Harrogate and District NHS Foundation Trust

Board of Directors Meeting (to be held in Public)
will be held on Wednesday, 28 July 2021 from 9.00am – 1.00pm
at the Pavilions, Great Yorkshire Show Ground,
Harrogate North Yorkshire, HG2 8QZ

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence** *Apologies: Jeremy Cross, Non-Executive Director*	Chairman	Note	Verbal	9.00
1.2	**Patient Story**	Deputy Director of Nursing	Note/ Discuss	Verbal	
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**	
1.4	**Minutes of the Previous Board of Directors meeting held on 26th May 2021**	Chairman	**Approve**	**Attached**	
1.5	**Matters Arising and Action Log**	Chairman	Discuss/ Note/ Approve	**Attached**	
1.6	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.30
1.7	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.40
1.8	**Corporate Risk Register**	Chief Executive	Discuss/ Note	**Attached**	
SECTION 2: Patients and Service Users (Quality and Operational Performance)					
Items for escalation					
2.1	**Integrated Board Report –** indicators 1.1 to 3.2	Executive Directors	Note/ Discuss	**Attached**	9.50
2.2	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	
2.3	**Director of Nursing Report**	Interim, Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	
2.4	**Medical Directors Report**	Executive Medical Director	Note/ Approve	**Attached**	
Board Reports					
2.5	**Maternity Incentive Scheme**	Interim, Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	10.40

2.6	**Strengthening Maternity and Neonatal Safety**	Interim, Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	
Comfort Break (11.00 – 11.15)					
SECTION 3: People and Culture					
Items for escalation					
3.1	**Integrated Board Report –** Indicators 4.1 – 4.6.2	Executive Directors	Note/ Discuss	**Attached at 2.1**	11.15
3.2	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	**Attached**	
3.3	**Director of Workforce and Organisational Development Report**	Director of Workforce and Organisational Development	Note/ Approve	**Attached**	
Board Reports					
3.4	**Medical Revalidation Annual Statement of Compliance**	Executive Medical Director	Approve	**Attached**	11.45
SECTION 4: Partnership and Strategic Impacts					
Board Reports					
4.1	**ICS Strategic Objectives**	Chief Executive	Note	**Attached**	12.00
SECTION 5: Financial Impacts					
Items for escalation					
5.1	**Integrated Board Report –** Indicators 3.3.1 – 3.5 and 5.1.1 – 7.5.2	Executive Directors	Note/ Discuss	**Attached at 2.1**	12.15
5.2	**Resources Committee Chair's Report –** *this report will follow due to meeting dates*	Resources Committee Chair	Note	**To follow**	
5.3	**Finance Report**	Deputy Chief Executive / Finance Director	Note/ Approve	**Attached**	
5.4	**Chief Operating Officers Report**	Chief Operating Officer	Note/ Approve	**Attached**	

SECTION 6: Governance Arrangements					
Items for escalation					
6.1	**Board Assurance Framework and Risk Management**	Chairman	Discuss	**Attached**	12.30
6.2	**Audit Committee Chair's Report**	Committee Chair	Note	**Attached**	
6.3	**Senior Management Team Report –** *this report will follow due to meeting dates*	Senior Management Team Chair	Note	**To Follow**	
7.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ Approve	Verbal	12.45
8.0	**Board Evaluation**	Chairman	Discuss	Verbal	12.55
9.0	**Date and Time of next meeting** Wednesday, 29th September 2021 at 9.00am				
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*					

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Board of Directors Register of Interest
As at 20th July 2021

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	Date	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Volunteer with Supporting Older People (charity). 4. Chair of NHSE Northern Region Talent Board 5. Member of Humber Coast and Vale ICS Partnership
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing 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) 2. Company director for the flat management company of current residence 3. Chief Executive of the Ewing Foundation
Jonathan Coulter	Deputy Chief Executive/ Finance Director	November 2017	Date	(Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
Jill Foster	Chief Nurse	July 2020	April 2021	Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Tim Gold	Interim Chief Operating Officer	August 2020	Date	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)	No interests declared		
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)			1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Emma Nunez	Interim Director of Nursing	April 2021	Date	Seconded from NHS Improvement
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 (ended July 2021) 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board (November 2020 and ongoing) 3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS (October 2020) and ongoing) 4. Chair of Non-Surgical Oncology Steering Group (April 2021 and ongoing)

				5. NHS Employers Policy Board Member (September 2020 and ongoing) 6. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 7. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)

Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board 4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company.
Mrs Laura Angus	NExT Non-executive Director	January 2021	Date	1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG 2. Chair of York and Scarborough Medicines Commissioning Committee 3. Interim Chief Pharmacist at Humber, Coast and Vale ICS 4. MTech Associate; Council Member PrescQIPP 5. Chair of Governors at Kirby Hill Church of England Primary School
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care)	April 2017	Date	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018	Date	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

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

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
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

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Board of Directors Meeting (held Public)

26 May 2021 at 9.00am

at 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 (*via MS Teams*)
Mr Richard Stiff, Non-executive Director
Mrs Maureen Taylor, Non-executive Director
Mr Wallace Sampson OBE, Non-executive Director *(from item BoD/05/21/10)*
Mr Steve Russell, Chief Executive
Dr Jacqueline Andrews, Executive Medical Director
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Mr Russell Nightingale, Chief Operating Officer
Mrs Emma Nunez, Interim Director of Nursing, Midwifery and Allied Health Professionals
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Mrs Laura Angus, NExT Non-executive Director
Mrs Emma Edgar, Interim Service Manager, Long Term Conditions and Unscheduled Care (LTUC) Directorate (*via MS Teams*)
Ms Lynn Hughes, Interim Company Secretary
Dr Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Directorate
Dr Matt Shepherd, Action Chief Operating Officer/Clinical Director for Long Term Conditions and Unscheduled Care Directorate
Dr Sarah Sherliker, Deputy Medical Director (Clinical Operations and Workforce Development)/Consultant Anaesthetist
Dr Matthew Milsom, Director of Undergraduate Education/Guardian of Safe Working

Observing
Mr B Cowans, Elected Public Governor
Mrs K McClune, Elected Staff Governor
Mr T Doveston, Elected Public Governor
Mr D Masterton, Elected Public Governor

BoD/05/21/01 Welcome and Apologies for Absence

1.1 The Chairman welcomed Emma Nunez, Interim Director of Nursing, Midwifery and AHP; and Russell Nightingale, Chief Operating Officer to their first Board meeting since they had joined the Trust in April 2021. She also welcomed Dr Sarah Sherliker, Deputy Medical Director (Clinical Operations and Workforce Development)/Consultant Anaesthetist, Dr Matthew Milsom, Director of Undergraduate Education/Guardian of Safe Working and the four

Governors: Mr Bob Cowans, Mrs Kathy McClune, Mr Tony Doveston and Mr Doug Masterton who were observing the meeting. She also reported that Kate Southgate would be joining the Trust for the next meeting as the new Company Secretary and thanked Lynn Hughes for supporting the Trust as Interim Company Secretary.

1.2 There Chairman explained that Wallace Sampson would be joining the meeting a little late. There were no apologies for absence.

BoD/05/21/02 Patient Story

2.1 Emma Edgar, Interim Service Manager for LTUC joined the meeting virtually to present the story of a patient who had sadly passed away. She explained that there had been a multi-agency complaint from the family of the patient who had agreed for the story to be shared.

2.3 The key learning was that if patients were concerned about attending due to poor weather conditions that we ensured they were aware they did not have to attend if they were worried. There were some further lessons about the communication that occurred in relation to the family of the patient.

2.4 The Chairman thanked Emma Edgar for sharing the patient story.

2.5 **Resolved:** the patient story was noted.

BoD/05/21/3 Declarations of Interest and Register of Interest

3.1 The register of interests was received and noted.

3.2 It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong is a Director of Harrogate Integrated Facilities (HIF). Wallace Sampson is Chief Executive of Harrogate Borough Council, Emma Nunez is seconded from NHS Improvement and England (NHSE/I) and Angela Wilkinson and Russell Nightingale are Directors of the ILS and IPS Pathology Joint Venture.

BoD/05/21/4 Minutes of the Meeting held on 31 March 2021

4.1 **Resolved:** the minutes of the last meeting held on 31 March 2021 were agreed as an accurate record.

BoD/05/21/5 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 four completed actions were agreed to be closed. Open actions with target dates set for 26 May 2021 were discussed in turn:

BoD/11/20/13.3 and 11.10 IBR. The draft content of the IBR had been discussed at the April 2021 Board Workshop and is now planned to be finalised for submission to the Board at its 28 July 2021 meeting.

BoD/01/21/15.4 Guardian of Safe Working Report. It was noted that the method for collecting verbatim comments would be discussed later on the agenda. It was agreed to close this action.

BoD/01/21/17.9 Strengthening and Optimising Board Oversight for Maternity and Neonatal Safety. It was noted that this was planned to be added to the June Board Workshop. It was agreed that the action would remain open until completed.

BoD/03/21/16.2 Medical Appraisals – the outcome of Internal Audit and remedial actions to be reported to the Board. It was noted that the internal audit had now been completed and would be reported to the June 2021 Audit Committee meeting. It was agreed an update would be provided to the next meeting and the action would remain open.

BoD/03/21/17.4 Chief Nurse Report. Pressure Ulcer benchmarking methods was noted to be included in the Director of Nursing, Midwifery and AHP's report on the agenda. It was agreed to close the action.

BoD/03/21/17.5 Chief Nurse Report. Breakdown of vacancies to cover Nurses and Midwives inclusive of the 0-19 service were included in the Director of Nursing, Midwifery and AHP's report on the agenda. It was agreed to close the action.

BoD/03/21/18.6 Maternity Incentive Scheme - Mandatory Training. It was noted that this information had been provided to the Board. It was agreed to close the action.

BoD/03/21/26.4 2021/22 Annual Plan. It was noted that a breakdown of Medical Equipment replacement costs had been provided to the Resource Committee meeting held earlier that week. It was agreed to close the action.

BoD6/05/21/6 Overview by the Chairman

6.1 The Chairman reported that the Board Workshop held 28 April 2021 had covered Board Effectiveness and the 'At Our Best' work. The afternoon session welcomed a number of BAME colleagues and considered the steps required to move towards becoming 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. The Workshop also had a strong focus on risk management including the Board Assurance Framework.

6.2 Subject to Council of Governors' approval the Annual Members Meeting will be arranged to take place on 6 September 2021 at the Pavilions, Harrogate. A decision has yet to be made if the event will need to be held virtually or in person.

6.3 Work continued to build the Trust's Culture with refreshed values and behaviours planned to be launched week commencing 31 May 2021. The Chairman thanked everyone that had been involved in the work to date.

6.4 The Chairman expressed thanks to all the Trust's volunteers and Governors who had supported the Trust in some unprecedented times during the last

year during the pandemic and reminded everyone that it was national Volunteers Week (week commencing 31 May 2021) .

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

BoD/05/21/7 Chairman's Annual Declaration

7.1 **Resolved:** the Chairman's Annual Declaration report was noted, which provided 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.

BoD/05/21/8 Chief Executive Report

8.1 The Chief Executive's report was received and noted and he drew attention to:

8.1.1 As recognition for the contribution of colleagues during an extra-ordinary year, an additional day of annual leave 'Thank you #teamHDFT' has been offered to all the Trust and HIF colleagues to take before 31 March 2022.

8.1.2 'At Our Best' - four behaviours which we value at HDFT and HIF have been agreed: Kindness, Integrity, Teamwork and Equality with a set of tools and practices to 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.

8.1.3 Risk Management was being further developed from ward to Board to support the Corporate Risk Register and Board Assurance Framework.

8.1.4 0-19 services continued to face pressure with a surge in demand and an increased vacancy rate (9%). Further resources for safeguarding have been provided to support teams and mandated contacts as part of the Healthy Child Programme with a combination of face to face and virtual contacts.

8.1.5 Recovery of services continued, and work had been undertaken to ensure this took account of inequalities. Initial analysis had found 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 was found to be marginally lower than others for both urgent and routine care.

8.1.6 The Trust continued to work 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.

8.1.7 Following consideration - the Board approved the Modern Slavery and Human Trafficking Act 2015 Annual Statement. It was noted that the statement would be displayed on the Trust's website.

8.2 Richard Stiff explained he was confident with the statement but queried the processes in place if a patient presented to the Trust's services which staff suspected could be subject to modern slavery. In response, Natalie Lyth explained that policies and processes were in place as part of the safeguarding process. Andy Papworth and Jeremy Cross shared their experiences of how training is provided in other organisations. Following discussion it was agreed that safeguarding training for all staff to cover this would enhanced and Emma Nunez would work with the Safeguarding team.

ACTION (Interim Director of Nursing)

8.3 Jeremy Cross queried if the Trust was fulfilling the current 0-19 Contracts. In response the Chief Executive explained that the Trust was fulfilling the mandated contacts but with some agreed flexibility on the method and a risk assessed approach to the timescales to ensure that resources were targeted at the most vulnerable families and those where there was the higher level of risk.

8.4 **Corporate Risk Register**

8.4.1 The Chief Executive outlined changes to the process of the review of risk registers and the Corporate Risk Register, with the introduction of an Executive Risk Group, chaired by the Chief Executive. Emma Nunez and Jackie Andrews were noted to be joint Executive leads for risk management. The Chief Executive drew attention to the following risks:

CRR34 – Autism Assessment. The target date is set for September 2021, but it is not anticipated this target score will be achieved by September. Plans are in place to review the model before consideration is given to amend the target date.

CR5 – 0-19 Nursing Shortage. Work is ongoing with the team targeting on skill mix and training with Emma Nunez providing additional support on safeguarding.

CR49 – ED Imaging. This risk had been removed since the summary Corporate Risk Register was presented to the Board.

Aseptic Unit, COVID testing platform, Anaesthetics workforce gaps and nursing leadership in planned and surgical care had been added to the Corporate Risk Register and were currently being further developed.

There were a number of risks where the target date had not been met. The adequacy of the action plans to reduce the risk would be considered at the Executive Risk Group.

8.4.2 Richard Stiff explained that from an Audit Committee view he commended the approach that was being taken forward to strengthen risk management.

8.5 **Resolved:** i) the Chief Executive's report was noted, including the Corporate Risk Register and plans in place to develop this.

Wallace Sampson joined the meeting.

BoD/05/21/9 Integrated Board Report

9.1 The Integrated Board Report for April 20201 was received and it was noted that:

- there had been three serious incidents (SI) reported;
- the number of hospital acquired pressure ulcers and inpatient falls had decreased;
- the number of complaints reported in April had decreased;
- performance against the Accident & Emergency 4 hour standard remained below the 95% target reported as 86.3%.
- Provisional data indicated that the cancer 62 day standard was delivered in April,
- the number of patients waiting over 52 weeks had reduced from 1,350 to 1,200 during April.

9.2 The Chief Executive highlighted that the Emergency Department had seen a significant increase in activity which had put added pressure on the team.

9.3 In response to Wallace Sampson's query it was agreed that supporting narrative would be provided on the maximum waiting times for Accident and Emergency in addition to the 4 hour standard information included.

ACTION (Chief Operating Officer)

9.4 In response to Jeremy Cross' query, Jackie Andrews confirmed that there had been a decision made for medical appraisals to be paused during COVID but, despite that, many appraisals completed. The doctors' revalidation process had also been paused but had now recommenced.

9.5 **Resolved:** the IBR was received and noted.

BoD/05/21/10 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 a focus on the 0-19 services

BoD/05/21/11 Board Assurance Framework

11.1 During 2020, the Board agreed to pause the Board Assurance Framework (BAF) to focus on operational risk management at the outset of the COVID pandemic. The Board then reviewed the BAF at the July 2020 and February 2021 Board Workshops and identified risks to the achievement of the Trust's strategic objectives. The BAF was further developed by Executive Directors with the inclusion of inherent risk scores and presented to the Board for approval.

11.2 Laura Robson queried the target date for #BAF4.4. In response, Jonathan Coulter explained that the target score had been achieved in April 2021.

11.3 Jeremy Cross commented on the supplementary reports that accompanied the summary CRR and the BAF, which he found most useful.

11.4 Following consideration the updated BAF was approved subject to the partnership risks being realigned to the Board Workshop instead of SMT. The Chairman explained that the partnership risks on the BAF would be reviewed under Hot Topics at future Board Workshops.

ACTION (Interim Company Secretary)

11.5 It was agreed that arrangements would be made for Board Committees to scrutinise the risks associated to each Committee at every meeting, with Committees providing assurance to the Board following each meeting. The complete BAF would be presented to the Board on a bi-monthly basis in future.

11.6 **Resolved:** i) the updated BAF was approved subject to the partnership risks being aligned to the Board Workshop for oversight and scrutiny;
ii) the proposal for Board Committees to scrutinise the risks associated to each Committee at every meeting with assurance provided to the Board following each meeting was approved; and
iii) the complete BAF was agreed to be presented to the Board in Public on a bi-monthly basis

BoD/05/21/12 Quality Committee Chair's Reports

12.1 The Quality Committee Chair's reports from the meetings held on 7 April and 12 May 2021 were noted.

12.2 From the 7 April 2021 meeting, reference was made to the presentation on a quality improvement project, which provided evidence on the reduction of waiting times for the continence service. The team had managed to maintain the work despite big changes in their working practice due to COVID.

12.3 The 12 May 2021 meeting was chaired by Andy Papworth, who drew attention to the presentation received on the Youth Forum, which meets monthly and aims make healthcare services better for children and young people. Since its inception in 2017, the Youth Forum has provided useful feedback and ideas across a range of areas. Forum members particularly enjoy face to face meetings and visits to departments, which it was noted would now become easier to re-introduce. He explained that the meeting received the outcome of the Annual Committee Effectiveness Survey and an update on the Quality Priorities. The risks noted during the meeting included: the Maternity Assessment Centre requires more than one person to staff the Centre effectively; and a recent increase in violence and aggression towards Emergency Department staff was reported. It was also noted that the risks were being addressed by departments. The items contained in the report for escalation were included within Director of Nursing, Midwifery and AHPs report and the People and Culture Committee had agreed to oversee the concern with regards to the appraisal rates.

12.4 The Chairman queried the Executive Director lead for the Youth Forum. It was confirmed that the Youth Forum was under the portfolio of the Director of Nursing, Midwifery and AHP at present.

12.5 **Resolved:** the Quality Committee Chair's reports from the meetings held on 7 April and 12 May 2021 were noted.

BoD/05/21/13 Medical Director Report

13.1 The Medical Director's report was received and noted. Actions underway included the quality priority to review unplanned care pathways and 7 day services, procurement of e-job planning and e-leave management, and refurbishment of the Junior Doctors Mess.

An update was also provided on the use of digital aspirant funding to support a review of the Trust's current digital and EPR strategy.

13.3 Wallace Sampson queried if the Trust's Digital Strategy included plans to move towards a paperless environment and how cash releasing savings would be achieved. In response, Jonathan Coulter explained that an expectation of the strategy was cash releasing savings and that progress against the Digital Strategy and its impact was monitored by the Resource Committee.

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

BoD/05/21/14 Guardian of Safe Working Quarter 4 Report

14.1 The Chairman thanked Matt Milsonfor attending the meeting to present the Guardian of Safe Working Quarter 4 report.

14.2 It was noted that there had been a reduction in reporting during COVID by Junior Doctors. Matt Milson confirmed that there had been no working time directive breaches during the reporting period.

14.3 In response to the Chairman's query, Matt Milson confirmed that any significant areas of concern were taken forward with clinical education supervisors.

14.4 **Resolved:** the Guardian of Safe Working Quarter 4 report was noted.

BoD/05/21/15 Learning from Deaths Quarter 4 Report

15.1 It was noted that Quarter 4 was heavily impacted by a "second wave" of COVID but despite that the Trust has re-established its routine data collection and interpretation. All deaths are scrutinised by the Medical Examiner and his team. The ongoing process to improve Learning from Deaths will form a workstream of the 'Learning at our Best' programme with discussions taking place to modernise and streamline education delivery to all staff in order that continual learning becomes a fundamental part of everyday practice.

15.2 Laura Robson explained that there had been a presentation delivered to a Quality Committee meeting previously on Autism and queried if the Trust was doing everything that it was required to do in relation to Autism. In response, Jackie Andrews explained that recording Autism is an area which still needs further improvement and that the Medical Examiner continued to encourage the recording of Autism.

15.3 **Resolved:** the Learning from Deaths Quarter 4 report including the processes for ensuring learning from deaths was noted.

BoD/05/21/16 Data Protection Officer Report

16.1 It was noted that Jackie Andrews is the Caldicott Guardian and Russell Nightingale is the Trust's Senior Information Risk Owner (SIRO).

16.2 The Annual Report of Data and Information Governance Steering Group was received and noted. Data protection and security reports to the Trust's Improving Patient Safety Steering Group.

16.3 Wallace Sampson queried if the Trust held exercises in relation to cyber security. In response, Jackie Andrews confirmed that there were regular exercises in place which are linked to the Emergency Planning and Resilience process in place.

16.4 **Resolved:** the Data Protection Officer Report, which included the Annual Report of the Data and Information Governance Steering Group was noted.

BoD/05/21/17 Director of Nursing Report

17.1 Emma Nunez spoke to the report and drew attention to the following:

- Workforce – A safe Staffing review was underway and she was working with Natalie Lyth and her team to ensure the 01-9 service was included;
- Complaints – key deliverables to improve the management of the complaints process had been approved by Executive Directors. Since the report was circulated it was noted that there had been a reduction in the turnaround times of complaints.
- Caring at Our Best – quality practice accountability had been aligned to ward/departmental managers. A bi-monthly panel was now in place to oversee all Pressure Ulcers and Falls. Ward assurance meetings were planned to commence in June to monitor the quality dashboard. A Clinical Quality Matron had been appointed and was due to commence in post on 28 June 2021; and there had been a Professional Practice Forum for Nursing, Midwifery and AHPs established.

17.2 The Chief Executive highlighted the large amount of work that was being taken forward by Emma Nunez since she joined the Trust at the beginning of April 2021, which the Board acknowledged.

17.3 **Resolved:** the Director of Nursing report was noted.

BoD/05/21/18 Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report

18.1 The Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report was received and noted. Reference was made to the following work that was currently being taken forward:

- Birth rate + and safer staffing assessment
- Information was being collected in response to the Ockenden report to provide self-assessment evidence against the national requirements
- The Maternity Team had received positive feedback from the regional team about the Ockenden requirements response.

18.2 Workforce risks were reported and noted to include gaps in middle grade rotas, training compliance and the impact of reduced face to face training, midwifery staffing, and sustainability of the Continuity of Care model.

18.3 It was noted that Kathy McClune had being actively working to improve the training arrangements in place and was continuing to drive this forward.

18.4 Sarah Armstrong queried if there had been an increase of concerns raised by patients following the publication of the national Ockenden report. In response, Kat Johnson explained that there had been a noted increase in the request for Caesarean births.

18.5 Andy Papworth as the Executive Director lead highlighted the enormous amount of work being taken forward and highlighted the action plan.

18.6 **Resolved:** the Strengthening and Supporting Board Oversight for Maternity and Neonatal Safety Report was noted.

BoD/05/21/19 People and Culture Committee Chair's Report

19.1 The People and Culture Committee Chair's report from the meeting held on 17 May 2021 was noted. Jeremy Cross, Chair of the Committee explained that the Committee received a presentation on Global Learning, Lived Experiences from the team responsible for the recruitment of nurses from overseas. The Committee was impressed by the professionalism and enthusiasm shown. Staff Network leads continued to support the effectiveness of meetings and following the appointment of the EDI lead arrangements are planned to look at the support offered to the Staff Networks.

19.2 It was noted that the Committee will continue to monitor the progress against the Anti-Racist work plan including the actions within the 'Patient Behaviour Towards Colleagues' plan.

19.3 **Resolved:** the People and Culture Committee Chair's report was noted.

BoD/05/21/20 Director of Workforce and Organisational Development Report

20.1 The Workforce and Organisational Development report was received and noted. Angela Wilkinson referred to the following:

- A new Virtual Learning Environment, which will support e-learning and is aimed to be in place by the summer 2021;
- Recruitment Values were being relaunched;
- Strengthened approach to Annual Appraisals was being launched in June 2021 as part of the At our Best Culture Change programme; and
- Conflict of Interest process had been announced on Team Talk.

20.2 Angela Wilkinson explained that the People and Culture Committee supported the appointment of a Well-being Guardian and proposed that Sarah Armstrong, Non-executive Director was appointed to this role to support the Trust and HIF, which was considered and approved.

20.3 **Resolved:** i) the Workforce and Organisational Development report was noted; and

ii) the appointment of Sarah Armstrong, Non-executive Director as the Trust's and HIF's Wellbeing Guardian was approved.

BoD/05/21/21 Caring At Our Best

21.1 The Caring At Our Best programme objectives and progress against the 12 workstreams was noted with the aim of: Delivering high quality care with collective responsibility for our patients…so that… we work as one team and deliver outstanding patient experience.

21.2 The Chairman commended the report and was pleased to see the work taking place.

21.3 Emma Nunez explained that the Trust had allocated funding for a full time project manager to lead this work for a fixed term period. She highlighted the focus to ensure shared learning.

21.4 Jackie Andrews highlighted the Quality Governance framework that had been launched at the beginning of May; and the meeting with the Governors to discuss Quality Priorities for inclusion within the Quality Account.

21.5 The Board noted the progress that had been made on Caring At Our Best since the Board Workshop on 24 February 2021 and welcomed regular updates on this area of work going forward.

21.6 **Resolved:** the Caring At Our Best update report was noted.

BoD/05/21/22 Proposal to Become an Anti-racist Organisation

22.1 The Chief Executive explained that work had been taking place to develop the plans to become an anti-racist organisation as part of the At Our Best programme; to improve culture within the Trust, to further embed the behaviours the Trust values around kindness, integrity, teamwork and equality. It was noted that the work was focussing on six areas:

- Governance
- Leadership and Management
- Recruitment
- Learning and Development (including Induction)
- Career Development
- Communications

22.2 It was noted that this work supported the legal requirements of the Equality Act 2010. On 31 March 2021, 20 colleagues joined the Trust's first workshop, 'Becoming an Anti-Racist Organisation' and ideas for strengthening the Trust's approach were brought forward and progressed. Particular interest was shown in improving the representation of the voices of BAME colleagues within existing governance structures. The Board welcomed colleagues from the BAME network to its Board workshop on 28 April 2021, which aided discussion on the ambition to become an anti-racist organisation. Powerful personal experiences were shared and contributions to roundtable discussions by BAME colleagues informed the further development and prioritisation of plans on Equality, Diversity and Inclusion, which were noted.

22.3 The Chairman reported that Wallace Sampson had agreed to take on the Non-executive Lead for this area of work. Wallace Sampson confirmed he was delighted to take this on and was fully supportive of the five year vision.

22.4 Following discussion the Board were supportive of the approach and noted that metrics were planned to be developed to support this work.

22.5 **Resolved:** i) the Proposal to Become an Anti-racist Organisation was approved.
ii) that Wallace Sampson would become the non executive lead for EDI

BoD/05/21/23 Audit Committee Chair's Report

23.1 The Audit Committee Chair's Report from the meetings held on 26 April and 4 May 2021 were noted. Richard Stiff, Chair of the Committee reported that the 26 April meeting considered the Trust's draft financial statements for 2020/21 prior to their submission to NHS England and Improvement.

23.2 Richard Stiff reported that at the 4 May 2021 meeting the External Auditors identified additional risks in relation to financial sustainability, which the Trust may wish to challenge in due course. Jonathan Coulter explained that the Internal Auditors had concerns with the number of limited assurance reports that had been repeated in the 2020/21 audits and the Audit Committee had noted that the process to oversee the management of Internal Audit reports had been strengthened recently. It was agreed that an update on the Limited Assurance Reports would be provided to the Board in Private.

ACTION (J Coulter)

23.3 **Resolved:** i) the Audit Committee Chair's reports from the meetings held on 26 April and 4 May 2021 were noted.

BoD/05/21/24 Resource Committee Chair's Reports

24.1 The Resource Committee Chair's reports from the meetings held on 26 April 2021, 10 May 2021 and 24 May 2021 were noted.

24.2 Maureen Taylor, Chair of the Committee explained that the meeting on 10 May 2021 was held to consider the workforce plan, taking into account the 2019/20 exit run-rates, with adjustments for service needs and non-recurrent items (such as COVID related schemes). Assumptions were made in respect of retained students and planned recruitment were reflected in the planned staffing numbers.

24.2 At the 24 May 2021, it was reported that the Trust achieved its planned break-even position in April 2021. The monthly cash forecast showed a steady use of cash throughout the year and reflected the capital programme commitment and the continuation of paying creditors promptly. The capital programme for 2021/22 was in excess of £32m, which included the Salix Carbon Reduction schemes. The Committee noted the ambitious programme, which they would be closely scrutinising throughout the year. The Terms of Reference were reviewed and it was noted that the Board Committee Terms of Reference were planned to be reviewed in the Autumn once the Quality Governance framework was in place.

24.4 **Resolved:** the Resource Committee Chair's reports from the meetings held on 26 April 2021, 10 May 2021, 24 May 2021 were noted.

BoD/05/21/25 Operational Report

25.1 The Operational Report was received and noted. Russell Nightingale drew attention to:
There had been high levels of demand for breast clinic appointments on the two week pathway and plans were underway to respond to the increases;
The RTT Waiting list continued to increase with longer waits in T&O, Ophthalmology, Gynaecology and Dental;
Safeguarding pressures were known, and work was taking place to mitigate the risk;
The reconfiguration of ED/the hot floor (Estates and Staffing) was planned to take place through the RPIW process, scheduled to take place on 7 and 8 June 2021; and
Increased focus on elective recovery was taking place across all points of delivery. The directorates had overachieved against the April 2021 plan levels, delivering 75% against 2019 levels of activity, which remained the focus for the months ahead. The 25% reduction against 2019 levels included a 16% Waiting list initiative (WLI) gap and 9% IPC restrictions and theatre efficacy. Plans were being developed to fill the WLI gap and IPC restrictions were being continuously reviewed.

25.2 In response to the Chairman's query, Russell Nightingale explained that discussions were taking place with York Trust around joint working to improve the waiting list position.

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

BoD/05/21/26 Finance Report

26.1 The Finance Report as at 30 April 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.

26.2 **Resolved:** the Finance Report as at 30 April 2021 was noted, which included the work being progressed to review investments and to agree a financial plan for H2; and

BoD/05/21/27 2021/22 Annual Plan

27.1 The Board noted that the planning process for 2021/22 was different from previous years, with a particular focus on the first half of the year and recognition that the NHS had managed throughout a pandemic and required to reset the work to be undertaken.

27.2 The Board considered and approved the proposed 2021/22 Annual Plan for submission to Humber Coast and Vale ICS for the beginning of June 2021.

27.3 **Resolved:** the planning submissions and priorities were noted and approved for submission to Humber Coast and Vale ICS for the beginning of June 2021.

BoD/05/21/28 Self-certification against Provider Licence

28.1 The Board considered the evidence to support sign off of the Self-certification against the Provider Licence. Richard Stiff confirmed that in his position as Chair of Audit Committee he supported the proposed sign-off.

28.2 **Resolved:** i) certified compliance against condition G6 (3) was noted including the evidence that the Trust had taken all precautions to comply with the licence, NHS Acts and NHS Constitution;
ii) certified compliance against Condition FT4 (8) governance arrangements were noted;
iii) certified compliance against Continuity of Services Condition 7 (3) that require resources to be available for acute services for 12 months from the date of the statement were noted;
iv) certified compliance against the Training of Governors obligation was noted; and
v) the plans in place to publish compliance against condition G6 (3) on the Trust's website by 30 June 2021 was approved.

BoD/05/21/29 Any Other Business

29.1 There was no other business.

BoD/05/21/30 Risks

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

BoD/05/21/31 Board Evaluation

31.1 It was noted that the meeting had enabled discussion on key strategic and operational issues and the format of papers provided positive assurance.

31.2 Laura Robson noted the enormous amount of work taking place and highlighted caution against executive burnout

BoD/05/21/32 Date and Time of Next Meeting

32.1 The next meeting will be held on Wednesday, 28 July 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 28 July 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/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 26 May 2021 28 July 2021	Under development	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	26/05/2021 29/09/21	**Update July 2021** - The GSW report is due at the September 2021 board meeting. Appropriate verbatium comments will be included as appropriate (information that could identify an individual will not be included). Action to close once GSW report received in September 2021	Open
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	**Update July 2021 -** The medical appraisal internal audit received significant assurance. 9 actions were agreed. 4 have been completed. Prtogress is being made against the remianing actions. **Previous update** nternal 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/05/21/8.2	26 May 2021	CEO Report - Corporate Manslaughter Annual Statement	Safeguarding training for all staff to cover this would enhanced and Emma Nunez would work with the Safeguarding team	Director of Nursing	DTBA		Open
BoD/03/21/11.4	26 May 2021	CRR and BAF	BAF risks agreed to be covered by associated Board Committee at each meeting and the complete BAF to be reviewed by the Board at its bi-monthly meetings for 12 months then the frequency will be reviewed	Board/Company Secretary	26 July 2021	**Update July 2021-** Company Secretary in the process of reviewing all sub-committies of the Board. Further information will be provided to the September 2021 Board of the revised corporate governance arrangements	Open
BoD/05/21/23.2	26 May 2021	Audit Committee Chair's Report	An update report on the Limited Assurance Reports would be provided to the Board in Private	Deputy Chief Executive/Finance Director	26 July 2021	**Recommendation to close** This will be routinely actioned as part of the agenda setting process.	Completed
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	**Recommendation to close** Workshop took place at July 2021 Board Workshop	Completed

BoD/11/20/13.3	25 November 2020	IBR	Non-executive Directors to be contacted to provide feedback on the format and content of the IBR to include within the current review. 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 31 May 2021	**Recommendation to close** IBR updated and included on the July 2021 Board Agenda	Completed
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	**Recommendation to close** Workshop took place at July 2021 Board Workshop	Completed
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**	**Recommendation to close** Action Plan provided to Board at its May 2021 meeting	Completed
BoD/03/21/9.3	26 May 2021	IBR	Supporting narrative would be provided on the maximum waiting times for Accident and Emergency in addition to the 4 hour standard information included	Chief Operating Officer	26 July 2021	**Recommendation to close** IBR updated and included on the July 2021 Board Agenda	Completed

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Report of the Chief Executive**
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Board with key updates and actions since previous meeting in May 2021.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	As noted in the Corporate Risk Report	
Report History:	Previous updates submitted to Public Board meetings	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Harrogate and District Hospitals NHS Foundation Trust

Board of Directors

28th July 2021

Report of the Chief Executive

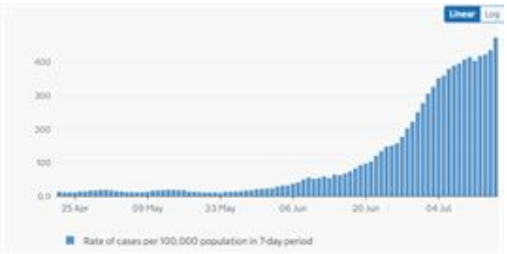
Introduction

1.1 Since the last Board meeting there has continued to be a significant focus on the priorities that we set (i) recovery of our 0-19 services, (ii) recovery of our elective services, (iii)

1.2 Matt Graham has been appointed as our first Director of Strategy following a two day process and he will join the Trust in early September 2021. The final stage of the selection process for the Director of Nursing, Midwifery and AHPs will take place on 2nd August.

1.3 Our Board workshop took place on 30th June 2020, and focused on Board development, an overview of our current Quality Improvement (QI) approach and options for the future, and a report out from the Kaizen event focused on the Emergency Department model. This was followed by a session on learning from deaths and mortality oversight.

1.4 Although legal restrictions which were introduced during the pandemic have been lifted from 19th July 2021, all of the measures we put in place to protect patients and colleagues remain in place. The community case rate is high, which is shown below, and was 473 per 100,000 population for the 7 day period ending 15th July 2021.



This has not translated into significant hospitalisation at this stage, but there is significant pressure on staffing across all our services due to the requirement for contacts to isolate, and many colleagues have reported being unwell. The pressure in staffing is also present in social care, and in the voluntary sector. The rise in cases does not mean the vaccine is not effective – it is most effective at preventing serious illness arising from COVID19, and it remains important to encourage younger adults in particular to take up the vaccine. There are pressures emerging in paediatric presentations, and the Trust is working with other WYAAT Trusts to plan for mutual aid.

Recovery of services

1.5 Whilst elective activity has continued to recover, the waiting list is growing because referrals have not only returned to previous levels but are greater than in 19/20, and although long waits are reducing at the moment, unless referrals reduce or we are able

to step up activity this position will not be sustained as the waiting list continues to rise because of the gap between demand and capacity.

1.6 Attendances at the Emergency Department are now 11% higher than in 2019/20 and emergency admissions are 5% higher which is placing considerable pressure on acute services and there is are increased risks due to waiting times, and occupancy. This also applies to community services where a combination of increased demand and only 75% of planned staffing available has resulted in prioritisation of urgent cases and some planned care has been delayed. The situation is forecast to improve in September but this does not change the current pressures colleagues are feeling, and the concerns around timeliness of care that can be provided.

1.7 There has been positive progress in our 0-19 services. There has been a successful over-recruitment of Band 5 nurses as part of the mitigation to the vacancies in school nursing and health visiting and the new safeguarding resources are coming into place alongside the internal mutual aid. There remains growing demand in safeguarding and much higher requirements for targeted support so there continues to be challenges, but the staffing situation is forecast to improve in September.

1.8 The first online recruitment event for 0-19 services was held recently, with colleagues sharing their positive experiences and a number of people who joined this have applied for roles. We will continue this model, alongside ongoing recruitment. We have also appointed to the majority of student placements for school nurses and health visitors.

1.9 We have continued to review waiting times for different populations and have identified some specialities where there is an apparent material disparity in waiting times between those on the waiting list from the third most deprived areas and the third least deprived areas. We do not yet know the reasons for this, and are continuing to assess this so that we ensure patients are not disadvantaged.

'At our best' – the HDFT way

1.10 "At our best" describes our ambition to achieve consistently high standards in everything that we do. The values of Kindness, Integrity, Teamwork and Equality have been launched and we continue to embed the tools and approaches into our daily work.

1.11 The teamHDFT app has gone live, which has had significant design input from the Your Voice panel and initial feedback has been very positive. We will continue to develop this based on feedback from colleagues.

1.12 The first Inpulse survey - which is a 3 minute survey accessed online or via the app, has opened, with a focus on Equality. Each survey will have a core set of questions about health and wellbeing, support and sentiment alongside a focus on one of the values. The feedback will be available to managers and the app is designed to support engagement with colleagues on practical improvements that can be made.

1.13 The goals for the 'leading at our best' have been drafted and following agreement, work will start on the key programmes to support leaders to be at their very best.

Planning for 2021/22

1.14 Notifications for the financial envelope for H2 of the year have not yet been received but are expected to be lower than H1 by c3-4%.

Partnerships

1.15 The Trust and North Yorkshire County Council have formally agreed and signed a Section 75 agreement for Children's services in North Yorkshire. This is a ten year partnership and we will now mobilise the new model of care, and the joint governance arrangements.

1.16 The Trust has received positive feedback from Gateshead Council particularly in respect of the wider support the 0-19 team have provided to the local response to COVID. They were highly complimentary of the local team.

1.17 Northumberland County Council have commenced consultation on their proposal to enter into a Section 75 partnership agreement with the Trust for 0-19 services in Northumberland.

Recommendation

The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Corporate Risk Register**
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Board with key updates and actions since previous meeting in May 2021.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Corporate Risk Register

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. **CRR34 – Autism Assessment**. The current position is that a further increase in referral rate had meant that baseline capacity is less than demand (6 month rolling referral average is now 56). This means the waiting list is not reducing. It currently stands at 590 (an increase from 576 last month and the longest wait is currently 71 weeks.

   At the current rate of referral the reduction/month will be reduced to 5, with the baseline funded capacity of 47 assessments plus the additional non-recurrent 12 months of an extra 14 assessments per month (61 total capacity per month).

   When the additional capacity is in place for the 14 assessments, which is expected in July 21, and if referral rates stay at their current rate with no further increases in complexity, it would leave the waiting list at 490 CYP at the end of the 12 month waiting list initiative (Q2 2022).

   The trajectory for a child referred today is that they should be assessed within 11 months and children referred this autumn should be assessed within 6 months.

   The Trust is developing a proposal to reduce the recovery timescales, and to support the service sustainably, which is due to be completed by September 2021 and will need to be discussed with commissioners.

3. **CR41 – RTT**. This risk remains scored as 12. The controls in place mean that 87% of P2 patients are waiting under 28 days, with those waiting longer largely being due to patient choice. The controls have also meant that outpatient activity is at 98% of 2019/20, day cases at 104% and inpatients at 82%. With the controls around scheduling, the number of over 52 week waits has reduced by 7% and is below the trajectory (1,006 actual against a trajectory of 1,237). However, the waiting list size has grown because referrals are higher that completed treatments, and further controls will be required to continue the reduction in long waits and to stabilise the waiting list. There are risks relating to continuing the level of activity due to annual leave, vacancies in theatres and self-isolation levels.

4. **CR52 – Insufficient capacity in the two week wait breast one stop service**. The title of this risk has been redefined to better reflect the issue. The baseline capacity is 40 per week, but referrals have been 50 per week since February 2021. The controls to mitigate risks include a triage process to identify high risk referrals, and there are ad hoc clinics to provide additional capacity. From the 15th May, independent sector capacity has been in place and the forecast is to return to compliance from September. Gaps in controls relate to a suitably configured environment and a case is being developed for this, and

sustainable internal capacity. The broader controls in respect of cancer pathways have meant whilst the 62 day standard was met.

5. **CR57 – Impact of safeguarding demand**. Data for Safeguarding strategy meetings shows activities continue to be at escalated levels. The average number from April 20 to Feb 21 was 812 per month which has increase to an average of 1,000 per month in March to May 21 (19% increase). To provide additional controls, a business case was approved in May 2021 to increase capacity in the safeguarding team to deal with the specialist work but also strategy meetings which will support the 0-19 teams to undertake more preventative work. It is expected people will start coming into posts from October 21. Additional mutual aid has been provided through redeployment of three colleagues in July 2021 to support Safeguarding Strategy Meetings and Sunderland strategy nurses have completed 6 week induction/preceptorship/competency programme. Additional controls are planned with the development of an OPEL framework for 0-19 and safeguarding. This will allow 0-19 teams flexibility to act in line with the agreed mitigations during times of pressure. The service continues in the main to meet the standards for the healthy child programme but there are constraints on the ability of teams to undertake preventative activities.

   CR5 – Nursing shortage. This risk remains at the same level. There are 19.24WTE RN and 8.75WTE CSW vacancies for in-patient wards (compared to 17.29WTE and 9.83WTE the previous month). The control mean overall fill rate has remained above 90%. Additional controls are planned with a programme of work focused on retention.

   There are 7.58WTE vacancies in school nurses and 26.41WTE in health visiting (compared to 9.95 and 26.52WTE vacancies the previous month). The controls put in place mean there is an over-recruitment to Band 5 roles of 11.57WTE.

   Cohort recruitment continues on a rolling basis, and on-line recruitment events have been expanded to 0-19 services and the initial event was successful with 4 applications following.

   In adult community nursing, only 76% of funded hours are available to rotas with pressure forecast over the summer arising from complexity of demand and the gap of 9.03 WTE (5.63 vacancies, with sickness and maternity leave the remainder). 7.4WTE are due to commence in post in September,. In consideration of controls exit interviews were reviewed and show the main reasons for resignation related to relocation and promotion. Controls in place include staff being supported to prioritise caseloads, thrive conversations are taking place, additional Band 7 roles (moving from 2.67 to 4.67WTE) and incentivisation of bank shifts over the summer.

6. **CR61 – ED 4 hour standard**. Although the risk has remained as 12, activity for ED attendances and emergency admissions are 111% and 105% of 2019/20 levels which is placing further pressure on performance (82.6% compared to 82.2% the previous month) and waiting times (92nd centile wait was 6hours 21 minutes compared to 6hours 1minute the previous month). Additional controls are being phased in following the RPIW with streaming at the weekend. The number of six hour waits is monitored.

7. **CR54 – Staff wellbeing and morale**. This risk relates to the short and long term mental health impacts on staff due to ongoing Coronavirus pandemic and remains at the same level. There are a broad range of controls in place through the health and wellbeing

support and the ICS based resilience hubs. Further controls introduced include de-escalation training for Matrons, the introduction of Mental Health Champions (18 are being trained) and proposals for further Schwartz facilitators and a mental health nurse have been made to the ICS. The launch of the Inpulse app is expected to provide more granular feedback on this to allow more focused support.

8. **New risks** which have been added, are as follows:

9. **CR48 – Mental Health services for ED patients.** This relates to the risk to patient and staff safety due to long delays in response from mental health services for patients at high risk. This is driven by the time taken to undertake a MHA assessment and locate a bed for patients requiring detention which is usually between 8 and 12 hours meaning ED staff are attempting to manage high risk patients in the ED.

   Whilst this has been escalated at the A&E Delivery Board, further controls need to be developed.

10. CR63 **– Violence and aggression from patients in ED.** This relates to the risk of physical and/or psychological harm to staff or other patients arising from the increasing number of incidents relating to violence or threat of violence to staff from patients attending ED. 12% of incidents reported in LTUC relate to this issue. The current controls rely on support from the general portering team and the police.

    A review of security has taken place, and the following controls are being introduced – body cameras, CCTV, additional training for portering staff, the creation of a designated security responder, a structured 'threat response' standard operating procedure and a more structured approach to follow up with patients. The Trust also plans to engage with the police to seek advice on the organisational approach. This should address the majority of the current gaps in control.

    There are some remaining gaps in control relating to the ability to secure specific parts of the site which is being reviewed and in the timeliness of the police response on occasions.

Removed risks

11. The following risks were removed from the Corporate Risk Register because they were re-scored and are below 12.

    CR66 – Aseptic Unit.
    CR67 – COVID testing platform.
    CR2 – Medical staffing vacancies

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

Harrogate and District NHS Foundation Trust

2.1

Board of Directors held in Public
28th July 2021

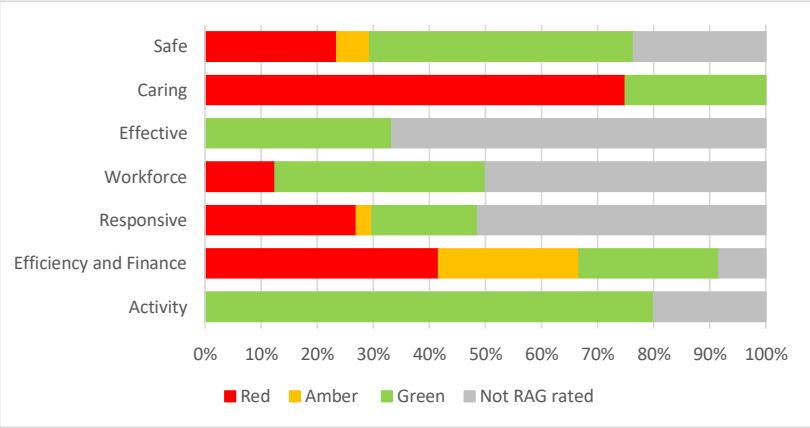
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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

Integrated Board Report - Summary of indicators - June 2021

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	4	1	8	4
Caring	4	3	0	1	0
Effective	6	0	0	2	4
Workforce	8	1	0	3	4
Responsive	37	10	1	7	19
Efficiency and Finance	12	5	3	3	1
Activity	5	0	0	4	1
Total	**89**	**23**	**5**	**28**	**33**



NHS System Oversight Framework (SOF) 2021/22

1. NHS England and NHS Improvement recently published their approach to oversight for 2021/22.

2. The NHS System Oversight Framework (SOF) provides clarity to Integrated Care Systems (ICSs), Trusts and Commissioners on how NHS England and NHS Improvement will monitor performance; sets expectations on working together to maintain and improve the quality of care; and describes how identified support needs to improve standards and outcomes will be co-ordinated and delivered.

3. It will be used by NHS England and NHS Improvement's regional teams to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require.

4. It describes how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local level to ensure our activities are aligned.

5. It introduces a new integrated and system focused Recovery Support Programme (RSP) that replaces the previously separate quality and finance 'special measures' regimes for provider trusts.

6. In total, there are 81 metrics in this year's framework, 47 of which are applicable to Trusts. The technical guidance documents that provide the detail around these metrics have not yet been published but are expected in August.
7. A significant number of the metrics are already included in this report.
8. Going forward, we will provide an overview of the Trust's performance on all applicable metrics within the framework.

Integrated Board Report - Summary of Jun-21 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.61
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	0.68
Safe	1.3	Inpatient falls per 1,000 bed days	4.9
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	16.74
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	4
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	92.5%
Safe	1.8.2	Safer staffing levels - CHPPD	8.6
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	100.0%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	7.4%
Safe	1.12	Infant health - % women initiating breastfeeding	84.8%
Safe	1.13	VTE risk assessment - inpatients	96.9%
Safe	1.14.1	Sepsis screening - inpatient wards	92.9%
Safe	1.14.2	Sepsis screening - Emergency department	88.9%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	93.7%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	96.5%
Caring	2.2.1	Complaints - numbers received	20
Caring	2.2.2	Complaints - % responded to within time	35%
Effective	3.1	Mortality - HSMR	96.6
Effective	3.2	Mortality - SHMI	93.2
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	38
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	144
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	
Workforce	4.1	Staff appraisal rate	58.9%
Workforce	4.2	Mandatory training rate	92.0%
Workforce	4.3	Staff sickness rate	3.90%
Workforce	4.4	Staff turnover rate	13.3%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies	
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies	
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting across all posts	

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	41
Responsive	5.1.3	RTT Incomplete pathways - total	20631
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	993
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	13
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	79.2%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	9754
Responsive	5.5	Data quality on ethnic group - inpatients	95.8%
Responsive	5.6	A&E 4 hour standard	82.6%
Responsive	5.7	Ambulance handovers - % within 15 mins	88.3%
Responsive	5.8	A&E - number of 12 hour trolley waits	0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	91.6%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	2
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	88.1%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	79.0%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	100.0%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	
Responsive	5.13.2	Children's Services - 2-3 years caseload	
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings	
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences	
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports	
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children	
Responsive	5.15	Children's Services - Ante-natal visits	89.8%
Responsive	5.16	Children's Services - 10-14 day new birth visit	94.9%
Responsive	5.17	Children's Services - 6-8 week visit	93.3%
Responsive	5.18	Children's Services - 12 month review	92.6%
Responsive	5.19	Children's Services - 2.5 year review	92.9%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	39.9%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	75.9%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 414
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	£ -
Efficiency and Finance	6.3	Capital spend	£ 1,856
Efficiency and Finance	6.4	Cash balance	£ 32,007
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	103
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	40
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	
Efficiency and Finance	6.7.1	Length of stay - elective	2.57
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.02
Efficiency and Finance	6.8	Avoidable admissions	208.00
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	83.4%
Efficiency and Finance	6.10	Day case conversion rate	1.9%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1.1	GP Referrals against plan	
Activity	7.1.2	GP Referrals against 2019/20 baseline	
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	121.9%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	97.6%
Activity	7.3.1	Elective activity against plan	110.0%
Activity	7.3.2	Elective activity against 2019/20 baseline	90.9%
Activity	7.4.1	Non-elective activity against plan	105.2%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	104.8%
Activity	7.5.1	Emergency Department attendances against plan	111.2%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	110.8%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	1.03	0.73	1.08	0.64	0.45	0.28	0.28	1.22	1.17	0.99	0.78	0.71	0.37	0.00	0.61	EN	Quality	tbc		
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.04	1.44	1.16	1.26	1.10	1.06	1.15	0.62	1.48	0.95	1.28	1.29	1.31	1.36	0.68	EN	Quality	tbc		
Safe	1.3	Inpatient falls per 1,000 bed days	12.5	9.7	8.7	5.4	6.2	5.0	6.0	6.4	6.5	7.4	11.0	7.3	5.1	6.1	4.9	EN	Quality	above HDFT average for 2020/21	0-20% below HDFT average for 2020/21	>20% below HDFT average for 2020/21
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	EN	Quality	>19 YTD		<=19 YTD
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	10.02	10.38	13.52	14.34	14.66	18.71	19.92	14.72	10.10	14.13	10.11	16.38	17.60	21.29	16.74	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	0	0	1	0	0	2	1	2	0	0	1	1	3	1	4	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	NA	NA	NA	NA	NA	NA	95.4%	93.3%	95.3%	95.3%	95.3%	93.9%	93.8%	93.1%	92.5%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	NA	NA	NA	NA	NA	NA	10.1	9.9	9.7	9.4	9.0	8.7	8.6	8.4	8.6	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	97.2%	100.0%	99.3%	100.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.4%	100.0%	100.0%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway																EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	5.7%	7.6%	5.3%	3.0%	2.8%	6.4%	6.7%	3.7%	6.3%	4.6%	8.1%	4.5%	6.6%	2.9%	7.4%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	85.1%	84.5%	90.2%	83.8%	84.4%	85.4%	89.9%	84.6%	87.1%	88.7%	91.5%	86.5%	83.6%	82.6%	84.8%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	95.0%	93.9%	92.3%	93.6%	95.0%	92.6%	95.1%	95.4%	94.2%	96.9%	96.8%	96.7%	96.7%	97.1%	96.9%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	92.8%	88.9%	95.0%	94.7%	91.4%	94.0%	94.8%	94.6%	94.8%	95.3%	94.2%	94.2%	91.8%	96.1%	92.9%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	89.2%	88.9%	92.8%	93.1%	93.1%	88.6%	88.8%	91.7%	91.3%	91.3%	88.0%	89.4%	85.9%	89.2%	88.9%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - Patients	96.6%	95.6%	95.8%	95.6%	95.8%	94.9%	94.2%	95.0%	95.0%	94.5%	95.2%	93.9%	94.2%	92.7%	93.7%	EN	Quality	<national average		>=national average
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	94.2%	98.2%	92.1%	95.3%	95.0%	93.9%	93.1%	98.1%	93.2%	93.4%	95.1%	87.5%	94.7%	95.5%	96.5%	EN	Quality	<national average		>=national average
Caring	2.2.1	Complaints - numbers received	5	10	9	18	11	21	12	16	19	17	16	38	15	24	20	EN	Quality	above HDFT average for 2020/21		On or below HDFT average for 2020/21
Caring	2.2.2	Complaints - % responded to within time														50%	35%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	107.42	106.86	108.69	109.26	107.36	106.73	106.02	102.2	97.21	97.22	98	96.6				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	95.73	94.74	95.49	94.56	94.16	93.67	93.97	94.13	92.91	93.18						JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	13	15	22	25	30	26	34	34	26	23	20	25	39	38		RN	Resources	tbc		
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	67	85	87	100	102	108	118	117	108	102	105	104	142	144		RN	Resources	tbc		
Effective	3.4	Returns to theatre																RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care																RN	Resources	tbc		
Workforce	4.1	Staff appraisal rate	74.6%	69.3%	64.1%	57.0%	49.3%	47.0%	48.7%	50.2%	50.4%	53.1%	54.8%	54.9%	56.3%	58.3%	58.9%	AW	People and Cultu	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	90.0%	85.0%	87.0%	89.0%	91.2%	91.4%	91.6%	91.8%	92.1%	91.9%	91.3%	91.2%	91.7%	92.1%	92.0%	AW	People and Cultu	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	4.54%	4.15%	4.36%	4.10%	4.10%	4.27%	4.67%	5.11%	4.67%	5.36%	4.93%	4.33%	3.90%	3.91%	3.90%	AW	People and Cultu	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	12.7%	13.0%	12.3%	12.3%	12.2%	12.4%	12.2%	13.0%	13.2%	13.4%	13.0%	12.7%	12.9%	12.0%	13.3%	AW	People and Cultu	>15%		<=15%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies																AW	People and Culture			
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies																AW	People and Culture			
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts																AW	People and Cultu	tbc		
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting																AW	People and Cultu	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	13	16	15	7	8	9	8	8	9	10	9	7	8	8	8	RN	Resources			
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	32	35	37	39	41	43	45	45	48	50	51	48	44	43	41	RN	Resources			
Responsive	5.1.3	RTT Incomplete pathways - total	9754	9593	11659	14039	15345	16379	16730	16733	16197	15397	15878	17323	18156	19476	20631	RN	Resources			

Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	18	53	139	293	421	524	639	789	974	1062	1268	1345	1196	1082	993	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks													3	5	13	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity																RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation																RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities																RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	44.7%	49.2%	65.7%	77.5%	75.6%	70.6%	79.2%	78.4%	73.7%	73.6%	80.5%	81.7%	79.7%	85.4%	79.2%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date									11812	11345	10694	9850	9792	9877	9754	RN	Resources	tbc		
Responsive	5.5	Data quality on ethnic group - inpatients	96.7%	96.2%	96.7%	96.0%	95.9%	95.9%	95.9%	95.9%	95.3%	95.2%	94.3%	95.2%	94.9%	96.5%	95.8%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	92.6%	93.4%	95.1%	91.3%	87.2%	89.5%	90.9%	90.1%	85.4%	85.8%	80.2%	83.7%	86.3%	82.7%	82.6%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	91.2%	96.0%	92.5%	95.0%	86.5%	87.8%	93.5%	96.5%	95.2%	93.8%	94.4%	93.7%	93.8%	93.6%	88.3%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	89.8%	79.4%	81.5%	92.6%	89.6%	87.2%	87.0%	88.7%	84.7%	84.8%	77.7%	85.4%	85.5%	87.1%	91.6%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	0	0	2	3	0	2	2	5	3	5	2	5	3	2	2	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	93.0%	97.3%	98.4%	94.9%	97.9%	97.7%	98.4%	83.7%	88.0%	91.8%	90.2%	89.0%	81.7%	85.7%	88.1%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)							74.1%	74.0%	81.3%	71.8%	79.0%	85.2%	80.2%	80.9%	79.0%	RN	Resources			
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	100.0%	95.2%	92.9%	100.0%	100.0%	98.8%	98.9%	97.1%	100.0%	100.0%	98.8%	97.1%	97.0%	96.6%	100.0%	RN	Resources	<94%		>=94%
Responsive	5.13.1	Children's Services - 0-12 months caseload																RN	Resources			
Responsive	5.13.2	Children's Services - 2-3 years caseload																RN	Resources			
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings																RN	Resources			
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences																RN	Resources			
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports																RN	Resources			
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children																RN	Resources			
Responsive	5.15	Children's Services - Ante-natal visits	92.3%	95.1%	95.5%	94.6%	94.9%	93.7%	93.4%	93.9%	93.0%	88.8%	93.2%	89.1%	85.9%	86.7%	89.8%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.0%	95.9%	96.6%	95.0%	96.4%	94.7%	94.7%	95.7%	92.1%	89.2%	93.6%	97.0%	95.4%	95.4%	95.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	94.1%	93.3%	94.3%	94.6%	93.7%	95.8%	95.2%	94.8%	91.2%	88.0%	90.0%	95.1%	91.9%	92.4%	93.3%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	98.9%	99.0%	97.7%	97.4%	97.1%	98.4%	97.9%	94.9%	92.9%	92.4%	92.5%	93.8%	93.1%	91.2%	92.6%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	94.0%	96.4%	95.3%	95.0%	94.8%	95.5%	94.5%	95.3%	93.4%	92.8%	93.2%	91.9%	91.5%	91.7%	93.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts																RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory																RN	Resources			
Responsive	5.22	Children's Services - OPEL level																RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards																RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service																RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits																RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level																RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	40.4%	36.4%	42.2%	46.2%	45.3%	41.2%	43.7%	46.2%	40.0%	42.0%	44.1%	40.1%	36.7%	35.5%	39.9%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	100.0%	100.0%	90.9%	100.0%	91.3%	85.7%	78.9%	93.8%	81.3%	100.0%	81.3%	89.3%	78.6%	86.2%	75.9%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	£ 367	£ 402	£ 411	£ 370	£ 288	£ 254	£ 310	£ 387	£ 424	£ 308	£ 336	£ 380	£ 419	£ 307	£ 414	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	£ -	£ -	£ -	£ -	£ -	£ -	-£ 340	-£ 693	-£ 491	-£ 402	£ 3,100	-£ 745	£ -	£ -	£ -	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	-	£ 2,069	£ 3,154	£ 4,084	£ 4,187	£ 5,100	£ 7,093	£ 8,129	£ 10,223	£ 10,797	£ 11,300	£ 16,356	£ 518	£ 834	£ 1,856	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan

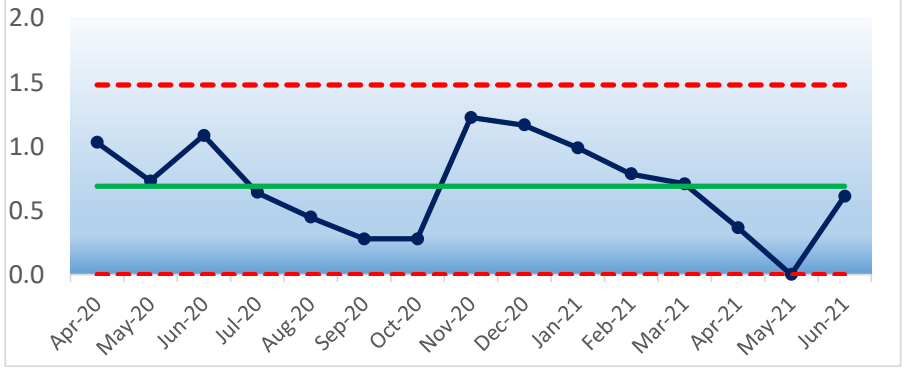
Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Efficiency and Finance	6.4	Cash balance													£ 39,900	£ 34,587	£ 32,007	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	64	63	65	75	78	96	80	89	92	111	127	122	119	114	103	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	23	19	22	27	26	40	28	22	27	38	48	48	48	44	40	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population																RN	Resources	tbc		
Efficiency and Finance	6.7.1	Length of stay - elective	2.80	1.59	1.53	2.61	2.72	2.46	2.15	2.51	2.53	3.25	3.12	2.37	2.26	2.60	2.57	RN	Resources	>2.3	2.0-2.3	<=2.0
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.12	3.42	3.27	3.43	3.33	3.96	3.70	3.59	3.78	4.19	4.40	4.35	4.28	3.93	4.02	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	104	138	151	148	166	173	177	202	199	145	162	178	187	208		RN	Resources	>130	100-130	<=100
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	56.2%	58.7%	53.0%	63.1%	64.3%	71.8%	76.8%	80.3%	78.3%	78.6%	88.7%	80.5%	81.2%	83.9%	83.4%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	0.9%	1.4%	2.4%	2.2%	2.0%	1.7%	2.2%	2.0%	2.5%	1.5%	1.4%	1.4%	2.2%	1.7%	1.9%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1.1	GP Referrals against plan																RN	Resources			
Activity	7.1.2	GP Referrals against 2019/20 baseline																RN	Resources			
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)													113.7%	106.9%	121.9%	RN	Resources			
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)													90.8%	86.5%	97.6%	RN	Resources			
Activity	7.3.1	Elective activity against plan													102.5%	97.3%	110.0%	RN	Resources			
Activity	7.3.2	Elective activity against 2019/20 baseline													74.8%	80.6%	90.9%	RN	Resources			
Activity	7.4.1	Non-elective activity against plan													96.5%	97.4%	105.2%	RN	Resources			
Activity	7.4.2	Non-elective activity against 2019/20 baseline													89.9%	98.6%	104.8%	RN	Resources			
Activity	7.5.1	Emergency Department attendances against plan													98.9%	106.6%	111.2%	RN	Resources			
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline													98.9%	106.6%	110.8%	RN	Resources			

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	0.61

Indicator description

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

SPC chart



Narrative

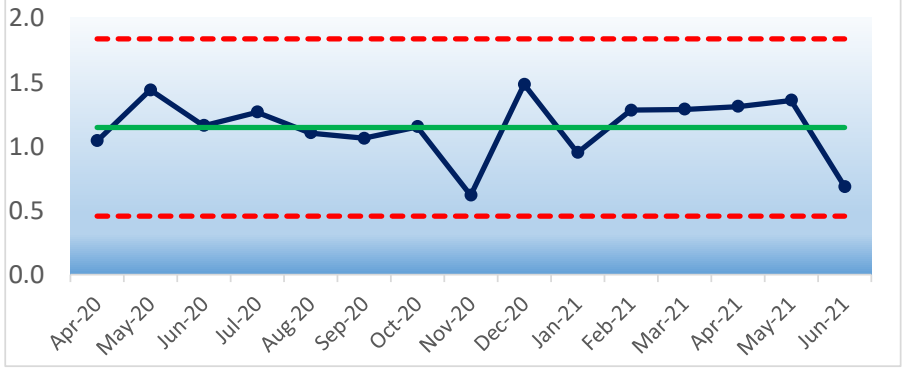
The Trust has seen a 10% increase in hospital acquired pressure ulcers in June 2021. Pressure ulcers on patient's heels make up 85% of these incidents and work is ongoing with pods to look at themes & additional training requirements. The majority of incidents are reported from Long Term and Unscheduled Care Directorate which cares for the majority of our elderly and frail population, however there is no evidence of this being concentrated on a particular ward. The Improvement Plan includes working with orthotics to consider a central store for wards to access repose wedges for easy access, individualised/personalised harm review - in line with other Trusts, increased visibility of Tissue Viability Nurse (TVN) within the Trust as new team members start, bite sized drop ins/training, increasing link nurses, reinstating the Pressure Ulcer Steering Group with falls and nutrition (Quality Steering Group).

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	0.68

Indicator description

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

SPC chart



Narrative

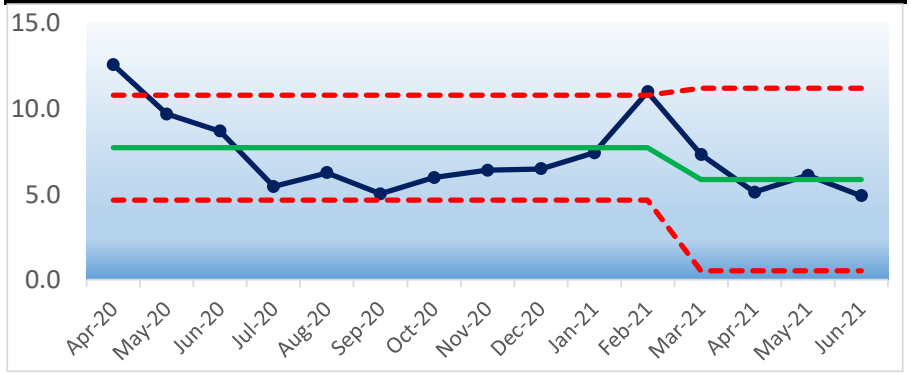
The Trust has seen a 19% reduction in community reporting of pressure ulcers (cat 3 and above). This follows a focussed piece of work on aligning the reporting definition in line with the current best reporting practice. It is likely that this is reflected in the reduction and therefore important that we monitor changes in our reporting with this revised definition.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	4.89

Indicator description

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

SPC chart



Narrative

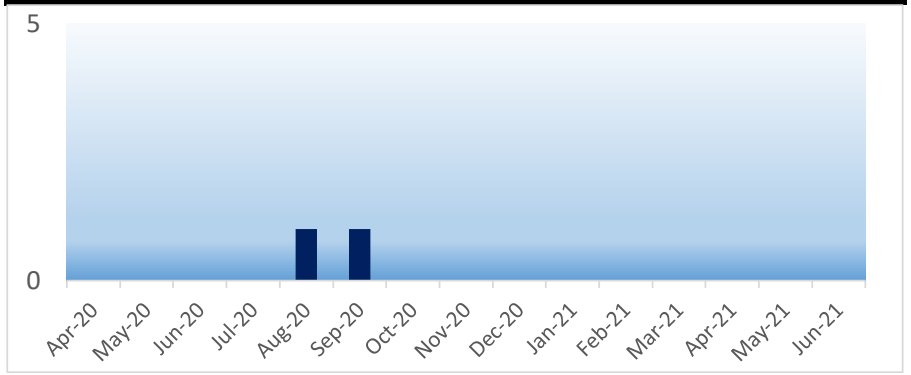
Overall the Trust saw an increase in Falls in February 2021. Following analysis work by the falls co-ordinator, it is suggested that acuity of patients has contributed to this increase. The Falls improvement plan has been developed and is currently being reviewed and agreed. In addition, the triangulation of quality metrics with staffing levels will be an important indicator in further understanding changes in acuity and dependency of our population.

Indicator	**1.4 - Infection control - C.diff hospital acquired cases due to a lapse in care**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT's C. difficile trajectory for 2021/22 is 19 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

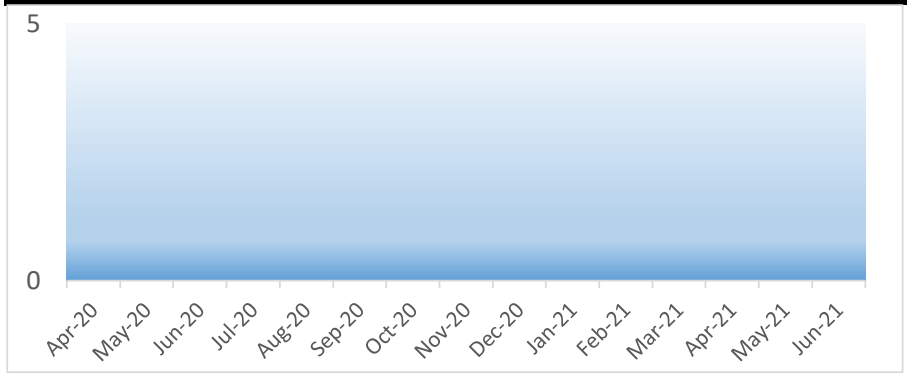
The Trust have reported 0 cases of hospital acquired Clostridium Difficile due to a lapse in care, which is positive.

Indicator	**1.4 - Infection control - MRSA hospital acquired cases due to a lapse in care**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	0

Indicator description

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

Trend chart



Narrative

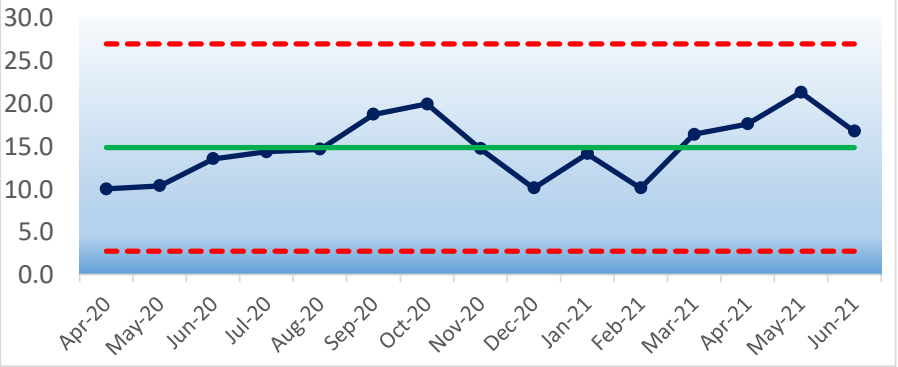
The Trust have had 0 cases of hospital acquired MRSA, which is positive.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	16.7

Indicator description

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

SPC chart



Narrative

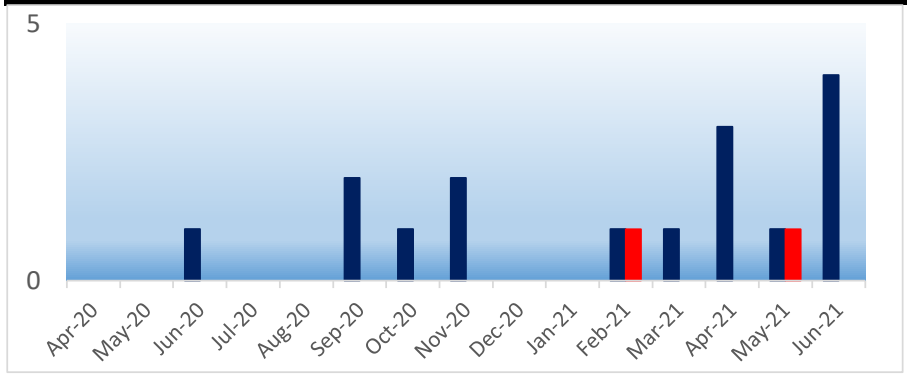
Work is ongoing in relation to this indicator. It is important that the Trust has an open culture in relation to Incident Reporting, this is mainly measured by the number of incidents reported that are low level harm and near misses which provide an early opportunity for learning. There is ongoing work nationally regarding the changes to incident reporting frameworks which we are aligning within the Trust via our Patient Safety Specialists.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	4

Indicator description

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

Trend chart



Narrative

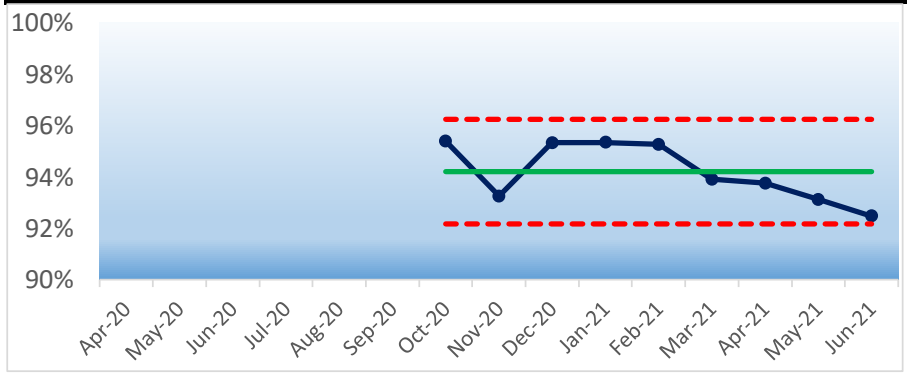
The Trust have seen a gradual increase in Serious Incident Reporting since the beginning of the year. This is in part due to increased awareness of the criteria of Serious Incidents and therefore recognition and reporting. The Medical Examiner process has also provided another opportunity to identify where incidents may have occurred and where these meet serious incident criteria, these have been reported as such. Reporting of Serious Incidents should not be viewed negatively as this provides an opportunity for in-depth learning and also family engagement in a process that identifies where care and/or treatment fell short of expected standards and aims to provide clarity of why that happened and how we can learn for improvement.

Indicator	**1.8 - Safer staffing - fill rate and care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	92.5%

Indicator description

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

SPC chart



Narrative

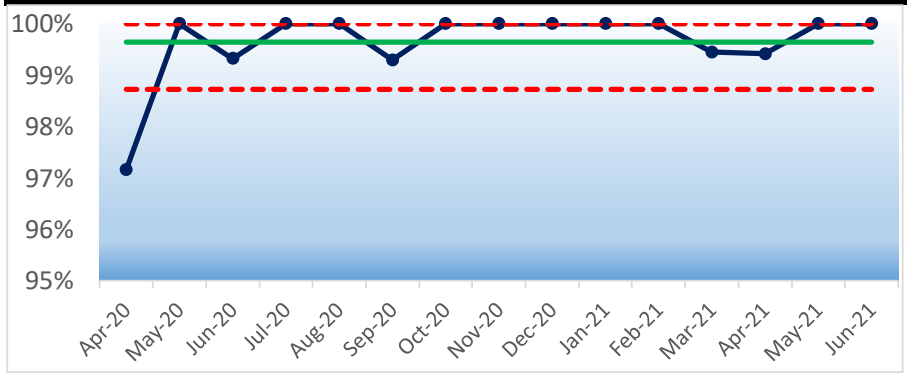
Further work is ongoing in relation to this indicator and completion of the Safe Staffing review in September 2021 will reset the baseline on which fill rates and CHPPPD are reported. Acuity and dependency of patients, vacancies and staff absence require continual review of the staffing position on each ward and area of the Trust to maintain appropriate staffing levels.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	100%

Indicator description

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

SPC chart



Narrative

The Trust is in a positive position in relation to this indicator.

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

Indicator description

This indicator is under development.

SPC chart

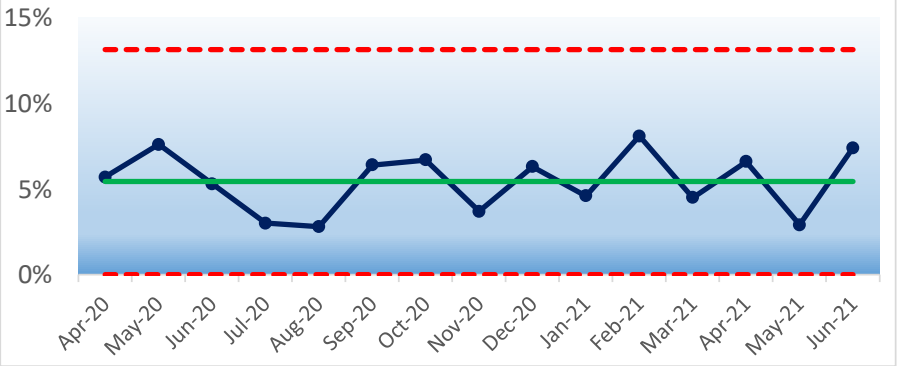
Narrative

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	7.4%

Indicator description

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

SPC chart



Narrative

The Trust have a relatively low rate of women smoking at the time of delivery in comparison to other Trusts across the local maternity system and region. Our most recent quarterly data shows 5.6% rate against a 12.7% average across Yorkshire and the Humber.

Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	84.8%

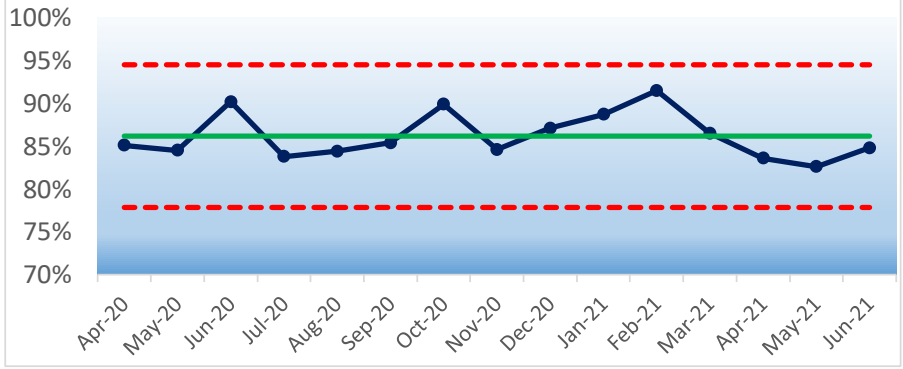
Indicator description

The % of women initiating breastfeeding

Narrative

Breastfeeding initiation rates for the Trust are positive. The average across Yorkshire and Humber Trusts is 68.7%. The Trust position is reflective of focussed areas of improvement and accreditation across the Trust e.g. UNICEF Baby Friendly accreditation.

SPC chart

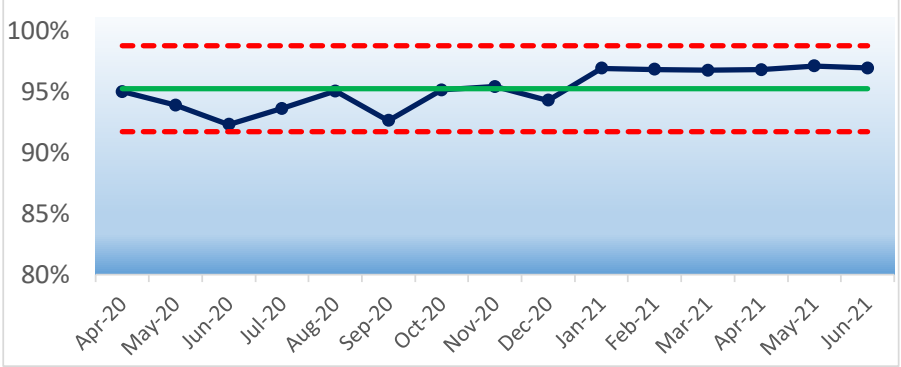


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	96.9%

Indicator description

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

SPC chart



Narrative

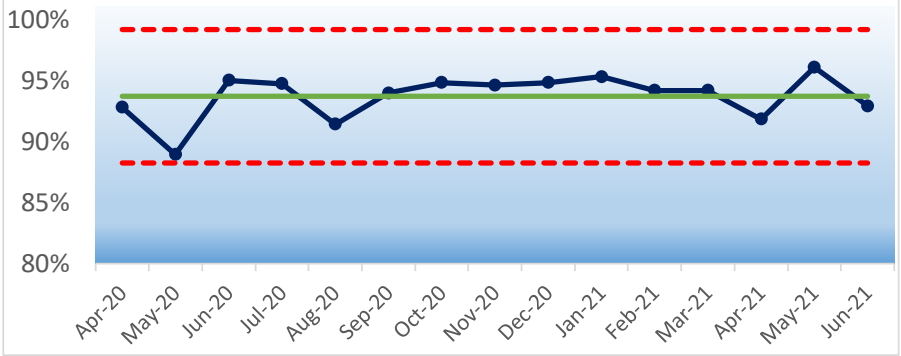
The Trust has performed well in relation to compliance with this standard over the last 6 months. Work is underway to encompass reporting of this standard into our quality monitoring arrangements from August 2021.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	92.9%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

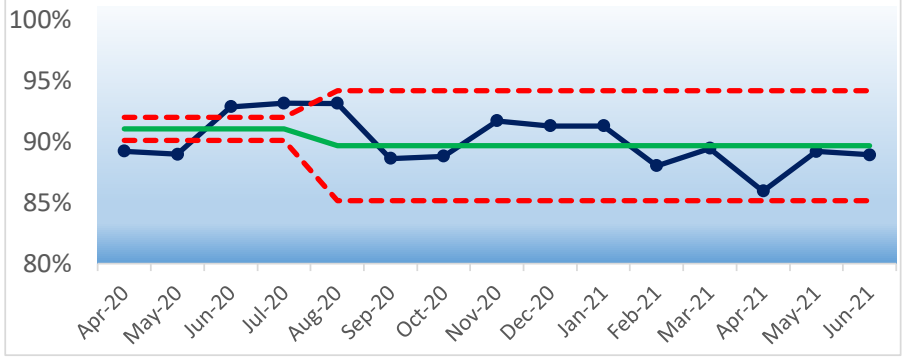
The Trust has performed well in relation to compliance with this standard, however there has been variation in this over the year. Work is underway to encompass reporting of this standard into our quality monitoring arrangements.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	88.9%

Indicator description

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

SPC chart



Narrative

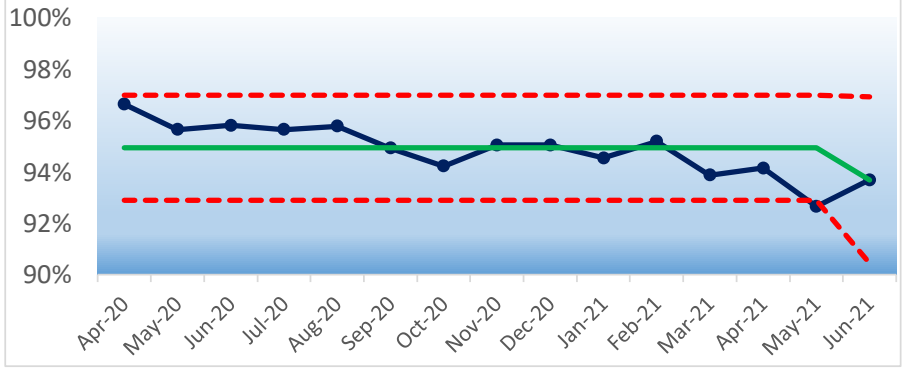
Further work is underway in relation to this indicator. The Trust has performed variably in relation to compliance with this standard and in particular over more recent months, which coincides with increased attendances in the Emergency Department. Further work is required to understand the reporting and monitoring against this standard to identify unwarranted variation before developing an improvement plan linked to ongoing quality monitoring.

Indicator	**2.1.1 - Friends & Family Test (FFT) - Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	93.7%

Indicator description

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

SPC chart



Narrative

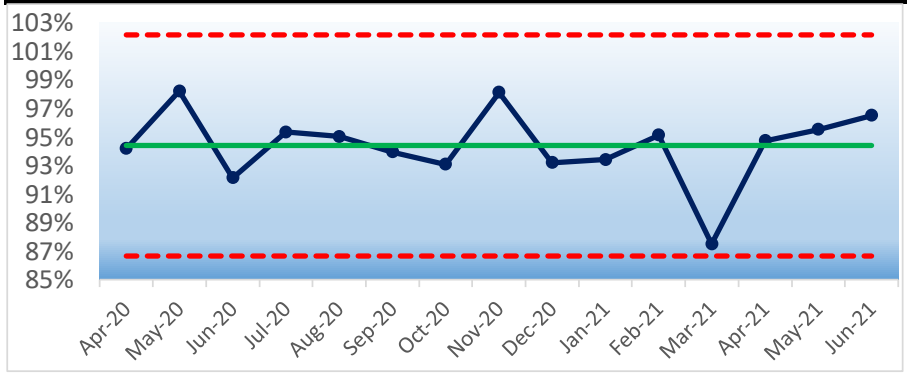
The Trust performs generally well with the Friends and Family Test. This links to the Trust priorities of Caring at Our Best and Making Experience Count and further plans are in development on these areas.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	96.5%

Indicator description

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

SPC chart



Narrative

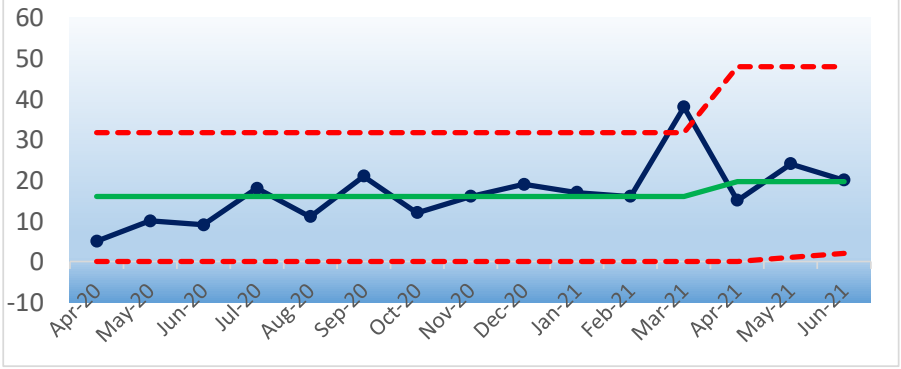
The Trust performs generally well with the Friends and Family Test for Adult Community Services. This links to the Trust priorities of Caring at Our Best and Making Experience Count and further plans are in development on these areas.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	20

Indicator description

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

SPC chart



Narrative

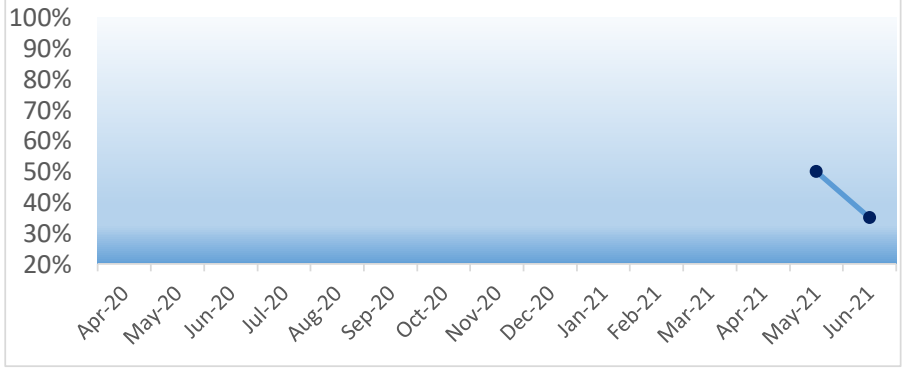
The Trust had a spike in complaints during March which is now reducing. A Complaints Improvement Plan is in place and further work is planned in relation to real time patient feedback.

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	35%

Indicator description

The number of complaints responded to within 20 days. The Trust's imrpovement trajectory for 2021/22 is to repsond to 95% of complaints on time by December 2021.

Trend chart



Narrative

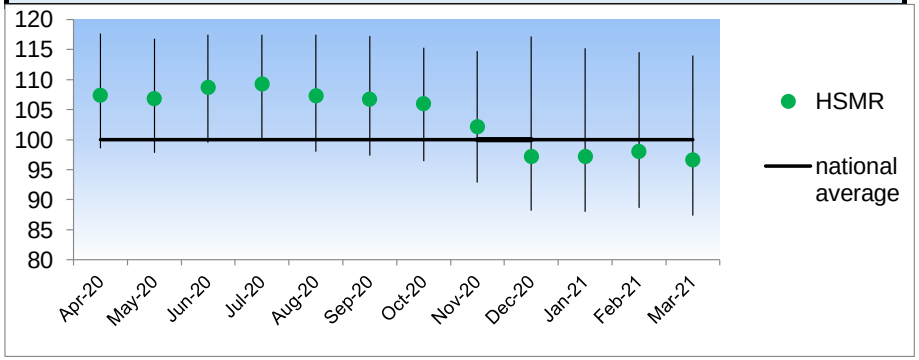
The Trust has an improvement trajectory in place for the management of the backlog of complaints across the organisation. The improvement trajectory was set on 12th May 2021 (22 outstanding complaints) with a plan to be at 0 by the end of July 2021. As of 14th July, we currently have 4 outstanding complaints from the backlog which is in line with the trajectory. Work continues to improve our performance against the 25 working day timeline which is 38% organisationally as at 14th July. Plans remain in place to improve the position to 95% by December 2021.

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Mar-21
Value / RAG rating	96.60

Indicator description

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

Trend chart



Narrative

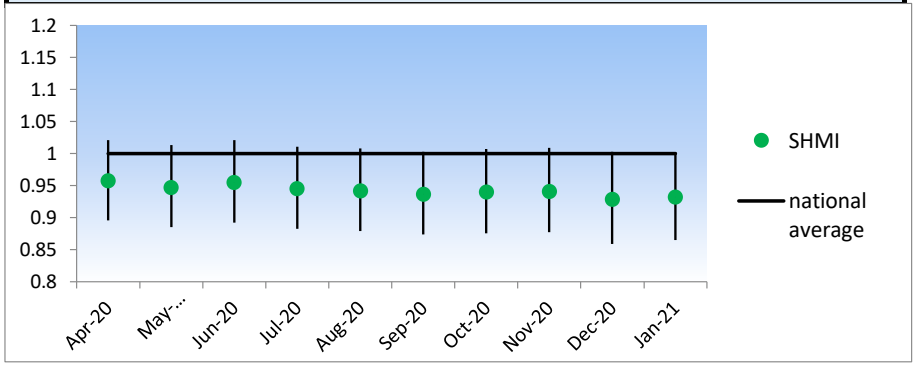
National average is 100. HDFT remains slightly below average and within the exepected range.

Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jan-21
Value / RAG rating	0.93

Indicator description

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

Trend chart



Narrative

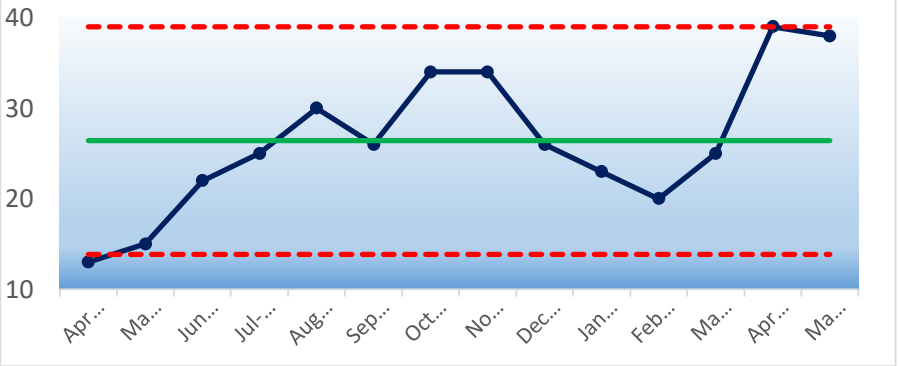
National average is 1. HDFT remains below average and within the expected range at 0.932

Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-21
Value / RAG rating	38

Indicator description

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

SPC chart



Narrative

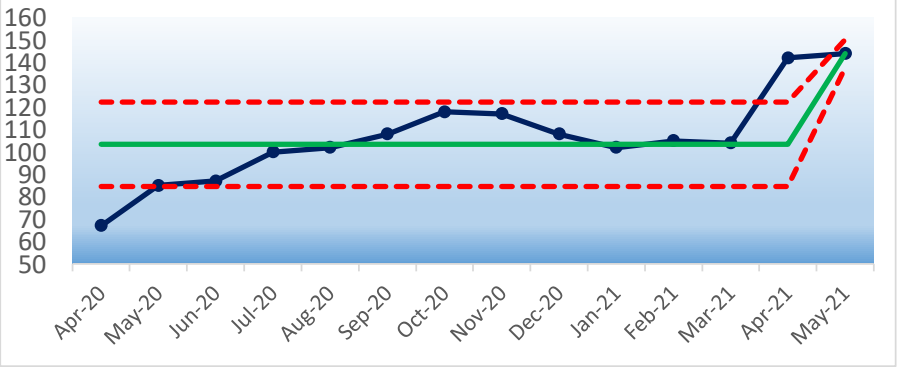
Emergency readmissions (to the same specialty) following an elective admission have increased. However this is reflective of an increase in elective admissions overall in the same period. In percentage terms, the number of elective admissions readmitted within 30 days is remaining static at around 1.5%.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-21
Value / RAG rating	144

Indicator description

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

SPC chart



Narrative

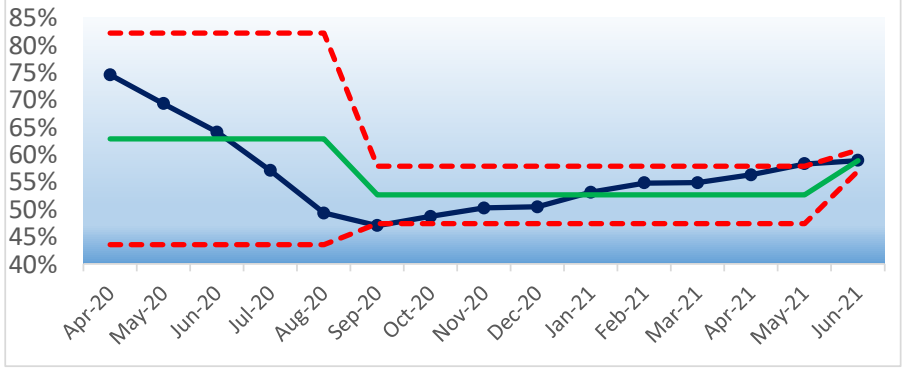
Emergency readmissions (to the same specialty) following an initial emergency admission have increased. This is partly reflective of an increase in overall emergency admissions in the same period. However in percentage terms, the number of emergency admissions readmitted within 30 days has increased from around 6% in 2020/21 to 7.4%.

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-21
Value / RAG rating	58.9%

Indicator description

The number of staff who had an appraisal within the last 12 months. The Trust aims to have 90% of staff appraised.

SPC chart



Narrative

Appraisal was paused during the Covid-19 pandemic and the formal requirement to complete appraisals was launched again on 1st June 2021. A new strengths based approach to appraisal was introduced at the time as part of the 'At Our Best' programme. Line managers are being supported with the implementation of the new approach.

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-21
Value / RAG rating	92.0%

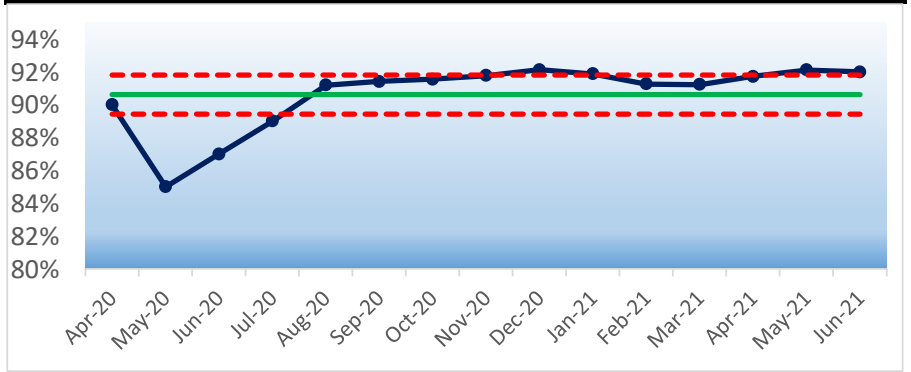
Indicator description

Latest position on the % of substantive staff trained for each mandatory training requirement

Narrative

Whilst core elements of Mandatory and Essential Training (MEST) were still a requirement during the Covid-19 pandemic, the majority of the MEST programme was paused. The programme and reporting is fully re-established and compliance levels are positive.

SPC chart

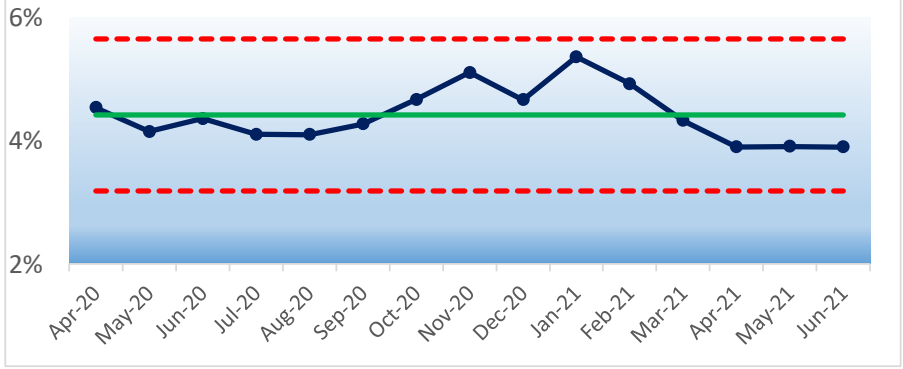


Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-21
Value / RAG rating	3.9%

Indicator description

Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%.

SPC chart



Narrative

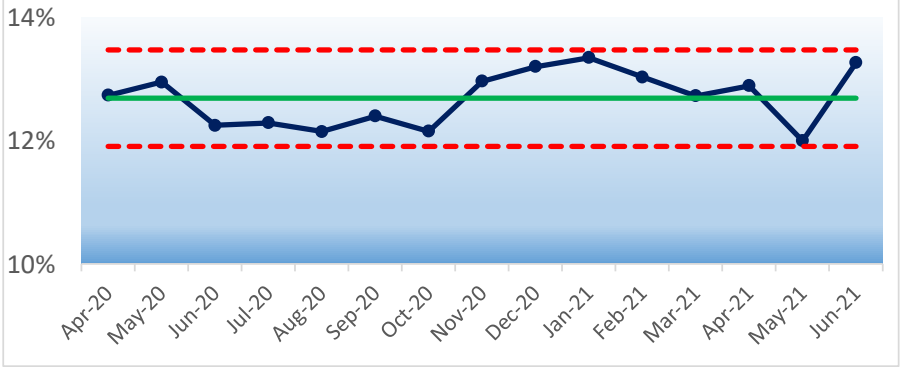
Sickness absence levels are in line with Trust targets. Covid-19 related absence has started to increase after a reduction. 72 employees are either isolating or off with Covid-19 as of 20th July 2021. We will continue to closely monitor, and act on the impact of absence both short term and long term.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-21
Value / RAG rating	13.3%

Indicator description

The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

SPC chart



Narrative

Whilst maintaining a steady turnover rate at HDFT, compared with our WYAAT comparator organisations, our turnover rate is relatively high. A programme of retention activities such as career cafes and itchy feet cafes are being implemented to support increased retention levels.

Indicator	**4.5 - Children's Services - 0-5 Service - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**4.6 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**4.7 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

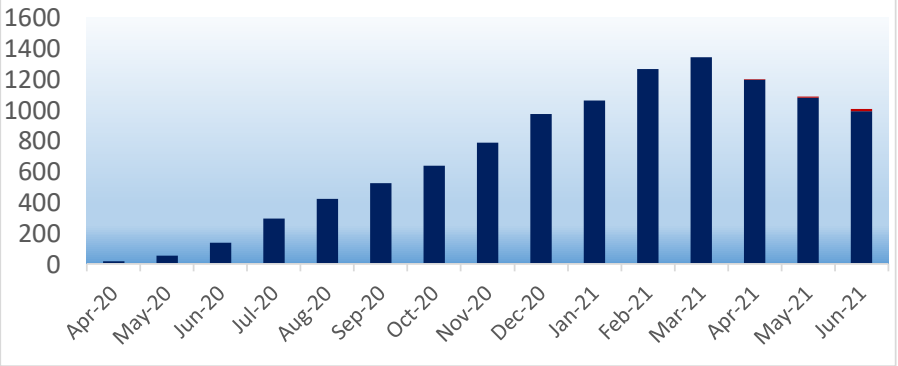
Narrative

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	1006

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

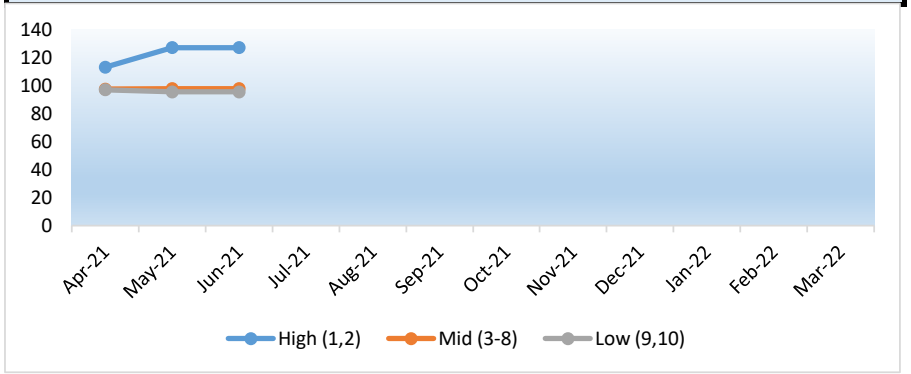
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021 at 1,345. There has been a steady decline to 1,006 in June 2021 with a combination of grip around the booking process and theatre efficiency, as well as the increase of elective work now underway. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters).

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

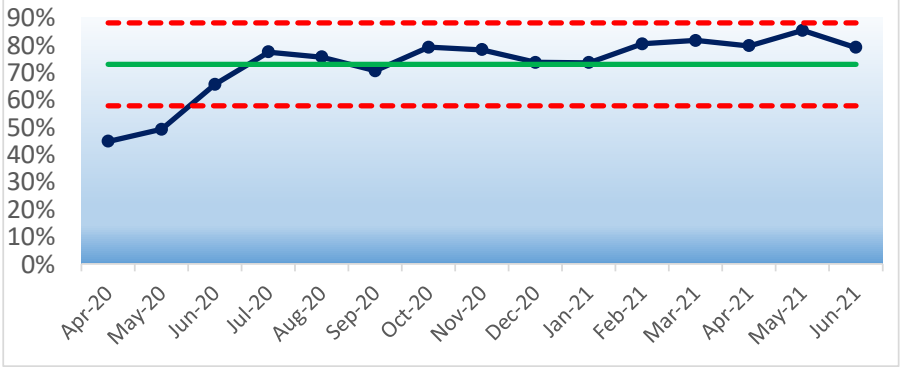
The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. There does appear to be a difference in waiting times by deprivation with patients from the most deprived postcodes waiting longer. A further analysis of this is being carried out looking at the data by clinical priority and by specialty.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	79.2%

Indicator description

Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%.

SPC chart



Narrative

79% of patients were waiting less than 6 weeks for a diagnostic test at end June. The main areas of concern are DEXA scans, non-obsteric ultrasound and MRI.

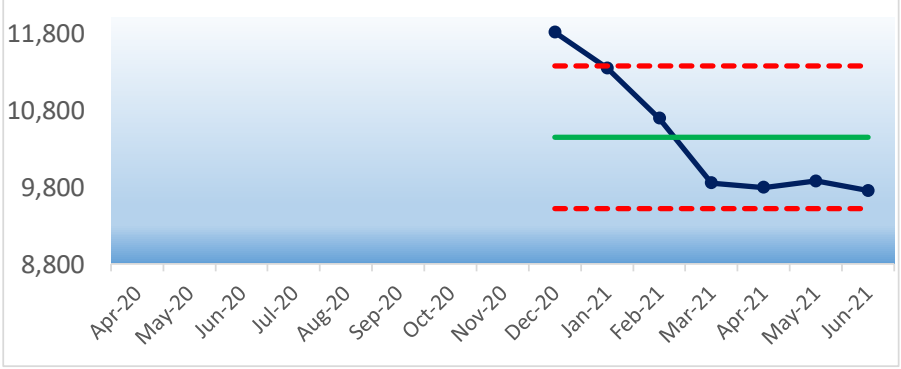
Indicator	**5.4 - Outpatients lost to follow-up - number of follow up patients past due date**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	9754

Indicator description

Narrative

The number of overdue outpatient follow up appointments has remained static in the last few months. Over half of these patients are waiting for either an ophthalmology or gastroenterelogy follow up appointment.

SPC chart

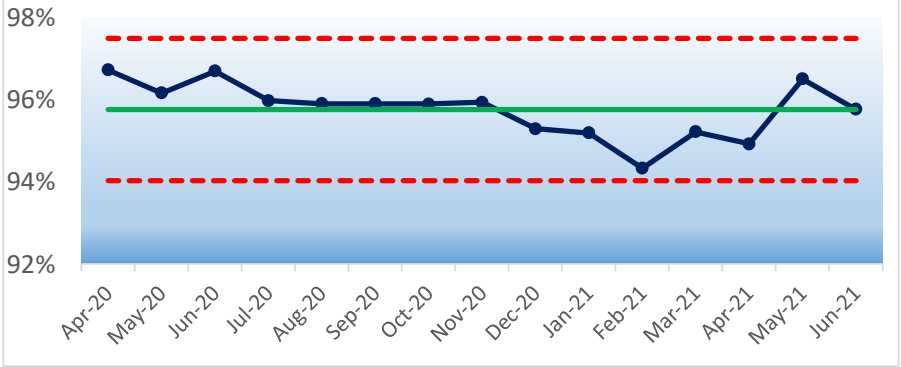


Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	95.8%

Indicator description

The number of inpatients with a valid ethnic group recorded on the Trust's PAS system.

SPC chart



Narrative

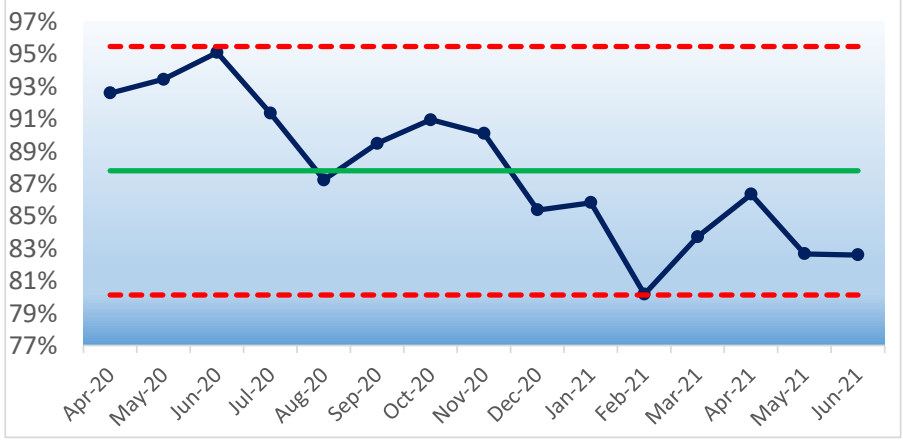
The Trust has an improving position against this indicator

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	82.6%

Indicator description

Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The data includes all A&E Departments, including Minor Injury Units (MIUs). The operational standard is 95%.

SPC chart



Narrative

Performance against the A&E 4-hour standard remained below the 95% standard in June 2021 at 82.6%. The 95th percentile wait was 6 hours 21 minutes

There were no 12 hour breaches in June.

Emergency Department (ED) attendances have continued to increase since February of this year, with May and June attendances both being above the upper control limits and 2019/20 levels, this continues to be a real challenge to flow through the department.

The Kaizen ED workshop took place at the end of June. It was well attended with positive outcomes for change process and approaching the problem through a different lens. An action plan has been produced and is currently being worked through.

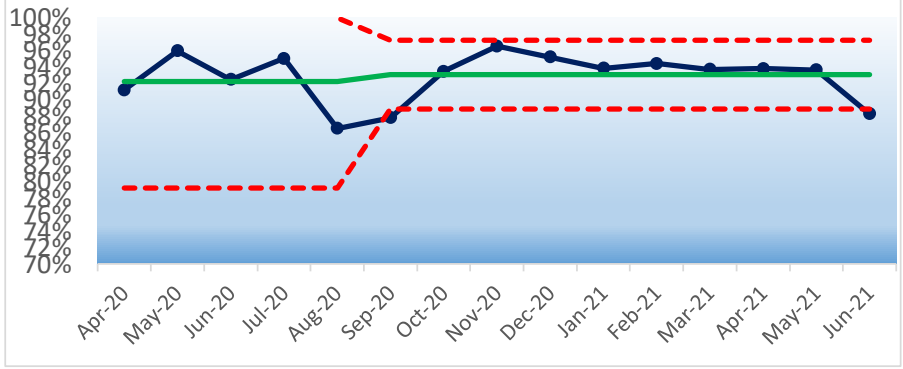
An Urgent and Emergency Care (UEC) dashboard has been developed that supported the workshop and has enabled monitoring of ED flow and performance to increase visibility.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	88.3%

Indicator description

The percentage of ambulance patients who were not handed over to Emergency Department staff within 15 mins.

SPC chart



Narrative

Ambulance handover performance deteriorated to 88% in June. The Trust has seen increased presentations at ED above 2019/20 levels. There were 26 over 30-minute handover breaches and 6 over 60-minute breaches in June.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	0

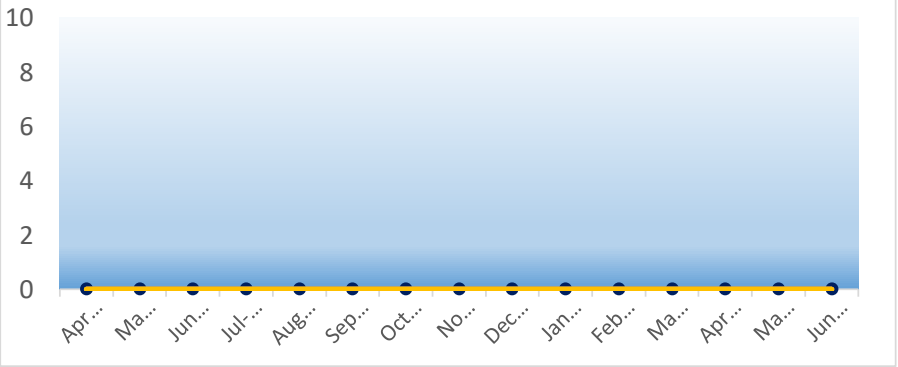
Indicator description

The number of patients spending more than 12 hours in the Emergency Department between a decision to admit and being admitted.

Narrative

There have been no over 12 hour trolley waits reported in 2021/22 to date.

SPC chart

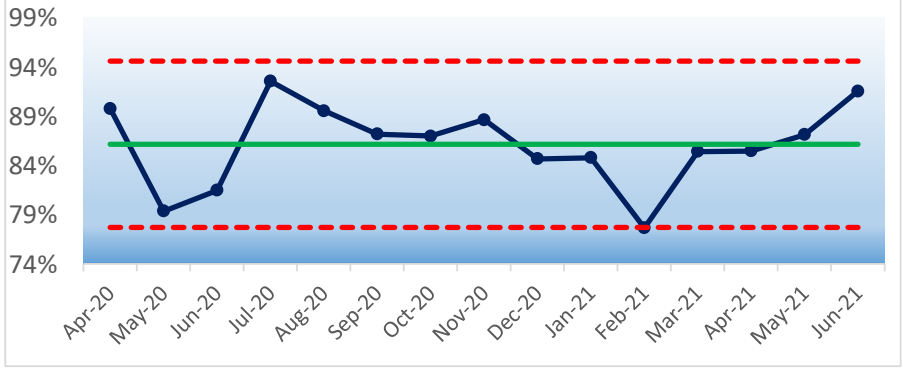


Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	91.6%

Indicator description

Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.

SPC chart



Narrative

Provisional data indicates that the 62 day standard was delivered in June (91.6%).

There were 83.0 accountable treatments (92 patients) in June with 7.0 treated outside 62 days. This represents a 22.7% increase in the number of 62 day treatments delivered compared to last month.

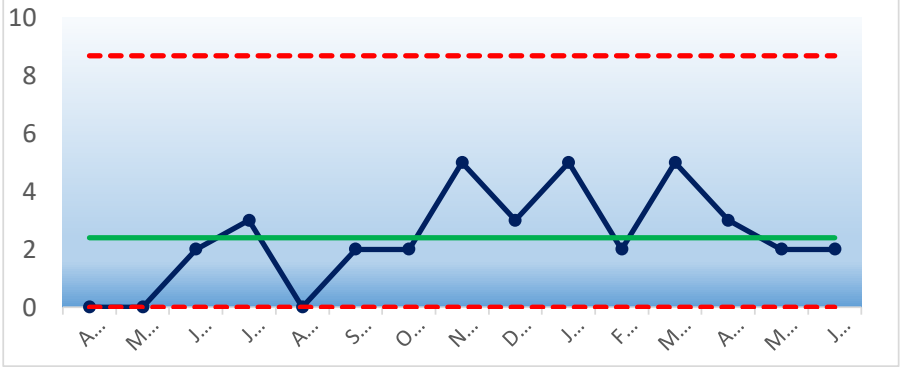
Of the 11 tumour sites treated in June, performance was below 85% for 4 (Colorectal, Gynaecology, Head and Neck, and Sarcoma). All pathway delays will be reviewed by the breach panel at the end of July. Provisional data indicates that 65% (13/20) of patients treated at tertiary centres in June were transferred for treatment by day 38, which is at a slightly higher proportion than last month (58.8%).

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	2

Indicator description

The number of cancer patients waiting 104 days or more since urgent GP referral.

SPC chart



Narrative

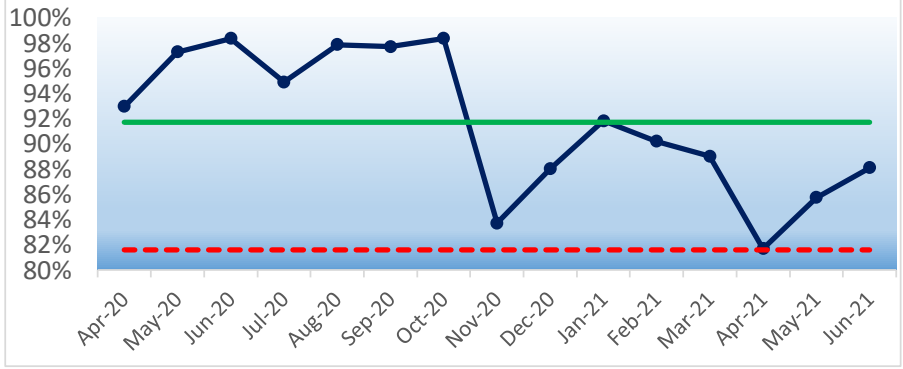
Two patients waited over 104 days for treatment in June (1 x York: Head and Neck; 1 x Leeds: Colorectal) – both of these patients were transferred for treatment after day 38. The York Head and Neck patient's wait was due to a delay to diagnostic imaging at Harrogate and then lack of surgical capacity at York. The colorectal patient's delay was due to diagnostic/medical complexity. Both patients are due for treatment in July 2021.

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	88.1%

Indicator description

Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.

SPC chart



Narrative

950 patients attended their first appointment for suspected cancer in June, which is a 6.6% increase on last month (891). 113 were seen after day 14 and of these, 100 were breast referrals. The average wait for a 2WW breast appointment in June (including Breast Symptomatic) was 18.2 days, which is around the same level as last month (18.4 days). Additional clinic capacity is being provided in order to clear the backlog with the aim of recovering performance over the coming months.

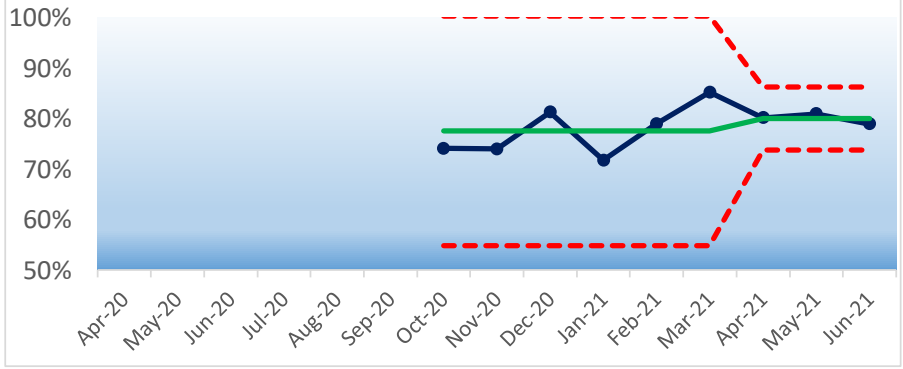
There are now plans in place for 5 Independent Sector (IS) lists to happen in July and August to clear the backlog and reduce the average wait. The Trust is polling at 17 days currently due to the increase in referal and lack of capacity. The IS lists will mitigate both the backlog and referrals. There is also a longer term plan being worked up for a one stop breast centre being developed on site.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	79.0%

Indicator description

From January 2022, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

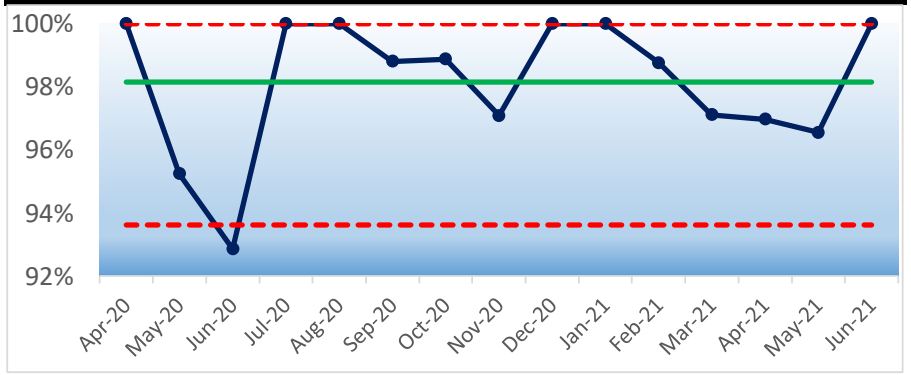
Provisional data indicates that there has been a slight deterioration in performance compared to recent months (79%) but performance remains above the proposed operational standard of 75%. Under-performing sites in June (based on suspected cancer type) were Gynaecology, Haematology, Colorectal, and Upper GI. There was a deterioration in colorectal performance in June compared to last month (73.8% vs 80.5%) - this is likely due to waits in endoscopy but from mid-July, patients are once again being triaged for straight-to-test endoscopy which should lead to an increased number of patients receiving a diagnosis by day 28.

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	100.0%

Indicator description

Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.

SPC chart



Narrative

In June, all patients received their First Definitive Treatment for cancer with 31 days of decision to treat.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.13 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	89.8%

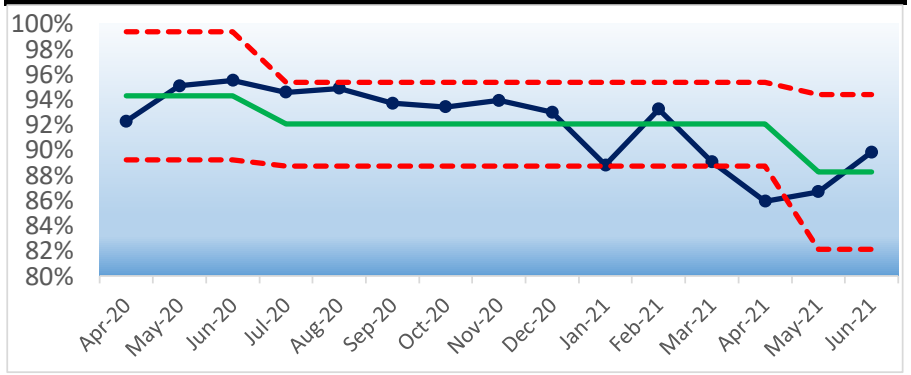
Indicator description

The number of mothers receiving a first face to face antenatal contact at 28 weeks or above before birth.

Narrative

Of 1,228 eligible pregnant women, 89.8% received an initial antenatal visit in June.

SPC chart

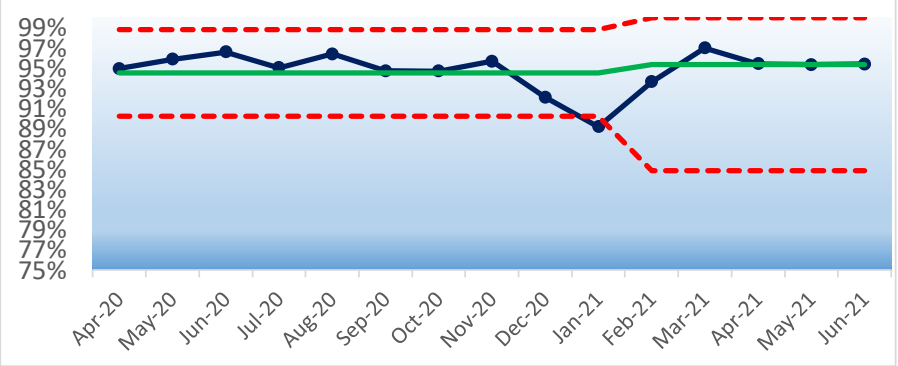


Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	95.4%

Indicator description

The number of eligible infants who received a face-to-face Health Visitor new birth visit undertaken within 14 days from birth.

SPC chart



Narrative

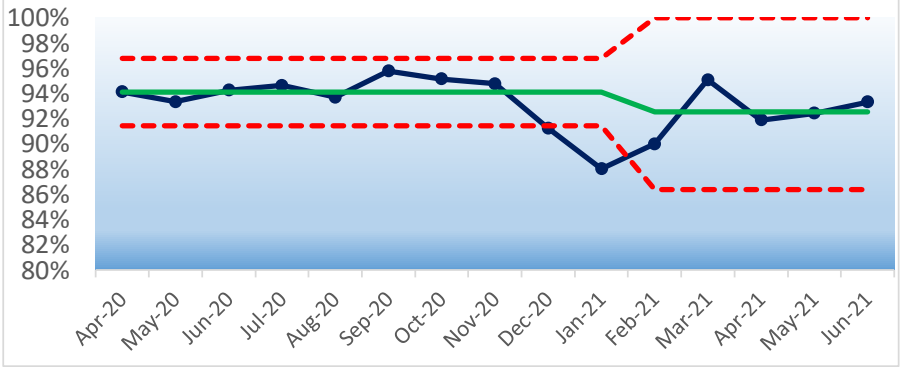
In June, of 1,393 eligible infants, 95.4% received a new birth visit within 10-14 days of birth.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	93.3%

Indicator description

The number eligible infants who received 6-8 week review by 8 weeks of age.

SPC chart



Narrative

In June, of 1,438 eligible infants, 93.3% received a 6-8 week visit by 8 weeks of age.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	92.6%

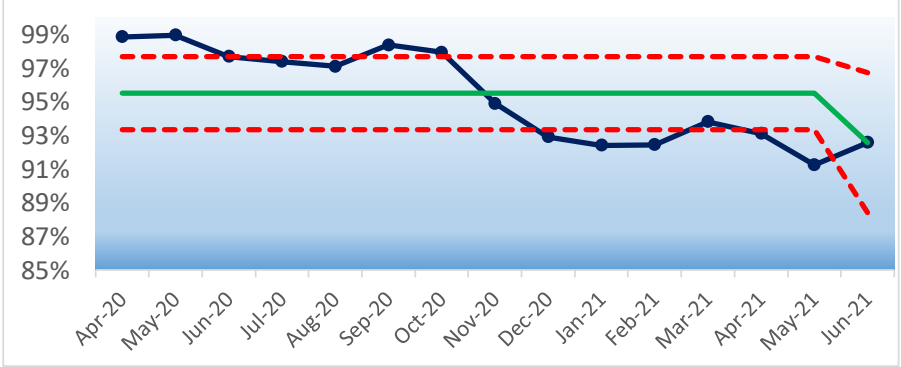
Indicator description

The number of children that received a 12 month review by 15 months of age.

Narrative

In June, of 1,466 eligible children, 92.6% received a 12 month review by 15 months of age.

SPC chart

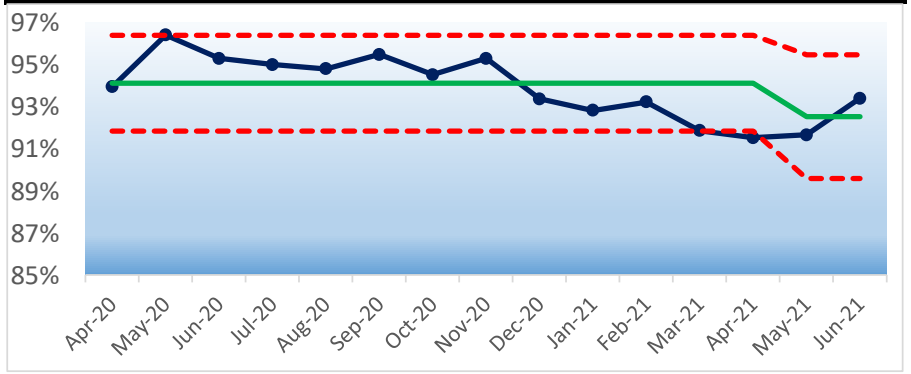


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	93.4%

Indicator description

The number of eligible children receiving a 2-2.5 year review by the time they were 2.5 years.

SPC chart



Narrative

In June, of 1,486 eligible children, 93.5% received a 2-2.5 year review by 2.5 years of age.

Indicator	**5.20 - Children's Services - % children with all 5 mandated contacts**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.21 - Children's Services - Delivery of Immunisation trajectory**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.22 - Children's Services - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.23 - Community Care Adult Teams - performance against new timeliness standards**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.20 - Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.25 - Community Care Adult Teams - Number of cancelled routine visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.26 - Community Care Adult Teams - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

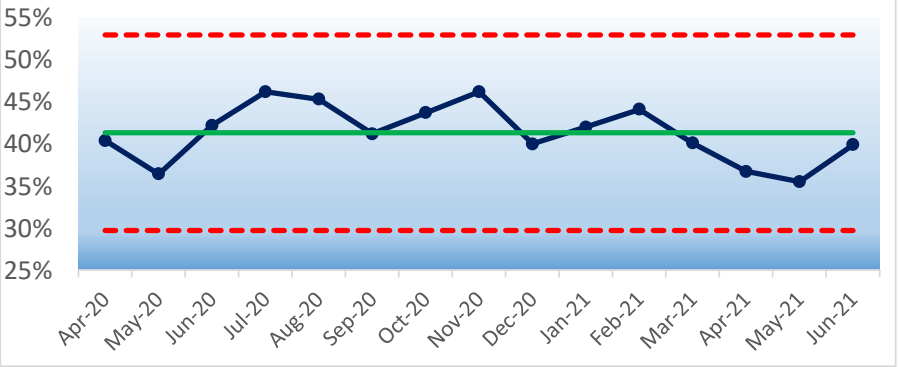
Narrative

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-21
Value / RAG rating	39.9%

Indicator description

The percentage of telephone clinical assessment for URGENT cases carried out within 20 minutes of call prioritisation.

SPC chart



Narrative

In June, 39.9% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation. This remains well below the standard of 95%.

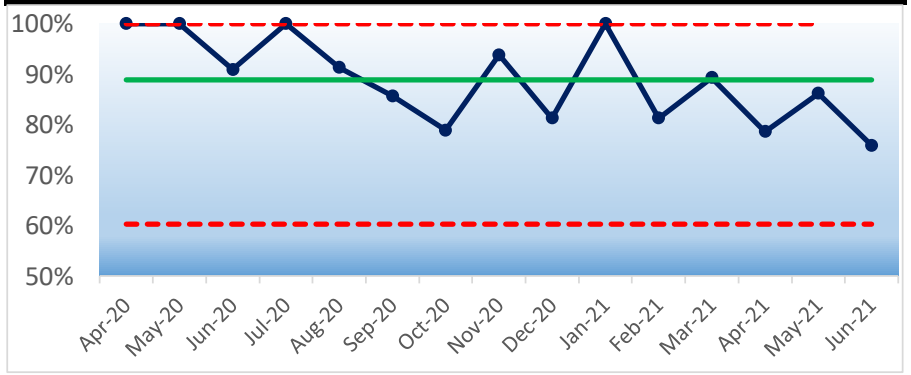
GPOOH have been supporting the wider ED during the evenings and overnight, this combined with an increase in GPOOH presentations has resulted in a reduction of urgent cases being called with 20 minutes. Work is underway with the primary care stream within HDFT to ensure these patients are being called in a timely fashion. This is forecast to be resolved by September 2021.

Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-21
Value / RAG rating	75.9%

Indicator description

The percentage of home visit face to face consultations started for URGENT cases within 2 hrs.

SPC chart



Narrative

In June, 75.9% of urgent GPOOH cases received a home visit face to face consultation within 2 hours. This remains well below the standard of 95%.

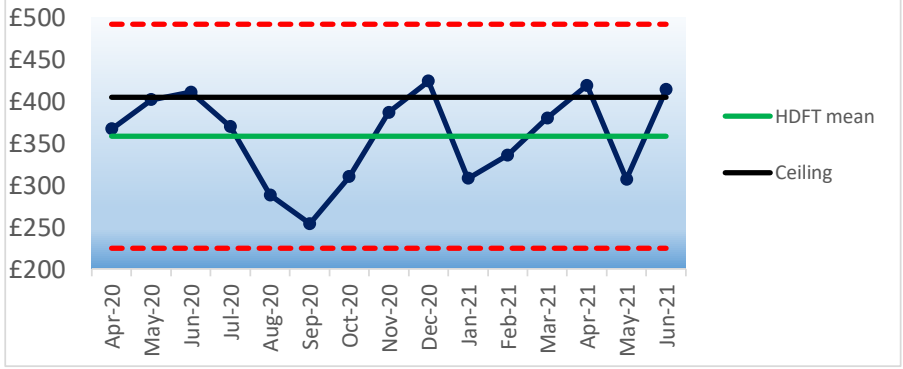
GPOOH have been supporting the wider ED during the evenings and overnight, this combined with an increase in GPOOH presentations has resulted in a reduction of urgent cases being seen face to face.Work is underway with the primary care stream withing HDFT to ensure these patients are being seen in a timely fashion. This is forecast to be resolved by September 2021.

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	£414

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

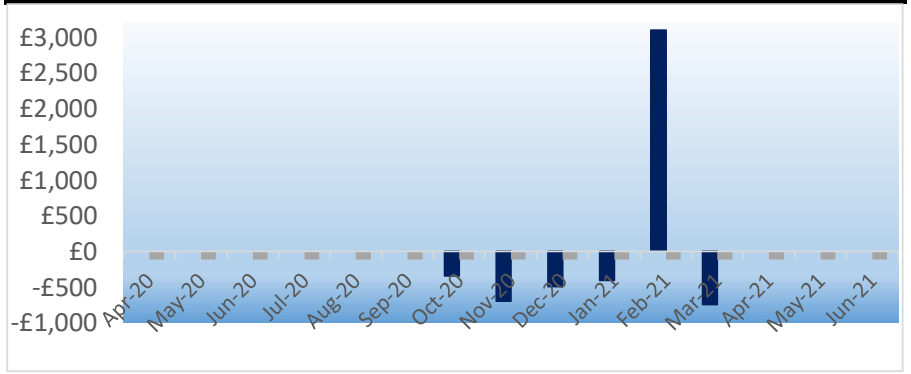
The spend on agency staff in June has increased from the previous month and is above the monthly ceiling equivalent. For the year to date however, the Trust remains under the total agency spend ceiling. The change in month reflects some of the pressures on expenditure within our wards, with a higher bed occupancy during June than planned. There also remain a number of specialties with Consultant vacancies which are being covered through temporary staff, largely within LTUC, and plans are to recruit to fill these posts. Discussions are to be completed in relation to the agreed future ward establishments which, along with the roll-out of the new rostering system, will increase the control on temporary spend on wards.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	£0

Indicator description

Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.

Trend chart



Narrative

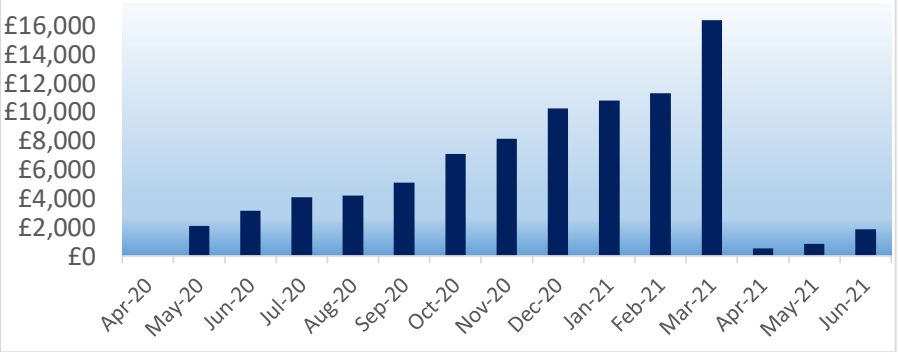
The Trust continues to report delivery of a balanced position in line with the plan for H1 of the financial year. Elective Recovery Fund (ERF) income is currently being matched against the costs of delivering the activity whilst we await confirmation of the level of income to be received. H2 allocations are yet to be received and planning is underway internally to set a plan for H2.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	£1,856

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

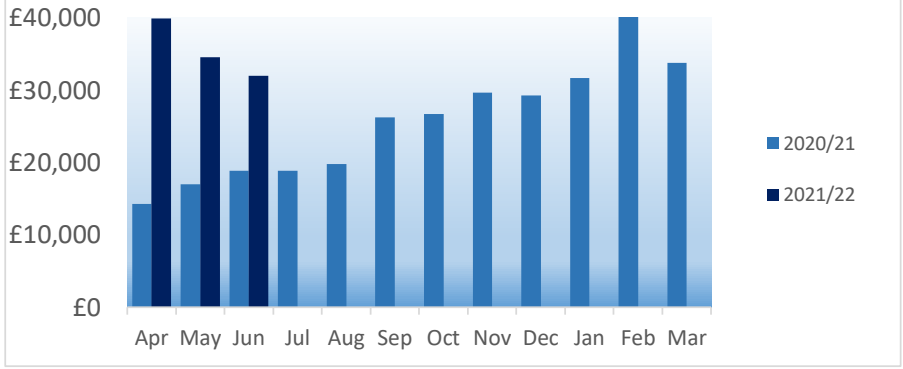
The current capital spend to the end of June is £1.9m, behind the plan of £6.8m. Part of the variance relates to the Salix programme (£3.6m) which is being managed through the Salix Board and is a function of the original grant request being phased over the first 7 months of the year rather than the full year. The expectation is still that the Salix project delivers in full in 2021/22. The remaining underspend of £1.3m is a greater concern and is being managed by the Capital Oversight Group. A capital 'recovery' plan is being developed for review at the end of August so that decisions in relation to further schemes can be taken in a timely way.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	£32,007

Indicator description

The Trust's cash balance by month (£'000s)

Trend chart



Narrative

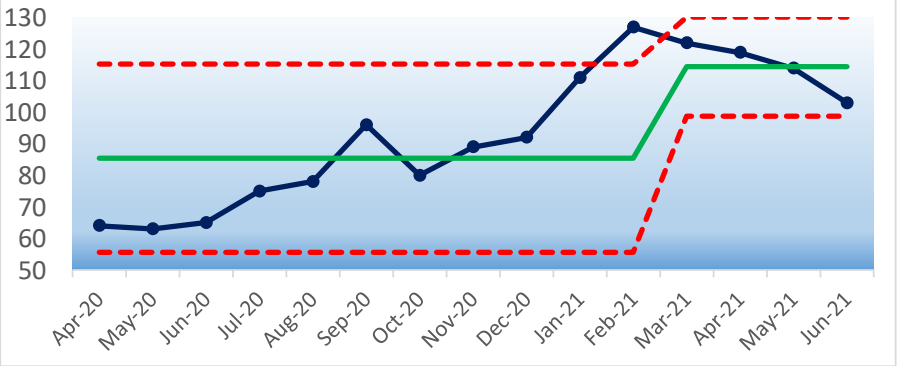
The cash balance remains strong at £32m. Work is being undertaken to further improve the timeliness of payments and deliver a BPCC of greater than 90%.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	103

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

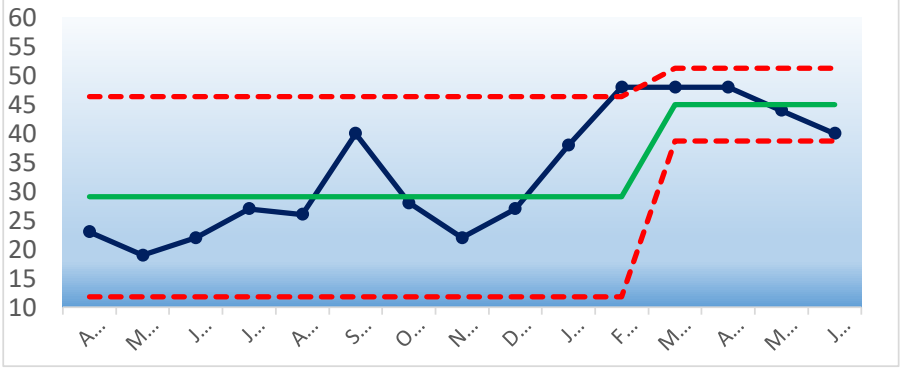
The number of long stay patients (> 7 days) is reducing but remains above historical levels.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	40

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

The number of long stay patients (> 21 days) is reducing but remains above historical levels.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

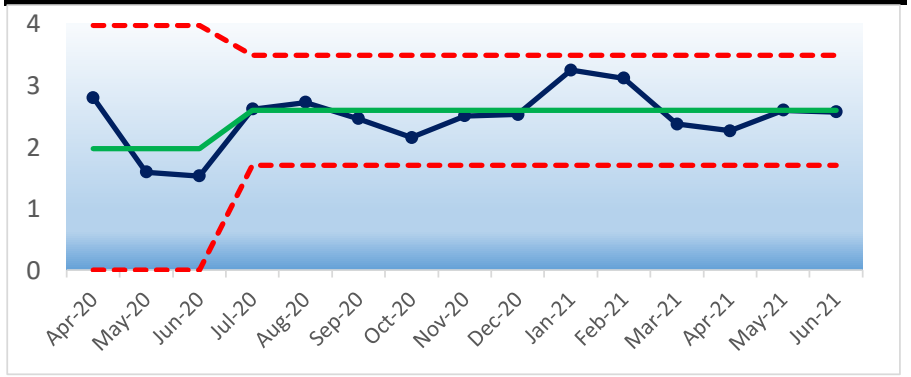
Narrative

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	2.6

Indicator description

Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.

SPC chart



Narrative

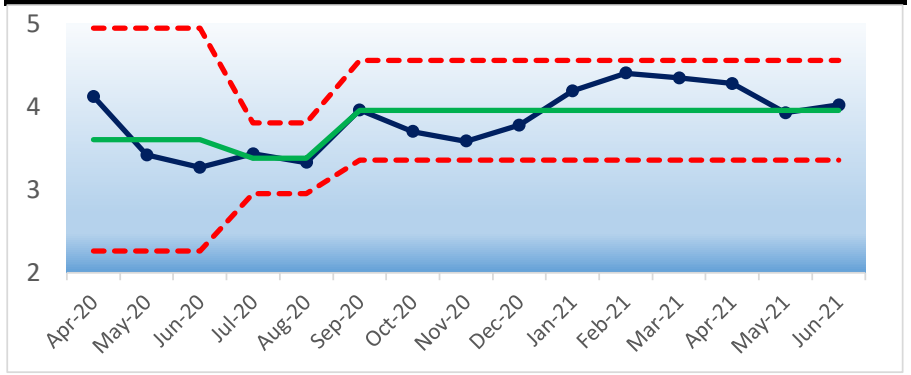
Elective length of stay has remained static at 2.6 days and above our local stretch target of 2.0 days. This is broadly in line with the trend seen over the last year.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	4.0

Indicator description

Average length of stay in days for non-elective (emergency) patients.

SPC chart



Narrative

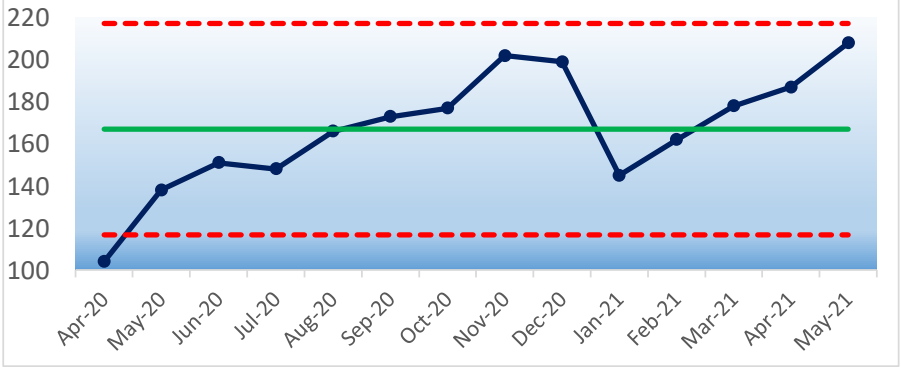
Elective length of stay has remained static at 4.0 days and just above our local stretch target of 4.0 days. This is broadly in line with the trend seen over the last year.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-21
Value / RAG rating	208

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart



Narrative

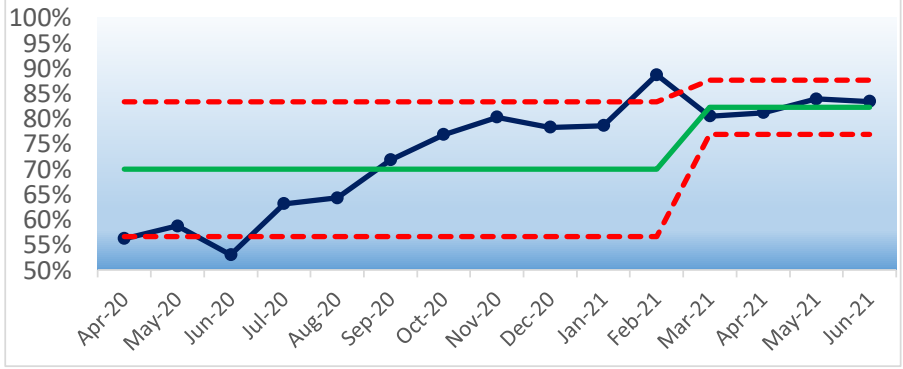
There were 208 avoidable admissions in May. The most common diagnoses were urinary tract infections, pneumonia, gastroenteritis and upper respiratory tract infections in children. This equates to 11% of all emergency admissions. Excluding children and admissions via CAT, the figure was 117.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	83.4%

Indicator description

The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions.

SPC chart



Narrative

Theatre utilisation is increasing even with the number of lists quintupling in the months of April, May and June.
Late start – Actual start time >= 15 beyond planned start time. Early finish – Actual finish time <= 30 before planned finish
The above data is discussed weekly at 6-4-2 scheduling meeting, by individual consultant list.
The median late start time is 26 minutes and median early finish time Is 56 minutes.
There is an element of infection control restriction still impacting on late start and utilisation due to the process for clerking patients in theatres.
HDFT's average list utilisation prior to the Covid-19 pandemic was 85%. Top quartile organisations for efficiency are achieving 92%-95% list utilisation.
The Chief Operating Officer is launching a perfect week to ascertain where the blockages are in the theatre processes in August 2021.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	1.9%

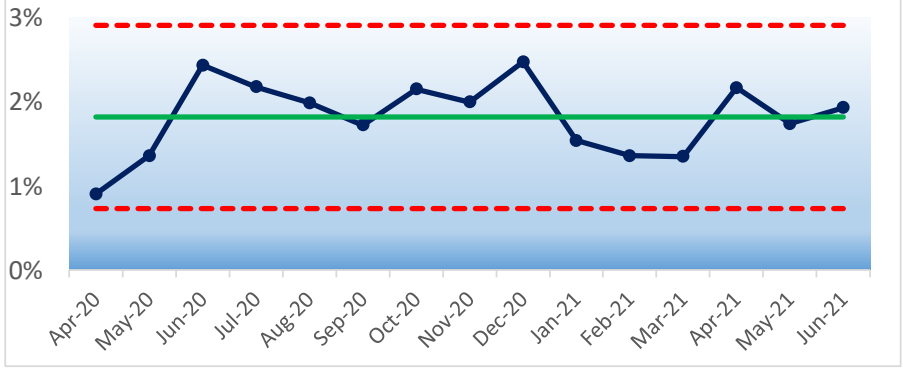
Indicator description

The percentage of intended elective day case admissions that ended up staying overnight or longer.

Narrative

1.9% of intended day cases stayed overnight or longer in June. This is broadly in line with the historical trend.

SPC chart



Indicator	**7.1 - GP referrals against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

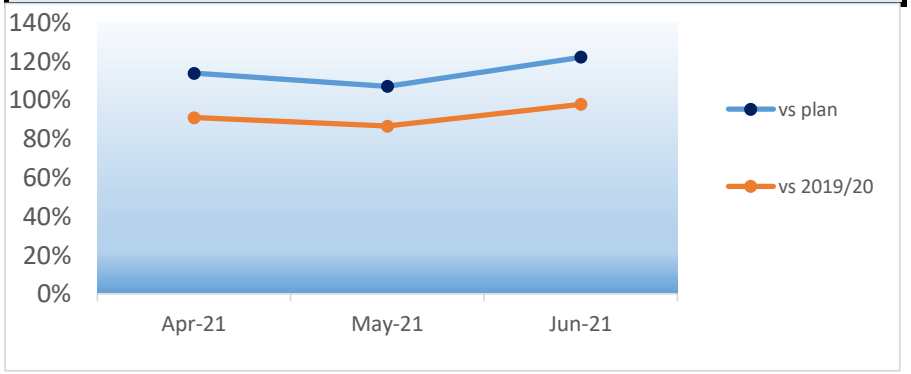
Narrative
This section will describe what the chart shows, what the underlying issues are and what is being done to address them and will be completed by the Executive Lead for the indicator.

Indicator	**7.2 - Outpatient activity (consultant led) against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	122% / 98%

Indicator description

Outpatient activity (consultant led) against plan and 2019/20 baseline. The data includes new and follow up attendances.

Trend chart



Narrative

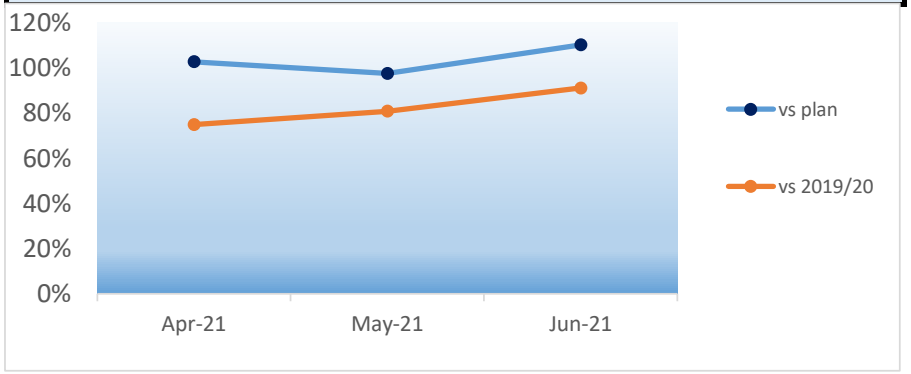
Outpatient activity was 22% above plan in June with both new and follow up attendances at a similar level above plan, over-delivering the Elective Recovery Fund (ERF) requirements.

Indicator	**7.3 - Elective activity against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	110% / 91%

Indicator description

Elective activity against plan and 2019/20 baseline. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

Elective admissions increased in June and are 10% above plan with both inpatient and day case admissions at a similar level above plan, hence delivering the Elective Recovery Fund (ERF) requirements.

Indicator	**7.4 - Non-elective activity against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	105% / 105%

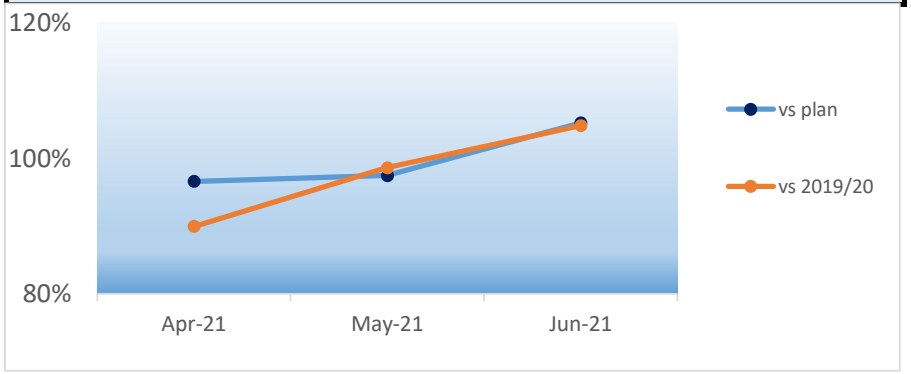
Indicator description

Non-elective activity against plan and 2019/20 baseline.

Narrative

Non-elective activity was 5% above plan in June.

Trend chart



Indicator	**7.5 - Emergency Department attendances against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-21
Value / RAG rating	111% / 111%

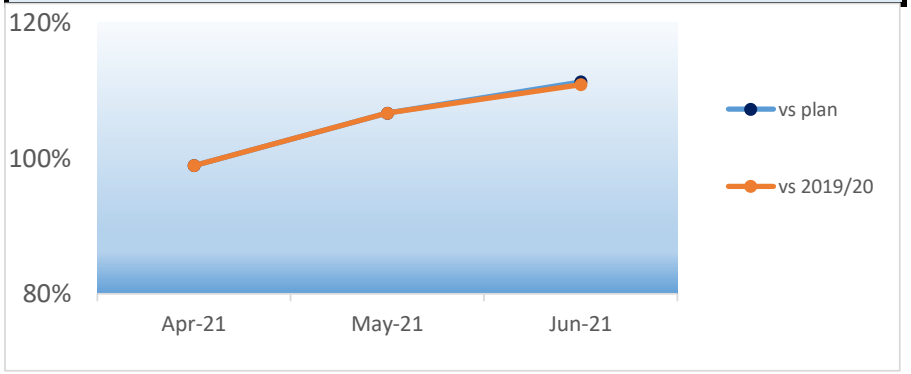
Indicator description

Emergency Department attendances against plan and 2019/20 baseline.

Narrative

Emergency Department attendances were 11% above plan in June.

Trend chart



NHS
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:	23rd June 2021
Date of Board meeting this report is to be presented	28th July 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Sue Eddleston Public Governor. This was Sue's last meeting of the current governor rotation and we are very appreciative of her contribution, insight and the assurance she provides to the governors that the committee is functioning appropriately.
- The meeting started with a presentation from Nicola Kinsell and Tracy May from Podiatry to explain their project to achieve silver quality accreditation. They introduced a system of peer support in their professional group. They had identified that newly qualified practitioners, in particular, were in need of support and mentorship until they gained confidence. The approach is being rolled out across the service. The benefits of their initiative were numerous including improved practice, more confident staff improving the quality of services for patients, retention etc. The members of the committee were impressed by their enthusiasm and commitment to providing the best quality of care for patients from confident and supported practitioners.
- This was the first of the revised Quality Committee with a change in membership. The membership has been reduced to enable operational staff to attend the new management group. The Quality Governance Management Group (QGMG) has started to meet, having its inaugural meeting on Friday 18th June. This group takes many of the routine reports previously provided to the Quality Committee and a report from QCMG will be provided for discussion and assurance to the Quality Committee. Non Executives will ensure that this format provides the assurance that the Board requires. Revised ToR for the Quality Committee and the QGMG will be agreed at the next meeting.
- The annual report of the Committee was received and discussed. This will be presented to the Audit Committee in September.
- We had no matters for escalation from the Board but received an update on the Freedom to Speak up Guardian position. This was in response to issues raised by the Governors at the council. We also received an update on the current COVID 19 cases in the hospital and community. The focus of the acute service is still on recovery and at present there are few in-patients with COVID 19 but other local Trusts are seeing escalation of inpatient cases and there is an increase of numbers in the community.

- The Quality report is to be presented to the July meeting in order to reach the Board at the end of July.
- Two limited assurance internal audit reports were presented to the committee. The first related to Community Dental 18 week Referral to Treatment. This is being managed through the operational services and action to address the improvements required is in hand. The second was a follow-up audit of Clinical Waste management which has important quality implications. The Deputy Chief Nurse is working with ward and department managers to ensure appropriate disposal at service level. Sarah Armstrong will follow the audit findings up with HIF services.
- The QGMG report was discussed, there were no matters for escalation. We were informed of an IT system incident which had resulted in some results not arriving in the right place this had required a paper based solution until the problem can be fixed and work was taking place with suppliers to find a solution. A group SI for all NHS organisations has been declared for all COVID HCAI deaths. The Trust is working with local colleagues to manage the incident. The QC was requested to consider the patient/colleague story it receives and whether changes should be made.
- A project manager for Caring at Our Best is to be appointed. Funding has been received for a matron post to support workforce and CQC developments.
- We were informed that the previous CQC action plan is being completed through concentrated action.
- The new IBR was provided but it was in very early stages of development and it was not ready for detailed scrutiny.

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

None

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

The QC currently receives a colleague story related to quality improvement. The committee finds this very informative and would like to retain this and the Board retain the patient story.

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:	21st July 2021
Date of Board meeting this report is to be presented	28th July 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Doug Masterton, Governor. This was Doug's first meeting and we were pleased to welcome him to the committee.
- The Committee began with a presentation and discussion on the Midwifery Continuity of Carer project. This item was discussed at the request of the Board. Beth Fisher, project lead, gave an excellent presentation that explained the project, the benefits of providing continuity of carer to mothers and babies, the process and the potential costs involved. Continuity of carer is a key objective of the National Maternity Transformation Plan. The Target has been adjusted and is now- by March 2023 all eligible women should be booked onto a Continuity of Carer pathway. Board members are aware that the Trust submitted a zero response to this target. Teams had been designed and implemented and progress was being made until the end of 2020 when as a result of the pandemic and staff shortages the teams began to struggle and there was a halt called to the rollout and teams were reconfigured. Three teams in the community providing antenatal and postnatal care and homebirth where required. Continuity of carer fell to zero in May 2021. The leadership team contend that in order to deliver this project in the future a total of 17 WTE additional midwives are required, funding is available for 10 of these midwives. The team are working on a business case to fund the additional posts. The QC were convinced of the outcome benefits of this project and were informed that the national maternity team have agreed that additional resource is likely to be required to fund the additional staff. The QC discussed recruitment and how this would be achieved and the particular issues relevant to Harrogate. The QC members are very supportive of the approach and recommend the Board support the process and pathway to be followed.
- A matter arising from the June meeting related to an increase in complaints from Selby MIU. Richard Stiff had visited the unit to talk to staff and identify any concerns they had regarding the unit that may have led to this increase. A discussion took place which raised the considerable pressure that ED and MIU colleagues in Selby and Ripon were under, due to an increase in attendance of a number of patients who were struggling to gain access to other services. The CCG representative present at the meeting was aware of the issues and

detailed action underway at the CCG to help manage demand, we were also informed of the work underway within the PCN to manage the situation. We were assured that no safety concerns had been raised from either of the MIUs.

- The Quality Account is still in draft form and not yet agreed by the Quality Committee. However, quality priorities are agreed and progress will be monitored on a rolling basis throughout the year.
- A report was received from the Quality Governance Management Group. Concern was raised regarding the escalation in COVID 19 related isolation that is putting pressure on the workforce.
- The Caring at our best programme is now embedded across the Trust. A number of actions are in place to embed quality initiatives in the performance of clinical teams and to ensure learning from complaints and incidents is shared. A plan is in place to develop a ward accreditation programme.
- A revised complaints process is now in place, the backlog of overdue complaints has significantly reduced. From 22 in May to four currently. The QC congratulated the teams for making significant progress on this longstanding goal.
- PESH (patient experience and safety huddle) is to be replaced by a Quality Summit.
- The outstanding CQC actions from the last visit will be closed by September. A CQC peer review process is to be implemented to ensure achievement of standards can be demonstrated. The Board may be required to revisit the Well Led review at some point.
- A summary of Sis from the current year was presented. No themes were identified.
- The Infection prevention and control report was received, there were no significant concerns.

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

Escalation in ED and MIU attendance is already a risk the board is aware of.

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

Plans to achieve the Continuity of Carer target for 2023 and the potential increase in staff numbers required.

Harrogate and District NHS Foundation Trust

2.3

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Director of Nursing, Midwifery and AHP Report**
Responsible Director:	Executive Director of Nursing, Midwifery and AHPs
Author:	Executive Director of Nursing, Midwifery and AHPs

Purpose of the report and summary of key issues:	The Board is asked to note the content of the report and receive assurance on actions underway in relation to: • Caring at Our Best – Quality • Safe Staffing • Complaints	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	x
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	Surge in Safeguarding as identified within the Corporate Risk Register. Note the continuing actions underway to mitigate this risk and ongoing actions to monitor.	
Report History:	Submitted for review at the Senior Management Team on 21st July 2021	
Recommendation:	The Board is recommended to note the report and the progress made in relation to the key areas identified above.	

Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

Serious Incidents
- 3 new Serious Incidents reported bringing the 21/22 YTD to 9
- Portfolio for Serious Incidents moves to Director of Nursing, Midwifery and AHPs.

Complaints
- Trust overall position currently 38% against 95% trajectory.

Staffing
- Midwife vacancies – 8.03 WTE – not taking into account the changes required for Continuity of Carer
- Community Adult Nursing continue with challenges re: vacancies. Additional recruitment will be in place by September 2021.
- Additional support to 0-19 safeguarding teams with mutual aid from hospital based staff. Additional recruitment to Band 5 posts. Health Visitors and School Nursing biggest challenge with a number of actions in place including SCPHN recruitment (31 Health Visitors and 4 School Nurses for this September 2021)

Major actions commissioned & work underway

Complaints
- The program of work to clear the complaints backlogs and deliver the staged trajectory continues.

Caring at Our Best - Quality
- Ward/Department Quality Boards being designed including Trust KITE
- Reviewing available ward accreditation models, 'Perfect Ward' being demonstrated to us on 3rd August 2021
- Quality Assurance Panels will be launched to incorporate Pressure Ulcers and Falls. Falls with moderate or severe harm will come to the panel. Falls RCA documentation is currently under review
- Establishment of Peer Review process across the organisation to identify compliance with standards, share best practice and identify where additional support requirements exist. Links to accreditation and assurance models.

Professional Nursing, Midwifery and AHP Forum
- Agreed collectively that Personalised Care agenda led by this forum.
- Establishment of new Quality Steering Group : (PU's, falls, delirium etc.) with focus on Improvement Collaborative in particular high risk areas, Pressure Ulcers and Falls

Positive news & assurance

Caring at Our Best – Quality

- Launch of Inaugural Quality Summit [to replace PESH] planned for the 4th August. Focus on escalation, thematic learning and sharing.
- Pressure Ulcer Panels – worked through main back log of old PU's; CCG attending and feedback is good. Early themes include: informed refusal form not completed; community and documentation – some cases of conversations taking place but no recording it; omissions case in hospital has been around repositioning

Complaints

- Remain on track to deliver backlog of complaints within agreed timescale

Staffing:

- Safer Staffing 1 month Acuity and Dependency Study completing on 21st July 2021. Analysis is underway.

Decisions made & decisions required Board

Harrogate and District NHS Foundation Trust

2.4

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Executive Medical Director Report**
Responsible Director:	Executive Medical Director
Author:	Executive Medical Director

Purpose of the report and summary of key issues:	The purpose of the report is to provide the Trust Board with areas of note and items for escalation from the Executive Medical Director portfolio.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	None	
Report History:	Submitted for review at the Senior Management Team on 21st July 2021	
Recommendation:	The Trust Board is recommended to review and note the content of the report.	

Medical Director Report
Date: July 2021 Public Board

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Matters of concern:
- Ongoing pressures of the COVID pandemic- effect of 4th wave on workforce and clinical capacity locally and regionally
- Increasing level of exception reporting for junior doctors related to COVID pandemic system pressures

Major actions commissioned & work underway

- Digital Aspirant Programme – AHLC/CoStratify workstream nearing completion
- WebV version 3.6 build into test (ward boards & handover)
- Maternity and cancer EPR systems at procurement stage
- Quality Improvement Programme 21/22 (Caring at our Best) ongoing- open QP for 20/21 and 21/22 now embedded
- Medical jobplanning and annual leave policies being updated and discussed with LNC
- WYAAT fragile clinical services review commenced
- Development and implementation of the new Clinical Standards Tool complete
- Development of a National Data opt-out process and communication plan is underway

Positive news & assurance

- Chief Registrar commences next month
- YH HEE Clinical Leadership Fellow commences next month
- New Quality Governance Framework will be fully implemented to time and target next month
- MD Business Unit of research, innovation, clinical effectiveness and quality improvement established – options appraisal for a shared continuous learning and improvement corporate system underway
- Clinical audit and effectiveness annual programme 2021-22 has been formally approved and is underway

Decisions made & decisions required of Board

NHS
Harrogate and District
NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Maternity Incentive Scheme – Year 3**
Responsible Director:	Director of Nursing, Midwifery & Allied Health Professionals
Author:	Alison Pedlingham (HOM), Danielle Bhanvra (Matron), Andy Brown (Risk Management Midwife)

Purpose of the report and summary of key issues:	This report provides the evidence required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year 3.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	Complaints response time	
Report History:	Submitted for review at the June 2021 Trust Board Development Day	
Recommendation:	The Trust Board is recommended to review and note the content of the report.	

MATERNITY INCENTIVE SCEHEME – YEAR 3

1.0 Executive Summary

This report provides the evidence required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year 3.

2.0 Introduction

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNST Maternity Incentive Scheme contributions were not taken in April 2020, as would normally have happened.

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

3.0 Proposal

This report provides all the evidence required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year 3. NHS Resolution provided updated guidance (March 2021) on the safety actions due to Covid-19.

SMT is asked to note the information provided in the report and if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year 3 prior to final sign off by the Chief Executive by 15th July 2021.

4.0 Quality Implications and Clinical Input

4.1 This report provides information on compliance with the ten maternity safety actions

5.0 Equality Analysis

5.1 An equality analysis has not been undertaken

6.0 Risks and Mitigating Actions

6.1 Training compliance for Prompt remains below the 90% however, the revised standards published in March 2021 have removed this threshold and recommend that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this, a plan is in place to do this as soon as possible.

7.0 Recommendation

7.1 Trusts must achieve all ten maternity safety actions

7.2 The Board declaration form must be signed three times and dated by the Trust chief executive to confirm that: - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety

actions' sub-requirements as set out in the safety actions and technical guidance document.

7.3 The content of the Board declaration form has been discussed with the commissioner(s) of the Trust's maternity services.

7.4 The Trust Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution by 15th July 2021. The Trust Board declaration form must be signed by the Trust's Chief Executive.

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Training compliance Prompt – revised standard in March 2021 and 90% threshold removed and plan in place to improve compliance as soon as possible	
Positive news & assurance	**Decisions made & decisions required of SMT**
• The maternity department are declaring full compliance with all 10 maternity safety standards	

Final information and narrative required in support of the requirements in the Maternity Incentive scheme – year 3.

Introduction

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

As in year two, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund. This document provides updated guidance on the safety actions for year three of the maternity incentive scheme, following the relaunch of the scheme on 1 October 2020.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 15 July 2021 and must comply with the following conditions:

In order to mitigate the financial impact of Covid-19, CNST MIS contributions were not taken in April 2020 as would otherwise have occurred meaning that trusts have had a 'year off' paying their contributions and additional time to implement the year three scheme, albeit with some revisions to the requirements when relaunched on 1 October 2020.

Trust submissions will be subject to a range of external verification checking points, including:

- MBRRACE-UK
- Data NHS Digital regarding submission to the Maternity Services Data Set and against the National Neonatal Research Database (NNRD) and
- HSIB (Healthcare Safety Investigation Branch) for the number of qualifying incidents reportable to the Early Notification scheme and HSIB
- Trust submissions will also be sense checked with the CQC, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- Trust regional chief midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity System (LMS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in year one and year two of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Impact of Covid-19

Due to the impact of Covid-19 the ten safety actions were initially updated in January 2021 and further revision of standards published in March 2021. Consequently, the date for final submission was postponed from 15th May to 15th July 2021.

https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

Local update

We are declaring full compliance with all of the 10 safety standards. Additional information on each safety action and the requirements of each safety action is included in the report.

Safety action 1

1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Parents informed of the review and their perspectives/any concerns have been sought	**Compliant**	***Required standard – pages 8 – 15***

All notifications from the 11th January onwards have been made and the surveillance forms completed using the MBRRACE – UK reporting website.

The multi-disciplinary review team review the care uses the perinatal mortality review tool (PMRT), and draft reports are generated via the PMRT. Parents are informed of the PMRT and their perspectives about their care and that of their baby are sought.

Please see report attached which provides more detail to support compliance with this safety standard.

Safety action 1
Report 042021 to 07

Safety action 2

2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? All 13 criteria are mandatory.	**Compliant**	***Required standard – pages 16 - 20***

In April 2021, the iCS team confirmed the MSDS data requirements had been submitted with all mandated items in the MSDS completed.

The WY&H LMS requested the submission of a local plan to improve the position, as there were a number of CQUIMs that we were failing that were more than the NHS Digital requirements – CQUIMPPH, CQUIMSmoking Delivery, and CQUIMTears.

A local plan was submitted to the WY&H LMS on 11th May 2021:

1) Confirm Data is Being Entered Correctly at Source by Maternity Staff Into the Silverlink iCS PAS System - complete.

Following on from these concerns raised regarding the data quality and subsequent failure of certain data fields, the data team have run reports to ensure that the data has been routinely and consistently entered into the Patient Administration System. This has been cross checked with data held within the Maternity Service by the Risk Management Midwife. In all of the relevant fields within Silverlink iCS, we have confirmed that data is being entered correctly and internal checks have confirmed that the data entry at source is correct.

- **CQIMDQ13** - at least one postpartum haemorrhage recorded in the previous 6 month. CQIM data indicate that there were no PPH in the previous 6 months. However, it has been confirmed that estimated blood loss at delivery is a *Mandatory* field within iCS and data is being entered continuously. For the 6 month period 1st July 2020 - 31st Dec 2020, interrogation of the PAS data indicates 863 mothers delivered, with 27 of these having PPH≥1500ml or more (359 had blood loss 500ml or more).

- **Smoking at Delivery CQIMDQ6 and CQIMDQ7** - percentage of women giving birth in the previous period for whom status was known & percentage of women giving birth in the previous reporting period for whose smoking status at delivery was recorded as known that WERE current smokers. CQIM data indicate that there was no submission for Smoking Status at Delivery in the previous reporting period. It has been confirmed that smoking status at delivery is a *Mandatory* field within iCS and is being entered. For the month of December 2020, there were 144 mothers delivered and 9 of those were recorded as Current Smoker at Delivery. The Maternity Service has routine reports set up to ensure this information is captured and used for reporting and performance purposes. In addition to this routine submissions are made to numerous CCGs on a quarterly basis for the smoking at time of delivery (SATOD) returns. No concerns or issues have been raised with the data quality and the smoking information tallies with the number of deliveries.

- **Perineal Tears CQIMDQ20** - percentage of spontaneous vaginal births with a 3rd or 4th degree tear in the current 3 months reporting period. The CQIM data suggests that 145 3rd/4th degree tears had been reported in the quarter. It has been confirmed that Perineal Tears is a *Mandatory* field within iCS and is being entered. For the 3 month period 1st October 2020-31st Dec 2020, there were 237 singleton babies born by spontaneous vaginal delivery, with 4 mothers having 3rd degree tear.

At this point in time, we can provide assurance that the quality of the data that we can see that has been captured in our PAS system, is up to date and of high quality. Consequently, we suspect the problem is more related to incorrect extraction of the data and mapping to the MSDS tables. Further investigation is now ongoing with additional plans:

1. Check output of test data to MSDS
2. Escalation to Silverlink to review automated mapping
3. MSDS/CQIM mapping

The WY&H LMS approved the Harrogate MSDSv2 plan on 24th May 2021 with the LMS Board requesting a progress update against all plans in November 2021. There was a recognition by the LMS Board that a new maternity IT system in Harrogate would improve the situation and that this is currently at the procurement stage of this process.

The WY&H LMS Board approved of the plan regarding CNST criteria.

Safety action 3

3	Demonstration transitional care services are in place to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme	**compliant**	***Required standard pages 21 – 26***

A report has been completed which demonstrates compliance with this safety standard.

Transitional Care report.docx

Safety action 4

4	Demonstration of an effective system of clinical workforce planning to the required standard	**compliant**	***Required standard pages 27 – 33***

Please see report below which provides more detailed information to support compliance with this safety standard.

The report shows evidence of full compliance with this safety standard for obstetric, anaesthetic, neonatal medical and nursing staff. A copy of the nursing workforce calculation using the CRG staffing (Dinning) tool is attached.

SOP Lost Training.doc

Copy of Dinning tool scbu March 202

The anaesthetic rota and theatre schedules attached below for the period 10th May to 18th June 2021.

Delivery suite - consultants cover 1(

Rota for Sections lists in theatre 3 - 1(

Senior Resident on call labour ward 10t

Anonymised data for delivery suite co\

Safety action 5

5	Demonstration of an effective system of midwifery workforce planning to the required standard	**Compliant**	***Required standard pages 34 – 37***

The bi-annual midwifery staffing report (Oct 2020 – March 2021) was submitted to the Board in May 2021 (report attached below).

Bi annual staffing report Oct 20-March

Safety action 6

6	Demonstration of compliance with all five elements of the Saving Babies' Lives care bundle version two -	**compliant**	***Required standard pages 38 – 45***

Please see report below which provides more detailed information to support compliance with this safety standard.

Report of compliance with MIS

Safety action 7

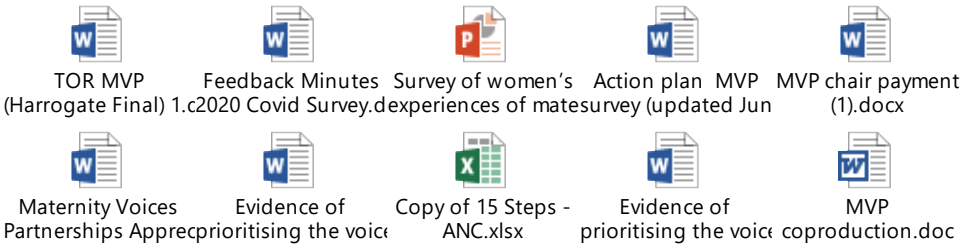
7	Demonstration of a mechanism for gathering service user feedback, and working with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	**Compliant**	***Required standard pages 46 – 47***

A Maternity Voices Partnership (MVP) is an NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care. The MVP provides a way for this team of people to design and improve maternity care together through co-production - different people working together sharing ideas and finding solutions for the design and improvement of maternity care.
The function of the MVP is more than simply to listen; it is a way of discussing challenges and ways of overcoming them.

The Harrogate Maternity Voice Partnership group launched in October 2018 and had quarterly meetings in a local children's centre. Due to Covid these quarterly meetings have continued remotely via zoom.

The group have access to a specific MVP bank account (opened with monies to be used for local MVP groups from the WY&H LMS) and know that monies can be claimed for travel expenses etc. however due to Covid-19 attendance at regional MVP meetings has not been required for the last 16 months.

Further information supporting the evidential requirements is attached below:



Safety action 8

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	**Compliant**	***Required standard pages 48 – 54***

In the current year the threshold of 90% has been removed. This applies to all of safety action 8 requirements. It is recommended that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.

December 2019 – March 2020 all training was face to face. Due to the restrictions of Covid-19, from April 2020 face-to-face training was suspended.

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

Prompt emergency skills training (online training package introduced February 2021)

	Medical staff (including anaesthetists)	**Midwives**
Early March 2020	85% (face to face)	88% (face to face)
End March 2021	25%	11%
Early May 21	51%	45%
31st May 21	47%	49%
Early - June 2021	47%	56%

Fetal monitoring training – K2 (online training package)

	Medical staff	**Midwives**
Early March 2020	93%	94%
End March 2021	15%	40%
Early May	61%	69%
31st May 21	78%	76%
Early June 21	98%	80%

The previous risk mentioned in the May report of not achieving 90% of each maternity unit staff group having attended in-house multi-professional emergency training session – this safety standard was revised by NHS Resolution in March 2021 - in the current year the threshold of 90% has been removed and applies to all of safety action 8 requirements. It is

recommended that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible. **Plan attached below.**

Safety Action 8 (Training plan).docx

Safety action 9

9	Demonstration that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues.	**Compliant**	***Required standard pages 55 – 61***
	Progress in meeting the revised Continuity of Carer action plan is overseen by the board on a minimum of a quarterly basis commencing January 2022		

The Trust has the following safety champions in place:

Dr Kat Johnson – Clinical Director, Consultant Obstetrician & Gynaecologist,

Alison Pedlingham, Head of Midwifery

Julie Walker, Matron Paediatrics

With executive level maternity safety champion – Emma Nunez – Executive Director for Nursing, Midwifery & AHP's and Andy Papworth – non-executive maternity safety champion (recruited in December 2020).

The maternity safety champions met bi-monthly and due to a change in the Executive Director for Nursing, Midwifery & AHP's and the raised profile of maternity services through receipt of the Ockenden report the group have been meeting monthly since April 2021.

There are meeting agendas and an action log for all meetings available. During 2020, monthly maternity and neonatal safety walkabouts were planned in diaries with the previous Chief Nurse and no safety issues were raised.

Recent locally identified issues escalated include;

Midwifery staffing:

- Reduced midwifery staffing levels due to an increased number of pregnant midwives, retirements and staff leavers
- The difference between the notice period for midwives and the length of time it takes to advertise, recruit and start date for new members of staff leaves gaps in the roster
- The impact of the continuity of carer model – different ways of working, difference in number of women in a caseload compared to the traditional midwifery model (hospital and community)
- Staffing levels on the Maternity Assessment Centre (MAC) – recently escalated via the maternity safety champions walkabout in May 2021 – additional band 3 MSW's now being advertised.

Middle grade medical staff

- Reduced numbers, staff doing additional shifts to cover the rota and being tired.


attendance log (maternity safety ch


TOR Maternity Safety Champions G


Agenda Maternity Safety Champions (M


Action log (updated post April


Pathway.pdf

Continuity of Carer model (local update)

The term 'continuity of carer' describes consistency in the midwife or clinical team providing care for a woman and her baby throughout the three phases of her maternity journey: pregnancy, labour and the postnatal period (NHS England 2017). Research has shown that women who receive midwifery-led continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth and report significantly improved experience of care across a range of measures (Sandall et al 2016). Safety for childbearing women and their partners and families also means emotional, psychological, and social safety. This holistic sense of safety is what they receive through continuity models of care.

The midwifery team have worked tirelessly to implement this model of care in Harrogate and to find the most appropriate model that suits the local women, the midwifery team and the maternity department.

There have been challenges during this journey in finding the right model of care and in engaging staff to work in a very different way to the traditional model of midwifery care. The action plan developed (attached below) has been shared with the executive level maternity and neonatal safety champions and how we continue this model so that we achieve the trajectories set by the national team.

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 do not fulfil the criteria for 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) launched in January 2021. The aim for the team is 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 at the end of May 2021 was 13% however due to a restructure within the team they are now only providing antenatal and postnatal continuity. Therefore, we are submitting zero % of women are on a continuity of carer pathway at the end of May.

Safety action 10

	Reporting 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS	**Compliant**	***Required standard***

10	Resolution's Early Notification (EN) scheme		***pages 62 - 64***

Report received from HSIB

Executive Summary

Cases to date	
Total referrals	9
Referrals / cases rejected	2
Total investigations to date	7 progressed to investigation
Total investigations completed	5 completed investigations
Current active cases	2
Exception reporting	0

The Early Notification Scheme requires Clinical Negligence Scheme for Trusts (CNST) members to notify maternity incidents that have the potential to become high value claims. These include term deliveries (37 completed week's gestation), following labour that resulted in severe brain injury diagnosed in the first seven days of life, babies that fall into the following categories:

- Was diagnosed with grade 3 hypoxic ischaemic encephalopathy (HIE) OR
- Was therapeutically cooled (active cooling only) OR
- Had decreased central tone AND was comatose AND had seizures of any kind

The Early Notification Scheme enables the following:

- To investigate potential eligibility for compensation and take proactive action to reduce legal costs and improve the experience for the family and affected staff;
- To share learning rapidly with the individual trust and the wider system in order to support safety improvement and prevent the same things happening again;
- To build on our Saying Sorry and Being Fair work to ensure the process to obtain compensation is not a barrier to openness, candour and learning;
- To preserve evidence to ensure we are able to respond to cases that a family may choose to bring at a later date; and
- To improve the process for obtaining compensation for families, meeting needs in real time where possible and trying to reduce the risk of claims increasing in value due to inflation or unmet needs (such as psychological support) translating into larger losses.

There were three babies born in Harrogate during the period 1st October 2019 to 31st March 2021, three were reported to NHS Resolutions Early Notification scheme.

Conclusion

This report provides all the evidence required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year 3. Due to the impact of Covid-19, NHS Resolution provided updated guidance in March 2021 and revision of the requirements of some of the safety actions.

The Trust Board need to be satisfied that the evidence within this report satisfies these requirements prior to final sign off by the Chief Executive by 15th July 2021.

Harrogate and District NHS Foundation Trust

Strengthening Maternity and Neonatal Safety Report

Board of Directors

28th July 2021

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

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update of the detail on the board level measures for the month of June as set out in the Perinatal Quality Surveillance model.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	SMT Maternity Risk management Meeting Maternity Safety Champions Meeting	
Recommendation:	The Board of Directors asked to note the updated information provided in the report and for further discussion.	

Board of Directors
Report: Strengthening Maternity & Neonatal Safety Report
Author: A. Pedlingham

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Prompt online training compliance – midwives and medical staff (plan in place)	• Ockenden bid monies received - £273,125 (7/12th midwifery and 75% medical staffing due to time in financial year) • Maternity Incentive Scheme (year 3) – submission 22nd July
Positive news & assurance	**Decisions made & decisions required of Board**
• Full compliance with 10 safety actions from MIS (year 3) – Board sign off 30th June • Submission of evidence required to support the Ockenden report • Monies received from Ockenden bid (5.0WTE midwives and 0.8WTE Consultant Obstetrician) • >90% fetal monitoring compliance training – midwives and medical staff	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of June 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 provider Board level measures required as part of the perinatal surveillance model.

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

3.0 Quality Implications and Clinical Input

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

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. The situation is expected to improve in August with the rotation of training grades, the appointment of the chief registrar and the second new consultant.

6.2 Maintaining competencies in management of obstetric emergencies through multiprofessional training (Prompt) has been compromised by the inability to hold face to face sessions and the transferring of this training to online due to the impact of Covid-19 restrictions.

6.3 The low compliance levels for obstetric emergency training (Prompt) present a risk to the delivery of high quality care, however the safety standard 8 of the Maternity Incentive scheme was revised in March 2021 and the threshold of 90% has been removed and applies to all of safety action 8 requirements. It is recommended that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible. The plan and progress on this plan is described in the paper below.

7.0 Recommendation

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

Narrative in support of the Provider Board Level Measures – May 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.

This report for SMT follows the overview on quality and safety and the response to the Ockenden Report last presented at the board meeting in June 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 August 20th 2021 (postponed from 4th June due to half term and increased numbers of staff members on annual leave).

Review of WY&H LMS dashboard

As part of implementing a revised perinatal quality surveillance model (December 2020; LMS action) the LMS are "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".

Discussions continue within the WY&H LMS about the content of maternity dashboards and the current variation between all six maternity units within the LMS – content, layout, and priorities. This work stream is being led by the LMS Programme analyst.

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

Since the last report in June, the following cases have been reported to MBRRACE:

- 23+4 Termination for fetal abnormality
- 29/40 Late termination for fetal abnormality

Both cases are reportable as they are over 22 weeks gestation however, they do not meet the criteria to warrant further investigation by use of the PMRT (Perinatal Mortality Review Tool).

There is currently one Perinatal Mortality Review in progress which has been delayed because of an HSIB investigation (Term intrapartum stillbirth).

Findings of review all cases eligible for referral to HSIB

In June 2021:

There were no new cases reported to HSIB. The two previously reported cases were being finalised:

- Final report received from case MI-003299 (Term stillbirth). Findings and recommendations noted in previous report in June. The report has been shared with the family. For final letter and action plan to be agreed at PESH.

- Draft report received from case 2011-2649 (Maternal death). Findings and recommendations noted in previous report in June. The report has been shared with the family and awaiting finalisation.

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

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.

In June no incidents reported as Moderate severity or above in this period (45 Low/No Harm incidents reported)

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%
31st May 21	47%	49%
Early - June 2021	47%	56%
1st July 2021	47% (16/34)	64% (44/69)
Mid-July	49% (19/39)	69% (48/69)

Fetal monitoring training (K2 online training package)

	Medical staff	Midwives
March 2020	93%	94%
End March 2021	15%	40%
Early May	61%	69%
31st May 21	78%	76%
Early June 21	98%	80%
1st July 2021	98%	91%
Mid-July	98%	91%

Fetal monitoring training
Both midwifery and medical staff training compliance are now above 90%.

Prompt emergency skills training
These figures are for completion of the online training package and do not include partial training for midwives and medical staff**.** There has been some progress in the number of chapters completed (within the 15 chapter package) by individual members of staff.

The previous risk mentioned in the June report of not achieving 90% of each maternity unit staff group having attended in-house multi-professional emergency training session – this safety standard was revised by NHS Resolution in March 2021 - in the current year the

threshold of 90% has been removed. It is recommended that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.

After discussion at the Board of Directors, meeting on 30th June it was agreed that all staff be required to complete Prompt online training by August 31st with the following plan in place:

- Completion rates are available and monitored fortnightly from learning and development department
- Compliance rates for staff members are shared with line managers for action – to allocate time where possible and when workload allows
- Staff are given TOIL if training completed in own time
- If Prompt online training is not completed by 31st August, those members of staff not fully compliant will be unable to care for women in labour including home births
- Face to face training will recommence in September 2021.

Minimum safe staffing in maternity services

The maternity team have been allocated £274,125 from the Ockenden bid monies to support the recommendations in the report – midwifery staffing (uplift to the establishment based on a recent Birthrate + acuity workforce review) - obstetric staffing and multi-disciplinary training.

- 5.0WTE midwives above funded establishment – plans to open the Maternity assessment centre 9-5 at the weekend and roster an additional midwife every night on Pannal ward. This recognises the increased acuity of mothers and babies on the ward and provides flexibility in a midwife being able to work on delivery suite at times of increased activity. The midwife on call will remain in place. This will reduce the number of times the unit is in escalation and women diverted to other maternity units.
- 0.8WTE Obstetric Consultant
- £16,000 of this amount allocated for training.

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 One gap due to speciality doctor having left One gap in on call cover due to change in training meaning ST3 cannot work on call without a resident senior Phased return of middle grade who has returned to work	Internal cover prioritising labour ward cover Additional middle grade doctor post recruited to but not yet in post Internal cover for short term sickness as required Consultants covering shortfall	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover Added to risk register March 2021

	following sickness absence		
Consultant	One consultant sick One consultant working less than full time	4 substantive consultant posts recruited, 2 now in post. New appointments start in August and September Internal cover for short-term sickness as required. Funding from Ockenden for 0.8WTE consultant-locum consultant post being advertised	Risk of fatigue in consultants due to covering shortfall

Midwife minimum safe staffing planned cover versus actual prospectively

June data gives an average shift fill rate of 95.3% for midwives and 85.6% for maternity support workers on Delivery suite and 88.8% for midwives and 101.1% maternity support workers on Pannal Ward.

Specialist midwives and ward managers have continued to support the service by working clinical hours. Staff have worked NHSP shifts and a small number of agency

Current midwifery/maternity support worker vacancies:

Band 6 midwifery interviews planned for 14th July (3 applicants).

Midwives – 4.54 WTE

Maternity support workers – interviews planned for 29th July band 3 MSW's to work on MAC.

Service User Voice feedback

During June, no concerns were received and one formal complaint – issues with antenatal care, communication and management of pregnancy (high risk).

Staff feedback from frontline champions and walkabouts

Emma Nunez visited Ripon to meet the team. There were discussions about a hub and possible work on Leon Smallwood.

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 June 2021.

Progress in achievement of CNST 10

Final submission of the Maternity Incentive Scheme (year 3) is now 22nd July; the additional week is due to a technical error identified in one of the automated fields in safety action 4 requiring a revised declaration form.

The final report, including evidence of compliance was presented at the Board of Directors meeting on 30th June; full compliance with the nine of the ten safety actions was agreed.

The previous risk mentioned in the June report of not achieving 90% of each maternity unit staff group having attended in-house multi-professional emergency training session (Prompt) – this safety standard was revised by NHS Resolution in March 2021 - in the current year the threshold of 90% has been removed and applies to all of safety action 8 requirements. It is recommended that trusts identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible. A clear plan is in place to achieve this.

Update on continuity of carer (CofC)

Update provided to SMT by Beth Fisher, continuity of carer project lead at the beginning of the meeting.

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 4 20/21 (the last published dataset).

No new quarterly Y&H dashboard available at this time. Dashboard and infographic for Q4 presented below.

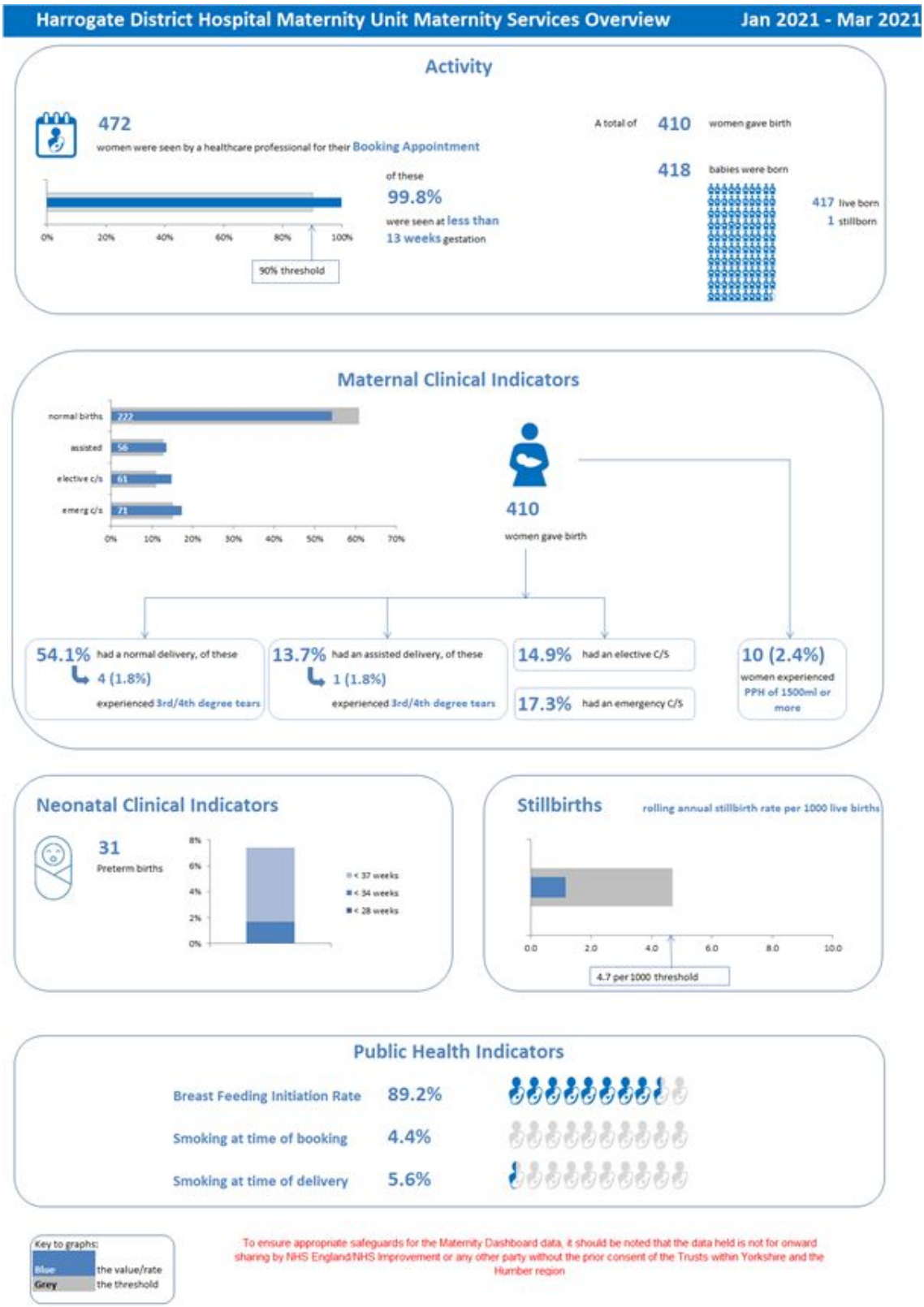
- Very high proportion of bookings < 13 week gestation (99.8%, Y&H average 91.7%
- Low number of homebirths
- Percentage of normal deliveries (54.1%) lower than Y&H average (59.7%)
- Higher rates of instrumental deliveries (13.7%) and elective Caesarean sections (14.9%) compared with Y&H average (10.6% and 12.8% respectively)
- Lower rates of 3rd/4th degree tears
- Lower PPH rates
- Lower pre-term birth rate
- Lower antenatal stillbirth rate
- Significantly higher breastfeeding rate (89.2%) compared with Y&H average (68.7%)
- Significantly, lower rate of smoking at time of delivery (5.6%) compared with Y&H average (12.7%)

Local dashboard

Local dashboard for June data experienced high rate of projected deliveries (186 for the month). This translated to 164 births in the month.

- In this month there was a high elective LSCS rate of 17.6%, contributing to an overall 37.0% Caesarean section rate for the month
- Normal delivery rate declined as a result to 47.9%
- Induction rate was 27.3% of deliveries
- Significant PPH ≥1500ml occurred in 6.7% of deliveries (with 8 of these occurring at Caesarean section or instrumental delivery)
- There were 3 third degree tears recorded
- Breastfeeding rates remained high at 84.8%.

YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - DATA QUALITY							Trust	Harrogate District Hospital N	Quarter/Year		
	Indicator	Measure	Trust's Quarterly Data				From MSDS where available	Y&H Average	Y&H Range	Y&H Interquartile Range	Previous Q	Y&H Avg
			Previous	Latest	Absolute Difference	% Difference						
	ACTIVITY INDICATORS											
1	Bookings	Number of women booked	462	472	10	2.2%		872	0 to 1865	563 to 1313		
2	Bookings <13 weeks	Number of women booked <13 weeks	462	471	9	1.9%		800	0 to 1742	528 to 1169		
3	% Bookings <13 weeks	% of women booked <13 weeks	100.0%	99.8%	0%	-0.2%		91.7%	0.0% to 99.8%	89.8% to 93.4%		
4	Women birthed	Number of all women birthed	445	410	-35	-7.9%		664	0 to 1396	367 to 1070		
5	Women who birthed a live baby	Number of women who birthed a live baby	445	409	-36	-8.1%		661	0 to 1388	365 to 1064		
6	Total births	number of all babies born	451	418	-33	-7.3%		672	0 to 1411	369 to 1079		
7	Live births	Number of live babies born	451	417	-34	-7.5%		669	0 to 1405	367 to 1072		
8	Live births at term	Rolling annual number of live babies born at term	1649	1620	-29	-1.8%		2604	0 to 5647	1325 to 4151		
9	Total births	Rolling annual number of all babies born	1748	1730	-18	-1.0%		2817	0 to 6170	1472 to 4437		
10	Planned homebirths	Number of planned homebirths	0	4	4	-		12	0 to 41	5 to 15		
11	Planned homebirths	% of planned homebirths	0.0%	1.0%	1.0%	-		1.8%	0.0% to 80.0%	0.9% to 2.8%		
	MATERNAL CLINICAL INDICATORS											
12	Normal births	Number of women - normal births	237	222	-15	-6.3%		396	0 to 774	213 to 642		
13	Normal births	% of women - normal births	53.3%	54.1%	0.9%	1.7%		59.7%	0.0% to 100.0%	57.7% to 63.0%		
14	Assisted vaginal births	Number of women - assisted vaginal births	57	56	-1	-1.8%		70	0 to 157	34 to 116		
15	Assisted vaginal births	% of women - assisted vaginal births	12.8%	13.7%	0.8%	6.6%		10.6%	0.0% to 14.6%	7.7% to 11.8%		
16	Elective C/S births	Number of women - El C/S	77	61	-16	-20.8%		85	0 to 219	39 to 123		
17	Elective C/S deliveries	% of women - El C/S	17.3%	14.9%	-2.4%	-14.0%		12.8%	0.0% to 16.4%	10.3% to 13.6%		
18	Emergency C/S births	Number of women - Em C/S	74	71	-3	-4.1%		113	0 to 289	64 to 176		
19	Emergency C/S deliveries	% of women - Em C/S	16.6%	17.3%	0.7%	4.1%		17.1%	0.0% to 24.4%	14.3% to 17.6%		
20	Number of C/S deliveries	No. of women - Total all C/S	151	132	-19	-12.6%		198	0 to 508	103 to 293		
21	C/S deliveries	% of women - Total all C/S	33.9%	32.2%	-1.7%	-5.1%		29.9%	0.0% to 36.4%	26.4% to 31.1%		
22	3rd/4th degree tear - normal birth	Number of women delivered - normal births	4	4	0	0.0%		8	0 to 21	4 to 10		
23	3rd/4th degree tear - normal birth	% of women delivered - normal births	1.7%	1.8%	0.1%	6.8%		1.9%	0.0% to 4.4%	1.3% to 2.3%		
24	3rd/4th degree tear - assisted birth	Number of women delivered - assisted births	1	1	0	0.0%		4	0 to 14	1 to 5		
25	3rd/4th degree tear - assisted birth	% of women delivered - assisted births	1.8%	1.8%	0.0%	1.8%		5.5%	0.0% to 14.3%	3.1% to 7.3%		
26	Induction of Labour	Number of women delivered	145	134	-11	-7.6%		242	0 to 513	152 to 387.0		
26a	Induction of Labour	% of women delivered - induction of labour	32.6%	32.7%	0.1%	0.3%		36.5%	0.0% to 54.1%	31.4% to 40.4%		
27	PPH ≥ 1500ml	Number of women delivered	11	10	-1	-9.1%		23	0 to 75	9.25 to 29.75		
28	PPH ≥ 1500ml	% of women delivered	2.5%	2.4%	0.0%	-1.3%		3.4%	0.0% to 5.4%	2.1% to 3.7%		
	NEONATAL CLINICAL INDICATORS											
29	Number of preterm births < 37 weeks	Number of babies <37 weeks	28	31	3	10.7%		54	0 to 137	27 to 84		
30	Preterm birth rate < 37 weeks	% of babies <37 weeks	6.2%	7.4%	1.2%	19.7%		8.0%	0.0% to 9.9%	6.1% to 8.7%		
31	Number of preterm births < 34 weeks	Number of babies <34 weeks	5	7	2	40.0%		17	0 to 50	6 to 30		
32	Preterm birth rate < 34 weeks	% of babies <34 weeks	1.1%	1.7%	0.6%	51.4%		2.5%	0.0% to 5.3%	1.5% to 2.8%		
33	Number of preterm births < 28 weeks	Number of babies <28 weeks	1	0	-1	-100.0%		4	0 to 16	0 to 7		
34	Preterm birth rate < 28 weeks	% of babies <28 weeks	0.2%	0.0%	-0.2%	-100.0%		0.6%	0.0% to 1.7%	0.0% to 0.7%		
35	Rolling annual number of low birth weight at term - live births	Rolling annual number of live babies at term < 2200g	10	8	-2	-20.0%		23	0 to 94	6 to 36		
36	Low birth weight at term - live births	% of live babies at term < 2200g	0.6%	0.5%	-0.1%	-18.6%		0.9%	0.0% to 4.2%	0.3% to 0.8%		
	STILLBIRTHS											
37	Stillbirths	Number of all babies stillborn	0	1	1	-		3	0 to 7	1 to 5		
38	Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	2	1	-1	-50.0%		10	0 to 27	5 to 14		
39	Stillbirth rate - Antenatal	annual rate for antenatal stillborn babies / 1000 births	1.1	0.6	-0.57	-49.5%		3.4	0.0 to 6.5	2.5 to 4.5		
40	Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	0	1	1	-		1	0 to 4	0 to 1		
41	Stillbirth rate - Intrapartum	annual rate for intrapartum stillborn babies / 1000 births	0.0	0.6	0.58	-		0.2	0.0 to 0.9	0.0 to 0.4		
	Rolling annual number of stillbirths	Rolling annual Stillbirths (antenatal) + Stillbirths (intrapartum)	2	2	0	0.0%						
42	Stillbirth rate - Total	annual rate for ALL stillborn babies / 1000 births	1.1	1.2	0.01	1.0%		3.7	0.0 to 6.5	2.6 to 4.9		
43	Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	2	2	0	0.0%		8	0 to 25	1 to 11		
44	Stillbirth rate - adjusted to exclude lethal abnormalities	annual stillborn babies / 1000 births excluding babies with lethal abnormality	1.1	1.2	0.01	1.0%		2.8	0.0 to 6.5	0.9 to 4.2		
45	Stillbirths at term	Rolling annual number of babies stillborn at term	0	1	1	-		3	0 to 10	1 to 4		
46	Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	0	0	-		1	0 to 4	0 to 1		
47	Stillbirths at term with low birth weight	annual % of stillborn babies < 2200g	N/A	0.0%	-	-		15.6%	0.0% to 100.0%	0.0% to 14.3%	##	
	PUBLIC HEALTH INDICATORS											
48	Breastfeeding	Number of women commenced breastfeeding	388	365	-23	-5.9%		454	0 to 1107	240 to 749		
49	Breast feeding initiation rate	% of women commenced breastfeeding	87.2%	89.2%	2.1%	2.4%		68.7%	0.0% to 89.2%	60.9% to 74.7%		
50	Smoking at booking - self reported	Number of women who smoke at booking - self reported	26	21	-5	-19.2%		101	0 to 213	69 to 138		
51	Smoking at time of booking	% of women who smoke at booking	5.6%	4.4%	-1.2%	-20.9%		11.6%	0.0% to 20.4%	7.5% to 17.5%		
52	Smoking at time of birth - self reported	Number of women who smoke at time of birth - self reported	25	23	-2	-8.0%		84	0 to 198	45 to 114		
53	Smoking at time of delivery	% of women who smoke at time of delivery	5.6%	5.6%	0.0%	-0.1%		12.7%	0.0% to 21.2%	8.9% to 14.9%		



To ensure appropriate safeguards for the Maternity Dashboard data, it should be noted that the data held is not for onward sharing by NHS England/NHS Improvement or any other party without the prior consent of the Trusts within Yorkshire and the Humber region

Harrogate and District NHS Foundation Trust

3.2

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Jeremy Cross
Date of meeting:	12 July 2021
Date of Board meeting this report is to be presented	28 July 2021

Summary of key issues

- We received an update from Steve Russell as to the progress on the Cultural Programme – and it is encouraging to see the progress made, particularly as it gets embedded into appraisal processes as well
- We also received an update from Steve against the Deloitte report actions from last year. The majority of actions are closed, and significant progress has been made against the remainder. We will keep this on the agenda for the committee until all are closed, and will revisit by the end of the year.
- We had a session with members of the North Yorkshire 0-19 team. They presented openly and honesty around some of the issues that they had been facing into – and while the issues were known to the committee, they were still difficult to hear. There is an 88 point action plan drawn up by the team that they are working through which is a significant programme of work. It was encouraging that all stated that the right issues were being addressed, and that progress was being made.
- We received an update from the Staff Network representatives – all have made good progress -including the Disability network which was previously the least well developed. In addition we heard from Charly Gill the interim Freedom to Speak Up Guardian – on the day that the change was announced to the wider trust – we wish her well in this important role. Before the appointment of the ED&I lead, we will need to provide some resource to the BAME network to make the most of the opportunity of Black History Month in October
- We had an update on turnover of staff, and in particular on learnings from Exit interviews. While the number of interviews performed is relatively low, there was still a lot of interesting data for the committee to consider – and it reinforced a number of the actions already in track. In particular we noted the high turnover of staff in 0-19 services. In addition we noted that over 600 trained nursing and midwifery staff members had left the Trust in the past 3 years – clearly if we could keep a % of these in the future (or encourage the ones we have lost back) we would find it easier to fill vacancies

- We had an update on the considerations around security with the Emergency Department. While not within the workplan of the committee it was great to have the visibility of this matter that had been raised with the committee chair by a member of the ED team.
- We had a new Governor attending the committee – Ian Barlow. It was encouraging to receive his positive feedback at the end of the meeting.

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

- No new risks were identified but the update from 0-19 services made these known risks come more alive. It is important progress continues in this area.

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

- None

Harrogate and District NHS Foundation Trust

3.3

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	Attached slides detail Workforce and OD priorities in terms of :- • Matters of Concerns and Risks to Escalate • Major Actions Commissioned and Actions underway • Positive News and Assurance	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within slides	
Report History:	N/A	
Recommendation:	Board of Directors are requested to note the content of this report.	

Director of Workforce and OD Report

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- E-Rostering decision making
- Management Restructure
- CC Recruitment
- Ability to meet increasing demand for OD Teams interventions (triage system in place to manage demand)
- Long term gap in EDI role and impact upon work programme and statutory reporting of *WRES, WDES – deadline of 31 August prior to new recruit starting. Out to advert for 2nd post, as previous candidate's offer withdrawn.*
- Increasing demand on complex ER casework
- Trade Unions opposing changes to Retire / Return Policy
- OH Capacity to meet increased demand (Business Case under review)
- Amount of simultaneous organisation change requiring line manager capacity, development and implementation

Major actions commissioned & work underway

- SAS Doctor Contract Reform – ongoing actions
- Implementation and embedding of Respecting Resolution (ongoing)
- Implementation and embedding of Recruiting to Values (ongoing)
- Implementation and embedding of Appraising to Values (ongoing)
- Implementation and embedding of Wellbeing conversations(ongoing)
- In-pulse Quality Staff Survey – final development
- EDI Anti-Racist Organisation Programme - Allyship Programme commenced
- Medical Annual Leave
- E-Job Planning, E-Leave, Manager Self Service
- VLE Project management implementation
- Chief Nurse and Director of Strategy Senior Recruitment
- Lifting of Covid restrictions

Positive news & assurance

- Line Manager Wevbinars attended by over 90 line managers. Further webinars to take place every two weeks.
- Full programme of line manager support and training in place for line managers until September – all tools now available on the intranet
- *New teamHDFT app launched*
- *Inpulse quarterly survey launched*
- Declare System launched – gifts , hospitality and Relation ships. Over 900 responses received.
- Wards moved to Health Roster – Littondale, Niddderdale, Farndale, Emergency Department, Woodlands, SCBU and Radiology
- VLE implementation underway
- E-Rostering Early Adopters – successful implementation
- Sickness absence levels at Trust threshold level

Decisions made & decisions required of the Board

Harrogate and District NHS Foundation Trust

Board of Directors – 28 July 2021

Workforce & Organisational Development Public Board Report

1. Purpose of the report

The attached report details Workforce and OD priorities in terms of:-

- Major Actions Commissioned and Actions underway
- Positive News and Assurance
- Any Matters of Concerns and Risks to Escalate

The Board of Directors are requested to receive and accept this report.

2. Introduction

This report is a key component of the Public Board Report submitted to the Board of Directors and contains information and up-dates on the key issues and developments taking place in the workforce and organisational development department.

3. Main body of report

3.1 SAS Doctor Contract Reform

The 2021 SAS contract reform was implemented in April 2021. 63 Specialty Doctors and 5 Associate Specialists within HDFT are eligible to express an interest to transfer to the new contract.
Medical Staffing and the departments are working closely to assist those doctors who have shown an interest with the information they require to make an informed decision. In order to do so, the department together with the doctors needs to undertake a Job Planning process to align with the new safeguards within the new contract.
The main safeguards to note is working hours (social hours are now aligned with Doctors in Training contract of 7am to 9pm), weekend frequency (no more than 1 in 4) and at least 46 hours rest after transition between day and night shifts.
SAS doctors have until 30th September to make the decision on whether to transfer across to the 2021 contract.

3.2 At Our Best – embedding the culture change and tools

To support the embedding of the At Our Best culture change and use of the tools introduced, such as the ABC of Appreciation (Action, Benefit, Continue) the following activities have been implemented:

- Three Values in Action masterclasses took place in June, with over 60 attendances. These workshops were for leaders who wished to further develop their expertise in the tools and techniques we have developed to support the embedding of our KITE values. Participating leaders are now “super users” who have the knowledge to train others in these tools and techniques.
- To support leaders further, 55 Leadership Support workshops are now taking place between June and September. They provide leaders with psychologically safe and convenient opportunities to test their use of the tools in smaller groups and receive personalised coaching and advice where needed.
- E-learning modules for all KITE tools and techniques is now available on ESR, intranet and the new teamHDFT colleague app (more on this below).

Next steps to further support embedding include:

- All colleagues to receive a personal letter from the Chief Executive outlining and commending the behaviours we value and signposting workforce experience and KITE resources.
- Further KITE branded resources (posters, pens, wall vinyl's, banners, style guide for reports, letters etc.) are in development. They will be distributed to colleagues across teamHDFT

3.3 Inpulse Survey Launch

Inpulse, an online platform for colleague engagement, framed around workplace satisfaction surveys and sentiment analysis has now been designed, in association with HDFT colleagues.

Inpulse is a quarterly survey of between 15 and 20 questions which has been launched during July to gather feedback from colleagues.
This process is aligned to the newly launched national quarterly Pulse survey and supplements the national NHS Staff Survey, which will continue to run as normal. The new quarterly survey will replace the Staff Friends and Family Test.

To support the alignment of colleagues' behaviour with that which we expect through the KITE behaviours, a themed approach to the survey questions is being taken. This will allow us to see the extent to which kindness, integrity, teamwork and equality are improving with teamHDFT. This quarter's theme is Equality.

3.4 teamHDFT Application Launch

A free smart phone app called simply "teamHDFT" is aimed at improving communication across the HIF and HDFT workforce. The app is being uploaded to all Trust mobile devices. It is available through download links on our website for staff to download it onto personal devices.

Unanimously positive feedback was received during testing, with further minor improvements suggested. A recent soft launch will be followed by a hard launch and live demonstration at Team Talk on 26th July 2021.

3.5 Medical Annual Leave

The Business Case to purchase an electronic e-leave system for medical staff has been approved. The system is in the process of being aligned with HDFT rules and policies and will be implemented across the Trust in a phased process.

3.6 Chief Nurse and Director of Strategy Recruitment campaigns

The Director of Strategy recruitment campaign concluded on the 11th June 2021. Matthew (Matt) Graham was our preferred candidate. Pre-employment checks have been completed successfully and Matt will commence on the 1st September 2021.

The Director of Nursing, Midwives and AHPs is in the process of going through the recruitment campaign. Longlisting was completed on the 13th July with interviews taking place on the 2nd August 2021.

3.7 Lifting of COVID19 restrictions

Following the lifting of a number of national restrictions due to Covid on 19th July 2021, HDFT's processes were reviewed around elements such as wearing PPE, travel restrictions, isolation guidance and childcare bubbles. It has been agreed that the Trust will maintain its original guidance at this time, that being:

- PPE in clinical area's - Retain surgical mask at all times. Continue with handwashing regimes, and appropriate application of PPE for Green, Amber and Red areas.

- PPE – non-clinical areas - Face Masks to be worn in public areas. Eyewear to be worn in addition to face masks where distance is less than 2m for 15 minutes.
- School Bubbles **-** Normal isolation rules apply where the child tests positive.
- Social distancing – 2m distancing remains in place
- Travel and isolation –
  Red - Colleagues should not visit Red countries.
  Amber - Colleagues must isolate in line with Government guidelines on their return to UK. Leave/ unpaid leave needs to be agreed with line managers prior to travel.
  Green - Colleagues no longer need to isolate if they go to a green country. However, if a countries status changes whilst the colleague is abroad then the colleague will need to use annual leave to unpaid leave to support their isolation period.
- Isolation **-** If symptomatic, then colleagues must isolate until they can be tested. If test negative – isolation ends. If test is positive then 10 days isolation must be completed. If contacted by test and trace colleagues need to isolate for 10 days. If someone has a positive lateral flow test they need to confirm with a PCR test. If PCR positive they need to isolate for 10 days. PCR negative isolation ends. If any member of a household has a positive test colleagues need to isolate for 10 days.

3.8 HealthRoster early adopters and Manager Self Service Implementation

HealthRoster has been successfully implemented into 13 early adopter wards / departments which is in line with the project plan. A number of issues have emerged as the Roster Team continue to implement the system across the Trust. A working group has been established to tackle these issues. The first meeting has recently taken place where actions were identified to reduce / resolve the issues raised.

Workforce Information has commences a phased implementation of Manager Self Service since the 1st April to approximately 800 staff members across the Trust, the majority of these are in Children's services and Human Resources.

3.9 Virtual Learning Environment Implementation

The Virtual Learning Environment (VLE) is a new online resource that will replace the course catalogue on ESR to enable a colleague focussed learning platform. It will revolutionise HDFT's Educational Resources by offering an engaging, easy to use, online area that allows access to e-learning modules, independent booking of programmes, webinars and forums for discussions about learning. It will centralise all educational resources in one easy to access area.

The name of the system was agreed on Wednesday 14th July – "Learning Lab" and has been set up by the organisational we have commissioned this software from -

Chambury Learning Solutions (CLS). The name of the VLE was part of a naming competition; Caroline Smith from the Learning & Development Team will be awarded a fruit basket with compliments of our Hospital Charity for her submission. Learning Lab has the strap line “Learning At Our Best” and is branded with the KITE behaviours and new branding colours.

The Learning Lab launch is scheduled for 20th July with the new doctors in training intake followed by a Trust wide launch on Tuesday the 10th August.

- 20th July - allow access to the system for 20 FY1 Drs on Tuesday 20th July, 2 days prior to the beginning of their shadowing period.
- 27th July – allow access to the system for the remaining 75 Drs in training (FY2 and above) who are due to start with HDFT on Wednesday the 4th August
- 10th August – allow access Trust wide in line with our current monthly mandatory training reporting cycle – all colleagues across the Trust will be on the VLE.

The VLE is currently in its most basic form however by July 2022 it is planned to have all additional services established as shown below.

- Jan 2022
    - Appraisal forms and THRIVE wellbeing conversations uploaded
    - Use of webinar software
    - Revalidation
    - Ability to book training independently
- July 2022
    - Forums open
    - Ability to upload research
    - Continuing Professional Development Portfolios available

3.10 BAME Allyship Programme

The BAME Allyship programme has been developed to build relationships of trust, consistency and accountability. The BAME Allyship Programme will be a continuous process in which someone with privilege and power seeks to first learn about the experiences of people who are from a BAME community, sympathise with their challenges and build relationships with them, enabling colleagues to add their voice to that of our BAME colleagues.

Prior to approval for implementation, the programme was shared for comment through the BAME staff network group, Staff side and Operational/Service Managers.
The Programme covers 6 facilitated sessions over a 12 week period with an opportunity for Allies to interact in between the sessions by way of “virtual” informal coffee/learning with BAME colleagues, to enhance the learning experience an exhibit the change process of becoming an antiracist organisation.
4 BAME colleagues have been recruited as Buddies for Allies to discuss and explore learning and discuss experiences; meetings will commence over the next 6-8 weeks.
Eight colleagues who identify as white British or White European have been recruited for cohort one which launched on Wednesday 14th July.

Programme feedback will be collaborated in its entirety at the end of the programme in December as much of the learning occurs between sessions. This evaluation process will inform the shape of cohort two.

4. Financial Implication/Risk assessment

There are no significant financial implications linked to issues covered in this report.

5. Risks

The impact of the lifting of COVID19 restrictions could have a detrimental impact on staffing levels, should significant numbers of colleagues have to isolate or contract COVID19. This is mitigated by the Trusts's decision to maintain pre-19 July measures and the up-take of the COVID vaccine by colleagues.

6. Recommendation

The Board/Committee is asked to receive and accept this report.

Name Shirley Silvester
Deputy Director of Workforce & Organisational Development
Date 20 July 2021

Harrogate and District NHS Foundation Trust

3.4

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

Title:	**Medical Revalidation Annual Statement of Compliance**
Responsible Director:	Dr Jackie Andrews, Medical Director
Author:	Lee-anne Hutchison, Head of Resourcing and Revalidation Lead

Purpose of the report and summary of key issues:	The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures. The Trust remains fully compliant with all the requirements of a Designated Body.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	Failure to comply with the requirements of annual medical appraisal and revalidation would place the Trust at risk of medical staff losing their Licence to practise medicine in England and the Trust losing status as a Designated Body under the General Medical Council.	
Report History:	The last annual statement of compliance was submitted to board in September 2019. The report was not submitted in 2020 due to Covid-19.	
Recommendation:	The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures. The Trust is fully compliant and met regulatory procedures.	

Harrogate and District NHS Foundation Trust

Board Report

Medical Revalidation Annual Statement of Compliance

1. Purpose of the report

The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures.
The Trust remains fully compliant with all the requirements of a Designated Body.

2. Introduction

The over-riding intention of this statement of compliance is to set out the key requirements for compliance with regulations and key national guidance. This allows us the opportunity to demonstrate not only basic compliance but continued improvement over time. This report provides the necessary assurance to the higher level responsible officer and the Trust's Board.

3. Main body of the report

3.1 Annual Statement of Compliance

- The organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).
- A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer.
- An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained.
- There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners.
- Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).
- All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken.
- There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners1 (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal.
- There is a process established for responding to concerns about any licensed medical practitioners fitness to practise.
- There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works.
- The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed;
- A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

4. Financial Implication/Risk assessment

A failure to employ a Responsible Officer, as required under the terms of the Medical Profession (Responsible Officers) Regulations 2011, could lead to loss of status as a Designated Body

5. Risks

No current risks

6. Recommendation

It is recommended that the Board:-

- Notes items included within the report
- Authorises the Chairman and Chief Executive to sign-off the Statement

Lee-anne Hutchison
Head of Resourcing and Revalidation Lead
19th July 2021

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

4.1

Title:	**Humber Coast and Vale Health and Care Partnership – Strategic Objectives**	
Responsible Director:	Chief Executive	
Author:	Chief Executive	
Purpose of the report and summary of key issues:	This report updates the Board on the Strategic Objectives agreed for the Humber Coast and Vale Health Care Partnership.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	None noted	
Report History:	None	
Recommendation:	The Board is asked to note and discuss the contents of this report.	

Humber, Coast and Vale Health and Care Partnership – Strategic Objectives 2021/22

Objective	Actions	Monitoring progress
Pandemic response	• Continue to strengthen partnership working at all levels to enable a combat the consequences of the pandemic and the post pandemic environment. • Support local systems and organisations in the response to COVID 19 and the associated resetting and redesign of services and functions • Ensure the ongoing delivery of vaccination programmes • Ensure the NHS is fully engaged in strong partnerships with local government strategies and plans and the Health & Wellbeing and Local Resilience Forums especially in relation to their lead role in the wider societal and economic impact of COVID 19. • Support local government and public health leaders through NHS investment, where appropriate, in addressing the wider societal and economic impact of COVID 19. • Continue to make the case for greater recognition of the need to 'level up' across our communities using the evidence base of the multi deprivation index and other data and research. • Strengthen the role of the NHS in developing the adult social care market to support recovery and resilience of services	Quarterly review of progress by the Partnership Executive and other stakeholders to March 2022

Objective	Actions	Monitoring progress
Deliver the Partnership operating plan 2021/22	• Support the health and wellbeing of staff and take action on recruitment and retention • Establish a System Quality Board to ensure that patients and citizens receive high quality care. • Assure the quality of services are maintained and improved in accordance with national best practice and policy and by listening and responding to citizens who use services • Deliver Mental health and Learning Disability recovery and transformation in accordance with national and local policies and requirements • Expand primary care capacity to improve access and address health inequalities • Transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission and reduce length of stay. • Deliver significant improvement in waiting times for patients awaiting elective treatment • Deliver the cancer services plan and programme • Support the third sector and voluntary community to further engage and contribute to health and care services. • Deliver the NHS mandated health inequalities priorities • Deliver the 2021/22 financial plan and control total • Under the collective banner of '***start well, live well, age and end life well***' -promote and support health improvement, public health and health and wellbeing strategies to address inequalities and improve the health of the population across Humber, Coast and Vale.	Quarterly review of progress by the partnership Executive to March 2022
Leadership &	• Implement the 2021/22 development plan for the partnership including linking as appropriate with the 4 into 1	Quarterly review of

Objective	Actions	Monitoring progress
Development of the Partnership (ICS)	North East and Yorkshire Regional programme for the development of integrated care systems • Deliver the 2021/22 People Plan that supports the development of the partnership as an integrated care system. • Implement actions from the BAME engagement programme supported and developed by the BAME network of networks. • Develop the 2022/27 Humber, Coast and Vale strategy building on the vision of ***'start well, live well, age and end life well'*** through a co-production exercise engaging place, communities and other stakeholders. • Implement the Humber, Coast and Vale population health management programme • Implement a revised primary care strategy for 2021/22 including the development of PCNs and primary care at scale. • Deliver the Humber, Coast and Vale 2021/22 o Digital strategy & plan for o Financial plan and control total o Estate and Capital strategy & plan • Oversee the next phases of the Humber Acute Services and the East Coast Strategy Programmes • Work in partnership with local systems across Humber, Coast and Vale to promote the opportunities for the health and care system and its organisations to maximise their role as anchor institutions, as major employers, purchasers and property holders. • Lead at scale action on population health/screening/smoking/alcohol/climate change in partnership with local government and public health leaders • Continue to ensure that the Partnership and its members has a significant & influential role on policy development nationally and regionally.	progress by the Partnership Executive and stakeholders to March 2022
Manage the	• Continue active engagement / joint working with local government especially in relation to the development of	Quarterly review of

Objective	Actions	Monitoring progress
transition to new arrangements for integrated care systems (aligned to the White Paper)	our 6 'places' as determined by local government unitary boundaries. • Continue to support local government devolution in North Yorkshire and York and the emergent proposals on the Humber. • Continue to make the case in National and Regional forums for a satisfactory local government settlement. • Strengthen relationships with Health and Wellbeing Boards through incorporating HWB plans and strategies into overall Humber, Coast and Vale planning. • Continue to support the development of the VCSE through stronger recognition of their contribution, investment and implementation of the VCSE strategy. • Successfully redeploy people in accordance with the employment commitment in the policy guidance for integrated care systems and the regional guidelines agreed by NHSE/I and the partnerships / integrated care systems in North East and Yorkshire. • Ensure the effective transition from the existing CCG arrangements to new integrated care system arrangements and responsibilities whilst ensuring current governance and legal accountabilities are not compromised. • Continue to develop the role of NEDs and local government members as the Partnership Board level governance is implemented. • Strengthen the role of the clinical & professional group and the Population Health and Inequalities Board in the business of the Partnership. • Develop a leadership development, succession planning and talent management framework. • Ensure an effective organisational development programme to support the transition to new arrangements from April 2022	progress by the Partnership Executive and stakeholders to March 2021

Stephen Eames May 2021

Harrogate and District NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	28th June 2021 and 26th July 2021
Date of Board meeting for which this report is prepared	28th July 2021

Summary of key issues:

1. **Month 2 – 28th June 2021 –** The Trust achieved a £16k deficit position in May 2021, in line with plan. 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.
2. 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 rostering of ward nurses and hotel services staff (HIF).
3. 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.
4. The capital programme for 2021/22 totals in excess of £32m including the Salix Carbon Reduction schemes. There are risks in timing associated with the Salix programme, CT replacement and relocation and ward refurbishment.
5. In terms of planned care recovery, the Trust met the Elective Recovery Fund targets across all points of delivery for both April and May.
6. RTT waiting list continued to rise in May as the Trust move towards full capacity. Longer waits are in Trauma and Orthopaedics, Ophthalmology, and Community Dental.
7. Performance against the ED 4 hour target was 82.2%. Work is underway to redesign the clinical model in ED.
8. Provisional data indicates the 62 day cancer standard was met in May. 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 May. Extra clinics are being set up and independent sector usage has increased.
9. Increasing safeguarding caseload putting pressure on staffing position in Children's and Community.
10. Substantive staff in post in May was ahead of plan by 8.53 whole time equivalents (wte) whilst bank and agency numbers were behind plan in May.
11. Non-recurrent posts stand at 200.78wte compared to 154 wte assumed in the work-force plan following increased scrutiny across directorates. Some posts are only part funded by Covid funding and if this is withdrawn this will present a financial risk for the Trust.

12. There are 49.77 wte school nurse and health visitor vacancies within Children's and Community directorate. An update on recruitment and retention initiatives was reported.
13. There is a strong pipeline of nurses due to join the Trust from May onwards. The pipeline for care support workers needs to be strengthened.
14. Temporary staffing was within the NHSEI plan in May.
15. The latest Salix carbon reduction programme operational update was received. Programming is taking place to schedule works whilst taking account of operational impacts within the hospital.
16. 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.
17. This was the last meeting attended by Steve Treece as observing Governor and he was thanked for his attendance at the Committee.

18. **Month 3 – June 2021 –** The Trust has continued to maintain its planned break-even position in June. Elective performance recovery means that the Trust will benefit from Elective Recovery Fund of around £1.7m for Months 1 & 2. However, in the second half year there will be an expectation of efficiencies, with an indication that the Trust will receive 3% less funding in the second half of the year. The ERF target for July has been increased nationally from 85% to 95% of 2019/20 activity.
19. 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. Work still taking place on rostering of ward nurses.
20. The capital programme spend is £5m behind plan at the end of the first quarter. £3.8m of this relates to the Salix programme. A revised forecast has reduced the programme from £32m to £25.5m for 2021/22 and a capital recovery plan is in place to ensure delivery is maximised. There is potential to bring forward schemes from 2022/23 if required.
21. The Trust achieved 90% against the 95% Better Payment Practice Code target which is a significant improvement from previous years. Actions to improve this are focused in specific areas.
22. For planned care recovery, the Trust met the Elective Recovery Fund targets across all points of delivery for the first quarter.
23. RTT waiting list continued to rise in June as the Trust move towards full capacity. Longer waits are in Trauma and Orthopaedics, Ophthalmology, and Community Dental.
24. Performance against the ED 4 hour target was 82.6%. Trial of the new clinical model in ED in July.
25. A challenging theatre position is forecast for July due to limited evening and weekend working and holidays, as well as sickness and staff self-isolating. A 'perfect' week will be launched in August to determine where blockages are.
26. Still high level of demand in 2WW cancer, performance increased to 88.1% in June. Independent sector use has increased and one stop clinic on site is planned. Colorectal one-stop clinic back up and running.
27. The RTT waiting list continued to increase through June. ED attendances have continued to increase throughout June and exceed 2019/20 levels.
28. Provisional data indicates the 62 day cancer standard was met in June (91%). 2WW referrals continue to be higher than the number of weekly appointment slots and subsequently the 2WW target was not met in June (88.1%). Extra clinics are being set up and independent sector usage has increased.
29. Detailed Healthy Child Programme metrics were received. Safeguarding cases

continue to increase putting pressure on resources available for preventative work.

30. Still a high number of Community dental waits over 52 weeks.
31. Substantive staff in post in June was ahead of plan by 20.67 whole time equivalents (wte) whilst bank and agency numbers were behind plan in June.
32. Non-recurrent posts stand at 182.27 wte. These are being monitored closely and actions being taken to confirm secured funding for the second half year. Some posts are only part funded by Covid funding and if this is withdrawn this will present a financial risk for the Trust.
33. The vacancy rate at the end of June was 6.40%, Children's and Community directorate are ahead of plan whilst LTUC are behind plan. There are 49.77 wte school nurse and health visitor vacancies within Children's and Community directorate. Vacancies in the CC directorate continue to be of concern. An update on recruitment and retention initiatives was reported and the position will be closely monitored.
34. There is a strong recruitment pipeline across all staff groups with a total of 187.87 wte due to join the Trust from June onwards. Cohort recruitment of care support workers needs to continue if the vacancy gap on inpatient wards is to be narrowed.
35. Temporary staffing was within the NHSEI plan in June.
36. An update was received on business developments; specifically, 0-19 services in North Yorkshire, Northumberland and an opportunity in Hull.
37. A WYAAT finance forecast report was received indicating that all Trusts will meets their plans at the end of September. A similar report is being drawn up for the Humber Coast and Vale ICS.
38. The Salix update report was received. Arrangements for submitting invoices and claiming grant are being fine-tuned.
39. Progress on revised Terms of Reference for the Committee was reported. A report will be considered at the August meeting.
40. A confidential item was discussed in relation to the upcoming audit of accounts for HIF.
41. A verbal request was received in relation to extending the current partnership agreement with our Principal Contractor for capital building works for a further 3 months, as is allowed in the agreement approved last year, in advance of establishing a HDFT construction framework. A paper is to be circulated to Committee members, outside the meeting, for approval.

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.
- There are a number of posts part funded by Covid funding which, if withdrawn, could create financial risk for the Trust.

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

None

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

5.3

Title:	**Financial Position**	
Responsible Director:	Deputy Chief Executive / Finance Director	
Author:	Deputy Chief Executive / Finance Director Deputy Director of Finance	
Purpose of the report and summary of key issues:	The report has been developed to give information and assurance on the financial position as reported at the end of June 2021. The position includes information on Revenue, Capital and Payment Practice. The Board is asked to note the contents of the paper.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	✓
	BAF4.4 To be financially stable to provide outstanding quality of care	✓
Corporate Risks	There are currently no issues of risk to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.	
Report History:	Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions. The paper has been discussed at the Trust Senior Management Team and Resources Committee in July 2021.	
Recommendation:	The Board is asked to note and discuss the contents of this report.	

Finance Director Report

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- There continue to be a number of areas of pressure that are being offset by underspends in relation to activity delivery and the 0-19 service vacancies
- The wards are overspent against current establishment
- There is slippage within our capital programme
- The ERF thresholds have been amended which reduces the opportunity to receive additional income for delivering elective work
- Allocation for H2 expected in September, and our runrate is higher currently than at the end of 2019/20, which we will need to manage and reduce.

Major actions commissioned & work underway

- Options development for H2 planning
- Confirmation of non-recurrent recovery funding for Directorates
- Finalise the ward establishments & funding
- Capital Oversight Group review of capital programme to deliver some options based upon forecast outturn for 21/22

Positive news & assurance

- Delivery against the ERF trajectories in Q1
- Delivery of the financial plan to date and forecast delivery for H1

Decisions made & decisions required of the Board

- n/a

Harrogate and District NHS Foundation Trust

Trust Board

Financial Position – June 2021

1. Purpose of the report

This paper has been developed to update the Resources Committee (the Committee) on progress against the annual Financial Plan. The Committee is asked to note the contents of the report.

As described below, the Trust Revenue position is aligned to plan. There are specific issues described in relation to the Capital Programme and Better Payment Practice Code (BPPC) performance.

2. Introduction

The paper is an update on the Trust Financial Position, and continues the monthly updates received by the Committee. The paper aims to provide assurance on the financial position, as well as provide opportunity to discuss the key financial issues across the organisation.

Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions. The paper has been discussed at the Trust Senior Management Team, and will be included with the update to Board from the Committee.

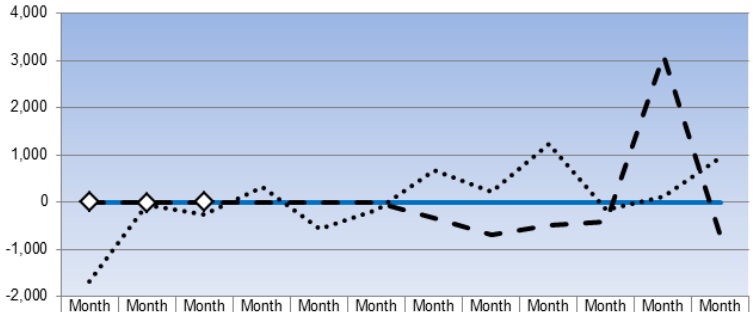
3. Financial Position

3.1 Revenue

Performance for June and the Year to date is outlined in the graph below. The breakeven position is in line with expectations set by NHS England and NHS Improvement.

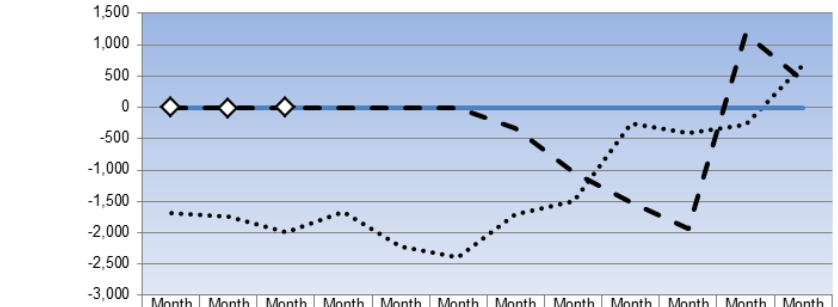
In future months detail will be included to reflect the accounting of the Salix Grant. While this does not affect the position regulators will hold the Trust to account against, it is material enough to warrant visibility within reporting. For context, the Salix Grant will be recognised as income, resulting in a £14m surplus within the Trust accounts. However, as outlined this will be adjusted for when reporting to NHS England and NHS Improvement.

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	-16	16									
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)

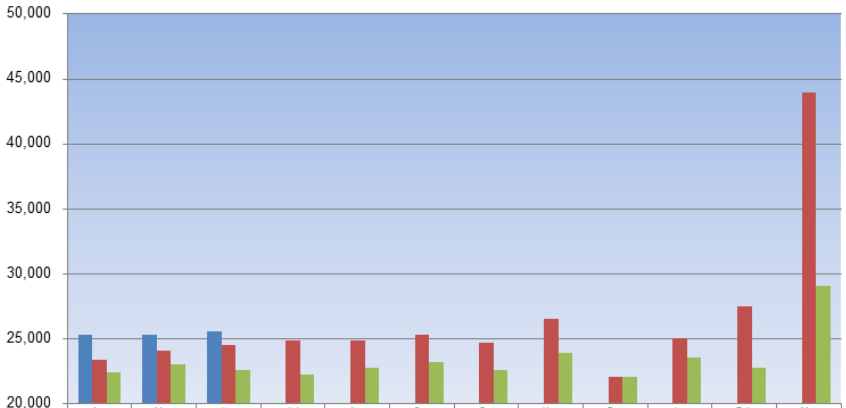


	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
2019/20	-1,677	-1,744	-2,000	-1,674	-2,229	-2,387	-1,713	-1,496	-254	-404	-278	682
Plan	0	0	0	0	0	0	0	0	0	0	0	0
Actual	0	-16	0									
2020/21	0	0	0	0	0	0	-340	-1,033	-1,524	-1,926	1,174	429

The above position includes income from commissioners which is largely fixed, as well as Top Up and Covid funding that has been agreed with the local system. Additional income is being reported as part of the Trust Elective Recovery Performance. Elective Recovery Fund (ERF) performance is currently reported at system level as £2.2m for the Trust. Our internal work on this suggests a lower level of income, largely as a result of casemix, reducing the position by £0.5m. Further information on the activity that underpins this position can be found in the Chief Operating Officer's report.

Whilst this is positive in the short term, there is an expectation that greater efficiencies will be required in the second half of the year (H2), and confirmation of allocations for H2 are not expected until September. Although there is a level of unknown risk here, the expectation is that expenditure run rates return to 2019/20 levels (with some technical adjustments). The information below outlines the current comparison for quarter 1.

HDFT Year on Year Expenditure (£'000s)



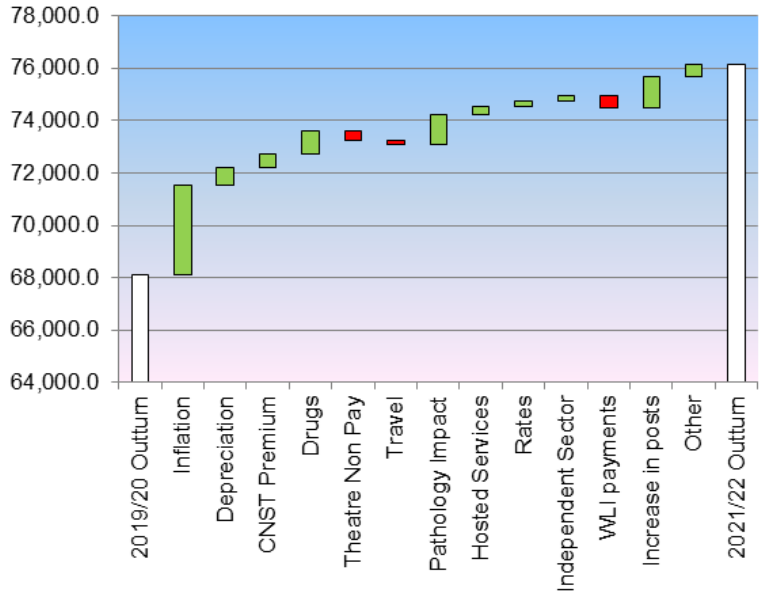
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	25,276	25,316	25,531									
2020/21	23,399	24,075	24,510	24,841	24,861	25,294	24,708	26,495	22,034	25,039	27,523	43,982
2019/20	22,467	23,031	22,617	22,218	22,759	23,233	22,638	23,922	22,073	23,590	22,786	29,060

£'000s	Pay	Non Pay
2021/22	48,135	27,989
2020/21	47,588	24,396
2019/20 Path Adj	45,738	23,340
2019/20	45,738	22,208

Movement	YTD (£'000s)
2019/20 Outturn	**68,116**
Inflation	3,433
Depreciation	653
CNST Premium	507
Drugs	916
Theatre Non Pay	(378)
Travel	(170)
Pathology Impact	1,132
Hosted Services	323
Rates	199
Independent Sector	204
WLI payments	(438)
Increase in posts	1,174
Other	452
2021/22 Outturn	**76,124**

Movement	8,008
Issues covered through additional income	1,962
Issues likely to be funded through national agreements	4,285
Other	1,760

Expenditure Bridge - 2019/20 to 2021/22 (£'000s)



There is a clear importance in managing directorate budgets to ensure the Trust financial plan is achieved. Current directorate performance is outlined below.

Directorate	YTD Budget (£'000s)	YTD Actual (£'000s)	YTD Var (£'000s)	YTD Var (%)
Community and Childrens	15,357	14,246	(1,111)	-7.23%
Corporate	11,061	11,289	228	2.06%
Long Term and Unscheduled Care	18,216	18,284	69	0.38%
Planned and Surgical Care	18,212	17,683	(529)	-2.91%
FT Position	**62,845**	**61,502**	**(1,343)**	**-7.70%**
HIF	(73)	37	110	
Consolidated Position	**62,771**	**61,539**	**(1,233)**	**-1.96%**

Within the directorate positions are some common areas of risk. These include –

- Ward Expenditure positions – work ongoing in establishing clear rostering position in line with 2019/20 staffing ratios.
- Medical Staffing pressures – there are some localised staffing pressures, with plans being developed and/or managed at Directorate level.
- Underspends within Children's Services, Adult Community Services, Theatres and Endoscopy.

These areas will be closely monitored across the year.

Community and Childrens	YTD Budget (£'000s)	YTD Actual (£'000s)	YTD Var (£'000s)	YTD Var (%)	Trend (2019/20 onwards)
Income	(421)	(433)	(11)	2.69%	
Pay	14,209	13,504	(705)	-4.96%	
Non Pay	1,570	1,175	(395)	-25.14%	
Total	**15,357**	**14,246**	**(1,111)**	**-7.23%**	

Corporate	YTD Budget (£'000s)	YTD Actual (£'000s)	YTD Var (£'000s)	YTD Var (%)	Trend (2019/20 onwards)
Income	(2,111)	(1,762)	350	-16.56%	
Pay	4,143	4,100	(43)	-1.03%	
Non Pay	9,029	8,950	(79)	-0.87%	
Total	**11,061**	**11,289**	**228**	**2.06%**	

Long Term and Unscheduled Care	YTD Budget (£'000s)	YTD Actual (£'000s)	YTD Var (£'000s)	YTD Var (%)	Trend (2019/20 onwards)
Income	(1,727)	(1,687)	40	-2.30%	
Pay	14,374	14,512	138	0.96%	
Non Pay	5,569	5,460	(109)	-1.96%	
Total	**18,216**	**18,284**	**69**	**0.38%**	

Planned and Surgical Care	YTD Budget (£'000s)	YTD Actual (£'000s)	YTD Var (£'000s)	YTD Var (%)	Trend (2019/20 onwards)
Income	(199)	(201)	(2)	0.86%	
Pay	13,109	13,125	16	0.12%	
Non Pay	5,302	4,759	(544)	-10.26%	
Total	**18,212**	**17,683**	**(529)**	**-2.91%**	

3.2 Capital

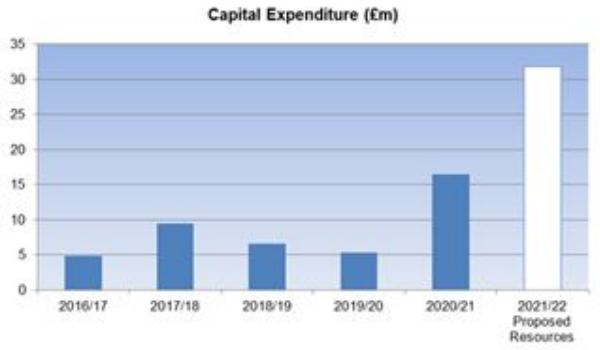
As the Committee will be aware, the agreed capital programme for 2021/22 was a significant increase in resource when compared to prior years. This is outlined in the graph to the right.

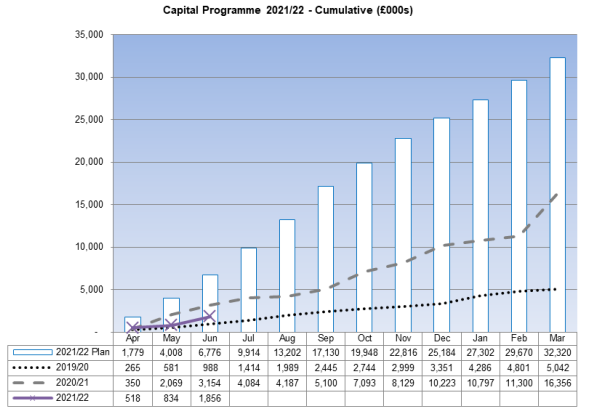
The current spend to the end of June £1,856k, against a plan of £6.8m. Clearly this is a significant variance. Part of this issue relates to performance against the Salix programme (£3.6m) and is being managed through the Salix Project Board.

The remaining variance of £1.4m is also of concern, as directorate colleagues are aware of the issue and working to address this at an individual level. Prioritised purchases are being monitored closely to ensure these are progressed.

Added to this, the timeline for some larger works has moved into 2022/23. This slippage will need to be carefully managed, with the impact reducing the capital resource available in 2022/23. The Senior Management Team are working through the impact and will update the Committee on progress.

The second graph on the right outlines the scale of expenditure still required in 2021/22.



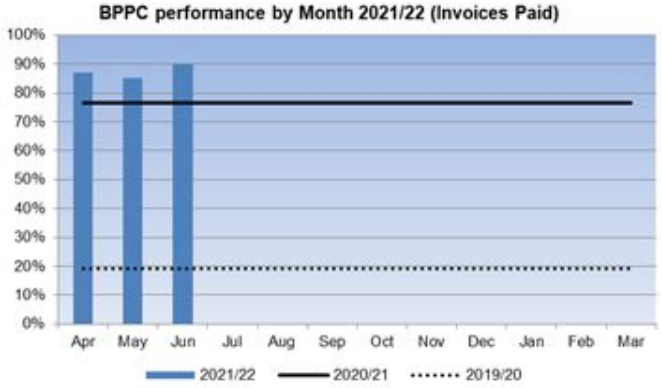


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Plan	1,779	4,008	6,776	9,914	13,202	17,130	19,948	22,816	25,184	27,302	29,670	32,320
2019/20	265	581	988	1,414	1,989	2,445	2,744	2,999	3,351	4,286	4,801	5,042
2020/21	350	2,069	3,154	4,084	4,187	5,100	7,093	8,129	10,223	10,797	11,300	16,356
2021/22	518	834	1,856									

3.3 Better Payment Practice Code

The Trust is required to adhere to the Better Payment Practice Code, which targets the payment of 95% of invoices within 30 days. For many years this position was challenging for the Trust, and in 2019/20 performance was as low as 19%. Improvements in processes within the Payments Team, as well as the resolution of historic debts and the improved payment terms as part of the Covid response has resulted in a significant improvement in performance. The graph to the right highlights this, with the June position reported at 90%.

Whilst performance remains below 95%, the improvement is significant and it is now possible to have a greater understanding of the underlying issues. There are a number of actions being taken forward, summarised into –



- Targeting specific areas of performance such as Pharmacy, transactions with HIF and processing of invoices related to the Pathology Joint Venture
- Plans to improve the system and develop training for colleagues using it to improve practice and reduce payment periods
- Working with regional NHSE/I team to ensure standard application of guidance, in particular the time and date commonly recognised when making BACS payments.

It is important that performance in this area continues to improve, in particular to support suppliers during the recovery that will be required for the economy following the pandemic. The Committee will continue to be updated on a monthly basis.

4. Financial Implication/Risk assessment

As described within the report. The Trust continues to balance the overall position, however, there remains pressures in some areas, with underspending issues as much an issue as those areas overspending.

As the Committee will be aware, the national financial regime has yet to be finalised for the second half of 2021/22. Therefore, as well as the above the issues described will obviously have implications as the Trust moves into the second part of the year, as well as into 2022/23.

5. Risks

There are currently no issues of risk to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.

6. Recommendation

The Committee is asked to note and discuss the content of this report.

Jonathan Coulter
Deputy Chief Executive / Finance Director
14th July 2021

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

5.4

Title:	**Chief Operating Officer Report**
Responsible Director:	Chief Operating Officer
Author:	Chief Operating Officer

Purpose of the report and summary of key issues:	To inform the Trust Board of the month 3 position regarding operational performance	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	✓
	BAF3.5 To provide high quality public health 0-19 services	✓
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	✓
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Monthly Trust Board Update	
Recommendation:	It is recommended that Trust Board note the items contained within this report.	

Harrogate and District NHS Foundation Trust

Trust Board - Operational Update

July 2021

Russell Nightingale
Chief Operating Officer

5.4

Operational Update June 2021

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• 2WW Cancer performance – high levels of demand continue to be seen in breast, plans continue to mitigate increases, August recovery date and increased performance in June (88.1%) • RTT Waiting list continued to increase in June as the Trust move to full capacity (whilst maintaining social distancing) to stem increased referral demand - longer waits in T&O, Ophthalmology and Community Dental • 4-hour ED performance – June performance 82.6%, increased presentations above 2019/20 levels, incorrect front door model and social distancing remains in place. New model is being trialled from 16/07, results to follow • Safeguarding pressures, continued workforce concerns in CC directorate due to increase in safeguarding caseload • No weekend working uptake and limited evening work underway combined with holiday and theatre staffing gaps highlight a difficult July position	• Reconfiguration of ED/ hot floor (Estates and Staffing) Kaizen event now completed and actions underway (Slide 9) • Band 6 SCHPN roles are still the key workforce issue for 0-19 services with 11.4% vacancy rate (46wte). 3wte staff have been redeployed to work in CC from other directorates in the Trust and start work in July which will also support pressures within the service. A recruitment and retention group for 0-19 services is in place and is overseeing the action plan devise to support medium to longer term workforce issues • Additional community dental sites to be AGP enabled and scheduling process now in place, robust 6-4-2 model now rolled out • Perfect Week in Theatres planned for w/c 16/08 • HDFT progressing Wharfedale usage conversation, scoping meeting with COOs planned for early July, data shared between providers, staffing a major concern currently • York independent sector capacity links established, first 30 patients IPT w/c 12/07 • Weekly access meeting established to monitor and improve performance across constitutional standards, including community • Reconfiguration to hospital wards/departments – improve adjacencies and fit with SALIX/capital plan works underway

Positive news & assurance	Decisions made & decisions required of Trust Board
• Active Against Cancer came second and were 'highly commended' in the NHS parliamentary wards • LTUC directorate now achieving an aggregate RTT incomplete position • ERF target met across all points of delivery for April, May and June 2021 • 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, IS sector usage increased – 5 x extra lists in July and August, progression with one stop clinic plans on site • 98.8% of patients waiting have clinical prioritisation in place. Average waits in weeks for treatment P2 (5), P3 (12), P4 (25) • Zero 12 hour breaches and 6 x 60 minute ambulance breaches in June • Complex Community Dental 52 week recovery ahead of plan • Safeguarding resource provided from wider Trust teams providing good support	• Partition removed in theatres to increase flow, agreed by DIPC • Agreement to treat LTHT and YTH endoscopy patients with HDFT extra capacity (150 cases per month) • ED X ray rooms now live in ED • The new Urodynamic machine has now been configured and clinical model approved. First clinic happened on 06/07 • Colorectal one stop clinic now back and running after a 12-month hiatus

Planned Care Recovery

Harrogate and District NHS Foundation Trust

Point of Delivery	Apr-21 Apr Actual	Apr Plan	Apr 2019/20	% Booked vs Plan	% Booked vs 19/20	May-21 May Actual	May Plan	May 2019/20	% Booked vs Plan	% Booked vs 19/20	Jun-21 Jun Actual	Jun Plan	Jun 2019/20	% Booked vs Plan	% Booked vs 19/20
Total Outpatients	**13,099**	**11,526**	**14,433**	**114%**	**91%**	**13,006**	**12,246**	**15,136**	**106%**	**86%**	**14,483**	**11,850**	**14,793**	**122%**	**98%**
New Outpatients (Cons Led)	4,294	3,823	4,849	112%	89%	4,326	3,924	4,973	110%	87%	4,950	4,004	5,007	124%	99%
Follow Up Outpatients (Cons Led)	8,805	7,703	9,584	114%	92%	8,680	8,322	10,163	104%	85%	9,533	7,846	9,786	122%	97%
Elective Daycases (excl endoscopy)	1,502	1,495	1,797	100%	84%	1,608	1,633	1,896	98%	85%	1,715	1,427	1,649	120%	104%
Elective day case endoscopy	657	617	1,099	106%	60%	809	848	1,079	95%	75%	775	829	1,055	93%	73%
Elective Daycase Total	**2,159**	**2,112**	**2,896**	**102%**	**75%**	**2,417**	**2,481**	**2,975**	**97%**	**81%**	**2,490**	**2,256**	**2,704**	**110%**	**92%**
Elective Inpatients	**196**	**185**	**253**	**106%**	**77%**	**222**	**229**	**297**	**97%**	**75%**	**239**	**226**	**293**	**106%**	**82%**

Apr 2021 v Plan %	>=95%	80-94%	<80%
Apr 2021 v 2019/20	>=70%	60-69%	<60%

May 2021 v Plan %	>=95%	80-94%	<80%
May 2021 v 2019/20	>=75%	60-74%	<60%

Jun 2021 v Plan %	>=95%	80-94%	<80%
Jun 2021 v 2019/20	>=80%	65-79%	<65%

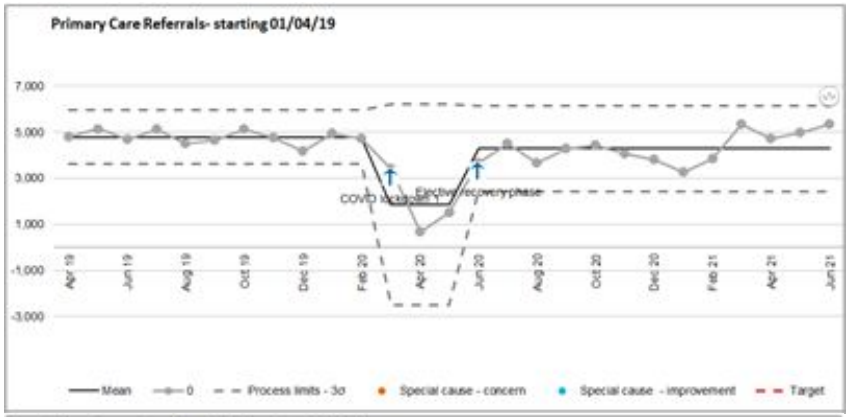
Note1: Booked day case numbers include an estimate for Clinical Haematology and Clinical Oncology

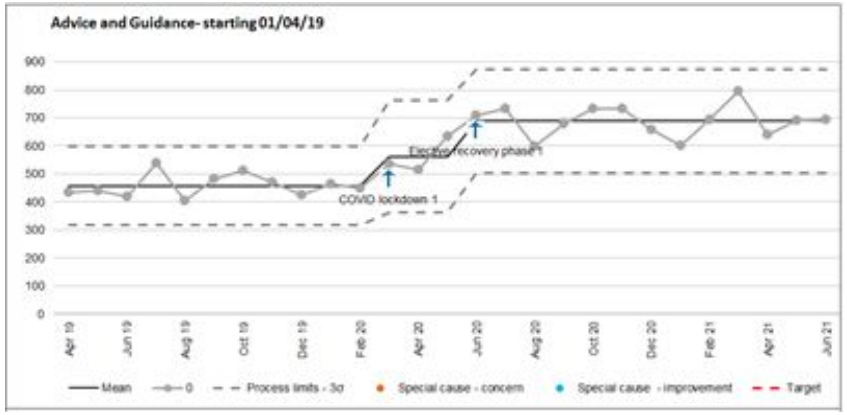
Note2: Booked Outpatient attendances include an estimate for Urgent Clinic attendances

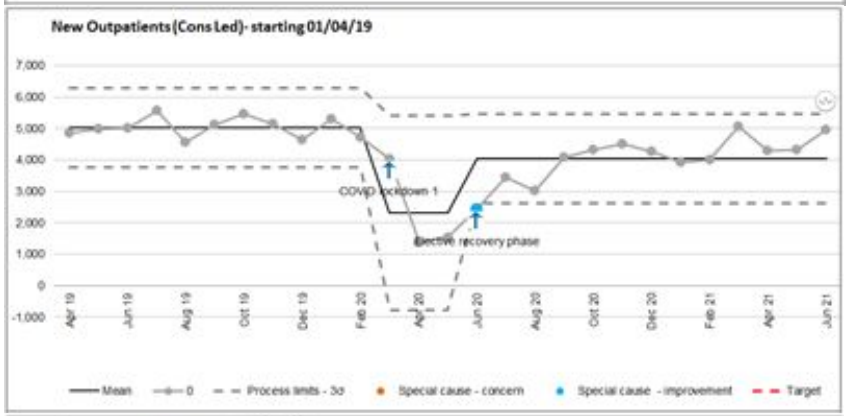
- All points of delivery are above the ERF requirement of 70%, 75% and 80% against the April – June 2019 target respectively
- To mitigate the WLI changes and annual leave rollover dynamic clinical sessions are in place to ensure most clinically pressured activity is covered
- The Trust increased beds on the Elective Surgical Unit to help mitigate increased activity levels
- The 5th room to support capsule endoscopy is now operational
- ERF target for July onwards amended nationally – increased from 85% to 95% of 2019/20
- Outpatient forecast for July is on plan, increasing elective admissions to-date is challenging, currently reduced staffing numbers in theatres owing to self isolation and sickness is a risk to delivery
- Continuing to support LTHT and YTH with endoscopy work c.150 patients per month

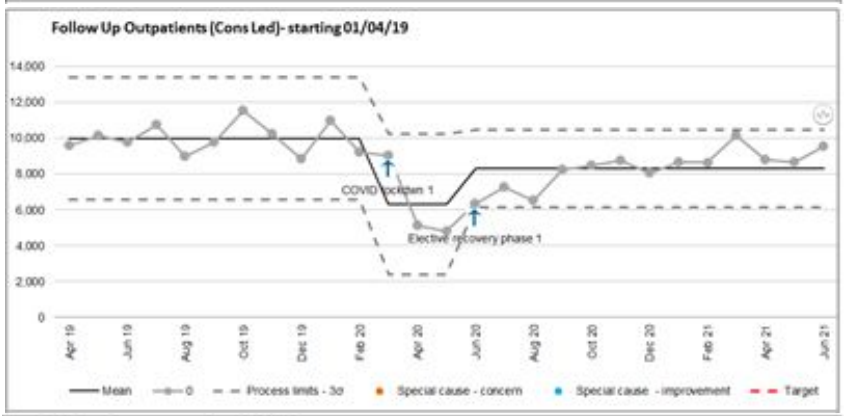
Elective Recovery

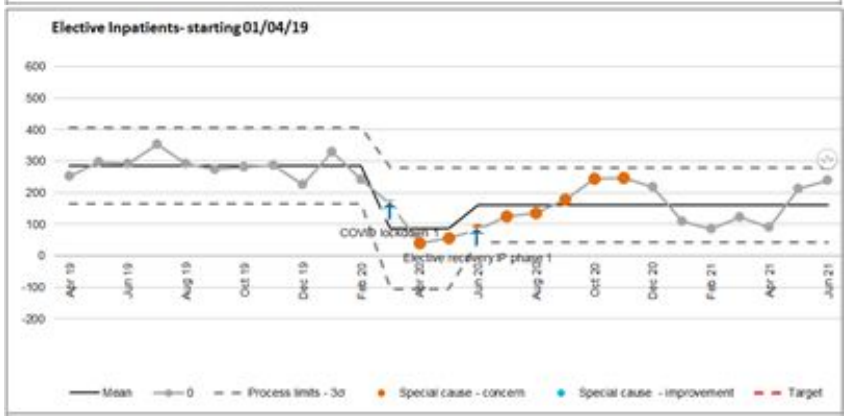
Harrogate and District NHS Foundation Trust

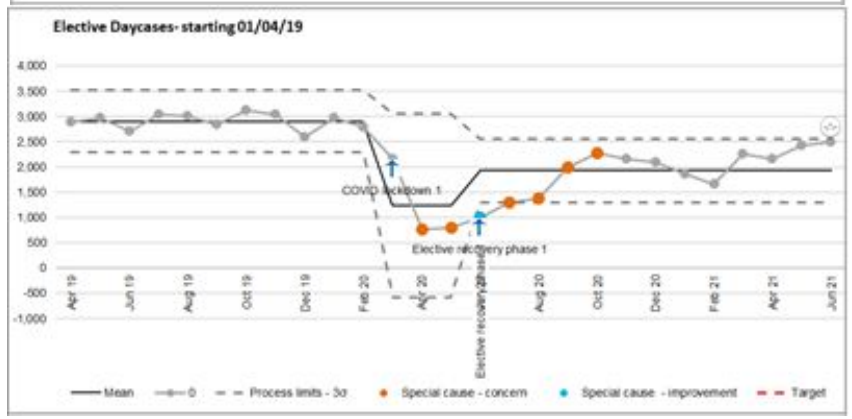








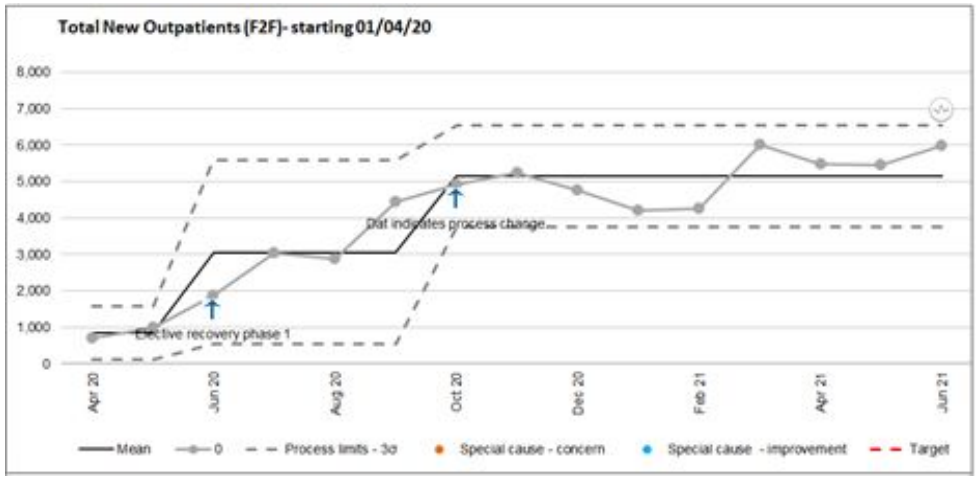


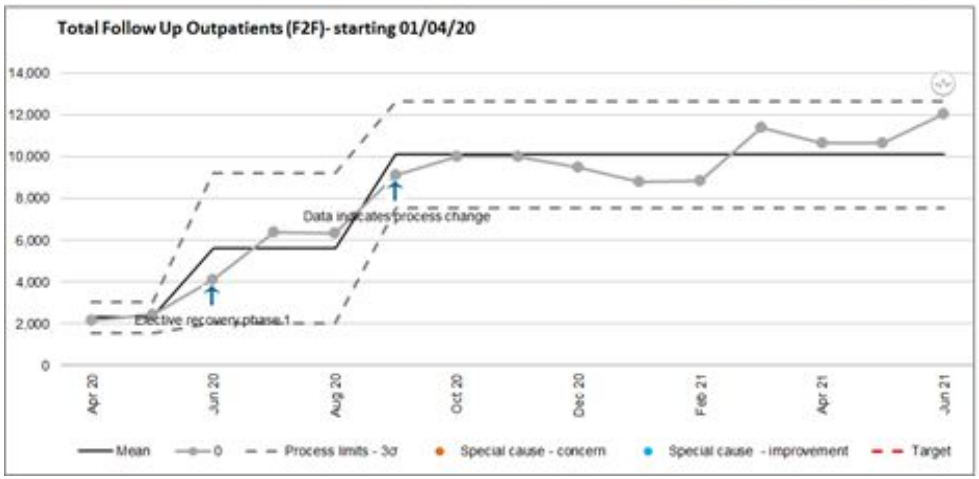


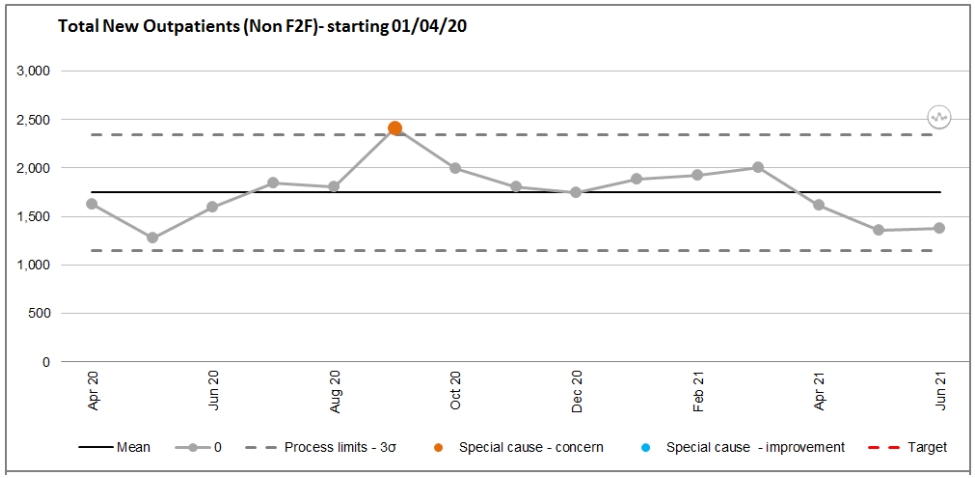
5.4

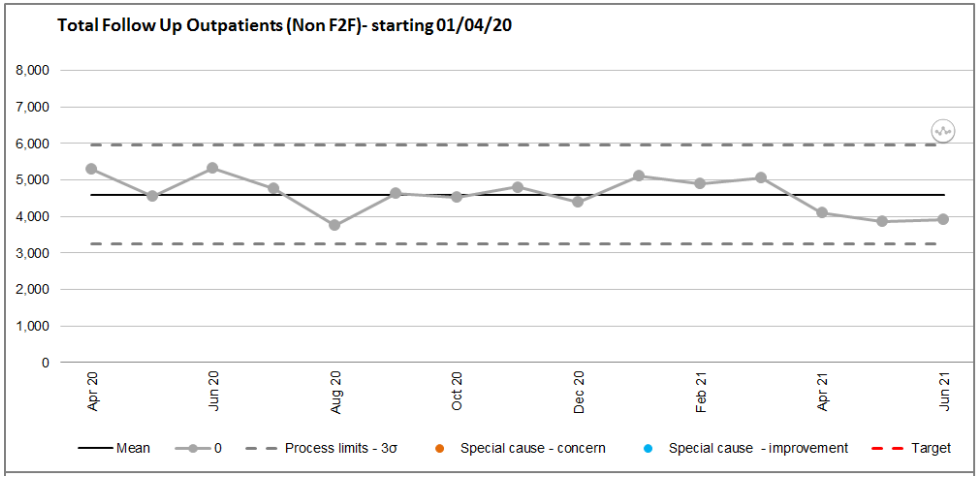
Elective Recovery

Harrogate and District NHS Foundation Trust









- Total outpatient activity increased in June and remains above plan and in line with 2019/20 activity levels for both new and follow up attendances, over-delivering the ERF requirements
- Non face to face outpatient attendances have reduced since March with June attendances being slightly higher than May, year-to-date position 24%. This features and is discussed in the weekly Access meeting and the Outpatient Transformation programme team is working closely with services to increase where appropriate
- Elective admissions increased in June and remain above the mean level for April, May and June and are also delivering the ERF requirements
- Elective theatres now fully up and running however reduced staffing as a result of sickness and staff isolating continues to be a challenge
- Theatres and Endoscopy staff have now returned to elective sessions
- Focus remains on stepping levels of activity back up to 2019/20 levels

5.4

Theatre Efficiency

Harrogate and District NHS Foundation Trust

April 2021

Actual

185

May 2021

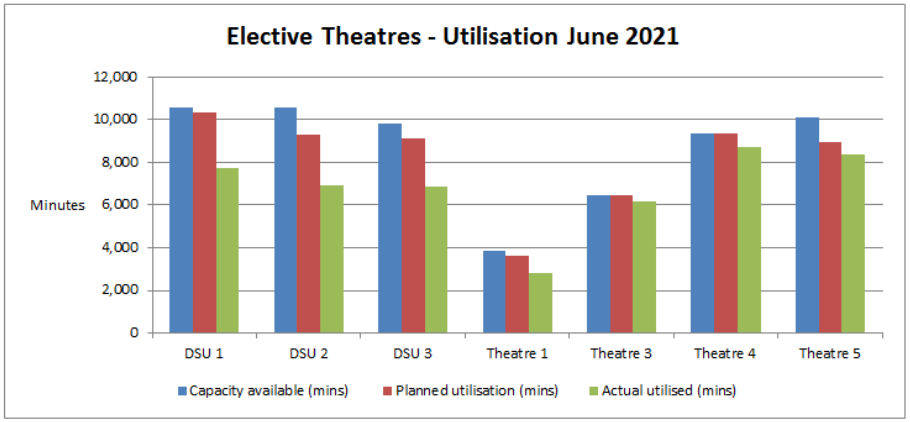
Actual

186

June 2021

Actual

190



- Late start – Actual start time >= 15 beyond planned start time. Early finish – Actual finish time <= 30 before planned finish
- Median late start for Jun: 26 minutes after scheduled list start time
- The above data is discussed weekly at 6-4-2 scheduling meeting, by individual consultant list
- The median late start time is 26 minutes and median early finish time Is 56 minutes.
- There is an element of IPC restriction still impacting on late start and utilisation due to process in clerking patients in theatres
- HDFT average list utilisation pre covid19 pandemic was 85%. Top quartile organisations for efficiency are achieving 92%-95% list utilisation
- The Chief Operating Officer is launching a perfect week to ascertain where the blockages are in the theatre processes in August 2021

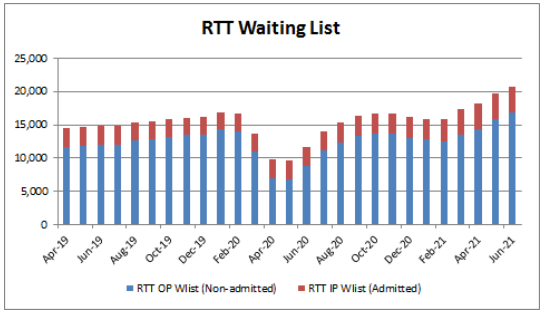
Elective Theatres – utilisation

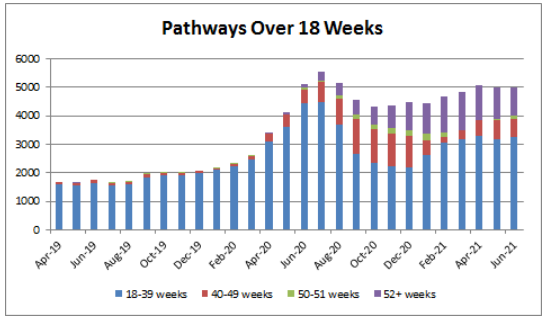
- Capacity available = weekdays Mon-Fri 8.30am - 5.30pm
- Theatre 1 - predominantly used for emergency and trauma work therefore reduced elective capacity
- Theatre 2 - solely used for trauma work with no elective sessions therefore not included in chart
- Theatre 3 – also used for emergency/ trauma and therefore reduced elective capacity

Referral to Treatment (RTT)

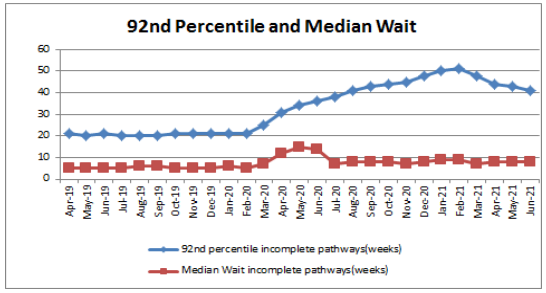
Harrogate and District NHS Foundation Trust

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
No. of pathways 18-39 weeks	3,101	3,627	4,418	4,463	3,699	2,674	2,342	2,224	2,185	2,615	3,047	3,173	3,310	3,168	3,255
No. of pathways 40-49 weeks	270	397	498	709	910	1,216	1,186	1,145	1,120	527	211	299	521	666	644
No. of pathways 50-51 weeks	17	32	67	74	106	138	168	208	179	219	155	11	21	62	91
No. of pathways 52+ weeks	18	53	139	293	421	524	639	789	974	1,075	1,268	1,345	1,201	1,087	1,006
Total >18weeks	3,406	4,109	5,122	5,539	5,136	4,552	4,335	4,366	4,458	4,436	4,681	4,828	5,053	4,983	4,996
Total RTT List	9,754	9,593	11,659	14,039	15,345	16,379	16,730	16,733	16,197	15,877	15,878	17,323	18,182	19,746	20,631





Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	78	2	0	284	311	295	0	0	970
3-4	3	0	0	61	108	194	0	0	366
5-6	2	0	0	26	65	167	1	0	261
7-8	0	0	0	8	69	166	0	0	243
9-10	0	0	0	5	40	159	0	0	204
11-12	0	0	0	2	35	128	0	0	165
13-14	0	0	0	1	22	104	0	0	127
15+	0	0	0	8	308	1,901	16	1	2,234
Total	83	2	0	395	958	3,114	17	1	4,570



RTT

The Trust had 20,631 patients waiting at the end of June, this is an 885 patient increase on the May position.
There are 1,006 patients waiting over 52 weeks, this is below the trajectory of 1,237 and a 7% reduction from the May position.
The 92nd centile and median wait in June is 41 weeks and 8 weeks respectively highlighting grip on the scheduling process.
Of the 4,570 patients waiting for a procedure, 37% are Orthopaedics, 20% General Surgery and 12% Ophthalmology.

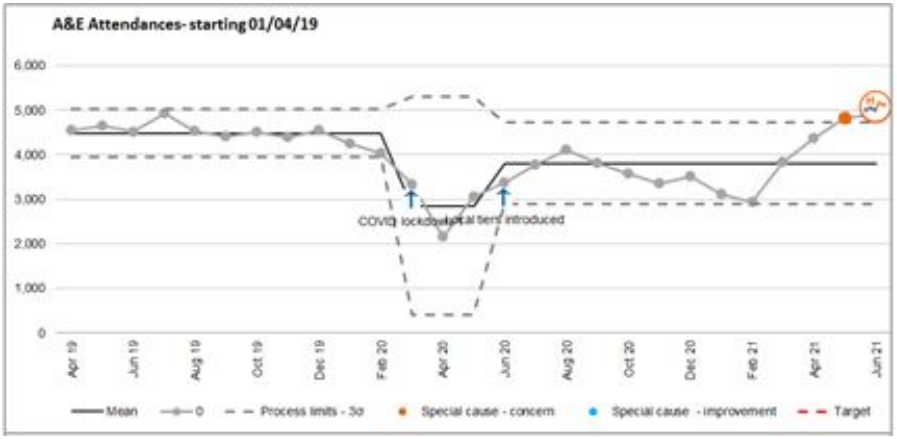
Clinical Prioritisation & Review

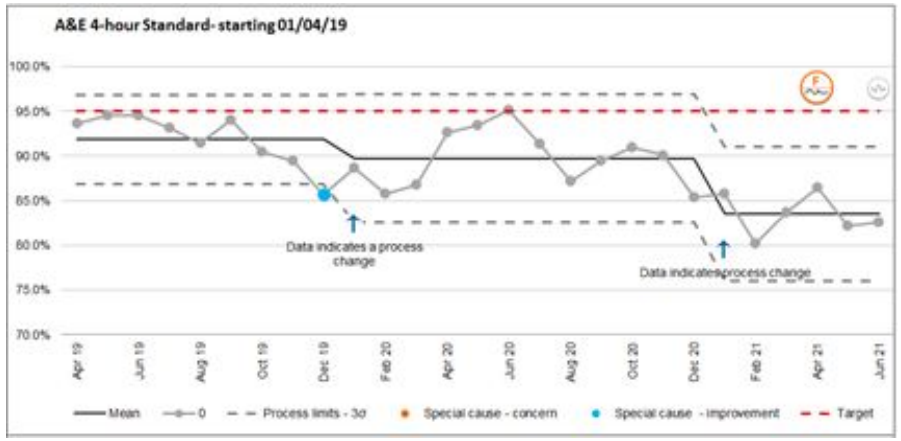
Clinical prioritisation and review continues for elective patients with 98% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (78/83) have been waiting <=2 weeks and are urgent endoscopy referrals. This information is tracked weekly.

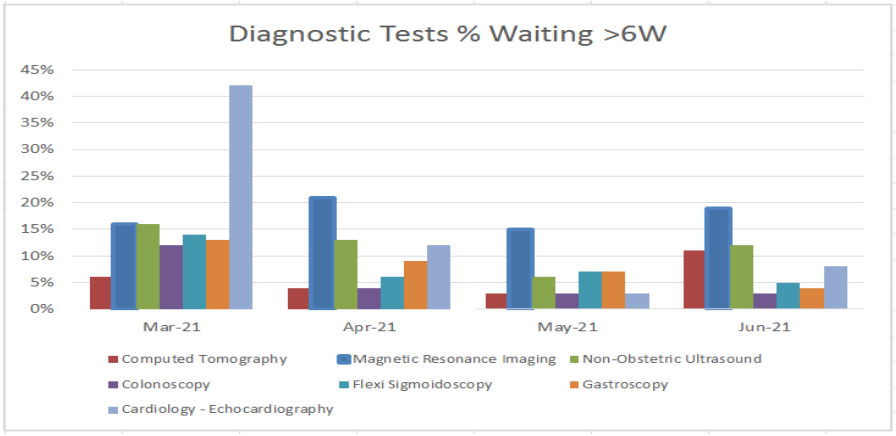
87% of P2 patients have been waiting less than 28-days and there is still a large element of patient choice owing to Covid-19. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

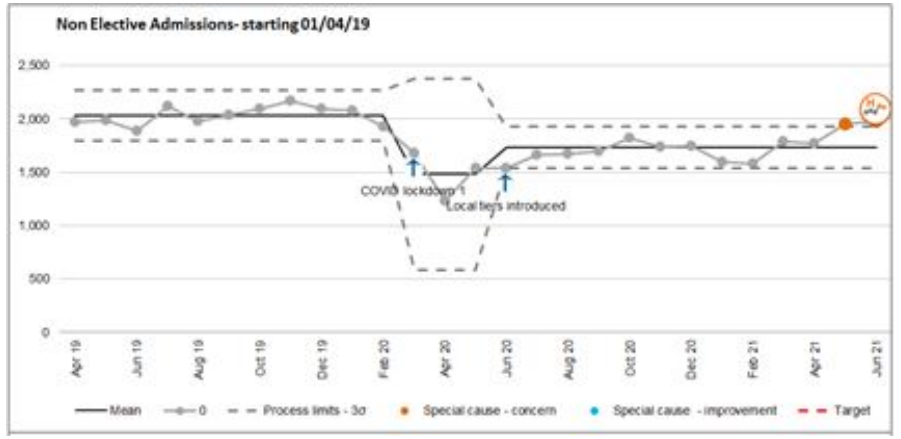
NHS
Harrogate and District
NHS Foundation Trust

Urgent Care and Diagnostics





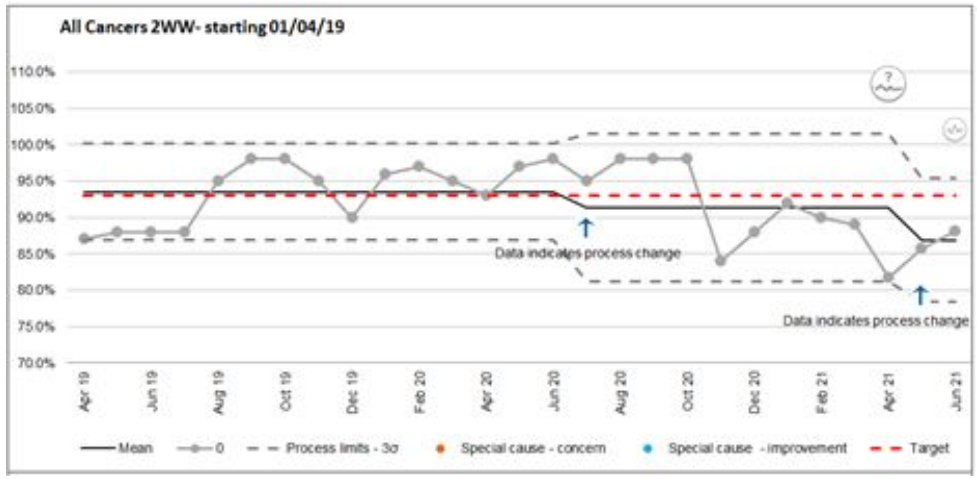


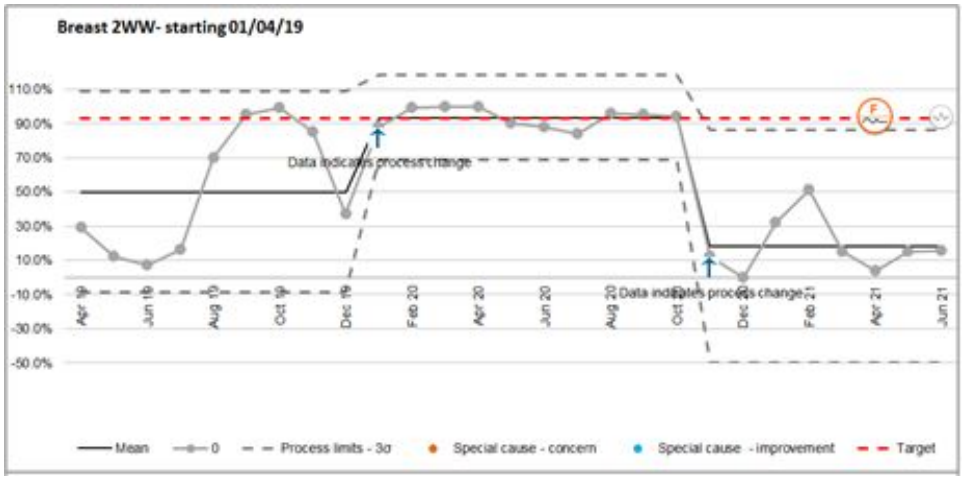


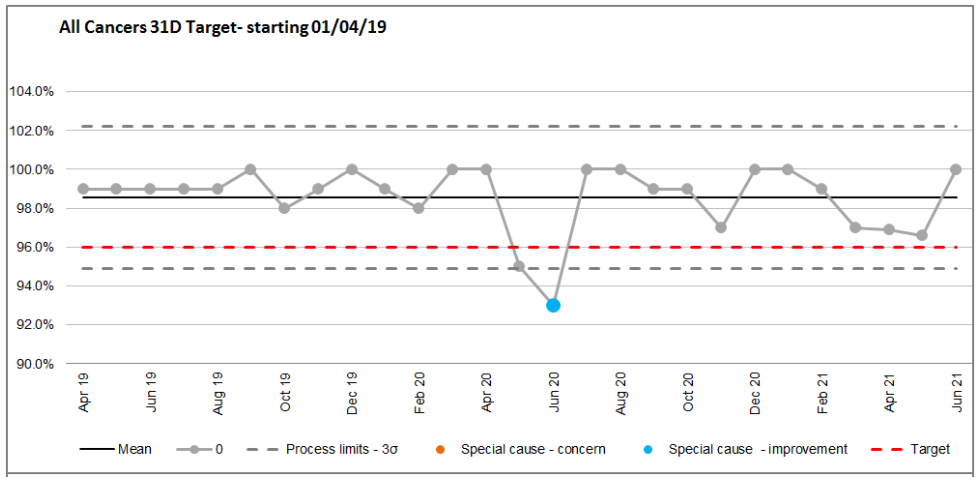
- Performance against the A&E 4-hour standard remained below the 95% standard in June 2021 at 82.6%. The 95th percentile wait was 6 hours 21 minutes
- There were zero 12 hour breaches in June
- There were 26 x 30-minute handover breaches and 6 x 60-minute ambulance handover breaches in June
- ED attendances have continued to increase since February of this year, with May and June attendances both being above the process limits and 2019/20 levels, this continues to be a real challenge to flow through the department.
- The Kaizen ED workshop took place at the end of June, was well attended with positive outcomes for change process and approaching the problem through a different lens. An action plan has been produced and is currently being worked through.
- A UEC dashboard has been developed that supported the workshop and has enabled monitoring of ED flow and performance to increase visibility.
- A number of diagnostic waits beyond 6-weeks increased slightly in June owing to staffing challenges and impact of self-isolation

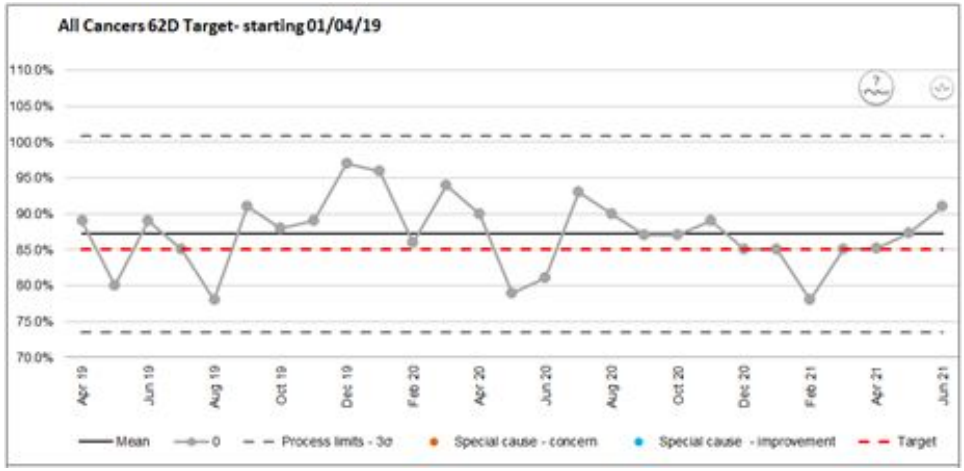
Cancer

Harrogate and District NHS Foundation Trust









- Provisional data indicates the 62-day standard was delivered in June 2021 (91%) and the 2-week wait standard failed at 88.1%
- 35 patients remain on an open cancer pathway over 62 days and 7 patients over 104 days. This remains one of the smallest PTL backlogs nationally when adjusted for size, however, remains a key area of focus. The main tumour site breaching is colorectal; demand and capacity analysis is underway to understand the shortfall and how to remedy the high breach numbers. The colorectal pathway has now resumed 'straight to test' which was stopped during the Covid pandemic, this should help the position
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics now confirmed.

Children's and Community

Harrogate and District NHS Foundation Trust

Healthy Child Programme

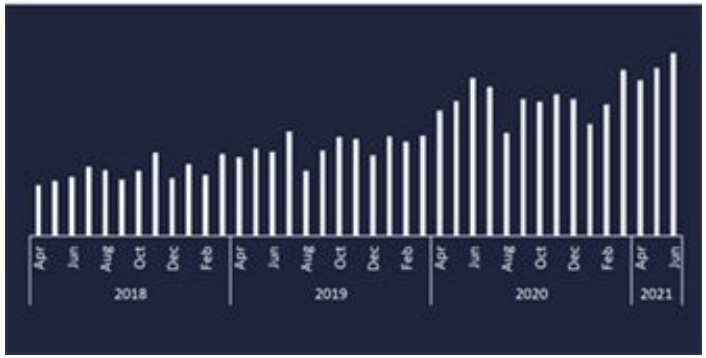
Metrics	Target	Quarterly Trend	Apr-21	May-21	Jun-21
% of antenatal contacts					
Darlington	90%	↓	95.8%	92.5%	97.4%
Durham	95%	↑	89.3%	91.1%	91.4%
Middlesbrough	90%	↑	92.9%	94.1%	93.9%
North Yorkshire	90%	↓	68.9%	72.2%	78.2%
Stockton	90%	↓	88.5%	86.2%	90.4%
Gateshead	80%		90.2%	95.0%	97.0%
Sunderland			98.0%	93.0%	94.1%
% New Birth Visits completed by 14 days					
Darlington	90%	↓	91.1%	97.6%	97.2%
Durham	95%	↓	96.1%	96.0%	96.3%
Middlesbrough	90%	↓	96.4%	97.4%	92.7%
North Yorkshire	90%	↓	92.6%	90.3%	92.3%
Stockton	75%	↓	89.4%	89.7%	92.4%
Gateshead	85%		96.5%	96.2%	97.9%
Sunderland	95%		98.9%	99.6%	98.3%
% of 6-8 week reviews completed by the time the infant is 8 weeks old					
Darlington	90%	↔	92.5%	100.0%	97.8%
Durham	95%	↓	88.6%	92.2%	91.5%
Middlesbrough	90%	↑	87.1%	85.2%	91.3%
North Yorkshire	90%	↓	92.0%	89.4%	92.4%
Stockton	75%	↓	89.7%	93.5%	91.5%
Gateshead	85%		96.6%	91.3%	97.1%
Sunderland	95%		96.3%	97.8%	94.3%
% of 12 month reviews completed by the time the child is 15 months old					
Darlington	90%	↔	95.1%	96.8%	96.1%
Durham	95%	↓	83.4%	80.2%	82.7%
Middlesbrough	90%	↑	97.8%	97.8%	97.8%
North Yorkshire	90%	↓	96.9%	90.5%	95.3%
Stockton	75%	↑	95.7%	94.4%	94.3%
Gateshead	85%		97.2%	99.3%	97.2%
Sunderland	95%		94.2%	96.0%	93.9%
% of 2-2.5 year reviews completed by the time the child is 2.5 years old					
Darlington	90%	↓	97.8%	98.9%	98.8%
Durham	95%	↓	90.1%	87.6%	90.4%
Middlesbrough	90%	↓	97.3%	94.9%	94.1%
North Yorkshire	90%	↑	82.6%	85.6%	91.9%
Stockton	75%	↑	92.9%	94.4%	91.8%
Gateshead	85%		95.0%	97.1%	97.2%
Sunderland	95%		97.8%	97.7%	94.5%

- **Update adult community nursing pressures**

Band	Contracted	LTS	Vac	Mat leave	Total	Available to roster now	Starting Jul-Sept
Band 5	38.87	1.6	5.63	1.8	9.03	29.83	7.4

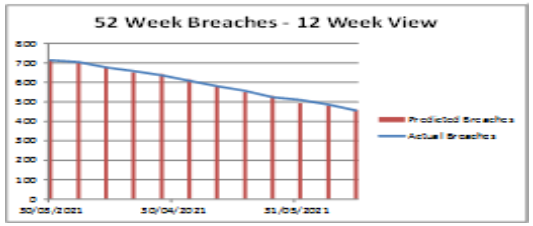
- 23% gaps over summer but with 7.4wte coming into post by Sept 21.
- Community has been at Opel 2/3 throughout June.
- All teams working at or above capacity at the beginning of the day and then are receiving unplanned work and referrals.
- Planned work being rescheduled to accommodate new referrals.
- Increased complexity of care being referred, especially in end of life care
- Impact of PULSE reviews on capacity
- Impact of isolating due to track and trace app (currently 5 nursing posts and 1 EOL coordinator)

Safeguarding



Community Dental Long Waits

Waiting List By Location					
	0-17	18-39	40-52	53-104	105+
Catterick	61	29	1	7	
Cornlands	144	56	15	60	
Kingswood	214	131	15	74	
Malton	80	34	17	18	
Monkgate	117	119	23	67	1
Northway	160	154	48	57	
Selby	81	49	15	19	
Settle	4	1			
Skipton	48	26	8	7	
Tanghall	88	36	7	19	
Whitby	59	16	10	13	
Zetland House	136	74	21	35	
Total	1192	725	180	376	1



Actions taken since last review meeting

- Ask of support from inpatient shared through inpatient HON and Matrons
- Met with Podiatry and agreed areas to progress for support
- Approved case to support increase in Band 7 roles. Current wte is 2.67 with a further 2wte approved. Roles will strengthen clinical leadership and role amended to include clinical case load to support service pressures.
- Agreement at OMG to incentive shifts with NHSP until summer.
- Staff exist interviews reviewed and man reason for leaving is promotion and relocation.
- Staff reminded of the health and wellbeing support available for them. Thrive conversations starting to take place
- Care plan devised for completion when visits rescheduled to ensure we have clear sight of the scale of the visits rescheduled and how many times
- We are aware Durham, York and Leeds have amended their policy to allow staff contacted by the track and trace app to return to work. Escalated whether HDFT needs to get a copy of their policy to implement.

June OPEL Level – 2

<u>0-19 Services</u>
Flexibility given to 0-5 services around delivery of universal visits as part of recovery & safeguarding pressures. Despite this delivery remains strong across all contract areas.

<u>Safeguarding</u>
The volume of safeguarding strategies involving 0-19 teams continues to grow impacting on capacity within these teams to deliver their preventative role.

<u>Community Dental</u>
Due to historical mismatch between capacity and demand, exacerbated by the loss of capacity due to CV19, community dental has a significant volume of patients waiting over 52 weeks.

<u>Adult Community Nurse Staffing</u>
Increased complexity of care being referred to service
All teams working at or above capacity
23% vacancy gap over summer period
Incentivising shifts with NHSP over summer
Approved case to support increase in B7

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Board of Directors
28th July 2021

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

Purpose of the report and summary of key issues:	The purpose of the report is to provide the Trust Board with details on the Board Assurance Framework.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Submitted for review at the May 2021 Board meeting	
Recommendation:	The Trust Board is recommended to review and note the content of the report.	

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 2. First Line Leaders Programme and other development programmes 3. Shadow SMT 4. Reverse mentoring programme 5. EDI work programme	Board of Directors Senior Management Team People and Culture Committee	Staff Survey Action Plan	Currently no oversight arrangements in place by regulators/ICS Cultural programmes are not embedded throughout the organisation	Inherent risk score added Assurances in controls added with the list of cultural projects currently being taken forward 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 2. First Line Leaders Programme and other development programmes 3. Shadow SMT 4. Reverse mentoring programme 5. EDI work programme	Board of Directors SMT People and Culture Committee	ICS metrics (TBC) Staff Survey	Currently no oversight arrangements in place by regulators/ICS EDI programme governance paused, a need to re-establish	Risk description slightly amended Inherent risk score added 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 SMT Medical Directorate Team meeting	HARA Yorkshire Health Network LMC	Distributed portfolio across Executive Directors for partnerships This risk could exasperate due to the potential local government and NHS (integrating care) re-organisation	Inherent risk score added	SMT	S Russell, Chief Executive 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 Quality Committee Workplan	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation	CQC Inspections Bi-monthly Assurance meetings with CCG	Do not have consistent quality control in place	Additional entries added to support internal assurances in controls 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:** Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common	No Project Management Support for clinical review and support to draft strategy	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; IBR: Directorate Board oversight	Adult and Young People Safeguarding Reports	CQC Outstanding Report OFSTED Reports JTAI Reports	No Transformation Team in-house to support and drive this 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 * Performance & Access Risk meeting established to track weekly progress against activity targets * Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review * Use of independent sector to increase inpatient, daycase and diagnostic capacity * Theatres Optimisation workstream lead by PA Consulting to improve pre-assessment, scheduling and on the day processes CCCC - dental -BC for paediatric specialist (to be permenant at cost pressure)	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review	NHSE/I Reporting		New risk added following recommendations made by the Board at its Workshop held on 24 February 2021 Elective Recovery progressing, Elective theatres now fully operational, Endoscopy Unit now fully operational, 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) • 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. • CAG agreement to reduce face to face visits until end of May 21 • Request made for support from wider Trust (needs to be nurses with experience of working with children and families) • Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) – June 21 • Development of OPEL to increase visibility of pressure & actions taken – June 21 • Agile / Base & Home working - Developing offers with teams to support alternative ways of working • 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

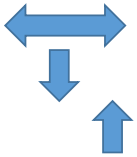
Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	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 Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation **External:** no governance structure or programme of work with Leeds regarding transformation	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 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 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 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 2. Annual audit cycle 3. PLACE Assessments 4. ICS and Place based networks	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities Ongoing dialogue Chief Executive and Deputy Chief Executive/Finance Director has with ICS's and regulators 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:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	4 June 2021
Date of Board meeting this report is to be presented	28 July 2021

Summary of key issues

The committee met via Microsoft Teams and was well attended. The matters considered included –

- Trust Annual Report and Annual Governance Statement – at the time of the meeting some errors of detail remained and External Audit work on the AGS in particular was not complete. In view of this the Committee agreed it could not sign these off in their entirety deferring this matter to the full Board. The Committee did agree to confirm and commend the Annual Governance Statement to the Board but asked that the final version should refer to the Internal Audit work that had led to a relatively high number of limited assurance reports over the last year. The Committee was advised by External Audit that they had no concerns over the Annual Governance Statement and its acceptance was agreed by the Committee.

- Financial Management – the Committee adopted a similar position in relation to the Trust's draft final accounts which at the time of the meeting also required completion in a small number of areas and further work from External Audit before the required assurances could be given. A number of points of detail were discussed including money owed to the Trust in respect of road traffic accidents. The Committee expressed its appreciation of the significant workload carried by the Finance team in preparing the financial statements against tight timescales.

- Internal Audit and Counter Fraud Reports – a number of reports from Internal Audit were reviewed by the Committee. The Community Dentistry report gave rise to some discussion given the high number of patients awaiting treatment. Assurance was sought in relation to procurements via a single tender process as to whether all such

procurements were in fact reported to the Committee, this question remains open. A report on cyber security related matters was considered.

- The formal Head of Internal Audit Opinion was received - during the Covid pandemic a period of reduced Internal Audit work had ensued with a larger than usual number of investigations being undertaken and reports completed at the end of the year. The following outcomes were noted in the opinion -

    i. 21 significant assurances
    ii. 10 limited assurances
    iii. 0 low assurances
    iv. 1 non-graded phishing exercise
    v. 4 limited assurance audits from the previous year had been resolved.

  Of the recommendations made 134 had been implemented, but 21 were overdue for implementation

  The Committee noted that the overall opinion was that the Trust was not in as good a position as it had been a year earlier, but also that it was not complacent about quality and accountability.

- HIF Internal Audits – completed reports were received and considered.

- Counter Fraud – the Annual Counter Fraud Report was received and considered. There was 100% compliance with functional standards, but the Trust was rated overall as amber. The amber rating was due to a number of new standards introduced in the last quarter of the year which were not achievable within the current year. This challenge would impact on all NHS Trusts. The three red rated areas arising from this produced the overall amber rating. Details in the report included progress on current investigations and outcomes. The need for a continued heighten level of fraud awareness during and post pandemic was noted.

- External Audit - outstanding actions for completion of work on the year end statements were noted. The auditors had noted that the Trust has significant liquidity due to special Covid financing measures and the auditors were keen to ensure that this additional income received proper treatment in the Trust's accounts. Accounting for the financial implications of the Flowers case, the valuation of property assets and the estimated cost of the carry forward of annual leave were areas requiring further consideration at the time of the meeting. It was noted that External Audit services would be reprocured at the end of the current year when the Trust's contract with KPMG expires.

The committee will meet next on Tuesday 7th September 2021.

Any significant risks for noting by Board? (list if appropriate)
Any matters of escalation to Board for decision or noting (list if appropriate)
None. Matters related to the Annual Report, Annual Governance Statement and final accounts were considered at a Board meeting held on 9th June 2021.

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Steve Russell, Chief Executive
Date of meeting:	21st July 2021
Date of Board meeting this report is to be presented	28th July 2021

6.3

Summary of key issues

- As part of the Chief Executive briefing it was highlighted that the Covid requirements within the Trust, such as PPE and social distancing remained unchanged at this time.
- The Executive Medical Director noted that a Chief Registrar would commence in August. The revised Quality Governance Framework would be fully implemented in August. The Quality Priorities for 20-21 and 21-22 were now fully embedded in the Caring at Our Best Programme.
- The Executive Nurse Director noted that three new Serious Incidents had been declared, bringing the year to date total to nine. A new Quality Summit would launch in August and this would replace PESH.
- The Chief Operating Officer updated SMT on operational pressures and recovery. Two-week wait was discussed alongside the ongoing high levels of demand in breast. Plans were in place to mitigate and bring performance back in line with the trajectory in the coming months. RTT waiting list continues to increase with ongoing reviews of mitigation. A new ED pathway was being trialled from the 16th July with analysis and results to be submitted to a future SMT.
- SMT discussed a revised Peer Review Process. The proposal noted that greater alignment would be seen across all directorates and consideration was given to enhanced support and quality improvement teams and projects in areas that had the greatest need. The proposal was agreed in principle with some changes noted in relation to the implementation plan and terminology used.
- SMT received an informative presentation on Continuity of Care. The presentation provided information on the risks and benefits of the model, staff views and perspectives as well as noting resource implications. SMT was in agreement with the principles of the presentation; further work was required in relation to resources. Next steps were reviewed which included submission of an appropriate business case.
- A report on strengthening maternity and neonatal safety was discussed. This highlighted ongoing challenges and compliance with new measures. This included the implementation of Ockenden requirements and the perinatal

quality surveillance tool.

- SMT received a presentation on Scan 4 Safety Medicines Management. Discussions were held on the implementation plan, benefits of the system including quality of care and time management. Discussions were also held on the revenue implications and the requirement for named nursing leads.
- An update was provided on current workforce and organisational development issues. It was noted that an ongoing management review was taking place and there had been an increase in demand on complex cases.
- The Finance Director provided an update on the current finance situation. It was noted that there were a number of areas of pressure being offset by underspend on areas of activity. A slippage in the capital programme was also noted.

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

GLOSSARY OF ABBREVIATIONS

A

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

BAF	*Board Assurance Framework*
BME	*Black and Minority Ethnic*
BoD	*Board of Directors*

C

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

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

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

FFT	*Friends and Family Test*
FIMS	*Full Inventory Management System*
FOI	*Freedom of Information*
FT	*NHS Foundation Trusts*
FY DR	*Foundation Year doctor*

G

GDMEC	*Governor Development and Membership Engagement Committee*
GIRFT	*Get it right first time*
GPOOH	*GP Out of Hours*

H

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

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

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

QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QPR	*Quarterly Performance Review*

R

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

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

TOR	*Terms of Reference*
TU	*Trade Union*
TUPE	*Transfer of Undertakings (Protection of Employment) Regulations 2006*

V

VC	*Vice Chairman*
VSM	*Very Senior Manager*
VTE	*Venous Throboembolism*

W

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

YTD	*Year to Date*

Further information can be found at:
NHS Providers – Jargon Buster –
http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster