritten patient records leading to significant inefficiencies and time/financial wastage<br>• Lack of pathways embedded in electronic system mean there is lack of prompting about appropriate management and potential for omissions in care<br>• More complexity in provision of community based care due to limited access to electronic records<br>• Potential loss to follow up | |
| CR67 | **Covid test analyser - risk of disruption to flow and elective work**<br>Risk to COVID-19 service provided by Microbiology, HDFT by loss of the single testing platform due to age of analyser or lack of available engineers to fix or maintain analyser. | Mar-21 | 12 | 12 | tbc | ↔ | **May 2021**<br>There is a risk of disruption to flow and elective work due to the risk of the single testing platform failing. The analyser was not designed for the recent workload and it failed x3 last month. There is some resilience and contingencies with neighbouring providers for elective work but there is a risk to acute work. A new platform is being developed and another is being trialled.<br><br>**We now have 4 different platforms capable of delivering COVID-19 testing which would lead to this being re-scored as 9 moving to LTUC risk register.** | No analyser resilience across the three sites in the JV. | tbc |
| NEW | **Anaesthetic gaps**<br><br>**Long term gaps on junior tier rota due to a number of reasons including trainees who are novices and not yet clinically able join the o/c rota in addition to maternity gaps.** | May-21 | 12 | | 2 (June-21) | New | **May**<br><br>**The Anaesthetic team are trying to appoint a locum post but have been unsuccessful to date. The team are working with the Finance manager to look to appoint a consultant post.**<br><br>**The Clinical lead is reviewing Anaesthetic Job plans to review redistribution of PAs where possible to fill gaps on the rota.** | Cancellation of theatre lists to prioritise P1 and P2 theatre lists<br>Patients get cancelled on the day or day before.<br>Poor patient experience<br>Increased length of wait for patients | tbc |

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| NEW | **Nursing leadership within the PSC directorate**<br><br>**Head of Nursing and two Matron leaving.** | May-21 | 12 | | 2 (Oct-21) | New | **May**<br><br>**Currently the 2x Matron posts are out to advert for secondments, the Deputy Head of Nursing post is due to be advertises.**<br><br>**The Deputy Chief nurse is to provide Nursing leadership support to the directorate whilst continuing to recruit into the vacant posts.** | Lack of Matron leadership across:<br>Endoscopy<br>Day surgery<br>Main theatres<br>ITU<br>Senior Nursing leadership around quality standards and complaints<br>Reduced Moral across Nursing teams | |

**Updates in May 2021 are highlighted in blue.**

**Appendix C**

# Board Assurance Framework Summary

**Key: new risks added highlighted in blue font**

| Risk ID | Principle Objective | Risk to the Delivery of the Objective | Current Risk Score | Target Risk Score |
|---|---|---|---|---|
| **1.Strategic Objective: TO BE AN OUTSTANDING PLACE TO WORK** | | | | |
| BAF#1.1 | 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 become an outstanding place to work, which in turn will impact on the quality of patient experience. | 12 | 4 |
| BAF#1.2 | 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 and ongoing behaviours impact colleagues behaviours making if more difficult for colleagues with protected characteristics to flourish in the organisation. | 12 | 4 |
| **2. Strategic Objective: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE** | | | | |
| 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. | 9 | 4 |
| 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 bandwidth to participate in both. This will impact on our ambition to be an active partner in population health and the transformation of health inequalities. | 9 | 4 |

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|---|---|---|---|---|
| **3. Strategic Objective: TO DELIVER HIGH QUALITY CARE** | | | | |
| 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 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. | 12 | 9 |
| 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. | 16 | 9 |
| BAF#3.3 | To provide high quality care to children and young people in adults community services | There is a risk that the Trust places insufficient focus on early years services and adult community based services because of the historic dominance of hospital services which will impact on the transformation opportunities and miss opportunities for long term outcomes and integrated care. | 16 | 9 |
| BAF#3.4 | To provide outstanding care and outstanding patient experience | There is a risk that the Trust is unable to increase activity because of the extended waiting time for treatment arising from the constraints on activity which may cause patient satisfaction to drop and harm to arise | 12 | 8 |
| BAF#3.5 | To provide a high quality public health 0-19 service | There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors. | 16 | 8 |
| **4. Strategic Objective: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY** | | | | |
| 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 | 12 | 6 |
| 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. | 8 | 8 |
| BAF#4.3 | To provide high quality care and to be a financially sustainable organisation | There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety | 12 | 9 |
| BAF#4.4 | To be financially stable to provide outstanding quality of care | Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality | 12 | 9 |

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Integrated Board report – April 2021



| | |
|---|---|
| **Agenda Item Number:** | **7.1** |
| **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 the following items of concern contained within this report:

- There were 3 serious incidents (SI) reported this month. However the number of hospital acquired pressure ulcers and inpatient falls both decreased.
- There was a decrease in the number of complaints received this month.
- HDFT's performance against the A&E 4-hour standard remained below 95% in April (86.3%). Provisional data indicate that the cancer 62 day standard was delivered in April, but all other cancer standards were not achieved for the month. For RTT, the number of patients waiting over 52 weeks is now 1,200, compared to 1,350 last month.

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## Integrated board report - April 2021

### Key points this month

1. The 4 key areas of concern this month relate to the Safety, Caring, Responsiveness and Workforce domains.

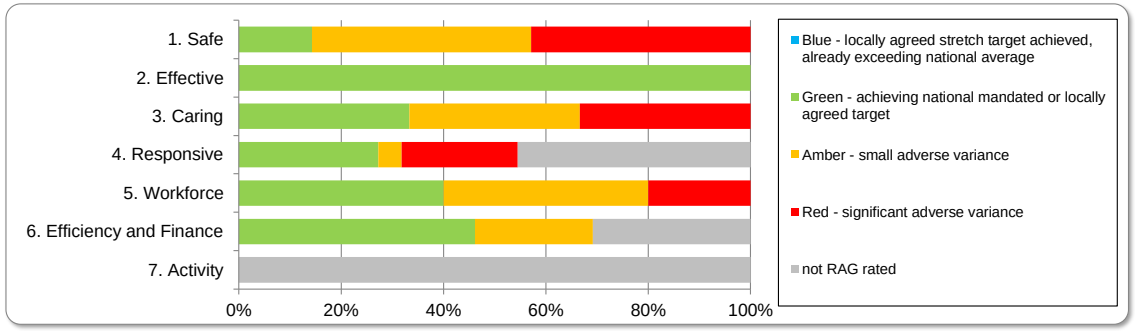
2. There were 3 serious incidents (SI) reported this month. However the number of hospital acquired pressure ulcers and inpatient falls both decreased.

3. There was a decrease in the number of complaints received this month.

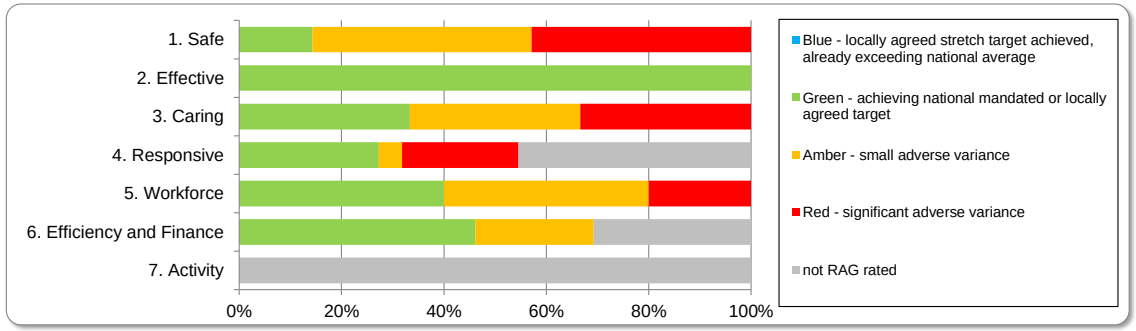
4. HDFT's performance against the A&E 4-hour standard remained below 95% in April (86.3%). Provisional data indicate that the cancer 62 day standard was delivered in April, but all other cancer standards were not achieved for the month. For RTT, the number of patients waiting over 52 weeks is now 1,199, compared to 1,350 last month.

5. Within Workforce, staff appraisal rates are increasing but remain well below the Trust's target of 90%.

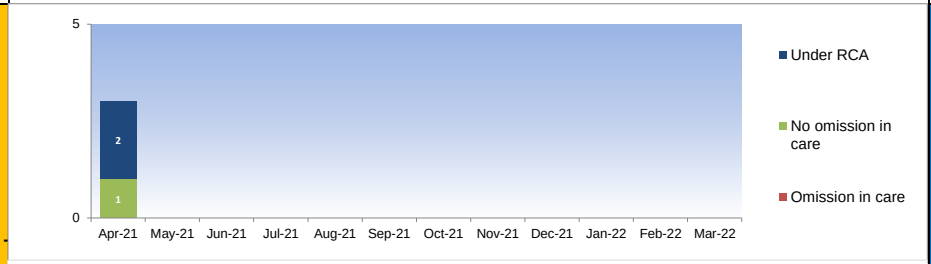
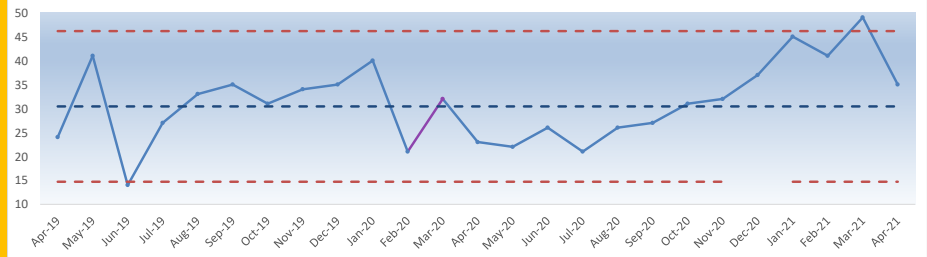
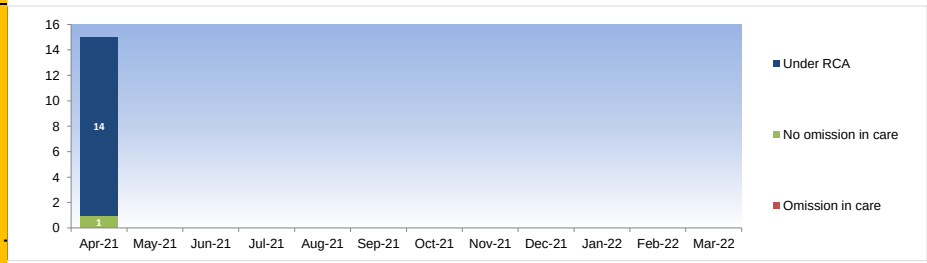
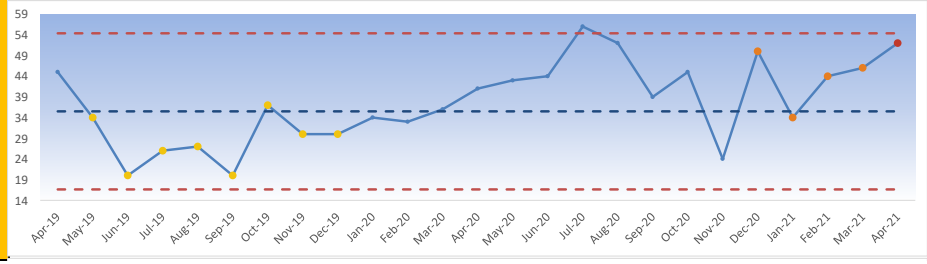
### Summary of indicators - current month




### Summary of indicators - year to date



## Section 1 - Safe - April 2021

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 1.1a | Pressure ulcers - hospital acquired |   | There were 3 hospital acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal), taking the total requiring RCA YTD to 3. This is lower than last year with an average of 5 per month reported in 2020/21. Of the 3 reported this month, there was 1 with no omission in care and 2 still under RCA (root cause analysis). |
| 1.1b | |   | The number of hospital acquired category 2 and above pressure ulcers reported in April was 35. This is decrease on previous months. The reported number is inclusive of device related and device related mucosal pressure ulcers. |
| 1.2a | Pressure ulcers - community acquired |   | There were 15 community acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal), taking the total requiring RCA YTD to 15. The average per month reported in 2020/21 was 13. Of the 15 reported this month, there was 1 no omission in care and 14 under RCA. |
| 1.2b | |   | The number of community acquired category 2 and above pressure ulcers reported in April was 52. The number reported is inclusive of device related and device related mucolsal pressure ulcers. |

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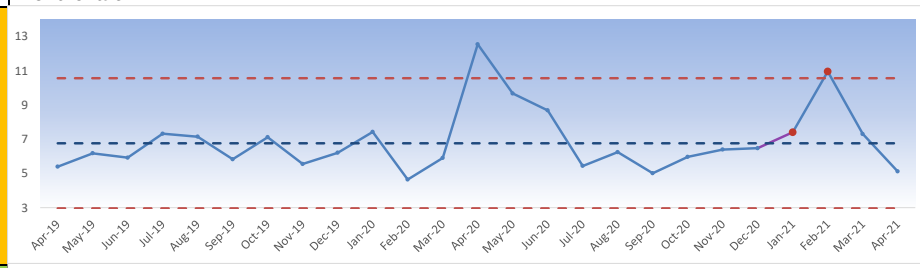
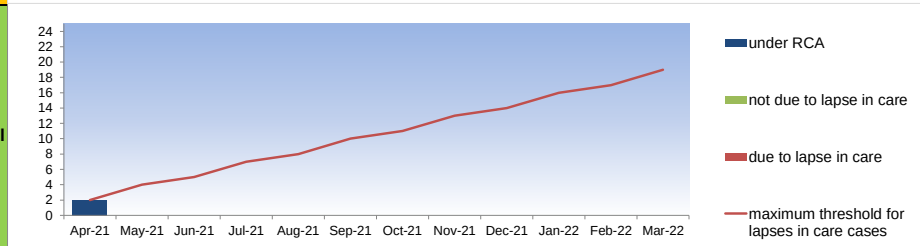
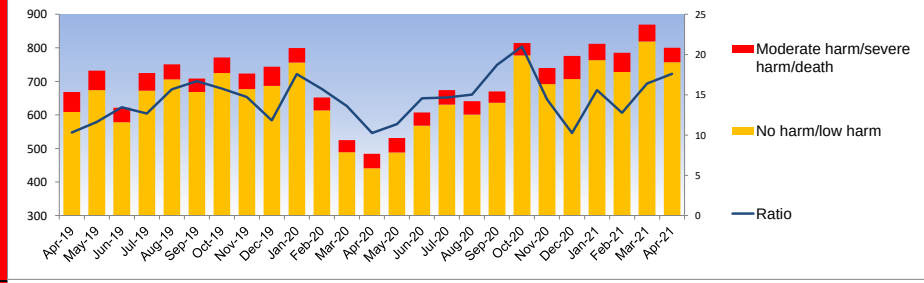
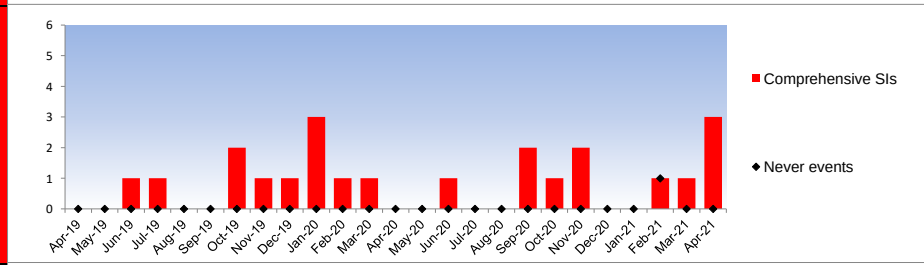
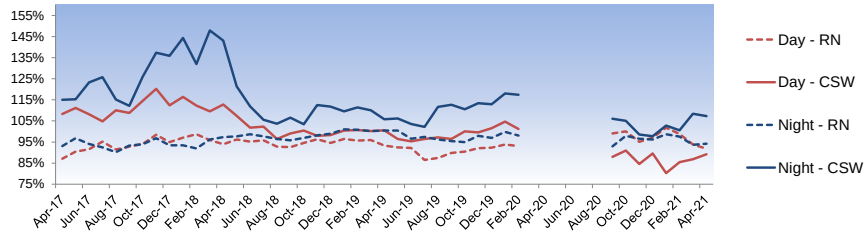
## Section 1 - Safe - April 2021

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 1.3 | Falls |  | The rate of inpatient falls was 5.11 per 1,000 bed days in April. This a decrease on recent months and lower than the average HDFT rate for 2020/21 (7.7). |
| 1.4 | Infection control |   | There were 2 cases of hospital apportioned C. difficile reported in April bringing the year to date total to 2 cases. The annual maximum threshold for lapses in care cases for 2021/22 is 19.<br><br>This graph shows cumulative data YTD.<br><br>No MRSA cases have been reported in 2019/20 or 2020/21 or 2021/22 to date. |
| 1.5 | Incidents - all |   | The latest published national data (for the period Oct 19 - March 20) shows that Acute Trusts reported an average ratio of 45.8 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 14.9, an increase on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for April gives a ratio of 17.6. |
| 1.6 | Incidents - Serious incidents (SI) and never events |   | 3 SI's were verified in April, with a position YTD at 3.<br><br>0 Never Events were reported in April, with the YTD position at 0 cases. There was 1 Never Event reported in 2020/21 and none reported in 2017/18, 2018/19 or 2019/20. |

## Section 1 - Safe - April 2021

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 1.7 | Safer staffing levels |  | After being suspended due to Covid-19, this indicator has now resumed.<br><br>In April, staff fill rates were reported as follows:<br>- Registered Nurses Day 92% and Night 94%<br>- Care Staff Day 89% and Night 107% |

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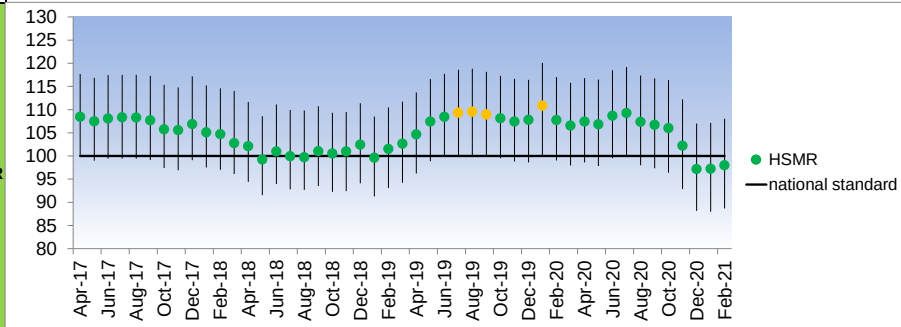
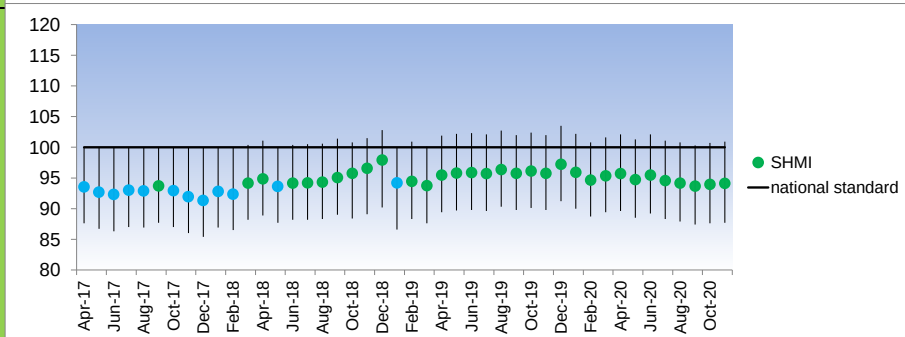
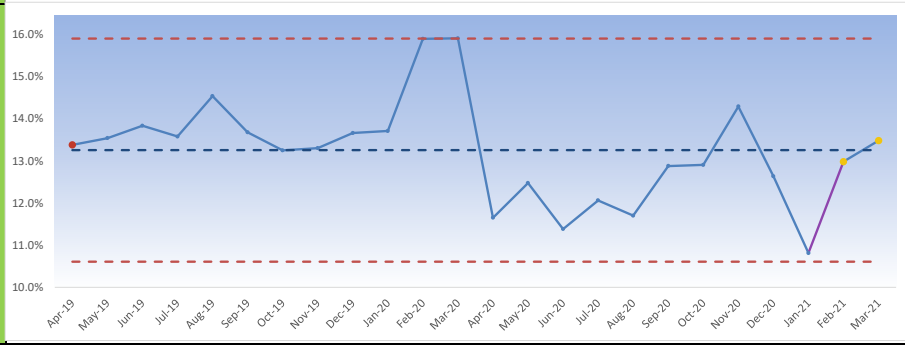
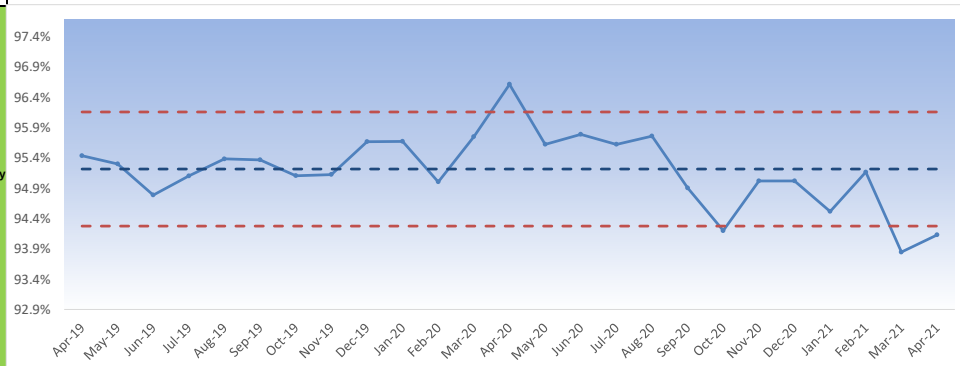
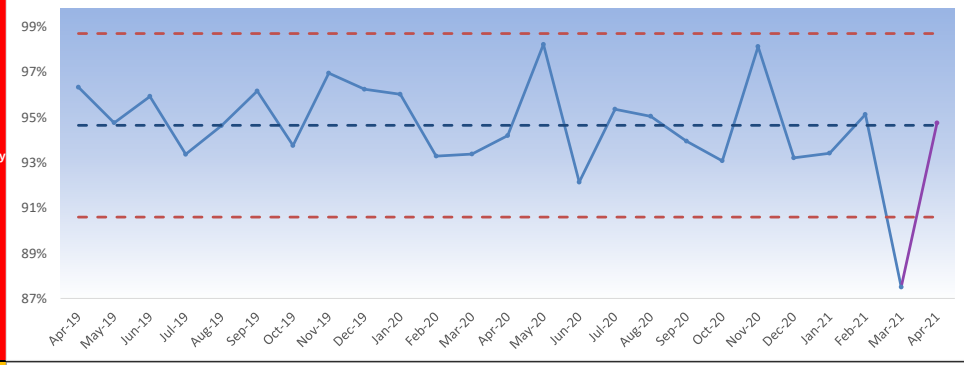
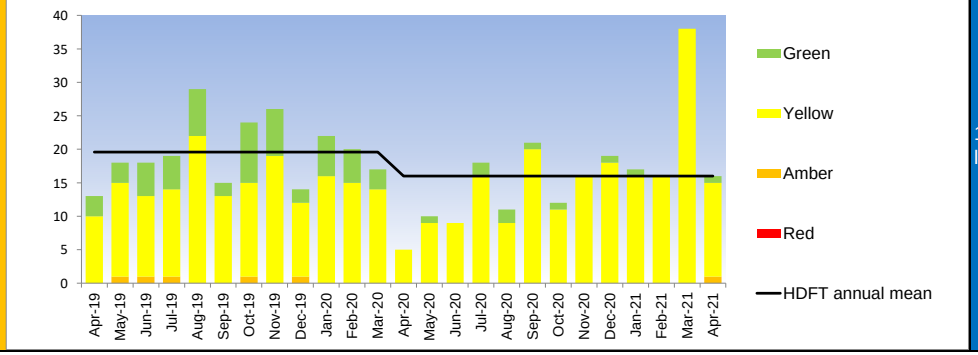
**Section 2 - Effective - April 2021**

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 2.1 | Mortality - HSMR |  | HDFT's HSMR increased to 98.00 for the rolling 12 months ending February 2021, but remains below the national average and within expected levels.<br><br>*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 November 2020 is 94.13, remaining below the national average and within 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.<br><br>*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 13.5% in March, but remain below the 2019/20 average of 14.0%. |

**Section 3 - Caring - April 2021**

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 3.1 | Friends & Family Test (FFT) - Patients |  | 94.2% of patients surveyed in April rated our services as good or very good, remaining above the latest published national average (93.3%, February 2020). Trusts are now required to submit this data to NHS England again on a monthly basis. Updated national benchmarking data is expected in the coming months.<br><br>2,804 patients responded to the survey this month, of which 2,640 would recommend our services. |
| 3.2 | Friends & Family Test (FFT) - Adult community services |  | 94.7% of patients surveyed in April rated our services as good or very good, an increase on last month (87.5%). The latest published national data (February 2020) shows 95.6% of patients surveyed would recommend the services. Trusts are now required to submit this data to NHS England again on a monthly basis. Updated national benchmarking data is expected in the coming months.<br><br>57 patients from our community services responded to the survey this month, of which 54 would recommend our services. |
| 3.3 | Complaints |  | 16 complaints were received in April (1 green, 14 yellow and 1 amber) which is 22 less than March, in line with the average for 2020/21 of 16 per month. |

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## Section 4 - Responsive - April 2021

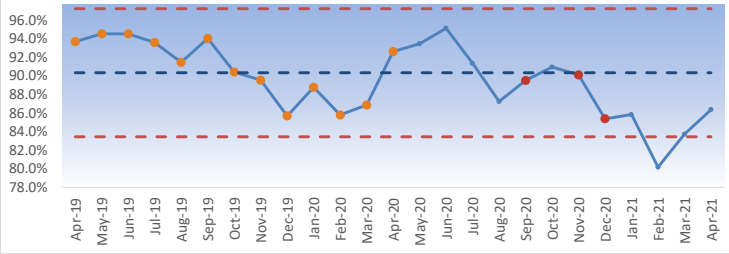
### NHS Improvement Single Oversight Framework

**4.1 NHS Improvement Single Oversight Framework**

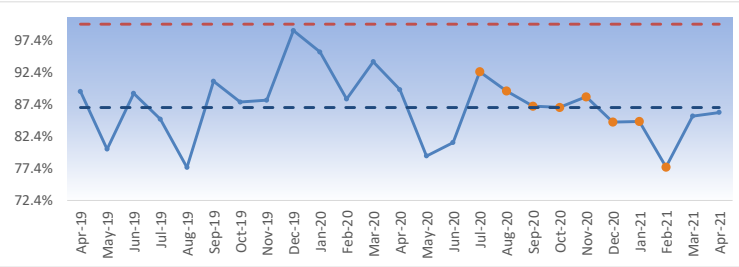
| Standard | Q1 to date | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|
| RTT incomplete pathways | | | | | |
| A&E 4-hour standard | 86.3% | | | | 86.3% |
| Cancer - 62 days | 85.1% | | | | 85.1% |
| Diagnostic waits | 79.7% | | | | 79.7% |
| Dementia screening - Step 1 | 95.5% | | | | 95.5% |
| Dementia screening - Step 2 | 100.0% | | | | 100.0% |
| Dementia screening - Step 3 | 100.0% | | | | 100.0% |

**4.2 RTT Incomplete pathways performance**

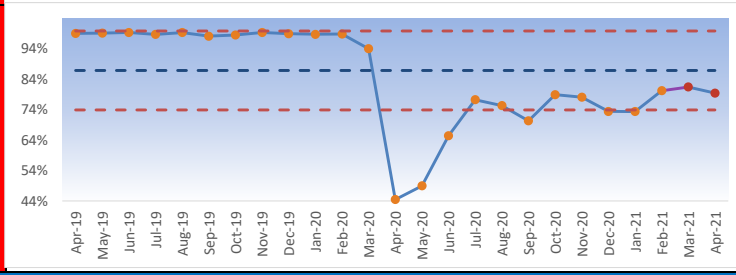
**4.3 A&E 4 hour standard**



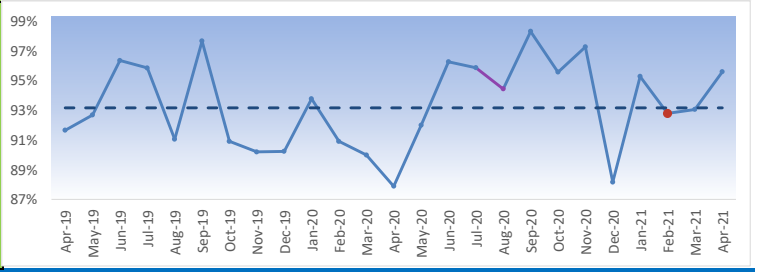

**4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment**




**4.5 Diagnostic waiting times - 6-week standard**




**4.6 Dementia screening**




**Narrative**

Performance against the A&E 4-hour standard improved in April but remains below the 95% standard at 86.3%.

Provisional data indicate that the cancer 62 day standard was delivered in April with performance at 86.2% – see further details below.

Data shows the performance on diagnostic waiting times decreased with 79.7% waiting less than 6 weeks at the end of April, 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 Steps 1, 2 and 3 were achieved in April.

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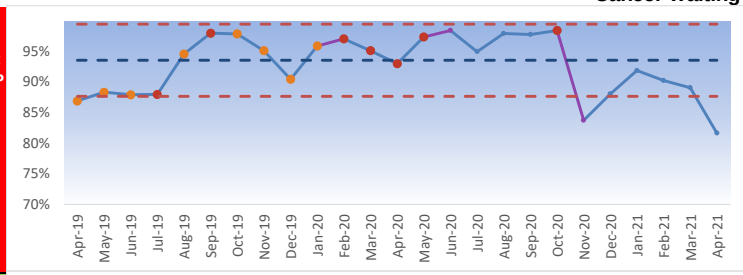
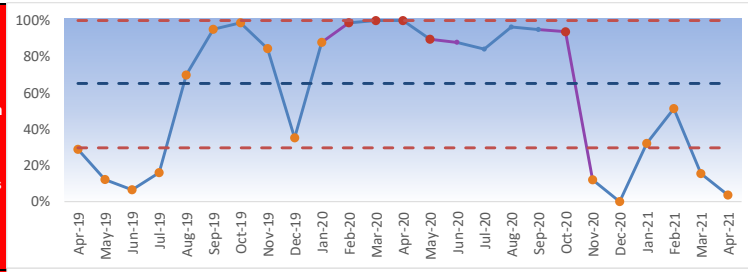
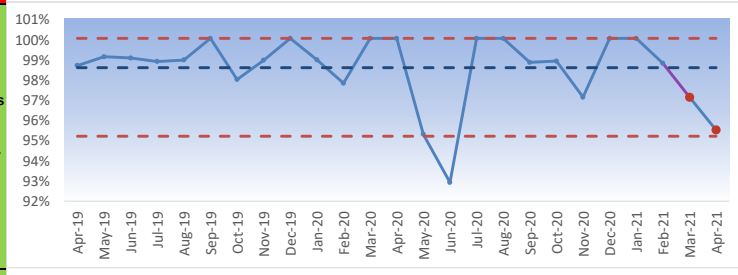
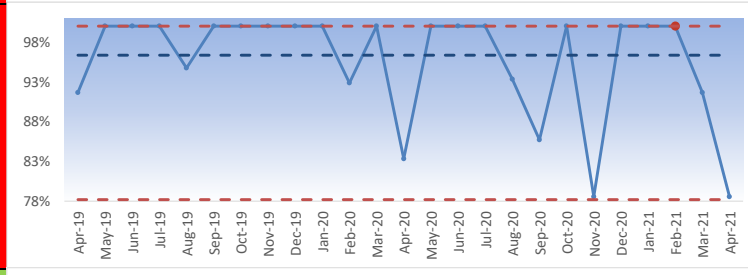
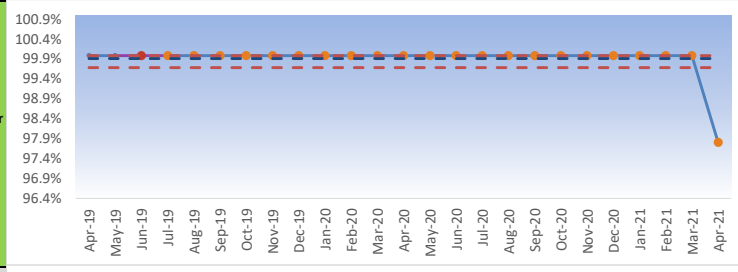
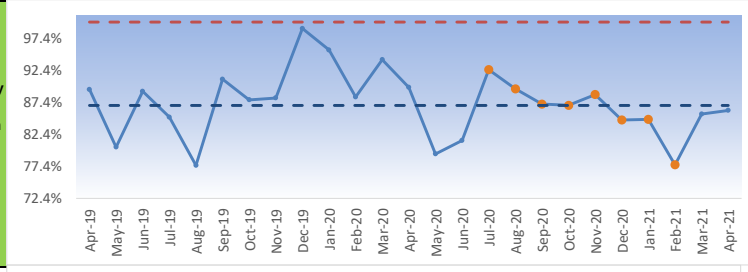
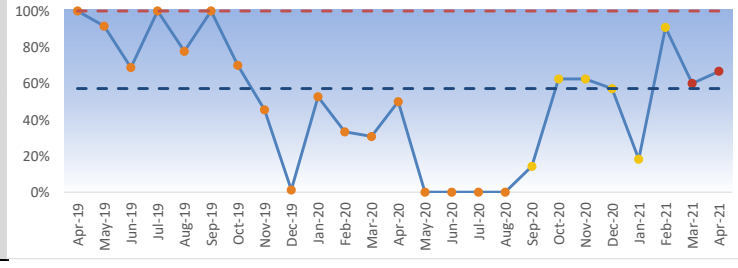
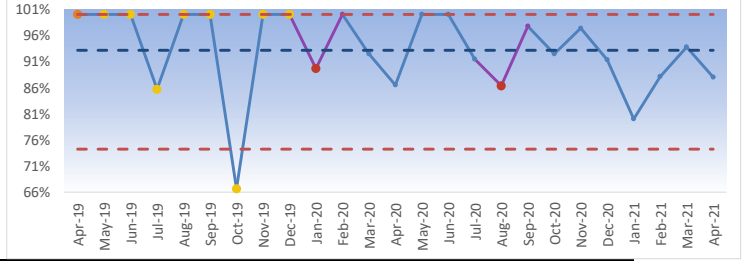
## Section 4 - Responsive - April 2021

### 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 - April 2021

**Narrative**

Provisional data indicates that 6 of the 7 applicable cancer waiting times standards were not achieved in April with only the 62 day standards delivered (86.2%).

The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots, and the average wait for a 2WW breast appointment in April was around 24 days, compared to 18 days last month. Of 805 first attendances for suspected cancer, 148 were seen after day 14 (81.6%) and of these, 129 were breast referrals. 2WW Breast symptomatic performance deteriorated further in April with performance at 3.6%, compared to 15.5% last month. Additional clinic capacity is being provided and discussions are also progressing with an external provider for additional support.

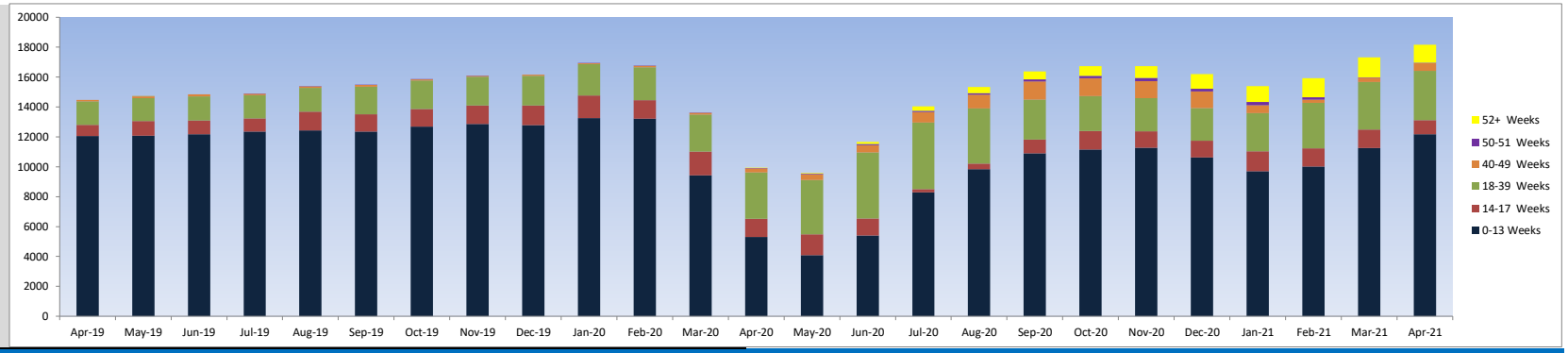
Provisional data indicates that the 62 day standard was delivered in April with performance at 86.2%. Provisionally there were 61.0 accountable treatments (70 patients) in April with 8.0 treated outside 62 days. Of the 10 tumour sites treated in April, performance was below 85% for 3 (Colorectal, Gynaecology, and Upper GI). 3 patients waited over 104 days for treatment in April (all treated at Leeds) – delays were due to medical/diagnostic complexity and diagnostic capacity for prostate biopsy. Provisional data indicate that 55.6% (10/18) of patients treated at tertiary centres in April were transferred by day 38, which is slightly lower than last month (62.5%).

62 day Screening performance was below the 90% standard in April, and activity levels were above the de minimus for the month with 10 patients attributable to HDFT (equivalent to 6.0 accountable treatments), and of these 3 patients was treated after day 62 (1 x Breast; 2 x Bowel) – when re-allocation rules are applied this equates to 66.7% of patients treated within 62 days.

88 first definitive treatments were delivered in April and 4 patients received their surgical treatment after day 31 (2 x Breast; 2 x Colorecta), and 6 surgical subsequent treatments were delivered in April after day 31 – these delays were largely due to a combination of reduced surgical capacity and patient safety considerations relating to Covid-19. One patient's subsequent chemotherapy treatment was delivered after day 31 in April - this was not related to any capacity constraints in oncology. With a total of 46 anti-cancer drug subsequent treatments in April and 1 over 31 days, provisional performance for the month was at 97.8% against the 98% operational standard.

All pathway delays will be reviewed by the breach panel at the end of May.

## Section 4 - Responsive - April 2021

| | | |
|---|---|---|
| 4.15 | RTT waiting list split by weeks |  |



**Narrative**

Provisional data shows that there were a total of 18,156 patients on the RTT waiting list at the end of April. There were 1,199 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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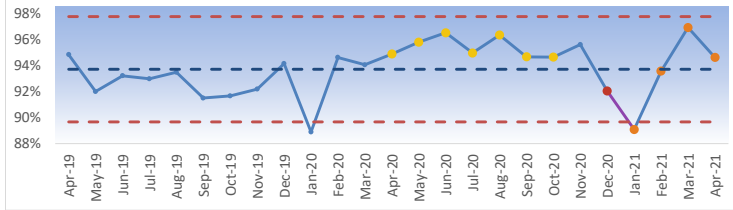
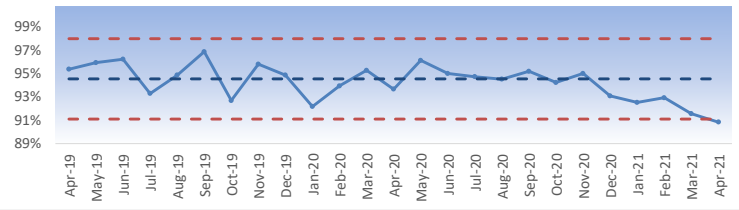
## Section 4 - Responsive - April 2021

### Children's Services metrics

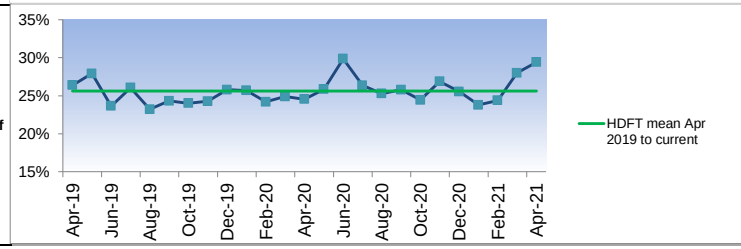
**4.16 Children's Services - 10-14 day new birth visit**




**4.17 Children's Services - 2.5 year review**

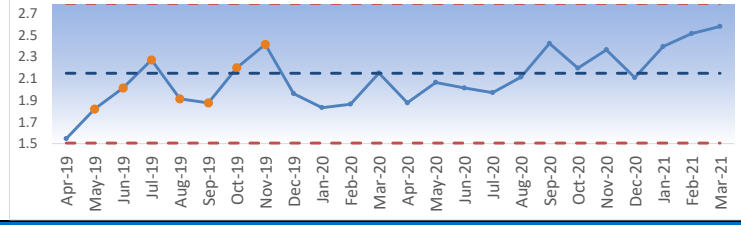



**4.18 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence.**

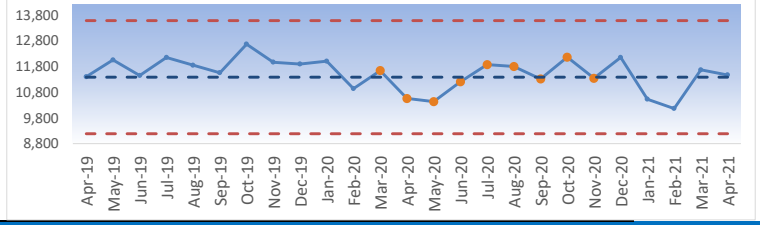



### Adult Community Services metrics

**4.19 OPEL level - Community Care Teams**




**4.20 Community Care Teams - patient contacts**




**Narrative**

*These indicators have not been updated yet for this month.*

The number of children receiving a 2 year review by age 2.5 has reduced in recent months but remains above the 90% threshold.

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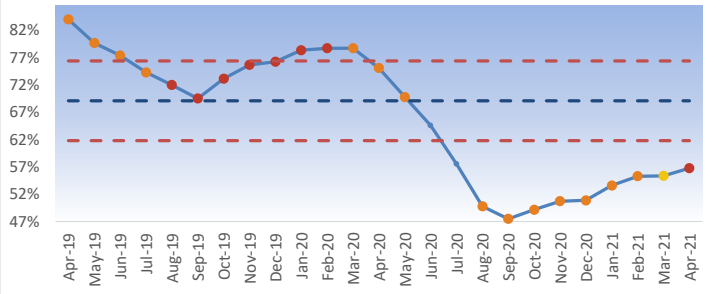
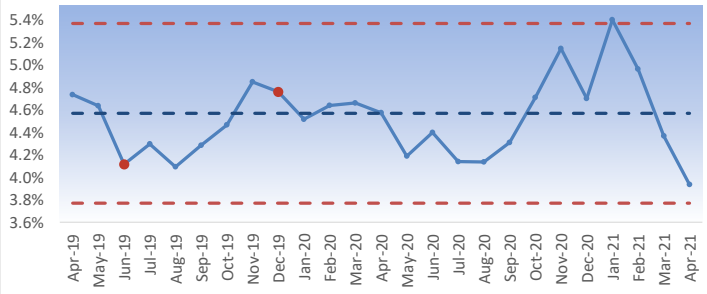
## Section 5 - Workforce - April 2021

| Indicator number | Indicator name | 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 56.3%. |
| 5.2 | Mandatory training rates | | The data shown is for the end of April. The overall training rate for mandatory elements for substantive staff is 92% and has increased since the last reporting cycle. |
| 5.3 | Sickness rates |  | The overall sickness rate has decreased in April 2021 to 3.9% and is below average. Non-Covid-19 related sickness was 3.7% this month. |



| Competence Name | Renewal Period | Required | Achieved | Compliance % |
|---|---|---|---|---|
| Information Governance and Data Security | Annual | 4126 | 3654 | 89% |
| Equality, Diversity and Human Rights | 3 Yearly | 4126 | 3864 | 94% |
| Fire Safety | Annual | 4126 | 3536 | 86% |
| Health, Safety and Welfare | 5 Yearly | 4126 | 3952 | 96% |
| Infection Control | Once Only | 4126 | 4032 | 98% |
| Safeguarding Children | 3 Yearly | 4126 | 3785 | 92% |
| Safer Manual Handling | 3 Yearly | 4126 | 3771 | 91% |
| Risk Awareness | Once Only | 4126 | 3933 | 95% |
| Fire Safety Facilitator Led Training | 2 Yeary | 4126 | 3535 | 86% |

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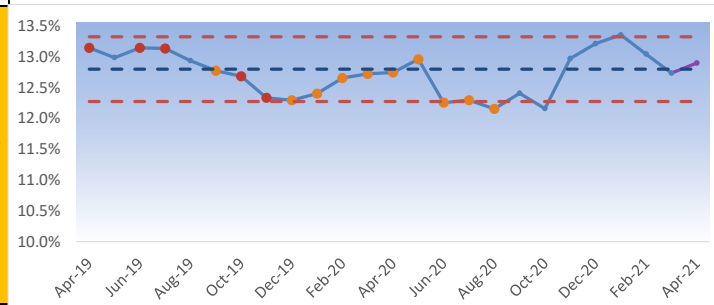
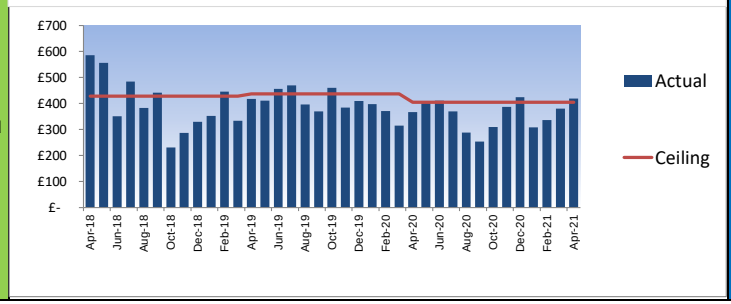
## Section 5 - Workforce - April 2021

| Indicator number | Indicator name | Trend chart | Interpretation |
|---|---|---|---|
| 5.4 | Staff turnover rate |  | Staff turnover remains within expected levels. Voluntary turnover increased this month, whilst involuntary turnover decreased. |
| 5.5 | Agency spend in relation to pay spend |  | Month 1 agency expenditure increased to £419k. The drivers for this are benig reviewed. |

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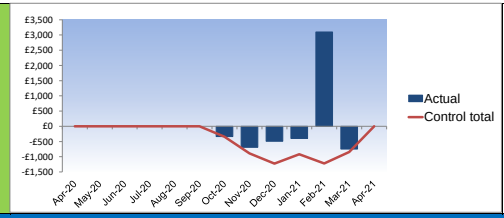
**Section 6 - Efficiency and Finance - April 2021**

## Finance

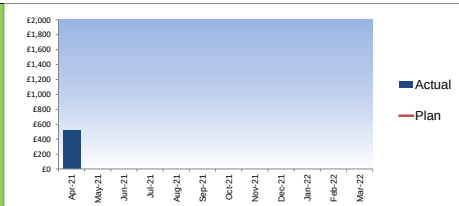
**6.1 Surplus / deficit and variance to plan**




**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**

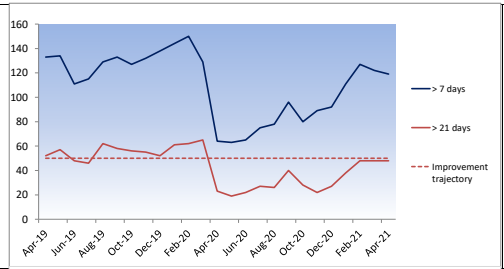
The Trust reported a breakeven position for month 1, aligned with the financial plan for the month.

The Use of Resources metric is currently reported as a 1. It should be noted that this rating is currently not being formally reported to NHSEI.

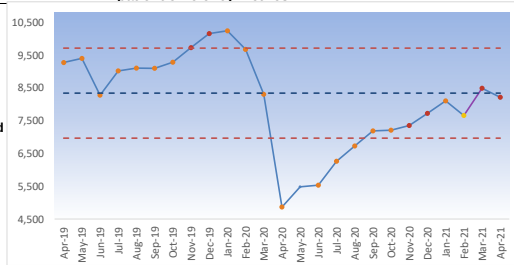
The Trust reported a £518k spend in month 1, significantly behind the £1,779k plan. It should be noted the plan needs to be updated to reflect the phasing of Salix works.

## Inpatient efficiency metrics

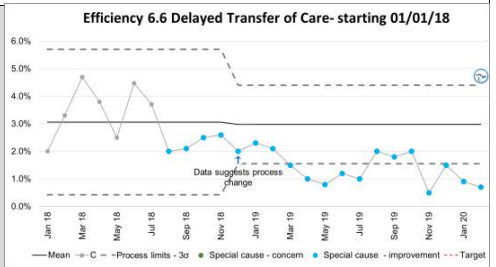
**6.4 Long stay patients**



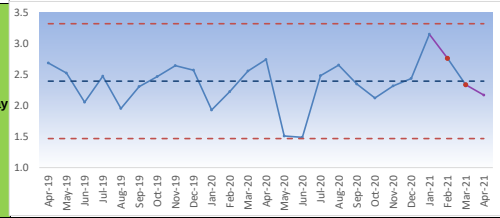

**6.5 Occupied bed days**



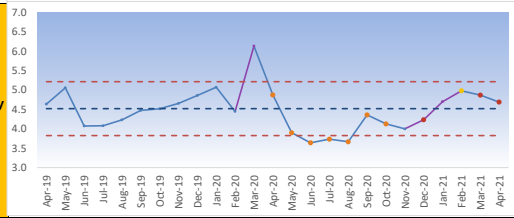

**6.6 Delayed transfers of care**



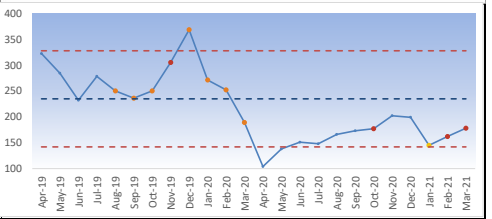

**6.7 Length of stay - elective**




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




**6.9 Avoidable admissions**




**Narrative**

In April, long stay patient numbers and occupied bed days remained stable. Elective and non-elective length of stay decreased. Avoidable admissions remain below the Trust mean.

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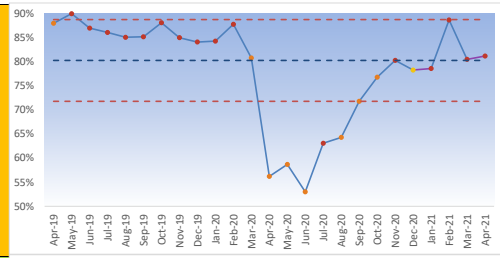
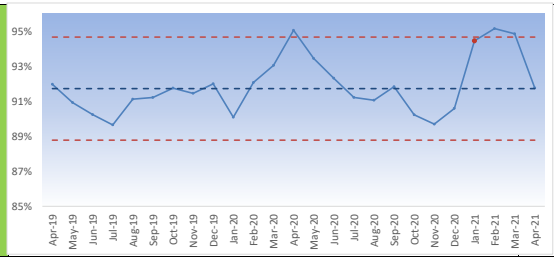
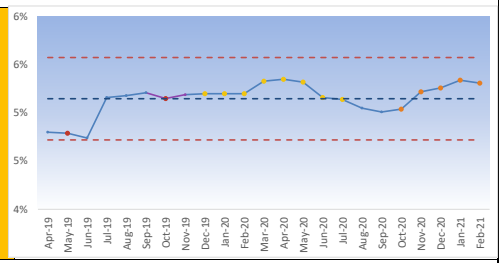
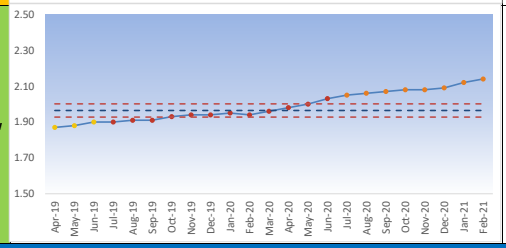
**Section 6 - Efficiency and Finance - April 2021**

| | | |
|---|---|---|
| 6.10 | **Theatre utilisation** |  |
| 6.11 | **Day case rate** |  |
| | **Outpatient DNA rate** |  |
| 6.13 | **Outpatient new to follow up ratio** |  |

**Narrative**

Theatre utilisation increased. Day case rate decreased in April but this reflects the increased inpatient elective activity within the month.

Outpatient DNA rates increased and the new to follow up ratio remained stable.

**Section 7 - Activity - April 2021**

**Narrative**

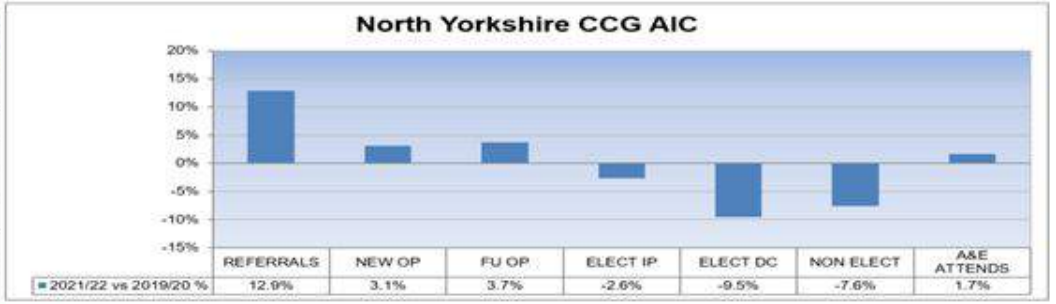
The tables below show activity by Point of Delivery by Contract Type: North Yorkshire AIC; All Other CCGs (PbR); NHSE, Yorkshire Hub Cost per Case.

In line with the comparisons made in the national planning requirements for 2021/22, the charts below compare 2021/22 activity to the equivalent period in 2019/20, rather than 2020/21

**Activity Summary**

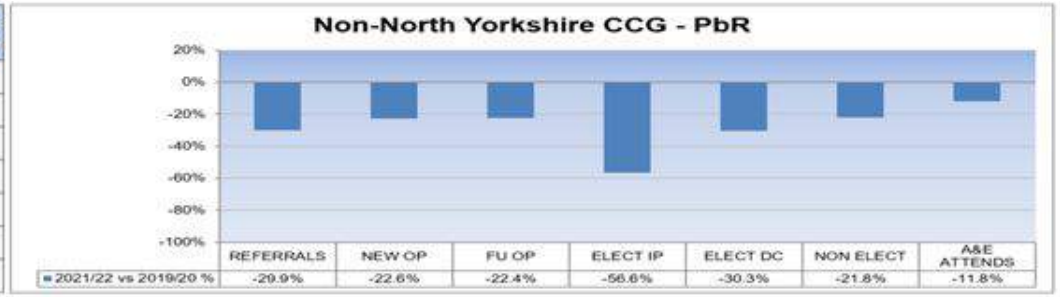
**North Yorkshire CCG AIC**

| GROUP | 2019/20 APR | 2021/22 APR | 2019/20 YTD | 2021/22 YTD | 2021/22 vs 2019/20 | 2021/22 vs 2019/20 % |
|---|---|---|---|---|---|---|
| REFERRALS | 3,203 | 3,615 | 3,203 | 3,615 | **412** | **12.9%** |
| NEW OP | 5,452 | 5,620 | 5,452 | 5,620 | **168** | **3.1%** |
| FU OP | 11,060 | 11,474 | 11,060 | 11,474 | **414** | **3.7%** |
| ELECT IP | 153 | 149 | 153 | 149 | **-4** | **-2.6%** |
| ELECT DC | 1,802 | 1,630 | 1,802 | 1,630 | **-172** | **-9.5%** |
| NON ELECT | 1,495 | 1,382 | 1,495 | 1,382 | **-113** | **-7.6%** |
| A&E ATTENDS | 3,241 | 3,296 | 3,241 | 3,296 | **55** | **1.7%** |




**Non-North Yorkshire CCG - PbR***

| GROUP | 2019/20 APR | 2021/22 APR | 2019/20 YTD | 2020/21 YTD | 2021/22 vs 2019/20 | 2021/22 vs 2019/20 % |
|---|---|---|---|---|---|---|
| REFERRALS | 1,564 | 1,097 | 1,564 | 1,097 | **-467** | **-29.9%** |
| NEW OP | 2,104 | 1,629 | 2,104 | 1,629 | **-475** | **-22.6%** |
| FU OP | 4,002 | 3,107 | 4,002 | 3,107 | **-895** | **-22.4%** |
| ELECT IP | 99 | 43 | 99 | 43 | **-56** | **-56.6%** |
| ELECT DC | 753 | 525 | 753 | 525 | **-228** | **-30.3%** |
| NON ELECT | 487 | 381 | 487 | 381 | **-106** | **-21.8%** |
| A&E ATTENDS | 1,224 | 1,079 | 1,224 | 1,079 | **-145** | **-11.8%** |

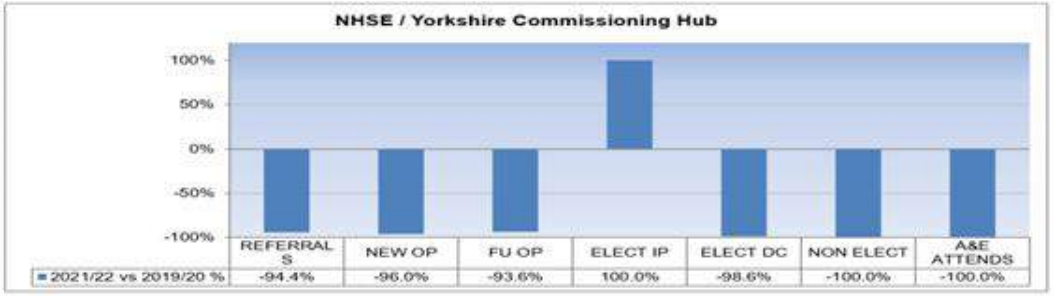



*Non-HaRD CCGs: Leeds CCG, Vale of York CCG, All Other CCGs

Harrogate and District NHS Foundation Trust

**NHSE / Yorkshire Commissioning Hub**

| GROUP | 2019/20 APR | 2021/22 APR | 2019/20 YTD | 2020/21 YTD | 2021/22 vs 2019/20 | 2021/22 vs 2019/20 % |
|---|---|---|---|---|---|---|
| REFERRALS | 234 | 13 | 234 | 13 | **-221** | **-94.4%** |
| NEW OP | 252 | 10 | 252 | 10 | **-242** | **-96.0%** |
| FU OP | 468 | 30 | 468 | 30 | **-438** | **-93.6%** |
| ELECT IP | 1 | 2 | 1 | 2 | **1** | **100.0%** |
| ELECT DC | 367 | 5 | 367 | 5 | **-362** | **-98.6%** |
| NON ELECT | 2 | 0 | 2 | 0 | **-2** | **-100.0%** |
| A&E ATTENDS | 10 | 0 | 10 | 0 | **-10** | **-100.0%** |



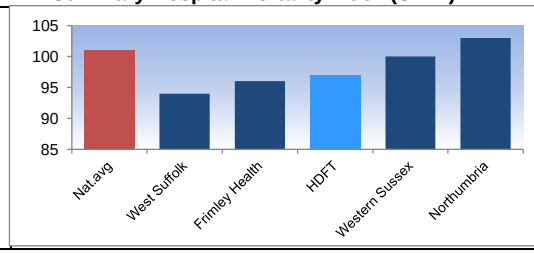

**Trust Total**

| GROUP | 2019/20 APR | 2021/22 APR | 2019/20 YTD | 2020/21 YTD | 2021/22 vs 2019/20 | 2021/22 vs 2019/20 % |
|---|---|---|---|---|---|---|
| REFERRALS | 5,001 | 4,725 | 5,001 | 4,725 | **-276** | **-5.5%** |
| NEW OP | 7,808 | 7,259 | 7,808 | 7,259 | **-549** | **-7.0%** |
| FU OP | 15,530 | 14,611 | 15,530 | 14,611 | **-919** | **-5.9%** |
| ELECT IP | 253 | 194 | 253 | 194 | **-59** | **-23.3%** |
| ELECT DC | 2,922 | 2,160 | 2,922 | 2,160 | **-762** | **-26.1%** |
| NON ELECT | 1,984 | 1,763 | 1,984 | 1,763 | **-221** | **-11.1%** |
| A&E ATTENDS | 4,475 | 4,375 | 4,475 | 4,375 | **-100** | **-2.2%** |

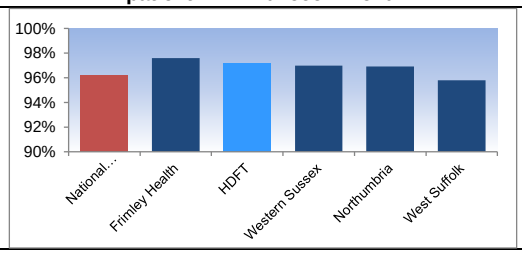
Harrogate and District NHS Foundation Trust

## Section 8 - Benchmarking - April 2021

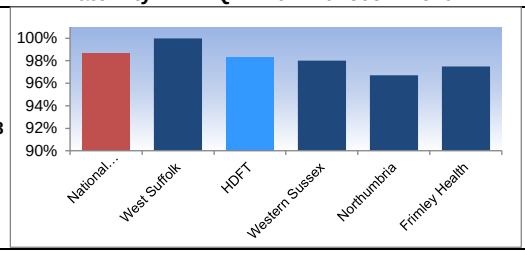
**8.1 Summary Hospital Mortality Index (SHMI)**



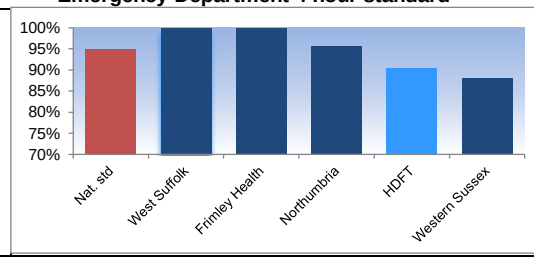

**8.2 Inpatient FFT - % recommend**




**8.3 Maternity FFT - Q2 Birth - % recommend**

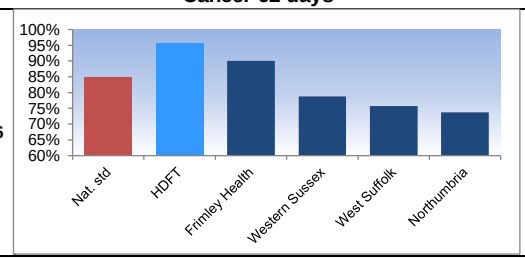



**8.4 Emergency Department 4 hour standard**

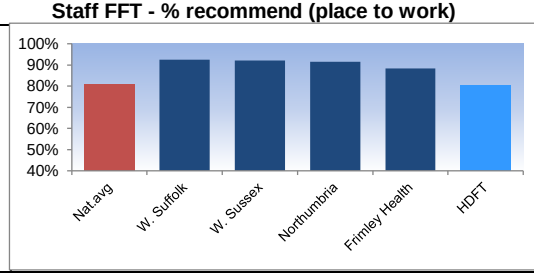



**8.5 RTT incomplete pathways**

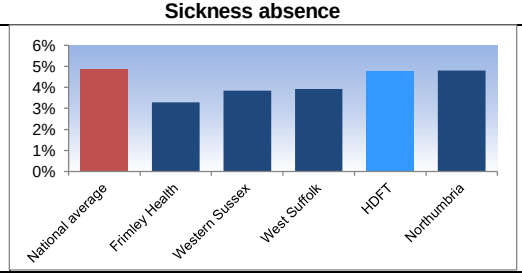
**8.6 Cancer 62 days**



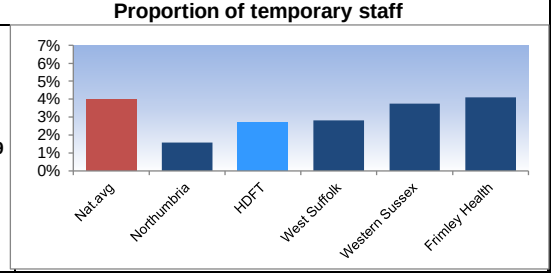

**8.7 Staff FFT - % recommend (place to work)**




**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 - April 2021

### 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.<br><br>The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.<br><br>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. The data includes hospital teams only. | Red if latest month > UCL, amber if latest month between HDFT historical average and UCL, green if latest month on or below HDFT historical average. | Locally agreed improvement trajectory based on comparison with HDFT historical performance. |
| 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 2020/21 onwards. 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. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The data includes community teams only. | Red if latest month > UCL, amber if latest month between HDFT historical average and UCL, green if latest month on or below HDFT historical average. | Locally agreed improvement trajectory based on comparison with HDFT historical performance. |
| 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 2020/21 onwards. 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 2020/21, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2020/21, Amber if YTD position is a reduction of up to 20% of HDFT average for 2020/21, Red if YTD position is on or above HDFT average for 2020/21. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| 1.4 | Safe | Infection control | HDFT's C. difficile trajectory for 2020/21 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 2020/21. 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.<br>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 serious incidents (SI) and never events | The number of Serious Incidents (SI) and Never Events reported within the Trust each month. The data includes hospital and community services.<br>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. | 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. |
| 2.2 | 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. | | |
| 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.<br>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 2020/21, Amber if latest month rate > HDFT average for 2020/21 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.<br>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 2020/21, Amber if on or above HDFT average for 2020/21, 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. |
| 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 |

| Indicator number | Domain | Indicator | Description | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|---|
| 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 - % 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 |
| 4.19 | 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 |
| 4.20 | 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 |
| 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.<br>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. | | |

Harrogate and District NHS Foundation Trust

| Indicator number | Domain | Indicator | Description | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|---|
| 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. | 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. |
| 6.9 | 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. | | |
| 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. | 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. |
| 6.13 | 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. | | 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. | Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%. | 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 |

NHS
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# Board of Directors Meeting (held in Public)

## 26 May 2021

| | |
|---|---|
| **Committee Name:** | Senior Managers Team Chair's Report |
| **Committee Chair:** | Chief Executive |
| **Date of meeting:** | 19 May 2021 |
| **Date of Board meeting this report is to be presented** | 26 May 2021 |



**Summary of key issues**

Shadow SMT met on 18 May 2021 and provided comments, advice and their recommended decisions on the items SMT considered at its 19 May 2021 meeting. SMT discussed and agreed the following:

**Operational Performance.**

- A slight reduction in the median and 92nd percentile RTT waiting time
- Risks to elective recovery in terms of capacity and flow with further work to be undertaken to improve the process in the elective pathway ongoing
- Risks to elective recovery in respect of additional activity.
- Risks in respect of current demand on ED; and an RPIW on new models for the HDH site
- The need to accelerate the short term work on interspecialty reviews

**0-19 services**

- The challenges in respect of demand and capacity and the planned actions underway already
- Further work was agreed to take place to provide additional support from across the Trust

**Quality**

- A task and finish review to complete the CQC action plan actions will take place in June
- A peer review process will be introduced within the next six months
- The complaints improvement trajectory was agreed
- A significant improvement in awareness of the management of compression bandages was reported and reporting has increased, which is positive.
- Further work (as part of Caring at our best) is required to improve the embedding of learning
- A further reflection for the critical care team will take place in respect of the learning from the serious incident.
- A strengthening of the consideration of human factors within an environment, especially when this changes is required.
- The approach taken to a serious incident investigation was commended

**People and Culture**

- The introduction of the new appraisal and wellbeing conversations which are aligned with the new behaviour and value framework were strongly supported. The launch will take place in June.
- The 0-19 service plan to consider how to introduce the strengths based tools to replace the current performance management system.
- The commencement of the new approach for declarations of interest and relationships at work
- The introduction of the virtual learning environment will provide an important step change in our approach to learning
- The proposals to become an anti-racist organisation were supported, with a workshop for SMT to take place to plan the introduction of this work
- There had been a positive and successful review by HEE of learning at the Trust.

**Financial Performance**

- Whilst in aggregate month one financial performance was on plan, PSC and 2Cs were underspent, whilst LTUC and Corporate were overspent.
- Actions were in progress to address the key drivers of the overspend, and to reduce the underspend which reflects lower elective activity and vacancies in the 0-19 service.
- The allocation for the second half of the year remains unknown, and processes are in place to plan to reduce the non-recurrent COVID spend.

The following were received and noted:
Integrated Board Report
DIPC report, including IPC, COVID and Flu vaccination update
Quality Performance
Corporate Risk Register
Corporate Risk Review Meeting Minutes
Directorate Chair's Reports:

There were no additional risks raised for inclusion on risk registers or the Board Assurance Framework.

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

There were no matters to escalate to the Board.

Harrogate and District NHS Foundation Trust

**Board of Directors (held in Public)**
**26 May 2021**
**Board Assurance Framework**



| | |
|---|---|
| **Agenda Item Number:** | **7.3** |
| **Presented for:** | Information/approve |
| **Report of:** | Chief Executive |
| **Author (s):** | Executive Directors<br>Interim Company Secretary |
| **Report History:** | Board Workshops (February and April 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 is asked to:

1. Accept the updated BAF (Appendix A), which is aligned to the Trust's Strategic Objectives;
2. Approve the proposal for Board Committees to scrutinise the risks associated to each Committee at every meeting, providing assurance to the Board following each meeting; and
3. Approve the arrangement for the detailed BAF to be accepted and reviewed by the Board on a quarterly basis.

# Board Assurance Framework (May 2021)

## 1.0 Background

Performance against the Board Assurance Framework (BAF) is reviewed at Board of Director meetings. The BAF is one of several tools the Board uses to monitor progress against the Trust's Strategic Objectives, including but not limited to the metrics included within the Integrated Board Report. In addition to the review of risks at Board meetings, significant risks to achieve the Trust's strategic objectives are also reviewed and reported at the Trust's Corporate Risk Review Group on a monthly basis.

During 2020, the Board agreed to pause the BAF to focus on operational risk management at the outset of the COVID pandemic. The Board then agreed to review the BAF at the July 2020 Board Workshop with the aim of arrangements to refresh and monitor the BAF being reinstated.

Following the July 2020 Board Workshop the BAF was updated with the support of Executive Directors and a further full review of the BAF took place with Board members at the February 2021 Workshop. All Board members attended the February 2021 Workshop and identified risks to the achievement of the Trust's strategic objectives and it was agreed the BAF would be further developed by Executive Directors, and an updated BAF would be provided to the Board at its 26 May 2021 meeting for review and acceptance. Attached at Appendix A is the updated BAF, which highlights all changes in blue font.



## 2.0 Harrogate and District NHS Foundation Trust Strategic Objectives

Risks associated to the following Strategic Objectives are planned to be reviewed by the Board, Board Committees and the Audit Committee (as required):

- To be an outstanding place to work
- To deliver high quality healthcare
- To work with partners to deliver integrated care
- To ensure clinical and financial sustainability

## 3.0 Content of the BAF

The content of the BAF is based on several key elements, which include:

- Strategic Aims
- Principle Risk and Risk Consequence - What is the cause of the risk? and, - What might happen if the risk materialises?
- Inherent Risk Rating – Impact and likelihood (without controls)
- Existing Controls - What controls/systems are currently in place to mitigate risk?
- Gaps in Controls - What controls should be in place to manage the risk but are not?
- Assurance - What evidence can be used to show that controls are effectively in place to mitigate the risk?
- Gaps in Assurance - What evidence should be in place to provide assurance that the Controls are working/effective but it is not currently available?
- Current Risk Rating - Impact and Likelihood (with Controls)
- Actions Required - Additional actions required to bridge gaps in Controls and Assurance
- Target Risk Rating - Impact and Likelihood – Based on successful impact of Controls to mitigate the risk

## 4.0 Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

| | 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 |

## 5.0 Proposals to Review the BAF

It is proposed that the:

1. Board Committees will scrutinise the risks aligned to each Board Committee at each of its meetings. (It is aimed that this approach will utilise the BAF to inform and guide the key areas of scrutiny with targeted deep dives taking place into areas requiring further assurance. This approach aims to ensure that the Committee agendas are aligned to the BAF risks, with the outcome of the Committee review providing assurances to the Board on the management of strategic risks).

2. Board of Directors will receive the full BAF on a quarterly basis with changes highlighted since the last review. (The Company Secretary will manage this process, providing a cover report to highlight changes made since the BAF was last presented to the Board with Executive Director risk Leads answering any queries that are raised by the Board).

## 6.0 Recommendation

The Board is asked to:

1. Accept the updated BAF (Appendix A), which is aligned to the Trust's Strategic Objectives;
2. Approve the proposal for Board Committees to scrutinise the risks associated to each Committee at every meeting, providing assurance to the Board following each meeting; and
3. Approve the arrangement for the detailed BAF to be accepted and reviewed by the Board on a quarterly basis.

## Board Assurance Framework

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

| Risk ID | Principle Objective | Principle Risk to the Delivery of Objective | Inherent Risk Rating | | | Residual (Current) Risk Rating | | | Target Risk Score | Target Date Risk Score will be met/closed | 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 | Likelihood | Conseq | Rating | | | | | Internal | External | | | | | |
| BAF#1.1 | 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 become an outstanding place to work, which in turn will impact on the quality of patient experience. | 3 | 4 | 12 | 3 | 4 | 12 | 2x2=4 | Apr-22 | Inherent risk score added | 1. Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work<br>2. First Line Leaders Programme and other development programmes<br>3. Shadow SMT<br>4. Reverse mentoring programme<br>5. EDI work programme | Board of Directors<br><br>Senior Management Team<br><br>People and Culture Committee | Staff Survey Action Plan | Currently no oversight arrangements in place by regulators/ICS<br><br>Cultural programmes are not embedded throughout the organisation | Inherent risk score added<br><br>Assurances in controls added with the list of cultural projects currently being taken forward<br><br>Gaps in assurances/controls added in relation to the cultural programmes not yet embedded | People and Culture Committee | A Wilkinson, Director of Workforce and OD | 06.05.21 |
| BAF#1.2 | 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 and ongoing behaviours impact colleagues behaviours making if more difficult for colleagues with protected characteristics to flourish in the organisation. | 4 | 5 | 20 | 3 | 4 | 12 | 2x2=4 | Apr-22 | Inherent risk score added | 1. Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work<br>2. First Line Leaders Programme and other development programmes<br>3. Shadow SMT<br>4. Reverse mentoring programme<br>5. EDI work programme | Board of Directors<br><br>SMT<br><br>People and Culture Committee | ICS metrics (TBC)<br><br>Staff Survey | Currently no oversight arrangements in place by regulators/ICS<br><br>EDI programme governance paused, a need to re-establish | Risk description slightly amended<br><br>Inherent risk score added<br><br>Gaps in assurances/controls added in relation to the need to re-establish governance for the EDI programme | People and Culture Committee | A Wilkinson, Director of Workforce and OD | 06.05.21 |

**2. STRATEGIC OBJECTIVE: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE**

| Risk ID | Principle Objective | Principle Risk to the Delivery of Objective | Inherent Risk Rating | | | Residual (Current) Risk Rating | | | Target Risk Score | Target Date Risk Score will be met/closed | 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 | 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 | 3 | 3 | 9 | 2x2=4 | Apr-23 | | Medical Director attendance at LMC and HARA | MD Board Report<br>SMT<br>Medical Directorate Team meeting | HARA<br>Yorkshire Health Network<br>LMC | Distributed portfolio across Executive Directors for partnerships<br>This risk could exasperate due to the potential local government and NHS (integrating care) re-organisation | Inherent risk score added | SMT | S Russell, Chief Executive<br>J Andrews, Executive Medical Director | 05.05.2021 |
| 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 | 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 | Inherent risk score added | SMT | J Andrews, Executive Medical Director | 05.05.2021 |

**3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE**

| Risk ID | Principle Objective | Principle Risk to the Delivery of Objective | Inherent Risk Rating | | | Residual (Current) Risk Rating | | | Target Risk Score | Target Date Risk Score will be met/closed | Change since last Report | Existing Key Controls | Assurances in Controls | | Gaps in Assurances/ Controls | Latest Update | Responsible Committee | Lead Executive Director | Date Reviewed or Added |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Likelihood | Conseq | Rating | 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 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. | 4 | 4 | 16 | 3 | 4 | 12 | 3x3=9 | Apr-22 | Inherent risk score added | Quality Assurance reports<br>Quality Committee Workplan | CQC Action Plan<br><br>Quality Account<br><br>Caring at Our Best programme<br><br>Appointment of Quality Matron to support rollout of ward/team accreditation | CQC Inspections<br><br>Bi-monthly Assurance meetings with CCG | Do not have consistent quality control in place | Additional entries added to support internal assurances in controls<br><br>Inherent risk score added | Quality Committee | Emma Nunez, Director of Nursing | 05.05.21 |
| 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 | 4 | 4 | 16 | 3x3=9 | Apr-23 | Inherent risk score added | **External:**<br>Carnell Farrer report<br>Ongoing Clinical Services review to develop Clinical Strategy<br>Ongoing conversations with WYATT | SMT<br>Directorate Oversight on Annual Clinical Plans<br>Quality Committee<br>Board of Directors | WYATT Committee in Common | No Project Management Support for clinical review and support to draft strategy | Inherent risk score added | Quality Committee | J Andrews, Executive Medical Director | 05.05.21 |
| BAF#3.3 | To provide high quality care to children and young people in adults community services | There is a risk that the Trust places insufficient focus on early years services and adult community based services because of the historic dominance of hospital services which will impact on the transformation opportunities and miss opportunities for long term outcomes and integrated care. | 4 | 4 | 16 | 4 | 4 | 16 | 3x3=9 | Apr-22 | Inherent risk score added | Quality Committee;<br><br>IBR:<br><br>Directorate Board oversight | Adult and Young People Safeguarding Reports | CQC Outstanding Report<br><br>OFSTED Reports<br><br>JTAI Reports | No Transformation Team in-house to support and drive this<br><br>Lack of tangible metrics | Risk moved from the risk that threatens the achievement of clinical and financial stability to risk to the delivery of high quality care | Quality Committee | Emma Nunez, Director of Nursing | 06.05.21 |
| BAF#3.4 | To provide outstanding care and outstanding patient experience | There is a risk that the Trust is unable to increase activity because of the extended waiting time for treatment arising from the constraints on activity which may cause patient satisfaction to drop and harm to arise | 3 | 4 | 12 | 3 | 4 | 12 | 2x4=8 | 31.03.2022 | New Risk | * Planned Care Recovery Programme in place<br>* Performance & Access Risk meeting established to track weekly progress against activity targets<br>* Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review<br>* Use of independent sector to increase inpatient, daycase and diagnostic capacity<br>* Theatres Optimisation workstream lead by PA Consulting to improve pre-assessment, scheduling and on the day processes<br>CCCC - dental -BC for paediatric specialist (to be permenant at cost pressure) | SMT/ Resource Committee/ Trust Board reporting<br>Performance Reporting - Resources Review | NHSE/I Reporting | | New risk added following recommendations made by the Board at its Workshop held on 24 February 2021<br><br>Elective Recovery progressing,<br>Elective theatres now fully operational,<br>Endoscopy Unit now fully operational,<br>Medinet insourcing now live | Quality Committee | Russell Nightingale, Chief Operating Officer | 17.05.2021 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAF#3.5 | To provide a high quality public health 0-19 service | There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors. | 5 | 4 | 20 | 4 | 4 | 16 | 2x4=8 | Apr-22 | New Risk | • Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing)<br>• Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work.<br>• CAG agreement to reduce face to face visits until end of May 21<br>• Request made for support from wider Trust (needs to be nurses with experience of working with children and families)<br>• Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) – June 21<br>• Development of OPEL to increase visibility of pressure & actions taken – June 21<br>• Agile / Base & Home working - Developing offers with teams to support alternative ways of working<br>• Work commenced on 0 -19 'Safer staffing' tool | SMT/ Quality Committee/ Resource Committee | | Workforce supply | New risk added following recommendations made by the Board at its Workshop held on 24 February 2021 | | Emma Nunez, Director of Nursing | 18.05.21 |

**4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY**

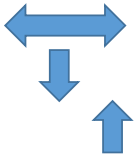
| Risk ID | Principle Objective | Principle Risk to the Delivery of Objective | Inherent Risk Rating | | | Residual (Current) Risk Rating | | | Target Risk Score | Target Date Risk Score will be met/closed | Change since last Report | Existing Key Controls | Assurances in Controls | | Gaps in Assurances/ Controls | Latest Update | Responsible Committee | Lead Executive Director | Date Reviewed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Likelihood | Conseq | Rating | Likelihood | Conseq | Rating | | | | | Internal | External | | | | | |
| BAF#4.1 | To continually improve services we provide to our population in a way that are more efficient | Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement | 4 | 4 | 16 | 4 | 3 | 12 | 2x3=6 | Mar-22 | Inherent risk rating added | Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT | SMT reports and oversight<br><br>Resource Committee reports and oversight<br><br>Board of Directors reports and oversight | WYAAT reports and Committee in Common engagement and oversight<br><br>NHSE/I regulatory oversight | **Internal:** capacity to deliver internal service transformation<br><br>**External:** no governance structure or programme of work with Leeds regarding transformation | Inherent risk rating added | Resource Committee | J Coulter, Deputy Chief Executive/ Finance Director | 06.05.21 |
| 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 | 4 | 2 | 8 | 4x2=8 | Mar-23 | Residual Risk Rating Reduced from 12 to 8<br><br>Inherent Risk Score Added | Capital asset register and planning process; financial plan; current financial regime | Capital Oversight Group | | **Internal:** No efficiency programme **External:** Currently no ICS Strategy or process in place | Inherent risk rating added<br><br>Residual (current) risk rating reduced from 12 to 8 due to the capital resources available locally and nationally | Resource Committee | J Coulter, Deputy Chief Executive/ Finance Director | 06.05.21 |
| BAF#4.3 | To provide high quality care and to be a financially sustainable organisation | There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety | 4 | 4 | 16 | 3 | 4 | 12 | 3x3=9 | Apr-22 | New risk | 1. Digital Strategy 2. Digital Board Training provided by NHS Digital/NHS Providers | Capital Oversight Group<br><br>Digital Strategy Group | | No Trust or ICS Estate Strategy or plan in place | New risk added following recommendations made by the Board at its Workshop held on 24 February 2021 | Resource Committee | J Coulter, Deputy Chief Executive/ Finance Director | 06.05.21 |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BAF#4.4 | To be financially stable to provide outstanding quality of care | Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality | 4 | 4 | 16 | 3 | 4 | 12 | 3x3=9 | Apr-21 | Inherent risk rating added | 1. Quality governance arrangements; Contracts with commissioners<br>2. Annual audit cycle<br>3. PLACE Assessments<br>4. ICS and Place based networks | Integrated Board Report<br><br>Chief Nurse Report<br>Quality Committee minutes<br>Clinical Audit Reports<br><br>SMT, Resource Committee and Board reports and oversight | CCG Meetings<br><br>CQC inspection reports<br><br>Memorandum of Understanding with CCG<br><br>Memorandum of Understanding with ICS's<br><br>HARA engagement<br><br>Relationships with Local Authorities<br><br>Ongoing dialogue Chief Executive and Deputy Chief Executive/Finance Director has with ICS's and regulators<br><br>Carnell Farrer Review | | Inherent risk rating added | Resource Committee | J Coulter, Deputy Chief Executive/ Finance Director | 06.05.21 |

## 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

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:** | 7 April 2021 |
| **Date of Board meeting this report is to be presented** | 26 May 2021 |

**Summary of key issues**

- The Quality Committee met via teleconference. The meeting was observed by Sue Eddleston, Public Governor
- We received a presentation from Will Greenwood, Clinical Locality Manager for Knaresborough and Boroughbridge CCT. Will presented his quality improvement project to reduce waiting times for the continence service in his patch. The work was undertaken just prior to, and during the pandemic. The team had managed to maintain the work despite big change in their working practice. Prior to his work The Continence service had an average waiting time of 152 days. Following application of improvement methodology the waiting time was reduced to an average of 19-22 days. As a result of the pandemic there has been a slight rise to between 30-35 days. The improvement in patient experience is obvious from these reductions. Will was congratulated on the improvement and receiving his silver award.
- Quality improvement priorities were discussed and a base line report for the quality priority to improve autism services and awareness. Members of the committee were surprised to note that the estimated prevalence of autism is approximately 1.76% indicating that approximately 7603 people having contact with HDFT will be autistic. Some of these patients may require additional support during their contact with the services. More work is required to achieve improvement in this service.
- The Quality dashboard was received and discussed. No significant issues were identified.
- The IBR was received. Quality issues regarding falls, pressure ulcers, cancer waiting time and ED performance remain on our list of concern.
- Minutes of the Improving Patient Steering Group for March were received.
- LTUC Q3 Quality Report was received and discussed
- Update on progress with the Ockenden action plan was received and discussed.

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

None

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

None

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## Board Committee Report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Quality Committee |
| **Committee Chair:** | Andy Papworth, Non-executive Director |
| **Date of meeting:** | 12 May 2021 |
| **Date of Board meeting this report is to be presented** | 26 May 2021 |

**Summary of key issues**

The Quality Committee met via teleconference.

- The meeting was chaired by Andy Papworth (Non Exec Director), and observed by Sue Eddleston (Public Governor) and Julie McGregor (North Yorkshire CCG).
- The Terms of Reference document has been updated for the addition of the Medical Director as a member.
- The committee received a presentation from Angie Colvin and Robyn Precious about the Youth Forum which has 23 members and meets every month, with the aim of helping make healthcare services better for children and young people. Since its inception in 2017, the Youth Forum has been involved in various activities in the past including senior appointments. The Forum provides useful feedback and ideas across a range of areas. Forum members particularly enjoy face to face meetings and visits to departments, which will now become easier to re-introduce.
- The Chair covered a summary of key areas of focus for the Quality Committee, which are to include: falls and pressure ulcers, complaints and incident reporting, caring at our best, safe staffing, ED flow and care, and the six Quality Priorities 20/21. Quality Committee will be receiving regular updates on all the areas of focus.
- The annual survey of the effectiveness of the Quality Committee has been completed. There were 10 responses (same as previous year). There was very positive feedback on the committee's purpose, membership, level of scrutiny, participation, clarity of outcome, and Laura's positive chair-ship. We discussed a few areas for continuous improvement mainly around ensuring "less busy" agendas, shorter papers and sufficient discussion time. The timing of the Quality Committee meetings has also been moved to better synchronise with monthly Board meetings.
- An update was received on ensuring quality, safety and confidentiality in Virtual Consultations, one of the six Quality Priorities 20/21. There are various aspects to this work including the right policy, access and accuracy of records, and ensuring we see the right patients. Progress is being made and the committee will receive quarterly updates.
- The Quality Dashboard and IBR were reviewed, with the dashboard including a ward level breakdown. The Trust has experienced increases in pressure ulcers, incidents and complaints, and the committee had a good discussion regarding assurance on the actions in response. The Executive Director of Nursing, Midwifery and AHPs will bring a summary of these actions to the board meeting on 26th May. Provisional data shows that the cancer 62 day standard has been met for the first time since November 2020. ED remains a focus and there will be a

Rapid Improvement Workshop to look at this.

- The committee also discussed staffing, where there is a safe staffing assessment underway that will complete by the end of June. Staff appraisal rates are behind target and the People and Culture Committee should look at this.
- An internal audit report on the Timely Notifications of Deaths was received with limited assurance. The report did highlight excellent communication between the Trust and bereaved families; and recent changes such as the medical examiner role should mean the timeliness issues are resolved by the time of the next audit.
- A verbal update on External reports was received. There have been four new reports and a new system of review has been developed. The Head of Risk Management will update on this at the next meeting.
- The minutes of the last meeting of the Improving Patient Safety Steering Group were provided. Going forward under the new clinical governance structure, the Patient Safety Forum will report into the Quality Management Group, from which the Quality Committee will receive minutes/escalations
- Reference was made to congratulating and thanking all nurses on International Nurses Day.
- The deputy director of Nursing provided an update on Learning from Patient Experience, which is changing to 'Making Experiences Count' with an increased focus on positivity and learning.
- The committee discussed a recent increase in violence and aggression towards Emergency Department staff. In response, some 'de-escalation' training is being planned, however, the committee also discussed the need for a clear policy and approach to be developed.
- An update on maternity was received. This included progress on the Ockenden report and actions, which will continue to be tracked. Seperately, the draft output from of the staffing review using Birthrate+ shows an additional 9 roles may be needed and a bid for funding has been submitted. The chair also updated on a recent visit to maternity departments at the hospital, where the issue of staffing the Maternity Assessment Centre had been raised and action is being taken in response by the Executive Director of Nursing, Midwifery and AHPs.
- Finally, the committee received the annual update from the Planned and Surgical Care Directorate. Members particularly welcomed a summary of Significant Incidents and other Directorates will be encouraged to use this as a format.

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

- Maternity Assessment Centre - requires more than one person to staff this effectively.
- A recent increase in violence and aggression towards Emergency Department staff.
-

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

- The Executive Director of Nursing, Midwifery and AHPs will bring a summary of actions being taken to address increases in pressure ulcers, incidents and complaints to the May Board meeting.
- People and Culture Committee should consider staff appraisal rates which are lower than usual.

8

Harrogate and District NHS Foundation Trust

**Board of Directors (held in Public)**
**26 May 2021**
**Medical Director Report**

| | |
|---|---|
| **Agenda Item Number:** | **8.1** |
| **Presented for:** | Information/approve |
| **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** | √ |

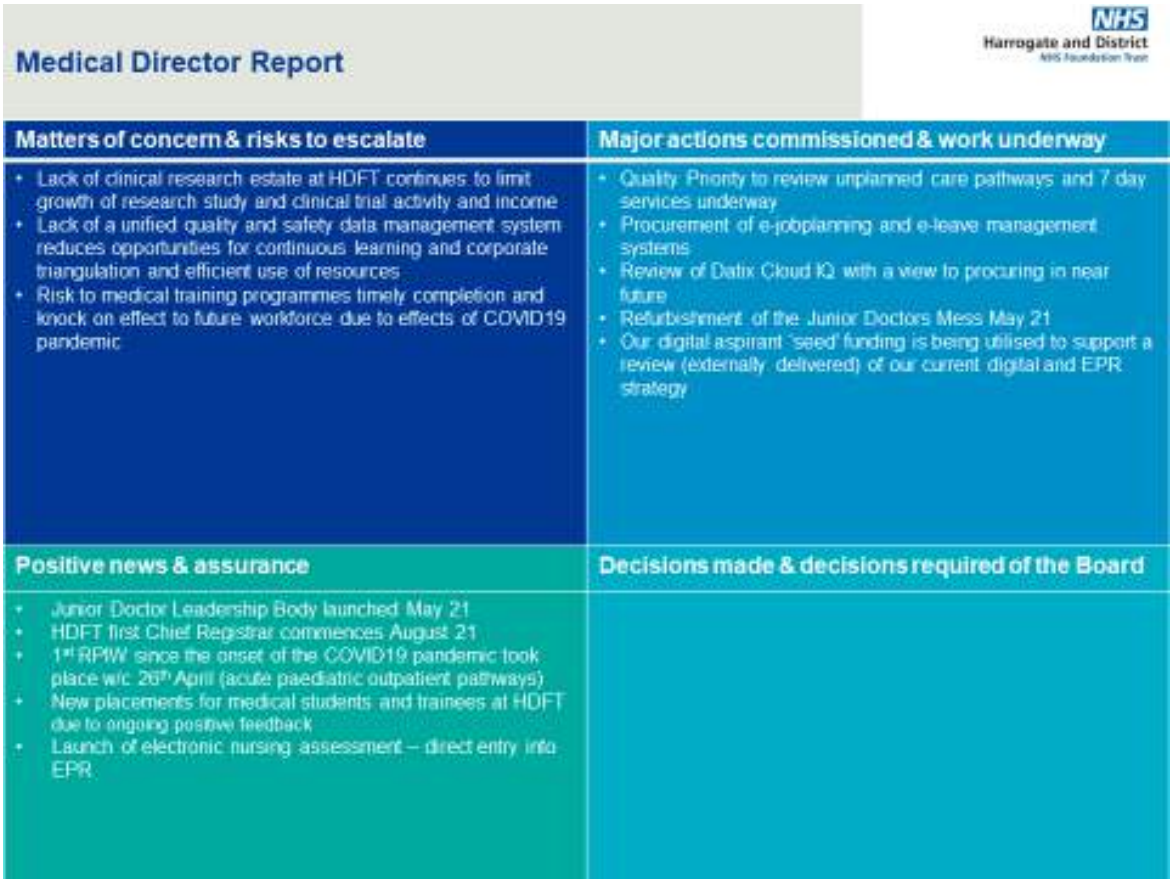
| **Recommendation:** |
|---|
| The Board is asked to approve this paper and its contents |

**Board of Directors Meeting (held in Public)**

**26 May 2021**

**Medical Director Report**

**Dr Jacqueline Andrews**




8.1

**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*
- *Infection prevention and control*

## 1. Clinical operations, professional standards and workforce development

Work is underway to move medical job planning and leave management to electronic systems, to align with medical appraisal which successfully transferred to an electronic format some time ago.
In partnership with the Directorate leadership teams and COO team, Dr Sarah Sherliker is leading a quality improvement programme entitled: “Develop an integrated clinical service for inpatient unplanned care – ensuring patients see the right clinician at the right time in the right place 7 days a week”. This projects overall aim is to make the hospital a better place for both patients and staff by reducing delays in patient care and increasing the efficiency of working practices, while at the same time maintaining or improving safety.
The inaugural “Junior Doctor Leadership Body” launched this month, with an overview of the structure of NHS provider Trusts and the role of the Medical Director. In addition, we have successfully appointed to the post of Chief Registrar for HDFT, with our first Chief Registrar taking up the position in August as part of nationwide cohort, led by the Royal College of Physicians. This is a senior leadership post for Doctors-in-Training and provides a vital bridge between senior clinical leaders, operational managers and the wider medical trainee workforce. In addition, the Chief Registrar is involved in improvement work around clinical services, education and training, and trainee engagement, morale, workforce and sustainability.

## 2. Quality Governance



### Clinical Effectiveness

The current priority for the Clinical Effectiveness team is to finalise and achieve formal approval of the 2021/22 clinical audit programme incorporating national and local clinical audits and patient surveys. The intention is that the programme will provide board with the assurance that as a Trust we have a sufficient system and processes in place to monitor the quality of services provided.

Clinical Effectiveness also continue to consider improvements to the reporting and assurance we provide following clinical audit. We intend to improve our processes by providing guidance with our report templates, introducing internal peer-review of completed reports and aligning local audit reports with CQC domains. We are also scoping formal risk or assurance assessment of audit action plans through sharing learning and practice discussions with other NHS audit colleagues within the Yorkshire and Humber Effectiveness and Audit Regional Network (YEARN).

An additional and continued priority is support of wider elements of Trust governance. We have supported the reformat of the standards log excel spreadsheet to provide assurance that meaningful up-to-date information can be monitored and extracted for reporting. This work stream also includes redesign of the “Statement of Compliance” to make this more user friendly, ensure it is an effective tool for gap analysis of published reports and includes an action plan template.

### Risk

Risk Management continue to support the ongoing improvement work in relation to wider elements of safety and governance. The 3 HDFT Patient Safety Specialists are currently reviewing the short and medium term priorities identified within the Patient Safety Strategy and a gap analysis will be produced for discussion and implementation via the Patient Safety Forum

In line with PSIRF, we are reviewing the Serious Incident investigation methodology, looking to move away from Root Cause Analysis and towards a more systems based and thematic analysis approach. Some virtual training has been identified which a small number of colleagues will be attending to support this work. The new case manager role for comprehensive SIs is working well with the most recent SI being delivered ahead of schedule.

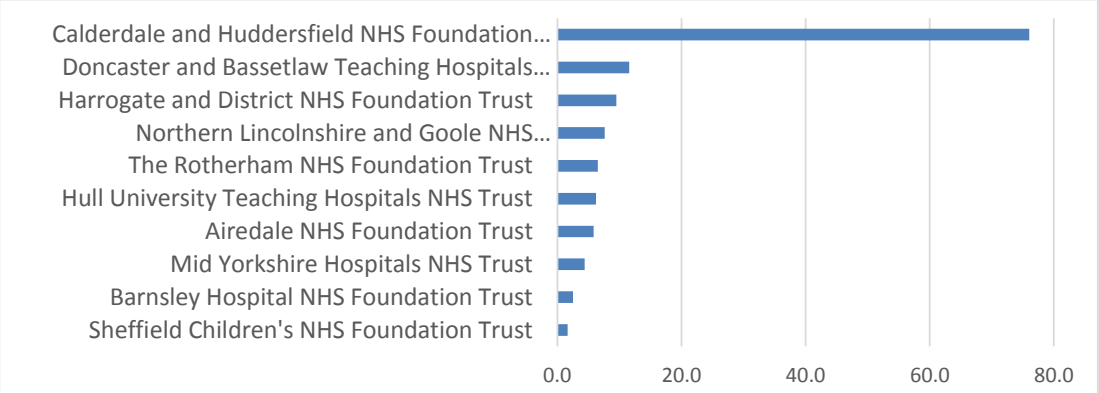
In relation to concise SIs, work is continuing with the Deputy Chief Nurse and TVNs to consider all aspects of the administrative process for Pressure Ulcer investigation, including duty of candour and Trust sign off. A new Pressure Ulcer Panel process is being developed and suggestions from the monthly CCG quality meetings are informing this work. We are agreeing a plan of how the team will work closely with the new Quality Matron to help achieve some of these objectives.

## 3. Research and Development

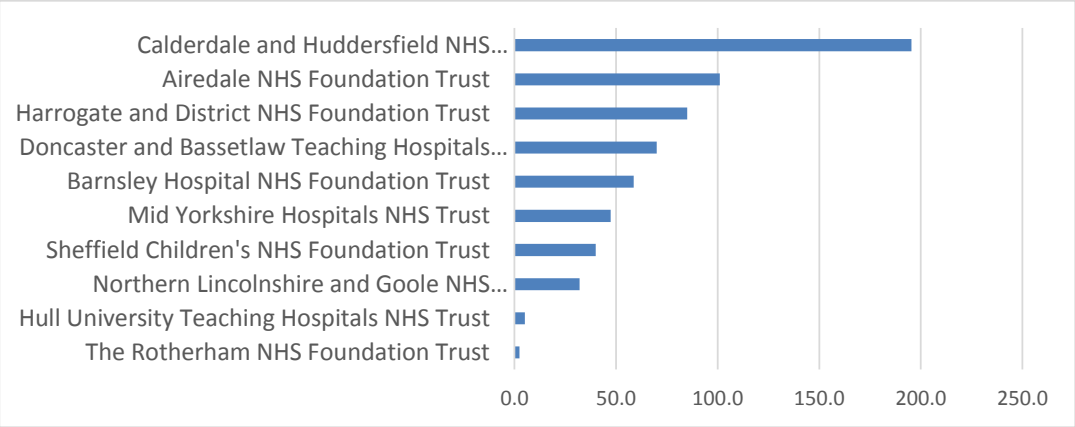
Research studies are now all starting to open to recruitment with only 10 of 168 approved projects still on hold as a result of the pandemic. 90% (n=151) of all studies are NIHR non-portfolio studies, the majority are non-commercial studies with just 14% (n=24) representing commercial trials. The lack of clinical research estate at HDFT continues to limit growth of research activity and income, with ongoing attempts to identify potential locations.
**Urgent Public Health studies**: Five UPH studies are still recruiting. As a percentage of the cases admitted, the trust has achieved consistent research participation and compares very favourably with other organisations in the region.



**Recruitment to RECOVERY, % of total admissions**




**Recruitment to CCP, % of total admissions**



The R&I unit are collaborating with UCL and have secured free use of a Long Covid App which has been developed in partnership with the NIHR and Living Health, a company which is are already working closely with our Rheumatology department. The Long Covid App has been developed with the implicit aim of supporting both patients and allied health professionals caring for the increasing numbers of cases with Long Covid. With the support of the trust digital and governance teams, the App will be embedded as part of a novel service development in the first instance. This has already demonstrated efficiencies for allied health professionals at other sites where the App has been adopted into service delivery. The approach will subsequently provide anonymised data for use in research examining the epidemiology of Long Covid.

**Spotlight on new studies:** The elderly care team have registered as a site for an NIHR supported study called the CHARMER trial- Comprehensive Geriatrician-led medication review. The purpose of the study is to conduct a Delphi process with the implicit aim of developing a core outcome set which will encompass the most important measures for evaluating hospital de-prescribing trials i.e. studies that evaluate the impact of stopping inappropriate medications. The Delphi survey will be sent to healthcare professionals and hospital managers looking after patients with frailty. Patients who are under a geriatrician and on > 5 medications will also be recruited.

**Non-medical research strategy:** Claire Arditto (Lead AHP HDFT) is leading work with colleagues across the ICS to develop an AHP regional strategy which will include developing research capability and pro-actively scope opportunities for research delivery that matches our population needs.



**4. Quality Improvement and Transformation**

I was delighted to act as sponsor for my first value stream and RPIW since joining HDFT. This was the 1st RPIW since the onset of the COVID19 pandemic, and reviewed Acute Paediatric Outpatient pathways on the w/c 26th April. A highly successful event, the main outputs included:

- Reduction in unnecessary inpatient appointments
- Implementation of Patient Initiated Follow up (PIFU)
- Greater compliance with the 18-week pathway
- Improved advice and guidance in ESR
- Clinical schedule redesign and improved use of space
- Skills development for Care Support Workers
- Better data quality to manager “was not brought rates”

Silver Level quality improvement training continues with a notable step change in the number of Quality Champions resuming their work or expressing an interest for new projects. Additionally, there has been an increasing number of requests for corporate QI support, including around paediatric diabetes, cyber-security and outpatients. The Planning and Palliative Care teams have gained Quality Improvement Team Accreditation to bronze (reaccreditation) and silver levels respectively.

Work has started to explore how learning from the quality improvement team accreditation scheme can inform the development of a clinical quality accreditation for wards, teams and departments as part of the Caring at Our Best programme.

**5. Medical Education**

The last two months have a return to more normal working patterns for our medical trainee workforce. Nichola Langdale's arrival as our new Head of Education, Learning and

Development has ensured the work required to procure and implement the new Virtual Learning Environment for the Trust will continue at pace. On May 5th we had the opportunity to promote the Trust's work in education and training to the Dean for Health Education Yorkshire and Humber (HEEYH)and their Quality Improvement Team at the annual Senior Leadership Engagement Visit. This was also an opportunity to receive feedback from the Deanery. They acknowledged the challenges all acute Trusts had had faced over the winter months, especially with regard to workload for general medical trainees and the impact on training for all specialty trainees, but particularly in the craft specialities. There were no recommendations for improvement issued to HDFT at the visit. Work will commence on May 17th to refurbish the Junior Doctors' Mess, with the help of funding from HEE. This will provide improved rest facilities for Doctor-in-Training to support their health and wellbeing.

The Foundation Year (FY) Entrepreneurship Programme in collaboration with Leeds Teaching Hospitals NHS Trust and University of Leeds (UoL) has been postponed until August 2022. However, we are working closely with UoL on a new scheme to bring Second Year medical students to Harrogate, commencing with a pilot programme in June. In addition we have worked with the LTUC team to secure 3 new GP specialty training posts (2 in acute medicine; 1 in haematology & oncology) starting in August this year. Finally, I'd like to welcome new members to the Medical Education team: Dr Thomasina Livingstone, Foundation Year One Training Programme Director; Dr Jane Paisley, Undergraduate Lead for Leeds University MBChB Year 3; and Dr Matt Milsom, Guardian for Safer Working. We're all looking forward to working with them and are certain that their appointments will bring innovations to further enhance education and training at Harrogate.



**6. Digital and IT Services**

The launch of electronic nursing assessment documents is imminent with implementation planned over the next 2-3 weeks. This will support direct entry into the electronic record and signal the first significant step away from paper for the inpatient pathways. To support this 'new' laptops on wheels are being deployed to wards and departments ensuring that access to IT equipment does not form a barrier. The second part of this move to paperless, the medical assessment documents, is being planned for September after the August rotation of junior doctors have 'settled in'.

Our digital aspirant 'seed' funding is being utilised to support a review (externally delivered) of our current digital and EPR strategy – this has commenced in earnest. We are liaising closely with NHSX with the outputs of this to develop a business case and refreshed strategy supported by access to the main digital aspirant funding stream. Prior to internal sign off and submission this will be presented to board/ subcommittees.

The success of IT in supporting colleagues who were unable to attend work or who were advised to work from home if possible is well established. We are now supporting this moving to an agreed longer term model of agile working. A policy is in development with IT supporting the various agile options this policy advocates.

N365 – the new Microsoft package to support connectivity and productivity in the NHS (of which Teams is a part) - continues to offer a multitude of 'new' or refreshed tools to improve collaborative working, sharing of information and patient interaction – the digital team have met with N365 experts to begin a program of maximising the use of this software and identifying where it replaces products we currently purchase separately."

**7. Infection Prevention and Control (Interim DIPC role)**

Following national guidance from NHSE/I, Covid vaccination hospital hubs were required to mobilise to deliver a Covid 1st dose and 2nd dose vaccine programme to all frontline health and social care staff across the local healthcare economy. The 2nd dose vaccination campaign

concluded in April achieving an 89.6% uptake of the Covid vaccination. 4360 HDFT/HIF staff and 3115 frontline health and social care staff from other providers accessed the Covid vaccination via the HDFT hospital hub. The programme was an overwhelming success with rapid uptake of the vaccine and completion of the programme within the timescales expected of NHSE/I.

Challenges identified during the programme included: capacity and resource to respond to extended scope of vaccination programme (HDFT/HIF staff and also all frontline health and social care staff), issues with Covidtrack response times and business resilience, challenges with receiving accurate employee information for non-ESR staff and managing high DNA rates from other providers for 2nd dose vaccination.

Despite these challenges, the programme was delivered safely with minimal avoidable vaccine wastage. This has been an excellent example of collaborative working across the healthcare system to deliver a programme at pace. The plans for hospital hubs in Phase 3 are still to be confirmed by NHSE/I. There are valuable lessons to learn from phase 1 and 2 of the programme to help design a robust and sustainable option to meet the anticipated requirement to deliver a booster 3rd dose of Covid vaccine to align with the annual staff flu programme in the autumn.

## INFECTION PREVENTION AND CONTROL SUMMARY 1st APRIL 2020 – 31st MARCH 2021

Table 1 – Dashboard of reportable infections for 2020/21

| Month | *C difficile* | | | | | MSSA BSI | | MRSA BSI | | *E.* coli BSI | | Klebsiella BSI | | *P. aeruginosa* BSI | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Trust (HA) | HOHA | COHA | COIA | COCA | HAI | CAI | HAI | CAI | HAI | CAI | HAI | CAI | HAI | CAI |
| **April 20** | 1 | 1 | 0 | 0 | 0 | 1 | 6 | 0 | 0 | 1 | 12 | 0 | 3 | 0 | 0 |
| **May 20** | 2 | 2 | 0 | 1 | 1 | 0 | 11 | 0 | 0 | 1 | 8 | 0 | 3 | 0 | 0 |
| **June 20** | 2 | 1 | 1 | 1 | 0 | 0 | 7 | 0 | 0 | 1 | 9 | 0 | 2 | 0 | 0 |
| **July 20** | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 11 | 0 | 2 | 0 | 0 |
| **August 20** | 2 | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 11 | 0 | 2 | 0 | 0 |
| **September 20** | 1 | 0 | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | 8 | 0 | 1 | 1 | 0 |
| **October 20** | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 5 | 1 | 4 | 0 | 1 |
| **November 20** | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 9 | 4 | 1 | 0 | 0 |
| **December 20** | 2 | 2 | 0 | 0 | 1 | 1 | 5 | 0 | 0 | 1 | 4 | 0 | 4 | 0 | 3 |
| **January 21** | 1 | 1 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 6 | 0 | 2 | 0 | 1 |
| **February 21** | 4 | 4 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 5 | 0 | 1 | 0 | 0 |
| **March 21** | 5 | 3 | 2 | 0 | 2 | 0 | 3 | 0 | 0 | 1 | 10 | 0 | 4 | 0 | 0 |
| **Total for year** | 22 | 18 | 4 | 5 | 12 | 4 | 39 | 0 | 0 | 9 | 88 | 5 | 29 | 1 | 5 |

Table 2 – Dashboard of reportable infections for 2021/2022

| Month | *C difficile* | | | | | MSSA BSI | | MRSA BSI | | *E.* coli BSI | | Klebsiella BSI | | *P. aeruginosa* BSI | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Trust (HA) | HOHA | COHA | COIA | COCA | HAI | CAI | HAI | CAI | HAI | CAI | HAI | CAI | HAI | CAI |
| **April 21** | 2 | 2 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 1 | 12 | 0 | 3 | 0 | 0 |
| **Total for year** | 2 | 2 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 1 | 12 | 0 | 3 | 0 | 0 |

**Notes:** Up until August 2020, the field epidemiology and surveillance teams at PHE produced monthly charts with the regions figures for reportable infections. The monthly reports ceased during the COVID-19 pandemic and have not been re-instated. National C.difficile objectives for hospital acquired infection (HOHA and COHA) have not been published since 2019/20.

**COVID-19:**

**Abbreviations:**
HOCI – Hosptial onset, COVID infection
HOpHA – Hospital onset, *probable* healthcare acquired (Positive on day 8-14 of admission)
HodHA – Hosptial onset, *definite* healthcare acquired (Positive on day 15+ of admission)

| | ***COVID-19 (HOCI)*** | |
|---|---|---|
| **Month** | **HOpHA** | **HOdHA** |
| **April 21** | 0 | 0 |
| **Total for year 2021/22** | 0 | 0 |

| | ***COVID-19 (HOCI)*** | |
|---|---|---|
| **Month** | **HOpHA** | **HOdHA** |
| **January 21** | 12 | 19 |
| **February 21** | 16 | 28 |
| **March 21** | 1 | 2 |
| **Total Q4 2020/21** | 29 | 49 |

**Recommendation:**
The Board is asked to approve the contents of the Medical Director report.

Harrogate and District NHS Foundation Trust

# Board of Directors (held in Public)

## 26 May 2021

## Guardian of Safe Working Hours Report Q4 2020/21 and Q1 2021/22

| | |
|---|---|
| **Agenda Item Number:** | **8.1.1** |
| **Presented for:** | Information |
| **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. |

8.1

**Board of Directors (held in Public)**

**26 May 2021**

# Guardian of Safe Working Hours Report (Q4 2020/21 and Q1 2021/22)

## 1.0 Executive Summary

This is the Fourteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st January 2021 to 17th May 2021, which covers two quarters [Q4 2020/21 and part of Q1 2021/22]. The 2nd wave of the COVID-19 emergency 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.

63 exception reports have been received from trainees in Q4 (52 in Q3) and 39 so far in Q1. This is a continuation of the higher-than-normal numbers seen in the last report. 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 Q4 and only 1 in Q1. Exception reporting remains comparable to other Trusts across the region. All local Guardians have reported an increase in reporting during Q4.

There have been no breaches of the European Working Time Directive, as such no fines have yet been levied. National trends in medical post-graduate training and indeed medical workforce numbers overall continue to be adverse.

There has been one regional meeting for Guardians in the current quarter. Trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue but have been stepped back to quarterly.

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 responded positively to the experience and have since returned to something resembling normal day-to-day activities.

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.

## 2.0 Introduction

This is the fourteenth 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.

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 May 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 9.5 gaps (7.8%).



| | Dept | Grade | Deanery or Trust | Whole Time Equivalent | Recruitment |
|---|---|---|---|---|---|
| **LTUC** | Acute Medicine | FY2 | Trust | 1 | Successful recruitment. Due to start in August 2021 |
| **LTUC** | Elderly Medicine | ST3+ | HEE | 2 | Re-advertising. 2 previous candidates withdrew prior to interview. Potential for extending a current LAS CT2 for a further 13months at CT3 grade. |
| **LTUC** | Elderly Medicine - IM3 | CT3/ IM3 | HEE | 1 | Waiting for confirmation from HEE as to whether we can recruit to this gap |
| **LTUC** | Emergency Medicine - ACCS | CT1 | HEE | 0.5 | Waiting for VC to be requested to recruit to other half of this gap |
| **PSC** | Dermatology | ST3+ | HEE | 1 | Dormant post – no recruitment plans |
| **PSC** | Obs & Gynae | ST2 | HEE | 1 | ST2 joining in August will be going on maternity leave Oct 2021. FY2 interested in LAS post. Awaiting confirmation of leave plans |
| **PSC** | Obs & Gynae | ST3+ | HEE | 1 | 3 candidates being interviewed 24/5/21 |
| **PSC/ LTUC** | Haem/GP/ Orthogeriatrics | FY2 | HEE | 1 | HEE are confident this will be filled via IFST or FY2 standalone recruitment processes. |
| **PSC/ LTUC** | Acute Medicine/ T&O/ Emergency | FY2 | HEE | 1 | HEE are confident this will be filled via IFST or FY2 standalone recruitment processes. |

## 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. 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 4 - 2020/21 & Quarter 1 – 2021/22

| Q4: 1.1.2021-31.3.2021<br>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 | 37 | 37 | 0 |
| General Surgery | 0 | 18 | 18 | 0 |
| Emergency Medicine | | 8 | 8 | |
| TOTAL | 0 | 63 | 63 | 0 |
| Q1: 1.4.2021- to date<br>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 | 35 | 27 | 8 |
| General Surgery | 0 | 3 | 1 | 2 |
| Emergency Medicine | 0 | 1 | 1 | 0 |
| | | | | |
| TOTAL | 0 | 39 | 29 | 10 |

There were no Education exception reports in Q4 and only 1 so far in Q1. Reports continue to be greatly increased on the resumption of normal rotas after the initial COVID-19 pandemic emergency and throughout the second wave.

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 misjudgement. Clinical supervisors are expected to guide their trainees in efficient working, prioritising clinical activities and making timely handovers to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is usually over-spent on medical locum costs for consultants and trainees.

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 must 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 took place. The consultants rightly said that everyone on medical wards was under an increased pressure of work and anxiety arising from the pandemic. Unfortunately, these discussions have yet to find a solution and the level of exception reporting has remained high. 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.

To this end an informal survey of Junior Doctors working on the medical rotas was conducted by an IMT1 doctor. With a response rate of 81%, the majority (80%) felt that staffing levels had worsened since August 2020. A full report is available upon request, detailing the issues felt for each of the shifts within the rota and some suggestions that warrant consideration if the levels of exception reporting do not improve now that we are past the peak of the second covid wave.

## 6.0 Vacancies

The vacancies have increased and sit at 9.5 (whole time equivalent) (7.8%) of established training posts. Of these vacancies, 1 has been filled pending an August start date, 1 is in recruitment, 1.5 are awaiting approval for vacancy control, 1 has the potential for an extended locum appointment and one is a 'dormant' post which the Trust has decided not to fill currently.

The Foundation Year posts are likely to be 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 lists all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report indicates the total amount of money levied in fines to date, the total amount disbursed and the balance in the Guardian of Safe Working Hours' account. A list of items against which the fines have been disbursed will be attached as an appendix if applicable.

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.



| 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 attended one regional meeting of Guardians in the current quarter, via MS Teams. Whilst previously it was reported that there had been a reduction in the number of exception reports filed by junior doctors across the region during the pandemic, there has now been a significant increase in reports as normal working patterns are resumed.

**9.0 Trainees' Forum**

Trainees' fora increased to monthly during the viral pandemic but have now been stepped back to the usual quarterly meetings. 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, courses, 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. The full impact of the pandemic on the training and successful progression through training programmes will only become apparent when the round of ARCPs are completed. There are likely to be some trainees that will require additional training time before they can progress.

## 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 each regional meeting. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. 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 previous Guardian had 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 new Guardian has taken over duties formally as of 1st January. The new Guardian would like to thank their predecessor for their help and guidance during the transition period.

## 15.0 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting during the COVID-19 emergency. Exception reports have continued along the increasing trend seen after the return to normal working patterns.
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 continuing to discuss 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. There remains some reluctance from educational supervisors to assist with this task.
e. There are gaps in rotas, but recruitment is ongoing, and it is likely for 5 of 9.5 vacancies.
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.

## 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.

## 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 continues to be 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 7 per cent.
e. The new Guardian has taken over all duties.

**Dr Matthew Milsom**
**Guardian of Safe Working Hours**

Harrogate and District NHS Foundation Trust

# Board Meetings Meeting (held in Public0
# 26 May 2021
# Learning from Deaths Quarterly Report Q4

| | |
|---|---|
| **Agenda Item Number:** | **8.1.2** |
| **Presented for:** | Information |
| **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 (held in Public)

## 26 May 2021

## Learning from Deaths

## Executive Medical Director



### 1.0 Executive Summary

Crude mortality rates for the trust continue to track the national trends, with the mortality rate from the second Covid-19 wave lower than during the first wave.

Standardised mortality rates continue to track as per previous years, with further reduction in HSMR rates at HDFT.

17 Structured judgement reviews have been undertaken since the last report. 15 cases had overall care described as good or excellent. 3 cases related to patients with Learning Difficulties.

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

Mortality from patients admitted to Critical Care is in the expected range, mirroring the slight rise seen nationally.

A review into death of patients under the care of Gastroenterology was undertaken following a previous HSMR and SHMI alert. This has highlighted a number of learning points but did not find any significant lapses in care.

### 2.0 Introduction

Quarter 4 was heavily impacted by a “second wave” of Covid-19. However, as working in a pandemic situation has become more familiar, we have been able to re-establish routine data collection and interpretation, so that moving forward these reports can be more in line with pre-pandemic content.

### 3.0 Findings

### 3.1 Crude Mortality Data

The crude mortality rate for admissions gives a longer-term view of trust mortality rates. In total, 199 deaths were recorded in Q4. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a “zoomed in” view of data from the last 2 years. Our mortality peak in the second wave appears lower than the national average.

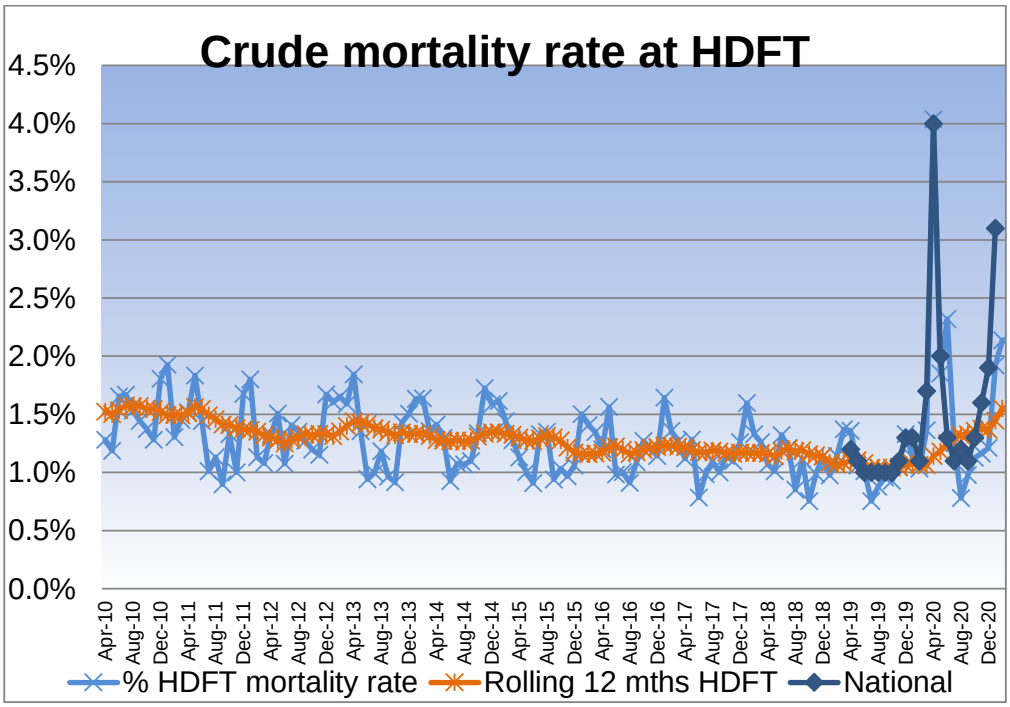



**Figure 1:** Crude mortality rates over the last 10 years (%deaths per hospital admission)

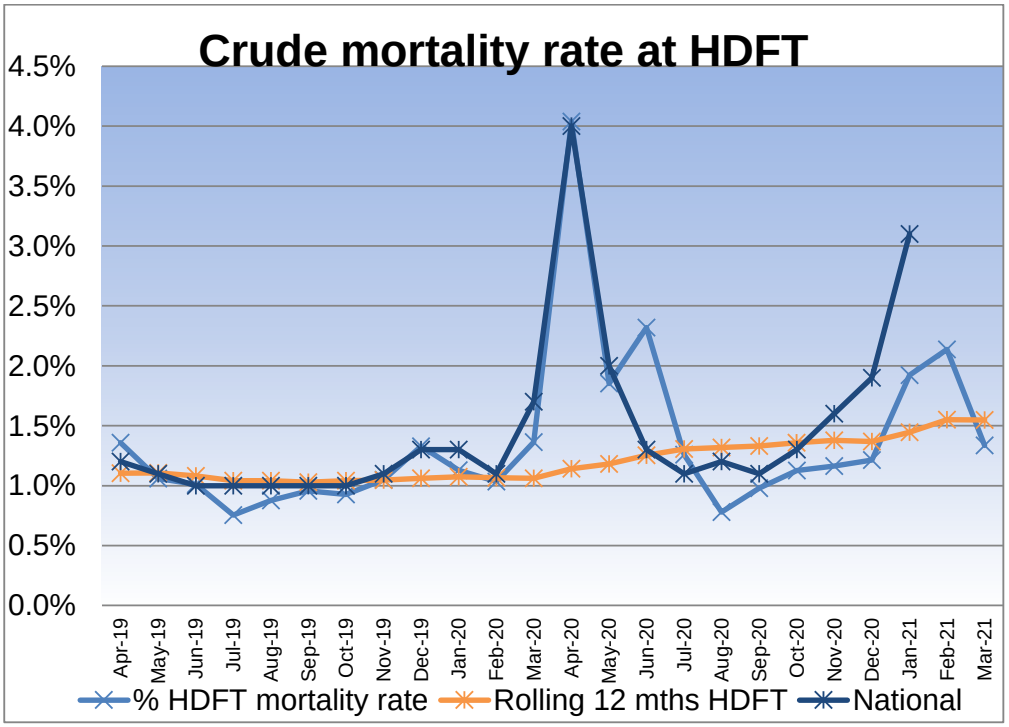



**Figure 2:** Expanded crude mortality rates over the last 2 years (%deaths per hospital admission)

8.1

### 3.2 Standardised Mortality Rates (HSMR and SHMI)

The HSMR has been falling since October 2020. There has been a technical issue relating to data submission for January so this data has not been included in Figure 3. Despite breaking down the data to specialty and diagnosis levels, we have not been able to identify specific causes for this decline. It is likely that this reflects the significant changes in operating conditions with the pandemic (including a changing case mix and focus on increased acute activity). 2 areas have been flagged as showing mortality above expected – stroke and syncope. Both are small in number and have been recently explored using SJRs with no lapses is care found and (for syncope) some coding issues identified.

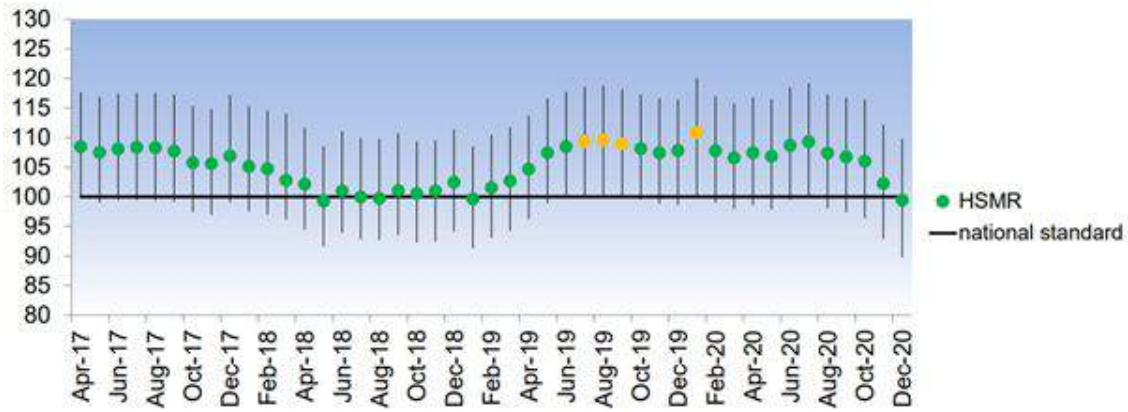



**Figure 3:** HSMR. Dots show the recorded values with error bars showing possible range of true values. Yellow dots indicate a deteriorating trend which is likely to be significant

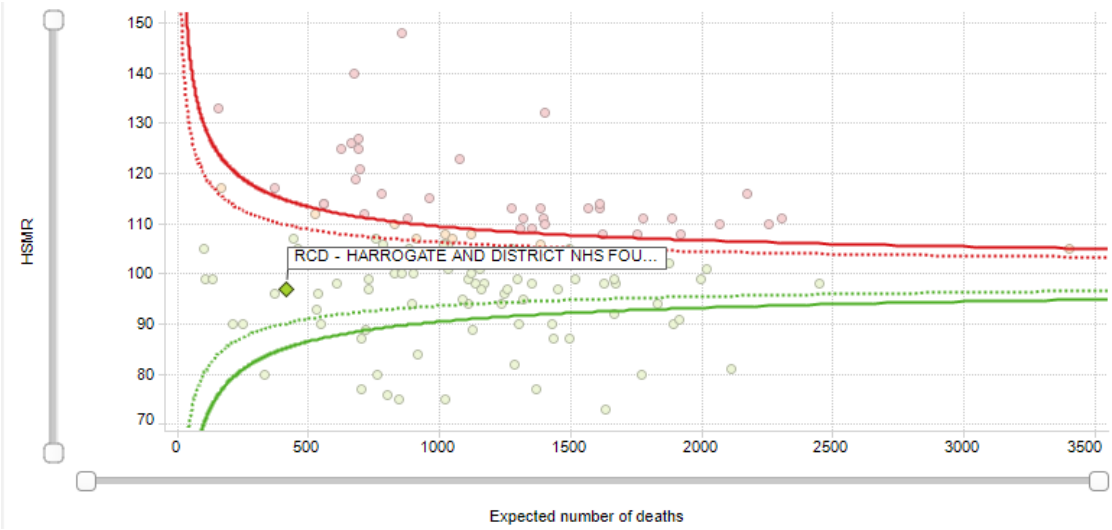



**Figure 4:** HSMR data up to Jan 2021 expressed as a funnel plot against values for other NHS Trusts

The SHMI rates (Figures 5 and 6) have also declined, having been consistently below100% (but within the expected range) on a rolling 12-monthly analysis. 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 January and December 2020.

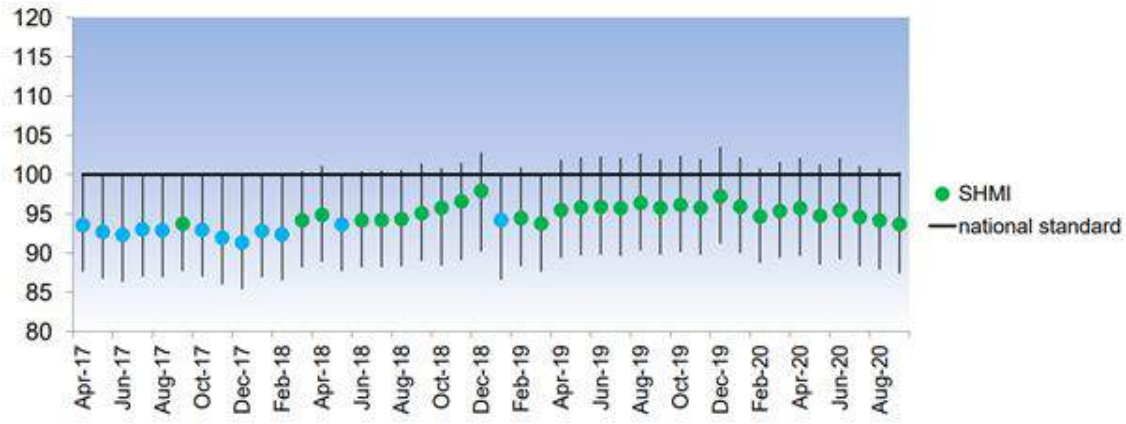



**Figure 5:** SHMI Dots show the recorded values with error bars showing possible range of true values. Blue dots indicate an improving trend which is likely to be significant



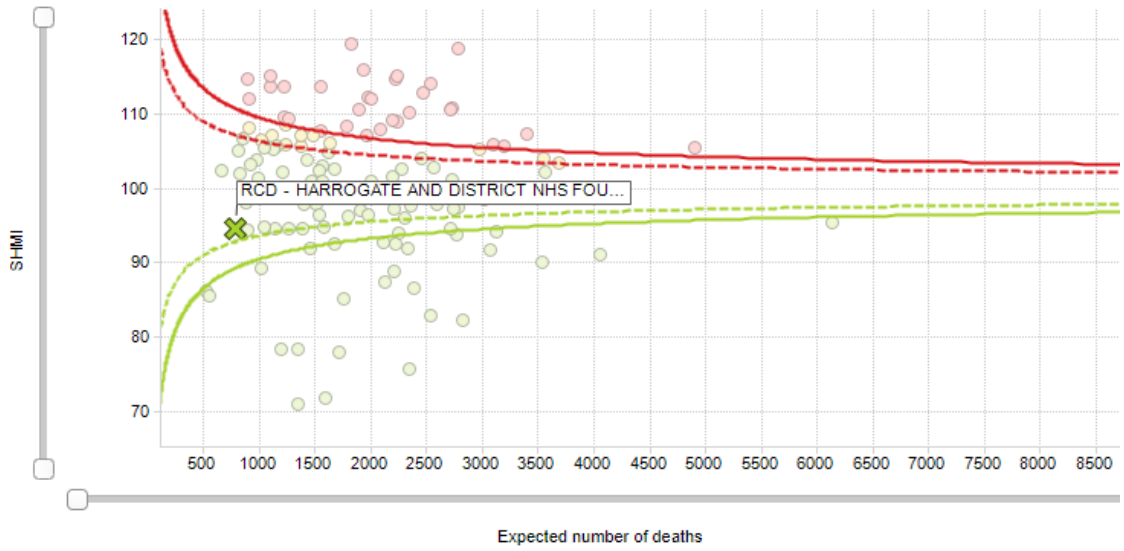



**Figure 6:** SHMI data up to Jan 2021 expressed as a funnel plot against values for other NHS Trusts

### 3.3 Structured judgement reviews

17 cases have been reviewed in this quarter, with 6 relating to deaths in this quarter, 6 from earlier in 2020-2021 and 5 from Q4 in 2019-2020 (reflecting reviews highlighted by previous HSMR/SHMI alerts). These include 9 in-hospital deaths with a gastroenterology diagnosis which were highlighted in a previous SHMI alert and are discussed later in this report.

The overall assessment of standard of care of all 17 cases 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** | | | 4 | 4 | 4 | 4 | 4 |
| **2** | | | 4 | 4 | 4 | 4 | 4 |
| **3** | | | 5 | 5 | 5 | 5 | 5 |
| **4** | | | 3 | | 3 | 3 | 4 |
| **5** | | | 5 | 5 | | 5 | 5 |
| **6** | Y | | 5 | | | 5 | 4 |
| **7** | | | 5 | 4 | 4 | 4 | 4 |
| **8** | Y | | 4 | 4 | 4 | 4 | 4 |
| **9** | | | 3 | 4 | 4 | 3 | 4 |
| **10** | | | 4 | 4 | 5 | 4 | 4 |
| **11** | | | 4 | 4 | 4 | 4 | 4 |
| **12** | | | 4 | | | 4 | 4 |
| **13** | | | 4 | 4 | 4 | 4 | 4 |
| **14** | Y | | 4 | | 4 | 4 | 4 |
| **15** | | Y | 4 | 4 | | 4 | 3 |
| **16** | | | 5 | 4 | 3 | 4 | 4 |
| **17** | Y | | 4 | 4 | 5 | 4 | 4 |
| **Median Score** | - | - | 4 | 4 | 4 | 4 | 4 |

**Table 1:** Structured Judgemental Reviews (SJR) conducted in Q4 2020-2021

3 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.

The new national policy for LeDeR was published in March 2021. Delivery of LeDeR currently lies with CCGs however this will now change to rest with ICSs. By 1 April 2022 all changes within the policy must be implemented by ICSs. This policy introduces the inclusion of autism into the programme for the first time. For the first 2 years, a focused review will be undertaken for all people with autism who do not have a learning disability. We have a robust process for notifying LeDeR of the deaths of patients with learning disabilities, as this is linked to our well established LD register, however this does not currently include people with autism. At present Medical Examiners have been asked to identify any deaths where the patient had autism,

however this is dependent on the visibility of an autism diagnosis within the patient's medical records.

### 3.4 Covid-19 Deaths

Table 2 on the following page show the hospital's Covid-19 mortality for Q1,2 ,3 and 4 for comparison. 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. As can be seen, Q4 was our busiest Covid-19 period to date. Reassuringly, the overall mortality has fallen from 34.6% in Q1 to 20.7% in Q4. This could be due to a number of factors – improved treatment (e.g. use of dexamethasone and tocilizumab), earlier presentation of patients to hospital and increased screening of all patients (such that some asymptomatic patients admitted with other conditions are logged as a positive Covid-19 case). Overall, Covid-19 was responsible for approximately 25% of deaths in the last year.

| 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 | 1 | 1 | 6.7% | 6.7% | 14.3% | 1.4% |
| 55-64 | 20 | 0 | 4 | 0.0% | 20.0% | 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% | 57.1% | 36.5% |
| 85+ | 73 | 2 | 34 | 2.7% | 46.6% | 28.6% | 45.9% |
| **Total** | **214** | **7** | **74** | **3.3%** | **34.6%** | | |

| 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 | 2 | 1 | 22.2% | 11.1% | 100.0% | 25.0% |
| **Total** | **33** | **2** | **4** | **6.1%** | **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 | 1 | 9 | 2.4% | 21.4% | 33.3% | 34.6% |
| 85+ | 39 | 2 | 11 | 5.1% | 28.2% | 66.7% | 42.3% |
| **Total** | **197** | **3** | **26** | **1.5%** | **13.2%** | | |

| Confirmed Covid-19 inpatient discharges (Jan-Mar 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 |
| 0-5 | 2 | 0 | 0 | 0.0% | 0.0% | 0.0% | 0.0% |
| 6-17 | 2 | 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 | 7 | 0 | 0 | 0.0% | 0.0% | 0.0% | 0.0% |
| 35-44 | 26 | 0 | 1 | 0.0% | 3.8% | 0.0% | 1.3% |
| 45-54 | 47 | 0 | 2 | 0.0% | 4.3% | 0.0% | 2.6% |
| 55-64 | 53 | 0 | 6 | 0.0% | 11.3% | 0.0% | 7.9% |
| 65-74 | 56 | 1 | 11 | 1.8% | 19.6% | 14.3% | 14.5% |
| 75-84 | 93 | 1 | 27 | 1.1% | 29.0% | 14.3% | 35.5% |
| 85+ | 80 | 5 | 29 | 6.3% | 36.3% | 71.4% | 38.2% |
| **Total** | **368** | **7** | **76** | **1.9%** | **20.7%** | | |

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

### 3.5 Mortality after Critical Care Admission

Figure 7 shows the risk adjusted hospital mortality for all patients admitted to Critical since 2016 and includes data up to the end of Q3 this year. As the last year only includes 9 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 in HDFT). In addition, some units which opened additional CPAP areas did not include these patients in their data,

whereas the majority of HDFT patients requiring CPAP have been admitted to Critical Care areas and therefore included in our report. What is becoming apparent is that overall Critical Care mortality across the country is higher this year, reflecting the significant mortality associated with Covid-19.

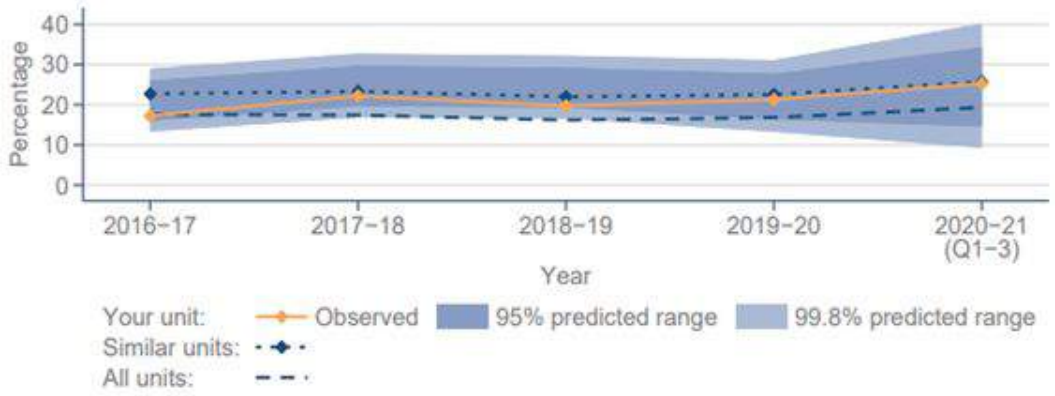



**Figure 7:** In-hospital mortality for all patients admitted to HDFT Critical Care Unit since April 2016. "Similar units" are defined as ones with a similar size and case-mix to ourselves. "All units" will include more specialist units which often have a lower mortality rate (eg. dedicated cardiac surgery units with a predominantly elective caseload)



### 3.6 Excess Death in Patients with a Gastroenterology Diagnosis

A previous SHMI and HSMR alert related to excess deaths in patients with a gastroenterology coding. Case-notes of the 9 patients with the lowest predicted mortality were reviewed using the SJR process. No lapses in care were apparent and the alerts had ceased in the most recent reporting period. However, there were some observations:

- "Gastroenterology" occasionally look after frail medical patients who, due to capacity reasons, are "medical outliers" on their wards. This may increase the specialty mortality rate when compared to other centres.
- Alcohol misuse is a prominent feature.
- One case was highlighted of an unexpected death following a procedure. Although there are no apparent lapses of care on SJR, a report from the consultant of care has been requested by Risk Management. It has highlighted a deficiency in incident reporting.

## 4.0 Future Plans and Learning

The Medical Examiner service now has a full complement of funded Medical Examiners and a Medical Examiner Officer. This means that all hospital deaths now receive independent scrutiny. This has already led to the identification of cases and themes for further investigation and is likely to be a major trigger for future SJRs.

The ongoing process to improve Learning from Deaths (and incidents in general) will form a significant workstream of our “Learning at our Best” program. Discussions have already begun in to how we can modernise and streamline education delivery to all staff so that continual learning becomes a fundamental part of everyday practice at HDFT.

## 5.0 Recommendation

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

# Appendix 1 – Dates of SJRs Undertaken and When those Deaths Occurred

**Quarter or year in which the death occurred**

**Number of structured judgement reviews (SJRs)**

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 Q1 | 2018/19 Q2 | 2018/19 Q3 | 2018/19 Q4 | 2018/19 | 2019/20 Q1 | 2019/20 Q2 | 2019/20 Q3 | 2019/20 Q4 | 2019/20 | 2020/21 Q1 | 2020/21 Q2 | 2020/21 Q3 | 2020/21 Q4 | 2020/21 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **No of inpatient deaths** | | | | 657 | 142 | 140 | 177 | 182 | 641 | 194 | 186 | 176 | 176 | 732 | 189 | 127 | 138 | 198 | 652 | |
| | | | | | | | | | | | | | | | | | | | | **Total undertaken** |
| **SJRs previously reported** | 4 | 27 | 40 | 31 | N/a | N/a | N/a | N/a | N/a | N/a | N/a | N/a | N/a | N/a | | | | | | 102 |
| **Total SJRs undertaken during 2018/19 by year of death** | | | | 31 | | | | | 29 | N/a | N/a | N/a | N/a | N/a | | | | | | 60 |
| Total SJRs undertaken during Q1 2019/20 by year and Q of death | | | | | | 2 | 3 | 4 | 9 | 2 | N/a | N/a | N/a | 2 | | | | | | 11 |
| Total SJRs undertaken during Q2 2019/20 by year and Q of death | | | | | | | 1 | 2 | 3 | 2 | 2 | N/a | N/a | 4 | | | | | | 7 |
| Total SJRs undertaken during Q3 2019/20 by year and Q of death | | | | | | | | | 0 | 0 | 1 | 4 | N/a | 5 | | | | | | 5 |
| Total SJRs undertaken during Q4 2019/20 by year and Q of death | | | | | | | | | 0 | 0 | 1 | 1 | 5 | 7 | | | | | | 7 |
| **Total SJRs undertaken during 2019/20 by year of death** | | | | | | | | | 12 | | | | | 18 | | | | | | 30 |
| Total SJRs undertaken during Q1 2020/21 by year and Q of death | | | | | | | | | | | | | 1 | 1 | 0 | N/a | N/a | N/a | 0 | 1 |
| Total SJRs undertaken during Q2 2020/21 by year and Q of death | | | | | | | | | | | | 1 | 1 | 2 | 4 | 0 | N/a | N/a | 4 | 6 |
| Total SJRs undertaken during Q3 2020/21 by year and Q of death | | | | | | | | | | | | | 4 | 4 | 4 | 1 | 5 | N/a | 10 | 14 |
| Total SJRs undertaken during Q4 2020/21 by year and Q of death | | | | | | | | | | | | | 5 | 5 | 1 | 0 | 5 | 6 | 12 | 17 |
| **Total SJRs undertaken during 2020/21 by year of death** | | | | | | | | | | | | | | 12 | | | | | 26 | 38 |
| **Total number of SJRs undertaken relating to deaths in the period** | 4 | 27 | 40 | 62 | 0 | 2 | 4 | 6 | 41 | 4 | 4 | 6 | 16 | 30 | 9 | 1 | 10 | 6 | 26 | 230 |

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Data & Information Governance Steering Group Annual Report 2020/21

| | |
|---|---|
| **Agenda Item Number:** | **8.1.3** |
| **Presented for:** | Information |
| **Report of:** | Executive Medical Director |
| **Author (s):** | Deputy Director of Performance and Informatics<br>Information Governance Manager |
| **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 items contained within this report. |

8.1

**Report title:** Annual report of Data and Information Governance Steering Group

**Report to:** Improving Patient Safety Steering Group

**Report author:** Jo Higgins, Information Governance Manager

**Date:** April 2021

**Reporting to:** Improving Patient Safety Steering Group

**Objectives for 2021-22**

This Group will:

- Continue to monitor the work streams of the Data Security and Protection Toolkit, ratify policies and consider strategic issues.
- Continue to promote the work of the Senior Information Risk Owner (SIRO), Data Protection Officer (DPO) and Caldicott Guardian.
- Continue to review the current information governance arrangements to ensure we remain in a strong position for the data assurance and information governance agenda.
- Continue to refer to and consult with the Caldicott Guardian and DPO where appropriate, and ensure the Caldicott Guardian and DPO are part of the sign off process for all applicable policies, information sharing agreements and risk assessments.
- Agree the Data Security and Protection Toolkit return and review action plans.
- Monitor Trust compliance with current and new data protection legislation
- Monitor Trust compliance with cyber security
- Monitor the Data Protection Impact Assessment process
- Monitor the Caldicott Guardian, SIRO and DPO roles
- Consider and drive the strategic issues
- Ensure that at least 95% of all staff have completed their annual Data Security Training in the period of 1st April to 31st March
- Continue Cyber Operational Readiness work

**Report of effectiveness of Data and Information Governance Steering Group during 2020-21**

Meeting frequency and attendance

The Group meet a minimum of 9 times a year and at least three members of the group are always in attendance (Please see Appendix 1).

Activity and review against the contents of the terms of reference

The following items have been discussed in the Steering Group throughout 2020-21:

- The Data Security and Protection Toolkit submission for 2020-21 has been extended to the end of June 2021 owing to the impact of COVID19. Work is ongoing to meet this deadline.
- NHS Digital commissioned an audit of the Data Security and Protection Toolkit. This was carried out by Internal Audit. The report was submitted to NHS Digital at the end of March 2021.
- In July 2020 the Chief Nurse was appointed as the SIRO.

- In April 2021 the Chief Operating Officer took over as SIRO.
- The Group discussed information governance and cyber incidents and referred, where appropriate, to the Caldicott Guardian and DPO for advice and guidance. All incidents were scored. Where trends of information governance incidents were noted, appropriate actions were undertaken.
- There were no serious incidents relating to information governance including data loss or confidentiality breach during 2020-21. One incident was logged and reported by the Trust as a data breach with the ICO; however the ICO reviewed the incident and informed the Trust that no further action was necessary.
- Sharing agreements, Data Protection Impact Assessments, Data Processing Agreements and Cloud Assessment continue to be monitored by the Group.
- Continued routine reporting of mandatory training with the aim that at least 95% of staff have completed their Data Security training.
- Cyber Operational Readiness work was carried out to identify and address Cyber Security vulnerabilities. Work has been completed to improve the Trust's cyber readiness and this work will continue into 2021-2022.

Extract from the Cyber Operational Readiness Support (CORS) – Remediation Report:

*"The Remediation Programme commenced in October 2019 and was managed by a Project Manager appointed by the Trust to coordinate improvement activities. The Programme was significantly affected COVID-19 which understandably reduced the time that the Trust could devote to the Programme. This Report sets out the progress made in Remediation and suggests future improvements that the Trust could make to improve its Cyber Security capabilities.*

*Overall, the Trust has shown a real appetite for Cyber Security capability improvement and has appointed a SIRO who clearly intends to be proactive in changing the Cyber Security culture at the Trust. The Trust has, despite the considerable challenges presented by COVID-19, made considerable improvements in all of the four strategic themes above and has greatly reduced its Cyber Security risk exposure.*

*However, given the size and complexity of the Trust's operations and the degree of change contemplated in the Trust's Digital Vision, the key recommendation of this report is for the Trust to maintain its focus on Cyber Security improvement and view this as a 'business as usual', continuous improvement activity, building upon the progress made over the period of this remediation programme"*

**Appendix 1: Attendance monitoring 2020-21**

| | Month | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total Meetings | |
| Meeting Took Place | Yes | No | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 10 | |
| Members | | | | | | | | | | | | | Total Attended | % |
| SIRO | 0 | N/A | 1 | 0 | N/A | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 6 | 60% |
| Data Protection Officer | 1 | N/A | 1 | 1 | N/A | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 9 | 90% |
| Information Governance Manager | 1 | N/A | 1 | 1 | N/A | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 9 | 90% |
| Head of Outpatient Access and Health Records | 1 | N/A | 1 | 1 | N/A | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 8 | 80% |
| Head of IT Systems | 1 | N/A | 1 | 0 | N/A | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 9 | 90% |
| Caldicott Guardian | N/A | N/A | N/A | 1 | N/A | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 6 | 75% |
| Quoracy = 3<br>Total members per meeting | 4 | N/A | 5 | 4 | N/A | 5 | 5 | 5 | 5 | 5 | 5 | 4 | | |

Harrogate and District NHS Foundation Trust

# Board of Director Meeting (held in Public)

## 26 May 2021

## Executive Director of Nursing, Midwifery & Allied Health Professionals (AHPs)



| | |
|---|---|
| **Agenda Item Number:** | **8.2** |
| **Presented for:** | Information |
| **Report of:** | Executive Director of Nursing, Midwifery & AHP's |
| **Author (s):** | Executive Director of Nursing, Midwifery and AHPs<br>Deputy Director of Nursing |
| **Report History:** | None |
| **Publication Under Freedom of Information Act:** | This paper can be 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 items contained within this report, including:

- Workforce
- Caring at Our Best - Quality, including Maternity
- Complaints

## Workforce, Caring at Our Best, Complaints

Harrogate and District NHS Foundation Trust

| Matters of concern & risks to escalate | Major actions commissioned & work underway |
|---|---|
| **Workforce**<br>• No embedded use of Safer Nursing Care Tool historically<br>• 0-19 services remain a service under significant challenge due to the workforce position (80.18WTE vacancies)<br><br>**Complaints**<br>• The trust currently has **53** open complaints **22** have exceeded their deadline for response.<br>• Average 95th percentile for response in 19/20 was **68** working days from date open to response to complainant 2020/21 average **70** working days response time.<br><br>**Caring at Our Best – Quality**<br>• Pressure Ulcer reporting continues to increase<br>• Lack of national consistency for definitions of reporting hindering ability to effectively benchmark | **Workforce**<br>• Safer Staffing Review underway underpinned by Safer Nursing Care Tool (Inpatient)<br>• Gap analysis against Nursing and Midwifery elements of 'Developing Workforce Safeguards'<br>• Review of Midwifery Staffing against Birth Rate +<br><br>**Complaints**<br>• Key delivery actions to improve and review current processes to meet trajectories that have been agreed via executive team.<br>• Review of roles and responsibilities in the complaints processes to help improve better collaboration between directorate and corporate teams.<br><br>**Caring at Our Best - Quality**<br>• Review role and responsibilities ward/department manager aligned accountability for quality practice in their area.<br>• New bi-monthly RCA panel sign off meeting for all PU's and Falls starts 3rd June chaired by DDoN.<br>• New quality dashboard monthly ward assurance monthly meetings being set up to commence June.<br>• Matron for Clinical Quality appointed – start date 28th June.<br>• Professional Practice Forum for Nursing, Midwifery & AHP's established chaired by Exec Director of Nursing. |
| **Positive news & assurance** | **Decisions made & decisions required of the Board** |
| **Workforce**<br>• HDFT successful in becoming test site for the Community Safer Nursing Care Tool – training in May 2021<br><br>**Complaints**<br>• Stocktake complete and position understood. Clear improvement trajectory set<br><br>**Caring at Our Best – Quality**<br>• Head of Nursing walking clinical areas to share specific learning from VAW case in person and leg ulcer management displays in all inpatient ward areas for colleagues to see.<br>• New ward assurance and professional practice forum well received by clinical team leads.<br>• Review of nursing establishments currently underway and plans to run SNCT audit through June.<br>• New quality governance forums due to start in June. | |

8.2

# Board of Directors Meeting (held in Public)

## 25 May 2021

## Executive Director of Nursing, Midwifery & AHPs

**Summary**

The purpose of this report is to provide Harrogate and District NHS Foundation Trust (HDFT) Board with a summary positon of key areas in relation to Quality of Care and Patient Experience.

As previous Board Reports have demonstrated, the COVID-19 Pandemic has contributed significant pressure in care delivery and achieving excellent patient experience. The senior Nursing, Midwifery and AHP team across the organisation continue to work collaboratively in responding to these challenges, supporting our teams and putting appropriate responsive measures in place.



### 1.0 Workforce

The National Quality Board (2016) set out its expectations of Trust Boards via the Developing Workforce Safeguards which include:

**Expectation 1: Right Staff** – 1.1 evidence based workforce planning, 1.2 professional judgement, 1.3 compare staffing with peers

**Expectation 2: Right Skills** – 2.1 mandatory training, development and education, 2.2 working as a multi-professional team, 2.3 recruitment and retention

**Expectation 3: Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility, 3.3 efficient employment and minimising agency
The above should be underpinned by measurement and improvement including outcome measures, financial sustainability, incident and red flag reporting, patient, staff and carer feedback.

A review of our position against the Nursing and Midwifery elements of the NQB Developing Workforce Safeguards has commenced and will report to the Board on completion. Below sets out the relevant update against these requirements which include:

<table>
<tr><th>Requirement</th><th>Current position</th></tr>
<tr><td>Right Staff:<br><br>Evidence based establishment setting</td><td>In April 2021, The Executive Director or Nursing, Midwifery and AHPs commissioned a full review of all inpatient bed holding nursing establishments in order to assure the board they remain set correctly, especially in light of the pandemic and as we continue to recover and reset our services.<br><br>Safer Nursing Care Tool (SCNT) which is the nationally recognised evidence based tool for inpatient/AMU/C&YP nurse establishment setting has not been in use in HDFT historically. The SNCT enables assessment of patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity / dependency terms. Training in the use of this tool commenced in May 2021 and data collection will take place throughout June 2021 before being reported back to the Board.<br><br>No community equivalent currently exists however HDFT have received notification that they have been accepted as a test site of the national community nurse staffing tool and training for this will take place throughout May 2021.<br><br>0-19 services – no equivalent tool currently exists for 0-19 services and it is not yet apparent whether the community tool will reflect 0-19 services.<br><br>Midwifery – Birth Rate + is the nationally recognised tool for evidence based assessment of midwifery staffing levels. Birth Rate + data collection is underway in HDFT and will form the overall report to the Board.<br><br>AHPs – no equivalent tool exists for AHP staffing, however there may be further national developments in this area. Regardless, consideration should be given to the multidisciplinary team and skills mix available in all workforce planning.</td></tr>
<tr><td>Right Skills:<br><br>Recruitment and Retention</td><td>Overall Trust registered nurse turnover (Band 5 – 8a) in detailed below for the period April 2020 to March 2021:<br><br>
<table>
<tr><td>Nursing and Midwifery Registered</td><td>Band 8a</td><td>7.94%</td></tr>
<tr><td>Nursing and Midwifery Registered</td><td>Band 7</td><td>16.97%</td></tr>
<tr><td>Nursing and Midwifery Registered</td><td>Band 6</td><td>15.25%</td></tr>
<tr><td>Nursing and Midwifery Registered</td><td>Band 5</td><td>14.11%</td></tr>
</table>
<br>Registered Nursing Hospital: Online recruitment events for registered nurses are currently occurring monthly facilitated by the Deputy Director of Nursing, Heads of Nursing, Matrons and members of the clinical teams, including recently qualified RNs who talk through their experiences of why they came to work at HDFT and what support they can typically expect to receive on arrival. Specific recruitment events for Theatres and Endoscopy teams have also taken place and further events are planned.<br><br>There are 14 registered nurses in the pipeline for the main hospital site (LTUC & PSC directorates) with 6 having come to post since the last report. There are a further 12 RN’s in the pipeline due to commence in the directorates in September 2021 once candidates have registered with the NMC. A summary of the current RN vacancy position is highlighted in table 1.1<br><br>Registered Nursing Community: The trust’s community teams currently face some of the biggest workforce challenges with 80.18 WTE vacancies across our North Yorkshire and Northeast footprint. The 0-19 services flag as one of the most vulnerable amongst Band 6 roles (vacancy rate 9%). There are also vacancies across all contract areas for School Nursing (except North Yorkshire). Vacancies also exist in our Durham and Middlesbrough Health Visiting Teams.<br><br>A community recruitment & retention group has been set up with an action plan put in place that is being progressed. Stand-alone specific recruitment events for the community are also taking place.<br><br>Because of the pandemic, community-safeguarding teams have reported increased activity, particularly in the Sunderland, Durham and Middlesbrough areas. This has had a direct impact on the 0-19 teams. A business case to increase resource in the specialist team has been submitted.<br><br>7 funded places have been secured from NHS England & Improvement for Community Professional Nurse Advocates which will support ongoing supervision and support to these staff as part of a supervision model.<br><br>Midwifery: In response to the interim Ockenden Report immediate safety actions HDFT have submitted a bid to the Local Maternity System to support additional staffing requirements of Midwives, Obstetricians and Training. Recruitment plans are in place to manage existing position and future recruitment.<br><br>Allied Health Professionals: The total number of vacancies for AHPs across HDFT is 16.97 WTE, however this is broken down by multiple different roles. The highest AHP vacancy currently is Operating Department Practitioners where we have 5.41WTE vacancy with some challenges in recruitment. Plans are in place to support recruitment.<br><br>HDFT are a key member of the Humber Coast and Vale AHP Strategy Group and have identified key priorities within HDFT for delivery of year 1 of the strategy. Further updates will be provided.</td></tr>
</table>

**Care Support Workers (CSWs):** Over the last six months, the trust has been actively involved in Health Education England's (HEE) Health Care Support Worker Zero Vacancy Programme and as a result is on course to have zero vacancies at Band 2. Currently there are 22 WTE Care Support Workers going through pre-employment checks and awaiting start dates.

**Table 1.1** Current RN/RM vacancies by Directorate

| Directorate | Vacancy position |
|---|---|
| Long Term and Unscheduled Care | 13.54 WTE |
| Planned and Surgical Care | 4.3 WTE |
| Maternity (sits within Planned and Surgical but reports RM separate to RN position) | 3.2WTE |
| Community & Children's | 80.18 WTE |

Staffing fill rates by Ward are detailed in Table 1.2 below. It should be noted that work is ongoing to realign actual fill rates with ward establishments following the repurposes of beds during the pandemic.

**Table 1.2 Staffing Fill Rates by Ward for April 2021**

| April 2021 | | | | |
|---|---|---|---|---|
| | **Day** | | **Night** | |
| | **RN** | **CSW** | **RN** | **CSW** |
| Ward | Fill (%) | Fill (%) | Fill (%) | Fill (%) |
| Byland | 100% | 91% | 98% | 150% |
| Farndale | 84% | 97% | 84% | 107% |
| Granby | 97% | 90% | 100% | 107% |
| Harlow | 78% | 80% | 76% | 97% |
| ITU/HDU | 102% | 100% | 106% | - |
| Jervaulx | 85% | 87% | 96% | 117% |
| Lascelles | 99% | 94% | 98% | 100% |
| Littondale | 102% | 106% | 103% | 100% |
| Maternity | 91% | 74% | 99% | 80% |
| Nidderdale | 90% | 116% | 98% | 143% |

| | | | | |
|---|---|---|---|---|
| Oakdale | 92% | 97% | 100% | 85% |
| SCBU | 98% | 10% | 100% | - |
| Trinity | 98% | 71% | 100% | 100% |
| Wensleydale | 93% | 88% | 73% | 124% |
| Woodlands | 76% | 90% | 97% | 93% |
| **Total** | **92%** | **89%** | **94%** | **107%** |

## 2.0 'Caring at Our Best' - Quality

The Caring at Our Best programme sets out our ambition:
'*To deliver high quality care with collective responsibility for our patients…so that…we work as one team and deliver outstanding patient experience*'.
The update below sets out actions in relation to realising this ambition.

The trust continues to report its month on month positon on fundamentals of care and patient safety with an internal quality dashboard (table 2.1). This is used by the clinical teams at ward level and is presented at the Quality Committee on a monthly basis.

8.2

**Table 2.1 Quality Dashboard – March 2021 positon**

**Trust Total**

| | | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Change | RED | AMBER | GREEN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Safety | Total Events | 480 | 521 | 599 | 668 | 641 | 670 | 814 | 740 | 776 | 812 | 785 | 833 | ↑ | | | |
| | % Events No Harm/Minimal Harm | 91.3% | 92.1% | 93.3% | 93.0% | 93.8% | 94.9% | 95.5% | 93.5% | 91.1% | 94.0% | 92.7% | 94.1% | ↑ | < 90% | 90-95% | 95% + |
| | Events: No Harm & Minimal Harm | 438 | 480 | 559 | 621 | 601 | 636 | 777 | 692 | 707 | 763 | 728 | 784 | ↑ | | | |
| | Events: Moderate (Short term Harm) | 41 | 36 | 38 | 46 | 38 | 32 | 33 | 45 | 64 | 49 | 54 | 48 | ↓ | | | |
| | Events: Severe (Death/Permanent/Long Term Harm) | 1 | 3 | 0 | 1 | 2 | 0 | 2 | 1 | 4 | 0 | 2 | 1 | ↓ | | | |
| | Total Medication Events | 22 | 32 | 44 | 36 | 42 | 37 | 53 | 51 | 59 | 38 | 30 | 46 | ↑ | | | |
| | % Medication Events No Harm/Minimal Harm | 100.0% | 96.9% | 97.7% | 97.2% | 100.0% | 100.0% | 98.1% | 98.0% | 100.0% | 100.0% | 100.0% | 100.0% | ↔ | | | |
| | Medication Events: No Harm & Minimal Harm | 22 | 31 | 43 | 35 | 42 | 37 | 52 | 50 | 59 | 38 | 30 | 46 | ↑ | | | |
| | Medication Events: Moderate (Short term Harm) | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | ↔ | | | |
| | Medication Events: Severe (Death/Permanent/Long Term Harm) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | ↔ | | | |
| | Patients with allergy status on drug chart (%) | 100.0% | 99.0% | 98.0% | 99.0% | 99.0% | 100.0% | 99.0% | 99.0% | 99.0% | 99.0% | 100.0% | 100.0% | ↔ | < 100% | | 100% |
| | Safety Thermometer - Harm free care (%) | | | | | | | | | | | | | ↔ | <95% | | 95% + |
| | Sepsis Screening (% Triggered Assessments Completed) | 91.5% | 88.9% | 94.3% | 94.1% | 92.1% | 91.6% | 92.4% | 93.4% | 93.4% | 94.0% | 92.2% | 92.4% | ↑ | <70% | 70%-90% | 90% + |
| Fundamental standards of care | Pressure Ulcers (Hospital Acquired) Total | 23 | 22 | 26 | 21 | 27 | 27 | 31 | 32 | 37 | 45 | 41 | 49 | ↑ | | | |
| | Pressure Ulcers non device: Category 2 (Hospital Acquired) | 15 | 15 | 14 | 13 | 19 | 19 | 22 | 15 | 22 | 27 | 25 | 35 | ↑ | | | |
| | Pressure Ulcers non device: Category 3 (Hospital Acquired) | 4 | 4 | 2 | 3 | 1 | 0 | 0 | 3 | 4 | 2 | 5 | 4 | ↓ | >=1 | | 0 |
| | Pressure Ulcers non device: Category 4 (Hospital Acquired) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | ↓ | >=1 | | 0 |
| | Pressure Ulcers non device: Unstageable (Hospital Acquired) | 1 | 0 | 1 | 0 | 2 | 3 | 1 | 4 | 0 | 1 | 0 | 1 | ↑ | >=1 | | 0 |
| | Pressure Ulcers non device: Deep Tissue Injury (Hospital Acquired) | 0 | 2 | 6 | 2 | 3 | 4 | 5 | 7 | 4 | 7 | 5 | 5 | ↔ | | | |
| | Device related pressure ulcer Category 2 (Hospital Acquired) | 3 | 1 | 0 | 2 | 1 | 1 | 2 | 1 | 2 | 3 | 5 | 3 | ↓ | | | |
| | Device related pressure ulcer Category 3 (Hospital Acquired) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | ↔ | >=1 | | 0 |
| | Device related pressure ulcer Category 4 (Hospital Acquired) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ↔ | >=1 | | 0 |
| | Device related pressure ulcer unstagable (Hospital Acquired) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | ↔ | >=1 | | 0 |
| | Device related Deep tissue injury (Hospital Acquired) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ↔ | | | |
| | Device related pressure ulcer Mucosal (Hospital Acquired) | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 1 | 4 | 4 | 0 | 1 | ↑ | | | |
| | Moisture associated skin damage | 4 | 14 | 16 | 7 | 18 | 12 | 9 | 16 | 18 | 16 | 20 | 19 | ↓ | | | |
| | Total Falls(Patient in inpatient areas) | 61 | 53 | 48 | 34 | 42 | 36 | 43 | 47 | 50 | 57 | 68 | 62 | ↓ | | | |
| | Falls Causing Harm (Moderate & Severe)(Patient in inpatient areas) | 3 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 2 | 0 | ↓ | >=1 | | 0 |
| | Nursing Audits Compliance against standards (%) | 96.0% Falls | 33.3% Fluids | 100.0% Nutrition | 100.0% PU | 100.0% Falls | 100.0% Fluids | 100.0% Nutrition | 100.0% PU | 100.0% Falls | N/A | N/A | N/A | | | | |
| | Patientrack: Nurse Observations Taken On Time (%) | | | | | | | | | | | | | ↔ | | | |
| | Patientrack: Nurse Median Response Time Of Nurse In Charge (Mins) | | | | | | | | | | | | | ↔ | | | |
| | Directors Inspections | | | | | | | | | | | | | ↔ | | | |
| | SAFER: Average Number Of Patients Over 7 Days | 84 | 68 | 74 | 73 | 70 | 88 | 75 | 80 | 83 | 100 | 109 | 108 | ↓ | | | |
| | SAFER: % Of Discharges Before 12:00 | 14.1% | 13.9% | 15.8% | 16.4% | 11.6% | 14.2% | 14.9% | 16.2% | 17.4% | 15.9% | 15.4% | 15.1% | ↓ | < 24% | 25-32% | 33% + |

| Key | |
|---|---|
| ↑ | Positive increase |
| ↑ | Negative increase |
| ↔ | No Change |
| ↓ | Negative Decrease |
| ↓ | Positive decrease |

The data on this sheet is representative of the trust wide totals, including community teams and departments that do not appear on the tabs in this dashboard

In the month of March 2021:

- Overall there was an increase in reporting of incidents. As HDFT progresses on its journey of continuous learning and improvement increased incident reporting should be viewed positively
- There was a positive increase in the number of patients who experienced no harm or minimal harm which coincides with a reduction in moderate and severe harm incidents.

- Medication errors increased in month at 46 (Feb'21 N=30). Human factors and some workspaces were cited as some reasons for this. The Heads of Nursing are reviewing through their directorate quality of care meetings and putting appropriate actions in place.
- An increase in the total number of hospital acquired pressure ulcers is seen for March 2021 and has continued to rise month on month since April 2020. Pressure Ulcers will form a significant element of our improvement plan via the Professional Nursing, Midwifery and AHP forum which will set clear ambitions in relation to improved care and reducing numbers of hospital acquired incidents as set out in section 2.2.

Since the last board report, the corporate nursing team have successfully appointed a Clinical Quality Matron. This new role will report to the Deputy Director of Nursing and work in collaboration with directorate teams. The Clinical Quality Matron will lead on specific quality initiatives, be an ambassador for high quality safe care and ensure we have a robust system in place for learning from incidents. Specifically work in aligning key quality teams more closely together and rolling out a ward accreditation programme over the next year will be key priorities.

A new monthly ward assurance meeting chaired by the Executive Director or Deputy Director of Nursing begins in June 2021. The meeting will be an opportunity for ward and department team leaders to discuss their key quality concerns and areas of good practice and to ensure that the quality dashboard is understood and owned at ward level.



## 2.2 Improving how we manage Tissue Viability

A key aspect of Caring at Our Best programme is focusing on how we improve management of tissue viability care, including pressure bandages and pressure ulcers. A Tissue Viability Service Review was commissioned by the previous Chief Nurse and completed in May 2021. The recommendations are currently being reviewed and further updates will be provided to the Board.

A revised bi-monthly Root Cause Analysis (RCA) panel process chaired by the Deputy Director of Nursing is now in place and attended by directorate colleagues, adult safeguarding and in the near future CCG colleagues, to review and sign off RCAs for all pressure ulcer incidents. This provides a 'check and challenge' assurance process for our internal reviews and was commended as an approach by the Tissue Viability Service Review.

Tables 2.3.1a & b below sets out the total number of hospital acquired pressure ulcers by month. There is currently no nationally agreed definition of 'in receipt of care' for the purposes of pressure ulcer reporting and therefore work is required to standardise and agree this.

Although HDFT are linked into the national working group on this definition, it is clear that agreeing a standard definition for our internal purposes of reporting (which is more in line with peer organisations definitions) would provide for more consistent benchmarking. These discussions are taking place through the Professional Nursing, Midwifery and AHP Forum for debate and agreement.

**Table 2.3.1a**

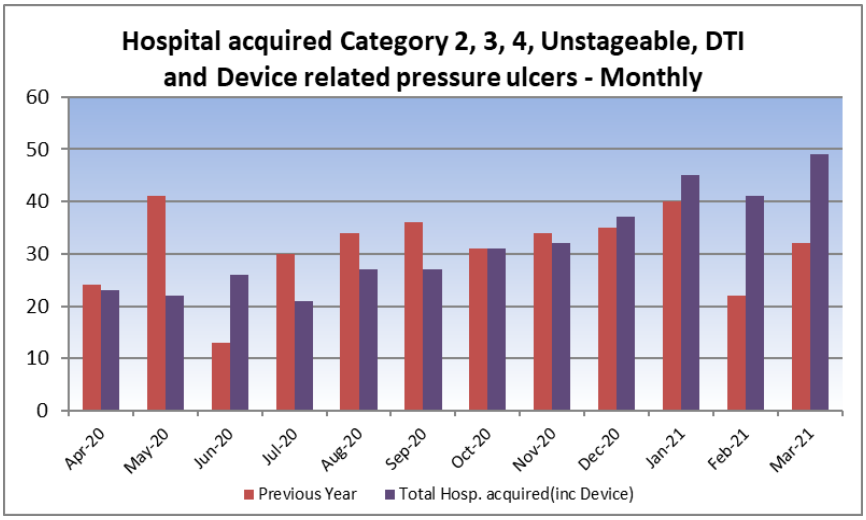
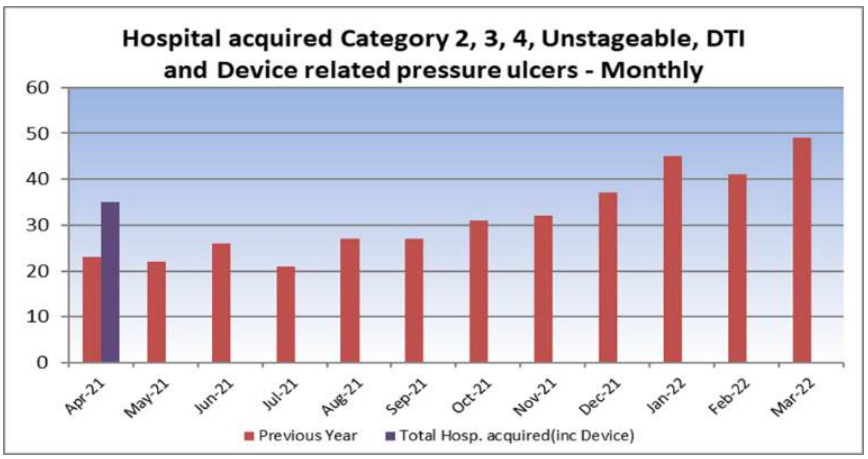



**Table 2.3.1b**




Work is ongoing regarding benchmarking of data across Provider organisations and will report back to the Board in due course.

## 2.4 Maternity

NHS England and Improvement published the revised perinatal surveillance model in December 2020, setting out six requirements to strengthen and optimise board oversight for maternity and neonatal safety.
The second report for board following the overview on quality and safety and response to the Ockenden Report was presented at the board meeting in February 2021.

Further detailed information on Maternity and Neonatal Quality and Safety is set out in Paper 8.2.1 Strengthening Oversight of Maternity and Neonatal Safety.

## 3.0 Complaints

Good complaint handling provides a direct and positive connection between those who provide services and the people who use them and provides opportunities for learning and improvement In 2019 HDFT set one of its quality priorities to:

*Ensure effective learning from incidents, complaints and good practice We will continue the work started in 2017/18 but with more focus on staff engagement, promoting a "just culture" locally and increasing understanding of human factors and the role they play in patient safety.*

This has remained a quality priority over the last three years, and whilst learning from complaints can be evidenced in the quarterly patient experience reports and the directorates monthly quality reports, delivery of the 95% standard for responding to complaints has not been delivered. As a result, a backlog of complaints has developed across the organisation that have exceeded the response within 25 working days' standard.

Table 3.1 below shows the complaints position across the organisation for 2019/20 and 2020/21.

**Table 3.1**

| | Q1 19/20 | Q2 19/20 | Q3 19/20 | Q4 19/20 | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 |
|---|---|---|---|---|---|---|---|---|
| **Total number or complaints received** | 50 | 63 | 64 | 59 | 23 | 50 | 47 | 71 |
| **Average number of days overdue*** | 17 | 20 | 15 | 11 | 15 | 11 | 23 | 13 |
| **Number of complaints overdue*** | 34 | 27 | 32 | 23 | 9 | 27 | 32 | 22 |
| **Longest number of days overdue*** | 53 | 101 | 58 | 29 | 53 | 23 | 90 | 34 |

| | Q1 19/20 | Q2 19/20 | Q3 19/20 | Q4 19/20 | Q1 20/21 | Q2 20/21 | Q3 20/21 | Q4 20/21 |
|---|---|---|---|---|---|---|---|---|
| **0-4 days** | 4 | 2 | 7 | 6 | 3 | 7 | 6 | 5 |
| **5-9 days** | 8 | 9 | 7 | 6 | 2 | 5 | 3 | 5 |
| **10-19 days** | 8 | 4 | 10 | 8 | 2 | 10 | 7 | 6 |
| **20-39 days** | 12 | 9 | 5 | 3 | 1 | 5 | 10 | 6 |
| **40 or more days** | 2 | 3 | 3 | 0 | 1 | 0 | 6 | 0 |

***at time of report that have been responded to**

At 8th May 2021 there were 53 open complaints across the organisation.

Of the 53 open complaints 22 had exceeded their deadline for a response.

The position against delivery of the 95% standard was 44%.

The organisational level data for the 95th centile in 2019/20 was 68 working days and in 2020/21, 70 working days.

HDFT have a significant number of re-opened complaints compared to other NHS organisations of a similar size. Work is currently underway to understand this position further.

Complaints recovery plan and trajectory for improvement.

The current complaints position is clearly unacceptable and it is now a priority for the organisation to clear the backlog of complaints and commit to deliver the 95% standard sustainably. In order to do this a recovery trajectory has been agreed as follows;

| |
|---|
| **31st July 2021 -** To clear all overdue complaints in the static backlog and be managing 55% of new complaints within the 25 working day standard. |
| **31st August 2021 -** Manage 75% of the new complaints that have tipped in during the backlog eradication phase within the 25-day standard. |
| **31st October 2021 -** Manage 85% of complaints within 25 working day standard. |
| **31st December 2021 –** Deliver the organisationally agreed standard of 95 % of complaints within 25 working days sustainably moving forwards. |

A number of key actions have been agreed to ensure the consistent focus on sustained high quality complaint responses:

- The weekly executive meeting will receive an update of progress against delivery of the trajectory
- Significant executive focus on delivery of the improvement trajectory at performance and quality meetings with triumvirates
- The HDFT Board will be briefed and updated bi-monthly on progress against trajectory.
- A process mapping exercise will be undertaken to identify and minimise the hand offs in the current process and work to streamline the process to be high quality, efficient and responsive.
- A composite complaints training package will be made available for all colleagues with specific focus on the expectations associated with writing high quality complaint responses letters.

A thematic analysis of the complaints backlog will be undertaken to ensure that all opportunities for learning from complaints are maximised and this will be reported to Board.

### 3.0 Recommendation

The Board is asked to note the items contained within this report, including:

- Workforce
- Caring at Our Best - Quality, including Maternity
- Complaints

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Strengthening Maternity and Neonatal Safety Report



| | |
|---|---|
| **Agenda Item Number:** | **8.2.1** |
| **Presented for:** | Discussion, Information |
| **Report of:** | Executive Director of Nursing, Midwifery and AHPs/Board Executive Safety Champion |
| **Author (s):** | Dr Kat Johnson (Clinical Director), Alison Pedlingham (HOM), Danielle Bhanvra (Matron) and Andy Brown (Risk management Midwife) |
| **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 information in this report is for information and discussion. |

## Strengthening Maternity and Neonatal Safety

NHS Harrogate and District NHS Foundation Trust

| Matters of concern & risks to escalate | Major actions commissioned & work underway |
|---|---|
| **Workforce**<br>• Gaps in middle grade rotas<br>• Training Compliance and impact of reduced face to face training<br>• Midwifery staffing – in particular Maternity Assessment Centre (MAC)<br>• Sustainability of Continuity of Carer model | **Birth Rate + safer staffing assessment**<br>• To determine evidence based assessment of safe maternity staffing in relation to midwives and maternity support workers<br>• Refresh of continuity of carer approach to address some of the challenges impacting on initial roll out<br><br>**Ockenden**<br>• Work is underway to now provide evidence to the national portal against the self assessment |
| **Positive news & assurance** | **Decisions made & decisions required of the Board** |
| **Ockenden response**<br>• Unit received positive feedback from regional team on return | |

8.2

### 1.0 Summary

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

### 1.0 Introduction

1.1 In January 2021 the Trust Board received a maternity report, including the mandated trust actions in response to the first Ockenden Report. One of these actions was to implement the Perinatal Quality Surveillance model including the provider level detailed here.

### 2.0 Proposal

2.1 The report covers the minimum provider Board level measures required as part of the perinatal surveillance model.

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

## 3.0 Quality Implications and Clinical Input

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

## 4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

## 5.0 Risks and Mitigating Actions

6.1 Middle grade staffing gaps remain a risk to the quality of care due to fatigue in this staff group. This has been added to the departmental risk register. The mitigations are described in the paper below.

6.2 Maintaining competencies in management of obstetric emergencies through multiprofessional training has been compromised by the inability to hold face to face sessions. This has been mitigated through the development of an online training package.

6.3 There has been some improvement in the compliance of fetal monitoring training, which is mandated by 31st May 2021, for both midwifery and medical staff. A considerable amount of work is required to ensure that all staff are compliant by 31st May 2021.

6.4 The low compliance levels for fetal monitoring training and obstetric emergency training present a risk to the delivery of high quality care and to compliance with the maternity incentive scheme standards and the accompanying financial return on this.



## 6.0 Recommendation

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

# Narrative in support of the Provider Board Level Measures – March 2021

## Introduction

NHS England and Improvement published the revised perinatal surveillance model in December 2020, setting out six requirements to strengthen and optimise board oversight for maternity and neonatal safety.

The second report for board following the overview on quality and safety and response to the Ockenden Report was presented at the board meeting in February 2021.

The maternity department have made the decision to incorporate the Perinatal Quality Surveillance model into the existing Maternity Services Forum that meets bi-monthly; the next meeting is planned for June 4th 2021.

### Review of WY&H LMS dashboard

As part of implementing a revised perinatal quality surveillance model (December 2020; LMS action) the LMS should be "leading on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMS".

A recent WY&H LMS scoping exercise was completed to identify key indicators and variation between all six maternity units within the LMS to ascertain if dashboards represent unit priorities, to review the layout of local dashboards (rag rating, SPC charts) and looking at indicators common to all dashboards. The exercise showed relatively few indicators are common to all dashboards. At a recent WY&H LMS meeting there was a discussion about the advantages and disadvantages of data comparison between maternity units.



## CQC peer review (update)

The maternity and gynaecology departments (combined) were assessed in 2016; this was part of a wider organisational CQC assessment and the services were rated as good.

The maternity department is currently reviewing the prompts, professional standards and sector specific guidance within the CQC maternity specific key lines of enquiry. The maternity leadership team have reviewed the CQC assessment undertaken in Nottingham (published December 2020).

At a recent meeting between senior midwives, the Operational Director and Service Manager for the Planned and Surgical Care Directorate next steps for the peer review had been agreed however due to the current challenges and requirements of the Ockenden report and the Maternity Incentive scheme, it was agreed to defer this work until after submission of evidence for the Maternity Incentive Scheme mid-July.

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

In March, there were no reportable perinatal deaths.

## Findings of review all cases eligible for referral to HSIB

In March 2021, one case was initially referred to HSIB. However, HSIB considered that their eligibility criteria for the case was not met and therefore was returned to the Trust for local investigation.

To date there have been a total of 7 eligible cases reported to HSIB since commencement of the notification scheme at HDFT in December 2018. Two of these are currently active and of these,

one draft report has now been issued to the Trust for checking of factual accuracy before finalising; the other active case is ongoing.

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

In April 2021, 1 incident was reported as Moderate Harm. This was rejected by HSIB (see above) and is being investigated as a local Serious Incident.

There is an agreed list of maternity specific clinical incidents for completion of a datix form as part of the trust clinical incident reporting process. Once a week, a multi-disciplinary panel (the Professional Advisory Panel – PAP) meet to discuss the clinical incidents from the previous week and actions are agreed. If, after discussion further escalation is required, a 72 hour/SBAR report is completed and referred to PESH (Patient Experience and Safety Huddle). A decision is then agreed with PESH to investigate further as an SE/SI.

At PAP, if any concerns about individual staff clinical practice are identified, further investigation by a senior member of staff is undertaken via the capability policy.

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

The revised standards for the Maternity Incentive Scheme Safety Standard 8 allow us to include staff trained between December 2019 – March 2020; therefore, these percentages have been incorporated in the compliance figures for early May.



**Prompt emergency skills training**

| | Medical staff (including anaesthetists) | Midwives |
|---|---|---|
| March 2020 | 85% (face to face) | 88% (face to face) |
| End March 2021 | 25% | 11% |
| Early May 21 | 51% | 45% |

**Fetal monitoring training**

| | Medical staff | Midwives |
|---|---|---|
| March 2020 | 93% | 94% |
| End March 2021 | 15% | 40% |
| Early May | 61% | 69% |

**Minimum safe staffing in maternity services to include:**

The maternity team have recently completed and submitted a bid for allocation of the £95 million available from NHSE/I to maternity units to support the recommendations in the Ockenden report – midwifery staffing (uplift to the establishment based on a recent Birthrate + acuity study), obstetric staffing and multi-disciplinary training. A decision on the bid is expected at the end of May and the final Birth Rate + report will be complete early June 2021.

**Obstetric cover on the delivery suite, gaps in rotas**

The maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below:

| Staffing Gaps and Contingencies | | | |
|---|---|---|---|
| **Grade of doctor** | **Staffing gaps** | **Contingency** | **Risks** |
| First on call rota FY2/ GPVTS/ ST1/2 | None | Internal cover for short term sickness as required | None identified |
| Second on call rota ST3-7/ specialty doctor | One vacancy due to trainee finishing ST7 and taking up a post elsewhere<br><br>One gap due to staff member working from home<br><br>One gap in on call cover due to change in training meaning ST3 cannot work on call without a resident senior | Internal cover prioritising labour ward cover<br><br>Locum shifts<br><br>Additional middle grade doctor post recruited to but not yet in post<br><br>Internal cover for short term sickness as required | Risk of fatigue in doctors on second on call tier<br><br>Risk of cancelling elective activity to protect Delivery Suite cover<br><br>Added to risk register March 2021 |
| Consultant | One consultant working from home<br><br>One consultant working less than full time | 2 locum consultants in post covering on call commitments<br><br>3 substantive consultant posts being recruited to<br><br>Internal cover for short term sickness as required | None identified |



**Midwife minimum safe staffing planned cover versus actual prospectively**

April data gives an average shift fill rate of 97.9% for midwives and 87.0% for maternity support workers on Delivery suite and 91.6% for midwives and 87.5% maternity support workers on Pannal Ward.

Specialist midwives and ward managers have continued to support the service by working additional clinical hours however; this data is not always captured on the Birthrate plus acuity tool.

The majority of shifts were covered by contractual hours, with 13.9% covered by NHSP, extra pay shifts on delivery suite / MAC (including the use of agency midwives and 17% on Pannal ward. There was 2 long-term sickness within this period).

A Birthrate plus prospective assessment is in progress (data collection commenced 1st March 2021 for 3 months) to review the current midwifery establishment against the acuity of the women we provide care to. An interim report was requested and received in April that formed part of the bid for monies from NHSE/I to support the recommendations in the Ockenden report.

The bi-annual midwifery staffing report (Oct 20 – March 21), part of safety standard 5 of the Maternity Incentive scheme has been completed and is attached to this report at Appendix 1.

**Current midwifery/maternity support worker vacancies:**

Midwives – 3.2WTE (interviews planned 19th May)

Maternity support workers – nil.

A number of staff have raised concerns about the current staffing in MAC (Maternity Assessment centre) and we plan to recruit 2.5 WTE Band 3 MSW's to support the midwife working in MAC. We are waiting for agreement of the band 3 job description by the WY&H LMS prior to advertising these posts. In the meantime this gap will be filled by existing band 2 MSW's and backfilling their posts with NHSP staff. Our plan is also to extend MAC opening times to weekends and this is part of the bid for the monies to support the recommendations in the Ockenden report as well as the findings from the interim Birthrate Plus workforce review.

**Service User Voice feedback** (complaints, compliments, Friends & Family)

A Maternity Voice Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. It uses both a formal committee structure, with written agendas and formal minutes of discussions and decisions, and incorporates the principles and practice of participatory co-design and co-production through small group work. Feedback from women is gathered by on-line surveys, hearing mother's voices. This feedback informs development, identifies themes and initiates co-production.

A recent survey of women's experiences of maternity services during Covid-19 has been completed with a very good response rate. The maternity team have completed an action plan; progress of the action plan is monitored at the Maternity Services Forum.

185 responses have been received for Friends and Family (FFT) in March 2021, the data submission issues from February have now been resolved. Of the 185 responses inputted for March 2021 99.46% responses were reported as good or very good.

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



During April, we had 1 concern that has been responded to and 2 formal complaints which are in progress.

**Staff feedback from frontline champions and walkabouts**

Due to recent changes to Executive and the introduction of a Non-Executive Safety Champion, a walkabout by Emma Nunez and Andy Papworth was completed on the 5th May, this date also coincided with the International Day of the Midwife. This walkabout provided an opportunity for the staff to talk to Emma and Andy regarding the positive work as well as the challenges they faced.

**HSIB/NHS Resolution/CQC or other organisation with a concern or request for action made directly with the Trust**

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

**Coroner Reg 28 made directly to Trust**

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

No Regulation 28 notifications have been received in March 2021.

**Progress in achievement of CNST 10**

Final submission of the Maternity Incentive Scheme (year 3) is due July 15th 2021.

Between now and June, there will be several reports included within this report which form part of the Trust Board oversight and sign off process.

**Local update**

Fully compliant with 6 of the 10 safety standards.

Partial compliance with 4 of the safety standards and working towards full compliance.

**Risk** – 90% of each maternity unit staff group have attended in-house multi-professional emergency training session – due to challenges of Covid-19 and the need to move from face to face to online training.



| No. | Safety standard | Compliance | Update |
|---|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? | **Compliant** | |
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? -. | **Compliant** | |
| 3 | Demonstration transitional care services are in place to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme | **Partial compliance** | Audit to be completed bi- monthly and action plan to address local findings |
| 4 | Demonstration of an effective system of clinical workforce planning to the required standard - | **Partial compliance** | To complete a report to Trust Board – obstetric, anaesthetic, neonatal (medical and nursing) |
| 5 | Demonstration of an effective system of midwifery workforce planning to the required standard | **Compliant** | Bi-annual midwifery staffing report now completed to share at Trust Board – May 2021. Workforce review – data collection in progress using Birthrate + acuity model for 2-3 months started March 1st |

| | | | |
|---|---|---|---|
| 6 | Demonstration of compliance with all five elements of the Saving Babies' Lives care bundle version two - | **Partial compliance** | Outstanding – uterine artery doppler – need training before implementation. If not introduced we are compliant as women have additional scans. CO monitoring re-introduced 22nd March 2021. Audit to be completed – 40 sets notes. |
| 7 | Demonstration of a mechanism for gathering service user feedback, and working with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | **Compliant** | MVP Chair has stepped down from her post, funding for hours worked to be agreed with North Yorkshire CCG |
| 8 | 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 - | | The impact of Covid-19 over the last 12 months has been significant with face to face training replaced by online. Prompt package just launched (Feb 21) – aim to be fully compliant (at least 90%) for all staff groups by end May.<br><br>Please see table below |
| 9 | Demonstration that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues. | **Compliant** | |
| | Progress in meeting the revised CoC action plan is overseen by the board on a minimum of a quarterly basis commencing January 2022 | | Midwifery staffing levels remains a challenge, little impact from the Covid-19 pandemic.<br><br>Current CofC % = 13% March |
| 10 | Reporting 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme | **Compliant** | |

**Update on continuity of carer (CofC)**

The Wren team was introduced in January 2021 as an on call model. Due to a combination of staff deciding to leave the organisation and maternity leave this team are currently providing antenatal and postnatal care with a small amount of intrapartum care.

There have been a number of issues identified and therefore the senior midwifery team decided to seek advice and support from the WY&H Lead midwife and the regional Lead midwife for continuity of carer. An initial meeting was arranged in early May and will be followed by a more extended visit on 25th May including a stakeholder event. The plan for the CofC model is to stabilise the existing teams and take a slow, phased approach to support new midwives to work in this way.

14% of women are on a continuity of carer pathway at the end of April.

**Clinical Indicators – Yorkshire and Humber Regional Dashboard**

Harrogate sits in the West Yorkshire and Harrogate Local Maternity System. There is a well-established regional dashboard. The table below shows the dashboard for Quarter 3 20/21 (the last published dataset).

**Activity Indicators**

These compare the number of bookings for antenatal care and the number of births in the quarter, and also show the number of homebirths. The number of bookings and births is the lowest in the region, consistent with previous and historical data; but in this quarter the number of bookings increased compared with the previous quarter.

During quarter 3 there were no homebirths, a reflection of the staffing challenges the unit faced which compromised the homebirth service. The homebirth service is now back in place.

**Maternal Clinical Indicators**

Maternal clinical indicators may be considered a reflection of the quality of the maternity service. However, it should be noted that these figures are crude and are not standardised for age, number of previous deliveries, size of babies etc.

The Maternity Dashboard below (Table 1.1) provides a Provider view across Yorkshire and Humber.



Based on this information the following should be noted:

- Overall caesarean section rate is almost the highest in the region in this quarter. The elective caesarean section rate is the highest in the region, but the emergency caesarean section rate is below the Y and H average. The caesarean section rate is a concern but must be considered in the context of maternal choice and maternal demographics (age, parity) which vary by unit. The elective caesarean rate has been increasing within HDFT and has recently been audited by the service (January 2020 – June 2020). The recommendations from the audit centred around clear documentation of risks/ benefits of caesarean birth and vaginal birth and appropriate perinatal mental health referral for women requesting caesarean due to mental health concerns.

- The rate of third and fourth degree tears fluctuates significantly and is tracked through the bimonthly maternity risk management group. The maternity team is implementing the Oasi bundle, a QI initiative from the RCOG which aims to reduce the incidence of third and fourth degree tears.

Table 1.1

| Indicator | Measure | Trust/Site Quarterly Data | | Y&H Average (Sites) | Y&H Range (Sites) | Y&H Interquartile Range (Sites) | Previous Q | Y&H Avg |
|---|---|---|---|---|---|---|---|---|
| | | Previous | Latest | | | | | |
| **ACTIVITY INDICATORS** | | | | | | | | |
| Bookings | Number of women booked | 412 | 462 | 821 | 0 to 1701 | 533 to 1231 | ↑ | ↓ |
| % Bookings <13 weeks | % of women booked <13 weeks | 99.8% | 100.0% | 91.7% | 86.1% to 100.0% | 90.7% to 93.1% | ↑ | ↑ |
| Women birthed | Number of all women birthed | 418 | 445 | 696 | 9 to 1560 | 364 to 1083 | ↑ | ↓ |
| Total births | Number of all babies born | 427 | 451 | 706 | 9 to 1595 | 393 to 1093 | ↑ | ↓ |
| Live births | Number of live babies born | 427 | 451 | 703 | 9 to 1592 | 392 to 1086 | ↑ | ↓ |
| Live births at term | Rolling annual number of live babies born at term | 1647 | 1649 | 2631 | 48 to 5791 | 1342 to 4134 | ↑ | ↓ |
| Total births | Rolling annual number of all babies born | 1745 | 1748 | 2854 | 49 to 6290 | 1497 to 4413 | ↑ | ↓ |
| Planned homebirths | % of planned homebirths | 0.9% | 0.0% | 1.5% | 0.0% to 100.0% | 0.5% to 2.2% | ↓ | ↓ |
| **MATERNAL CLINICAL INDICATORS** | | | | | | | | |
| Normal births | % of women - normal births | 56.2% | 53.3% | 59.1% | 53.3% to 100.0% | 57.3% to 64.3% | ↓ | ↓ |
| Assisted vaginal births | % of women - assisted vaginal births | 9.3% | 12.8% | 10.9% | 0.0% to 16.8% | 7.9% to 11.8% | ↑ | ↑ |
| Elective C/S deliveries | % of women - El C/S | 16.5% | 17.3% | 12.6% | 0.0% to 17.3% | 10.4% to 13.8% | ↑ | ↑ |
| Emergency C/S deliveries | % of women - Em C/S | 17.9% | 16.6% | 17.6% | 0.0% to 22.2% | 14.8% to 18.5% | ↓ | ↓ |
| C/S deliveries | % of women - Total all C/S | 34.4% | 33.9% | 30.2% | 0.0% to 34.4% | 27.0% to 31.6% | ↓ | ↑ |
| 3rd/4th degree tear - normal birth | % of women delivered - normal births | 3.0% | 1.7% | 1.9% | 0.0% to 9.1% | 1.5% to 2.4% | ↓ | ↓ |
| 3rd/4th degree tear - assisted birth | % of women delivered - assisted births | 15.4% | 1.8% | 5.9% | 0.0% to 18.8% | 3.6% to 7.1% | ↓ | ↓ |
| Induction of Labour | % of women delivered | 32.8% | 32.6% | 36.2% | 0.0% to 45.2% | 31.6% to 40.3% | ↓ | ↓ |
| PPH ≥ 1500ml | % of women delivered | 3.3% | 2.5% | 3.9% | 0.0% to 6.0% | 2.4% to 4.1% | ↓ | ↓ |
| **NEONATAL CLINICAL INDICATORS** | | | | | | | | |
| Preterm birth rate < 37 weeks | % of babies <37 weeks | 7.0% | 6.2% | 7.7% | 0.0% to 13.6% | 5.5% to 8.4% | ↓ | ↓ |
| Preterm birth rate < 34 weeks | % of babies <34 weeks | 0.7% | 1.1% | 2.1% | 0.0% to 3.4% | 1.0% to 2.4% | ↑ | ↓ |
| Preterm birth rate < 28 weeks | % of babies <28 weeks | 0.0% | 0.2% | 0.4% | 0.0% to 0.9% | 0.0% to 0.4% | ↑ | ↓ |
| Low birth weight at term - live births | Rolling annual % of live babies at term < 2200g | 0.5% | 0.6% | 0.7% | 0.0% to 2.6% | 0.4% to 0.8% | ↑ | ↓ |
| **STILLBIRTHS** | | | | | | | | |
| Stillbirths | Number of all babies stillborn | 0 | 0 | 3 | 0 to 12 | 0 to 3 | ↑ | ↓ |
| Stillbirth rate - Antenatal | Rolling annual rate for antenatal stillborn babies / 1000 births | 1.7 | 1.1 | 3.4 | 0.0 to 7.1 | 2.4 to 3.8 | ↓ | ↓ |
| Stillbirth rate - Intrapartum | Rolling annual rate for intrapartum stillborn babies / 1000 births | 0.6 | 0.0 | 0.2 | 0.0 to 1.5 | 0.0 to 0.4 | ↓ | ↓ |
| Stillbirth rate - Total | Rolling annual rate for ALL stillborn babies / 1000 births | 2.3 | 1.1 | 3.6 | 0.0 to 7.8 | 2.5 to 4.1 | ↓ | ↓ |
| Stillbirth rate - adjusted to exclude lethal abnormalities | Rolling annual stillborn babies / 1000 births excluding babies with lethal abnormality | 2.3 | 1.1 | 3.1 | 0.0 to 7.1 | 2.0 to 3.5 | ↓ | ↓ |
| Stillbirths at term with low birth weight | Rolling annual % of stillborn babies < 2200g | 0.0% | N/A | 13.1% | 0.0% to 50.0% | 0.0% to 23.2% | ## | ## |
| **PUBLIC HEALTH INDICATORS** | | | | | | | | |
| Breast feeding initiation rate | % of women commenced breastfeeding | 84.7% | 87.2% | 67.8% | 56.8% to 88.9% | 61.2% to 74.5% | ↑ | ↑ |
| Smoking at time of booking | % of women who smoke at booking | 6.8% | 5.6% | 12.0% | 0.6% to 21.4% | 10.1% to 18.2% | ↓ | ↓ |
| Smoking at time of delivery | % of women who smoke at time of delivery | 4.1% | 5.6% | 13.1% | 0.0% to 20.8% | 9.8% to 15.8% | ↑ | ↓ |

### Stillbirths

The number of stillbirths is too small to make meaningful comparisons by quarter but is reported in the Perinatal Quality Surveillance model.

### Public Health Indicators

The number of women smoking at the time of delivery was increased in this quarter, and may be a reflection of the challenges COVID has placed on the smoking cessation quality improvement work. For example, the carbon monoxide testing throughout pregnancy was placed on hold due to risks of covid transmission, This important initiative has now been reinstated.

### Local Dashboard

The local maternity dashboard requires a refresh with data represented as SPC charts, instead of RAG ratings, which will allow more meaningful analysis of data and a more intelligent approach to quality improvement within the unit.

**Appendix 1**

| ***Bi Annual Staffing Report*** | |
|---|---|
| | **Time Period of data**<br>**1st October 2020 – March 31st 2021** |
| **Name & designation of person completing the summary** | **Danielle Bhanvra**<br>**Matron** |
| **Clinical area/s covered by summary:** | Delivery Suite<br>Maternity Assessment Centre (MAC)<br>Pannal Ward<br>Community Midwifery<br>Antenatal Clinic<br>Continuity of Carer |
| **Sources of data collection** | Information obtained from E-Roster, HDFT Staffing Levels, BirthRate Plus acuity tool, NHS professionals. |

**Executive Summary**

1. The aim of this bi-annual report (Oct 20 – March 21) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the Maternity Incentive Scheme, safety action 5.

2. The report provides assurance that there is the following:

- A systematic evidence based process to calculate midwifery staffing establishment and action taken to address staffing shortfall.

- A process in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels. This includes one team leader huddle per week to review planned midwifery staffing levels against the agreed establishment for each clinical area. Daily staffing reviews are held by the team leaders/delivery suite coordinators to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

- Action taken to address the findings of BirthRate + report

- Evidence from an acuity tool that demonstrates 100% compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour

- Monitoring of red flag incidents (associated with midwifery staffing).

3. The evidence described in this paper provides assurance that HDFT has an effective system of midwifery workforce planning and monitoring of safe staffing levels between October 2020 – March 2021

**There is a clear breakdown of BirthRate + to demonstrate how the required establishment has been calculated.**

The Birthrate Plus acuity tool provides a systematic, evidence-based process to determine if the current midwifery establishment is correct for the number and acuity of the women delivered. The tool was purchased in September 2018 and some information from this tool is included within this report. Information is currently collected from in-patient areas only (Delivery Suite and Pannal ward). In conjunction with the BirthRate Plus tool the maternity department is currently involved in a systematic assessment of the workforce required for all services including the community setting. This will provide a baseline establishment that can be compared to the currently funded one. This information will incorporate the staffing for Continuity of Carer teams as well as core services to help with workforce planning going forwards.

Data extracted from BirthRate Plus during this time period show there was a compliance completion rate of the tool of 81.41% on delivery suite and 83.52% for Pannal Ward. There were no relevant staffing factors identified for 65% of the time on delivery suite and 81% of the time on Pannal ward. The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required.

The agreed staffing levels in all areas of the maternity department are outlined in the minimum staffing guideline (maternity). The minimum staffing levels have been agreed based on activity levels, current bed base and the numbers of midwives required to provide safe care to women and their babies. The maternity escalation policy provides clear guidance for the midwife in charge to follow in order to manage a shortfall in staffing and clinical and/or management actions in the BirthRate + acuity tool can also be used in order to manage this shortfall if required. A review of the current and planned activity is undertaken to support the decision

**Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.**

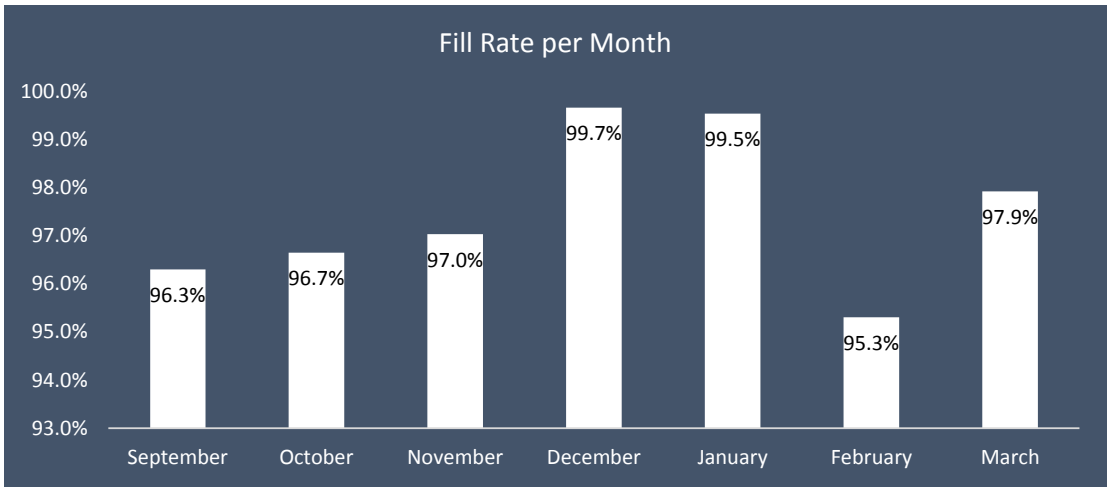
The tables below show the monthly overall fill rate for both Delivery Suite and Pannal Ward with average fill rates for both midwives and maternity support workers higher at night than during the day. It is a priority to cover nights and weekends as during daytime hours any shortfalls in staffing levels can be covered with midwifery managers and specialist midwives. Covid 19 has had an impact on staffing levels with midwives unable to work clinically due to shielding or medical isolation.

A weekly midwifery manager's huddle has recently commenced (every Monday) to review the planned staffing against the agreed establishment for each clinical area with the ability to redeploy staff when required.

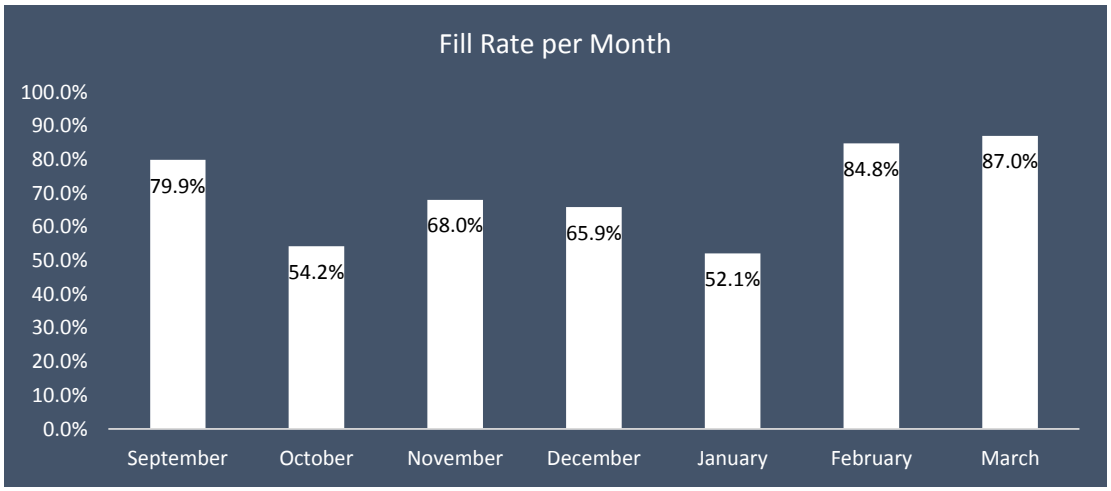
Actions were taken as per the Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives working clinically" as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift.

**Delivery Suite**

Midwives



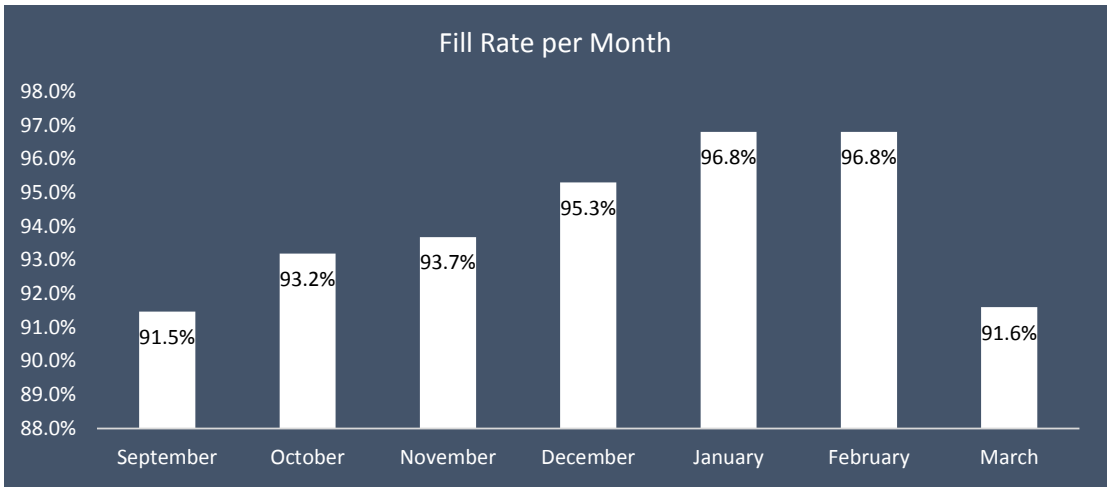

Maternity Support Workers



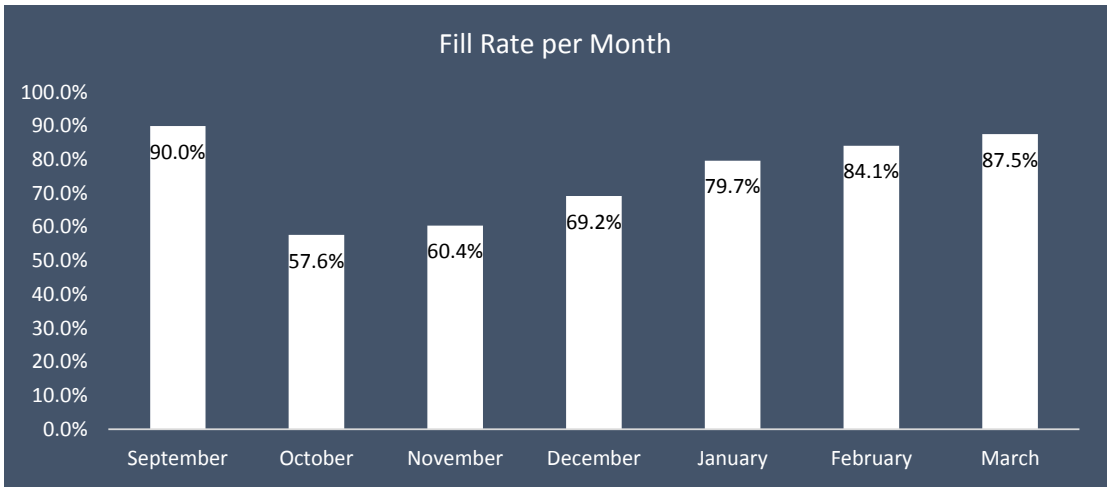

8.2

**Pannal Ward**

Midwives




Maternity Support Workers




8.2

**An action plan to address the findings from the full audit of BirthRate +, where deficits in staffing levels have been identified**

An action plan to address the findings from the full audit or table-top exercise of Birth Rate Plus or equivalent will be undertaken once the full 3-month data collection has been completed (June 21). Where deficits in staffing levels have been identified.

Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

- There is an escalation policy for staff to use in the event of staffing short falls.
- A gap analysis will be completed against the recommended staffing levels in the BirthRate Plus report with any deficit being identified and actions taken to mitigate in the short and long term

The maternity department continues to actively recruit new staff. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between Oct and March.

| | **Midwives** | **Maternity Support Workers (MSW's)** |
|---|---|---|
| New Starters | 8.6 WTE | 0.8 WTE |
| Leavers | 3.7WTE | 0.6 WTE |
| Maternity Leave | 9.4 WTE | 0.6 WTE |

**Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls**

There has been no action plan to demonstrate an increase in staffing levels as this has not been identified as an issue prior to the introduction of Continuity of Carer.

Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the Birthrate Plus acuity tool. Because of the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on 15 occasions with 11 women diverted to another hospital. The Covid-19 pandemic may be the reason for this increase with less staff available due to sickness, self-isolation or need to shield. A datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All datix forms are discussed by a multi-disciplinary team at the Professional Advisory Panel on a weekly basis.

With a continued fall in the birth rate at Harrogate over the last 5 years and the implementation of the continuity of carer model (NHS England, 2016) a review of the maternity staffing establishment was about to start in March 2020 with a focus on the numbers of midwives who will be required to fully deliver the CofC model. This work was delayed due to the Covid 19 pandemic and will commence in April 2021.

## Midwife: birth ratio

The midwife: birth ratio recommended by Safer Childbirth (Kings Fund, 2011) is 28 births to one WTE midwife for hospital births; Birthrate Plus determines this figure should be 1:29.5.

The monthly midwife to birth ratio is currently calculated using the number of whole time equivalent midwives employed and the total number of births in the month. This is the contracted or established Midwife to birth ratio. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour.

| Midwife to Birth ratio | October | November | December | January | February | March |
|---|---|---|---|---|---|---|
| Funded | 28.86 | 28.86 | 28.86 | 28.86 | 28.86 | 28.86 |
| In Post | 30.10 | 28.46 | 28.18 | 29.82 | 29.39 | 29.39 |

The Head of Midwifery or Matron are not included in the midwife to birth ratio however specialist midwives and team leaders have both their management and clinical time included. A more accurate midwife to birth ratio would take into account those midwives who are not available for work due to sickness or shielding whilst adding in the WTE bank shifts completed in each month. This “worked” calculation will show greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. The reporting of the contracted ratio is a useful measure to assess the recruitment and retention of midwives to the service although will show small fluctuations due to this as well as changes in birth numbers each month. Work to capture this data will commence in 2021.



## The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birthrate + accounts for 8-10% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The current percentage is 11.5%, slightly above the 8-10% accepted by BirthRate Plus acuity tool. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours.

The specialist roles support national recommendations to ensure the service has the correct specialist posts for the demographic served and are in line with current national initiatives.

The service has a wide range of specialist midwifery posts as detailed below:
- Bereavement 0.4 WTE
- Infant feeding 0.8 WTE
- Risk / governance 1.00 WTE
- Professional development midwife 0.6 WTE
- Safeguarding & Public health (part of ANC manager hours)
- Antenatal and Newborn Screening 1.00 WTE
- Professional Midwifery Advocate (Not a substantive post)
- Fetal Monitoring Lead Midwife 0.4 WTE

**Evidence from the acuity tool demonstrating 100% compliance with the supernumerary labour ward coordinator status and the provision of 1:1 care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.**

The labour ward coordinator has supernumerary status, defined as having no caseload of their own during their shift (NHS Resolution, Maternity Incentive Scheme, 2020) to enable oversight of all the birth activity within the service. To ensure consistency and accuracy in collection of this information on the Birthrate + acuity tool the following definition has been agreed locally and applied;

*'The DS coordinator is defined as being supernumerary when they are able to safely provide oversight of all the activity on the ward by remaining visual and accessible to the staff working on the shift. When allocating the workload to the staff on duty you should be aware of the full acuity of the activity on Pannal ward and whether additional support can be provided by the ward if required. Do not hesitate to use this support if it is available and ensures that you are supernumerary. As long as you are not providing 1:1 care to a woman in established labour (over a prolonged period of time) and you feel that you can provide oversight of the ward safely you should document that you are supernumerary'.*

There is always a delivery suite coordinator (or suitably experienced band 6 midwife) rostered to be in charge on delivery suite and will aim to be supernumerary in order to provide oversight of all birth activity in the service. Harrogate is a small maternity unit and there is full recognition of the advantages of the delivery suite coordinator being supernumerary in improving outcomes for both mother and baby but in practice this is extremely difficult to achieve at times of acute sickness and increased activity, this being the nature of maternity services.

All information was collated using the Birthrate Plus acuity tool. Compliance in completion for the 6-month period was 81.41%.

During this time period there were 85 occasions when the coordinator was not supernumerary out of a completed 1092 occasions which equates to 92.21%. Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialists midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

1:1 care in labour has been shown to improve outcomes for both mother and baby. During this time period 1:1 care in labour was achieved 96.5% of the time.

There were 869 babies born

855 women delivered (14 sets of twins)

825 women had 1:1 care **(96.5%)**

30 women listed as not having 1:1 care (9 of these were listed as BBA/delivery with paramedics; a further 12 of these were listed as elective LSCS - staff stating not 1:1 as did not labour)

**Did Covid-19 cause impact on staffing levels?**

- **Was the staffing level affected by the changes to the organisation to deal with Covid 19**
- **How has the organisation prepared for a sudden staff shortages in terms of demand, capacity and capability during the pandemic and for any future waves**

Covid 19 risk assessments were undertaken for all HDFT maternity staff. Mitigation secondary to the risk outcome was put in place for all staff with a moderate to high risk score or those who were shielding. This meant that a number of patient facing staff moved to administration duties or working from home. The resulting shortfall was however backfilled by specialist and management midwifery hours and with NHSP shifts. This meant minimal disruption to clinical care. No midwifery or nursing staff were redeployed to intensive care units or within the organisation during this time period.

Each department midwifery lead prepared a pandemic response plan in the form of an Escalation Action Card. This looked at what clinical work could be undertaken, dependent on the percentage of staff loss occurred during Covid. This outlined services that could continue depending on the number of staff available to provide patient facing clinical care. We did not need to put any of these plans into action as the maternity service remained appropriately staffed throughout Q3 and Q4.



**Continuity of Carer**

Better Births (NHS England, 2016), the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised and put the needs of the women, their 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 continuity of care and relationship between care giver and receiver has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience.

Following on from the challenges of the Covid 19 pandemic, the national Continuity Of Carer (CofC) trajectories have changed from 51% of women aligned to a CofC pathway by March 2021. The steer from the national team is that each maternity unit should aim to have a system where building blocks are put in place by March 2022 so that Continuity of Carer is the default model of care offered to all women by March 2023. The CofC project lead is working closely with midwives and the senior midwifery leadership team to co-design plans to achieve compliance with national principals and standards, phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic. To support this work HDFT have included CofC in the BirthRate Plus data collection process to understand the midwifery workforce requirements to support this model.

With Covid 19 having a significant impact on the ability to safely staff the inpatient areas the two original CoC teams, Ivy and Willow were unable to continue to work solely in a continuity model. The teams have now been realigned to two geographical areas with some of the team members working as integrated midwives (covering both community and delivery suite). The two new teams Robin and Kingfisher are unable to be classed as continuity models at present as they provide intrapartum care for any woman and not exclusively for women on their caseloads. Once HDFT staffing is fully established these two teams will become fully integrated Continuity of Carer models. Alongside the Robin and Kingfisher team HDFT plan to introduce the Birth after Cesarean team (BACS) to caseload women who have had a previous caesarean section and plan to either have an elective caesarean section or aim for a vaginal delivery.

The first case loading team at HDFT (The Wren team) was launched in January 2021. The aim for the team is they they will provide 24/7 on call intrapartum cover for the women booked onto their caseload. The current number of women booked onto the pathway by the team is currently 13%.

**Number of red flag incidents (associated with midwifery staffing) reported in a consecutive 6-month period within the last 12 months. How they are collected, where/how they are reported/monitored and any actions arising.**

Red flag events have been agreed locally and are available on the BirthRate Plus acuity tool (listed in appendix 1).

During the 6-month period between October 1st 2020 – March 31th 2021, red flag events identified;

Delivery Suite 6 red flags were identified
Pannal ward 35 red flags were identified

Staffing levels are continually reviewed by the Head of Midwifery, Matron and senior midwifery team leaders in line with known workload and projected maternity bookings in Maternity Services and information from the Birthrate Plus acuity tool. The minimum staffing levels are agreed within the Maternity staffing guideline for the department and the Birthrate Plus acuity tool offers additional information on these levels and the acuity of the women however, it is for in-patient areas only and does not include Antenatal clinic (ANC) or community/continuity of carer midwifery teams.

**Recommendations**

To add the information from BirthRate Plus as a standing agenda item for Maternity Services Forum (bi-monthly meeting) and any concerns/themes or trends will be discussed further at the Maternity Risk Management Group, escalated to the Maternity Safety Champions meeting and the Planned and Surgical Directorate quality and governance meeting (monthly) if required.

| Delivery Suite - Red Flags | October | November | December | January | February | March |
|---|---|---|---|---|---|---|
| Delayed or cancelled time critical activity | 0 | 0 | 0 | 0 | 0 | 0 |
| Missed or delayed care | 0 | 0 | 0 | 0 | 0 | 0 |
| Missed or delayed mediation > 30 mins | 0 | 0 | 0 | 0 | 0 | 0 |
| Delay in providing pain relief > 30 mins | 0 | 0 | 0 | 0 | 0 | 0 |
| Delay between presentation and triage >30 mins | 1 | 0 | 0 | 0 | 0 | 0 |
| Full clinical examination not carried out when presenting in labour | 0 | 0 | 0 | 0 | 0 | 0 |
| Delay between admission for induction and beginning of process | 0 | 0 | 0 | 0 | 0 | 0 |
| Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) | 0 | 0 | 0 | 0 | 0 | 0 |
| Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0 | 0 | 0 | 0 | 0 |
| Midwife unable to provide 1:1 high dependency care for AN or PN patient | 1 | 2 | 2 | 0 | 0 | 0 |

| **Pannal Ward - Red Flags** | October | November | December | January | February | March |
|---|---|---|---|---|---|---|
| Delayed or cancelled time critical activity | 4 | 0 | 0 | 0 | 0 | 3 |
| Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) | 0 | 0 | 1 | 5 | 0 | 0 |
| Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication) | 0 | 0 | 0 | 0 | 0 | 0 |
| Delay in providing pain relief | 1 | 0 | 1 | 4 | 0 | 1 |
| Delay between presentation and triage | 1 | 0 | 0 | 1 | 1 | 1 |
| Full clinical examination not carried out when presenting in labour | 0 | 0 | 0 | 0 | 0 | 0 |
| Delay between admission for induction and beginning of process | 1 | 3 | 1 | 4 | 0 | 0 |
| Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) | 0 | 0 | 0 | 0 | 0 | 0 |
| Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour | 0 | 0 | 0 | 1 | 0 | 1 |



Provider Board level measures
Monthly report
May 2021 (April data)

NHS
Harrogate and District
NHS Foundation Trust

# Board Committee Report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | People and Culture Committee |
| **Committee Chair:** | Jeremy Cross |
| **Date of meeting:** | 17 May 2021 |
| **Date of Board meeting this report is to be presented** | 26 May 2021 |

**Summary of key issues**

- The Committee received a presentation from the team responsible for the recruitment of nurses from overseas entitled "Global Learning, Lived Experiences". All the committee were impressed and excited by the professionalism and enthusiasm that was shown – both by the leasers responsible, and from the 2 nurses who joined us. Of note is that of the 42 professionals recruited, 41 are still with the Trust (and the other 1 chose to move closer to family at an adjoining Trust). These levels of retention point to a well thought out and well led programme, which puts the wellbeing of our people at its heart.
- The Staff Network representatives presented their activities – they have again been busy, and it was good to hear the progress made. After the recruitment of our ED&I lead in the next few days we will revisit how best to provide resource to the Networks and ensure we are making the most of their potential
- We received an update from the outgoing Freedom to Speak Up Guardian who is soon to retire from the NHS after 40 year's service. We are grateful for the commitment that Shona has given to this role recently. All agreed that when the new FTSUG arrangements are in place we will need a relaunch to publicise.
- The People Plan update was in a new format which worked really well – and was summarised under the key headings of the People Plan ambitions. A proposal for the KPI metrics was well received and we look forward to seeing these populated in future months. While progress is being made in the "Patient Behaviour Towards Colleagues" action plan, this is a difficult piece of work which impacts across all areas of the Trust – we will continue to monitor and offer support in future meetings.
- It was noted that great progress is being made in the Culture Programme – and of particular note was that we were hearing about the actions of the Programme under all headings of the Committee's work – showing that it is beginning to impact on the way we do things.
- We received the Staff Survey results. The response rate was lower than in previous years as a result of the Covid work pressures, and also as a result

| |
|---|
| of priority being given to the Cultural Programme responses. Nevertheless, it is another data point for us to work with. We noted that the issues for BAME colleagues remain unaltered from previous years – emphasising the need to continue with the Trust ambition to become an Anti-Racist organisation. We also discussed the importance of the results being reflected in the appraisal process for team leaders to ensure they are dealing with the lower scores in individual areas. In addition we noted there may be learnings from areas where scores were higher than average. |
| **Any significant risks for noting by Board? (list if appropriate)** |
| • The Committee will continue to monitor the progress against the Anti-Racist work plan and in particular the actions within the "Patient Behaviour Towards Colleagues" plan. |
| **Any matters of escalation to Board for decision or noting (list if appropriate)** |
| • The excellent results from the overseas recruitment team<br>• The Staff Survey results<br>• The importance of the ED&I recruitment that is ongoing |

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)

## 26 May 2021

## Workforce & Organisational Development Report

| | |
|---|---|
| **Agenda Item Number:** | **9.1** |
| **Presented for:** | Note |
| **Report of:** | Director of Workforce and Organisational Development |
| **Author (s):** | Deputy Director of Workforce & Organisational Development |
| **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 approve note this report. |

# Board of Directors Meeting (held in Public)

## 26 May 2021

## Workforce and Organisational Development Report


9.1

### 1.0 Executive Summary

The Workforce & Organisational Development Board of Directors paper for May 2021 contains several up-dates for information and also papers for review, feedback and action.

1.1 Updates include:

- Virtual Learning Environment
- Wellbeing Guardian formal approval of appointment to role
- At Our Best Appraisal and Wellbeing Discussions
- Health Education England Senior Team Visit

## 2.0 Virtual Learning Environment

2.1 Background

The geographical spread of Harrogate and District NHS Foundation Trust has imposed many limitations on the delivery of critical and essential training and education. The available estate for delivering face-to-face training is extremely restricted and has not grown in line with the level of training needs within the Trust. Access for staff working away from the Lancaster Park Road site or working outside Monday to Friday daytime hours is also challenging.

In order to improve access to this essential service in a more equitable manner, and ensure our colleagues access education, learning and development that enables them to provide a high quality of patient care and outcomes, it was necessary for the Trust to embrace an innovative approach to delivery of training going forward.

Our current system Oracle Learning Management (OLM) ELearning has a number of limitations including its inability for customisations and its lack of tools such as forum and discussion threads. Its unintuitive layout leads to frustrations for users and in turn reduced engagement with learning content.

2.2 Business case approval for a new Virtual Learning Environment (VLE)

Research was undertaken and a subsequent business case development to allow the procurement of a VLE. Our chosen solution is by Chambury Learning Solutions who will host our new VLE on Totara Learn, a custom distribution of Moodle.



The system will provide us with all the functionality available to us via OLM ELearning accessible to us in an intuitive clear, customisable web based format in addition to new functionality to enhance all learners experiences such as forums, discussion threads, ability to upload and download documentation and a hub for the hosting of resources allowing learners to access to all pre-course, post course learning resources in one place.

An interface between our new VLE and the NHS Electronic Staff Record (ESR) will ensure our continued commitment to the transferability of mandatory learning nationally across the NHS reducing duplication of training and optimum use of employee's time to complete the learning they require when they require it. The VLE has an annual cost of £35k after initial set up cost of £16k.

The new VLE will allow us to have a platform for Continuous Learning & Improvement and the VLE will be a real asset to the Trust, increasing knowledge share, numbers of colleagues accessing learning and development and employee engagement. All of these are directly linked to the quality of patient care and experience.

2.3 Timescale for implementation

The proposed implementation programme will begin with a move from our current system of OLM ELearning to initially provide existing functionality and records in a more intuitive, accessible format for all learners, managers and facilitators by summer 2021.

The system will then continue development to provide opportunity for facilitators, learners and managers to embrace with additional functionality to allow a wider ownership of learning content, communication tools including forums, discussions threads, on demand reporting and real time training attendance data.

## 3.0 Wellbeing Guardian formal approval of appointment to role

3.1 Background

The NHS People Plan 2020-21 sets out an ambition of the introduction of a Wellbeing Guardian in every NHS organisation. Wellbeing Guardians are likely to be board members who strategically steer and hold an NHS organisation to account for the wellbeing of its employees.

3.2. Who can be a Wellbeing Guardian?

Where organisations have non-executive directors (NEDs), it is recommended that it is one of them who is appointed into the Wellbeing Guardian role.

The Wellbeing Guardian should:

- Care about people, find ways to connect with staff and staff networks and listen well.
- Work closely with and support the HR Director and other executives who lead in this area.
- Feel confident in challenging the Board and other senior leaders, questioning decisions that could impact on the wellbeing of our NHS people, and challenging behaviours or aspects of the culture that are likely to be detrimental to others

.

- Be fully cognisant of the protected characteristics outlined in the Equality Act and be committed to ensuring that disparities on the basis of a protected characteristic are eradicated



3.3 The Role of the Wellbeing Guardian

The Wellbeing Guardian role will be different in each healthcare organisational context and setting. Therefore, NHSE have developed role guidelines should be considered developmental and adapted to the HDFT and HIF context and used as a flexible starting point, rather than mandate.

NHSE advise that when implementing the Wellbeing Guardian role, the organisation should keep in mind that the role is that of leadership and strategic assurance to enable a culture of wellbeing. It is not intended to be a management or operational delivery role. Therefore, the organisation should ensure that there is operational infrastructure and support available to empower the Guardian to be effective and maximise their time in role.

The NHSE development role profile for the Wellbeing Guardian is shown in Appendix 1.

3.4 Approval of Appointment at HDFT and HIF

The Board of Directors are asked to approve the appointment of Sarah Armstrong to the role of Wellbeing Guardian.

As a Non-Executive Director for both HDFT and HIF, and a member of the People & Culture Committee for HDFT and Chair of the People and Culture Committee for HIF, Sarah is well placed to fulfil this role for both organisations, her role across both organisations will bring synergy to the health and wellbeing work undertaken.

The Director of Workforce & OD and team are delighted with the prospect of Sarah fulfilling the role of Wellbeing Guardian and look forward to working closely with her on this very important agenda and in shaping the role of Wellbeing Guardian at HDFT and HIF.

## 4.0 Appraising for Values

4.1 The Board will be aware that the compulsion regarding achieving appraisal targets was paused during the pandemic (previous target was 95%) although an expectation was that appraisal discussions and wellbeing discussions (risk assessment based) would still continue where possible. The appraisal rates have been running at approximately 50% over recent months. The process is now being relaunched with a view to improving the quality and also the compliance rates.

4.2 As an important element of the At Our Best Culture Change Programme a new, strengths based approach to annual appraisal is being launched from the 1 June 2021.

The approach to be used has been introduced by A Kind Life, and has been well researched in development of the approach and has an evidence base to indicate that this is as an engaging, motivating way of carrying out appraisal. Effective and meaningful appraisal supports high performance and behaviours that are in line with those that we value – Kindness, Integrity, Teamwork and Equality (KITE).

4.3 The appraisal discussion is based around four S's - as shown below:


4.4 The 4 S; s appraisal template and guidance for line managers and colleagues to be appraised are available.

4.5 In addition to the guidance documents, further support materials, such as an eLearning package are available to all colleagues in using the new appraisal approach effectively, and At Our Best webinars are to be scheduled for Line Managers, to support them further in running appraisals using this approach.

4.6 In terms of frequency of conversation - every colleague should have a 4 S's discussion at a minimum of 1 per 12 month period, however, it is to be encouraged that this becomes more of an on-going dialogue between line managers and their team members, to provide support, encouragement, celebrate success and stop any struggles being encountered from developing.

## 5.0 Wellbeing Discussions - Thrive

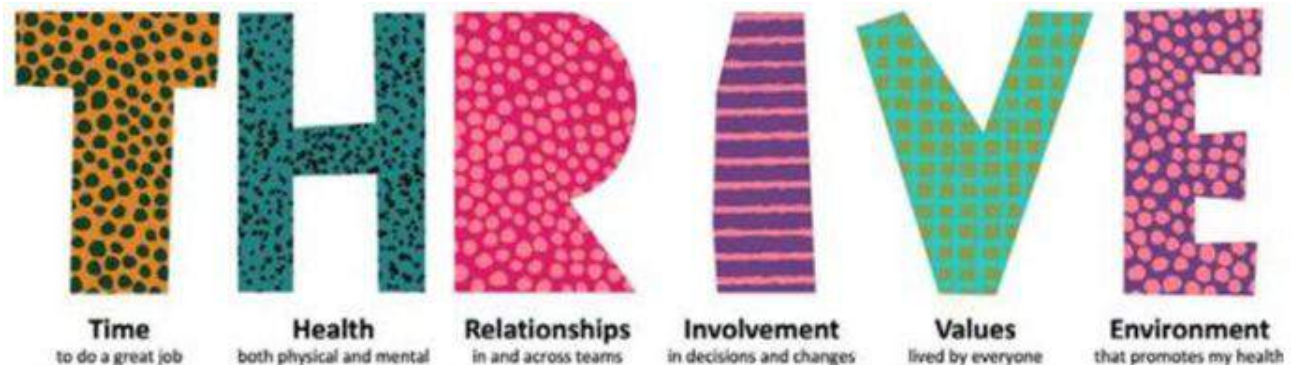
5.1 Background to Wellbeing Discussions

To deliver high-quality patient care, HDFT needs staff that are healthy, well and at work. Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care. Poor workforce health has high and far reaching costs to HDFT and ultimately our patients.

Research shows that where NHS trusts prioritise staff health and wellbeing and actively engage with staff to develop work in this area, levels of engagement increase, as does staff morale, loyalty, innovation, productivity, all resulting in higher quality patient care.

5.2 The Thrive template

The Thrive model shown below provides an excellent framework for a THRIVE conversation






5.3 The THRIVE template and guidance for line managers and colleagues to participate in a wellbeing conversation are available, including a useful template for colleagues to prompt their thinking in preparation for the meeting to enable them to gain the most benefit from the discussion.

5.4 In addition to the guidance documents, further support materials are available to all colleagues in using THRIVE model, and At Our Best webinars are to be scheduled for Line Managers, to support them further in using this approach to wellbeing discussions and to dealing with potential outcomes of the discussions.

5.5 In terms of frequency the THRIVE conversation should be:

- included in the annual SSSS Appraisal as a mandatory discussion
- ideally this will be followed up with 6 monthly follow-up discussion.
- included in the new starter on-boarding process and 6 months into employment.

## 6.0 Health Education England Senior Team Visit (HEE)

6.1 Background

As a provider of educational placements for undergraduate and post graduate medical trainees, and nursing and allied health professional students, we are assessed and audited

on a regular basis by the Health Education England (HEE) Quality Team to ensure that students on placement with the Trust receive a high quality educational experience that enables them to meet their learning outcomes.

HEE hold regular Monitoring of the Learning Environment (MLE) meetings with the Education Team at Harrogate and District NHS Foundation Trust (HDFT) and have and we have excellent working relationship with the Quality Team.

MLE meetings are Multi-professional and always productive and provide us with the opportunity to demonstrate progress against requirements, discuss trainee feedback and highlight any concerns or good practice.

6.2 HEE Senior Leadership Visit – 5 May 2021

The HEE Senior Leadership team conducted a virtual visit to the Trust on 5 May to review our Quality Update Report. The meeting was very positive, with the senior team being very impressed with the At Our Best Cultural Change Programme.

They were also pleased to report that overall feedback from learners at the Trust is good with positive outcomes in the domains of Communication & Teamwork, Health & Wellbeing, Clinical supervision and Speaking up & Voice from medical students.

The full Quality Update Report is shown in Appendix 2.

Supporting Information:

Appendix 1 – NHSE Developmental Role Profile for Wellbeing Guardian

Appendix 2 - Quality Update Report – Harrogate and District NHS Foundation Trust

# Wellbeing Guardian: Example Role Description

**The Wellbeing Guardian role will be different in each healthcare organisational context and setting. Therefore, these role guidelines should be considered developmental and adapted to the local context and used as a flexible starting point, rather than mandate.**

**When implementing the Wellbeing Guardian role, the organisation should keep in mind that the role is that of leadership and strategic assurance to enable a culture of wellbeing. It is not intended to be a management or operational delivery role. Therefore, the organisation should ensure that there is operational infrastructure and support available to empower the Guardian to be effective and maximise their time in role.**

Developmental



## Purpose

The overriding purpose of the Wellbeing Guardian is to routinely challenge the organisation's activities and performance to create a compassionate environment which promotes the culture of wellbeing of our NHS people, where organisational activities empower the holistic health and wellbeing of its NHS people.

**Promoting Holistic Wellbeing**: Enabling the organisation to consider a holistic health and wellbeing approach, intended to reflect:

- ***equality and inclusion*** *– eg taking steps to understand and support the individual and diverse needs of people working in the organisation so that they can thrive at work*
- ***civility and respect*** *– eg addressing incivility which can lead to bullying*
- ***physical wellbeing*** *– eg taking proactive steps to create a healthy working environment, including by making food available, providing equipment to keep our people safe and active, and ensuring rest breaks and working patterns support good health*

- ***mental/psychological wellbeing*** *– eg recognising that we all have mental wellbeing and that we need a psychologically safe environment to work in, with support available when it is needed*
- ***social wellbeing*** *– eg recognising that informal chats, shared rest spaces and moments of down-time enable our people to re-charge, bond and share resilience*
- ***spiritual wellbeing*** *– eg creating a working environment where our people feel able to share their whole selves, beyond just their beliefs or faith (including people of no faith), sharing who we are as individuals, our relationships and what gives us meaning and purpose.*
- ***financial wellbeing*** *– eg ensuring that the employer recognises the diverse ways that our NHS people are financially impacted by internal or external activities, making different sources of support available for all*

**Seeking Assurance:** The Wellbeing Guardian may request information from the executive/operational management team, to give the board / senior leadership team the necessary assurance that a healthy working environment is being created. This should enable the board / senor leadership team to determine what is important for them to pay attention to so that improvement can be made and shared. For example, they may wish to request frontline feedback in the form of stories from our NHS people and the corresponding updates and assurance from the executive/management team that the organisation is taking action if required.

**Questioning:** The Wellbeing Guardian should, through their line of questioning, help the board / senior leadership team to be mindful of the organisational responsibility to the health and wellbeing of our NHS people. The Wellbeing Guardian should challenge the board / senior leadership team to account for its decisions and their impact on the health and wellbeing of our NHS people. Any identified unintended negative consequences of organisational actions need to be reviewed with a view to mitigating them. As this becomes routine board practice, the Wellbeing Guardian's need to challenge should reduce over time.

**Diversity of people:** The Wellbeing Guardian will recognise and respond to the need for a tailored, holistic health and wellbeing approach for different groups within the workforce. Diverse cultural backgrounds may need to be engaged in different ways and may require different responses, and the potential impact of intersectionality needs to be recognised. For

Developmental

example, different cultures and faith groups do not approach bereavement and grief in the same way and therefore more than one support offer may be needed.

**Connectivity:** Operating in an inclusive manner, the Wellbeing Guardian will actively encourage leadership of the wellbeing agenda across all executive/management functions in a way that engages ownership and advocacy across the organisation, valuing and building on existing internal resource.

## Values

The Wellbeing Guardian will act as a critical friend to board / senior leadership team colleagues, based on the available evidence showing that organisations which promote workforce wellbeing deliver safer, higher quality patient care.

Leadership that focuses on how people are treated as well as what they achieve is critical to a wellbeing culture. The Wellbeing Guardian will therefore role model the values of fairness, compassion and inclusivity.

Wellbeing inequalities are particularly damaging, and an organisation's most vulnerable people are therefore at greatest risk. The Wellbeing Guardian should therefore be mindful of their perceived seniority and will actively promote opportunities for the most vulnerable in the workforce to contribute.

Consideration of personal characteristics is critical when deciding who to appoint to the Wellbeing Guardian role. A successful Guardian will be open, honest and willing to challenge the status quo in promoting a wellbeing culture within the organisation.

Developmental



## Recommended main duties and responsibilities

To meet the aims and principles of this role, the Wellbeing Guardian may:

- Request **evidence** on behalf of the board to provide assurance of the organisation's strategic approach to a culture which is supportive of NHS staff and learners, fostering the ambition of creating a happy, healthy and psychologically safe workplace.
- Routinely **challenge** senior leaders, to ensure that holistic health and wellbeing is considered in all aspects and levels of the organisational structure.

- Support the development of the organisation's **holistic health and wellbeing strategy** to meet the requirements outlined in the NHS People Plan.
- Encourage high level engagement with the wellbeing strategy, questioning whether the **appropriate level of resource, capacity, infrastructure and capability** are in place to deliver sustainable change and improvement.
- Provide opportunities for existing **good practice** to be shared and recognised more widely to aid learning.
- **Challenge the board / senior team to monitor** and receive reports on the implementation and delivery of the wellbeing strategy, benchmarking progress on the principles supported by the Wellbeing Guardian and the high impact actions of the NHS People Plan. This will include identification of immediate risks to staff and learner holistic health and wellbeing and the mitigating actions.
- Receive **evidence and assurance** that an appropriate programme structure is in place to yield **successful delivery** of the wellbeing strategy, including scope, objectives, project plans, risks, interdependencies, resources and measures of success.
- Confront and **challenge organisational behaviours** that are detrimental to staff and learner health and wellbeing at the individual, team and system level.
- Influence senior managers in the organisation through complex and **cultural change**, promoting involvement and engagement for wellbeing improvements.
- Provide **innovative and progressive thinking**, guidance and challenge to senior stakeholders about what it means to be a supportive organisation.
- Where appropriate, participate in regional and national Wellbeing Guardian networks to **maximise the opportunity for system-wide partnerships** and cross-organisational learning.

Developmental



## Recommended principle-specific responsibilities

- Influence senior leaders in the organisation to ensure that the same **weight is given to holistic health and wellbeing** as to other aspects in organisational performance assessment.

- Receives assurance that **health and wellbeing strategies protect holistic health and wellbeing** and meet the specific needs of the organisation's staff and learners.
- Request strategic oversight on the **organisation's environment and infrastructure** (eg civility and respect, inequalities, etc) to ensure that it is safe and supportive of the holistic health and wellbeing needs of staff and learners.
- **Support the lead for the organisational People Plan** (sometimes called the Workforce Strategy or part of the organisational Strategic Development Plan).
- Request assurance for the board that the necessary process and infrastructure is in place for a self-referral, **proactive and confidential occupational health service** that protects wellbeing and meets the specific needs of the organisation's staff and learners.
- Request assurance for the board on the development of the policy and infrastructure required to provide meaningful and timely **wellbeing impact assessments** for staff and learners following their exposure to difficult or distressing incidents (including but not limited to clinical incidents).
- Request progress updates on the implementation of the organisation's **wellness induction** (previously wellbeing 'check-in') policy, process and reporting systems.
- Request reports evidencing the organisation's compliance with meeting the wellbeing needs and necessary adjustments for the **nine groups protected under the Equality Act 2010** (including consideration for how intersectionality may impact on wellbeing).
- Challenge the board to ensure that policies and processes are implemented to provide assurance that the **spiritual and cultural needs** of the organisation's staff and learners are protected, and that the support available to staff is equitable and appropriate.
- If ever appropriate, commission the **independent examination** of a death by suicide of a member staff or learner on placement with the organisation. Invite presentation of the findings of 'death by suicide reviews' to the board, and leading frank and open discussions of deliverable improvement plans, where recommended.

Developmental

Appendix 2

Health Education England

# Quality Update Report – Harrogate and District NHS Foundation Trust

## Background

The Quality Team hold regular Monitoring of the Learning Environment (MLE) meetings with the Education Team at Harrogate and District NHS Foundation Trust (HDFT) and have an excellent working relationship. MLE meetings are Multiprofessional and always productive with opportunities for the Trust to demonstrate progress against requirements, discuss trainee feedback and highlight any concerns or good practice. The last MLE was held on 26 November 2020, and 2 requirements were closed and 1 was de-escalated. There are currently 3 open requirements relating to surgical handover specifically in Urology and General Surgery, Out of Hours ward cover for Acute Medicine and access to clinics for elderly medicine trainees. The CQC overall rating is Good.

The Trust have reported on their SAR that their current challenges are the geographical spread of Community Services across the North East and North Yorkshire and the size of the geographic footprint which create specific challenges in relation to multiple education providers working to a variety of assessment tools. Vacancy rates within Doctor in Training rotas and career grades for medical and dental staff as a result of national labour market shortages, together with availability rates of short-term locum staff and vacancy rates within Registered Nurses establishment as a result of national labour market shortages.

The COVID-19 pandemic has brought many challenges to the Trust, which have been handled admirably. The Trust delivered upskilling training to approximately 700 staff in 3 weeks and quickly implemented an escalation rota that increased the support available to medical trainees and was well received by the junior doctors. Re-deployment was kept to a minimum and the health and wellbeing of all staff across the Trust has been a high priority, for example charitable foundation funding was used to refurbish the on-call room has been refurbished to support junior doctor wellbeing impact

The Trust has recently embarked on a programme of promoting and developing new values and workplace behaviours and a series of cultural diagnostic workshops were held during 2020 and the Trust is now in the process of rolling out a Trust-wide programme of activities designed to promote the Trust values and empower employees to challenge poor behaviour.

## Recent discussions/feedback

Overall feedback from learners at the Trust is good and at the last MLE 2 requirements were closed. The GMC NTS Covid 2020 survey was very positive with 59 above outliers and just 9 below outliers. The positive outliers were largely for the domains of Communication & Teamwork, Health & Wellbeing, Clinical supervision and Speaking up & Voice. The NETS data was also positive with 100% positive responses

for a number of professions and specialties, though there were some below outliers in Foundation Surgery, but it is important to remember this survey ran during the peak of the pandemic.

The PARE data for the period 1 October 2019 – 28 April 2021 showed 100% positive response rates for Good examples of patient care and Handover. 100% of 130 learners over the period said that they had never or rarely experienced bullying or undermining behaviour.

The last GoSWH report received covered the period 1 July – 31 December 2020 (Q2 & 3 of 2020/2021) reported an increase to the usual number of Exception reports with an increasing trend (appendix 3) there were 3 exception reports relating to missed educational activity during Q3. The report for Q4 is still to be submitted to the board but the Guardian has advised that between 1 January and 30 April 2021 there were 83 exception reports from 19 junior doctors, 4 of which account for 38% of the reports submitted. No fines were issued, and all the reports relate to working late or missed breaks. 70% of the reports are in General Medicine.

The Trust has made good progress recently with historical concerns in handover. The current open requirement was downgraded at the last MLE and the Paediatric and Medicine elements were closed. The DME requested that the surgery element remains open as he had recently had some negative feedback from trainees in Urology and General Surgery, progress will be reviewed at the MLE meetings.

## Recent concerns raised

Bullying and undermining concerns in Clinical Radiology were raised in August 2020 and these have been managed at a senior level. The November 2020 NETS data shows that there are no reports of ongoing issues from Junior Doctors in training.

## Open Requirements

| Database Reference | Comments | Action |
|---|---|---|
| 15/0057 | Concern identified QM Visit on 03 February 2015<br>The panel noted that handover systems in Obstetrics & Gynaecology were felt to be particularly positive with a Consultant led handover occurring every morning of the week.<br><br>However, there are concerns about the consistency and robustness of handover in Medicine. The Trainees | MLE Update on 26 November 2020:<br>Medicine and Paediatrics update<br>• The Paediatric HOS has previously confirmed that there are no longer concerns with the handover in Paediatrics. Similarly, SH advised that there have been a lot of quality improvement projects in Acute Medicine and as a result there are no longer concerns for medicine handover and it was agreed that these elements should be closed. |

| | | |
|---|---|---|
| | reported that the Monday-Thursday handover involved what only was felt to be important. The quality of information depended on who had been on duty prior to them. Handover on Fridays at 5.00pm is done via a PC using a word document. Doctors from different specialties all contribute, and trainees report having a wait of up to an hour before they are able to input. The panel feel this system in unwieldy and open to error.<br><br>Paediatric trainees demonstrated confusion regarding who should be present at handover, reporting that nurses are not present at either morning or evening handover.<br><br>Surgical trainees report that a general surgical consultant is not always present at handover. The T&O trauma handover was however Consultant led. The panel felt that this is necessary to have senior involvement at handover, both from a patient safety and teaching perspective. | Surgery update<br>• SH advised that he has asked for feedback from all specialties and has only had negative feedback from Urology and General Surgery.<br>• SH requested that the surgery element of the requirement remains open until he is sure that the changes to surgery handover have been made.<br>• It was agreed that the next available survey results would be reviewed with a view to closing the requirement if no concerns are raised. |
| 17/0009 | Concern identified at QM Visit on 04 October 2016 - CMT Trainees report that there are insufficient staff on duty at weekends to provide a safe level of patient care.<br><br>There is insufficient ward cover on nights and weekends. With one core trainee based in the Acute Unit with a registrar. There is another core trainee covering 6 wards with no foundation support.<br>There are concerns with jobs not being completed. Trainees are requesting tests on a Friday however when they return on a Monday they find that they have not been completed. | MLE Update on 26 November 2020:<br>• An additional Foundation year trainee was allocated to provide cover at the weekends back in August 2018 and the GMC NTS survey results from 2019 do not have any negative outliers. An escalation rota was implemented at the start of the pandemic which increased the level of support available, so it has not been possible to ascertain if the improvements have been sustained.<br>• There are also concerns that when the trainees return to their normal rotas the concerns will re-emerge. MR asked if SAS grades could be used to enhance levels of support. Except for Gastroenterology there are not currently any SAS grades in Medicine. SH advised that the GP school have approached the Trust to see if they could accommodate 4-6 extra posts in August 2021 which if allocated to medicine could help alleviate workload, but this will not be until August 2021 if the Trust agree to fund |

| | | |
|---|---|---|
| | | • SR to request feedback from the Medicine HOS to see if this is a concern across the region in other Trusts. |
| 17/0011 | QM Visit on 23 November 2016 – Elderly Medicine<br>Whilst the post offers the potential for a broad experience in elderly medicine, trainees are unable to take advantage of them. Although the broad availability of clinics is good the booking process is felt to be a barrier. One trainee reported that in the 6 weeks they had been at the Trust they had only attended one clinic. The system involves trainees having to look on the rota for clinics then book in with the secretary and then book in with the rota co-ordinator, there are no fixed session/week. It is recommended that there is an expectation that trainees will do one clinic/week. | MLE Update on 26 November 2020:<br>• SH surveyed all the Elderly Medicine trainees in late 2018 and they all reported being able to get to sufficient clinics. It was agreed at the last MLE to await the GMC NTS results, but the survey did not take place due to COVID and during the pandemic it is apparent that the trainees are not able to get to clinics, so it is not possible to determine whether this issue remains.<br>• It was agreed to review the requirement at the next MLE in May. |

## Summary of Forthcoming meetings

- The next West Yorkshire and Harrogate QSG meeting will take place on 27 May 2021
- The next MLE meeting is yet to be organised but is planned for September 2021





Board of Directors Meeting - 26 May 2021 - held in Public-26/05/21

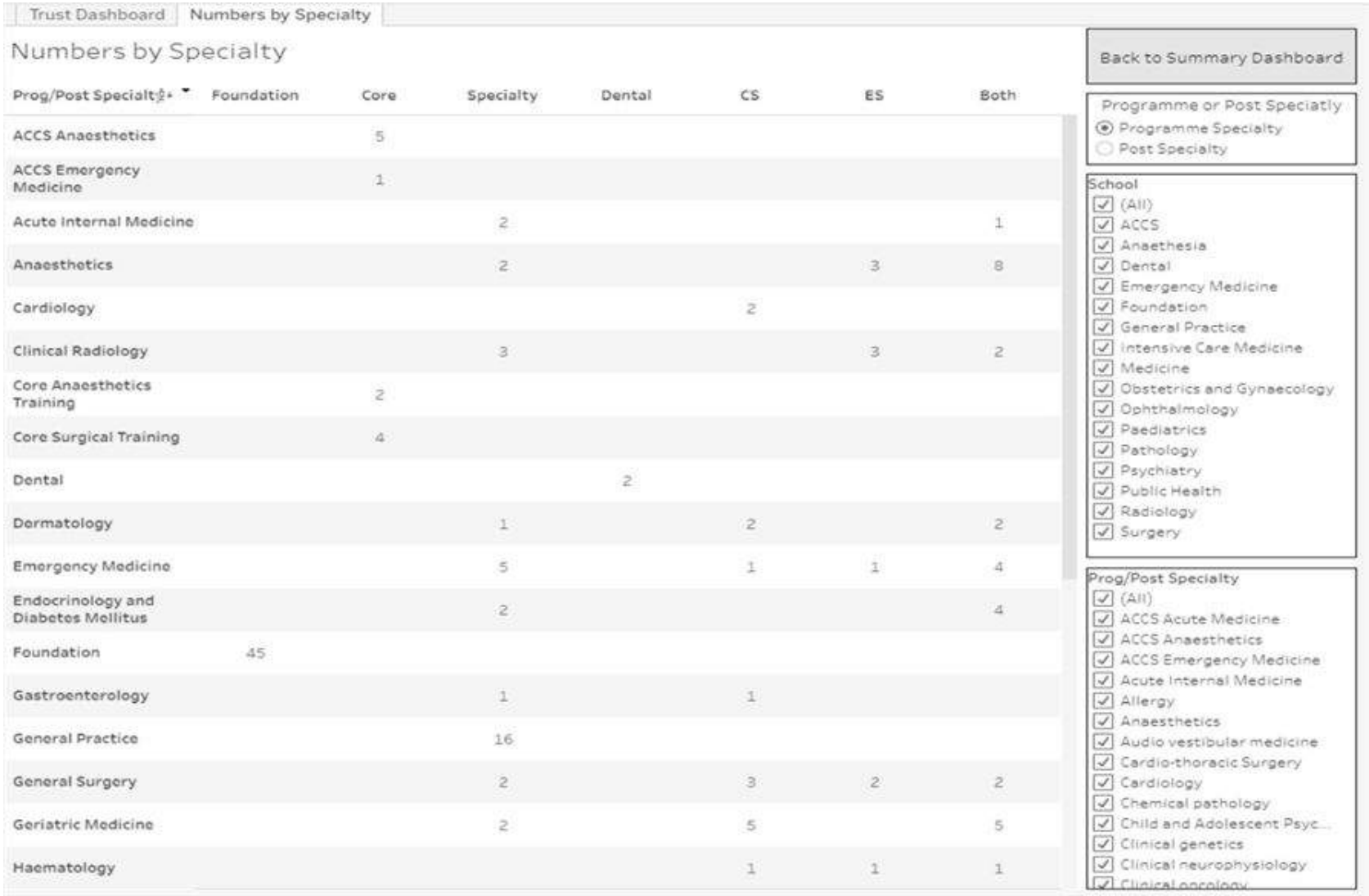
Appendix 2

Health Education England

## North Trust Summary Dashboard


5

Health Education England



Trust Dashboard | Numbers by Specialty

## Numbers by Specialty

Back to Summary Dashboard

| Prog/Post Specialty | Foundation | Core | Specialty | Dental | CS | ES | Both |
|---|---|---|---|---|---|---|---|
| ACCS Anaesthetics | | 5 | | | | | |
| ACCS Emergency Medicine | | 1 | | | | | |
| Acute Internal Medicine | | | 2 | | | | 1 |
| Anaesthetics | | | 2 | | | 3 | 8 |
| Cardiology | | | | | 2 | | |
| Clinical Radiology | | | 3 | | | 3 | 2 |
| Core Anaesthetics Training | | 2 | | | | | |
| Core Surgical Training | | 4 | | | | | |
| Dental | | | | 2 | | | |
| Dermatology | | | 1 | | 2 | | 2 |
| Emergency Medicine | | | 5 | | 1 | 1 | 4 |
| Endocrinology and Diabetes Mellitus | | | 2 | | | | 4 |
| Foundation | 45 | | | | | | |
| Gastroenterology | | | 1 | | 1 | | |
| General Practice | | | 16 | | | | |
| General Surgery | | | 2 | | 3 | 2 | 2 |
| Geriatric Medicine | | | 2 | | 5 | | 5 |
| Haematology | | | | | 1 | 1 | 1 |

Programme or Post Specialty
- (•) Programme Specialty
- ( ) Post Specialty

School
- [x] (All)
- [x] ACCS
- [x] Anaesthesia
- [x] Dental
- [x] Emergency Medicine
- [x] Foundation
- [x] General Practice
- [x] Intensive Care Medicine
- [x] Medicine
- [x] Obstetrics and Gynaecology
- [x] Ophthalmology
- [x] Paediatrics
- [x] Pathology
- [x] Psychiatry
- [x] Public Health
- [x] Radiology
- [x] Surgery

Prog/Post Specialty
- [x] (All)
- [x] ACCS Acute Medicine
- [x] ACCS Anaesthetics
- [x] ACCS Emergency Medicine
- [x] Acute Internal Medicine
- [x] Allergy
- [x] Anaesthetics
- [x] Audio vestibular medicine
- [x] Cardio-thoracic Surgery
- [x] Cardiology
- [x] Chemical pathology
- [x] Child and Adolescent Psyc...
- [x] Clinical genetics
- [x] Clinical neurophysiology
- [x] Clinical oncology

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Appendix 2

NHS
Health Education England

# Appendices

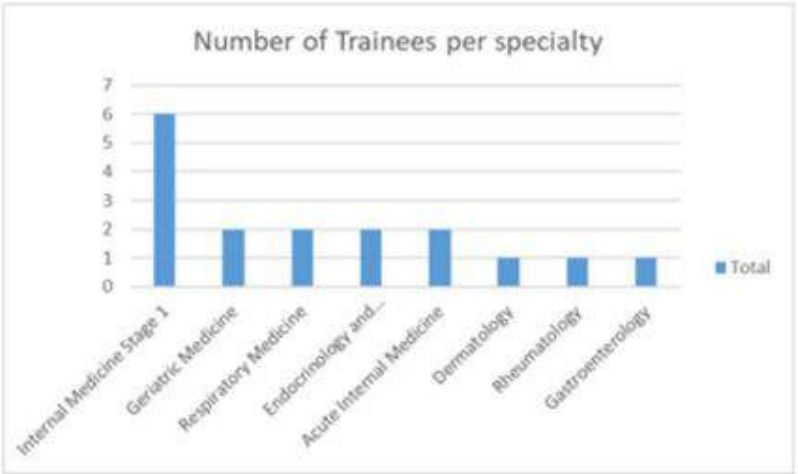
## Appendix 1 - Programme Management Data (Medicine only)

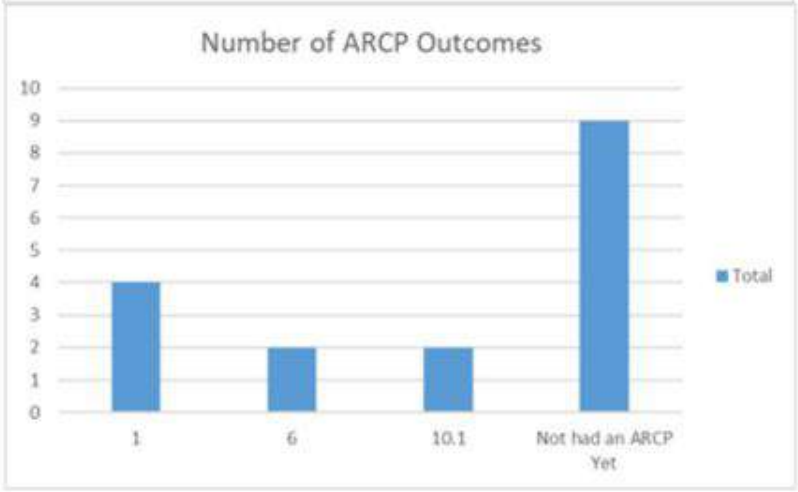
**Quality Data Report:**
Report Period: Snapshot as of 07/04/2021

| | |
|---|---|
| Number of trainees: | 17 |
| Number of MRCP Part 1 Passes: | 4 (out of 5) |
| Number of MRCP Part 2 Passes: | 2 |
| Number of PACES Passes: | 2 |
| Number of Specialty Exam Passes: | 2 (both in Geriatric Medicine) |
| Fill rate: | 89% |

| Report Highlights |
|---|
| The Number of Trainees per specialty chart shows us that there are a broad range of specialty training posts at Harrogate, the majority of posts are Internal Medicine |
| As the majority of trainees are IM1 they have yet to have an ARCP, from the chart we can see there were only two 10.1s awarded, both in Geriatric Medicine (one for incomplete evidence due to COVID and one due to redeployment) this indicates that despite COVID the trainees were able to get their competencies achieved. Two trainees completed training during this time. |
| The pass rate is high for the exams |
| 89% is a good fill rate for all the available posts |

*Please note the data from the ePortfolio is not from a HEE source therefore we cannot guarantee its accuracy*



Health Education England

## Appendix 2 - NETS Free Text Comments

| Organisation Name | Specialty | Subspecialty | Response | Total |
|---|---|---|---|---|
| Harrogate And District NHS Foundation Trust | Core Surgical Training | CST - Urology | Difficulty with rota coordinator | 1 |
| Grand Total | | | | 1 |

## Appendix 3 - ER Data (from GoSWH reports)

The guardian reports a large increase on exception reports from Q1 (7) and a steady increase in exception reports over the period of the report, rota gaps are generally around 5%, at the time of the report there were 6 gaps which equates to 4.9%. The top reporting speciality group was medicine with 83 exception reports over the period of the report.

| | |
|---|---|
| **Date of report** | **27 January 2021** |
| **Reference period of report** | **July 2020 – December 2020 (quarters 2 &3)** |
| **Total number of exception reports received** | **101** |
| **Number relating to immediate patient safety issues** | **0** |
| **Number relating to hours of working** | **98** |
| **Number relating to pattern of work** | **0** |
| **Number relating to educational opportunities** | **3 (all in Q3)** |
| **Number relating to service support available to the doctor** | **0** |
| **Fines issued** | **£0** |





Board of Directors Meeting - 26 May 2021 - held in Public-26/05/21



Tab 9.1 9.1 Director of Workforce and Organisational Development Report

Health Education England

## Appendix 4 – Self-Assessment Report 2020 (see also full SAR in portal)

### Successes:

- Global Health Exchange – leading Trust on the establishment of the Earn, Learn and Return programme for International Recruitment. We have relocated 32nurses to date to work in our Trust for a 3-year period, securing a talent pipeline and providing development and growth opportunities which are translated back into the originating country on their return. Through providing practice placement infrastructure, supported by HEE, we have delivered a 100% success rate with gaining NMC registration for nurses on this programme to-date.

- Since 2018 we have introduced 3 cohorts of trainee nursing associates across our clinical teams in wards, departments and community services. Our first cohort of 9 students qualified in January and we have similar size cohorts completing in January 21 and 22. The introduction of this new role is a welcomed career development opportunity for the support workforce which will improve patient care and recruitment and retention of a skilled new workforce.

- HDFT has a Quality Charter to recognise and reward excellent quality of care. The scheme provides QI training across the Trust and supports all staff and trainees to deliver improvement projects within their area of practice. The scheme also recognises and rewards teams who identify, work towards, achieve and then sustain a vision for providing high quality services in their area. All Foundation Year 1 doctors undertake Bronze Quality Improvement Training.

### Challenges:

- Geographical spread of Community Services across the North East and North Yorkshire. The size of the geographic footprint creates specific challenges in relation to multiple education providers working to a variety of assessment tools.

- Vacancy rates within Doctor in Training rotas and career grades for medical and dental staff as a result of national labour market shortages, together with availability rates of short-term locum staff. Vacancy rates within Registered Nurses establishment as a result of national labour market shortages.

- Proposed withdrawal of the Health Education England(NE) funding for post-registration professional qualifications for Specialist community and Public Health Nurses (SCPHN) and District Nurses on the introduction of the new apprenticeship standards for post-registration professional qualifications; also extension of the training by an extra 6 months for SCPHN and 12 months for DN. Currently the Trust receives full HEE funding for the university training and salary costs are funded at mid-point of Band 5 for SCPHN and DN

students. The course is 12 months induration commencing annually in September, this year the Trust is training 2 District Nurse Students, 31 SCPHN Health Visitors Students and 10 SCPHN School Nurse Students.

## Appendix 5 - PARE Report

Provide relevant PARE reports

Refer to portal.

## Appendix 6 - Good practice (taken from 2020 SAR)

| Best Practice | Impact |
|---|---|
| Student forums and quality improvement workshops for nursing and medical undergraduates | Feedback on experiences and identification of concerns allows some 'real-time' improvement or resolution of problems to occur during the placements. It also provides the opportunity to explore the issues thoroughly while the students are still on-site. |
| Schwartz rounds and Personal Resilience Training. The Trust has developed a training programme in 'Building Personal Resilience' This is an evidence-based psychological skills training programme open to all staff and medical students. It is facilitated by a number of trainers who have undertaken training by City, University of London, and demonstrates a range of techniques designed to enhance psychological health, personal resilience, and general life effectiveness. The Trust operates Schwartz rounds which give participants the opportunity to explore current workplace issues in a supportive and confidential environment. | The aim is to enable staff and students to learn and practise techniques that have a strong evidence base in behavioural science and have the potential to transform an individual's experience in the workplace and other areas of their lives and runs over a 4-week period. This provides support for both learners and educators to develop the personal skills necessary for learning and delivering services in the complex healthcare environment. |
| Continued success and positive evaluation of our clinical skills training across the Trust. This incorporates ward-based clinical skills teachers, simulation lead and human factors training; | This supports the embedding of learning and education across the multi-professional workforce, providing opportunities for learning within a multi-professional team. |





Board of Directors Meeting - 26 May 2021 - held in Public-26/05/21

NHS
Harrogate and District
NHS Foundation Trust

# *Caring at Our Best:*
# *Improving for the Future- Board Update*

Dr Jacqueline Andrews
Emma Nunez

Board of Directors Meeting, 26 May 2021

## *Why Caring at Our Best?*

Following review of events and complaints at HDFT, we have identified some cases where care we provided for our patients was not "at our best". Put simply, the standards have fallen short of the levels of patient experience and team work we would naturally expect at HDFT.

On analysis, themes that have emerged include:

- **A failure to work collaboratively and achieve collective accountability for the patient** – e.g. too many professions and professionals assuming that an action was not their job and that someone else must be taking care of it, leading to essential care being missed;
- **A lack of clear accountability in ward and team leadership roles**, leading to a failure to hold colleagues to account and identify when steps in care were being missed;
- Evidence that we can **fail to listen to and respond to patient and family feedback** in a timely and empathetic way; and
- **The historic quality and safety governance model has not readily supported the rapid and early identification of quality risks** and provided line of sight from ward to Board.

To respond effectively to these issues, a strategic, programmatic approach is now required.

HDFT will deliver the ***Caring at Our Best*** programme to restore confidence that outstanding patient care and experience is once again our default position. ***Caring at Our Best*** will be implemented across all HDFT wards, however it is much more than another corporate initiative. ***Caring at Our Best*** will be led and developed by HDFT colleagues and is our core approach for **Caring, Learning** and **Leading at Our Best**.

## *Caring at Our Best: 3 Programme Objectives*

*Caring at Our Best*

Deliver high quality care with collective responsibility for our patients…so that…

we work as one team and deliver outstanding patient experience.

*Learning at Our Best*

Create and embed a Continuous Learning & Improvement System…so that…

we learn from our mistakes and listen to our patients and staff.

*Leading at Our Best*

Define and embed new leadership standards, training and performance management…so that…

we identify quickly when standards slip and we hold ourselves to account.

# *Caring at Our Best: 12 Workstream Objectives*

## *Senior Responsible Owner (SRO): Dr Jacqueline Andrews*

### W1: Caring at Our Best; *Integrating Care With Collective Responsibility*

**Delivery Lead – Simon Riley-Fuller**

1. Produce and implement an action plan to rapidly improve how we manage tissue viability, pressure bandages and pressure ulcers
2. Define and roll-out the HDFT Model Ward, including: Nursing Fundamentals, The Model Ward Round, Working as an MDT, Collective Patient Accountability, Continuous Learning & Improvement, Responding to Patient & Staff Feedback & Digital Enablers
3. Design and roll-out *Caring at Our Best* Ward Accreditation Scheme and revised Matron Assurance and Nursing Checklists

### W2: Learning at Our Best; *Creating a Continuous Learning System*

**Delivery Lead – Dr Dave Earl**

4. Communicate the need for *Caring at Our Best* in order to achieve collective learning and "mark-time" moment
5. Develop and implement the HDFT Quality Governance Framework
6. Develop and embed the HDFT Continuous Learning & Improvement system and tools
7. Be assured patient and staff feedback is heard in a timely fashion and informs ward practice, continuous improvement and accreditation

### W3: Leading at Our Best; *Embedding Leadership, Standards & Performance*

**Delivery Lead – Dr Matt Shepherd**

8. Clarify roles, responsibilities and standards for all wards, services and directorate leadership roles
9. Define and roll-out key skills training, e.g. Managing Under Performance and Maintaining Professional Standards, Giving Quality Feedback (using BUILD), Responding to Feedback (staff, patient, visitor)
10. Design & Re-embed the Quality Dashboard
11. Design and implement Monthly Ward Assurance Meetings
12. Design and implement revised Performance & Quality Review Meetings

# *Caring at Our Best: 12 Workstream Objectives*

## *Senior Responsible Owner (SRO): Dr Jacqueline Andrews*

**W1: Caring at Our Best; *Integrating Care With Collective Responsibility*** **Delivery Lead – Simon Riley-Fuller**

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2. Define and roll-out the HDFT Model Ward, including: Nursing Fundamentals, The Model Ward Round, Working as an MDT, Collective Patient Accountability, Continuous Learning & Improvement, Responding to Patient & Staff Feedback & Digital Enablers
3. Design and roll-out *Caring at Our Best* Ward Accreditation Scheme and revised Matron Assurance and Nursing Checklists

- Realignment of Tissue Viability Nursing service to Corporate Nursing.
- External review of Tissue Viability Service undertaken and recommendations for service model being considered.
- New bi-monthly Root Cause Analysis panel sign off meeting for all Pressure Ulcers and Falls commences 3rd June chaired by Deputy Director of Nursing.
- New quality dashboard monthly ward assurance meetings established to commence June led by Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and/or Deputy Director of Nursing.
- Matron for Clinical Quality appointed – start date 28th June with key priority being development of Ward/Team Accreditation programme which includes real time patient and staff feedback (digitally enabled)
- Professional Practice Forum for Nursing, Midwifery & AHP's established chaired by Exec Director of Nursing, Midwifery and AHPs; inaugural meeting held 14th May 2021.
- Head of Nursing walking clinical areas to share specific learning from incidents in person and leg ulcer management displays in all inpatient ward areas for colleagues to see.
- Review of nursing establishments currently underway and plans to run SNCT audit through June.
- New Quality governance forums due to start in June linking work together – Making Experience Count will focus on Patient Feedback and links to continuous learning and improvement. Suggested Quality Priorities 21/22:
  - Ensure we are actively listening to patients at every contact
  - Develop a real time patient feedback system (including complaints management)

# *Caring at Our Best: 12 Workstream Objectives*

## *Senior Responsible Owner (SRO): Dr Jacqueline Andrews*

**W2: Learning at Our Best; *Creating a Continuous Learning System*** **Delivery Lead – Dr Dave Earl**

4. Communicate the need for *Caring at Our Best* in order to achieve collective learning and "mark-time" moment
5. Develop and implement the HDFT Quality Governance Framework
6. Develop and embed the HDFT Continuous Learning & Improvement system and tools
7. Be assured patient and staff feedback is heard in a timely fashion and informs ward practice, continuous improvement and accreditation

- MD communication, HDFT Grand Round and leg ulcer presentation and educational video shared with clinical body
- New HDFT Quality Governance Framework "live"- based on CQC domains and continuous learning, innovation and improvement
- New Trust-wide Head of Learning and HDFT Learning Exchange concept agreed - VLP business case approved and in procurement
- **Suggested Quality Priorities 21/22:**
  - **Ensure we are actively listening to patients at every contact**
  - **Develop a real time patient feedback system (including complaints management)**

# *Caring at Our Best: 12 Workstream Objectives*

## *Senior Responsible Owner (SRO): Dr Jacqueline Andrews*

**W3: Leading at Our Best; *Embedding Leadership, Standards & Performance*** **Delivery Lead – Dr Matt Shepherd**

8. Clarify roles, responsibilities and standards for all wards, services and directorate leadership roles
9. Define and roll-out key skills training, e.g. Managing Under Performance and Maintaining Professional Standards, Giving Quality Feedback (using BUILD), Responding to Feedback (staff, patient, visitor)
10. Design & Re-embed the Quality Dashboard
11. Design and implement Monthly Ward Assurance Meetings
12. Design and implement revised Performance & Quality Review Meetings

- Review of directorate management and nursing structures underway – led through Operation Management Group – embedding triumvirate models, role descriptions, emphasizing and developing role of ward/department manager and giving 'more time' to deliver and take on responsibility and accountability for quality practice in their area.
- Proposal developed for ward reconfiguration including triumvirate leadership allocations
- Leading with values workshops to train first line leaders have taken place
- Directorate Resources Meetings being reviewed with COO to allow appropriate focus on quality.

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Becoming an Anti-Racist Organisation

| | |
|---|---|
| **Agenda Item Number:** | **9.3** |
| **Presented for:** | Decision/Approval |
| **Report of:** | Chief Executive |
| **Authors:** | Deputy Director – Improvement and Transformation<br>Deputy Director – Workforce and Organisational Development |
| **Report History:** | None |
| **Publication Under Freedom of Information Act:** | This paper is made available under the Freedom of Information Act 2000 |

**9.3**

| **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 approve this approach and plan of action. |

## 1.0 Executive Summary

1.1 HDFT is working to become an anti-racist organisation.

1.2 The report establishes why this is important, explains the journey we have taken so far, describes our ambition and vision, and outlines six areas of focus – with actions for each. The areas of focus are:

1.2.1 Governance
1.2.2 Leadership and Management
1.2.3 Recruitment
1.2.4 Learning and Development (including Induction)
1.2.5 Career Development
1.2.6 Communications

1.3 It concludes with a description of how we will implement the work and the indicators we will monitor to know if it has been successful.

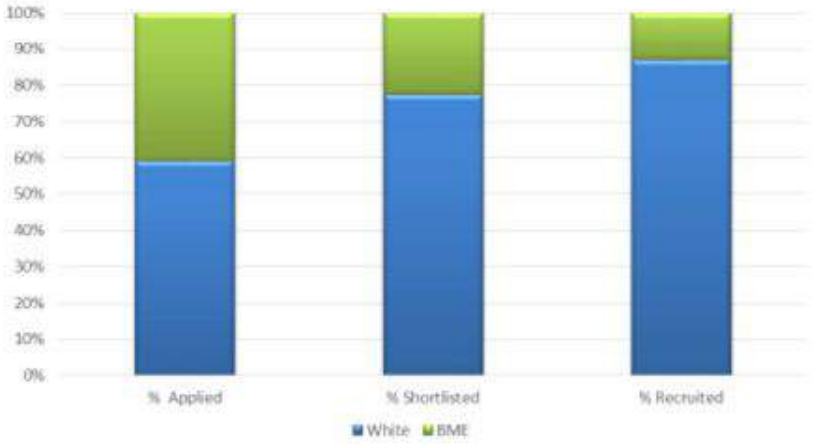
## 2.0 Introduction: Why are We Doing This?

2.1 HDFT is working to become an anti-racist organisation. This forms part of our ambitious At Our Best programme, which works to improve culture within HDFT, and will help to further embed the behaviours we value around kindness, integrity, teamwork and equality.

2.2 There are overriding moral reasons why we are seeking to become and anti-racist organisation. We also know that diverse teams, where members feel a sense of belonging, are more likely to be able to provide high quality care. There are legal reasons why this is important, too, including our general duty under the Equality Act 2010 to have due regard to the need to eliminate discrimination; to advance equality of opportunity; and to foster good relations.

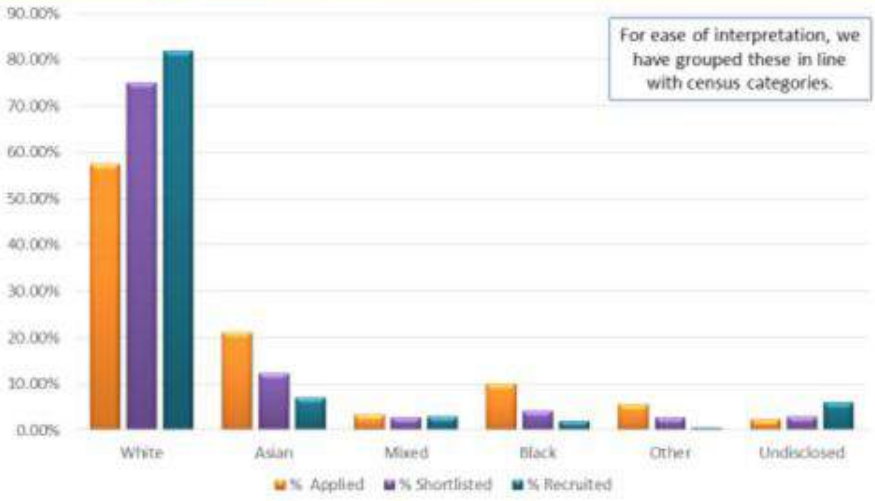
2.3 There is evidence that racism (both direct and indirect) affects people throughout their time with HDFT, starting from the time that they apply to work here. HDFT data shows us that Black, Asian and Minority Ethnic Group (BAME) applicants are less likely to be shortlisted for jobs, and, if shortlisted, then even less likely to be recruited. This is illustrated in the graphs shown over the page:

## Snapshot – Recruitment - Inequalities in shortlisting and recruitment




You matter most

## Snapshot - Recruitment- Inequalities in shortlisting and recruitment

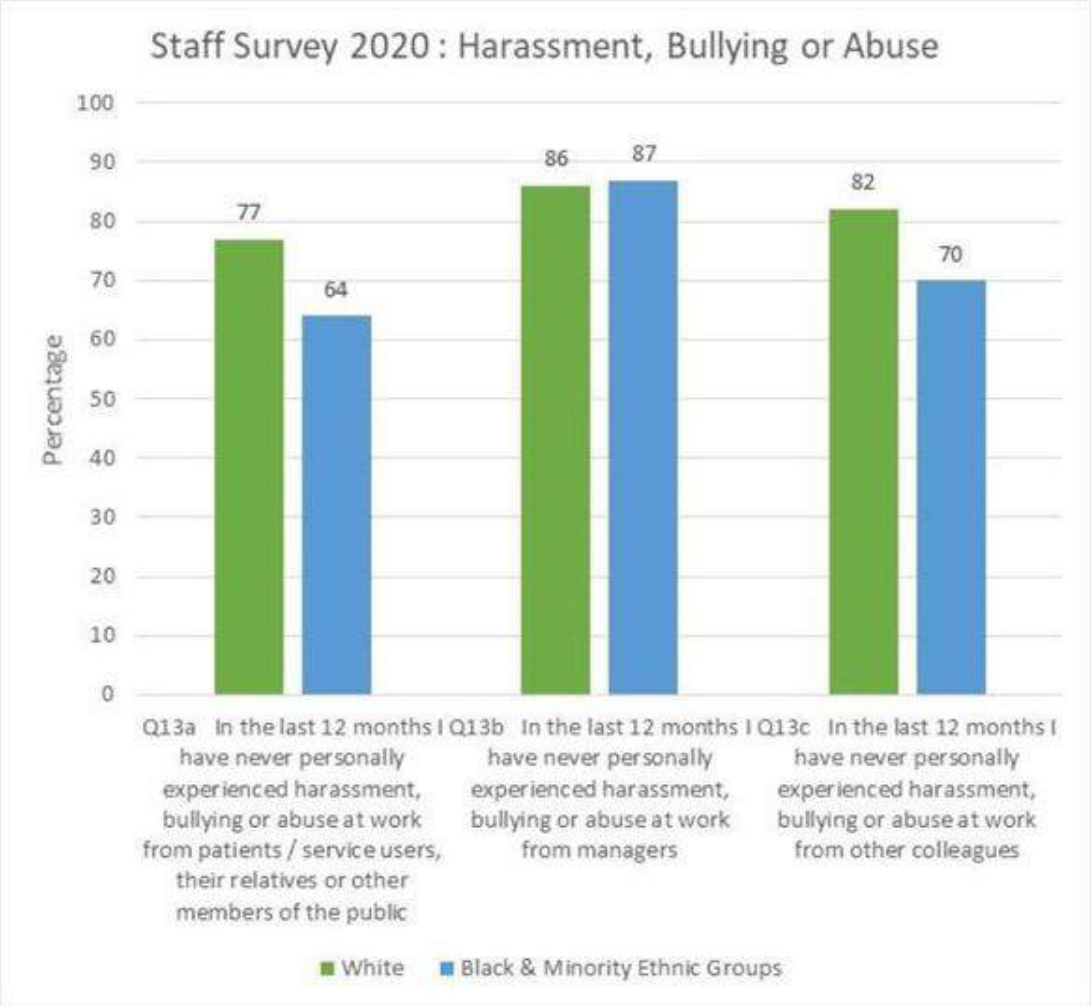



You matter most

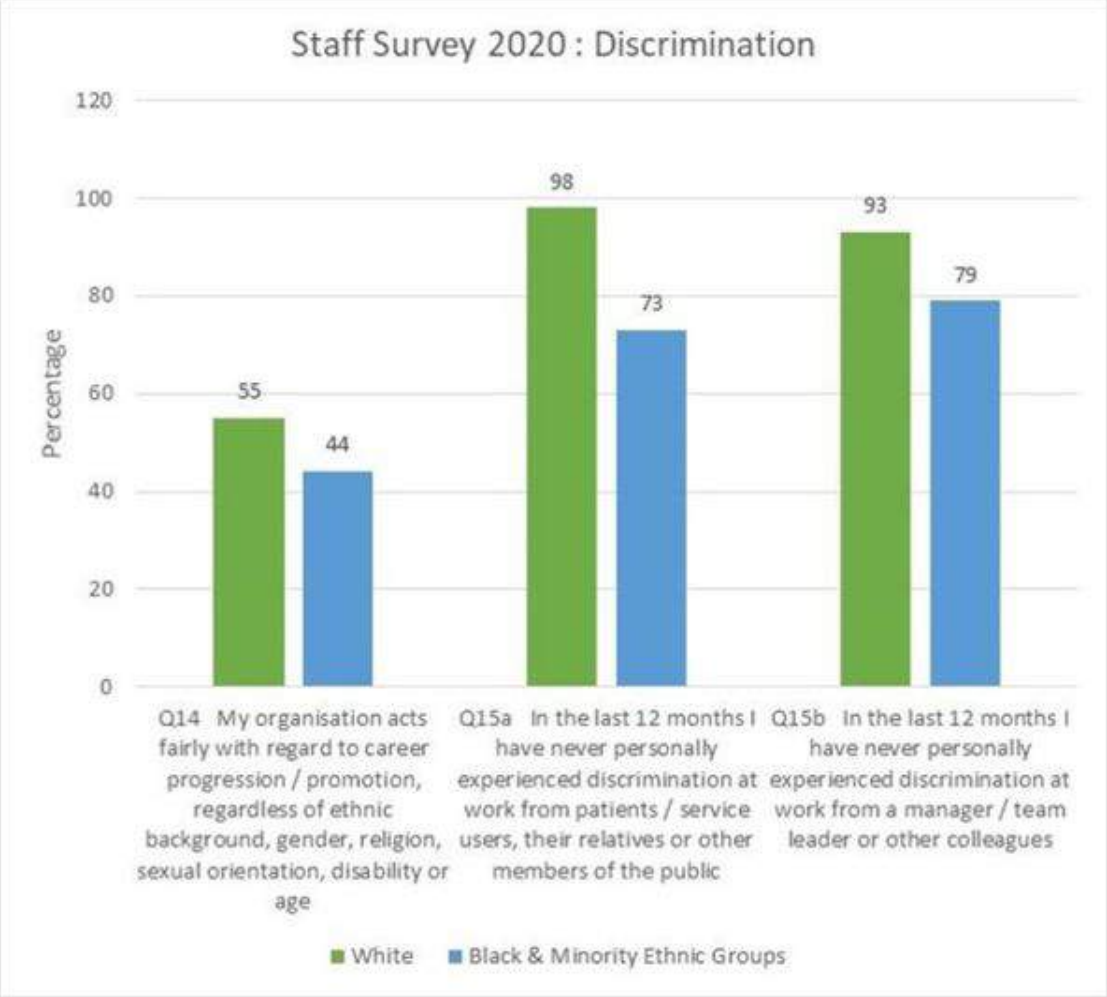
9.3

3

2.4 Racism at HDFT goes beyond just recruitment. Colleagues from BAME groups are significantly more likely to experience discrimination as well as harassment, bullying, and abuse from other colleagues as well as from patients, patients' relatives or members of the public. BAME colleagues also experience significantly higher levels of discrimination from managers, team leaders, and other colleagues. You are more likely to experience physical violence as a BAME colleague. This is illustrated in the graph shown below:




2.5 Evidence indicates that less than half of our BAME colleagues (44%) feel that the organisation behaves fairly in relation to remuneration, promotion and career progression compared to white colleagues (55%). These data are further reinforced by the personal experiences of BAME colleagues, some of whom have told us how they have come to expect to face discrimination as part of their work at HDFT. This is illustrated in the graph shown over the page. There is also evidence showing that there is an ethnicity pay gap at HDFT – see Appendix 1 for the HDFT Ethnicity Pay Gap Report – 31.03.21.






2.6 The case for change is not yet widely enough understood at HDFT, with some white colleagues insisting that the unequal experiences had by BAME colleagues "wouldn't happen here". The evidence shows that they do happen here. And they are happening now. The message from the Board of Directors is: "We have to be honest with ourselves: Black, Asian and Minority Ethnic people aren't treated equally, and without ally-ship, and thinking about equality and diversity in everything we do, there will be another moment when we become outraged at an injustice because we haven't made enough change."

## 3.0 The Journey so far

3.1 In recent years we have fulfilled statutory reporting requirements with regard to our Workforce Race Equality Scheme and Equality Delivery System 2 and delivered related action plans, but this has not achieved the step-change in the reduction of racism which we require. The Workforce Race Equality Scheme Report and Action Plan (shown in Appendix 2) has informed the development of the re-prioritised actions proposed later in this report.

3.2 In late 2019 The EDI Lead role was re-established following a number of years of disestablishment.

3.3 We have an active BAME Staff network which, including allies, now has 59 members. It provides HDFT with a fantastic opportunity to drive forward race equality and to change the lived experiences of its BAME colleagues. The network has had good involvement in meetings and campaigns (e.g. Black History Month, cultural calendar to raise awareness of diversity), and has made links and shared learning with the LGBT+ and Disability networks at HDFT.

3.4 In 2020 equality, diversity and inclusion was identified as a workstream within the Trust's At Our best culture improvement programme. This led to a clear articulation of our ambitions and some key priorities for this agenda, including an aim to become an anti-racist organisation, "a place where we are more than just not racist – we are actively anti-racist… We will gather clear evidence of our progress as an anti-racist organisation and this will set the standards for all other equality, diversity and inclusion agendas."

3.5 This year, work has progressed on making our recruitment processes fairer from the moment the need for a role is identified, through how the job role and person specification is designed to how the job is advertised and how the selection process is managed. These changes are necessary but not sufficient in themselves to address the inequalities currently evident, so work is progressing now to identify bolder, targeted actions that will accelerate the improvements we need in the way we recruit.

3.6 On 31st March 2021, 20 colleagues joined our first Becoming an Anti-Racist Organisation workshop. 52 ideas for strengthening our approach were brought forward and 12 of these progressed on the day. There was particular interest in improving the representation of the voices of BAME colleagues within existing governance structures. Subsequently, colleagues from this workshop were invited to attend the HDFT Board workshop at the Pavilions, Harrogate on 28th April, during their discussion of the Board's role in helping us to become an anti-racist organisation. Powerful personal experiences were shared and contributions to roundtable discussions by BAME colleagues have informed the further development and prioritisation of our plans for this area of work, as set out later in this report – see Appendix 3 for our Equality, Diversity and Inclusion – Vision and Scope.

3.7 A useful model in terms of assessing individual and organisation maturity is shown in Appendix 4.



## 4.0 Our Ambition

4.1 Truly anti-racist organisations realise that it is not enough for each who work there to say "I am not racist". We need to fully support and engage with the anti-racism movement, and listen to colleagues' experiences in order to learn. More specifically, we will:

4.1.1 Create and secure support for the compelling case for change
4.1.2 Level the differences between BAME and White colleagues in access to employment, progression and remuneration and in their experience of inclusion across Harrogate & District NHS Foundation Trust (HDFT) and Harrogate Integrated Facilities (HIF). Evidence suggests that improving the lived experience of BAME colleagues improves the lived experience for all colleagues regardless of race
4.1.3 Reject cultural stereotypes and standards
4.1.4 Identify and change policies, processes and practices that reinforce race inequalities
4.1.5 We want all colleagues to become allies so that we can all be courageous and bold in speaking up against all racist behaviours and practices and taking action for change
4.1.6 Look to ourselves in understanding how our own behaviours and actions make an impact on anti-racism
4.1.7 Be curious in seeking to see the world through others' perspectives
4.1.8 Look after our people so that we all feel that we belong to teamHDFT and teamHIF
4.1.9 The impact of race-related micro-aggressions is understood by all and reduced to zero
4.1.10 Reduce racism from colleagues and patients/ service users to zero.

## 5.0 5 year Vision

5.1 By 2026, TeamHDFT will know we are taking steps towards achieving our ambition of being an anti-racist organisation when:

5.1.1 There is a 30% improvement in BAME colleagues progressing from short list to securing employment, meaning over 100 additional BAME colleagues work for teamHDFT.
5.1.2 A BAME colleague sits on all recruitment panels for roles at band 8a and above.
5.1.3 Through the Listening At Our Best programme, BAME colleagues feel confident that their voice is heard. They feel able to bring their whole selves to work and have a strong sense of belonging at teamHDFT.
5.1.4 There is no glass ceiling for BAME colleagues preventing their career progression at teamHDFT, for example, SAS Grade Doctor securing Consultant level and Band 5 nurses being able to progress through Bands 6 and 7.
5.1.5 BAME colleagues work in a least 10% of Band 8a and above roles.
5.1.6 Cultural diversity is evident through our communications, celebrations and daily catering provision. The physical environment accommodates different cultural needs.
5.1.7 Direct racism is a "never" event; indirect racism is something allies are working to eliminate.

**6.0 What will we do next?**

6.1 At the Becoming an Anti-Racist Organisation workshop in March, conversation repeatedly returned to the six areas that participants felt would make the biggest difference to anti-racism. These went on to be considered by the Board. Informed by work to date, our current equalities performance, learning from what other organisations have done to tackle racism, and discussions in the two workshops mentioned, below is a proposal for the top 20 actions that should be prioritised in each of these areas in Year 1.

| Action | What difference will it make? | Who? | When? |
|---|---|---|---|
| **Governance** | | | |
| 1. Include anti-racism performance/ progress on **directorate Boards and HIF Board agendas**. | Ensures that teams are regularly discussing their work on anti-racism. Helps to address the problem that some colleagues "don't quite get it." | Jonathan Coulter, Kat Johnson, Matt Shepherd, Natalie Lyth | July 2021 |
| 2. **Protected time for BAME colleagues** who wish to participate in events, networks and meetings. | Being "on shift" is currently cited by some colleagues as a barrier to their involvement. Ensures that BAME colleagues who wish to participate in and/or influence work on anti-racism are supported by their line manager to do so. | Angela Wilkinson and Executive Committee | July 2021 |
| 3. **Representation from BAME colleagues in key decision-making forums**, including where temporary incident command arrangements are in place. | Diverse groups make better decisions. Diverse organisations are more likely to deliver higher quality of care and achieve better patient/ service user outcomes. | Jackie Andrews, Claire Jones, Lynn Hughes | October 2021 |
| 4. **Create an Equality, Diversity and Inclusion Guardian and a Steering Group** to guide the work. | To further raise the profile of the work at HDFT meets the national NHS requirement to have an EDI guardian and to provide consistent direction on the EDI agenda. | Shirley Silvester | July 2021 |
| 5. Undertake a thorough assessment against EDS2 as required. | To comply with statutory requirements and to provide a neutral review across the 4 EDS domains. | Emma Nunez, Shirley Silvester | September 2021 |

| | | | |
|---|---|---|---|
| **Leadership and Management** | | | |
| 6. **Recognise and/or reward anti-racist behaviour** by theming our approach to the Chairman and Chief Executive's Team of the Month and Making a Difference awards. | By highlighting the practice that we want to encourage, more colleagues are likely to behave that way. | Steve Russell, Angela Schofield | Starts July 2021, with a quarterly theme based on KITE behaviours |
| 7. **Deliver a reciprocal mentoring programme** involving 12 BAME colleagues as mentors and 12 members of Board and SMT as mentees. | To build greater understanding in a bottom up way of the daily lived experience of BAME colleagues to enable senior leaders to take positive action.<br>To expose BAME colleagues to a wider breadth of knowledge, gained from partnership with their mentee. | Shirley Silvester | July 2021-July 2022 |
| 8**.** Deliver a programme of training on **how to be an ally.** | To educate non-BAME colleagues in the challenges BAME colleagues face, and how to support colleagues experiencing direct and indirect discrimination. | Shirley Silvester | First programme runs: 14 July – December 2021 |
| 9. Launch a programme to support line managers in developing their **generic coaching skills.** | To support high quality well-being conversations (using the RECOVER model) and to embed the behaviours we value in the KITE model. | Shirley Silvester | Starts 1st June then ongoing |
| 10. Ensure all **discretionary pay** is managed and distributed fairly e.g. clinical excellent awards, locum shifts and waiting list initiatives | To ensure that no colleague suffers financial detriment on the basis of their race. | Jackie Andrews, Sarah Sherliker | September 2021 |
| **Recruitment** | | | |
| 11. Take **bolder short-term measures** to improve the fairness of recruitment processes. | To propose bolder action to tackle long-standing inequalities more quickly. | Angela Wilkinson, Matt Shepherd | July 2021 - July 2022 |
| **Learning and Development** | | | |
| 12. To change the **corporate induction programme** to incorporate clear and strong messaging about our commitment to anti-racism and our KITE behaviours. | To clarify expectations of colleagues' behaviour from on-boarding onwards. | Shirley Silvester | September 2021 |
| 13. **Refresh mandatory EDI training** to create a compelling and engaging programme, which includes the voice of BAME colleagues. | To improve the quality of training to make it more impactful so that it improves collective understanding of the wider EDI agenda, the lived experience of BAME colleagues, including micro-aggressions. | Shirley Silvester | TBC |
| 14. Ensure equality of access to **learning and development** for BAME colleagues. | To support fairness in career development. | Shirley Silvester | TBC |
| **Career Development** | | | |
| 15. **To deliver bespoke leadership development** for BAME colleagues. | To ensure better representation of BAME people in leadership roles. | Shirley Silvester | Threshold programme launches |

| | | | |
|---|---|---|---|
| | | | 18th May 2021 |
| 16. **Confirm aspirational targets** Set aspirational targets for the number of BAME colleagues in band 8a and above positions, and SAS grade doctors being promoted to a more senior level. | To improve decision-making across strategic and operational issues by bringing in diverse views and perspectives. | Steve Russell, Angela Wilkinson, Jackie Andrews, linking to People and Culture Committe | TBC |
| 17. **Deliver development centres** for BAME colleagues. | To provide a supportive process for BAME colleagues to help them stand a fair chance of securing their next career step. | Shirley Silvester | January 2022 |
| **Communications** | | | |
| 18. To clarify expectations about **patient and service user behaviours** towards BAME colleagues. | To show that we do not tolerate racist behaviours and to support cultural shift – this is everyone's issue – we all have a role to play in making HDFT a safe, welcoming, inclusive Trust to work in. | Shirley Silvester | August 2021 |
| 19. To create and communicate a compelling **case for change,** including the use of directorate/ team/ profession level data. | To "shout from the rooftops" the reasons that we need to act on anti-racism. | Shirley Silvester, Paul Widdowfield | July 2021 |
| 20. To promote an **annual diversity calendar**, celebrating key events in different cultures, e.g. Ramadan, Eid. | To enable all colleagues to bring their whole selves to work by sharing and celebrating important events and therefore help to build cultural understanding among non-BAME colleagues. | Shirley Silvester | Ongoing |



## 7.0 Quality Implications and Clinical Input

7.1 The changes outlined in this report are designed to improve workforce experience by tackling discrimination. We know that happy and engaged teams are more likely to provide high quality care.

## 8.0 Equality Analysis – Year 1: How will we know the anti-racist organisation programme has made a difference

8.1 The proposal of action to tackle racism will contribute to improving our performance on equalities, diversity and inclusion, particularly in relation to the experience of BAME job applicants and colleagues. The following outputs, outcomes and targets are in development:

| Measure | Outputs/Targets/Outcomes in development |
|---|---|
| Improvement against WRES indicators | TBC |
| EDS2 | Review across all 4 domains |
| Colleague feedback from Listening At Our Best | 30% improvement against base line for equalities questions |
| Recruitment indicators | Short-term bold measures TBC |
| BAME colleagues accessing education, learning and development (beyond MEST) | % of BAME colleagues accessing |
| BAME representation within clinical and corporate governance structures | Meetings to be defined |
| No. of BAME colleague in Band 8a and above positions | Target to be agreed |
| Celebration of Diversity events | Identified cultural events celebrated |
| Equality based Making a Difference Awards made | 10 in a 3 month period |
| Number of BAME development centres run | 1 per quarter |
| Number of BAME colleagues being promoted internally | Target to be agreed |

## 9.0 Risks

9.1 This risks to this programme are:

9.1.1 Ability to make a compelling case for change that colleagues believe in
9.1.2 Embedding ownership of the need to change culture amongst all our senior leaders
9.1.3 Ambitious programme of work, involving sensitive content (white fragility) and the need for difficult conversations about race equality and behaviours, which we have a poor track record of tackling in the past
9.1.4 Incomplete baseline picture for outcome measures – making it difficult to track progress
9.1.5 Alignment between Board of Directors' high expectation and internal capacity to deliver simultaneous actions at pace.



## 10.0 Conclusion

10.1 By developing and implementing a robust anti-racist organisation programme teamHDFT and HIF can make a positive difference to the lived experience of BAME colleagues and help create a more diverse and inclusive culture. Improvements gained by implementing the action plan will be directly linked to stronger race equality performance which is directly linked to the quality of care provided to our patients, service users and wider community.

## 11.0 Recommendation

11.1 The Board of Directors is asked to comment on and approve the contents of this paper.

## 12.0 Supporting Information

12.1 The following papers are Appendices to this report:

12.1.1 Appendix 1: HDFT Ethnicity Pay Gap Report – 31.03.21
12.1.2 Appendix 2: Workforce Race Equality Scheme Report and Action
12.1.3 Appendix 3: Equality, Diversity and Inclusion – Vision and Scope
12.1.4 Appendix 4: The Maturity Model

**Appendix 1 – HDFT Ethnicity Pay Gap Report – 31.03.21**

## 1. Ethnicity pay gap reporting

Diversity and inclusion are fundamental to the success of an organisation; in the service it provides and in creating a fair, diverse and inclusive environment for its workforce.

Research shows that organisations with diverse workforces and inclusive cultures perform better because they benefit from having a range of lived experiences and deeper understanding and viewpoints in the room. This in turn promotes diverse, creative and innovative decision-making.

The culture of an organisation also depends on these values; a place where people are proud to work, where they feel valued, recognised and supported to develop their true potential.
While there is currently no legal requirement to publish ethnicity pay gap data in the UK, we are reviewing this data alongside our mandated Gender Pay Gap data as good practice and in line with our commitment on closing gaps in workplace inequalities between our Black, Asian and Minority Ethnic (BAME) staff and White staff.

The disclosure of diversity data, such as ethnicity, is optional for staff. The data used in this report is based on a snapshot of data from 31 March 2020 for colleagues who have chosen to disclose their ethnicity. While this is the first time we are reporting on this information, we will continue in the future to track our progress.

Our mean ethnicity pay gap, shows the difference in average pay between BAME colleagues and White colleagues and takes into account all roles at all levels within Harrogate and District NHS Foundation Trust (HDFT). This is different to the concept of equal pay i.e. the comparison in pay received by BAME and White colleagues performing the same roles at the same grade.



HDFT pays most employees, excepting some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the band 5 scale with the same level of qualifications and experience would be paid the same irrespective of ethnicity; they would then have the opportunity to progress up the pay scale annually

The report will provide a breakdown of:

- Mean ethnicity pay gap in hourly pay.
- Median ethnicity pay gap in hourly pay.
- Mean bonus ethnicity pay gap.
- Median bonus ethnicity pay gap.
- Proportion of White and BAME colleagues receiving a bonus payment.
- Proportion of White and BAME colleagues in each pay quartile.

## 2. Harrogate and District NHS Foundation Trust

HDFT employs more than 4,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds, and children's services in North Yorkshire and the North East in County Durham, Darlington, Middlesbrough, Stockton-on-Tees, Gateshead and Sunderland.

The total number of staff eligible for inclusion in this report was 4,023 from a workforce of 4,239. The data in this report is based on those who have chosen to disclose their ethnicity which accounts for 95% of the workforce.

| | 31 March 2020 | | 31 March 2019 | |
|---|---|---|---|---|
| | Headcount | % | Headcount | % |
| BAME | 379 | 9% | 287 | 8% |
| White | 3,644 | 91% | 3,484 | 92% |
| **TOTAL** | **4,023** | | **3,771** | |

It should be noted that during the Coronavirus Pandemic, HDFT's workforce ethnicity declaration rates have increased. This followed an ethnicity status data collection exercise carried out in May 2020 in order to prioritise risk assessments for colleagues who identify as BAME. This accounts to the increase in both BAME and White headcounts from 2019 to 2020. This is good progress, but we must continue to encourage staff to declare their ethnicity. The disclosure rate is important as it reflects how comfortable, or not, people are about sharing these details with us and more broadly whether we are creating an environment where people can truly be themselves.

Figure 1 illustrates the ethnicity distribution within HDFT at 31 March 2020

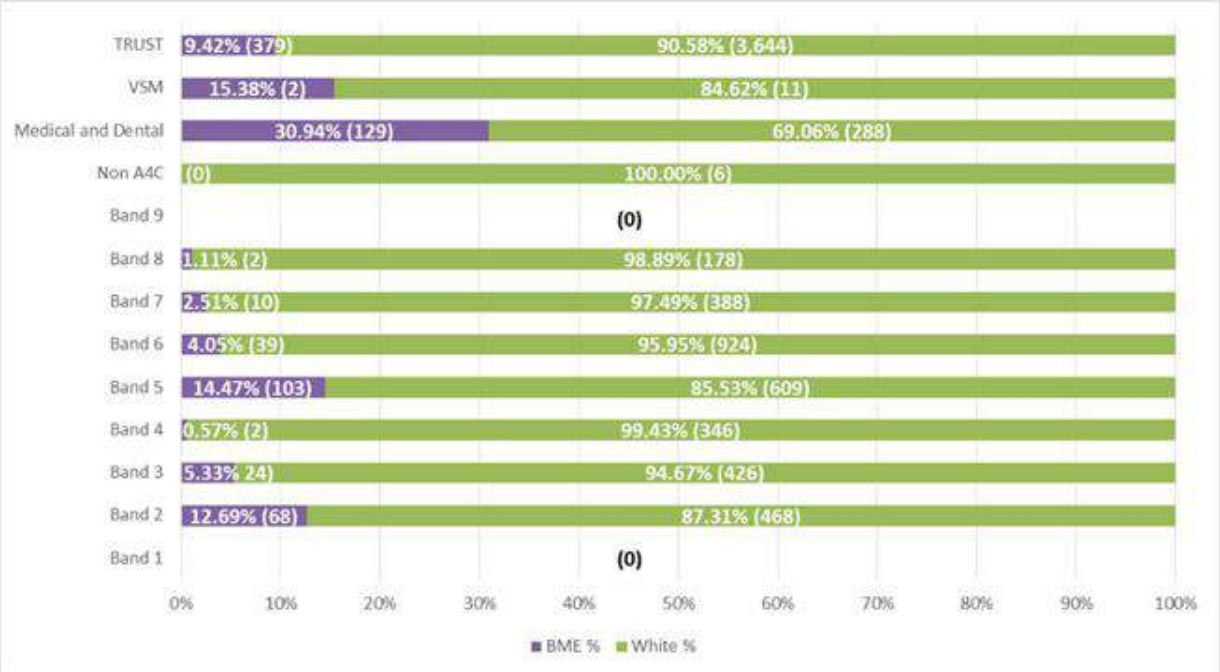
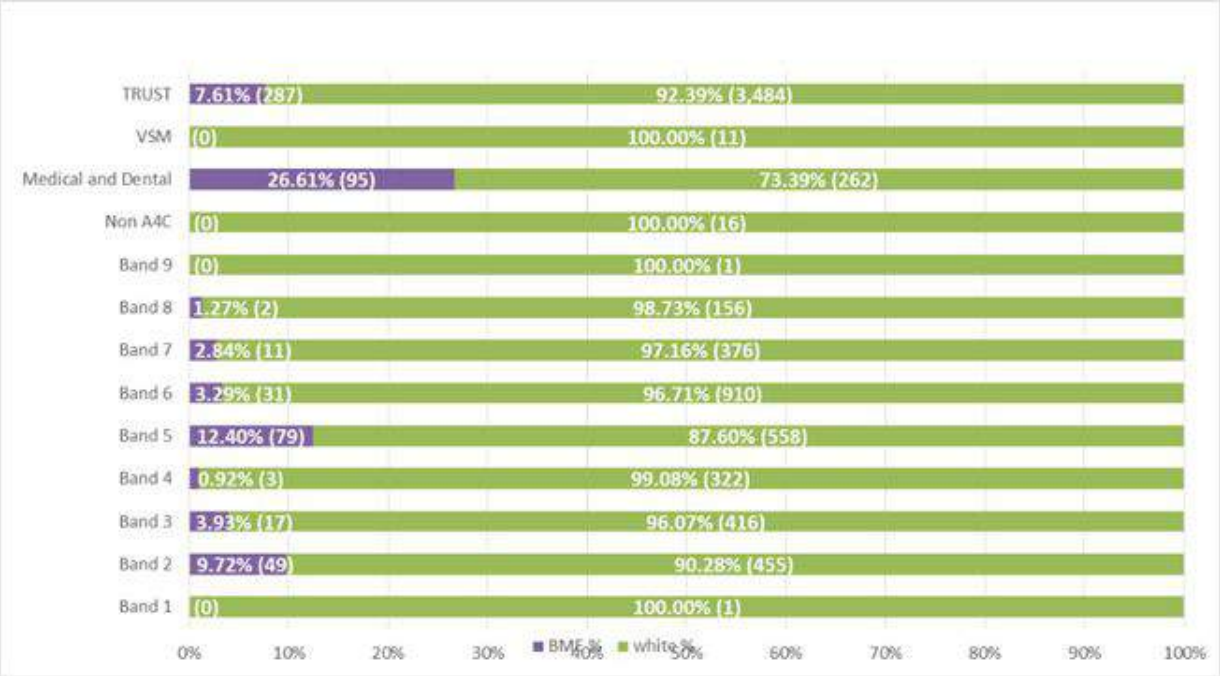


Figure 2 illustrates the ethnicity distribution within HDFT at 31 March 2019




Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and all existing staff on a Band 1 contract at HDFT transitioned over to Band 2 from April 2019.The data above shows that prior to the transition there was 1 employee in a Band 1 position as at 31 March 2019.



### 3. Definitions and scope

The Ethnicity Pay Gap is a measure that shows the difference in average earnings between BAME colleagues and White colleagues across an organisation

The report is based on rates of pay for the financial year 2019/20. It includes all workers in scope at 31 March 2020. A figure above zero indicates an Ethnicity Pay Gap disadvantageous to BAME colleagues; a minus figure indicates the ethnicity pay gap disadvantageous to White colleagues.

The Ethnicity Pay Gap is described in two different terms. Firstly, the difference between the mean of hourly rates of White colleagues and the hourly rates of BAME colleagues and secondly as the difference between the median of hourly rates of White colleagues and the median hourly rates of BAME colleagues.

Mean and Median

- The "mean" is an average of all hourly rates of pay.
- The "median" is the middle value in a complete list of all hourly rates of pay.

## 4. Mean and median ethnicity pay gap in hourly pay

| Ethnicity | Mean Hourly Rate 2020 | Median Hourly Rate 2020 | Mean Hourly Rate 2019 | Median Hourly Rate 2019 |
|---|---|---|---|---|
| **White (£)** | 17.91 | 15.57 | 17.40 | 15.15 |
| **BAME (£)** | 22.23 | 18.19 | 22.24 | 17.68 |
| **Difference (£)** | -4.31 | -2.62 | -4.84 | -2.53 |
| **Pay Gap %** | -24.07 | -16.81 | -27.85 | -16.70 |

- As highlighted in Figure 1, the proportion of BAME staff is much higher in the medical and dental staff group than in any other pay band.
- As shown above, HDFT is reporting a minus ethnicity pay gap of -24.07%, meaning that based on an average hourly rate BAME employees are paid 24.07% more than White employees. This is a decrease of 2019's figure of -27.85%.
- The figures also demonstrate that HDFT has a minus median ethnicity pay gap of -16.81%, a slight increase on 2019's figure of -16.70%.

## 5. Mean and median bonus ethnicity pay gap

HDFT pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards.

CEA are awarded based on the performance of a consultant. The CEA process requires the consultant to apply for the award and their application is then reviewed by a Panel.

Based on consultants who have declared their ethnicity, HDFT employs 144 consultants of whom 114 identify as White and 30 identify as BAME (as at 31.3.20). Of the total workforce who have declared their ethnicity, 84 White consultants (73.68%) which are 2.31% of all White colleagues employed received a CEA payment and 17 BAME consultants (56.67%) which are 4.49% of all BAME colleagues employed received a CEA payment.

| Ethnicity | Mean Bonus 2020 (£) | Median Bonus 2020 (£) | Mean Bonus 2019 (£) | Median Bonus 2019 (£) |
|---|---|---|---|---|
| **White** | 11,667.70 | 7,540.00 | 11,990.84 | 7,540.00 |
| **BAME** | 5,907.81 | 6,032.00 | 5,334.55 | 5,278.00 |
| **Difference** | 5,759.89 | 1,508.00 | 6,656.29 | 2,262.00 |
| **Pay Gap %** | 49.37 | 20.00 | 55.51 | 30.00 |

- This shows a positive reduction in both the mean and median ethnicity bonus gap differential by 6.14% and 10.00% respectively from 2019 to 2020 however both pay gaps remain significantly high in the favour of White consultants.
- In 2019 the CEA payment rules were changed – part-time consultants (mostly female) who were awarded a CEA received the full award payment rather than a pro-rata payment based on their working hours.

<u>The Influence of Medical and Dental Staff</u>

Medical and Dental staff have a substantial impact on HDFT's Ethnicity Pay Gap, as individuals in this staff group tend to be paid higher wages than other HDFT employees.

Although HDFT currently has 114 White consultants and 30 BAME consultants, because HDFT employs fewer BAME colleagues overall, the number of BAME consultants as a proportion of the overall BAME workforce at 7.92% is higher than that of White consultants 3.13% of the overall White workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that taking out the medical and dental staff from the calculations, the Ethnicity Pay Gap percentage for the average mean hourly rate in 2020 changes from -24.07% to 3.53% and similarly the median hourly rate pay gap percentage is also more favourable to White colleagues.

| Ethnicity | Mean Hourly Rate 2020 | Median Hourly Rate 2020 | Mean Hourly Rate 2019 | Median Hourly Rate 2019 |
|---|---|---|---|---|
| **White (£)** | 15.77 | 15.40 | 15.41 | 15.14 |
| **BME (£)** | 15.22 | 14.23 | 14.95 | 14.70 |
| **Difference (£)** | 0.56 | 1.17 | 0.46 | 0.44 |
| **Pay Gap %** | 3.53 | 7.58 | 2.97 | 2.89 |

### 6. Proportion of White and BME colleagues receiving a bonus payment

Long Service Awards include a £40 bonus paid to any member of staff eligible and in recognition of 25, 30, 35, 40 and 50 years' service at HDFT. As this bonus is paid out equally to White colleagues and BAME colleagues it would have no influence on the figures.

Due to the Coronavirus pandemic, Long Service Award celebrations in 2020 were postponed. Staff who would have been eligible for an award in 2020 will be honoured in 2021.

Taking both CEA and Long Service Awards into account, as a proportion, 4.49% of BAME colleagues (17) received a bonus compared to 2.31% of White colleagues (84).

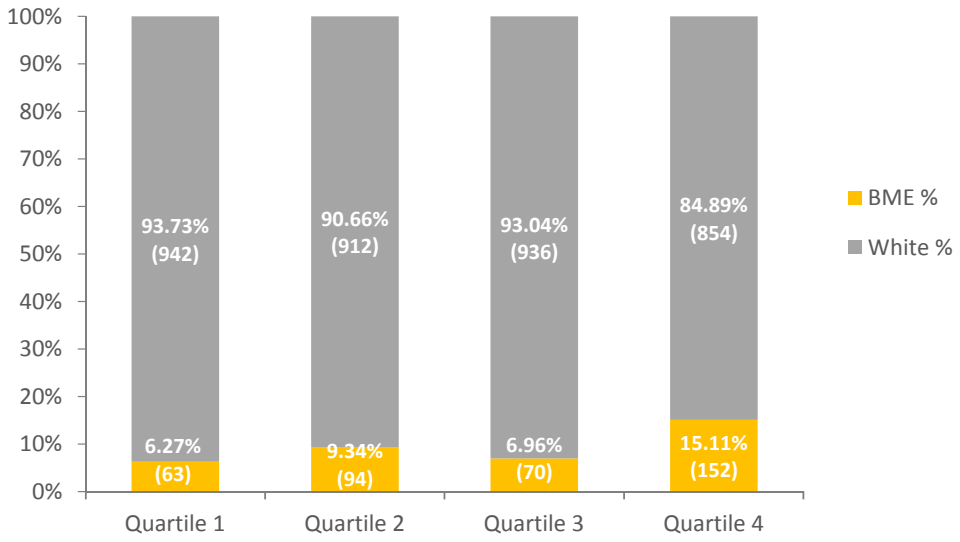
### 7. Proportion of White and BAME colleagues in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

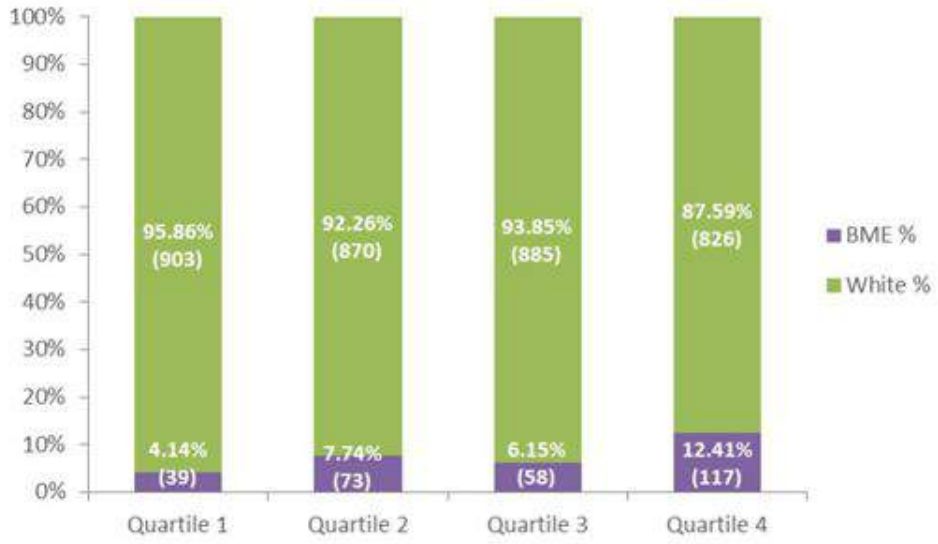
- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 - upper

The graph below shows that the highest proportion of White colleagues is found in the upper middle quartile and lowest quartile. The highest proportion of BAME colleagues is found in the upper quartile compared with other quartiles. This is influenced by the large proportion of BAME doctors and dentists within HDFT. The percentage of BAME in the upper middle and upper quartiles has decreased from the 2019 figures.

2020




2019




9.3

## 8. Summary and next steps in reducing the ethnicity pay gap

The data in this report is based on those who have chosen to disclose their ethnicity.

In total, 9% of colleagues who have shared their data identify as BAME, based on a 95% disclosure rate from colleagues across HDFT.

We acknowledge there is a lot more to do to continue making improvements and bring positive changes for our BAME colleagues, and to welcome a more diverse workforce to HDFT. In line with our Workforce Race Equality Standard (WRES) Action Plan and our Recruitment and EDI work streams as part of the 'At our Best' programme, HDFT is committed to increase the

ethnic diversity of both our overall and senior workforce, to put a greater focus on recruiting and developing BAME staff, and driving initiatives that will demonstrate that we're serious about real cultural change.

The Ethnicity Pay Gap report has been shared with HDFT Board to make informed decisions on actions that are required to improve the ethnicity pay gap.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations (10% of the overall workforce), the pay gap percentage for the average mean hourly rate and median rate in 2020 changes in favour of White staff, providing a reflection of the larger proportion of the workforce.

Further workforce analysis is required to continue efforts in reducing the ethnicity pay gap and identifying patterns and trends within service areas, departments, and occupations. This will be monitored by the Equality Diversity and Inclusion Steering Group to include:

- Progressing recruitment, progression and culture will take significant steps to help close this current gap.
- Encourage the take up of shared parental leave, job-share and part-time working and promote flexible working arrangements in vacancies including part-time, job share, compressed hours, home working etc.
- Promote training and education including unconscious bias training as part of the First Line Leaders programme and Pathway to Management.
- Continue to listen to the lived experiences of the BAME and Ally Staff Network, engage with and value their expertise.
- Encourage staff to feel confident in declaring their ethnicity status on ESR.
- Develop talent pipeline and encourage conversations with staff to discuss progression/promotion and goal setting through annual review processes.
- Continue work in relation to encouraging more applications for CEA from BAME consultants and providing support for individuals who have submitted unsuccessful applications in the past.
- Diverse representation on the CEA Panel.

**Appendix 2 – Workforce Race Equality Scheme Report and Action**

Harrogate and District NHS Foundation Trust

## NHS Workforce Race Equality Standard (WRES)

Annual Report 2020

Harrogate and District NHS Foundation Trust

## CONTENTS

## 1 Introduction

The Workforce Race Equality Standard (WRES)

Welcome to our WRES Annual Report 2020 which includes a data report for 2019/20 and an action plan for 2020/21.

The WRES was introduced in 2015 and is designed to close gaps in workplace inequalities between our black and minority ethnic (BME) and white staff.[1.]

Commissioned and overseen by the NHS Equality and Diversity Council and NHS England, the WRES is included in the NHS Standard Contract and trusts are required to publish their WRES data and action plans on an annual basis.

It consists of nine indicators, based on workforce data and staff experience from the NHS Staff Survey and an action plan which can then be tracked year on year to demonstrate continuous improvement to tackle the root causes of discrimination.

The WRES supports our compliance with the Public Sector Equality Duty, as part of the Equality Act 2010.[2.] It reinforces the improvements set out in the NHS Long Term Plan and is integral to the NHS People Promise within the NHS People Plan 2020/21, a promise we must all make to each other – to work together and improve the experience of working in the NHS for everyone.[3.]

Progress on the WRES is considered as part of the 'well-led' domain in the Care Quality Commission's (CQC) inspection programme.[4.]

The WRES complements the Workforce Disability Equality Standard (WDES) and both are vital to ensuring that the values of equality, diversity and inclusion lay at the heart of the NHS.



Our Values

Whether you're a patient, a visitor or a member of staff, our Vision sets out what you can expect from us – 'You Matter Most.'[5.]

Our values describe and define our culture. In everything we do, we aim to be:

- Respectful
- Responsible
- Passionate

Our Commitment

It is clear from our WRES data analysis that we need to improve the experience for our BME colleagues and continue focussing on closing the gaps in workplace inequalities between our BME and white staff.

We are committed to delivering our robust WRES action plan as part of the Equality, Diversity and Inclusion strategy; a golden thread which runs through our newly developing and exciting 'Culture Change Programme'.

We all need to treat each other with kindness, civility and compassion and we know that improving the experience of all our colleagues will lead to better care for our patients.

We have introduced Staff Networks during 2019/20, a catalyst to empower, encourage, and promote equitable opportunities for staff with disabilities, and a safe and supportive space for

colleagues to come together, share their experiences and feedback on a wide range of actions and decisions. Our BME Staff Network is still in its infancy, but is growing in numbers and will play a vital role in supporting and guiding the organisation to drive forward WRES improvements over the coming months and beyond.

Staff across the organisation have been given the opportunity to input to the development of the action plan along with the BME Staff Network who have focussed on the WRES in detail. We are very grateful to those who shared their experiences and to everyone who have engaged in our WRES journey. We now look forward to working together throughout 2020/21 to deliver the actions in the plan and improve workplace and career experiences for our BME colleagues across **#teamHDFT**.


1. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
2. https://www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty
3. https://www.england.nhs.uk/ournhspeople/
4. https://www.cqc.org.uk/
5. https://www.hdft.nhs.uk/about/trust/this-is-us/

## 2 Executive summary

**"The aim of the NHS Constitution is clear, to treat everyone, regardless of background with kindness, respect and care. The WRES is built on the values of the constitution and aims to ensure that all members of staff, regardless of background, have the opportunity to be the best that they can be. The evidence is that closing the gaps on workforce race equality in the NHS improves patient care, patient safety and patient satisfaction, saves money and saves lives".**[6]
Yvonne Coghill, ex-Director, Workforce Race Equality Standard Implementation NHS England

Our organisation is made up of over four and a half thousand people who care for the population in Harrogate and the local area as well as across North Yorkshire and Leeds. We also provide children's services in the North East in County Durham, Darlington, Middlesbrough, Stockton-on-Tees, Gateshead and Sunderland.

Based on workforce data and feedback from the NHS Staff Survey, detailed in Appendix 1, we have developed a robust WRES action plan, described in Appendix 2, which will be progressed over the next twelve months to help close gaps in workplace inequalities between our BME and white staff.

Key headlines from the WRES data shows:

- Under representation of BME staff at Band 7 and above.
- Inequalities in recruitment – white people are nearly twice as likely to be appointed from shortlisting compared to BME people.
- 39.81% of BME staff who completed the NHS Staff Survey said that they had experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- 23% of BME staff who completed the NHS Staff Survey said that they had experienced harassment, bullying or abuse from staff in the last 12 months.
- 13.5% of BME staff who had completed the NHS Staff Survey said that they had personally experienced discrimination at work from their manager/team leader or other colleague.

The WRES highlights the importance of how we must all treat each other with kindness, civility and compassion, and through our newly developing and exciting 'Culture Change Programme', we can all make a difference towards the Trust becoming a more inclusive and equitable place to work.

We are very proud this year to have launched our BME Staff Network who, along with our Disability and Long-Term Illness Staff Network and our Lesbian, Gay, Bisexual and Transgender (LGBT+) Staff Network, will have a vital role to play in driving forward equality, diversity and inclusion and celebrating the best of everyone in our organisation. They will also have an important role in overseeing progress of the WRES action plan and strengthening collaboration between the Board and BME staff across the organisation. The WRES will be a standard item on the network's monthly meetings and network members will continually seek updates on its progress and welcome innovative ideas for further improvements.

The Trust has also appointed an Equality, Diversity and Inclusion (EDI) Lead this year who will have a key role in working with the networks to support and guide the organisation in improving the experience for people who access and work within our services.

Why Race?

**The Legal Case** - working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.[7.] The WRES also supports our compliance with the Public Sector Equality Duty, as part of the Equality Act 2010.

**The Moral Case** – now more than ever has Covid-19 and the Black Lives Matter movement highlighted the moral case for the WRES. We are committed to understanding and tackling race inequality and recognising its impact on the lived experiences of our BME colleagues and communities.

**The Quality Case** – the experience of our staff is linked to patient satisfaction, patient safety and high quality patient care.

**The Financial Case** – improved workforce efficiency improves organisational financial efficiency.

The action plan focuses on the steps we need to take to close the gaps in workplace inequalities between our BME and white staff; to drive changes in attitude, to increase employment and career opportunities and implement long-lasting change for BME people.
Help support the staff network in championing an organisation which is committed to an open culture, reducing bullying, and improving staff wellbeing.

**"Our BME staff network will play a vital role in driving up standards to improve our WRES data over the next year through the WRES action plan. Empowering our BME colleagues to use their voices through the network, sharing their lived experiences to educate and through the action plan we will improve outcomes for BME colleagues and patients." Co-chair of the BME *Staff Network***

6. https://www.england.nhs.uk/wp-content/uploads/2019/07/wres-participants-bios-v2.pdf
7. https://www.gov.uk/government/publications/the-nhs-constitution-for-england

## 3 WRES progress in 2019/20

Nationally one in five NHS staff are from a BME background (19%). At Harrogate and District NHS Foundation Trust 85.7% of staff are white and 9% are BME (5.3% unknown – staff have not declared their ethnicity on the electronic staff record). We know from national reports and our own WRES analysis BME colleagues report a poorer experience at work than their white colleagues.

Throughout 2019/20 the number of BME staff across the workforce increased from 7.5% to 9%.

Since June 2016, we have worked in partnership with Health Education England's (HEE) Global Learners Programme to develop an effective pathway for internationally qualified Registered Nurse's to work and complete recognised learning in the NHS. In 2019/20, we welcomed 18 Global Learner nurses who took up roles on medical and surgical adult inpatient wards, theatres, and the Emergency Department. In the coming year we expect 8 further international nurses to take up roles. The Trust is also supporting international nurses that are currently working as Care Support workers to gain their Nursing and Midwifery Council registration by providing Objective Structured Clinical Examination preparation. We are incredibly proud that 32 BME members of staff who have joined us from the Global Learners Programme since October 2017 are still part of our workforce (only one member of staff has left to work in another trust).

There were also a number of improvements in the workforce data and from feedback in the NHS Staff Survey in relation to BME staff, these included:

- An improvement in the indicator which shows the relative likelihood of BME staff entering the formal disciplinary process compared to white staff.
- In July 2019, NHS England and NHS Improvement published 'A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce'.8. This document set out the need for accelerated improvement in BME staff experience and representation across the NHS in relation to likelihood to enter the formal disciplinary process.
- We achieved the aspiration of reducing this indicator to within the non-adverse range of 0.8 – 1.25 set out in this document. Our data has improved from 1.3 to 1.19.
- BME staff are more likely to access non-mandatory training and continuous professional development.
- A reduction in the number of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months. Although this figure had reduced from the previous year, there is still a lot to do to work towards eliminating this behaviour.
- An increase in the number of BME staff who believe the Trust provides equal opportunities for career progression or promotion.
- A reduction in the number of BME staff who have personally experienced discrimination at work from their manager/team leader or other colleague.
- An increase in BME representation at Board level.

The appointment of an EDI Lead and the development and launch of staff networks, including the BME Staff Network, has been pivotal in prioritising the EDI agenda, improving staff engagement, and driving the focus on improving the experience and outcomes for our staff. Other ways we have supported race equality and worked towards closing the gaps in workplace inequalities include:

- Participation in the national NHS WRES Experts Programme which aims to develop equality experts dedicated to addressing and advocating for issues related to workforce race inequality. The EDI Lead is a currently participating in cohort 3 and at the end of the programme will have an in depth understanding of the WRES, as well as the skills, knowledge and expertise in race equality to work confidently with this complex agenda and be an advocate for change.
- The ESR self-service portal gives all staff the ability to update their personal details as required.
- Training and development - First Line Leaders Programme and Pathway to Management aligned to the Trust's values and behaviours framework including unconscious bias, inclusiveness and fairness.
- We have actively promoted the Freedom to Speak Up Guardians and our network of Fairness Champions has grown from strength to strength; promoting the Trust values and behaviours, an open culture and speaking up, and specifically addressing undermining and bullying behaviours and unfairness.
- Team Talk; listening events to explore staff experiences across the Trust.

8. https://www.england.nhs.uk/publication/a-fair-experience-for-all-closing-the-ethnicity-gap-in-rates-of-disciplinary-action-across-the-nhs-workforce/

## 4 Conclusion and next steps

We acknowledge there is a lot more to do to continue making improvements and bring positive changes for our BME colleagues, and to welcome a more diverse workforce into **#teamHDFT**. Our senior leaders and the BME Staff Network will be sighted on the progress of our action plan. We will continue to communicate the WRES to all staff across the organisation so we can all be involved in celebrating our achievements.

The WRES will continue, with other work streams, to help ensure that there is momentum and continuous improvement in the workforce race equality agenda. It will help drive our culture change programme and help meet the goals set out in the People Plan 2020/21.

Having a diverse workforce who feel engaged and supported within the workplace is critical; research shows that how we treat and value our minority staff is a good barometer of how well patients are likely to feel cared for.[9] Our staff experience impacts on patient care, patient safety as well as organisational efficiency.

We will continue to listen with fascination to what our staff with lived experience have to say, we will capture the richness in their stories, and ensure these inform how we deliver the actions in this plan and shift the culture so we can say - Harrogate and District NHS Foundation Trust is the best place to work.

9. https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/

## APPENDIX 1 WRES DATA REPORT

Detailed below is the organisation's WRES data which was submitted in August 2020 covering the period 1 April 2019 to 31 March 2020

**Indicator 1** **Percentage of staff in each of the Agenda for Change (AfC) bands 1 – 9 and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.**

**(Data source: ESR).**

### 1a. Non-clinical workforce

| | BME staff in 2019 | BME staff in 2020 | BME staff in 2019/2020 | White staff in 2019 | White staff in 2020 | White staff in 2019/2020 | Unknown /null staff in 2019 | Unknown /null staff in 2020 | Unknown /null staff in 2019/2020 | Total staff in 2019 | Total staff in 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Percentage (%) | Percentage (%) | % points difference (+/-) | Percentage (%) | Percentage (%) | % points difference (+/-) | Percentage (%) | Percentage (%) | % points difference (+/-) | Headcount | Headcount |
| Cluster 1 (Bands 1 - 4) | 2.4% | 3.4% | +1% | 89.5% | 93.4% | +3.9% | 8.1% | 3.2% | -4.9% | 542 | 533 |
| Cluster 2 (Band 5 - 7) | 5.3% | 2.9% | -2.4% | 92.7% | 95.7% | +3.0% | 2.0% | 1.4% | -0.6% | 150 | 140 |
| Cluster 3 (Bands 8a - 8b) | 0% | 0% | No change | 100% | 100% | No change | 0% | 0% | No change | 49 | 55 |
| Cluster 4 (Bands 8c – 9 & VSM) | 0% | 5.9% | +5.9% | 100% | 94.1% | -5.9% | 0% | 0% | No change | 16 | 17 |

## 1b. Clinical workforce

| | BME staff in 2019 | BME staff in 2020 | BME staff in 2019/2020 | White staff in 2019 | White staff in 2020 | White staff in 2019/2020 | Unknown/ null staff in 2019 | Unknown/ null staff in 2020 | Unknown/ null staff in 2019/2020 | Total staff in 2019 | Total staff in 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Percentage (%) | Percentage (%) | % points difference (+/-) | Percentage (%) | Percentage (%) | % points difference (+/-) | Percentage (%) | Percentage (%) | % points difference (+/-) | Headcount | Headcount |
| Cluster 1 (Bands 1 - 4) | 6.9% | 8.2% | +1.3% | 82.3% | 84.6% | +2.3% | 10.8% | 7.2% | -3.6% | 953 | 969 |
| Cluster 2 (Band 5 - 7) | 5.7% | 7.2% | +1.5% | 84.9% | 86.5% | +1.6% | 9.4% | 6.3% | -3.1% | 2174 | 2202 |
| Cluster 3 (Bands 8a - 8b) | 0.9% | 1.7% | +0.8% | 92.7% | 98.3% | +5.6% | 6.4% | 0% | -6.4% | 109 | 121 |
| Cluster 4 (Bands 8c – 9 & VSM) | 14.3% | 16.7% | +2.4% | 85.7% | 83.3% | -2.4% | 0% | 0% | No change | 7 | 6 |
| Cluster 5 (Medical and Dental staff, Consultants) | 19.0% | 21.8% | +2.8% | 76.7% | 76.9% | +0.2% | 4.3% | 1.3% | -3% | 163 | 156 |
| Cluster 6 (Medical and Dental staff, Non-consultant career grade) | 27.6% | 11.3% | -16.3% | 59.9% | 59.6% | -0.3% | 12.5% | 29.1% | +16.6% | 192 | 213 |
| Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades) | 22.9% | 33.5% | +10.6% | 59.0% | 62.6% | +3.6% | 18.0% | 3.9% | -14.1% | 205 | 155 |

**Indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts.**
(A figure below '1' would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting)

**(Data source: Trust's recruitment data)**

| | Relative likelihood in 2019 | Relative likelihood in 2020 | Relative likelihood difference (+-) |
|---|---|---|---|
| **Relative likelihood of staff being appointed from shortlisting across all posts** | **2.08** | **1.96** | **-0.12** |

**Indicator 3 – Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.**
(A figure below '1' would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process)

**(Data source: Trust's HR data)**

| | Relative likelihood in 2018/19 | Relative likelihood in 2019/20 | Relative likelihood difference (+-) |
|---|---|---|---|
| **Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation** | **1.30** | **1.19** | **-0.11** |

**Indicator 4 – Relative likelihood of staff accessing non-mandatory training and CPD.**

(A figure below '1' would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff)

**(Data source: Trust HR data)**

| | Relative likelihood in 2018/19 | Relative likelihood in 2019/20 | Relative likelihood difference (+-) |
|---|---|---|---|
| **Relative likelihood of staff accessing non-mandatory training and CPD.** | **0.91** | **0.80** | **0.11** |

**Indicators 5 – 8**

**(Data source: NHS Staff Survey)**

| | BME staff responses to 2018 NHS Staff Survey | White staff responses to 2018 NHS Staff Survey | % points difference (+/-) between BME staff and white staff responses 2018 | BME staff responses to 2019 NHS Staff Survey | White staff responses to 2019 NHS Staff Survey | % points difference (+/-) between BME staff and white staff responses 2019 |
|---|---|---|---|---|---|---|
| | Percentage (%) | Percentage (%) | | Percentage (%) | Percentage (%) | |
| **5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months** | **33.3%** | **24.0%** | **+9.3%** | **39.8%** | **23.8%** | **+16%** |
| **6 – Percentage of staff experiencing harassment, bullying or abuse** | **31.2%** | **24.0%** | **+7.2%** | **23.0%** | **26.4%** | **-3.4%** |

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| **from staff in the last 12 months** | | | | | | |
| **7 – Percentage believing that the Trust provides equal opportunities for career progression or promotion** | **77.3%** | **90.7%** | **-13.4%** | **79.4%** | **88.5%** | **-9.1%** |
| **8 – In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues** | **17.0%** | **4.8%** | **+12.2%** | **13.5%** | **7.0%** | **+6.5%** |

**Indicator 9 – Percentage difference between the organisation's Board voting membership and its overall workforce.**

**(Data source: NHS ESR and/or trust's local data**

| | BME Board voting members in 2019 | White Board voting members in 2019 | Board voting members with ethnicity status unknown in 2019 | % points difference (+/-) between BME Board voting members and BME staff in overall workforce | BME Board voting members in 2020 | White Board voting members in 2020 | Board voting members with ethnicity status unknown in 2020 | % points difference (+/-) between BME Board voting members and BME staff in overall workforce |
|---|---|---|---|---|---|---|---|---|
| | Percentage (%) | Percentage (%) | Percentage (%) | | Percentage (%) | Percentage (%) | Percentage (%) | |
| **Percentage difference between the organisation's Board voting membership and its organisation's overall workforce** | Voting = 0%<br><br>Exec = 0%<br><br>Non-Exec =0% | Voting = 100%<br><br>Exec = 100%<br><br>Non-Exec = 100% | Voting = 0%<br><br>Exec = 0%<br><br>Non-Exec = 0% | Total Board = 0%<br><br>Overall workforce = 7.5%<br><br>Difference = -7.5 percentage points | Voting = 14.3%<br><br>Exec = 16.7%<br><br>Non-Exec = 12.5% | Voting = 85.7%<br><br>Exec = 83.3%<br><br>Non-Exec = 87.5% | Voting = 0%<br><br>Exec = 0%<br><br>Non-Exec = 0% | Total Board = 14.3%<br><br>Overall workforce = 9.0%<br><br>Difference = +5.3 percentage points |

## APPENDIX 2 - WRES ACTION PLAN 2020/21

| Metric | Objective | Action/s | Timescales | Lead/s | Why | Progress |
|---|---|---|---|---|---|---|
| 1 | Improve our ethnicity declaration rates to build a more accurate picture of the diversity of our workforce.<br><br>Improve diverse representation across the workforce, at all levels of Agenda for Change and profession. | 1. Work with the Staff Network to raise awareness of the WRES and encourage staff to feel confident in declaring their ethnicity status on ESR. | March 2021 | Director of W&OD<br>EDI Lead/WRES Expert<br>BME Staff Network<br>Communications and Marketing Manager | To build a more accurate picture of the diversity of our workforce. | Email asking those who had not declared ethnicity status issued and resulted in increase to 463 colleagues. |
| | | 2. Review our recruitment processes to promote our commitment to be an inclusive workplace that welcomes people from BME backgrounds. | October – December 2020 | Recruitment Lead | To celebrate the diversity of our workforce and encourage everyone to bring their whole-self to work.<br><br>To review fairness in our recruitment processes. | 2 day recruitment workshop held to review our process. 14 products have been identified to take forward. |
| | | 3. Complete detailed analysis of data by directorate and profession to identify areas of under-representation and barriers to career progression. | October 2020 | HR Analyst<br>EDI Lead/WRES Expert<br>Directorate Leads | Identify potential barrier to recruitment/promotion of BME staff.<br><br>To understand where we have gaps/under representation. | |
| | | 4. Review and set aspirational targets - Model Employer: Increasing BME representation at senior levels across | November 2020 | Director of W&OD<br>EDI Lead/WRES Expert | To identify role models and leaders in the pipeline | |

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| | | Harrogate and District NHS Foundation Trust<br><br>5. Continue to work with our existing volunteering and work experience programmes, and our Youth Forum, to promote the wide range of career opportunities across the Trust.<br><br>6. Review models for connecting opportunities and engaging with BME communities towards gaining and sustaining employment. | <br><br>Apr/Jul 2021<br><br>April 2021 | <br><br>EDI Lead/WRES Expert<br>Corporate Affairs and Membership Manager<br>Volunteer Services Manager<br><br>Director of W&OD<br>W&OD Lead<br>EDI Lead/WRES Expert | Commitment to meet the aspirations on improving BME representation across the workforce and at leadership positions in the NHS, as set-out in both the NHS Long Term Plan and within the WRES 'Model Employer' leadership representation strategy.<br><br>To become a model employer, be compassionate and inclusive, and improve how we recruit, retain and develop BME people.<br>To agree local aspirational goals and ambitions to improve BME representation. | Have committed to the Kickstart programme to provide 6 month placement opportunities to 16 to 24 year olds who are not in education, employment or training. |
| 2 | Reduce the inequality in recruitment shortlisting from 1.96 to 1.00. | 1. Review of our recruitment practices:<br>- Criteria for appointment<br>- Management of unsuccessful candidates<br>- Promotions, acting up and secondments | October – December 2020 | Director of W&OD<br>Recruitment Lead<br>BME Staff Network | To improve career progression prospects for BME staff (see action 5 below). | |

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| | Review recruitment practices to ensure the process is equitable and inclusive where everyone can thrive. | - Job adverts – length of advert, communications about the advert, wording, JDs<br>- Complaints about recruitment practices<br>- Barriers for staff applying, and being successful at reaching senior posts | | | To ensure the lived experiences of BME staff are taken into account – 'We have a voice that counts'. | |
| | | 2. BME representation on recruitment and selection panels. | November 2020 – January 2021 | Recruitment Lead<br>BME Staff Network | To ensure diversity in thought when decisions are being made. | |
| | | 3. Staff Network to receive regular review of recruitment activity. | Jan/April/Jul 2021 | Recruitment Lead<br>BME Staff Network | | |
| | | 4. Review training and education, including 'Pathway to Management', to improve managers' awareness and understanding of the benefits of diversity and to understand the barriers to career progression for BME staff. | January 2021 | HR Lead | To improve awareness and understanding. | |
| | | 5. Continue to promote awareness and understanding of unconscious bias through the First Line Leaders programme. | January 2021 | W&OD Lead | | |
| | | 6. Engage with the BME Staff Network to review and promote the First Line Leaders programme to BME staff. | September 2020 | Deputy Director of W&OD / Head of Employee Experience<br>BME Staff Network | To review the programme and identify modules to support BME leadership. | |
| | | 7. Launch Listening Partners' Programme - reciprocal mentoring. | | Deputy Director of W&OD / Head of Employee Experience | Advance the career aims of BME staff in leadership roles and improve | |

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| | | | | Senior Management Team<br>BME Staff Network | organisational performance through a more inclusive leadership. | |
| 3 | Retain the non-adverse range of staff entering the formal disciplinary process and reduce from 1.19 to 1.00.<br><br>Promote active engagement and consultation in policy review ensuring that any decisions that impact BME people involve them in the decision-making process. | 1. Review progress of relative likelihood of staff entering the formal disciplinary process based on the non-adverse range 0.8 – 1.25 goal and provide update to Staff Network.<br><br>2. Engage with the Staff Network when reviewing disciplinary policies.<br><br>3. Invite Staff Network member on to the Trust's Partnership Advisory Group.<br><br>4. Review training and education, including 'Pathway to Management'.<br><br>5. Continue to promote awareness and understanding of unconscious bias through the First Line Leaders programme. | February 2021<br><br>February 2021<br><br>September 2020<br><br>January 2021<br><br>January 2021 | Director of W&OD<br>HR Lead<br>BME Staff Network<br><br>HR Lead<br>BME Staff Network<br><br>HR Lead<br>BME Staff Network<br><br>HR Lead<br><br>W&OD Lead | To increase the confidence of staff entering into the disciplinary process that they will be treated fairly.<br><br>To ensure that any decisions that impact BME people involve them in the decision-making process.<br><br>To improve awareness and understanding of unconscious bias and stereotyping. | |
| 4 | To continue to promote and recognise all staff accessing non-mandatory training and CPD. | 1. To review the process for applying for non-mandatory training including:<br>- Recording/documentation<br>- Capturing people who have been denied/declined access?<br>- Funded versus non funded training<br>- Career progression post training | April 2021 | Director of W&OD<br>W&OD Lead | To understand link between BME staff undertaking non-mandatory training and CPD and under-representation at senior levels. | |

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| | | - Shadowing, secondments, coaching | | | | |
| 5 | Reduce the incidence of BME staff experiencing harassment, bullying and abuse from patients, relatives or the public (currently stands at 39.8%). | 1. To promote the Culture Change Programme and work together to drive the importance of the WRES throughout the current work streams and future initiatives.<br><br>2. To continue listening across a variety of platforms where colleagues feel safe to share their lived experiences. Focus on the drive to eliminate harassment, bullying and abuse and reassure staff that concerns will be acted on appropriately.<br><br>3. Raise awareness of the WRES with the Council of Governors and the Equality Stakeholder Group. Support staff by producing zero-tolerance materials.<br><br>4. Encourage colleagues to participate and provide feedback in the NHS Staff Survey.<br><br>5. WRES Expert/EDI Lead, Freedom to Speak Up Guardians, Fairness Champions, BME Staff Network Chairs, Staff Governors and Bullying | October 2020<br><br>Oct 2020/Jan/Apr/ Jul 2021<br><br>January 2021<br><br>November 2020<br><br>Oct 2020 / Jan/Apr/Jul 2021 | Culture Change Programme Leads<br>BME Staff Network<br>EDI Lead/WRES Expert<br><br>Director of W&OD<br>BME Staff Network<br>EDI Lead/WRES Expert<br><br>EDI Lead/WRES Expert<br>BME Staff Network<br>Communications and Marketing Manager<br><br>Director of W&OD<br>HR Lead<br>BME Staff Network<br><br>EDI Lead/WRES Expert<br>Freedom to Speak Up | Part of the overall organisational goal to create an inclusive culture.<br><br>To ensure that that BME staff are involved in the Culture Change Programme and are valued in making a difference.<br><br>To build on the culture of the organisation in order to drive initiatives to reduce harassment, bullying and abuse from members of the public.<br><br>Understand the lived experience behind the data.<br><br>Value the richness of staff feedback to inform actions. | |

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| | | and Harassment Advisors to triangulate learning from themes in relation to the experiences of BME staff and feedback to senior management team.<br><br>6. In line with the NHS People Plan, focus on work streams to ensure that we create a culture where everyone feels they belong.<br><br>7. Promote reporting racist incidents on Datix | <br><br><br><br><br>January 2021<br><br><br>December 2020 | Guardians/Fairness Champions<br>BME Staff Network Chairs<br>Staff Governors<br>Bullying and Harassment Advisors<br><br>Culture Change Programme Leads<br><br><br>Risk Management Lead<br>BME Staff Network | To work together in partnership so that all staff, and in particular our BME staff, feel safe to speak up, knowing that the right actions will be taken.<br><br>Celebrate our diversity and enjoy learning about cultures.<br><br>Support staff to speak up. | |
| 6 | Reduce the incidence of BME staff experiencing harassment, bullying or abuse from staff (currently stands at 23%). | 1. Actions as above (indicator 5) | As above | As above | As above | |
| 7 | Increase career progression and promotion opportunities for BME staff (currently 79.4% of staff | 1. Encourage colleagues to participate and provide feedback in the NHS Staff Survey. | November 2020 | Director of W&OD<br>HR Lead<br>BME Staff Network<br><br>Director of W&OD<br>BME Staff Network<br>Recruitment Lead | Value the richness of staff feedback to inform actions. | |

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| | believe the Trust provides equal opportunities for career progression or promotion). | 2. Arrange a series of engagement focus groups to listen to BME colleagues, share experiences about career progression and promotion, and feed back themes which can inform the recruitment review and appraisal and development review.<br><br>3. Listening Partners Programme – reciprocal mentoring (as Indicator 2 above) | December 2020 – January 2021<br><br>As above (Indicator 2) | HR Lead<br><br>As above (Indicator 2) | Insight into the lived experience of BME staff to inform policy and process reviews.<br><br>As above (Indicator 2) | |
| 8 | Reduce the incidence of BME staff experiencing discrimination at work (currently stands at 13.5%) | 1. Encourage colleagues to participate and provide feedback in the NHS Staff Survey.<br><br>2. To promote the Culture Change Programme and work together to drive the importance of the WRES throughout the current work streams and future initiatives.<br><br>3. Encourage colleagues to speak up. | November 2020<br><br>October 2020<br><br>Oct 2020 / Jan/Apr/Jul 2021 | Director of W&OD<br>HR Lead<br>BME Staff Network<br><br>Culture Change Programme Leads<br>BME Staff Network<br>EDI Lead/WRES Expert<br><br>BME Staff Network<br>Freedom to Speak Up Guardians / Fairness Champions | Value the richness of staff feedback to inform actions.<br><br>Part of the overall organisational goal to create an inclusive culture.<br><br>To ensure that that BME staff are involved in the Culture Change Programme and are valued in making a difference.<br><br>Support staff to feel safe to speak up, knowing that the right actions will be taken. | |

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| 9 | Increase diversity of Board. | 1. Ensure the process for appointment of Executive and Non-Executive Directors encourages BME applicants.<br><br>2. As a demonstration of Trust commitment to 'Nothing about us without us' and inclusion, include reciprocal mentoring programme for BME Staff Network members to have mentoring relationship with Board members. 'Walk a mile in someone else's shoes'. From hearing insights and lived experiences, Board members will be better informed in making decisions that benefit all staff and patients. | July 2021<br><br>July 2021 | Director of W&OD Recruitment Lead<br><br>Director of W&OD Board Champion Staff Network | To demonstrate visible leadership in this area at senior levels.<br><br>Importance of leadership role models. | |
| All Metrics | To close the gaps between the workplace and career experiences of BME staff. | Across all, or multiple indicators, the following actions will champion positive WRES outcomes and improved staff experience:<br><br>1. Recognition of the value of the Staff Network across the organisation – benefits the organisation as much as the individual:<br>- Resources<br>- Time – facility time for Network Chairs and time for staff to attend,<br>- Support<br><br>2. The WRES will be a standard item on the BME Staff Network monthly agenda. | October 2020 – July 2021 | | Improve the experience of BME staff.<br><br>Improve the culture of the organisation.<br><br>Compliance with:<br>- Public Sector Equality Duty, Equality Act 2010.<br>-<br>- NHS Standard Contract.<br>-<br>- NHS Long Term Plan.<br>- | |

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| | | 3. Listening with fascination and sharing lived experience – story telling to bring the lived experience alive, which along with the data and the feedback through the Staff Survey gives a whole perspective and has such a powerful impact, e.g. Schwartz Round, Board of Directors' meetings, People and Culture Committee.<br><br>4. Reciprocal mentoring – using this model to raise awareness of inequalities and promote diversity of thought.<br><br>5. Integrate the WRES within mainstream business and ensure BME representation across the organisation's governance structures including regular reporting via the Integrated Board Report and as part of the Culture Change Programme.<br><br>6. Regular communications to bring WRES alive and celebrate achievements. Produce innovate ways to communicate e.g. infographics.<br><br>7. Sharing good practice:<br>- Resources and guidance via NHS Employers<br>- Networks – Yorkshire and Humber Regional EDI Leads Network<br>- Staff Networks in other Trusts<br>- Collaboration with West Yorkshire and Harrogate BME | | | - NHS People Plan | |

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| | | Network and active involvement in the Review Panel Leadership Deep Dive - Ensuring our leadership is reflective of our communities and our staff have a voice<br>- Collaboration with Regional WRES Experts | | | | |

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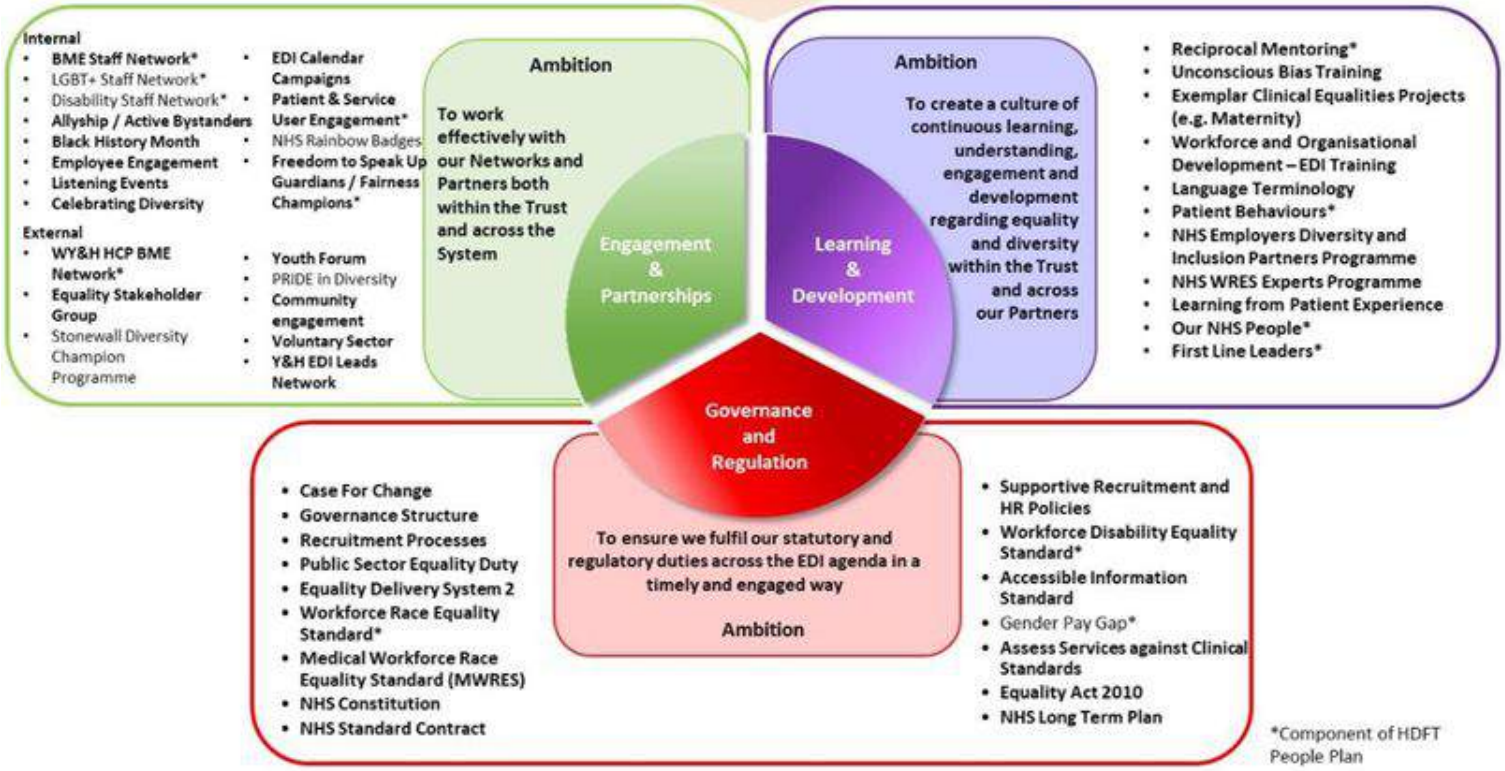
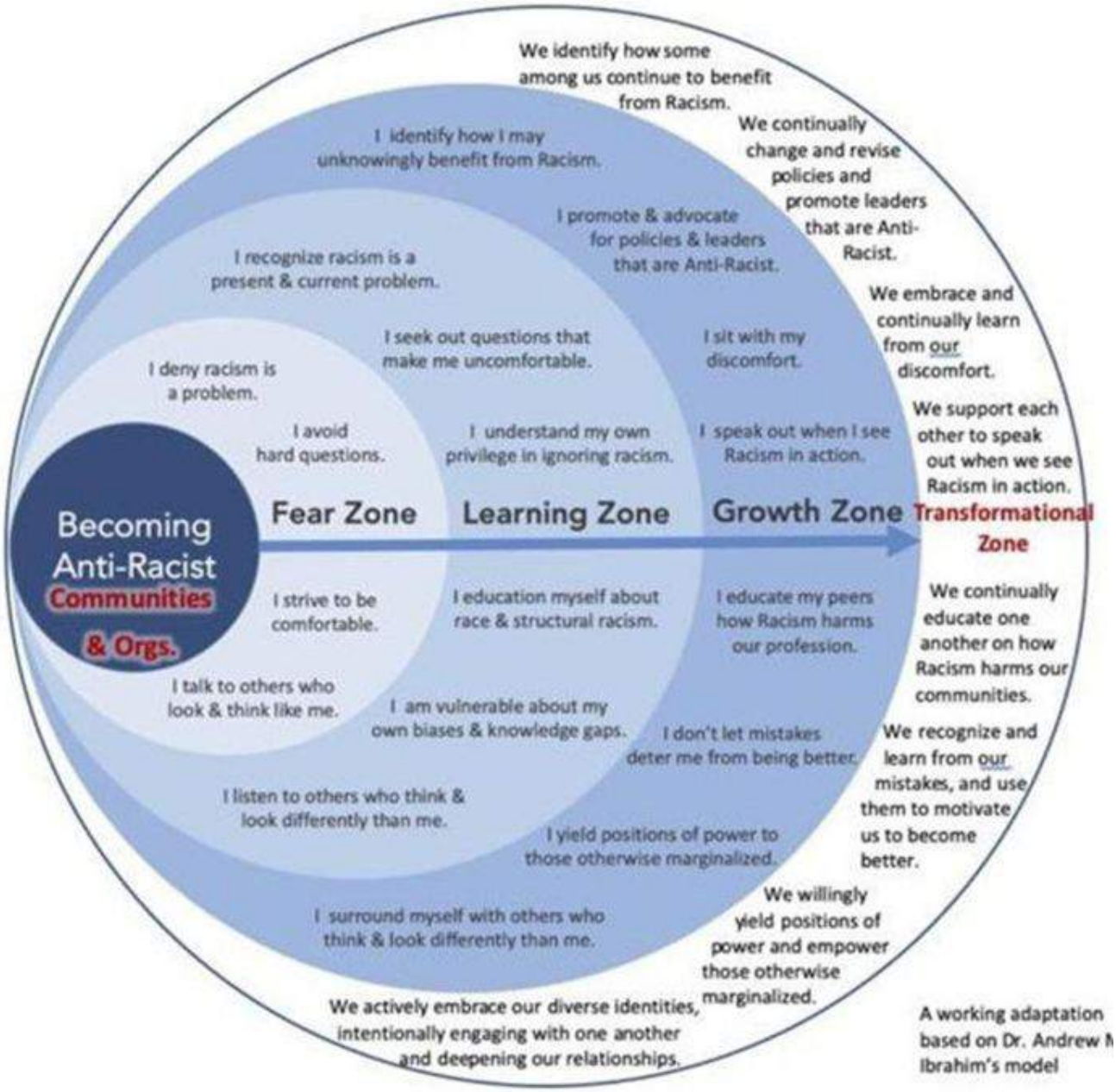
| **Note: How have BME staff have been involved in developing and delivering the actions.**<br><br>Consultation has been undertaken with the BME Staff Network members, and BME staff across the organisation who are not members of the Staff Network, to review the data and develop the action plans within this report. | |

## Appendix 3 – EDI Vision and Scope

We want Team HDFT & HIF to be a place where we can talk comfortably about EDI issues and support each other to **tackle inequality, value diversity** and **facilitate inclusion**. A place where we are more than just 'not racist' – we are **actively anti-racist.** A place where our diversity ensures that we are able to provide a higher quality of care to our patients and service users ensuring that they receive the best possible outcomes. As an **Anchor Organisation** we will promote inclusivity and diversity within the communities, systems and partners we work with and in. We will gather clear evidence of our progress as an **Anti-Racist Organisation** and this will set the standards for all other EDI agendas



**Appendix 4 – The Maturity Model**




9.3

Harrogate and District NHS Foundation Trust

# Board Committee Report to the Board of Directors

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| **Committee Name:** | Audit Committee |
| **Committee Chair:** | Richard Stiff |
| **Date of meeting:** | 26 April and 4 May 2021 |
| **Date of Board meeting this report is to be presented** | 26 May 2021 |

**Summary of key issues**

**26 April**

The Committee NEDs met via MS Teams with the Deputy CEO/Director of Finance and members of the Finance team to discuss the Trust's draft financial statements for 2019-20 prior to their submission. This was an additional and informal meeting and was Lara Robson's first meeting as a member of the Committee.

The main purpose was to provide Committee members with an opportunity to be consider the proposed treatment of a number of "significant issues" in the draft statements. Committee members gained assurance that the proposed treatments were appropriate.

**4 May**

The Committee met via MS Teams and was well attended. The meeting was observed by Doug Masterton on behalf of the Council of Governors.

The main items of business were as follows.

- The Committee received and considered the latest Corporate Risk Review Group minutes and the current iteration of the Corporate Risk Register. Mr Coulter covered these items at Committee following the departure of Dr Wood from the Trust. Members requested that clarity was provided at the earliest opportunity as to who would have ongoing responsibility for the CRRG and presentation of its work to the Audit Committee. There were no matters arising from the update.

- The Committee received the annual report and work plan of the Local Security Management Specialist (LSMS). Incidents of violence or aggression in some operational areas was noted including ED and in inpatients as patients expressed their dissatisfaction with treatments or

Covid arrangements. This was felt to be an issue in common with other acute trusts and not unique to HDFT. The LSMS was asked to include more detail in future annual reports on the location and timing of such incidents. It was noted that HDFT may be an outlier in not having on site security. Police response to requests for assistance was good, although incidents requiring police support were extremely rare. The Committee was told that further training and more suitable PPE for our Porters was under consideration and a trial of body worn cameras was under consideration.

- A verbal update on the redevelopment of the BAF was provided by the Company Secretary.

- The Committee received an update on the work of the Quality Committee.

- The Committee considered the Trust and Charitable Accounts. The Committee's year end meeting will be held on June 4th prior to the consideration of the accounts by the Board in June. An increase in the KPMG audit fee for work on the charity accounts was noted.

- The Committee discussed the latest Internal Audit progress report. The report on the Pathology JV was discussed at some length. The findings were disappointing particularly in relation to poor communication, the absence of KPIs and lack of a clear vision or development strategy and the limited visibility of the JV in the Trust.

- The draft Head of Internal Audit Opinion was presented by Helen Kemp-Taylor. The draft report recognised significant assurance, but the Committee was told that this was a judgment close to the threshold for this rating given the number of limited assurance reports in 2020-21, continuing uncertainties about a number of relevant issues, and turnover in senior management during the year. A "general erosion of systems of control" had been observed in the Trust, many arising from the necessities of managing through Covid-19. It would be important for the Trust to be mindful of these issues in the year ahead as operations normalised.

- A draft Assurance Statement for HHFM was presented along with a progress report on HHFM internal audits. There is no formal requirement for an Assurance Statement for HHFM, it has been prepared in line with best practice guidance in the PSIAS. There were no matters arising from these reports.

- External Audit colleagues from KPMG presented three reports at this meeting. They included the regular Sector Update and Benchmarking reports. The third item was an external audit progress report. This

report set out the current position of KPMG's thinking in relation to the Trust's financial statements and the auditor's value for money assessment. In relation to value for money KPMG have identified new reporting requirements including a risk assessment in relation to financial sustainability, governance and improving economy, efficiency, and effectiveness. A significant risk for the Trust (and the NHS as a whole) in relation to financial sustainability has been identified. Committee members offered some challenge to this proposition. The outcome of KPMG's work will be presented to the Audit Committee at its meeting on 4th June.

- There were no Post Project Review Group minutes or Single Tender Actions to consider at this meeting.

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

None.

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

External Auditors have identified additional risks for the Trust in relation to financial sustainability which the Trust may wish to challenge in due course.

10

# Board Committee report to the Board of Directors

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|---|---|
| **Committee Name:** | Resources Committee |
| **Committee Chair:** | Maureen Taylor |
| **Date of last meeting:** | 26 April 2021, 10 May 2021, 24 May 2021 |
| **Date of Board meeting for which this report is prepared** | 26 May 2021 |

**Summary of key issues:**

1. **Month 12 – March.** The trust achieved its plan for March, reporting a deficit position of £745k against a planned deficit of £845k. This position recognises funding of £3.7m received to offset 'lost income'. Without this the in-month position would be a deficit of £546k. The cumulative position is a surplus of £429k against a planned deficit of £5,450k. This plan was based on an underlying break-even position with the impact of lost non-NHS income and the annual leave accrual resulting in a deficit plan. These two items have now been funded centrally.
2. Covid costs to date total £11.6m. After adjusting for Covid costs in the year to date, all Directorates are living within their budgets.
3. The efficiencies of £1.91m have been delivered against a plan of £1.8m.
4. Pre-payment of NHS incomes ceased in March so the cash position has reduced from £43m in February to £33.8m in March. Performance against the Better Payment Practice Code is positive and improving.
5. Spend on the capital programme is very positive achieving £16.3m against a plan of £16.5m. The opportunity was taken to purchase items of equipment that were scheduled for 2021/22.
6. The Committee received an updated COVID Management Report showing both inpatients and critical care patients have reduced.
7. Planned care recovery continues. All areas were ahead of recovery plan targets with the exception of elective day case endoscopy (86%) and elective inpatients (62%) which was an improvement on February. MediNet continue to provide weekend lists. The 5th room to support capsule endoscopy is close to being operationalised. Clinical prioritisation has progressed with 98.4% of patients now reviewed.
8. The waiting list has increased in March with 17,354 patients on the waiting list. The average wait has reduced slightly and the percentage being treated within 18 weeks has increased.
9. Provisional data indicate that 3 of the 7 applicable cancer waiting times standards were achieved in March, a continuation from previous months. Breast referrals exceed the number of slots available and additional clinic capacity is being provided. There are some pathway delays particularly in colorectal surgery. Overall for 2020/21, all cancer standards were delivered with the exception of 14 day breast symptomatic attendances

and the 62 day screening treatments.

10. ED performance against the 4-hour standard was below 95% in March with a year-to-date performance of 89%. ED attendances rose sharply in March following the easing of lockdown measures.
11. Planning to site re-configuration post Covid is being finalised.
12. Work continues to improve performance/waiting times in community dental. Sickness and capacity in the paediatric team is continuing to impact on complex cases.
13. The workforce position in March showed substantive staffing behind plan by 72.89 whole time equivalents (wte), an improvement from February, whilst bank and agency staff exceeded plan by 36.99 and 12.92 wte respectively. The Trust vacancy rate was 3.56% in March, down from 3.96% in February.
14. The biggest vacancy rate remains in Children's and Community Directorate at 8.49% (88.31 wte variance to plan in March). The majority of vacancies are in community nursing, a number of which are planned vacancies as a result of the changing service model planned for the North Yorkshire service.
15. A forecast of recruitment activity towards full establishment was provided for registered nurses and care support workers. There is a strong workforce pipeline in the coming months but the volume of Care Support Worker recruits needs to be planned to ensure vacancies don't continue to increase.
16. The first half year planning totals for 2021/22 within the North Yorkshire and York system have now been agreed. The HDFT budgets set for the half year exceed the amount allocated by £3.4m. However, some costs are not included within the system allocation and there will be separate income for these. Taking this into account, assurance was given that the first half year planning position was favourable. Discussions continue in relation to allocations for the second half year and in particular around Covid costs seen as non-recurrent. Internal planning for the second half year is focusing on managing appropriately Covid and recovery costs as well as other cost pressures.
17. Activity planning for 2021/22 focuses on getting back to 2019/20 activity levels and a phased plan was presented. All points of activity are forecast to reach 85% of 2019/20 activity levels by July, however, this assumes no impact of social distancing by this point or change in case mix.
18. We expect very long waiting times to improve in 2021/22 but unless activity levels exceed 2019/20 levels it is likely that numbers waiting will remain at current levels.
19. An update was given on business development activity largely in relation to 0-19 services.
20. Progress report was given on the Salix Carbon Reduction Project. Grant of £1m has been requested so far and works will be dovetailed into the operation of the hospital in the coming months. A monthly update will be presented to the Resources Committee.
21. The Resources Committee Annual report and Effectiveness Survey were presented.

22. **10th May 2021** – This meeting was called to give scrutiny to the 2021/22 activity and work-force plans in advance of finalisation. The assumptions made in formulating the work-force plan were outlined and scrutinised by the Committee.

23. The work-force plan has been formulated taking account of planned staffing, reflecting 2019/20 exit run rates, with adjustments for service needs and non-recurrent items (such as Covid-19 related schemes). Assumptions have been made in respect of retained students. Projected staffing numbers throughout 2021/22 incorporate planned recruitment based on 2020/21. Similarly, sickness levels in excess of the 3.9% included in the staffing establishment, is assumed to be filled by bank and agency staff.

24. One area of risk for the Trust is the recruitment of Health Visitors and School Nurses. Recruitment plans need to be developed to ensure vacancies do not increase throughout the year. Close monitoring of this position is required.

25. The activity plans for 2021/22 are based on returning to 2019/20 activity levels phased throughout the year. Planning guidance is to aim for 70% elective recovery overall in April 2021, rising to 80% in June and 85% in September. The activity plans have been drawn up from Directorates and assurances were received that staffing numbers within the workforce plan were sufficient to deliver the activity plans presented.

26. **Month 1 – 24th May 2021 –** The Trust achieved its planned break-even position in April 2021. NHS commissioner income is agreed for months 1 to 6. Local Authority income is based at contract levels and other non-NHS income is based on directorate plans. Additional NHS income has been claimed for testing, vaccinations and trainee nurse associates.
27. Favourable variances are reported overall from directorates however this position includes some significant overspends when seen alongside service delivery and therefore present a risk going forwards. Key actions to address these overspends include private patient income, addressing non-recurrent costs, rostering of ward nurses and hotel services staff (HIF).
28. The monthly cash forecast shows a steady use of cash throughout the year reflecting the capital programme commitment and the continuation of paying creditors promptly.
29. The capital programme for 2021/22 totals in excess of £32m including the Salix Carbon Reduction schemes. This is an ambitious programme and will need careful monitoring throughout the year to keep it on track.
30. There are currently no Covid-19 inpatients with the hospital. In terms of planned care recovery, 100% of the April plan has been achieved across all points of delivery. All points of delivery are above the Elective Recovery Fund requirement of 70% (against April 2019), with the exception of day case endoscopy.

31. Numbers on the waiting list at the end of April are forecast to be up from the March position. The average wait increased from 15.1 to 16.9 weeks and the percentage waiting within 18 weeks increased by 1% (to 73%). People waiting more that 40 weeks are concentrated in 6 specialties (general surgery, urology, Trauma and Orthopaedics, Ophthalmology, Gynaecology and Community Dental).
32. Elective theatres are now fully up and running with focus on stepping levels back up to 2019/20 levels. 98.6% of patients on the admissions list have been clinically reviewed. The majority of those outstanding have been waiting up to 2 weeks and are endoscopy referrals.
33. Provisional data indicates the 62 day cancer standard was met in April. The number of 2WW and non-cancer related breast symptomatic referrals continue to be higher than the number of weekly appointment slots and subsequently the 2WW target was not met in April.
34. The 95% A&E 4-hour standard was not met in April (86.3%). Work continues to reduce bottle necks to flow linked to Covid-19 processes. 6 hour stays in ED remain low. ED attendances are back to pre-Covid levels.
35. Pressure remains on community dental services, seeking to increase capacity.
36. Substantive staff in post in April was ahead of plan by 38.65 whole time equivalents (wte) and these were across all four directorates. Bank and agency numbers were also ahead of plan in April. Rostering to be reviewed to make sure we are rostering at optimum levels.
37. There are 42.56 wte vacancies within community nursing. Recruitment and retention initiatives are in progress. Rolling adverts will be progressed throughout the year. The current level of vacancies could impact on service delivery in the 0-19 services.
38. There is a strong pipeline of nurses and care support workers due to join the Trust from May onwards. Changes to the workforce information presented were requested to better triangulate vacancies and pipeline numbers in key areas.
39. Temporary staffing exceeded the NHSEI plan in April.
40. The Committee received and noted a summary of the plans that have been included within the overall system plan for 2021/22, all of which were considered by Resources Committee at earlier meetings.
41. A verbal operational update on the Salix carbon reduction programme was received. It is confirmed that all grant monies must be spent by March 2022.
42. The Committee Terms of Reference were considered and some changes proposed to better reflect the responsibilities of the Committee. These will be presented at the next meeting.

**Are there any significant risks for noting by Board? (list if appropriate)**

- Vacancies in Health visitors and school nurses are significant and will impact on the service unless a solution to fill the gaps can be developed.

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

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Operational Update

| | |
|---|---|
| **Agenda Item Number:** | **10.2** |
| **Presented for:** | Discussion, Information |
| **Report of:** | Chief Operating Officer |
| **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** | √ |

**10.2**

| **Recommendation:** |
|---|
| The Board is asked to discuss and note this report. |

Harrogate and District
NHS Foundation Trust

# Operational Report

## Board of Directors Meeting
## 26 May 2021

Russell Nightingale
Chief Operating Officer

# 11.1 Operational Update May 2021

NHS
Harrogate and District
NHS Foundation Trust

## Matters of concern & risks to escalate

- 2ww Cancer performance – high levels of demand in breast, plans underway to mitigate increases
- RTT Waiting list continues to grow - longer waits in T&O, Ophthalmology, Gynaecology and Dental
- 4-hour performance – recovery to mid eighty percent performance – difficulty exceeding 90-95% performance whilst COVID testing, increased presentations and social distancing remains in place (detail in ED slide)
- Safeguarding pressures, workforce concerns in CC directorate
- Increased focus on elective recovery across all points of delivery. The directorates overachieved against April 2021 plan levels however only delivered 75% against 2019 levels of activity which will remain the focus in the coming months. The 25% reduction against 2019 levels is primarily made up of a 16% Waiting list initiative (WLI) gap and 9% IPC restrictions and theatre efficacy. Plans are being worked up on how to bridge the WLI gap and IPC restrictions are being continuously reviewed.

## Major actions commissioned & work underway

- Increase theatre efficacy: theatre scheduling, 6:4:2, slot and time utilisation, review of job plans, review of annual leave process
- Reconfiguration to hospital wards/departments – improve adjacencies and fit with SALIX/capital plan works, completion 31/08/21
- Reconfiguration of ED/ hot floor (Estates and Staffing) – RPIW to design model and implementation scheduled for 7th and 8th June
- CC – workforce actions and tracking of pressures, 0-19 Band 6 roles are currently experiencing a 9% vacancy rate. Combined with an increase in referrals, senior support working with directorate team to mitigate
- Additional community dental sites to be AGP enabled
- HDFT In discussion with LTHT regarding Wharfedale increased usage 7 days per week.
- Weekly access meeting established to monitor and improve performance across constitutional standards

## Positive news & assurance

- Re-established Elective Surgical Ward and recommenced main theatre elective activity, increase grip on productivity
- COVID -19 - numbers have now decreased to two inpatients across the Trust (11/05/21) and zero patients in ICU with Covid-19
- MediNet insourcing is now live, five rooms are now operational
- ERF target met across all points of delivery for April 2021
- Green Surgical High Observation Bay established to improve treatment of complex surgical cases
- Length of Stay performance is stable, ARCHS have consistently supported 37 patients in the community who would normally be in a hospital bed
- Additional breast clinic work is now underway
- 98.6% of patients waiting have clinical prioritisation in place. Average waits in weeks for treatment P2 (5), P3 (12), P4 (25)
- Cancer long waiters have reduced by 4 patients from March position
- Zero 12 hour breaches and zero 60 minute ambulance b

## Decisions made & decisions required of the Board

- Increased day case recovery from 10 to 18 beds as agreed by IPC and DIPC

# COVID Management Report @11.05.2021

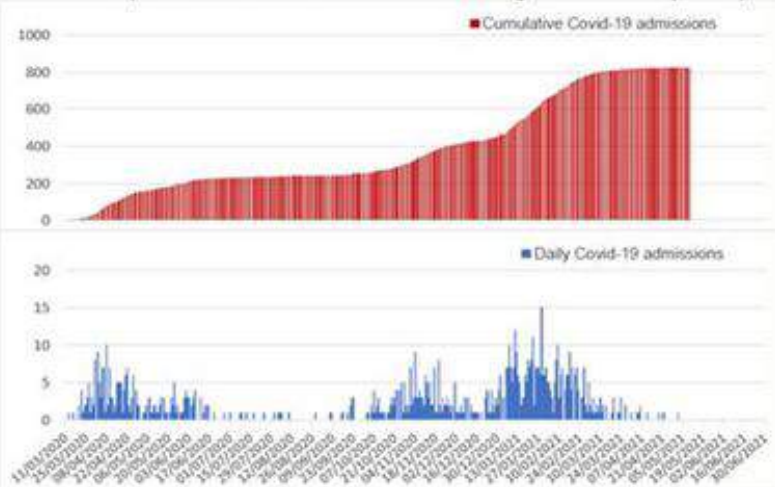
NHS
Harrogate and District
NHS Foundation Trust

***Currently 2 Covid inpatients with 0 patients in ICU***

## HDFT COVID-19 MANAGEMENT REPORT

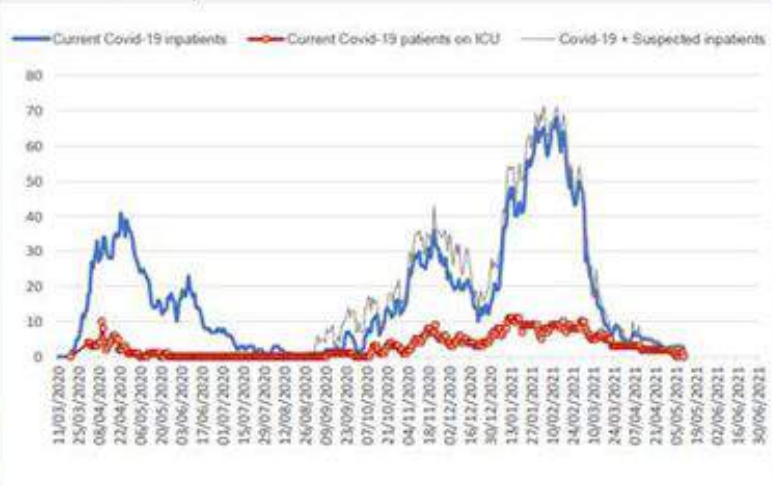
### Inpatients with confirmed Covid-19 (NHSE Daily Sit Rep)

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




| Yesterday | To date | Last 7 days | 8-14 days ago |
|---|---|---|---|
| 0 | 825 | 0 | 1 |

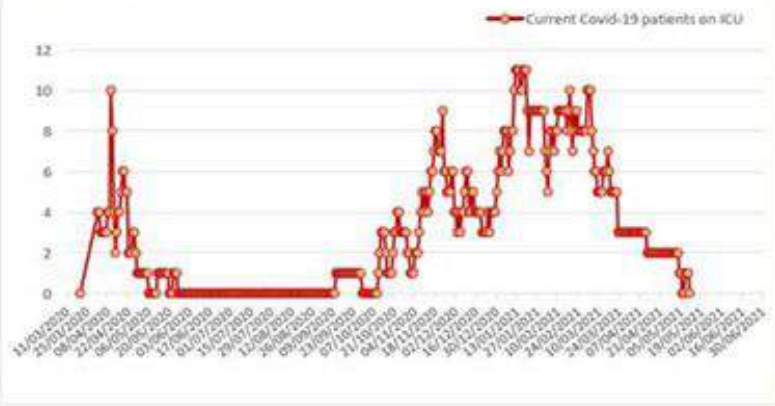
**Current Covid-19 inpatients**




| Today | Yesterday | 7 days ago | 14 days ago |
|---|---|---|---|
| 2 | 3 | 3 | 2 |

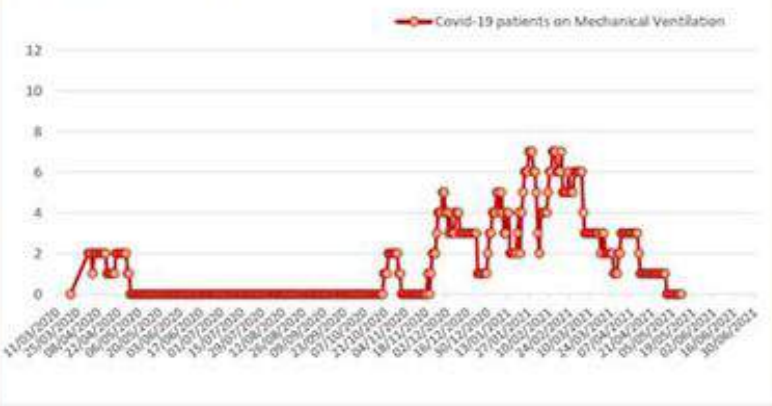
***Note**: Admission data **excludes** inpatients whose first positive swab was reported after discharge, and **includes** patients with a positive result who died in hospital before the result was known*

**Current ICU patients**




| Today | Yesterday | 7 days ago | 14 days ago |
|---|---|---|---|
| 0 | 1 | 1 | 2 |

**Mechanical Ventilation**




| Today | Yesterday | 7 days ago | 14 days ago |
|---|---|---|---|
| 0 | 0 | 0 | 1 |

10.2

# Planned Care Recovery

## Planned Care Recovery – Performance Against Plan and 2019/20

| TRUST TOTAL | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **12,984** | **11,515** | **14,449** | **113%** | **90%** |
| New Outpatients (Cons Led) | 4,262 | 3,818 | 4,847 | 112% | 88% |
| Follow Up Outpatients (Cons Led) | 8,722 | 7,697 | 9,602 | 113% | 91% |
| Elective Daycases (excl endoscopy) | 1,503 | 1,495 | 1,796 | 101% | 84% |
| Elective day case endoscopy | 657 | 617 | 1,099 | 106% | 60% |
| **Elective Daycase Total** | **2,160** | **2,112** | **2,895** | **102%** | **75%** |
| **Elective Inpatients** | **194** | **185** | **253** | **105%** | **77%** |

| PSC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **10,367** | **8,965** | **11,919** | **116%** | **87%** |
| New Outpatients (Cons Led) | 3,585 | 3,027 | 4,011 | 118% | 89% |
| Follow Up Outpatients (Cons Led) | 6,782 | 5,938 | 7,908 | 114% | 86% |
| Elective Daycases (excl endoscopy) | 586 | 540 | 832 | 109% | 70% |
| Elective day case endoscopy | 657 | 617 | 1,099 | 106% | 60% |
| **Elective Daycase Total** | **1,243** | **1,157** | **1,931** | **107%** | **64%** |
| **Elective Inpatients** | **183** | **177** | **244** | **103%** | **75%** |

| LTUC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **2,083** | **1,988** | **1,979** | **105%** | **105%** |
| New Outpatients (Cons Led) | 552 | 653 | 673 | 85% | 82% |
| Follow Up Outpatients (Cons Led) | 1,531 | 1,335 | 1,306 | 115% | 117% |
| Elective Daycases (excl endoscopy) | 903 | 933 | 933 | 97% | 97% |
| Elective day case endoscopy | 0 | 0 | 0 | - | - |
| **Elective Daycase Total** | **903** | **933** | **933** | **97%** | **97%** |
| **Elective Inpatients** | **6** | **7** | **8** | **86%** | **75%** |

| CCCC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **534** | **562** | **551** | **95%** | **97%** |
| New Outpatients (Cons Led) | 125 | 138 | 163 | 91% | 77% |
| Follow Up Outpatients (Cons Led) | 409 | 424 | 388 | 96% | 105% |
| Elective Daycases (excl endoscopy) | 14 | 22 | 31 | 64% | 45% |
| Elective day case endoscopy | 0 | 0 | 0 | - | - |
| **Elective Daycase Total** | **14** | **22** | **31** | **64%** | **45%** |
| **Elective Inpatients** | **5** | **1** | **1** | **500%** | **500%** |

| | | | |
|---|---|---|---|
| Apr 2021 v Plan % Delivered RAG | >=95% | 80-94% | <80% |
| Apr 2021 v Apr2019 % Delivered RAG | >=70% | 60-69% | <60% |

### Summary

- >100% performance against plan in April across all points of delivery
- All points of delivery are above the ERF requirement of 70% against April 2019 (except for Endoscopy)
- Outpatients were 113% against plan in April and 90% against April 2019. The Trust continues to encourage patients to attend booked appointments, the DNA rate for outpatients was 3.5% for New attendances and 5% for Follow Up Attendances in April.
- Day case and endoscopy cases were 102% against plan in March and 75% against April 2019, this will continue to improve in May with MediNet supporting the endoscopy work at weekends, the opening of elective theatres, increased open beds on the Elective Surgical Unit. The plan for the 5th room to support capsule endoscopy is close to being operationalised.

# Planned Care Recovery – Performance



**Outpatient clinics**

- Outpatient activity was above plan in April for both new and follow up attendances achieving 90% of April 2019 outturn. Performance was also above the ERF requirement of 70%.
- Current forecast for May is in line with April's outturn and will be shared separately

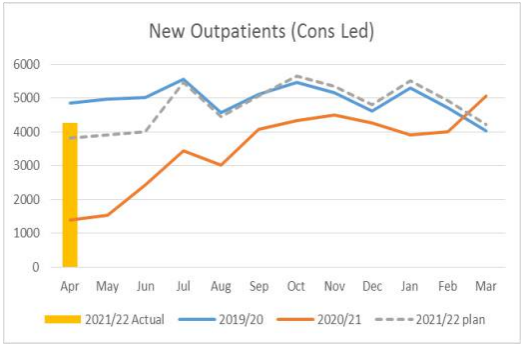
**Elective Recovery**

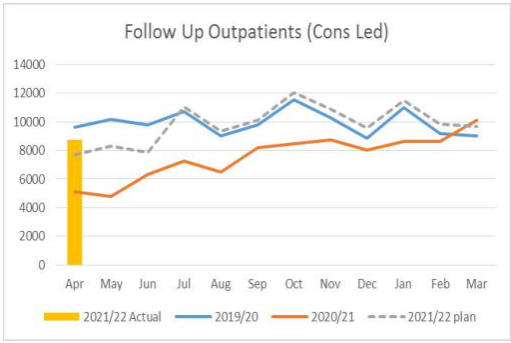
- Elective theatres now fully up and running whilst adhering to IPC guidance
- Theatres and Endoscopy staff have now returned to elective sessions
- Focus remains on stepping levels of activity back up to 2019/20 levels despite local ERF targets

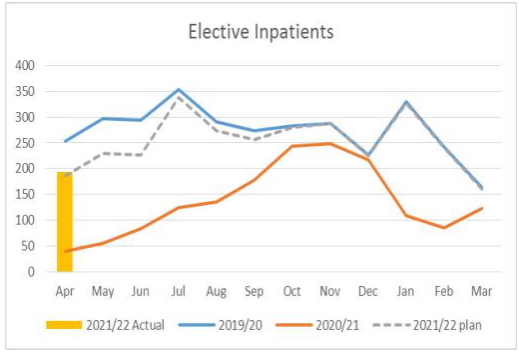
**Clinical Prioritisation & Review**

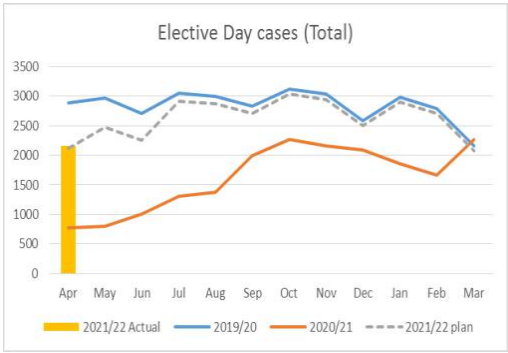
- 98.6% of patients have now been clinically reviewed and allocated a P1-6 national classification for surgery rating. The majority of those outstanding (39/63) have been waiting <=2 weeks and are urgent endoscopy referrals. This information is tracked weekly at the newly formed Access Meeting.
- 88% of P2 patients have been waiting less than 28-days, there is still a large element of patient choice due to Covid-19 and the type of procedure. A new monitoring process is now in place and for May there will be an RCA completed for every patient not booked within the time parameters with a subsequent harm review if a breach.
- Clinical Prioritisation and review to be reviewed through PSC Quality & Safety Governance Meeting.

**Planned Care Recovery**



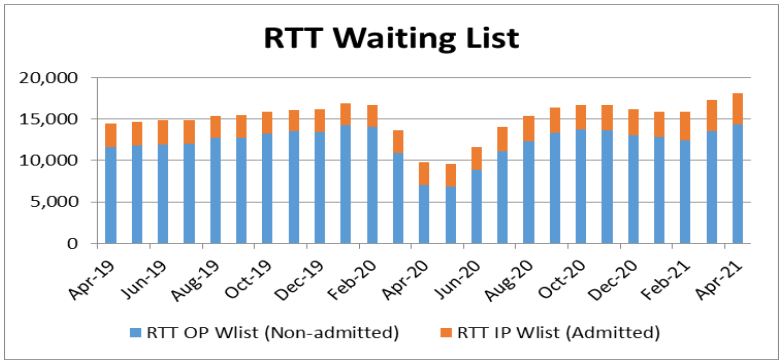



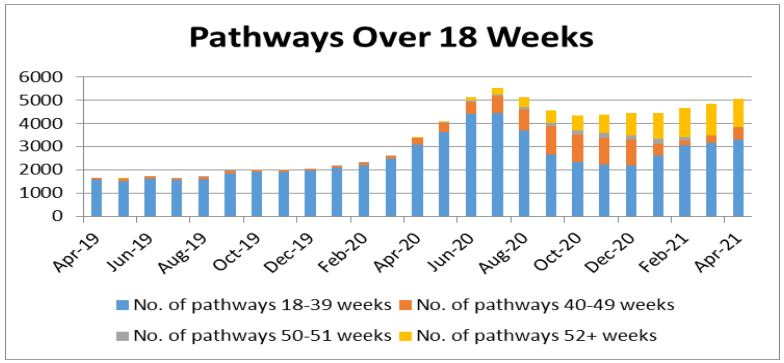



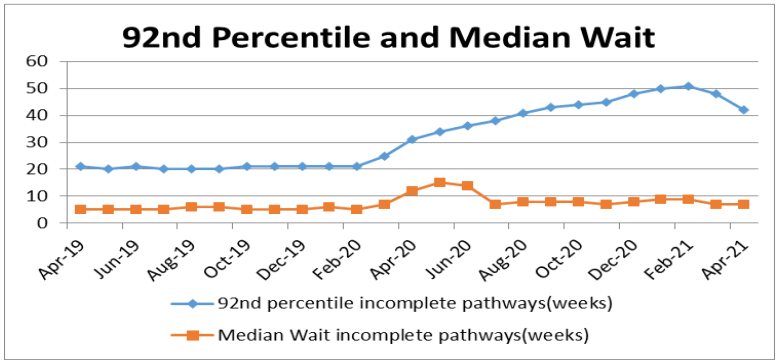

Waiting Times by Clinical Priority including endoscopy (Admissions)

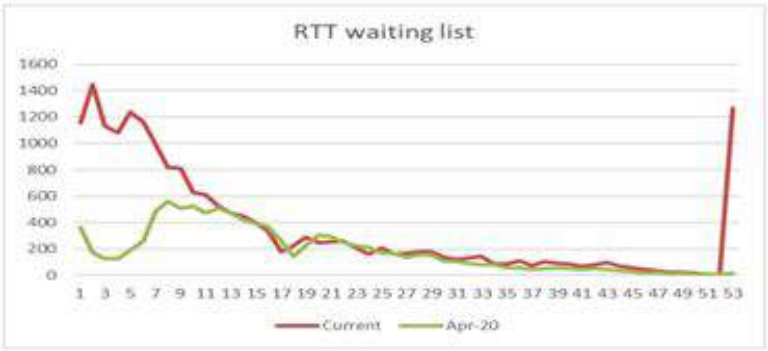
| Weeks Waiting | Not Rec | P1A | P1B | P2 | P3 | P4 | P5 | P6 |
|---|---|---|---|---|---|---|---|---|
| 0-2 | 39 | 1 | 0 | 279 | 264 | 253 | 0 | 0 |
| 3-4 | 5 | 0 | 0 | 34 | 101 | 114 | 0 | 0 |
| 5-6 | 6 | 0 | 1 | 17 | 58 | 168 | 0 | 0 |
| 7-8 | 9 | 0 | 0 | 5 | 63 | 139 | 0 | 0 |
| 9-10 | 1 | 0 | 0 | 4 | 41 | 167 | 3 | 0 |
| 11-12 | 0 | 0 | 0 | 0 | 56 | 218 | 3 | 0 |
| 13-14 | 0 | 0 | 0 | 2 | 38 | 202 | 5 | 0 |
| 15+ | 3 | 0 | 0 | 11 | 358 | 1,755 | 25 | 0 |
| Total | 63 | 1 | 1 | 352 | 979 | 3,016 | 36 | 0 |

# Planned Care Recovery – RTT Performance




| Treatment function | 40-52 | 52-62 | 62-72 | 72-82 | 82-92 | 92-104 | 104+ | Total - 40+ |
|---|---|---|---|---|---|---|---|---|
| General Surgery | 84 | 23 | 50 | 39 | 24 | 8 | 0 | 228 |
| Urology | 31 | 13 | 36 | 30 | 10 | 6 | 0 | 126 |
| Breast Surgery | 0 | 1 | 3 | 3 | 1 | 0 | 0 | 8 |
| Vascular Surgery | 11 | 5 | 2 | 0 | 0 | 0 | 0 | 18 |
| T&O | 236 | 23 | 64 | 79 | 41 | 17 | 1 | 461 |
| ENT | 7 | 3 | 4 | 1 | 0 | 0 | 0 | 15 |
| Ophthalmology | 17 | 11 | 36 | 24 | 1 | 0 | 0 | 89 |
| Oral & max fax | 18 | 1 | 6 | 3 | 0 | 0 | 0 | 28 |
| Gastroenterology | 12 | 2 | 3 | 0 | 0 | 0 | 0 | 17 |
| Endocrinology | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 5 |
| Hepatology | 10 | 1 | 0 | 0 | 0 | 0 | 0 | 11 |
| Cardiology | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| Dermatology | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 5 |
| Respiratory Medicine | 13 | 0 | 0 | 3 | 0 | 0 | 0 | 16 |
| Nephrology | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Medical Oncology | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Neurology | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Rheumatology | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Paediatrics | 5 | 1 | 0 | 1 | 0 | 0 | 0 | 7 |
| Elderly Medicine | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Gynaecology | 45 | 13 | 34 | 35 | 18 | 15 | 1 | 161 |
| Physiotherapy | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Community Dental | 90 | 184 | 247 | 88 | 3 | 0 | 0 | 612 |
| Grand Total | 594 | 282 | 489 | 307 | 99 | 46 | 2 | 1819 |

**Referral to Treatment (RTT)**

- The Trust now has over- 18,987 patients waiting at the end of April, this is a 926 patient increase on the March position; 1,225 patients waiting over 52 weeks and 1,819 waiting over 40 weeks
- The 92nd centile reduced from 48.7 to 42.4 and the median wait remained static at 9.1 weeks highlighting grip on the scheduling process

# Cancer Performance

NHS
Harrogate and District
NHS Foundation Trust

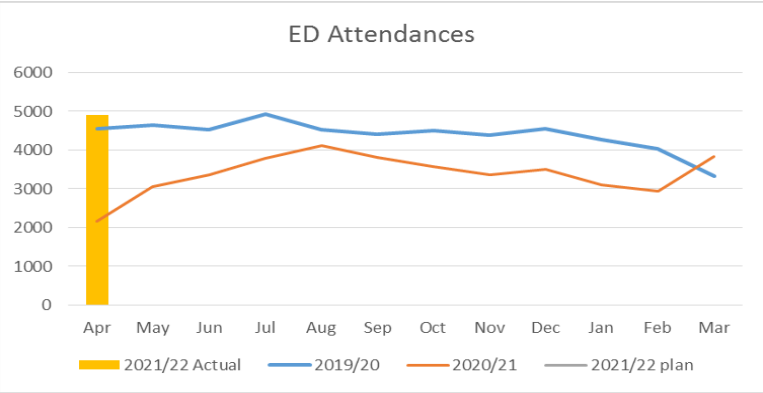
## Summary

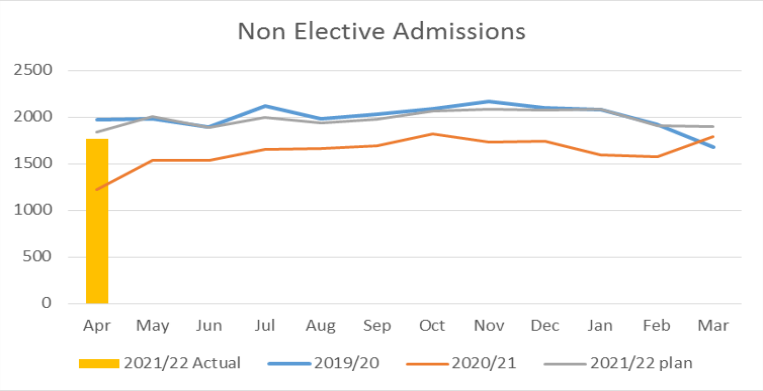
- Provisional data indicates the 62 day standard was delivered in April 2021 (86.2%) and the two week wait standard failed at 86% for the seventh consecutive month.
- 21 Patients over 62 days and 6 patients over 104 days waiting for treatment, a marked reduction over previous months but a key area of focus with the main tumour site breaching is colorectal. Demand and capacity analysis is currently underway to understand the shortfall in colorectal capacity and how to remedy the high breach numbers. An output will be presented to June board.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots, and the average wait for a 2WW breast appointment in April was around 24 days, compared to 18 days last month. Of 805 first attendances for suspected cancer, 148 were seen after day 14 (81.6%) and of these, 129 were breast referrals.
- 62 day Screening performance was below the 90% standard in April, and activity levels were above the de minimus for the month with 10 patients attributable to HDFT (equivalent to 6.0 accountable treatments), and of these 3 patients was treated after day 62 – when re-allocation rules are applied this equates to 66.7% of patients treated within 62 days.
- 88 first definitive treatments were delivered in April and 4 patients received their surgical treatment after day 31 (2 x Breast; 2 x Colorectal), and 6 surgical subsequent treatments were delivered in April after day 31
- Pathway delays are reviewed every month by the breach panel.

## Cancer Long waits by clinical site

| | 31/08/2020 | | | 30/09/2020 | | | 31/10/2020 | | | 30/11/2020 | | | 31/12/2020 | | | 31/01/2021 | | | 28/02/2021 | | | 31/03/2021 | | | 30/04/2021 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 2 | 18 | 1 | 1 | 13 | 0 | 1 | 12 | 0 | 0 | 20 | 1 | 0 | 16 | 3 | 0 | 17 | 1 | 0 | 13 | 0 | 0 | 16 | 1 | 0 |
| Children | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Colorectal | 253 | 32 | 39 | 243 | 42 | 16 | 246 | 24 | 11 | 172 | 11 | 6 | 222 | 26 | 2 | 188 | 19 | 5 | 194 | 13 | 9 | 178 | 13 | 7 | 213 | 14 | 5 |
| Gynaecological | 35 | 1 | 1 | 42 | 4 | 0 | 40 | 3 | 1 | 36 | 0 | 0 | 66 | 3 | 0 | 40 | 4 | 0 | 38 | 2 | 0 | 46 | 0 | 1 | 65 | 1 | 0 |
| Haematological | 7 | 0 | 0 | 2 | 0 | 0 | 7 | 0 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 6 | 0 | 0 | 5 | 0 | 0 | 6 | 1 | 0 | 7 | 1 | 1 |
| Head and Neck | 23 | 2 | 1 | 36 | 1 | 0 | 21 | 3 | 0 | 20 | 0 | 0 | 39 | 0 | 0 | 24 | 1 | 0 | 17 | 2 | 0 | 27 | 0 | 1 | 34 | 0 | 0 |
| Lung | 7 | 1 | 0 | 10 | 0 | 0 | 6 | 0 | 0 | 8 | 1 | 0 | 7 | 0 | 0 | 11 | 0 | 0 | 6 | 1 | 0 | 6 | 0 | 0 | 9 | 1 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 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 | 59 | 1 | 0 | 78 | 6 | 0 | 72 | 0 | 0 | 49 | 1 | 0 | 79 | 3 | 0 | 42 | 4 | 0 | 66 | 0 | 0 | 63 | 1 | 0 | 90 | 2 | 0 |
| Testicular | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 |
| Upper Gastrointestinal | 90 | 18 | 13 | 81 | 11 | 8 | 67 | 8 | 3 | 39 | 1 | 2 | 57 | 3 | 2 | 38 | 0 | 1 | 24 | 3 | 1 | 34 | 1 | 1 | 52 | 0 | 0 |
| Urological | 45 | 1 | 1 | 47 | 3 | 1 | 44 | 6 | 0 | 31 | 1 | 2 | 30 | 3 | 0 | 29 | 0 | 0 | 34 | 2 | 0 | 38 | 4 | 0 | 38 | 1 | 0 |
| Total | 532 | 56 | 57 | 558 | 68 | 26 | 516 | 44 | 16 | 372 | 15 | 10 | 525 | 39 | 4 | 396 | 31 | 6 | 402 | 24 | 10 | 414 | 21 | 10 | 528 | 21 | 6 |

# Urgent Care




## ED Performance

### Type 1

| | Apr 2021 |
|---|---|
| Seen | 4368 |
| Breaches | 669 |
| Performance (%) | 84.68 |

### Type 3

| | Apr 2021 |
|---|---|
| Seen | 534 |
| Breaches | 1 |
| Performance (%) | 99.81 |

### Overall Performan

| | Apr 2021 |
|---|---|
| Seen | 4902 |
| Breaches | 670 |
| Performance (%) | 86.33 |

## Summary

Performance against the A&E 4-hour standard remained below the 95% standard in April 2021 at 86.3%

There were zero 12 hour breaches in April

There were 7 x 30 minute handover breaches and 1 x 60 minute ambulance handover breaches.

ED attendances in April are now back at pre COVID levels.

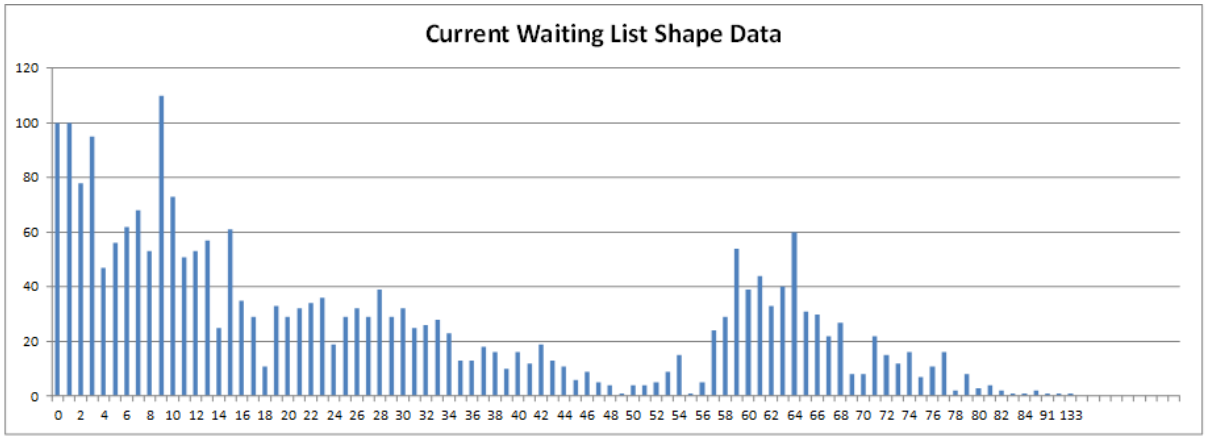
Non-Elective admissions also saw an increase with April's admissions at 90% of April 2019 levels. The Trust continued to experience bed pressures in April as a result of the flow of patients into beds and the number of yellow beds available.

The current ED clinical model will not deliver 95% performance. The model is medically led with no functional streaming in place. June 7th and 8th have been identified for an ED workshop to redesign the clinical model in ED and rapidly implement changes. NMUH are attending to help facilitate discussions regarding the change process and approaching the problem with a different lens.

A UEC dashboard will be launched during May for a live monitoring of ED flow and performance to increase Visibility

# Community and Children's Services -Community Dental

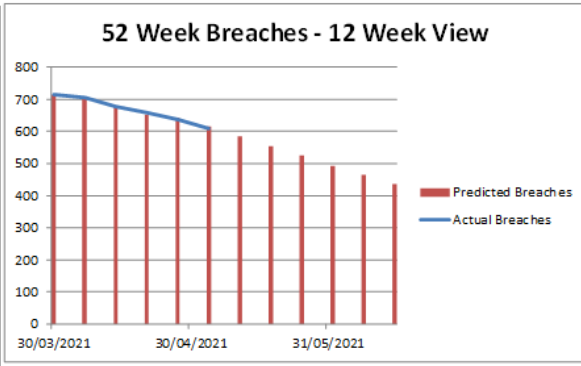
**Performance Summary**




| Performance Information | Current | Last Week |
|---|---|---|
| **Current Waiting List Size:** | 2,422 | 2,403 |
| No. Waiting for 1st Appointment: | 1,620 | 1,611 |
| No. Waiting for Outpatient Treatment: | 570 | 557 |
| No. Waiting for GA Treatment: | 232 | 235 |
| Longest Waiter: | 133 | 132 |
| | | |
| Average Weekly Referrals: | 58 | 65 |
| Weekly Outpatient Capacity: | 93 | 93 |
| Weekly GA Capacity: | 10 | 10 |
| | | |
| Outpatient Backlog Clearance Time (Weeks): | 23 | 24 |
| GA Backlog Clearance Time (Weeks): | 18 | 24 |

**52 Week Breaches**

| Week | Planned Activity | Actual Breaches | Predicted Breaches | Diff (+/-) |
|---|---|---|---|---|
| 30/03/2021 | 22 | 714 | 714 | 0 |
| 06/04/2021 | 31 | 705 | 703 | 2 |
| 13/04/2021 | 31 | 678 | 679 | -1 |
| 20/04/2021 | 31 | 659 | 652 | 7 |
| 27/04/2021 | 31 | 637 | 643 | -6 |
| 04/05/2021 | 33 | 609 | 614 | -5 |
| 11/05/2021 | 33 | | 585 | -585 |
| 18/05/2021 | 33 | | 553 | -553 |
| 25/05/2021 | 33 | | 525 | -525 |
| 01/06/2021 | 33 | | 493 | -493 |
| 08/06/2021 | 33 | | 464 | -464 |
| 15/06/2021 | 33 | | 437 | -437 |
| 22/06/2021 | 33 | | 415 | -415 |
| 29/06/2021 | 33 | | 386 | -386 |




- Recovery business case approved to increase capacity to 67% of pre-covid activity. This includes non-recurrent funding to recruit three dentists. Recruited two but unable to recruit the third (paediatric specialist dentist). Business case approved to change post to permanent – recruitment process in progress.

**Key risks**

- Sickness/capacity in paediatric team continuing to impact on complex Paeds cases.
- IV sedation capacity reduced on East Coast following capability issue.

Harrogate and District
NHS Foundation Trust

# Trust Board Operational Update

## 26 May 2021

**Russell Nightingale**
**Chief Operating Officer**

# 11.1 Operational Update May 2021

NHS
Harrogate and District
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## Matters of concern & risks to escalate

- 2ww Cancer performance – high levels of demand in breast, plans underway to mitigate increases
- RTT Waiting list continues to grow - longer waits in T&O, Ophthalmology, Gynaecology and Dental
- 4-hour performance – recovery to mid eighty percent performance – difficulty exceeding 90-95% performance whilst COVID testing, increased presentations and social distancing remains in place (detail in ED slide)
- Safeguarding pressures, workforce concerns in CC directorate
- Increased focus on elective recovery across all points of delivery. The directorates overachieved against April 2021 plan levels however only delivered 75% against 2019 levels of activity which will remain the focus in the coming months. The 25% reduction against 2019 levels is primarily made up of a 16% Waiting list initiative (WLI) gap and 9% IPC restrictions and theatre efficacy. Plans are being worked up on how to bridge the WLI gap and IPC restrictions are being continuously reviewed.

## Major actions commissioned & work underway

- Increase theatre efficacy: theatre scheduling, 6:4:2, slot and time utilisation, review of job plans, review of annual leave process
- Reconfiguration to hospital wards/departments – improve adjacencies and fit with SALIX/capital plan works, completion 31/08/21
- Reconfiguration of ED/ hot floor (Estates and Staffing) – RPIW to design model and implementation scheduled for 7th and 8th June
- CC – workforce actions and tracking of pressures, 0-19 Band 6 roles are currently experiencing a 9% vacancy rate. Combined with an increase in referrals, senior support working with directorate team to mitigate
- Additional community dental sites to be AGP enabled
- HDFT In discussion with LTHT regarding Wharfedale increased usage 7 days per week.
- Weekly access meeting established to monitor and improve performance across constitutional standards

## Positive news & assurance

- Re-established Elective Surgical Ward and recommenced main theatre elective activity, increase grip on productivity
- COVID -19 - numbers have now decreased to two inpatients across the Trust (11/05/21) and zero patients in ICU with Covid-19
- MediNet insourcing is now live, five rooms are now operational
- ERF target met across all points of delivery for April 2021
- Green Surgical High Observation Bay established to improve treatment of complex surgical cases
- Length of Stay performance is stable, ARCHS have consistently supported 37 patients in the community who would normally be in a hospital bed
- Additional breast clinic work is now underway
- 98.6% of patients waiting have clinical prioritisation in place. Average waits in weeks for treatment P2 (5), P3 (12), P4 (25)
- Cancer long waiters have reduced by 4 patients from March position
- Zero 12 hour breaches and zero 60 minute ambulance b

## Decisions made & decisions required of the Board

- Increased day case recovery from 10 to 18 beds as agreed by IPC and DIPC

# COVID Management Report @11.05.2021

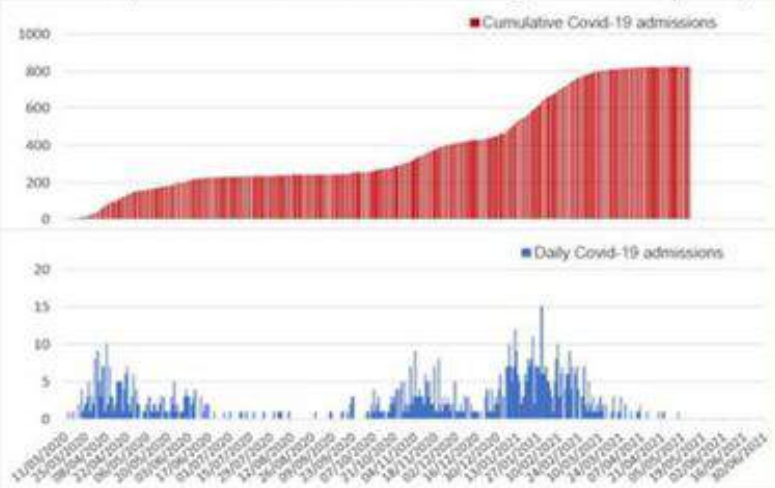
NHS Harrogate and District NHS Foundation Trust

***Currently 2 Covid inpatients with 0 patients in ICU***

## HDFT COVID-19 MANAGEMENT REPORT

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

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



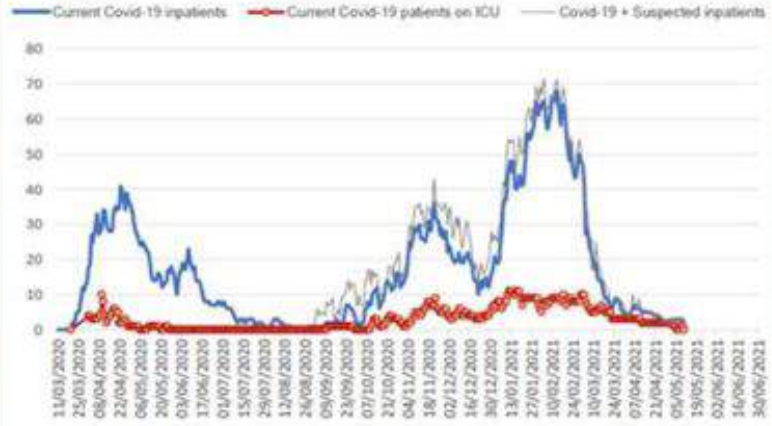

Yesterday 0

To date 825

Last 7 days 0

8-14 days ago 1

**Current Covid-19 inpatients**




Today 2

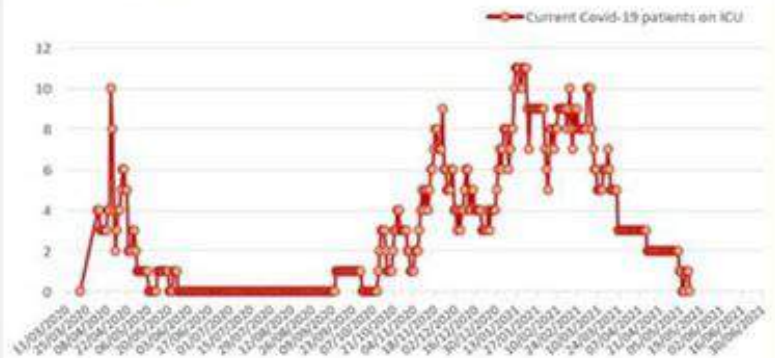
Yesterday 3

7 days ago 3

14 days ago 2

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

**Current ICU patients**



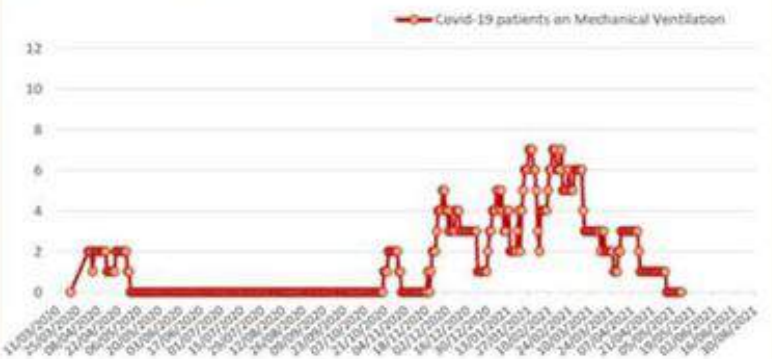

Today 0

Yesterday 1

7 days ago 1

14 days ago 2

**Mechanical Ventilation**




Today 0

Yesterday 0

7 days ago 0

14 days ago 1

10.2

# Planned Care Recovery

## Planned Care Recovery – Performance Against Plan and 2019/20

| TRUST TOTAL | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **12,984** | **11,515** | **14,449** | **113%** | **90%** |
| New Outpatients (Cons Led) | 4,262 | 3,818 | 4,847 | 112% | 88% |
| Follow Up Outpatients (Cons Led) | 8,722 | 7,697 | 9,602 | 113% | 91% |
| Elective Daycases (excl endoscopy) | 1,503 | 1,495 | 1,796 | 101% | 84% |
| Elective day case endoscopy | 657 | 617 | 1,099 | 106% | 60% |
| **Elective Daycase Total** | **2,160** | **2,112** | **2,895** | **102%** | **75%** |
| **Elective Inpatients** | **194** | **185** | **253** | **105%** | **77%** |

| PSC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **10,367** | **8,965** | **11,919** | **116%** | **87%** |
| New Outpatients (Cons Led) | 3,585 | 3,027 | 4,011 | 118% | 89% |
| Follow Up Outpatients (Cons Led) | 6,782 | 5,938 | 7,908 | 114% | 86% |
| Elective Daycases (excl endoscopy) | 586 | 540 | 832 | 109% | 70% |
| Elective day case endoscopy | 657 | 617 | 1,099 | 106% | 60% |
| **Elective Daycase Total** | **1,243** | **1,157** | **1,931** | **107%** | **64%** |
| **Elective Inpatients** | **183** | **177** | **244** | **103%** | **75%** |

| LTUC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **2,083** | **1,988** | **1,979** | **105%** | **105%** |
| New Outpatients (Cons Led) | 552 | 653 | 673 | 85% | 82% |
| Follow Up Outpatients (Cons Led) | 1,531 | 1,335 | 1,306 | 115% | 117% |
| Elective Daycases (excl endoscopy) | 903 | 933 | 933 | 97% | 97% |
| Elective day case endoscopy | 0 | 0 | 0 | - | - |
| **Elective Daycase Total** | **903** | **933** | **933** | **97%** | **97%** |
| **Elective Inpatients** | **6** | **7** | **8** | **86%** | **75%** |

| CCCC | Apr-21 | | | | |
|---|---|---|---|---|---|
| Point of Delivery | Actual 01/04 - 30/04 | Apr Plan | Apr 2019/20 | % vs Plan | % vs 19/20 |
| **Total Outpatients (Cons Led)** | **534** | **562** | **551** | **95%** | **97%** |
| New Outpatients (Cons Led) | 125 | 138 | 163 | 91% | 77% |
| Follow Up Outpatients (Cons Led) | 409 | 424 | 388 | 96% | 105% |
| Elective Daycases (excl endoscopy) | 14 | 22 | 31 | 64% | 45% |
| Elective day case endoscopy | 0 | 0 | 0 | - | - |
| **Elective Daycase Total** | **14** | **22** | **31** | **64%** | **45%** |
| **Elective Inpatients** | **5** | **1** | **1** | **500%** | **500%** |

| | | | |
|---|---|---|---|
| Apr 2021 v Plan % Delivered RAG | >=95% | 80-94% | <80% |
| Apr 2021 v Apr2019 % Delivered RAG | >=70% | 60-69% | <60% |

### Summary

- >100% performance against plan in April across all points of delivery
- All points of delivery are above the ERF requirement of 70% against April 2019 (except for Endoscopy)
- Outpatients were 113% against plan in April and 90% against April 2019. The Trust continues to encourage patients to attend booked appointments, the DNA rate for outpatients was 3.5% for New attendances and 5% for Follow Up Attendances in April.
- Day case and endoscopy cases were 102% against plan in March and 75% against April 2019, this will continue to improve in May with MediNet supporting the endoscopy work at weekends, the opening of elective theatres, increased open beds on the Elective Surgical Unit. The plan for the 5th room to support capsule endoscopy is close to being operationalised.

# Planned Care Recovery – Performance

NHS Harrogate and District NHS Foundation Trust

**Outpatient clinics**

- Outpatient activity was above plan in April for both new and follow up attendances achieving 90% of April 2019 outturn. Performance was also above the ERF requirement of 70%.
- Current forecast for May is in line with April's outturn and will be shared separately

**Elective Recovery**

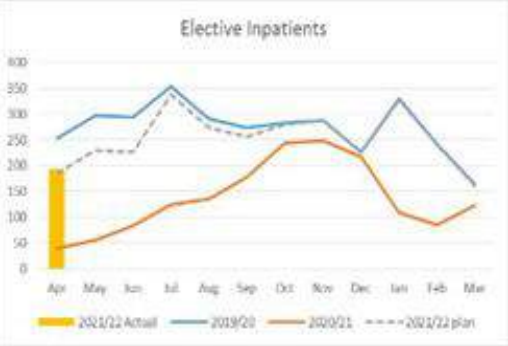
- Elective theatres now fully up and running whilst adhering to IPC guidance
- Theatres and Endoscopy staff have now returned to elective sessions
- Focus remains on stepping levels of activity back up to 2019/20 levels despite local ERF targets

**Clinical Prioritisation & Review**

- 98.6% of patients have now been clinically reviewed and allocated a P1-6 national classification for surgery rating. The majority of those outstanding (39/63) have been waiting <=2 weeks and are urgent endoscopy referrals. This information is tracked weekly at the newly formed Access Meeting.
- 88% of P2 patients have been waiting less than 28-days, there is still a large element of patient choice due to Covid-19 and the type of procedure. A new monitoring process is now in place and for May there will be an RCA completed for every patient not booked within the time parameters with a subsequent harm review if a breach.
- Clinical Prioritisation and review to be reviewed through PSC Quality & Safety Governance Meeting.

**Planned Care Recovery**







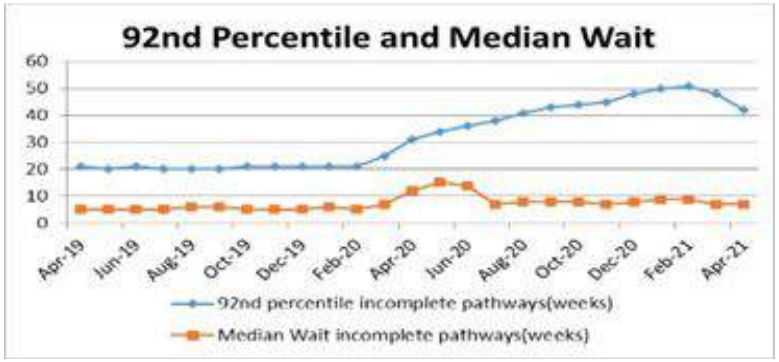
Waiting Times by Clinical Priority including endoscopy (Admissions)

| Weeks Waiting | Not Rec | P1A | P1B | P2 | P3 | P4 | P5 | P6 |
|---|---|---|---|---|---|---|---|---|
| 0-2 | 39 | 1 | 0 | 279 | 264 | 253 | 0 | 0 |
| 3-4 | 5 | 0 | 0 | 34 | 101 | 114 | 0 | 0 |
| 5-6 | 6 | 0 | 1 | 17 | 58 | 168 | 0 | 0 |
| 7-8 | 9 | 0 | 0 | 5 | 63 | 139 | 0 | 0 |
| 9-10 | 1 | 0 | 0 | 4 | 41 | 167 | 3 | 0 |
| 11-12 | 0 | 0 | 0 | 0 | 56 | 218 | 3 | 0 |
| 13-14 | 0 | 0 | 0 | 2 | 38 | 202 | 5 | 0 |
| 15+ | 3 | 0 | 0 | 11 | 358 | 1,755 | 25 | 0 |
| Total | 63 | 1 | 1 | 352 | 979 | 3,016 | 36 | 0 |

# Planned Care Recovery – RTT Performance

Harrogate and District NHS Foundation Trust







| Treatment function | 40-52 | 52-62 | 62-72 | 72-82 | 82-92 | 92-104 | 104+ | Total - 40+ |
|---|---|---|---|---|---|---|---|---|
| General Surgery | 84 | 23 | 50 | 39 | 24 | 8 | 0 | 228 |
| Urology | 31 | 13 | 36 | 30 | 10 | 6 | 0 | 126 |
| Breast Surgery | 0 | 1 | 3 | 3 | 1 | 0 | 0 | 8 |
| Vascular Surgery | 11 | 5 | 2 | 0 | 0 | 0 | 0 | 18 |
| T&O | 236 | 23 | 64 | 79 | 41 | 17 | 1 | 461 |
| ENT | 7 | 3 | 4 | 1 | 0 | 0 | 0 | 15 |
| Ophthalmology | 17 | 11 | 36 | 24 | 1 | 0 | 0 | 89 |
| Oral & max fax | 18 | 1 | 6 | 3 | 0 | 0 | 0 | 28 |
| Gastroenterology | 12 | 2 | 3 | 0 | 0 | 0 | 0 | 17 |
| Endocrinology | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 5 |
| Hepatology | 10 | 1 | 0 | 0 | 0 | 0 | 0 | 11 |
| Cardiology | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| Dermatology | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 5 |
| Respiratory Medicine | 13 | 0 | 0 | 3 | 0 | 0 | 0 | 16 |
| Nephrology | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Medical Oncology | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Neurology | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Rheumatology | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Paediatrics | 5 | 1 | 0 | 1 | 0 | 0 | 0 | 7 |
| Elderly Medicine | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Gynaecology | 45 | 13 | 34 | 35 | 18 | 15 | 1 | 161 |
| Physiotherapy | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Community Dental | 90 | 184 | 247 | 88 | 3 | 0 | 0 | 612 |
| Grand Total | 594 | 282 | 489 | 307 | 99 | 46 | 2 | 1819 |

**Referral to Treatment (RTT)**

- The Trust now has over- 18,987 patients waiting at the end of April, this is a 926 patient increase on the March position; 1,225 patients waiting over 52 weeks and 1,819 waiting over 40 weeks
- The 92nd centile reduced from 48.7 to 42.4 and the median wait remained static at 9.1 weeks highlighting grip on the scheduling process

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# Cancer Performance

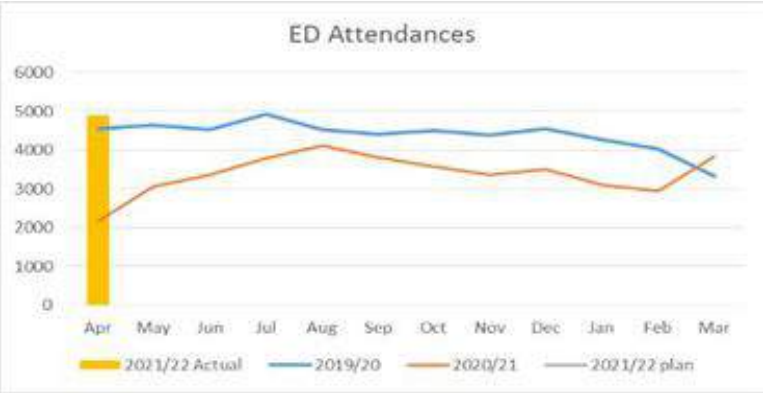
## Summary

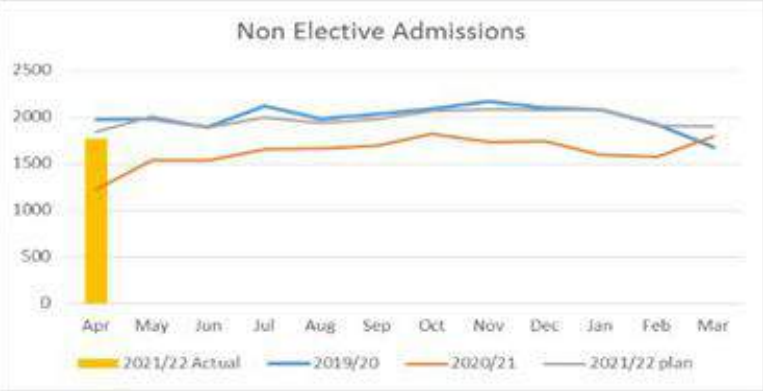

- Provisional data indicates the 62 day standard was delivered in April 2021 (86.2%) and the two week wait standard failed at 86% for the seventh consecutive month.
- 21 Patients over 62 days and 6 patients over 104 days waiting for treatment, a marked reduction over previous months but a key area of focus with the main tumour site breaching is colorectal. Demand and capacity analysis is currently underway to understand the shortfall in colorectal capacity and how to remedy the high breach numbers. An output will be presented to June board.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots, and the average wait for a 2WW breast appointment in April was around 24 days, compared to 18 days last month. Of 805 first attendances for suspected cancer, 148 were seen after day 14 (81.6%) and of these, 129 were breast referrals.
- 62 day Screening performance was below the 90% standard in April, and activity levels were above the de minimus for the month with 10 patients attributable to HDFT (equivalent to 6.0 accountable treatments), and of these 3 patients was treated after day 62 – when re-allocation rules are applied this equates to 66.7% of patients treated within 62 days.
- 88 first definitive treatments were delivered in April and 4 patients received their surgical treatment after day 31 (2 x Breast; 2 x Colorectal), and 6 surgical subsequent treatments were delivered in April after day 31
- Pathway delays are reviewed every month by the breach panel.


## Cancer Long waits by clinical site

| | 31/08/2020 | | | 30/09/2020 | | | 31/10/2020 | | | 30/11/2020 | | | 31/12/2020 | | | 31/01/2021 | | | 28/02/2021 | | | 31/03/2021 | | | 30/04/2021 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 2 | 18 | 1 | 1 | 13 | 0 | 1 | 12 | 0 | 0 | 20 | 1 | 0 | 16 | 3 | 0 | 17 | 1 | 0 | 13 | 0 | 0 | 16 | 1 | 0 |
| Children | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Colorectal | 253 | 32 | 39 | 243 | 42 | 16 | 246 | 24 | 11 | 172 | 11 | 6 | 222 | 26 | 2 | 188 | 19 | 5 | 194 | 13 | 9 | 178 | 13 | 7 | 213 | 14 | 5 |
| Gynaecological | 35 | 1 | 1 | 42 | 4 | 0 | 40 | 3 | 1 | 36 | 0 | 0 | 66 | 3 | 0 | 40 | 4 | 0 | 38 | 2 | 0 | 46 | 0 | 1 | 65 | 1 | 0 |
| Haematological | 7 | 0 | 0 | 2 | 0 | 0 | 7 | 0 | 0 | 3 | 0 | 0 | 1 | 0 | 0 | 6 | 0 | 0 | 5 | 0 | 0 | 6 | 1 | 0 | 7 | 1 | 1 |
| Head and Neck | 23 | 2 | 1 | 36 | 1 | 0 | 21 | 3 | 0 | 20 | 0 | 0 | 39 | 0 | 0 | 24 | 1 | 0 | 17 | 2 | 0 | 27 | 0 | 1 | 34 | 0 | 0 |
| Lung | 7 | 1 | 0 | 10 | 0 | 0 | 6 | 0 | 0 | 8 | 1 | 0 | 7 | 0 | 0 | 11 | 0 | 0 | 6 | 1 | 0 | 6 | 0 | 0 | 9 | 1 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 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 | 59 | 1 | 0 | 78 | 6 | 0 | 72 | 0 | 0 | 49 | 1 | 0 | 79 | 3 | 0 | 42 | 4 | 0 | 66 | 0 | 0 | 63 | 1 | 0 | 90 | 2 | 0 |
| Testicular | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 0 |
| Upper Gastrointestinal | 90 | 18 | 13 | 81 | 11 | 8 | 67 | 8 | 3 | 39 | 1 | 2 | 57 | 3 | 2 | 38 | 0 | 1 | 24 | 3 | 1 | 34 | 1 | 1 | 52 | 0 | 0 |
| Urological | 45 | 1 | 1 | 47 | 3 | 1 | 44 | 6 | 0 | 31 | 1 | 2 | 30 | 3 | 0 | 29 | 0 | 0 | 34 | 2 | 0 | 38 | 4 | 0 | 38 | 1 | 0 |
| Total | 532 | 56 | 57 | 558 | 68 | 26 | 516 | 44 | 16 | 372 | 15 | 10 | 525 | 39 | 4 | 396 | 31 | 6 | 402 | 24 | 10 | 414 | 21 | 10 | 528 | 21 | 6 |

# Urgent Care




## ED Performance

### Type 1

| | Apr 2021 |
|---|---|
| Seen | 4368 |
| Breaches | 669 |
| Performance (%) | 84.68 |

### Type 3

| | Apr 2021 |
|---|---|
| Seen | 534 |
| Breaches | 1 |
| Performance (%) | 99.81 |

### Overall Performan

| | Apr 2021 |
|---|---|
| Seen | 4902 |
| Breaches | 670 |
| Performance (%) | 86.33 |

## Summary

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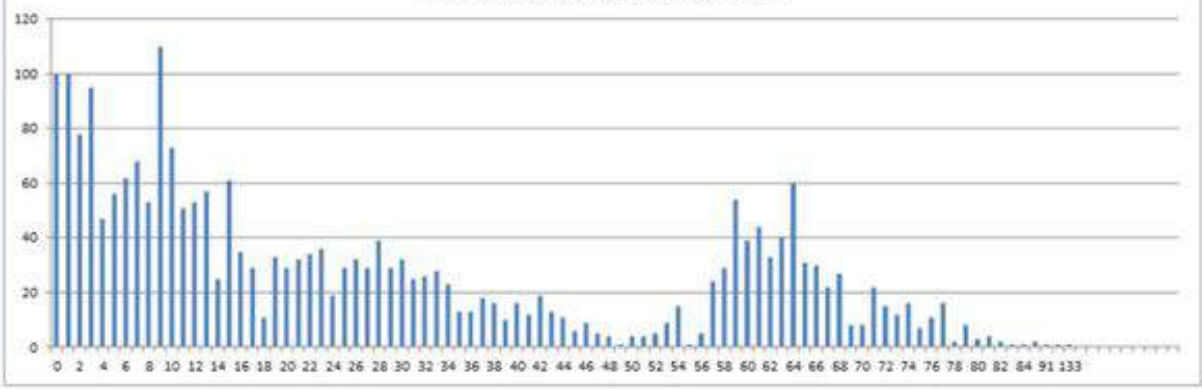


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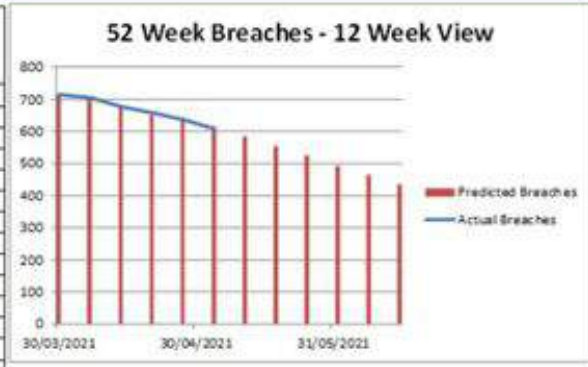
| 01/06/2021 | 33 | | 493 | -493 |
| 08/06/2021 | 33 | | 464 | -464 |
| 15/06/2021 | 33 | | 437 | -437 |
| 22/06/2021 | 33 | | 415 | -415 |
| 29/06/2021 | 33 | | 386 | -386 |




- Recovery business case approved to increase capacity to 67% of pre-covid activity. This includes non-recurrent funding to recruit three dentists. Recruited two but unable to recruit the third (paediatric specialist dentist). Business case approved to change post to permanent – recruitment process in progress.

**Key risks**

- Sickness/capacity in paediatric team continuing to impact on complex Paeds cases.
- IV sedation capacity reduced on East Coast following capability issue.

Harrogate and District NHS Foundation Trust

# Board of Directors Meeting (held in Public)
# 26 May 2021
# Financial Position and Annual Plan Update

| | |
|---|---|
| **Agenda Item Number:** | **10.3 and 10.3.1** |
| **Presented for:** | Discuss/Note |
| **Report of:** | Deputy Chief Executive/Finance Director |
| **Author (s):** | Deputy Chief Executive/Finance Director<br>Deputy Director of Finance |
| **Report History:** | Senior Management Team, 19 May 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** | ✓ |

10.3

**Recommendation:**

The Board is asked to:

1. note the work being progressed to review investments and to agree a financial plan for H2; and
2. note the planning submissions and priorities that are to be included within the system plan for HCV

Harrogate and District
NHS Foundation Trust

# Financial Position

## Board of Directors – 26/05/2021

10.3

# Financial performance & annual plan update

Harrogate and District NHS Foundation Trust



## Matters of concern & risks to escalate

- A number of areas of financial pressures that are being offset by savings due to lower levels of activity being delivered than 19/20 and by vacancies, particularly within the 0-19 service
- ensuring our ward rosters are in line with establishment, noting the work ongoing to return ratios to 19/20 levels
- Ability to utilise the additional funding available to deliver additional activity
- Ensuring delivery of capital investment programme
- The challenge of delivering our agreed plans and aligning our commitments with future available resources.

## Major actions commissioned & work underway

- Review of ward rosters and establishment to return the ratios to 19/20 levels
- Review of investments that were funded through non-recurrent Covid support funding. To be completed by end of June.
- Development of efficiency programme to reflect the current agreed cost pressures (£0.9m) and any other areas of financial risk later in the year.
- Modelling the impact of activity delivery on achievement of the Elective Recovery Fund (ERF)

## Positive news & assurance

- Delivery of financial plan overall at Trust level
- Significant investment programme contained with the financial plan (capital programme and supporting At Our Best)
- Annual plan developed and positive discussion and feedback received from the local system

## Decisions made & decisions required of the Board

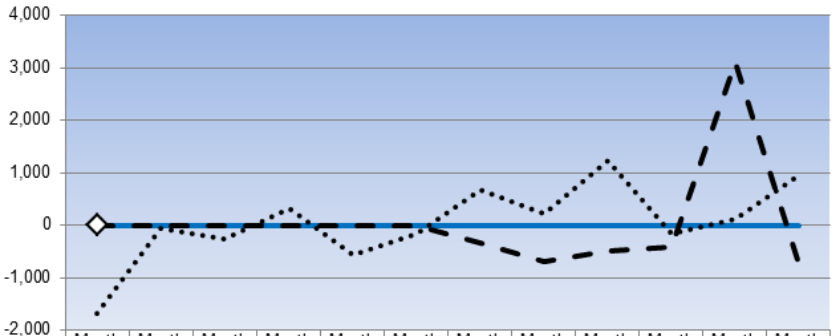
- To note the work being progressed to review investments and to agree a financial plan for H2.
- To note the planning submissions and priorities that are to be included within the system plan for HCV

# Financial Position

Harrogate and District NHS Foundation Trust

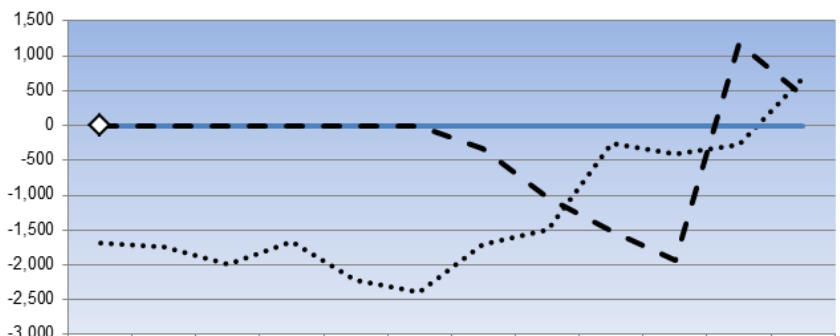
The Trust reported a breakeven position in April in line with the current plan. This is outlined in the graphs below.

**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 | 0 | 0 | 0 | 0 | 0 | 0 |
| Actual | 0 | | | | | | | | | | | |
| 2019/20 | -1,677 | -67 | -256 | 326 | -554 | -158 | 674 | 217 | 1,241 | -150 | 126 | 960 |
| 2020/21 | 0 | 0 | 0 | 0 | 0 | 0 | -340 | -693 | -491 | -402 | 3,100 | -745 |

**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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2019/20 | -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 | 0 | 0 | 0 | 0 | 0 | 0 |
| Actual | 0 | | | | | | | | | | | |
| 2020/21 | 0 | 0 | 0 | 0 | 0 | 0 | -340 | -1,033 | -1,524 | -1,926 | 1,174 | 429 |

NHS commissioner income is set at the block contract levels outlined by NHS England. These are agreed for month 1 to 6. Local Authority income is based at contract levels, and other non NHS income is set based on directorate plans.

This position is supported by £2.3m of Top up and Covid-19 funding. Top up funding is agreed for month 1 to 6, whilst Covid-19 funding will be reviewed at system level for quarter 2.

Finally in relation to income, NHS income outside of block has been claimed for testing, vaccinations and trainee Nurse Associates.

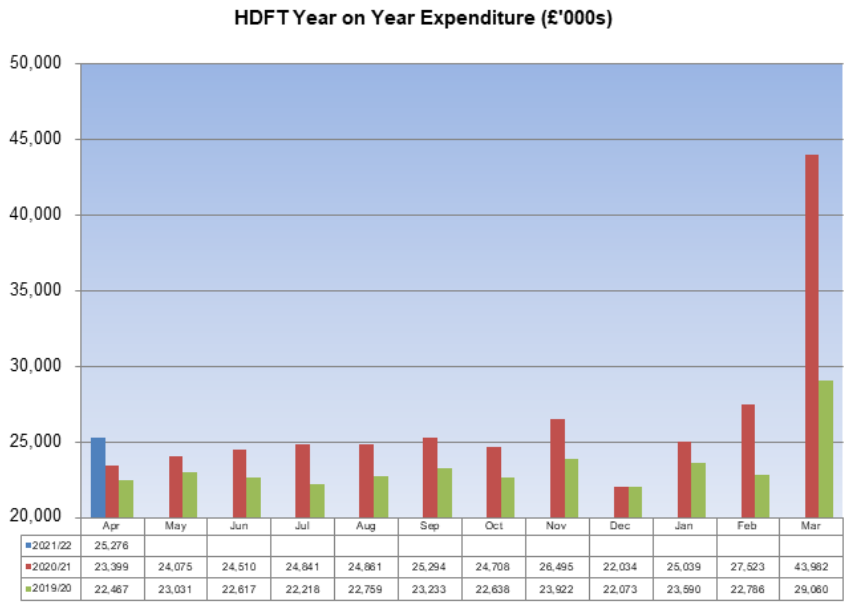
The following slide outlines the Trustwide expenditure position and Directorate financial performance.

Budgets are fully agreed for quarter 1, with quarter 2 expected to be finalised in the coming weeks. The impacts for the second half of the financial year are likely to result in efficiency requirements across the Trust.

# Expenditure and Directorate Position

Harrogate and District NHS Foundation Trust

The graph below outlines the Trustwide expenditure position.




The above outlines the significant increase in expenditure on a monthly basis compared to April 2019. No inflation has been included, however, this would only account for 1/3 of the movement. The tables below outline the same information in month for Pay and Non Pay.

| £'000s | Pay | Non Pay |
|---|---|---|
| 2021/22 | 15,847 | 9,429 |
| 2020/21 | 15,788 | 7,612 |
| 2019/20 | 15,268 | 7,199 |

The table below outlines directorate financial performance, including the overall consolidated position for HIF.

| Directorate | Apr Budget (£'000s) | Apr Actual (£'000s) | Apr Var (£'000s) | Apr Var (%) |
|---|---|---|---|---|
| Community and Childrens | 5,077 | 4,726 | (351) | -6.92% |
| Corporate | 3,679 | 3,789 | 110 | 3.00% |
| Long Term and Unscheduled Care | 6,077 | 6,113 | 36 | 0.59% |
| Planned and Surgical Care | 5,960 | 5,546 | (414) | -6.94% |
| **FT Position** | **20,792** | **20,174** | **(619)** | **-10.27%** |
| HIF | (17) | 65 | 82 | |
| **Consolidated Position** | **20,776** | **20,239** | **(537)** | **-2.58%** |

Whilst favourable variances are reported overall there are some significant overspends.

The underspends within Community and Childrens Directorate reflect the level of vacancies within the services, and the underspend within PSC Directorate is a reflection of our activity levels being below pre-CoVid levels. Whilst these variances could be viewed as positive financially, they are a reflection of service delivery risk and therefore need as much focus as areas where the financial position is an overspend.

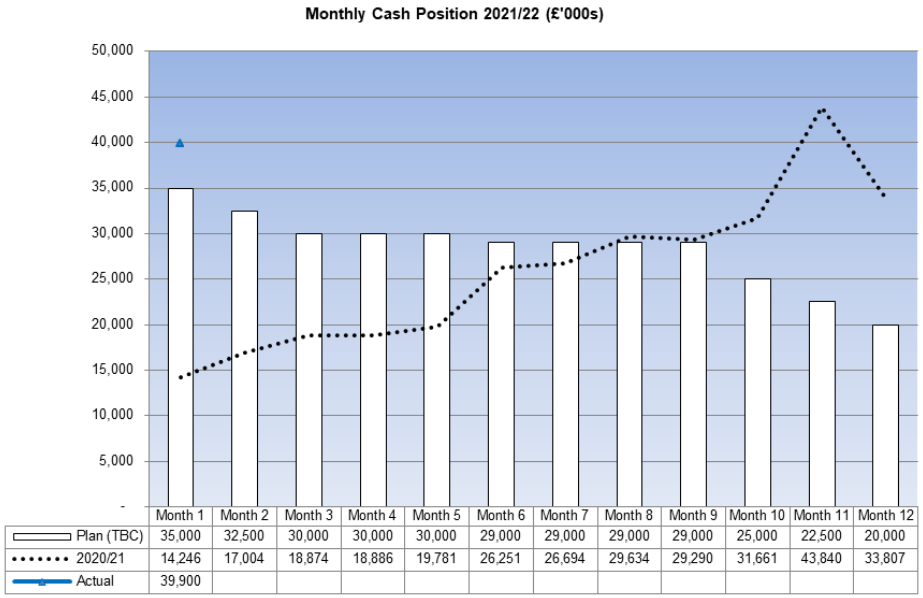
Directorates have been reviewing and addressing the drivers for the overspends. Key actions include private patient income and addressing some non-recurrent costs (corporate), the rostering of ward nurses (LTUC) and the rostering of hotel services staff (HIF)

# Cash and Capital

NHS Harrogate and District NHS Foundation Trust

## Cash

The graph below outlines the current cash position for the Trust.

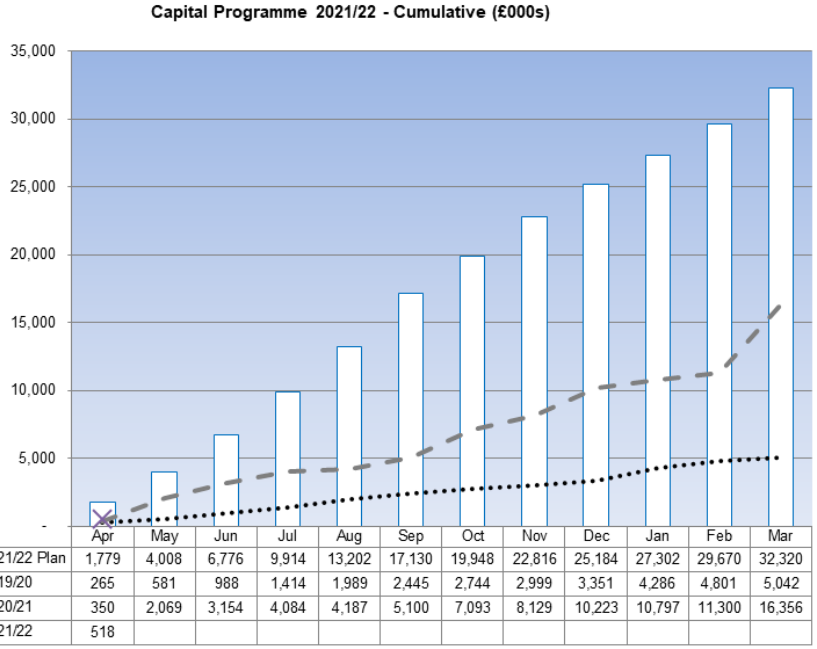



| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan (TBC) | 35,000 | 32,500 | 30,000 | 30,000 | 30,000 | 29,000 | 29,000 | 29,000 | 29,000 | 25,000 | 22,500 | 20,000 |
| 2020/21 | 14,246 | 17,004 | 18,874 | 18,886 | 19,781 | 26,251 | 26,694 | 29,634 | 29,290 | 31,661 | 43,840 | 33,807 |
| Actual | 39,900 | | | | | | | | | | | |

The plan is currently being finalised, with adjustments associated with the cash flows related to Salix still to be incorporated into the above. The reduction in cash balance through the year reflects the capital programme commitment for 21/22, the completion (in cash payment terms) of the capital schemes for 20/21, and continuing to target quick payment of invoices from suppliers whilst we return to a national cash regime that is sustainable.

## Capital

The graph below outlines cumulative capital expenditure for 2021/22.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2021/22 Plan | 1,779 | 4,008 | 6,776 | 9,914 | 13,202 | 17,130 | 19,948 | 22,816 | 25,184 | 27,302 | 29,670 | 32,320 |
| 2019/20 | 265 | 581 | 988 | 1,414 | 1,989 | 2,445 | 2,744 | 2,999 | 3,351 | 4,286 | 4,801 | 5,042 |
| 2020/21 | 350 | 2,069 | 3,154 | 4,084 | 4,187 | 5,100 | 7,093 | 8,129 | 10,223 | 10,797 | 11,300 | 16,356 |
| 2021/22 | 518 | | | | | | | | | | | |

As the Board will be aware, we have committed to a significant capital programme for 2021/22 (see later slides re the plans for 2021/22). This programme is being overseen by both the Capital Oversight Group and the SALIX programme board, with reports to the Resource Committee. Delivery of the programme will require tight management and control as we progress through the year.

Harrogate and District
NHS Foundation Trust

# Annual Plan update

## Board of Directors – 26/05/2021

10.3

# Annual plan 2021/22

NHS
Harrogate and District
NHS Foundation Trust

## Introduction & Context

The following few slides pull together the output of a number of separate streams of work that have been undertaken and reported through our internal governance processes and onto the local system (HCV ICS). These include our activity plan, workforce plan, and financial plan, and our local agreed priorities.

As the Board will be aware through previous reports/discussions, the planning process for 2021/22 has been different from other years, with a particular focus on the first half of the year and a recognition that the NHS has been managing within a pandemic and needs to reset the work that is undertaken. To that end there will be ongoing planning work that needs to be dynamic and reflect any changing national circumstances, with a view to preparing and submitting a plan for the second half of the year at some point over the next 3 months.

Internally, we have agreed our plans and are managing ourselves against them for the initial months of the year. We are in the process of reviewing service commitments for the second half of the year and assessing the level and need for recurrent investments and the impact that this will have on a likely efficiency requirement. This will be influenced by the yet to be announced national allocation settlement and future funding for the system.

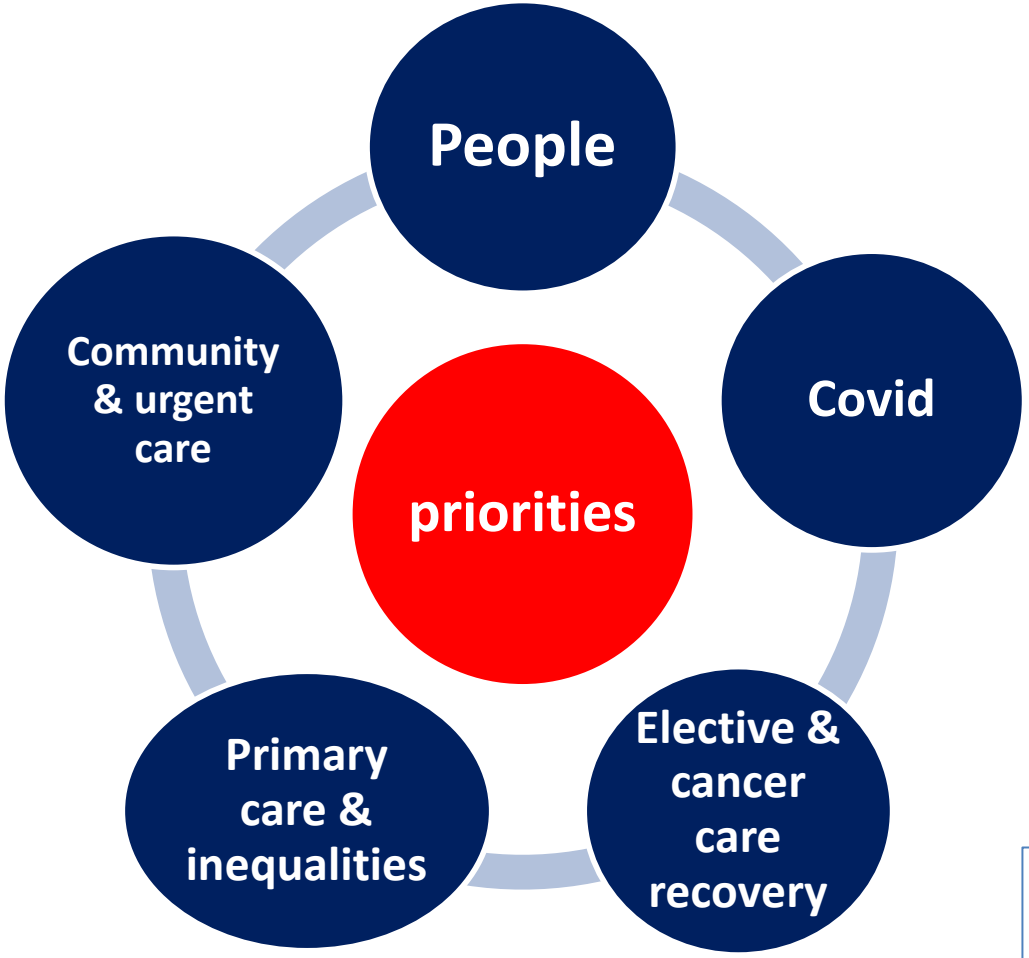
It is necessarily a more flexible and fluid position currently, but we have agreed our plans internally and will be managing to these commitments whilst we reflect on any changes we might need to make in the light of national or local requirements later in the year.

The information contained within these slides is the basis of the information we have submitted to the system to contribute to the system plan that is due to be submitted from HCV ICS in early June.

# Annual plan 2021/22 - priorities

Harrogate and District NHS Foundation Trust

The priorities – **national guidance** / **local additions**




Underpinned by system working

| | | |
|---|---|---|
| Maternity Ockendon recommendations | O-19 service recovery | Improved services for LD and autism |
| At Our Best | A Green plan | Our local Quality Priorities |
| Expanded primary care workforce | Site / estate strategy | Food standards |
| | Digital | |

Whilst recognising the range of work that we will be undertaking, our top priorities are:

- **Caring at our best**
- **0-19 service recovery**
- **Elective recovery**
- **Health & Wellbeing**

# Annual plan 2021/22 - resources

NHS Harrogate and District NHS Foundation Trust

## Activity, workforce and finance plans

*Activity* – the summary outlines the % of activity planned to be delivered in the first 6 months compared to the baseline from 2019/20
*Workforce* – the summary highlights the planned establishment for the year, alongside assumptions in relation to staff changes each month
*Finance* – the summary is the approved Trust Income & Expenditure plan for H1, alongside the approved Directorate budget

These plans will be compared with actual delivery on a monthly basis and reviewed through the Resources Committee.

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planning Guidance - Elective Recovery % Required | 70% | 75% | 80% | 85% | 85% | 85% | | | | | | |
| New Outpatients | 78% | 78% | 79% | 99% | 99% | 99% | | | | | | |
| Follow Up Outpatients | 84% | 85% | 84% | 102% | 102% | 103% | | | | | | |
| Elective Inpatients | 73% | 77% | 77% | 96% | 94% | 93% | | | | | | |
| Elective Day case | 83% | 86% | 87% | 94% | 93% | 93% | | | | | | |
| Elective Day case Endoscopy | 56% | 79% | 79% | 99% | 99% | 99% | | | | | | |
| Elective Day case TOTAL | 73% | 84% | 83% | 96% | 96% | 96% | | | | | | |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budgeted Establishment | 3,620.17 | 3,619.17 | 3,619.17 | 3,620.97 | 3,620.97 | 3,621.97 | 3,634.61 | 3,634.47 | 3,634.47 | 3,618.47 | 3,618.47 | 3,618.47 |
| Non recurrent (See table below) | 169.45 | 154.85 | 154.85 | | | | | | | | | |
| Non Recurrent items TBC | | | | 154.85 | 154.85 | 154.85 | 44.75 | 44.75 | 44.75 | 44.75 | 44.75 | 44.75 |
| TOTAL Establishment | 3,789.62 | 3,774.02 | 3,774.02 | 3,775.82 | 3,775.82 | 3,776.82 | 3,679.36 | 3,679.22 | 3,679.22 | 3,663.22 | 3,663.22 | 3,663.22 |
| Staff in Post | 3,562.19 | 3,579.11 | 3,573.85 | 3,592.61 | 3,591.54 | 3,579.58 | 3,615.18 | 3,643.32 | 3,641.41 | 3,626.49 | 3,633.25 | 3,659.41 |
| Planned Recruitment | 52.90 | 25.90 | 53.30 | 38.56 | 32.92 | 79.03 | 64.96 | 37.52 | 31.31 | 44.91 | 53.47 | 44.87 |
| Leavers (Turnover) | 35.99 | 31.16 | 34.54 | 39.63 | 44.87 | 43.43 | 36.81 | 39.43 | 46.23 | 38.16 | 27.31 | 42.42 |
| Variance/Gap | 227.43 | 194.91 | 200.17 | 183.21 | 184.28 | 197.24 | 64.18 | 35.90 | 37.81 | 36.73 | 29.97 | 3.81 |
| Excess sickness | 19.72 | 16.83 | 12.92 | 14.00 | 13.98 | 16.60 | 27.67 | 35.91 | 36.20 | 25.87 | 27.03 | 26.53 |
| Planned Bank | 74.14 | 63.52 | 63.93 | 59.16 | 59.48 | 64.15 | 27.56 | 21.54 | 22.20 | 18.78 | 17.10 | 9.10 |
| Planned Agency | 49.43 | 42.35 | 42.62 | 39.44 | 39.65 | 42.77 | 18.37 | 14.36 | 14.80 | 12.52 | 11.40 | 6.07 |

Summary I&E

| Type | £'000s |
|---|---|
| Income | 71,000 |
| Pay Expenditure | - 44,057 |
| Non Pay Expenditure | - 26,942 |
| **Surplus** | **0** |

Directorate budgets

| Directorate | £'000s |
|---|---|
| Long Term & Unscheduled | - 19,515 |
| Planned & Surgical | - 17,818 |
| Children's & CWCC | - 13,508 |
| Corporate | - 11,277 |
| **Total** | **- 62,118** |

# Annual plan 2021/22

Harrogate and District NHS Foundation Trust

**Summary**

These slides combine the activity, workforce and financial plans that have been shared and approved at separate times into one place.

It should be recognised that in addition to the numbers-based information that has been submitted to the ICS, that locally we have agreed a set of Trust priorities. These are

- Caring at our best
- 0-19 service recovery
- Elective care recovery
- Health & Wellbeing

The submissions we have made to the ICS will be a part of the system-wide plan for HCV ICS, due in early June.

Delivery of the plan will be overseen across our Board & Board committees, and will be reflected through key indicators within our IBR

The Board is asked to note the plans that have been approved and submitted to the ICS.

Harrogate and District NHS Foundation Trust

**Board of Directors Meeting (held in Public)**

**26 May 2021**

**NHS Provider Licence Annual Self-assessment**

**Report of the Chief Executive**

| | |
|---|---|
| **Agenda Item Number:** | **10.4** |
| **Presented for:** | Note/Approve |
| **Report of:** | Chief Executive |
| **Author (s):** | Interim Company Secretary |
| **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:

1. Note the certified compliance against condition G6 (3) and that the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution;
2. Note the certified compliance against Condition FT4(8) governance arrangements;
3. Note certified compliance against Continuity of Services Condition 7 (3) that require resources will be available for acute services for 12 months from the date of the statement;
4. Note certified compliance against the Training of Governors obligation; and
5. Note and approve the plans in place to publish compliance against condition G6 (3) on the Trust's website by 30 June 2021.

# Board of Directors Meeting (held in Public)

## 26 May 2021

## NHS Provider Licence Annual Self-assessment

### 1. Background

Each year, the Board of Directors is required to self-certify compliance with certain conditions against its licence as issued by "Monitor". ("Monitor" was the independent regulator of NHS Foundation Trusts whose functions are now undertaken by NHS Improvement).

The specific conditions we are required to self-certify against are: General Condition G6, Foundation Trust Condition FT4, and Continuity of Services Condition CoS7.

In addition, the Board is required to self-certify that it has met its legal (Section 151(2) of the Health and Social Care Act 2012) and Constitutional (paragraph 14.2) obligation to "…take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."

This report is aimed to provide information to determine if the Board can confirm compliance against these conditions.

### 2.0 The Timetable for Board Sign-off

The table below provides a description of each condition and the deadline date for sign-off by the Board:

**NHS provider licence conditions**

| | | |
|---|---|---|
| Condition G6(3) | The Trust has taken all precautions to comply with the licence, NHS acts and NHS Constitution | By 31 May |
| Condition G6(4) | Publication of condition G6(3) self-certification | By 30 June |
| Condition FT4(8) | The Trust has complied with required governance arrangements | By 30 June |
| Condition CoS7(3) | The Trust a reasonable expectation that required resources will be available to deliver the designate services for the 12 months from the date of the statement. | By 30 June |

NHS Improvement provides a template to assist the recording of self-certifications, should the Trust be audited by NHS Improvement. This template is no longer mandatory but it can be used to illustrate compliance with the process and maintained for record keeping purposes should the Trust be audited by NHS Improvement.

### 3.0 Condition G6(3)

Condition G6(3) requires NHS providers to confirm or not confirm that they have processes and systems that:

- Identify risks to compliance with their licence, NHS Acts and the NHS Constitution
- Guard against those risks occurring.

### 3.1 The Board's determination of compliance with General Condition G6

The question that this condition asks is if the Trust has identified the risks to compliance and if it has taken steps to mitigate such risks.

Evidence to support compliance against this condition is provided in Appendix A.

### 4.0 Condition FT4(8)

Condition FT4(8) is regarding systems and processes for good governance and if the Trust has governance systems and processes in place to achieve compliance against condition FT4.

Having taken into account the well-led framework for governance reviews, NHS Foundation Trust Code of Governance and the Single Oversight Framework, Appendix A references evidence to support the Board's determination of compliance against FT4(8).

### 5.0 Continuity of Services Condition 7

Only NHS Foundation Trusts that are designated as providing Commissioner Requested Services (CRS) are required to self-certify under condition CoS7(3).

#### *What is CRS designation?*

CRS are services commissioners consider should continue to be provided locally even if the provider is at risk of failing financially and, as such, are subject to closer regulation by NHS Improvement. Providers can be designated as providing CRS because:

- There is no alternative provider close enough
- Removing the services would increase health inequalities
- Removing the services would make other related services unviable

The Trust has received confirmation that its acute services have been confirmed as CRS by its commissioners as part of the annual contract review process.



Under this requirement the Trust is required to confirm one of three statements below and to provide supporting narrative explaining the reasons for the chosen statement:

a. The required resources will be available for 12 months from the date of the statement;
b. The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
c. The required resources will not be available over the next 12 months.

The Trust would like to confirm against (a) above, which was considered as part of its annual planning process, we are assured that that required resources will be available for acute services for 12 months from the date of the statement.

### 6.0 Other Self-certifications
### 6.1 Training of Governors

NHS Foundation Trusts are required to review if their Governors have received enough training and guidance to carry out their roles.

Throughout the year Governors have been continually communicated and engaged throughout the pandemic, in addition to this induction training is offered, there are opportunities

to join local and national network events with presentations and information by Directors and officers provided throughout the year.

## 7.0 Recommendation

The Board is asked to:

1. Note the certified compliance against condition G6 (3) and that the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution;
2. Note the certified compliance against Condition FT4(8) governance arrangements;
3. Note certified compliance against Continuity of Services Condition 7 (3) that require resources will be available for acute services for 12 months from the date of the statement;
4. Note certified compliance against the Training of Governors obligation; and
5. Note and approve the plans in place to publish compliance against condition G6 (3) on the Trust's website by 30 June 2021.

**Appendix A**

| **G6 (3) - Systems for compliance with licence (deadline for Board sign off - 31 May 2021** | | | |
|---|---|---|---|
| The Board is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required. | | | |
| | **Statement** | **Response (and supporting information/ assurance)** | **Risks and Mitigations** |
| | Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution | **Confirmed**<br>At Audit Committee on 4 May 2021 the draft annual accounts and the draft charitable accounts were received. The Trust's Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that "there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently".<br><br>The Head of Internal Assurance Report is planned to be presented to the Audit Committee at its 4 June 2020 meeting. This is a key piece of evidence to support compliance against this condition of the provider licence. Further evidence to support this condition includes the Board Workshops and Board meeting discussions on the Annual Plan 2021/22, including all known risks to compliance, risk reports presented to each Audit Committee and Board meetings, the development of the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports, the Integrated Board Reporting arrangements, the quality governance review and the "Our Best" programme of work.<br><br>The Trust's information processes provide the opportunity to review performance data across multiple domains, to improve the availability and accuracy of data and the flow of information and assurance through the governance structure. | No risks identified |

| FT4 Declaration - Corporate Governance Statement & Training of Governors (deadline for Board sign off - 30 June 2021) | | | |
|---|---|---|---|
| The Board is required to respond 'Confirmed' or 'Not confirmed' to the following statements, setting out any risks and mitigating actions planned for each one. | | | |
| | **Statement** | **Response (and supporting information/ assurance)** | **Risks and Mitigations** |
| 1. | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | **Confirmed**<br>The Annual Governance Statement (AGS) outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. (the AGS for 20/21 is planned to be considered by the Audit Committee on 4 June 2021)<br><br>There is an internal audit programme including clinical audits in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested.<br><br>The external auditors deliver a robust annual audit plan reporting directly to the Audit Committee. | No risks identified |
| 2. | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time. | **Confirmed**<br>Declaration of compliance included in Annual Report;<br>NHSI segmentation as per its Single Oversight Framework;<br>Well Led assessment by the CQC last rated as "Good. | No risks identified |
| 3. | The Board is satisfied that the Licensee implements:<br>(a) Effective Board and Committee structures<br>(b) Clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those Committees; and | **Confirmed**<br>The Board Committee structures reporting to the Board are defined and supported through a review of Committee Terms of Reference and reporting arrangements. The Board has formally delegated specific responsibilities to the Committees listed below, summary Chair's reports and formal minutes are provided to the Board following each of their meetings.<br><br>• Quality Committee | No risks identified |

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| | (c) Clear reporting lines and accountabilities throughout its organisation. | • Resource Committee<br>• Remuneration Committee<br>• Audit Committee<br>• People and Culture Committee<br><br>The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the divisions to Senior Management Team (SMT) and SMT supporting groups, providing assurance to the Board and its Committees. The quality/clinical governance structure has been reviewed and revised and continuation of the corporate governance review is being taken forward.<br><br>The monthly SMT meeting provides scrutiny and monitoring of operational performance, which supports the working of the Board's Committees, with SMT directly reporting to the Board of Directors.<br><br>An internal audit review of governance through the working of the Board Assurance Framework and conflict of interest policy and processes was carried out during 2020/21. Findings of the audit is planned to be presented to the 4 June 2021 Audit Committee meeting. | |
| | The Board is satisfied that the Licensee effectively implements systems and/or processes:<br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; | **Confirmed**<br>The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently. During the year the Trust adjusted its systems and processes during the COVID pandemic to ensure it could perform as well as it could in such unprecedented times. Gold command structure was initiated reporting up to the Board with a main focus on operational delivery for part of the year before recovery plans and strategic developments were reinstated.<br><br>There are clear escalation routes up to the Board of Directors (as described above). | No risks identified |

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| | (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; | b) SMT and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified. | |
| | (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; | c) The Quality Committee reviews the patient experience and quality report, with quality performance data available and the Trust's compliance with CQC fundamental standards using an on-line tool to support service self-assessments against the CQC domains. The Trust also commissioned an independent review of its clinical and quality governance to ensure it can continually adjust to the changing needs internally and externally, to provide the best possible care to its patients, families and carers.<br><br>An approved Quality Improvement and Audit Programme is in place, overseen by the Audit Committee.<br><br>The requirement for the Trust to produce an Annual Quality Report for 2020-21 for inclusion in the Annual Report has been paused nationally due to COVID-19 pandemic; the Trust will, however, produce an Annual Report in accordance with the revised Annual Reporting Manual.<br><br>The Trust will also produce a Quality Account in accordance with regulatory requirements. | |
| | (d) For effective financial decision-making, management and control *(including but not restricted to appropriate systems and/or processes to ensure the Licensee's* | d) The Trust reviewed its Standing Financial Instructions (SFIs) in 2019/20 to reflect current procurement practices and to respond to COVID; this determines the agreed framework for financial decision making, management and control. Follow consideration by the Audit Committee and Board these temporary changes were made permanent in 2020/21. | |

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| | *ability to continue as a going concern*); | Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors.<br><br>The Resource Committee and Audit Committee are the principal Committees that maintain oversight on this area. It is determined that there are robust systems and processes in place to monitor and oversee all CIP schemes.<br><br>The Trust has a good track record of effective financial management and of achieving its statutory financial duties and this is of particular note during the COVID pandemic period. | |
| | (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; | e) The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance.<br><br>The Standing Orders for the Practice and Procedure of the Board of Directors enable the Chairman to call a meeting of the Board at any time.<br><br>The review of the quality governance framework is evidence of continued review and refresh required to ensure the information provided to the Board is timely and up to date. | |
| | (f) To identify and manage (*including but not restricted to manage through forward plans*) material risks to compliance with the Conditions of its Licence; | f) The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. The BAF was paused during 2020/21, a decision the Board made to enable greater focus on operational areas, which it believed was required during the earlier months of the pandemic.<br><br>Directorates review their risks locally at department level and also at directorate level reporting to the Corporate Risk Review Group on a | |

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| | | monthly basis, which discussed the management of risks to also assess common themes, which could create a greater risk to the Trust and could affect the achievement of the Trust's strategic objectives. Any such risks would be added to the BAF. SMT monitors corporate risks and receives an overall organisational risk update to determine the robust management of risks prior to an update being presented to the Board.<br><br>The Board receives a summary of the Corporate Risk Register/Board Assurance Framework at each of its meetings. | |
| | (g) To generate and monitor NHS Improvement delivery of business plans *(including any changes to such plans*) and to receive internal and where appropriate external assurance on such plans and their delivery; and | g) The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved. | |
| | (h) To ensure compliance with all applicable legal requirements. | h) The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant. | |
| 5. | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: | **Confirmed** | No risks identified |
| | (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; | a) There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-executive Directors, including the Chairman and to the Remuneration Committee for the Executive Directors including the Chief Executive. | |

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| | (b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations; | b) There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered. | |
| | (c) There is collection of accurate, comprehensive, timely and up to date information on quality of care; | c) The Quality Committee supports the monitoring of information on the quality of care; the monthly SMT receive a quality performance report from the Chief Nurse/Director of Nursing and the Quality Committee consider a detailed patient experience and quality report. Review and refresh of the quality/clinical governance in 2020/21 aims to further strengthen this area.<br><br>The Quality Committee Chair reports any key decisions, risks and escalations to the Board. | |
| | (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; | d) As above - the Board receives a report from the Quality Committee Chair and receives approved minutes of the Committee at the Board meeting held in private. The Board also receives the Quality Account. | |
| | (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account, as appropriate, views and information from these sources; and | e) During the pandemic Board members face to face visits were paused in accordance with lock down rules and social distancing requirements. There were alternative arrangement put in place. Virtual meetings were held from the outset of the pandemic, the Freedom to Speak Up arrangements were strengthened with the support of associate FTSUGs and champions, the "At Our Best" programme to support the cultural agenda, the health and well-being offer was particular strengthened, which was all overseen by a newly formed People and Culture Committee.<br><br>One of the Non-executive Directors (NED) is nominated as a NED lead to support 'Freedom to Speak Up' for the Trust and the Chief Nurse and Director of Workforce and OD support the assurance | |

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| | | arrangements in place to provide advice and support to the Board as necessary.<br><br>The members of the Board, particularly NEDs met with the Council of Governors virtually during 20/21 to continually communicate and engage and to take account of views from outside the organisation, the members and public who the Governors represent.<br><br>The Council of Governors Membership and Engagement Committee had met to consider agile ways of working to engage with members and the public in restricted social distancing arrangements and non-social distancing arrangements to feed into the member engagement plan. | |
| | (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | f) There is clear accountability for quality of care through the governance structures in place across the Trust, which reported to the Chief Nurse, Medical Director and Chief Executive. This area was strengthened during 2020/21 with the appointment of the Deputy Chief Nurse; Deputy Medical Directors and a clinical governance lead. | |
| 6. | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | **Confirmed**<br>All members of the Board, Clinical Directors, Deputy Medical Directors and Deputies and those that carrying out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation. All members of the Board and senior decision makers are required to comply with the declaration of interests including loyalty interest policy, which was refreshed and processes and systems strengthened during the year.<br><br>The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate. | No risks identified |

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| | | The Board of Directors during the year had considered its development needs discussing through its Board Workshops. External facilitation was engaged to support the Board development agenda throughout the year. | |

**GLOSSARY OF ABBREVIATIONS**

# A

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|---|---|
| **A&E** | *Accident and Emergency* |
| **AfC / A4C** | *Agenda for Change* |
| **AHPs** | *Allied Health Professionals* |
| **AIC** | *Aligned Incentive Contract* |
| **AMM** | *Annual Members' Meeting* |
| **AMU** | *Acute Medical Unit* |
| **AQP** | *Any Qualified Provider* |
| **ARCHS** | *Acute Response and Rehabilitation in the Community, Home and Hospital Service* |

# B

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| **BAF** | *Board Assurance Framework* |
| **BME** | *Black and Minority Ethnic* |
| **BoD** | *Board of Directors* |

# C

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| **CAT** | *Clinical Assessment Team (Will be ACU)* |
| **C.diff** | *Clostridium difficile* |
| **CC** | *Community & Children's Directorate* |
| **CCG** | *Clinical Commissioning Group* |
| **CCU** | *Coronary Care Unit* |
| **CE / CEO** | *Chief Executive Officer* |
| **CEA** | *Clinical Excellence Awards* |
| **CEPOD** | *Confidential Enquiry into Perioperative Death* |
| **CIP** | *Cost Improvement Plan* |
| **CLAS** | *Children Looked After and Safeguarding Reviews* |
| **CoG** | *Council of Governors* |
| **COO** | *Chief Operating Officer* |
| **CQC** | *Care Quality Commission* |
| **CQUIN** | *Commissioning for Quality and Innovation* |
| **CRR** | *Corporate Risk Register* |
| **CRRG** | *Corporate Risk Register Group* |
| **CSW** | *Care Support Worker* |
| **CT** | *Computerised Tomography* |
| **CT DR** | *Core trainee doctor* |

# D

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| **Datix** | *National Software Programme for Risk Management* |
| **DBS** | *Disclosure and Barring Service* |
| **DNA** | *Did not attend* |
| **DoH** | *Department of Health* |
| **DoLS** | *Deprivation of Liberty Safeguards* |
| **Dr Foster** | *Provides health information and NHS performance data to the public* |
| **DToC** | *Delayed Transfer of Care* |

# E

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| **ECIST** | *Emergency Care Improvement Support Team* |
| **ED** | *Emergency Department* |
| **EDI** | *Equality, Diversity & Inclusion* |
| **EDS2** | *Equality Delivery System 2* |
| **eNEWS** | *National Early Warning Score* |
| **ENT** | *Ear, Nose and Throat* |
| **ERCP** | *Endoscopic Retrograde Cholangiopancreatography* |
| **ESR** | *Electronic Staff Record* |
| **EWTD** | *European Working Time Directive* |

# F

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|---|---|
| **FFT** | *Friends and Family Test* |
| **FIMS** | *Full Inventory Management System* |
| **FOI** | *Freedom of Information* |
| **FT** | *NHS Foundation Trusts* |
| **FY DR** | *Foundation Year doctor* |

# G

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| **GDMEC** | *Governor Development and Membership Engagement Committee* |
| **GIRFT** | *Get it right first time* |
| **GPOOH** | *GP Out of Hours* |

# H

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|---|---|
| **HaRD CCG** | *Harrogate and Rural District Clinical Commissioning Group* |
| **HaRCVS** | *Harrogate and Ripon Centres for Voluntary Service* |
| **HBC** | *Harrogate Borough Council* |
| **HCV** | *Humber Coast & Vale* |
| **HDFT** | *Harrogate and District NHS Foundation Trust* |
| **HDU** | *High Dependency Unit* |
| **HEE** | *Health Education England* |
| **HFMA** | *Healthcare Financial Management Association* |
| **HHFM** | *Harrogate Healthcare Facilities Management Ltd* |
| **HIF** | *Harrogate Integrated Facilities* |
| **HR** | *Human Resources* |
| **HSE** | *Health & Safety Executive* |
| **HSMR** | *Hospital Standardised Mortality Ratios* |

# I

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|---|---|
| **ICS** | *Integrated Care System* |
| **ICU or ITU** | *Intensive Care Unit or Intensive Therapy Unit* |
| **IG** | *Information Governance* |
| **IBR** | *Integrated Board Report* |
| **IT or IM&T** | *Information Technology or Information Management & Technology* |

# K

**KPI** *Key Performance Indicator*
**KSF** *Knowledge & Skills Framework*

# L

**LAS DR** *Locally acquired for service doctor*
**LAT DR** *Locally acquired for training doctor*
**LCFS** *Local Counter Fraud Specialist*
**LMC** *Local Medical Council*
**LNC** *Local Negotiating Committee*
**LoS** *Length of Stay*
**LPEG** *Learning from Patient Experience Group*
**LSCB** *Local Safeguarding Children Board*
**LTUC** *Long Term and Unscheduled Care Directorate*

# M

**MAC** *Maternity Assessment Centre*
**MAPPA** *Multi-agency Public Protection Arrangements*
**MARAC** *Multi Agency Risk Assessment Conference*
**MASH** *Multi Agency Safeguarding Hub*
**MAU** *Medical Admissions Unit*
**MDT** *Multi-Disciplinary Team*
**Mortality rate** *The ratio of total deaths to total population in relation to area and time.*
**MRI** *Magnetic Resonance Imaging*
**MRSA** *Methicillin Resistant Staphylococcus Aureus*
**MTI** *Medical Training Initiative*

# N

**NCEPOD** *NCEPOD (National Confidential Enquiry into Perioperative Death)*
**NED** *Non-Executive Director*
**NHSE** *National Health Service England*
**NHSI** *NHS Improvement*
**NHSR** *National Health Service Resolution*
**NICE** *National Institute for Health & Clinical Excellence*
**NMC** *Nursing and Midwifery Council*
**NPSA** *National Patient Safety Agency*
**NRLS** *The National Reporting and Learning System*
**NVQ** *National Vocational Qualification*
**NYCC** *North Yorkshire County Council*

# O

**OD** *Organisational Development*
**ODG** *Operational Delivery Group*
**OSCE** *The Objective Structured Clinical Examination*

# P

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|---|---|
| **PACS** | *Picture Archiving and Communications System – the digital storage of x-rays* |
| **PbR** | *Payment by Results* |
| **PEAT** | *Patient Environment Action Team* |
| **PET** | *Patient Experience Team* |
| **PET SCAN** | *Position emission tomography scanning system* |
| **PESH** | *Patient Experience Safety Huddle* |
| **PHSO** | *Parliamentary and Health Service Ombudsman* |
| **PMO** | *Project Management Office* |
| **PROM** | *Patient Recorded Outcomes Measures* |
| **PSC** | *Planned and Surgical Care Directorate* |
| **PST** | *Patient Safety Thermometer* |
| **PSV** | *Patient Safety Visits* |
| **PVG** | *Patient Voice Group* |

# Q

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| **QIA** | *Quality Impact Assessment* |
| **QIPP** | *The Quality, Innovation, Productivity and Prevention Programme* |
| **QPR** | *Quarterly Performance Review* |

# R

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| **RCA** | *Route Cause Analysis* |
| **RIDDOR** | *The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* |
| **RTT** | *Referral to Treatment. The current RTT Target is 18 weeks.* |

# S

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|---|---|
| **SALT** | *Speech and Language Therapy* |
| **SAS DR** | *Speciality and associate specialist doctors* |
| **SCBU** | *Special Care Baby Unit* |
| **SHMI** | *Summary Hospital Mortality Indicator* |
| **SI** | *Serious Incident* |
| **SID** | *Senior Independent Director* |
| **SIRI** | *Serious Incidents Requiring Investigation* |
| **SLA** | *Service Level Agreement* |
| **SMR** | *Standardised Mortality rate – see Mortality Rate* |
| **SMT** | *Senior Management Team* |
| **SpR** | *Specialist Registrar – medical staff grade below consultant* |
| **ST DR** | *Specialist trainee doctors* |
| **STEIS** | *Strategic Executive Information System* |
| **STP** | *Sustainability and Transformation Plan* |
| **SVPSG** | *Supporting Vulnerable People Steering Group* |

# T

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| **TOR** | *Terms of Reference* |
| **TU** | *Trade Union* |
| **TUPE** | *Transfer of Undertakings (Protection of Employment) Regulations 2006* |

# V

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| **VC** | *Vice Chairman* |
| **VSM** | *Very Senior Manager* |
| **VTE** | *Venous Throboembolism* |

# W

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| **WLI** | *Waiting List Initiative* |
| **WTE** | *Whole Time Equivalent* |
| **WY&H HCP** | *West Yorkshire and Harrogate Health Care Partnership* |
| **WYAAT** | *West Yorkshire Association of Acute Trusts* |

# Y

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| **YTD** | *Year to Date* |

**Further information can be found at:**
NHS Providers – Jargon Buster –
http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster