Board of Directors Meeting (Public)
will be held on Wednesday 26th January 2022 from 9.00am – 1.00pm
To Be Held via MS Teams

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence**	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 24th November 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	9.20
SECTION 2: CEO Updates					
2.1	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.30
2.2	**Corporate Risk Register**	Chief Executive	Discuss/ Note	**Attached**	
SECTION 3: Use of Resources and Operational Performance					
3.1	**Resource Committee Chair's Report**	Resource Committee Chair	Note/ Discuss	**Verbal** *(timing of meeting)*	9.40
3.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	**Attached**	
3.3	**Director of Finance Report**	Deputy Chief Executive / Finance Director	Discuss	**Attached**	9.50
3.4	**Chief Operating Officer's Report**	Chief Operating Officer	Discuss	**Attached**	10.00
3.5	**Workforce Report**	Director of Workforce and Organisational Development	Discuss	**Attached**	10.10

SECTION 4: Patients and Service Uses (Quality and Safety)					
4.1	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	10.20
4.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Note/ Discuss	**Attached**	
4.3	**Caring at Our Best**	Executive Medical Director / Director of Nursing, Midwifery and AHPs	Note/ Discuss	**Attached**	
Comfort Break (10.45 – 11.00)					
4.4a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	11.00
4.4b	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Discuss / Note	**Attached**	11.10
4.4c	**Freedom to Speak Up Guardian Quarterly Report**	Freedom to Speak Up Guardian	Discuss / Note	**Attached**	11.20
4.4d	**Embedding Service User Experience and Engagement**	Director of Nursing, Midwifery and AHPs	Discuss/ Note	**Attached**	11.30
4.5a	**Medical Director Report**	Executive Medical Director	Note	**Attached**	11.40
4.5b	**Guardian of Safe Working Quarterly Report**	Guardian of Safe Working	Note	**Attached**	11.50
4.5c	**Paterson Inquiry Update**	Executive Medical Director	Note	**Attached**	12.00
SECTION 5: People and Culture					
5.1	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	**Attached**	12.10
5.2	**Integrated Board Report –** Indicators from Workforce domain	Executive Directors	Note/ Discuss	**Attached**	
5.3	**Organisational Development Report**	Director of Workforce and Organisational Development	Note/ Approve	**Attached**	

SECTION 6: Strategy & Partnerships					
Board Reports					
6.1	**Board Assurance Framework**	Chairman	Note	**Attached**	12.20
6.2	**Director of Strategy Report**	Director of Strategy	Note	**Attached**	12.25
SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Report December 2021**	Committee Chair	Note	**Attached**	12.35
7.2	**Senior Management Team Report January 2022**	Senior Management Team Chair	Note	**Attached**	
7.3	**Resource Committee Terms of Reference**	Resource Committee Chair	Note	**Attached**	
7.4	**2021-22 Board Workplan**	Chairman	Note	**Attached**	
7.5	**Board Appointed Non-Executive Directors**	Chairman	Approve	**Attached**	
7.6	**Non-Executive Directors Board Sub-Committee Membership**	Chairman	Approve	**Attached**	
8.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ Approve	Verbal	12.45
9.0	**Board Evaluation**	Chairman	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 30th March 2022				

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.

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interest
As at 26th January 2022

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. Member of the Yorkshire & Humber NHS Chairs' Network 4. Volunteer with Supporting Older People (charity). 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 (ended September 2021) 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
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	March 2021	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
Matt Graham	Director of Strategy	September 2021		Governor (Chair of Finance & Premises Committee) – Malton School
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	Director of Nursing	April 2021	Date	No interests declared.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society
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

				3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS 4. Co-Chair of WY&H Planned Care Alliance 5. Chair of Non-Surgical Oncology Steering Group 6. NHS Employers Policy Board Member (September 2020 and ongoing) 7. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 8. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)

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 Nicholas	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 (until June 2021)	Familial relationship with KLS Martin Ltd, a company providing services to the NHS
Kate Southgate	Company Secretary (from June 2021)	No interests declared

Board of Directors Meeting
Wednesday,24th November 2021 from 9.00am – 1.30pm
at the Pavilions, Great Yorkshire Show Ground,
Harrogate North Yorkshire, HG2 8QZ

Present
Angela Schofield, Chairman
Sarah Armstrong, Non-executive Director
Jeremy Cross, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Maureen Taylor, Non-executive Director
Steve Russell, Chief Executive
Jacqueline Andrews, Executive Medical Director
Jonathan Coulter, Finance Director/Deputy Chief Executive
Russell Nightingale, Chief Operating Officer
Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals
Matthew Graham, Director of Strategy
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Laura Angus, NExT Non-Executive Director
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Natalie Lyth, Clinical Director for Community and Children's Directorate
Matt Shepherd, Deputy Chief Operating Officer/Clinical Director for Long Term and Unscheduled Care Directorate
Kate Southgate, Company Secretary

Amanda Russell, Staff Nurse (*In attendance for BD/11/21/2)*
Simon Riley-Fuller, Deputy Director of Nursing, Midwifery and AHPs (*In attendance for BD/9/21/9*)
Charly Gill, Quality Matron (*In attendance for BD/9/21/9)*

Observing
Mary Kelly, Governor
Steve Treece, Governor
Giles Latham, Head of Communications
Hannah Cummins, Administrative Assistance
Jo Pew, NHS Professionals

Item No.	Item
BD/11/21/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting.
1.2	Apologies for absence were noted from Wallace Sampson OBE, Non-executive Director Richard Stiff, Non-executive Director
BD/11/21/2	**Patient Story**
2.1	Amanda Russell, Staff Nurse attended to provide a patient story about a gentleman who was admitted directly to the intensive care unit with a diagnosis of respiratory failure secondary to Covid19 infection. The patient deteriorated and his family were called to the unit to spend some time with him as he was not expected to survive.

2.2	Following interventions including a tracheostomy he was initially transferred to Byland Ward on Christmas Eve but moved to Rowan ward the following day. There he remained for a prolonged period of rehabilitation and input from the respiratory team. The patient was discharged home, after which he was followed up for a brief period of time through the covid virtual ward. The patient provided HDFT with invaluable feedback regarding his admission
2.3 **2.4**	Laura Robson raised the important of supporting families and relatives as well as patients Emma Nunez confirmed that scheduled visiting now permitted.
2.5 **2.6**	**Resolved:** the patient story was noted. *Amanda Russell left the meeting.*
BD/11/21/3	**Declarations of Interest and Register of Interests**
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, and Angela Wilkinson and Russell Nightingale are Directors of the ILS and IPS Pathology Joint Venture.
3.3	**Resolved:** the declarations were noted.
BD/11/21/4	**Minutes of the Previous Board of Directors meeting held on 29th September 2021**
4.1	A correction was noted: • Jeremy Cross, Non-Executive Director was in attendance • 35.5 – To read *noted the stark reminder.*
4.2	**Resolved:** the minutes of the last meeting held on 29th September 2021 were agreed as an accurate record subject to the change noted above.
BD/11/21/5	**Matters Arising and Action Log**
5.1	No matters arising not included on the agenda or action tracker were noted. The following updates on outstanding actions were noted: BoD/7/21/11.5 – Safe Staffing Report – Action closed BoD/7/21/16.9 – Management Restructure – to be included on the December 2021 workshop – Action closed BoD/7/21/22.6 – Avoidable Admissions – Action closed BoD/9/21/14.4 - Digital Programme – Action closed BoD/9/21/18.12 - Flexible Working Deep Dive – Action closed BoD/9/21/33.1 - Trust Board Workshop Workplan – Action closed
5.2	**Resolved:** sufficient assurance was received to update and / or close actions as detailed.

BD/11/21/6	**Overview by the Chairman**
6.1	The Chairman noted the excellent Board Workshop that had taken place in October 2021 in Morpeth on the 0-19 service. It was noted that a review was taking place of the constitution in light of the changes to the composition of services within HDFT.
6.2	Tribute was paid to colleagues who were working in continued exceptional times, for all of their hard work and dedication.
6.3	The Harrogate Charity Christmas Market was noted as taking place on Sunday 28th November 2021.
6.4	**Resolved:** The Chairman's report was noted.
BD/11/21/7	**Chief Executive Report**
7.1	The Chief Executive noted the contents of his report as read and highlighted a number of key points.
7.2	Teams were working incredibly hard in continued difficult circumstances. Attention was drawn to continued pressures within the social care setting and there was a high level focus on 104 week waits and ambulance handovers. Collaboration, mutual support and partnership working remained central to HDFT's approach.
7.3	Areas of risk were noted in colleague's resilience due to continued ongoing pressures, flow and waiting times across the system. Ongoing pressures relating to safeguarding were also noted. In terms of mitigation it was highlighted that in addition to the work to directly address the areas, listening events had identified actions that could be taken to reduce the burden on teams which could positively impact on workload and wellbeing. The importance of remaining connected to the issues teams are facing, particularly during this period, was of high importance.
7.4	Sarah Armstrong updated on a walk around of the acute site with colleagues.
7.5	Sarah Armstrong queried ambulance handovers and HDFT's current position. Russell Nightingale, noted that ED prioritise ambulance handover and the culture of the team was zero tolerance to ambulance handover breaches.
7.6	Laura Robson, highlighted a discussion at Quality Committee on 12 hour waits. The senior team had been very clear that 12 hour breaches were unacceptable and would not be tolerated.
7.7	Maureen Taylor queried incident response plans. Steve Russell confirmed HDFT has its own Business Continuity Plans, they had commonalities to other trusts, however they are bespoke to HDFT. A piece of work was ongoing to ensure that all plans were up to date.
7.8	Andy Papworth noted the importance of leadership visibility at the present time. It was also noted that there had been a reduction in violence and aggression incidents within the ED as noted in the Corporate Risk Register. In addition, staff vaccination compliance were noted. 72% of colleagues having received a COVID19 booster. Clarification was given regarding the information currently available of the term "fully vaccinated", noting that further national guidance regarding the regulations were awaited.
7.9	**Resolved:** The Chief Executive's Report was noted.

BD/11/21/8	**Corporate Risk Register**
8.1	The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks.
8.2	**Resolved:** the updates were noted.
BD/11/21/9	**Safer Nursing Care Tool (SNCT)**
9.1	The agenda was taken out of order at this point to allow Simon-Riley Fuller and Charly Gill to join the meeting to update on the report.
9.2	Emma Nunez, introduced the report and took it as read. The inpatient review took place in June and July 2021. In terms of the evidence based tool it is recommended that 3 data collections take place before any substantial changes are made to staffing composition. It is envisaged that the 2nd data collection would take place in February 2022.
9.3	Simon Riley-Fuller and Charly Gill provided additional details on SNCT including the difference in wards from an acuity perspective, and the triangulation process of professional judgement and quality / safety indicators. Charly Gill also noted the key recommendations of the report.
9.4	Jeremy Cross queried the engagement and buy in from ward teams. Emma Nunez confirmed that they had received excellent engagement. Discussions also took place on the data on individual wards. It was confirmed that fill rates would remain in the IBR on current establishment not on the numbers contained in this report due to two further data collections being required for a full analysis to take place.
9.5	Andy Papworth commended the clarity of the report. It was confirmed that study leave and maternity leave would be included in the numbers, however, it was noted that staff were commencing maternity leave earlier due to Covid. Discussions also took place on volunteers. It was confirmed that as part of the non-clinical review, volunteer support would be considered.
9.6	Sarah Armstrong queried how transferable colleagues were between wards. Emma Nunez noted the mitigation of risk on a daily basis requiring staff moves between wards. It was highlighted that staff morale could be affected `by ward moves. Andy Papworth highlighted that a change in line management can have a significant impact on the anxiety felt by colleagues.
9.7	**Resolved:** The Board noted the report including the immediate recommendations. *Simon Riley-Fuller and Charly Gill left the meeting.*
BD/11/21/10	**Quality Committee Chair Report**
10.1	Laura Robson as Chair of the Quality Committee presented her report on the October and November 2021 meetings as read and highlighted a number of key issues.
10.2	It was noted that the Waste Management Limited Assurance report was being monitored via the Committee. A Limited Assurance report of the Discharge Process was noted and updates were provided at the Committee by the operational leads. The Committee had also undertaken a focused piece of work on mental health patients in the ED.
10.3	The IBR that is received at the Quality Committee does not include the executive lead descriptions due to the timing of report production and the timing of meetings. It was confirmed that for 2022 report production and meeting timings were being reviewed by

	the Director of Finance and the Company Secretary. In addition, it was noted that some IBR indicators did not have information contained in the report. The Director of Finance confirmed that a number of these were now in a position to have the information included.
10.4	A deep dive into incidents resulting in moderate harm had been completed. A response had also been provided to a Governor on patient experience and engagement.
10.5	**Resolved:** The Board noted the content of the report**.**
BD/11/21/11	**Integrated Board Report**
11.1	The IBR Indicators linked to Quality were noted.
11.2	**Resolved:** The Board noted the content of the report**.**
BD/11/21/12	**Director of Nursing Report**
12.1	The Director of Nursing, Midwifery and Allied Health Professionals noted her report as read and highlighted the following issues in relation to the indicators in the IBR.
12.2	Indicator 2.2.2 Complaints – complaints were currently at 50% in October, the position in November has improved to 70% month to date. In addition, the quality of response has improved. Sarah Armstrong noted the significant progress made regarding complaints in recent months.
12.3	Improvements had been seen in pressure ulcers and falls. Thematic reviews continued on falls on a range of wards. Improvements had also been seen with an increase in reporting of low and no harms which highlighted a strong safety reporting culture.
12.4	The revised fundamentals of care programme was currently out to consultation. The new programme included leadership development and clinical supervision for care support workers. A Practice Educator dedicated to care support workers had been appointed.
12.5	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/11/21/13	**Safeguarding Adult Annual Report**
13.1	The Executive Director of Nursing presented the report as read and noted the following.
13.2	A review was currently taking place on combining the safeguarding children and adults safeguarding team to enhance resilience.
13.3	Changes to current requirements for Deprivation of Liberty were highlighted included legislative changes.
13.4	Jeremy Cross queried the concerns raised against HDFT. Emma Nunez confirmed that these were reviewed by an external body and closed down or provide recommendations as required.
13.5	Maureen Taylor queried an issue with an absconding patient. **Action** Emma Nunez confirmed that a detailed description would be provided to Maureen Taylor outside of the meeting.
13.6	Laura Robson noted that nationally it was highlighted that domestic violence was thought to have increased during the pandemic. Emma Nunez confirmed that the

	Safeguarding Board were reviewing this issue and further information would be provided as required back to HDFT.
13.7	**Resolved:** The Board noted the content of the report and approved the report.
BD/11/21/14	**Strengthening Maternity and Neonatal Safety**
14.1	The Executive Director of Nursing presented the report as read and noted the following.
14.2	Safeguarding training was noted as having been impacted by the covid pandemic. Ongoing work was noted with regards to the daily escalation arrangements within the wider Trust.
14.3	Positive feedback had been received from the regional team regarding HDFTs Ockenden submission.
14.4	Jeremy Cross noted the number of times the unit had been closed in recent months. Kat Johnson highlighted regional discussions that were occurring regarding escalation and decision making. Emma Nunez noted that the time the unit was closed could vary significantly, however this level of detail was not included in the report. Further work would continue to provide additional information.
14.5	Laura Robson queried if Birth Rate Plus operated all of the time. Emma Nunez confirmed that it was not all of the time, it was a specified period of time.
14.6	It was confirmed that the report would be reviewed in Board Workshop during Hot Topics. In addition, the report would be reviewed at SMT each month and would be circulated to Andy Papworth as Maternity Safety Champion.
14.7	**Resolved:** The Board noted the content of the report.
BD/11/21/15	**Medical Director Report**
15.1	The Executive Medical Director introduced her report as read and highlighted the following.
15.2	Updates were provided on the interim Quality Governance Structure and portfolio. Leadership arrangements were also noted on the HEE Clinical Fellowship in Digital Innovation and interim PMO support for the Caring At Our Best programme.
15.3	A new Learning at Our Best forum had been initiated to identify, share and discuss learning. Angela Scofield queried the governance arrangements. It was confirmed that this would report into Quality Governance Management Group.
15.4	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/11/21/16	**Learning from Deaths Report – Quarter 2 2021-22**
16.1	The Executive Medical Director presented the report and took it as read. She highlighted the following points.
16.2	Crude mortality rates for HDFT continued to track the national trends. Standardised mortality rates continued to be within the expected range.
16.3	16 Structured Judgement Reviews had been undertaken since the last report. All cases had overall care described as “good”. There have been 9 Covid-19 deaths in this quarter.

16.4	A review into deaths of patients with a diagnosis of pneumonia was undertaken following previous HSMR alert. This did not find any significant lapses in care.
16.5	The HDFT Medical Examiner was performing well when benchmarked against regional data.
16.6	Andy Papworth noted the high quality of the report.
16.7	Angela Scofield queried the Medical Examiner with Primary Care. It was confirmed that primary care would come into statute from 1st April 2022. Plans were in place to ensure HDFT were in a position to be able to deliver this service.
16.8	**Resolved:** The Board noted the content of the report.
BD/11/21/17	**Infection Prevention Control Service Annual Report**
17.1	The Executive Medical Director presented the report and highlighted the following.
17.2	The report was developed in three parts: performance related to Infection, Prevention and Control (IPC), progress against the annual plan for 2020-21 and the annual plan of work for 2021-22 to reduce the risk of Healthcare Associated Infections (HCAI's).
17.3	An update was provided on IPC leadership, the structure of the IPC team as well as governance arrangements.
17.4	The Statement of Compliance against the Hygiene Code would be presented to the January 2022 Board.
17.5	Sarah Armstrong queried the training for hand hygiene. Jackie Andrews confirmed that face to face training had re-commenced.
17.6	Laura Robson noted that zero surgical site infections were reported against fractured neck of femur and if this could be reported on a wider scale. Jackie Andrews confirmed that this information was available and was discussed at Mortality and Morbidity meetings.
17.7	Laura Robson queried the attendance level at the formal IPC Committee. Jackie Andrews confirmed that it was well attended.
17.8	Jeremy Cross queried the recommendations and actions regarding the Covid 19 SI. Jackie Andrews confirmed that the it would be discussed in the Learning Forum. **Action** A summary of the Covid 19 SI Report would be brought to the Board once confirmed by the CCG and it would also be brought in full to Private Board.
17.9	Laura Angus queried where the Antimicrobial Forum fed into the Governance Structure. It was confirmed that it was to the IPC Committee.
17.10	**Resolved:** The Board noted the content of the report and approved the Annual Report.
BD/11/21/18	**People and Culture Committee Chair's Report**
18.1	Jeremy Cross as Chair of the People and Culture Committee highlighted key issues of his report.
18.2	It was noted that an informative presentation had been received regarding the Allyship Programme. Updates were provided on the People Plan and an in-depth discussion

	was held in the Committee on exit interviews and the work required to improve the systems to ensure they were well embedded.
18.3	Thrive (wellbeing) discussions were highlighted. It was noted that metrics required further work, however, health and wellbeing discussions were noted as taking place and held significant importance. Angela Wilkinson provided additional information on the forms that wellbeing conversations take place across HDFT. The recording system for these discussions was being reviewed.
18.4	Andy Papworth noted concerns that the numbers of those recording that wellbeing discussions had been held and queried if the app could be used to record it and samples taken via the Inpulse surveys. Angela Wilkinson confirmed this would be considered.
18.5	Angela Scofield queried when further discussions would be held within the Committee regarding Thrive and Wellbeing conversations. It was confirmed that this would be regularly monitored via the People and Culture Committee.
18.6	**Resolved:** The Board noted the content of the report**.**
BD/11/21/19	**Director of Workforce and Organisational Development Report**
19.1	The Director of Workforce and Organisational Development presented the IBR indicators and escalation report as read. An update was provided on current workforce issues.
19.2	Demand and capacity imbalance continue to impact on service delivery across occupational health, EDI and HR operations.
19.3	The sickness rate continues to note an increasing trend. The October 2021 position is 6.04%. Excluding Covid sickness, the sickness rate is 5.51%, which is an increase from 4.7% in the previous month. Covid related sickness remains at a similar level compared to last month. Short term sickness has seen an increase from 1.63% in September to 2.38% in October 2021. Long term sickness remains at 3.6%. Capacity within the HR Team is being reviewed with a Business Case being developed. Bite size events have been implemented to provide support to mangers.
19.4	Turnover has seen a further increase from 14.47% in September to 14.64% in October 2021. This does however, remains below the HDFT threshold of 15%. Scrutiny has increased for exit interviews. Support is being sought from an external organisation. Demonstrations are being scheduled for the upcoming weeks.
19.5	It was noted that potential industrial action discussions were underway with GMB in relation to the dispute regarding national pay awards.
19.6	Mandatory vaccines were highlighted from an HR perspective. Work was continuing within the HR network however; national guidance has not been fully received. Indicative guidance from care homes was being reviewed.
19.7	Sarah Armstrong noted that a recruitment event for HIF was taking place and how this was a very proactive form of recruitment. Angela Wilkinson also noted the positive impact that current online events were having.
19.8	Laura Robson raised that managers do not receive the details of exit interviews for their members of staff. Angela Wilkinson confirmed that information was provided to managers. Angela Scofield queried if this would continue to occur were an external agency to be appointed. It was confirmed that this would form part of the process.

19.9	Laura Robson queried in the Grid LTUC rise in sickness was the greatest, however in the IBR it states the greatest rise is in the Darlington Immunisation Community Team. Angela Wilkinson confirmed that the directorate with the highest increase was LTUC, and the team with the highest rise is Darlington Immunisation Community Team.
19.10	Andy Papworth queried the figures regarding time to high colleagues in terms of the time it takes from verbal offer to formal offer. Angela Wilkinson confirmed that this number was currently being monitored within the senior HR Team.
19.11	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed. *Steve Treece left the meeting.*
BD/11/21/20	**Board Assurance Framework**
20.1	The Chief Executive presented the updated Board Assurance Framework. Colleagues had reviewed and tightened up the mitigation actions and reviewed the definitions of risk. It was noted that in relation to: • Strategic Objective 1: Becoming and Outstanding Place to Work, significant work was ongoing within Theatres and in relation to Inclusivity – Allyship and Reciprocal mentioning programme was ongoing and an update would be provided at the December Board workshop. • Strategic Objective 4: To ensure clinical and financial sustainability. The extent of recurrent efficiency savings in 21/22 posed a risk in relation to exit run rate, This is being closely monitored at Resources Committee. • Add the one re public health service and highlight the issue that due to SG activity and the COVID-19 12-15 programme that whilst the Universal Service is being maintained some elements of the enhanced support were constrained.
20.2	**Resolved:** the report and updates were noted.
BD/11/21/21	**Director of Strategy Report**
21.1	The Director of Strategy noted his report as read and highlighted the following issues.
21.2	The Trust Strategy refresh had commenced, but tight timescales were noted. A review of programme governance was also underway as was an assessment of HDFT against the HCV anchor institutions framework.
21.3	A successful workshop on 0-19 services had been held with the Board and the output would feed into the development of the Trust and Clinical Strategy.
21.4	Laura Robson noted that clinical strategy workshops had already been held and questioned if Matt Graham had seen them. It was confirmed that a range of information had been provided to him.
21.5	**Resolved:** The Board noted the update.
BD/11/21/22	**Development of the Trust and Clinical Strategy**
22.1	The Director of Strategy noted his report as read and highlighted the following issues.
22.2	The current Strategy ran from 2014-2019, therefore a refresh of Trust Strategy is required especially in the context of the changing health and social care environment. The report noted the approach to the development of the refresh. The Strategy will create clarity and a common understanding of what is trying to be achieved and the purpose of the organisation.

22.3	The timetable for development and delivery of both the Trust Strategy and the Clinical Strategy was reviewed and confirmed.
22.4	Jeremy Cross noted that financial sustainability should be included as well as environmental sustainability in the priorities. Jonathan Coulter confirmed that this would be reviewed and included.
22.5	Andy Papworth queried what best practice from high performing Trusts was being used. Matt Graham confirmed that this would form part of the development process.
22.6	**Action:** To include the Trust Strategy at the February 2022 Workshop
22.7	**Resolved:** The Board noted the update. *Mary Kelly left the meeting.* *Jo Pews left the meeting.*
BD/11/21/23	**H2 Strategy**
23.1	The Director of Finance noted the report as read. This had previously been discussed at the Resource Committee. It was noted that the pay award was funded, there is a national efficiency expectation of 0.82% as well as a 6% reduction in funding to support Covid. It was confirmed that the Trust was forecasting to delivery the financial plan.
23.2	**Resolved:** The Board noted the update.
BD/11/21/24	**Resources Committee Chair's Report**
24.1	Maureen Taylor as Chair of Resources Committee presented the October and November 2021 Committee reports.
24.2	The capital plan was noted as remaining under review by the Committee. Key performance metrics were also noted and reviewed at the Committee including ED, Cancer, waiting list initiatives, staffing numbers and retention, H2.
24.3	Salix de-carbonisation scheme was discussed in relation to a contract with Imtek. Some variations on the contract are required, this is commercially sensitive and the detail will be provided in Part 2 of the Board meeting.
24.4	The Terms of Reference of the Committee were updated and agreed and would be submitted to Board for final approval. **Action:** Resource Committee Terms of Reference submitted to the Board for approval**.**
24.5	At the Committee the uplift of the living wage was discussed. **Action:** The principal of uplifting the living wage every year to be brought back to the January 2022 Board
24.6	**Resolved:** The Board noted the content of the report and agreed the uplift of the living wage for 2021/22.
BD/11/21/25	**Director of Finance Report**
25.1	The Finance Director discussed with the Board the points raised in relation to the current financial position.

25.2	Andy Papworth queried the slippage in the capital plan. Jonathan Coulter noted that slippage does not automatically roll over into the next financial year. Each Trust was required to undertake a robust forecast position in December 2021 to allow for national planning.
25.3	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/11/21/26	**Chief Operating Officer's Report**
26.1	The Chief Operating Officer highlighted key themes from the report and IBR indicators.
26.2	There had been an increase in Covid admissions resulting in requirements to open additional beds and create a Covid ward. 68% of elective theatres lists ran and lost lists were due to theatre staffing vacancies and sickness across October. Updates were provided against 104 week wait patients and the plans to have zero tolerance from March 2022. There were 260 patients currently on the list with 50% of patients having been given a date.
26.3	Two week wait cancer performance was at 82% in comparison to a 93% target. Demand remains high and the Trust continues to full capacity. Demand for new outpatient ECHO test has increased from 39% based on 2019 demand.
26.4	Zero 12 hour breaches have been noted in November to date. Eleven 60-minute ambulance handover breaches were noted in October, all of which were under 80 minutes. The continued ED refurbishment and flow redesign was ongoing and progress well. Learning was taken to update the process for flow meetings including the timings of meetings. On-call handbooks were in the process of being developed. In addition, Governance had been improved.
26.5	Winter plans were on going, a number of schemes have been prioritised for HDFTs 550k allocation. These included pharmacy weekend cover, winter ward development, transfer team, increased middle grade doctor cover, additional patient transport, GP steaming model, expanded respiratory virtual ward and increased site management.
26.6	The validation of RTT data had commenced with an external organisation.
26.7	Sarah Armstrong noted the wide range of activity taking place and the continued areas of improvement.
26.8	Angela Scofield queried the impact of patient choice of 104 week waits. Russell Nightingale confirmed that this was a factor and it was important to ensure that the process was as simple as possible for patients.
26.9	Laura Angus queried if the positive direction of HDFTs 104 week waits, would see increased pressure from system partners. Russell Nightingale noted that it was important that HDFT were a strong system partner and Steve Russell confirmed that the Trust has taken a positive decision to actively support other Trusts where we are able to, and noted that the Trust was also receiving support from others.
26.10	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.

BD/11/21/27	**Organisational Development**
27.1	The Director of Workforce and OD noted the report as read. All key areas had been discussed during previous agenda items.
27.2	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/28	**Audit Committee Chair's Report**
28.1	It was noted that the Audit Committee had not met during the time period.
BD/11/21/29	**Senior Management Team Report**
29.1	The Chief Executive noted the contents of the two SMT reports for October and November. They were taken as read and noted that all key issues had been discussed in other agenda items throughout the meeting.
29.2	**Resolved:** The Board noted the content of the report
BD/11/21/30	**2021-22 Board Workplan**
30.1	**Resolved:** The content of the workplan was agreed.
BD/11/21/31	**Treasury Management Policy**
31.1	**Resolved:** The Treasury Management Policy was reviewed and approved.
BD/11/21/32	**0-19 Task and Finish Group**
32.1	Angela Scofield updated the Board on the Terms of Reference. It was noted that Matt Graham would also be included in the membership.
32.2	**Resolved:** The Board agreed the proposal.
BD/11/21/33	**Any Other Business**
33.1	There were no other areas of business raised.
BD/11/21/34	**Board Evaluation**
34.1	The Chairman posed the question about what had worked well and not as well with the meeting today.
34.2	It was noted that significant work had been covered during the meeting.
BD/11/21/36	**Date and Time of the Next Meeting**
36.1	The next meeting would be held on Wednesday, 26th January 2022.
BD/11/21/37	**Confidential Motion**
37.1	**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Board of Directors (held in Public) Action Log for January 2022 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/11/21/17.8	24 November 2021	Infection Prevention and Control Annual Report - Covid 19 SI Report	A summary of the Covid 19 SI Report to be submitted to Board once confirmed by the CCG.	Executive Medical Director	01 March 2022	**Update January 2022** Due in March 2022	Open and on Track
BoD/11/21/24.5	24 November 2021	Uplifting of the Living Wage	The Principal of uplifting the living wage each year to be brought to the Trust Board	Director of Workforce and OD	01 November 2022	**Update January 2022** Included on the work programme for November 2022	Complete
BoD/7/21/16/16.9	28 July 2021	Management Restructure	For a Board Workshop to be held on the management restructure	Director of Workforce and OD	01 December 2021	**Update January 2022** Non-Executive Briefing was held in December 2021. Feedback from the Nonexecutives is being taken into account. A further Non-Executive briefing will be held in January / February 2022. In light of this the Board does not require a workshop and this action is recommended to be closed. **Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Complete
BoD/11/21/13.5	24 November 2021	Safeguarding Annual Report - Absconding Patient	A case was noted in the Annual Report regarding an absconding patient. The Director of Nursing Midwifery and AHPs to provide further detail to Maureen Taylor (NED)	Director of Nursing, Midwifery and AHPs	26 January 2022	**Update January 2022** Information was provided and it is recommended that the action be closed.	Complete
BoD/11/21/22.6	24 November 2021	Trust Strategy	The Trust Strategy would be included on the February Board Workshop	Company Secretary / Director of Strategy	26 January 2022	**Update for January Board Meeting** The Trust Strategy has been included on the Trust Board Workshop Work Programme. Recommended that the actions is closed.	Complete
BoD/11/21/24.4	24 November 2021	Resource Committee Terms of Reference	Resource Committee Terms of Reference for approval	Company Secretary	26 January 2022	**Update for January Board Meeting** TOR included for approval on the 25th January 2022 Trust Board Agenda. Recommended that the action is closed.	Complete
BoD/11/21/17.8	24 November 2021	Infection Prevention and Control Annual Report - Covid 19 SI Report	The complete Covid 19 SI Report to be submitted to Private Board once confirmed by the CCG	Executive Medical Director	01 March 2022	**Update January 2022** Due in March 2022	Complete
BoD/7/21/11/11.5	28 July 2021	Safe Staffing Report	Safer Staffing Report to be submitted to the September 2021 Board	Director of Nursing	~~29/09/2021~~ 24 November 2021	**Update for the November Board meeting** The report is included on the agenda. Recommended that the action is closed. **Update from September 2021 Board Meeting** It was confirmed that this would be a Board report in November 2021 rather than a board workshop. To remain on the tracker until delivered in November 2021. **Update September 2021** Report required to be submitted through internal governance systems. To be submitted to the November 2021 Board	Closed at the November 2021 Board Meeting
BoD/7/21/22/22.6	28 July 2021	Avoidable Admissions	Further information to be provided on 6.8 Avoidable admissions in the IBR	Chief Operating Officer	~~29/09/2021~~ November 2021	**Update from September 2021 Board Meeting** It was confirmed that information was included in the IBR, however, further information would be brought to the November 2021 Board.	Closed at the November 2021 Board Meeting
BoD/9/21/5/5.4	29 September 2021	PLACE	Workshop to be held in December 2021 - partners from North Yorkshire and Harrogate to be invited	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** PLACE added to the December Workshop,	Closed at the November 2021 Board Meeting
BoD/9/21/14.1	29 September 2021	Digital Programme	Workshop to be held in April 2022 on the Digital Aspirant Programme	Medical Director	01 December 2021	**Update November 2021** **Recommendation to close** Digital Aspirant Programme added to the April 2022 Workshop,	Closed at the November 2021 Board Meeting

BoD/9/21/18.12	29 September 2021	Flexible Working Deep Dive	Flexible working deep dive to be included on the People and Culture Agenda	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** Flexible working deep dive has been included on the January 2022 People and Culture Committee Agenda	Closed at the November 2021 Board Meeting
BoD/9/21/33.1	29 September 2021	Trust Board Workshop Plan	Workshop plan to be developed	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** Workshop plan developed and circulated to Board Members	Closed at the November 2021 Board Meeting

2.1

Board of Directors (Public)
26th January 2022

Title:	**Chief Executive's Report**
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held on 24th November 2022. The report highlights key challenges, activity and programmes currently impacting on the organistaion.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

CHIEF EXECUTIVE'S REPORT

Introduction

1. Since the last Board meeting in November colleagues across all services have had to respond to routine winter pressures, the challenges of flow arising from capacity in social care and the Omicron wave.

2. Whilst the number of COVID in-patients did rise to nearly 30 at the peak the majority of patients were not in hospital because of COVID, but with other illnesses whilst also having COVID. Very few patients during this period required critical care support. This is positive and highly likely due to the generally high rates of vaccination in the Harrogate and District area given that vaccination and boosters are known to protect against more serious illness.

3. However, there has been a significant impact on staffing during this period of time arising from the need for colleagues to isolate. At peak over 300 colleagues were absent from work solely due to COVID, with aggregate absence having been around 10% including other short and long term sickness. This clearly has placed very significant pressures on teams because staffing levels were heavily impacted.

4. The levels of staffing meant that people were unable to deliver the quality of care that they would have wanted to, and had to prioritise what they focused their time on. We have seen the resulting moral injury stressors that colleagues have experienced because of this.

5. In addition to redeploying staff in particular to in-patient areas to provide direct support we wrote to all colleagues to recognise that they have been working under considerably more pressure than normal, working late and not getting breaks alongside not being able to do everything that they would have wanted to for patients and families. We wanted to make clear that the responsibility for this sits with the organisation, rather than with individual practitioners, although recognising they feel the burden in their practice. We had helpful feedback on where we could make some aspects of work easier and we will need to continue to build on this approach and make it more of a business as usual practice.

6. At the time of writing, absence has reduced from a critical level but remains very high at 4.7% for COVID alone. In the last 14 days it has ranged between 196, 277 and 239 and so remains quite volatile.

7. There have been a number of changes to the national guidance on testing and isolation which we have implemented on a risk assessed basis. Where we deviate from the national guidance it is to exercise a higher degree of caution (for example we still undertake a risk assessment to return people to work between days 0 and 5 where they are a contact). We continue to operate restricted visiting which we recognises poses challenges to patients, families and friends and to our colleagues.

8. We have been able to continue elective activity during this period, but have done so because cancellation of routine activity would not have released material volumes of staff given the need for green capacity for urgent surgery.

9. The planning guidance has now been published, and whilst the NHS has not been asked to prioritise this during the month of January, there are important considerations for us and we have a process to consider this during February. We expect income reduction of c£9m with a reduction in COVID support, the requirement to deliver productivity savings and a return to a tighter financial environment in 22/23.

Vaccination as a condition of deployment

10. The regulations requiring staff who are deployed for the purposes of a CQC regulated activity come into force on 1st April 2022. This means colleagues who intend to be vaccinated must have their first vaccine by 3rd February 2022. Where colleagues choose not to be vaccinated and are 'in scope' of the regulations this will have significant implications for their future.

11. It is our intention to support as many colleagues to have their COVID vaccination as possible, but we recognise this is a personal choice. Where colleagues choose not be vaccinated we will do everything possible to redeploy colleagues, or to signpost and support them into other careers. However, redeployment may not be possible.

12. There are five main groups of colleagues. (i) those we know to be vaccinated as they allowed us to access their vaccination record; (ii) those who have allowed us to access their records, but we have not been able to confirm their status; (iii) those who have told us they object to us accessing their records who we are now asking for evidence of status; (iv) those who have told us they do not intend to be vaccinated and (v) those who are hesitant.

13. Each group require a different approach and will conclude by 3rd February whether people are vaccinated/intend to be fully vaccinated or whether they do not intend to be vaccinated to then move to the next steps for those who are not/do not intend to be vaccinated to confirm whether they are in our out of scope of the regulations.

14. Nearly 5,000 staff have been confirmed to have had two doses of vaccine, and around 260 fall across the other categories. At this time the majority are in group two, but a number of colleagues have told us that they do not intend to be vaccinated.

15. Throughout the process we are considering the impact on service provision and seeking to mitigate the potential risks as they become clearer.

Urgent and Emergency Care

16. December saw significant challenges with four-hour performance at 69%, and twenty-three 12-hour trolley waits, and three 60-minute ambulance handover delays.

17. We ran 'perfect week' for a fortnight in January to promote flow and there has been considerable learning from this about the consistency of systems and processes as well as the model of acute care (some of which was known but the impact more starkly apparent with additional focus).

18. Improving the model of in-patient care will be important for quality standards, continuity of care, and multi-disciplinary team working.

19. Whilst there is an existing action plan in place, the implementation of actions is behind and SMT discussed this in detail in the January meeting.

20. Positively, during perfect week new models for ARCHS' to work with wards were trialled and proved to be successful and the Trust is working with North Yorkshire County Council to consider additional options to provide packages of care in areas where capacity is very limited. This is a very positive piece of partnership working.

Planned care

21. The Trust continues to work in partnership with WYAAT and at the current time we are still forecasting that all patients waiting over 104 weeks will be treated by the end of March. This is a significant achievement. The planning process will need to consider the more medium term capacity, and how this is best strategically managed in order to reduce the waiting list size and long waiters to previous levels as a minimum.

22. Fundamental to this will be a need to have fully robust green capacity on the HDH site in addition to being able to access off-site green capacity. This will require capital investment alongside a workforce strategy, and clearly there are close links to the work being undertaken in the development of the Trust's strategy and clinical services strategy.

23. The Trust has received the first draft of the review of culture and colleague experience in theatres. We will follow a similar process to that which was undertaken with the Deloitte review.

0-19 services

24. The level of pressure across our 0-19 services remains high, with all but two of the services operating at OPEL level 3 (1 being the lowest, and 4 the highest levels of pressure). The number of safeguarding strategies, which is a marker of complexity and demand, has continued at the previous levels and remains higher than in previous years.

25. The pressure placed on school immunisation services in the previous calendar year in respect of the extension of flu and the COVID 12-15 vaccination programme has manifested with other areas of the immunisation programme (such as HPV, and MenACWY) where uptake rates are lower than we would like. An initial review of the service delivery has highlighted some fragilities which are being addressed but there are risks which are now reflected on the Directorate Risk Register and an improvement plan will be developed. A meeting with NHS England has taken place to discuss the issues and engagement with local authority colleagues who have an important interest in these issues (and who will offer help and support on interventions to support uptake) is being planned. The key area of focus is in Durham and Tees Valley, with a priority focus on MenACWY. The timing of the school based 'catch up' programme has been brought forward to January to support with this.

Quality and Safety

26. We continue to encourage curiosity and a culture of reporting of incidents. We have identified some themes in a group of serious incidents and are taking forward the learning from this.

27. WYAAT have a programme of work to implement a new model for Pharmacy Aseptic Services, and this includes seeking external capital to support this. The model incudes 'spokes' in every Trust.

28. There have been estates challenges in the current Aseptic Unit at the Trust and repairs have been made pending the larger bid for capital. However, a recent review has highlighted that the measures taken to prolong the life of the unit have come under pressure. This means that more significant improvement is going to be needed, and that this cannot wait for the WYAAT wide bid. As such contingency measures are being developed for the period during which work takes place and we will need to consider how to approach the capital requirement. This has been added to the corporate risk register.

29. We have expanded mortuary facilities and this has allowed us to address the historical issues related to supporting bariatric patients, and addresses a long standing risk.

Strategy

30. The work to develop the Trust Strategy and the Clinical Strategy is now well underway, and SMT and Board workshops are planned for February 2022.

31. We are working with NYCC and Harrogate College to implement Project Search Internships at the Trust, and expect this to commence in Autumn 2022.

SMT

32. During September and October members of SMT undertook a workshop to review the function of SMT, focusing on what was going well, what could be improved, what could be done differently and what the membership should be.

33. This led to the development of a set of team rules, how members should prepare for the meeting, and what the meeting should focus on.

    a. It was agreed that the membership would remain, and be extended to include the HIF Managing Director and a Shadow SMT representative.

    b. The team rules were agreed as being that all members of SMT would:-

        i. Come prepared, having read all the core papers and explored the supplementary ones, to create optimal conditions for discussion, challenge and holding each other to account.
        ii. Commit to the KITE behaviours: challenge should be kind and respectful.
        iii. Create a space where there can be appropriate levels of support and appropriate levels of challenge.
        iv. Be focused on improvement, which means that there is no such thing as a stupid question.
        v. Be interested in the meeting and curious about its content even when it is not in your core area of expertise.
        vi. Be present in the room – no emails.
        vii. Hold support and challenge in the meeting, and think carefully about how to cascade messages appropriately to our wider teams.

    c. That SMT meetings will be a place where:

        i. Each person feels able to ask the questions that no one else is.
        ii. Everyone is engaged.

iii. Everyone feels included and supported.
iv. We are all in it together: acting as a unitary team.

34. In addition to this, we have agreed a set of key programmes that represent the key priorities for the Trust and a programme structure is being put in place to manage the work. SMT will focus part one of the meeting on operational delivery, and part two on the key programmes of work. In addition, there will be four workshops a year, one of which non-executive directors will join.

Risk and Assurance

35. Through the Executive Risk Group, more structured arrangements are in place to systematically review both the risk register but also the internal audit programme and the resulting actions. This has supported progress, particularly in respect of the internal audit programme.

36. An internal well-led review is taking place, led by the Company Secretary. The desktop phase of this has now been completed and a broader internal review across the key CQC standards is being planned.

Land and Property

37. The following land and property matters were completed: -

- A 10-year renewal lease of Gibraltar House office accommodation in Northallerton has recently been signed and completed.
- A renewal of the egress point across Heatherdene with the Harrogate Town Football Club has recently been signed and completed

Steve Russell
Chief Executive
January 2022

Board of Directors (Public)
26th January 2022

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

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held in on 24th November 2022. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and the Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report.	
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. The January 2022 report has been reviewed at the Executive Risk Review Meeting (January 2022) and the Senior Management Team meeting (January 2022).	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

CORPORATE RISK REGISTER

1.0 INTRODUCTION

The Corporate Risk Register consist of operational risk scoring 12 or above. It is reviewed monthly at the Directorate Performance Reviews and at the Executive Risk Management Group. This report provides a summary of the position in January 2022.

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

The current position regarding Registered Nurses is as follows:

Month	Vacancy WTE	Vacancy %
Nov 21	94.36	5.86%
Oct 21	102.28	6.39%
Sep 21	98.93	6.62%
Aug 21	107.93	7.27%

The current position regarding Care Support Workers is as follows:

Month	Vacancy WTE	Vacancy %
Nov 21	93.25	17.7%
Oct 21	56.80	11.4%
Sep 21	74.32	14.5%
Aug 21	63.78	12.5%

Of note is that budgets were increase in November 2021, which is the overriding reason for the vacancy increase compared to previous months for Care Support Workers.

In terms of mitigation, it is noted that HDFT had a successful bid with NHSE/I to recruit additional Care Support Workers which will assist in bringing the figures to zero vacancies, with additional over recruitment proposed into the next financial year (2022-23).

Further the Care Support Worker Development Programme has been redesigned and increased clarity of career progression from a Care Support Worker to a Registered Nurse and the points between. Preceptorship programmes are also in place to retain newly qualified and new starters.

The Target Risk is 9 (3x3) – revised to March 2022 (from October 2021).

The Current Risk is 12 (3x4) – January 2022. This is the same rating as December 2021.

2.2 CRR6 – Wellbeing of Staff

Work continues with the support and development programme to assist in colleagues wellbeing. Of note is that a Mental Health Nurse and a Colleague Wellbeing Programme Lead role have both been recruited to and are due to commence in Quarter 4 2021-22

During December, in response to the Covid Omicron variant surge, all Trusts were asked by NHSE/I to revisit our colleague wellbeing offer to ensure a focus of activity into supporting the wellbeing of those working in critical care settings was available. In response to this the following actions were taken:

- We are developing a quiet room in the Education Centre (Enterprise Room)
- Refreshed Trust Wellbeing webpage & intranet with updated support offers & in-the-moment self-help
- Enhanced promotion around support offers with updated emails and poster circulation
- Re-promote EAP offer (now online/telephone/face-to-face) and NHS Wellbeing Hubs
- Mental Health Champions asked to enhance out-reach where they can & scheme re-promoted via Champion specific posters around site
- Thrive wellbeing conversations promoted & guidance provided
- A reminder sent via OMG about lessons learnt from Wave 1 and a reminder about End Well - checking out at the end of a shift as a process to support wellbeing
- Psychology drop-in/easy book sessions to be offered on main site from 21/12/2021
- Wider psychology staffing pool being approached to see if additional support is feasible via other specialities/TEWV if needed.

The Target risk 8 (2x4) has been amended from July 2021 to September 2022.

Current risk is 12 (3x4) – January 2022 this is the same rating as December 2021

2.3 CRR34 – Autism Assessment

The numbers on the waiting list is currently 464 (down from 590 in May 2021). The longest wait is current 60 weeks (down from 71 weeks in May 2021). The referral rate for a 6 month rolling average is now 50.

Based on the current additional funding being available for 12 months and with the continued high rates of referral, the projecting waiting list of 362 children at the end of the 12 months with the longest wait predicated at 24 weeks.

A capacity scheduler is in development to assist in the reducing pressures.

The Target Risk is 6 (3x2) – March 2023 from March 2022

The Current Risk is 12 (3x4) – January 2022. This is the same rating as December 2021.

2.4 CRR41 – RTT

Elective recovery work continues to be a major focus, and we continue to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.

To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered. There has been increased beds on the Elective Surgical Unit; these remain in place to help mitigate increased activity levels over the winter period. The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week.

Clinical prioritisation and review continues for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded.

104+ week waiters
Through Quarter 3, we have been working collectively with our partner Trusts across WYAAT to understand how each Trust could support pressures on waiting lists, redesigning pathways and agreeing governance for identifying capacity to support the treatment of long waiting patients and ensuring consistent communication.

As part of this process HDFT have supported both Bradford Trust and Leeds HT in the treatment of both ENT and Max Fax paediatric long waiting patients. The patients/carers were contacted and consented to transfer their care to Harrogate and will now receive their treatment before the end of March '22. Capacity offered for the specialty areas has not had a detrimental impact on our ability to treat patients waiting for treatment in the same specialties. Our support continues to be monitored carefully with the clinical and managerial teams.

Internally the trust continue to review all patients on the Admitted pathway over 80 weeks and have initiated a weekly PTL meeting. With the service manager, admissions manager and 18-week lead each patient is reviewed to ensure that there are clear plans in place.

The specialties of concern are currently Urology (33 patients waiting) due to increased demand and Gynaecology (32 patients most with a date for treatment but very close to the end of March leaving little flexibility) due to capacity.

Conversations have already been initiated with colleagues across WYAAT and independent providers to source support for capacity and potential transfer of patients. Further to this Locum consultant support for undertaking additional, work on a Saturday.

Additional theatre lists at a weekend
Significant progress has been made in engaging with clinicians to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery and Urology. The first theatre lists will start on Saturday the 15th January. Staffing in theatres continues to be challenging with vacancies gaps and covid related sickness but there is now a greater up take for covering additional theatre lists in the evening and at weekends.

The Target Risk is 6 (3x2) – March 2023, amended from March 2021

The Current Risk is 12 (3x4) – January 2022. This is the same rating as December 2021

2.5 CRR57 – Safeguarding Demand

The levels of activity in relation to safeguarding have remained at the raised levels identified in the Covid Recovery period. There have been no significant further increases other than a recent increase in the number of strategies in the Middlesbrough area.
The OPEL level process was introduced and piloted in Quarter 2-3 and has now been formalised and rolled out across 0-19/ safeguarding. All areas are at OPEL level 3 other than Darlington which is at OPEL level 2

Pressures remain within the workforce however the robust systems and processes that are now embedded into service delivery, pressures in relation to safeguarding have not escalated. Due to the uncertainty regarding the national policy in relation to further lockdowns, the risk level remains the same.

Of note is that national guidance of safeguarding in relation to high profile cases (Artur and Star) note that there should be no further deployment of 0-19 / safeguarding staff. The National Review of Safeguard in Infants advices further endorsement of ICON principles at 3-5 weeks and by GPs at 6-8 weeks. As such the 0-19 teams will utilise push notifications through text messages at 3-5 weeks and 6-8 weeks to reinforce ICON information to be compliant with advice.

Target risk is 8 (2x4) with an amended date of March 2022 (originally July 2021)

Current risk is 16 (4x4) – January 2022. This is the same rating as December 2021.

2.6 CRR61 – ED 4-hour Standard

A&E 4-hour standard remained below the 95% standard in December 2021. Significant improvement in 6-hour harm indicator was seen (790>6 hour stays total for December) which equates to 7.7 harms due to longer stay in December. 12 hour breaches did occur in December 2021 over 3 days in December with 6-8, 12 hour breaches each day. With regards to Ambulance handover performance, there were an average of 1 > 60-minute handover per day, and 4 > 30 minute delays in December.

A deterioration was noted in November and December as bed occupancy and COVID numbers increased. Pressures were also noted due to workforce challenges.

In terms of further mitigation, a business case for a new walk in streaming model is in development. A full action plan developed from the kaizen event is in the process of being implemented. Hospital flow programme to support ED flow has also commencing. In was noted that capital works over next 6 months had been initiated to centralise acute services at the front door and provide enhanced access to diagnostics.

The Target Risk is 6 (3x2) – March 2022. This is a change in target risk from 8 (4x2)

The Current Risk is 15 (3x5) – January 2022. This is the same rating as December 2021.

2.7 CRR63 – Violence and Aggression (ED)

The number of incidents relating to violence and aggression were:

- Datix incidents for aggression in the ED – 31 episodes through July
- Datix incidents for aggression in the ED – 28 episodes through August.
- Datix incidents for aggression in the ED – 12 episodes through September.
- Datix incidents for aggression in the ED – 8 episodes through October.
- Datix incidents for aggression in the ED – 11 episodes through November.
- Datix incidents for aggression in the ED – 9 episodes in December.

A review of security has taken place, and the following controls have been 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 has also engaged with the police to seek advice on the organisational approach. This should address the majority of the current gaps in control.

Staff body cams have been scheduled to be piloted in the ED January 2022 and the ED Manager is currently looking at an adapted SOP and will confirm the date to proceed supported by the LSMS Managers.

Emergency Security Response training (PMVA Level 2 equivalent) has now been completed for all Charge-hands and Deputy Charge-hands. A progressive roll out/refresher of Conflict resolution & De-escalation training is also continuing for both Healthcare Portering and HDFT colleagues.

The Target Risk is 8 (2x4) – February 2022 - target risk rating changed from September 2021

The Current Risk is 12 (3x4) – January 2022 this is the same as December 2021

2.9 Health and Safety

Following discussions at the November 2021 Trust Board the Director of Finance and the Company Secretary agreed to undertake a gap analysis of the governance arrangements regarding Health and Safety. This is due to be submitted to the January 2022 Trust Board in Private. Initial recommendations, include a revised agenda for the Health and Safety Committee that includes discussions on RIDDOR, COSH, Risk Assessments and training compliance.

In addition, a Health and Safety Manager job description has been drafted and is currently being reviewed for banding. Once this has been completed the post will be advertised.

In addition, the Deputy Director of Estates commences in post on 10th January 2022. This will provide additional expertise to develop an action plan to reduce the levels of risk.

The Target Risk is 8 (4x2) – March 2022 – revised from December 2021

The Current Risk is 16 (4x4) – January 2022, this rating is the same as December 2021.

2.10 Pharmacy Aseptic

It was agreed at the January 2022 Executive Risk Management Group that a Pharmacy Aseptic risk would be submitted onto the corporate risk register.

It was noted that there is a risk to service delivery that the Trust is not able to provide some cancer and other treatments because HDFT have to close (or external regulators direct us to close) the Aseptic Production Unit at short notice because we are unable to maintain QA standards because the transfer hatches, air handling unit do not meet the required standards. Due to capacity constraints in NHS and private sector aseptic production units it is unlikely that we would be able to source all products externally.

There is a risk to patient safety because QA standards for the aseptic production of medicines may not be met because the transfer hatches and air handling unit do not meet the required standards.

There is a risk to staff safety due to exposure to substances harmful to health because the transfer hatches and air handling unit do not meet the required standards.

There is a financial risk if the unit has to close because we would have to seek external provision of medicines which is likely to be at increased cost.

The Target Risk is 4 (1x4) – March 2023

The Current Risk is 12 (3x4) – January 2022 (New Risk)

3.0 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Company Secretary

January 2022

Board of Directors (Public)
26th January 2022

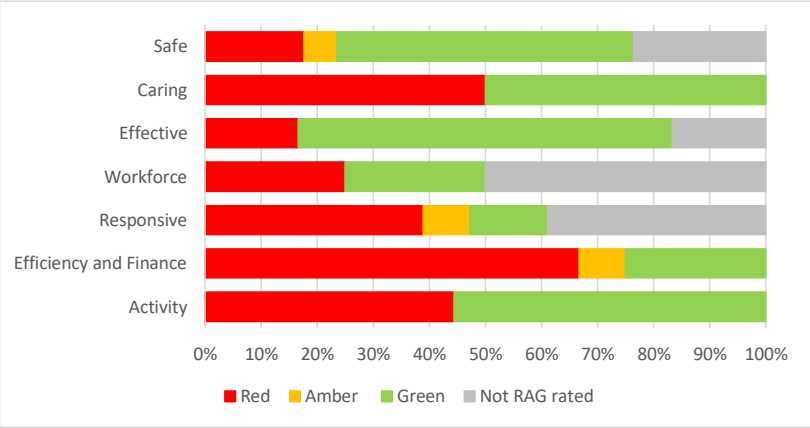
Title:	**Integrated Board Report**
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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 - December 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	3	1	9	4
Caring	4	2	0	2	0
Effective	6	1	0	4	1
Workforce	8	2	0	2	4
Responsive	36	14	3	5	14
Efficiency and Finance	12	8	1	3	0
Activity	9	4	0	5	0
Total	**92**	**34**	**5**	**30**	**23**



NHS System Oversight Framework (SOF) 2021/22

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 were expected in August but have not yet been published.

6. We have recently received confirmation from NHS England and NHS Improvement that HDFT has been placed in **Segment 2**. This indicates that there are targeted areas of challenges with plans in place that have the support of system partners.

Integrated Board Report - Summary of Dec-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	0.90
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.76
Safe	1.3	Inpatient falls per 1,000 bed days	7.7
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	1
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	33.88
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	2
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	88.0%
Safe	1.8.2	Safer staffing levels - CHPPD	7.4
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	99.3%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	4.6%
Safe	1.12	Infant health - % women initiating breastfeeding	85.9%
Safe	1.13	VTE risk assessment - inpatients	96.3%
Safe	1.14.1	Sepsis screening - inpatient wards	92.3%
Safe	1.14.2	Sepsis screening - Emergency department	92.9%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	94.0%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	95.4%
Caring	2.2.1	Complaints - numbers received	19
Caring	2.2.2	Complaints - % responded to within time	53%
Effective	3.1	Mortality - HSMR	96.84
Effective	3.2	Mortality - SHMI	0.96
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	1.5%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	7.3%
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	20.4%
Workforce	4.1	Staff appraisal rate	59.8%
Workforce	4.2	Mandatory training rate	85.0%
Workforce	4.3	Staff sickness rate	5.42%
Workforce	4.4	Staff turnover rate	13.7%
Workforce	4.5	Children's Services - 0-19 Services - vacancies	66.64
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	10
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	42
Responsive	5.1.3	RTT Incomplete pathways - total	23464
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1130
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	47
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	82.4%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	92.8%
Responsive	5.6	A&E 4 hour standard	68.9%
Responsive	5.7	Ambulance handovers - % within 15 mins	88.4%
Responsive	5.8	A&E - number of 12 hour trolley waits	23
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	83.2%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	3
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	87.3%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	79.1%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	97.2%

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	Children's Services - Safeguarding caseload	
Responsive	5.15	Children's Services - Ante-natal visits	76.1%
Responsive	5.16	Children's Services - 10-14 day new birth visit	96.1%
Responsive	5.17	Children's Services - 6-8 week visit	89.2%
Responsive	5.18	Children's Services - 12 month review	93.9%
Responsive	5.19	Children's Services - 2.5 year review	92.5%
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	2/3
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	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	28.5%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	83.3%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 500
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-
Efficiency and Finance	6.3	Capital spend	£ 11,503
Efficiency and Finance	6.4	Cash balance	£ 46,027
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	152
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	65
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	61.6
Efficiency and Finance	6.7.1	Length of stay - elective	2.78
Efficiency and Finance	6.7.2	Length of stay - non-elective	5.76
Efficiency and Finance	6.8	Avoidable admissions	253
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	84.7%
Efficiency and Finance	6.10	Day case conversion rate	1.6%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	111.5%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	104.0%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	95.2%
Activity	7.3.1	Elective activity against plan	104.8%
Activity	7.3.2	Elective activity against 2019/20 baseline	84.6%
Activity	7.4.1	Non-elective activity against plan	89.4%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	88.8%
Activity	7.5.1	Emergency Department attendances against plan	91.4%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	96.1%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-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	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.06	0.61	0.74	0.90	EN	Quality	tbc		
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.38	1.36	0.61	1.01	1.25	0.66	0.56	0.89	1.76	EN	Quality	tbc		
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.4	8.6	6.0	7.6	7.7	EN	Quality	above HDFT average for 2020/21 (7.7)	0-20% below HDFT average for 2020/21 (7.7)	>20% below HDFT average for 2020/21 (6.2)
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	1	0	0	1	2	4	1	EN	Quality	>19 YTD		<=19 YTD
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	50.76	66.71	33.88	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)	All	3	1	4	1	3	0	0	1	2	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	0	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	86.2%	89.6%	88.0%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	7.5	7.4	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	99.3%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC										EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	7.2%	4.6%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	88.2%	85.9%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	96.8%	96.3%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	89.8%	92.3%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	92.5%	92.9%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	92.7%	94.0%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	90.5%	95.4%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	31	19	13	9	19	EN	Quality	above HDFT average for 2020/21 (16)		On or below HDFT average for 2020/21 (16)
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	53%	53%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.45	95.61	91.58	95.56	98.45	99.68				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.964	0.978	0.988	1.008	1.021					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 - as % of all elective admissions	All	1.9%	1.6%	1.7%	1.8%	2.1%	1.7%	2.0%	1.5%		RN	Resources	> 3%	2% - 3%	<= 2%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	9.5%	8.2%	7.3%	8.2%	8.4%	7.9%	7.9%	7.3%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC										RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	7.4%	20.4%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	58.2%	59.8%	AW	People and Cult	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	85.0%	85.0%	AW	People and Cult	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	5.53%	5.42%	AW	People and Cult	>3.9%		<=3.9%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	13.8%	13.7%	AW	People and Cult	>15%		<=15%
Workforce	4.5	Children's Services - 0-19 Services - vacancies	CC			33.99	33.54	36.94	35.33	36.21	37.28	66.64	AW	People and Cult	tbc		
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting	All										AW	People and Cult	tbc		
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting	All										AW	People and Cult	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	9	10	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	41	42	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	22714	23464	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1196	1082	993	968	932	1008	1037	1063	1130	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	34	47	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All										RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All										RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All										RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	86.1%	82.4%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	All										RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	94.5%	92.8%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	76.0%	68.9%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	92.8%	91.8%	86.5%	87.6%	89.1%	92.8%	86.1%	89.2%	88.4%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	2	23	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	89.1%	81.2%	78.5%	83.2%	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	LTUC	3	2	2	5	2	6	3	3	3	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.8%	88.2%	83.4%	86.0%	92.2%	83.8%	82.5%	87.3%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.7%	68.7%	70.3%	73.9%	73.4%	78.7%	77.4%	79.1%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.6%	99.0%	100.0%	97.2%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC										RN	Resources			
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC										RN	Resources			
Responsive	5.14	Children's Services - Safeguarding caseload	CC										RN	Resources			
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	83.9%	78.2%	76.1%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.4%	92.5%	96.1%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.3%	88.8%	89.2%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.4%	93.8%	93.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	91.0%	92.3%	92.5%	RN	Resources	<75%	75% - 90%	>=90%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC										RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC										RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC									2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness	CC										RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported	CC										RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC										RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC									3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20	LTUC	36.7%	35.5%	39.9%	38.6%	34.5%	40.6%	40.3%	38.5%	28.5%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	97.4%	90.5%	86.7%	83.3%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	£ 485	£ 500	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	-	-	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	£ 10,861	£ 11,503	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	£ 40,119	£ 46,027	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	151	152	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	67	65	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	50.8	53.9	50.7	55.3	56.4	52.8	60.5	58.4	61.6	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	2.35	2.78	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	5.26	5.76	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	264	227	206	236	253		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	81.0%	84.7%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	1.1%	1.6%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	95.4%	94.1%	113.1%	99.6%	101.1%	112.0%	97.1%	109.1%	111.5%	RN	Resources	<95%		>=95%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	103.2%	111.6%	104.0%	RN	Resources	<95%		>=95%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	80.1%	100.6%	95.2%	RN	Resources	<95%		>=95%
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.4%	104.1%	104.8%	RN	Resources	<95%		>=95%
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.9%	79.7%	84.6%	RN	Resources	<95%		>=95%
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.2%	87.1%	89.4%	RN	Resources	<95%		>=95%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.1%	84.1%	88.8%	RN	Resources	<95%		>=95%
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.5%	99.2%	91.4%	RN	Resources	<95%		>=95%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.5%	104.3%	96.1%	RN	Resources	<95%		>=95%

Integrated Board Report - December 2021

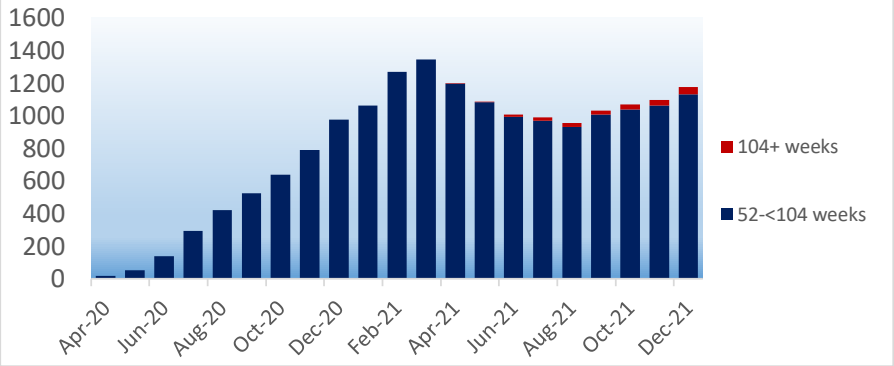
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	1110

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

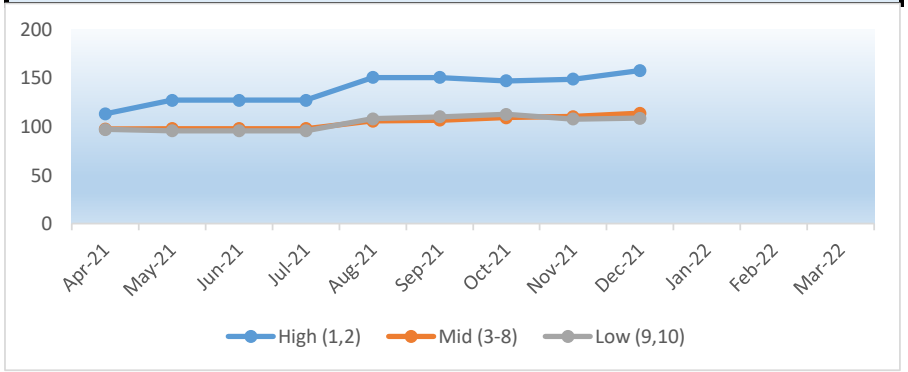
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Current end of financial year target is to reduce this figure to below 950 patients.

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

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

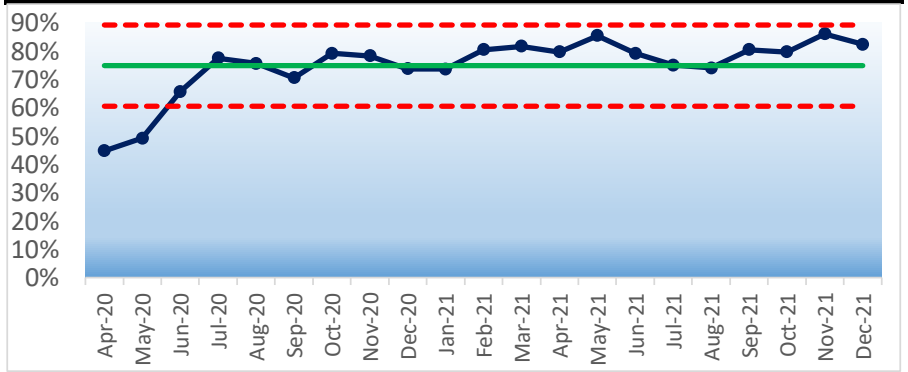
The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. 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	Dec-21
Value / RAG rating	82.4%

Indicator description

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

SPC chart



Narrative

82% of patients were waiting less than 6 weeks for a diagnostic test at end December against a 99% target.

There were 742 over 6 week breaches, of which 552 were waiting for a Dexa scan. Extra kit ordered and being delivered in December 21. Echocardiography demand remains significantly higher than pre-covid with a significant number waiting over 6 weeks. Additional support from a locum has added 55 scans per week of capacity which is reducing the waiting list. Compliance forecast by end of Feb 22.

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	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

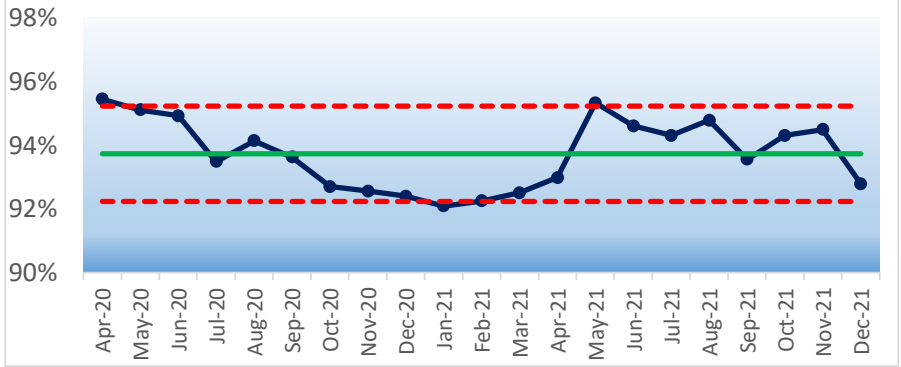
A data quality exercise is underway to review the follow up outpatient waiting list data and to understand the full scope of this problem and determine how many patients still require a follow up appointment. This work includes reviewing the way that we store and retain information from our follow up waiting lists to enable easier reporting of historical data. It is likely that we will refine the metric for reporting in this report as part of this work.

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	92.8%

Indicator description

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

SPC chart



Narrative

The Trust remains below the required standard of 97%. A revised focus on ethnicity data collection is underway, this measure is monitored at Trust weekly access meetings.

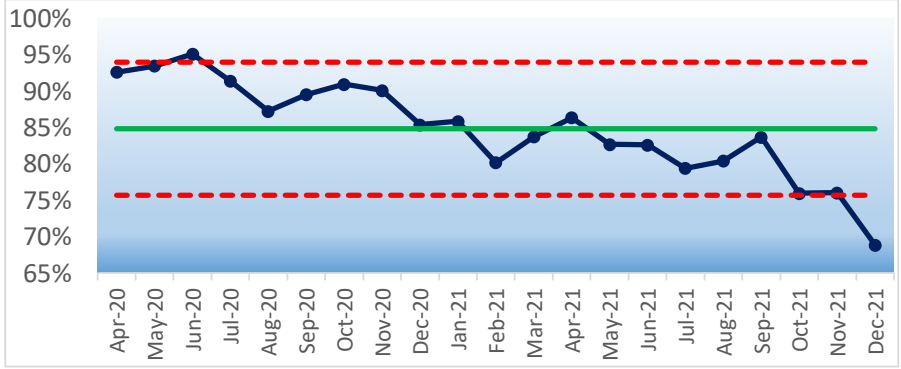
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions that we will join once details shared
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process.
- Exploring option of sending electronic forms to patients for completion and return.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	68.9%

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 remains below the 95% standard and deteriorated in December reflecting the significant pressures over the period with high bed occupancy relating to discharge challenges and staff absenses. Current work underway to improve this posisiton:

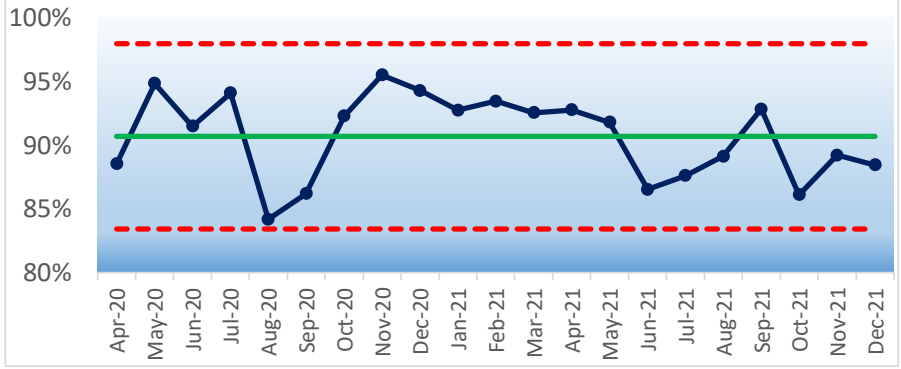
- delivering 7 day SDEC to provide alternatives to ED attendance;
- agreed a direct to SDEC pathway with YAS to divert patients to the right place, first time rather than unnecessary ED contacts;
- staffing a minors stream wherever possible to reduce the bottle neck at the front door and release senior clinicians to see patients with higher level treatment needs;
- ran a Perfect Fortnight at the beginning of January to enable admin and managers to support the wards to facilitate flow;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising SDEC opportunities;
- educating other specialties to avoid using ED as their triage and assessment service;
- increased GP Out of Hours provision to avoid Primary Care attendance.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	88.4%

Indicator description

The percentage of ambulance patients who were handed over to Emergency Department staff within 15 mins.

SPC chart



Narrative

88% of ambulance handovers took place within 15 minutes in December. There were 26 over 30-minute handover breaches including one over 60-minute breache in December which has been reviewed and the patient did not come to harm. Despite poor performance, there remains a focus on releasing ambulance crews rapidly and performance remains significantly higher than surrounding organisations.

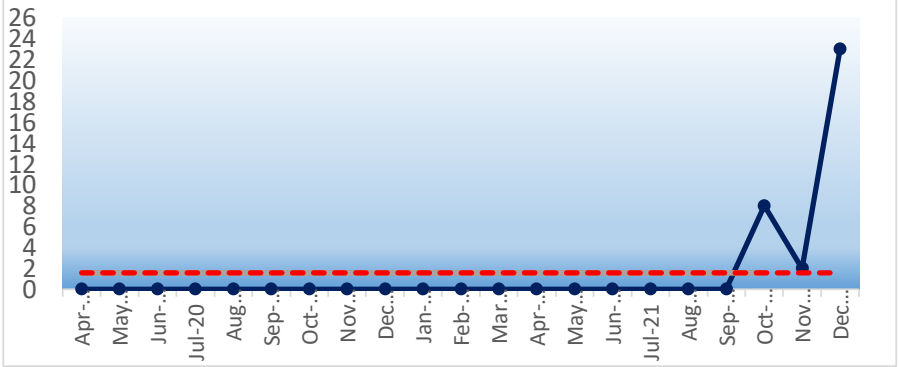
Actions included in wider UEC plan for focussed improvement.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	23

Indicator description

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

SPC chart



Narrative

In December where we reported 23 over 12 hour trolley waits, this was in line with the national picture and was related to very high bed occupancy, high staff absence coupled with significant challenges in community care provision resulting in poor outflow from the ED department.

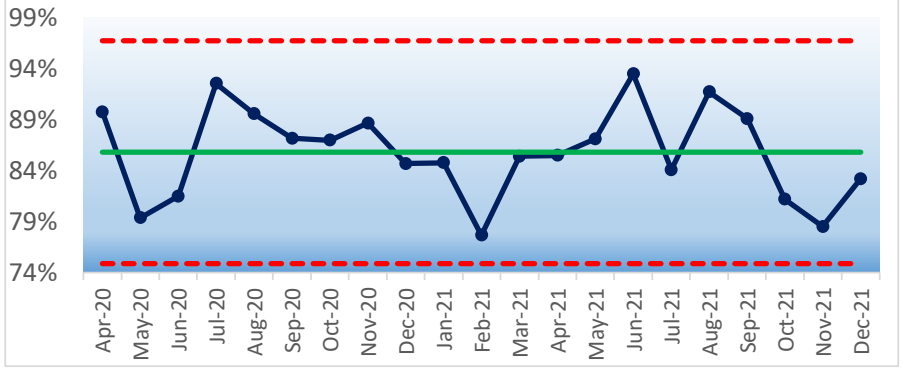
A strong focus on flow, combined with stabilised ED attendance,s has facilitated an improved position in January to date, although the ED continues to see long stays between 4 and 12 hours due to high bed occupancy from ongoing discharge challenges within social care partners.

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	Dec-21
Value / RAG rating	83.2%

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 not delivered in December for the third consecutive month (83.2%). There were 62.5 accountable treatments (75 patients) in December with 10.5 treated outside 62 days. Of the 10 tumour sites treated in December, performance was below 85% for 6 (Breast, Gynaecology, Haematology, Colorectal, Lung, and Upper GI). All pathway delays will be reviewed by the breach panel at the end of January.

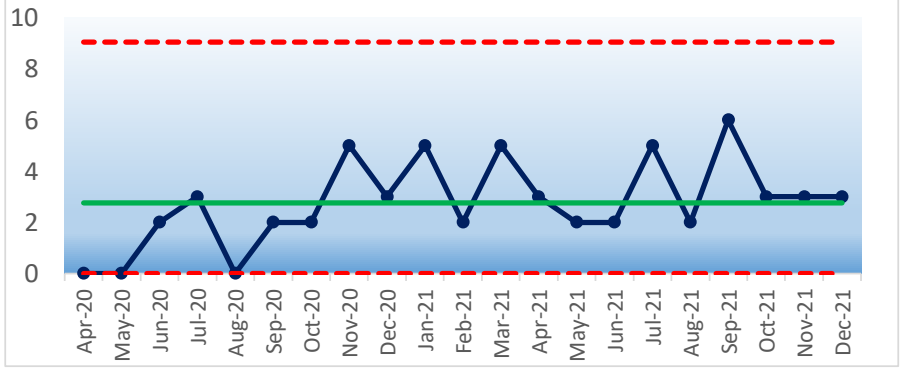
Provisional data indicates that 61.1% (11/18) of patients treated at tertiary centres in December were transferred for treatment by day 38, which is an improvement on last month (47.4%).

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	Dec-21
Value / RAG rating	3

Indicator description

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

SPC chart



Narrative

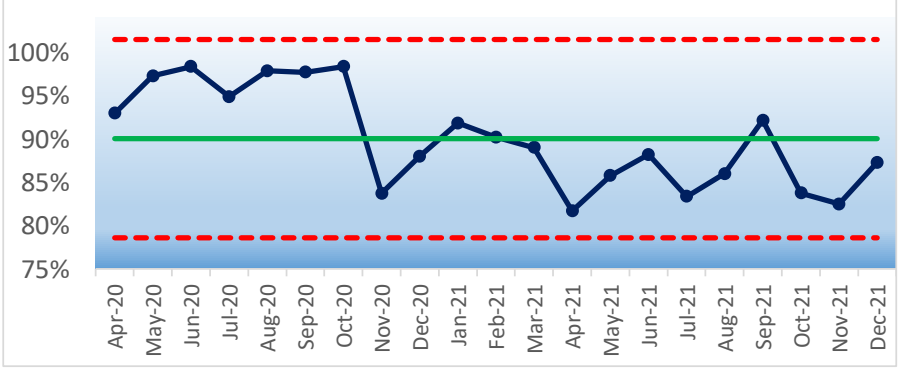
3 patients waited 104+ days for treatment in December (1 x Harrogate Lung; 1 x Harrogate Colorectal, 1 x Leeds Upper GI). The Leeds patients was transferred after day 38 (day 44) but the pathway was then further delayed at Leeds as the patient required further diagnostics and then surgical/oncology assessement. The 2 other delays were predominately due to diagnostic/medical complexity, and both required input from the teams at Leeds before being returned to HDFT for treatment. All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of January.

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	Dec-21
Value / RAG rating	87.3%

Indicator description

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

SPC chart



Narrative

927 patients attended their first appointment for suspected cancer in December - 118 patients were seen after day 14 (compared to 176 last month) and of these 27 were Breast referrals, 45 were Lower GI referrals, and 23 were Urology referrals. GI capacity remains a challenge due to the rise in the number of patients referred who aren't appropriate to go straight to test and require outpatient review. Concurrently, periods of staff sickness has led to a reduction in outpatient capacity. A Colon Capsule Endoscopy (CCE) service has been established, but updated NG12 referral guidance is awaited before patients can be optimally triaged between traditional endoscopy and CCE. Urology continues to be a challenge mainly due to staff absence and an increase in referrals in December and capacity issues are continuing into January. However, plans are in place to improve performance towards the end of January by prioritising workload and outpatient clinic utilisation with additional capacity scheduled in January.
The breast 2WW standard has deteriorated slightly in December (63.5%). The position is expected to improve in January and current data indicates that peformance is above 93%. A YMS hybrid clinic has been set up for 22nd January as the data suggests referral rates increase again mid-late January.

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	Dec-21
Value / RAG rating	79.1%

Indicator description

From October 2021, 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

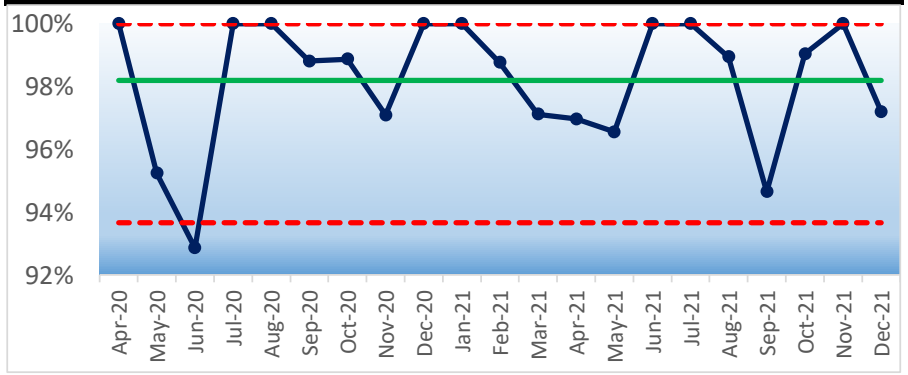
Provisional data indicates that combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has improved in recent months and in December was above the proposed operational standard of 75%. Whilst Screening is still significantly below 75% performance has improved slightly in recent months, and both 2WW standards remains above 80%.

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	Dec-21
Value / RAG rating	97.2%

Indicator description

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

SPC chart



Narrative

Provisional data indicate that 107 patients received First Definitive Treatment for cancer at HDFT in December which is at a similar level to the number of patients treated in recent months. 3 patients were treated outside 31 days of decision to treat (all colorectal) but overall peformance was above the expected standard of 96%. Challenges continue for colorectal surgery resulting in 31 day breaches, both in terms of theatre and staffing capacity.

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	**5.14 - 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	Dec-21
Value / RAG rating	76.1%

Indicator description

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

SPC chart

Narrative

76% of eligible pregnant women received an initial antenatal visit in December.

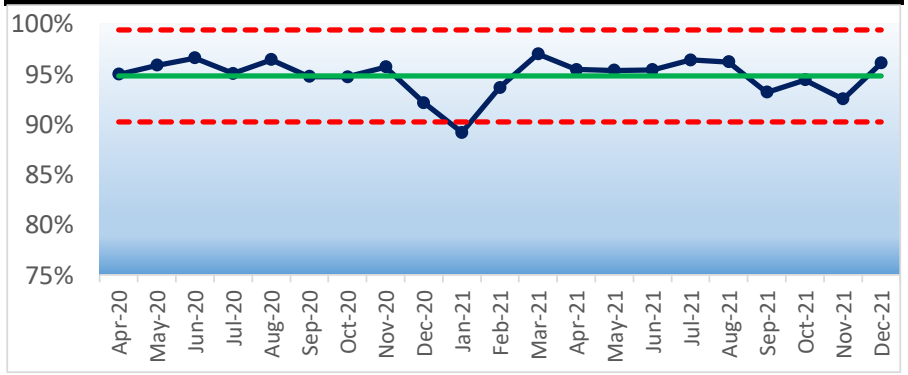
Data for Northumberland will be included from next month.

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	Dec-21
Value / RAG rating	96.1%

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

96% of infants received a new birth visit within 10-14 days of birth during December.

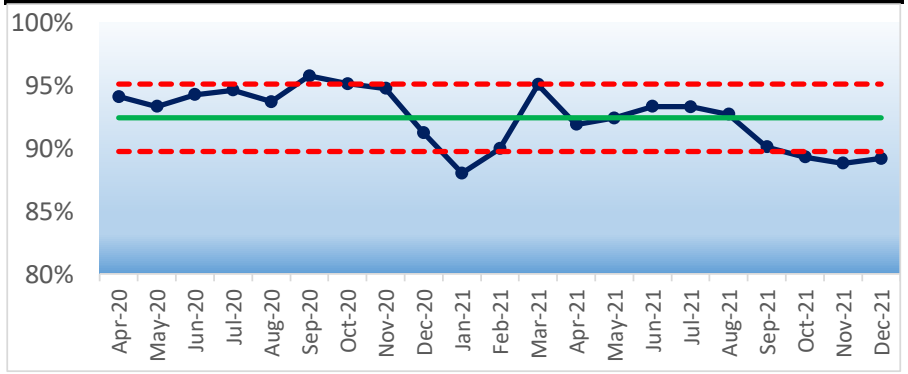
Data for Northumberland will be included from next month.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	89.2%

Indicator description

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

SPC chart



Narrative

89% of infants received a 6-8 week visit by 8 weeks of age during December.

Data for Northumberland will be included from next month.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	93.9%

Indicator description

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

Narrative

94% of eligible children received a 12 month review by 15 months of age during December.

Data for Northumberland will be included from next month.

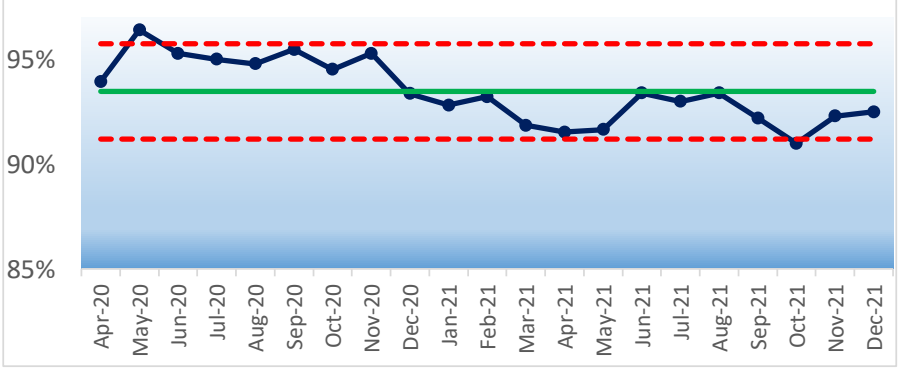
SPC chart

Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	92.5%

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

93% of eligible children received a 2-2.5 year review by 2.5 years of age during December.

Data for Northumberland will be included from next month.

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

A one-off audit was carried out on North Yorkshire data in 2021 which looked at children born in 2017/18 and how many mandated contacts they had received. This showed that 62% of children had received all mandated contacts. 0.4% of children were recording as not having had any mandated contacts. A list of these children was shared with service managers to follow up.

The intention is to repeat this audit annually and extend to include all localities covered by HDFT's Children's Services.

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

CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The overall position for December was the following services were reporting level 2 - Darlington, Stockton and Northumberland 0-19 Services and the following services were reporting level 3 - Sunderland, Gateshead, Durham, Middlesbrough and North Yorkshire 0-19 Services, Safeguarding and Acute Paediatrics.

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

The NHS Operational Planning and Contracting Guidance 2021/22 set out the first stage for implementing the community two-hour crisis response standard in England by March 2022. All integrated care systems (ICSs) in England must ensure that crisis response care is available to all people within their homes or usual place of residence, including care homes, within two hours.

The Trust is currently preparing to be able to report this data from March 2022 onwards.

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

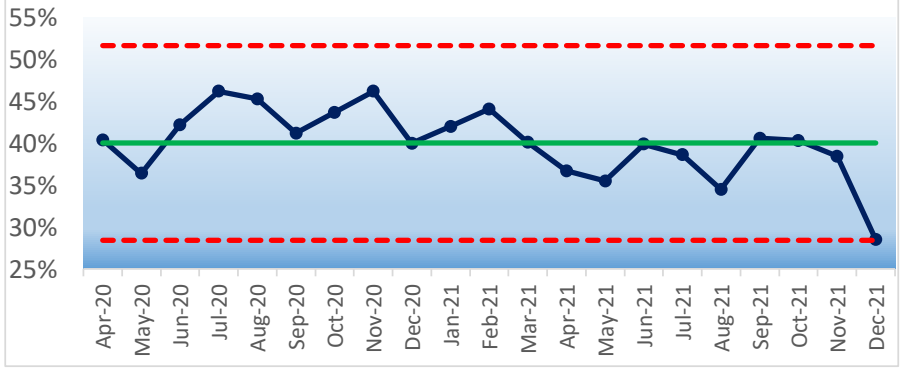
CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The overall position for December was level 3 for Adult Community Services.

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	Dec-21
Value / RAG rating	28.5%

Indicator description

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

SPC chart



Narrative

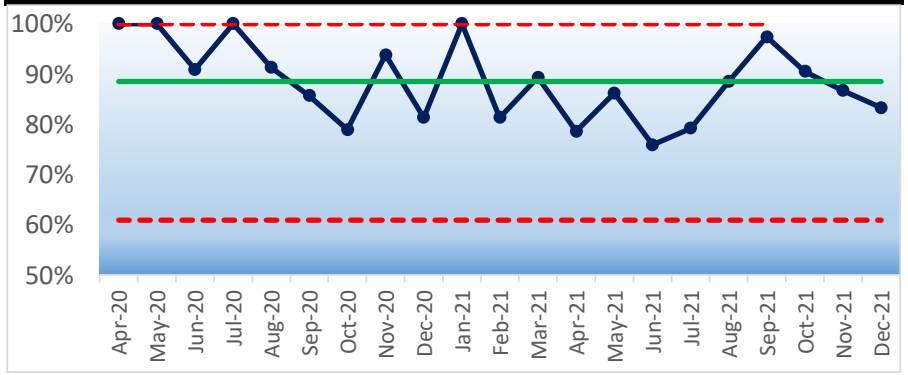
In December, 29% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target.

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	Dec-21
Value / RAG rating	83.3%

Indicator description

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

SPC chart



Narrative

In December, 83% of urgent GPOOH cases received a home visit face to face consultation within 2 hours. There has been an increase in the number of face to face consultations requested as the country moves out of the most recent Covid wave and demand and capacity planning is underway looking to see if the 95% target is achievable with the increase.

Integrated Board Report - December 2021

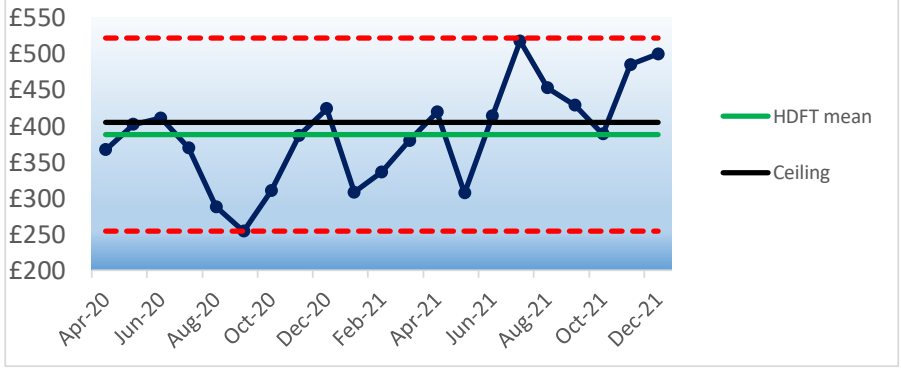
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	£500

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

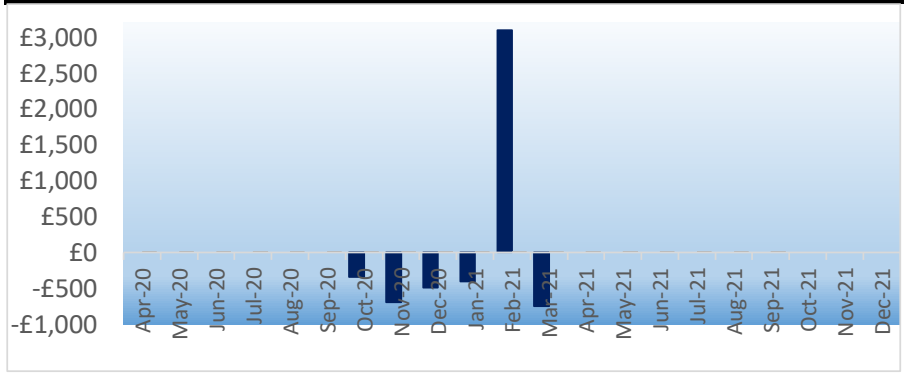
Agency spend continues to be significant. Having reviewed our agency suppliers, we have included a specific supplier of theatre staff that had previously been omitted, and have restated the agency costs for the year to date. Particular medical staffing pressures in LTUC predominantly, with an excess cost (the cost incurred in December compared to having a person in post on average salary) of c£140k. Work is ongoing through the planning process to review and identify specific actions to reduce reliance on this form of temporary workforce.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-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

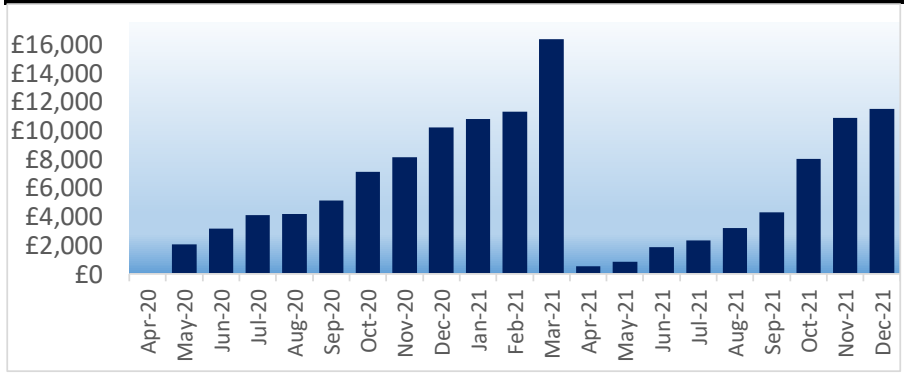
We continue to deliver a break-even position against our plan, and are forecasting delivering our plan at the end of the financial year.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	£11,503

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

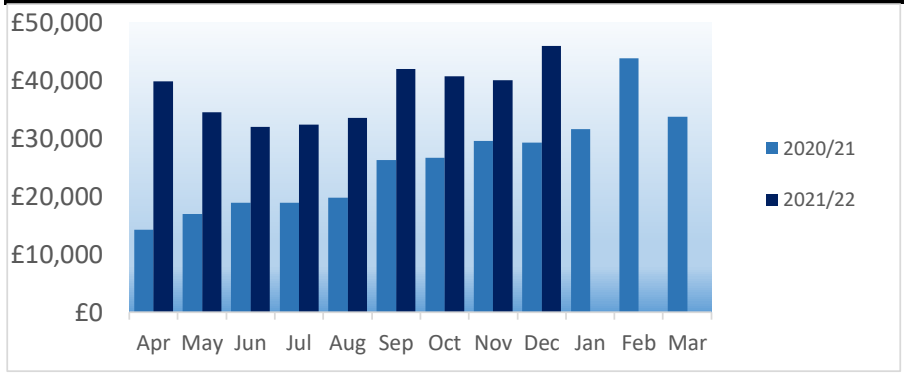
Capital spend remains behind plan. The forecast currently is to have slippage of c£4m at the end of the year without further action. This is partly related to additional resources being released to HDFT recently. There are a series of options now being created that will be brought for discussion to Resources Committee this month, including bringing forward equipment replacement from future years and repaying some of our loans, with the intention of creating headroom from 2022/23 onwards.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	£46,027

Indicator description

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

Trend chart



Narrative

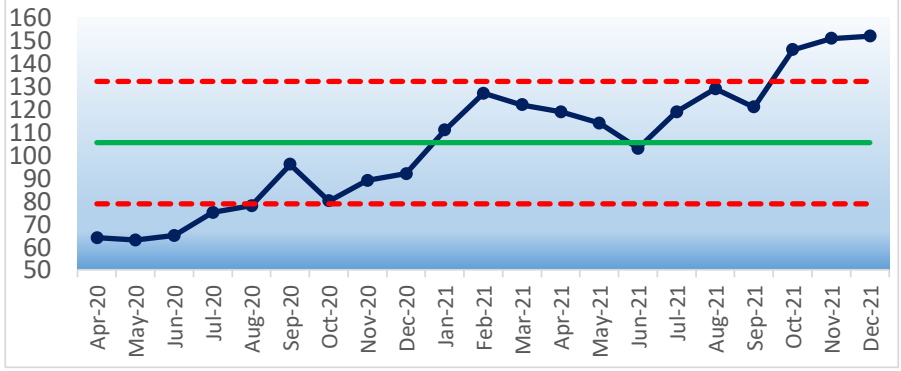
The cash balance continues to be strong and we continue to pay and receive cash in a timely manner.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	152

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

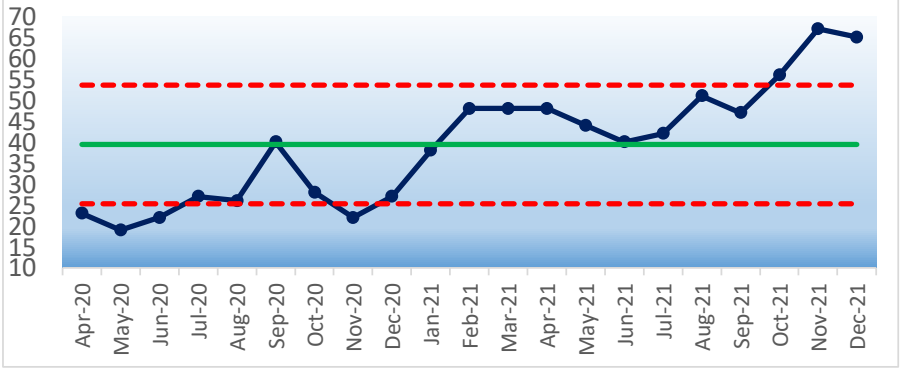
The number of long stay patients (> 7 days) remained static in December.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	65

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

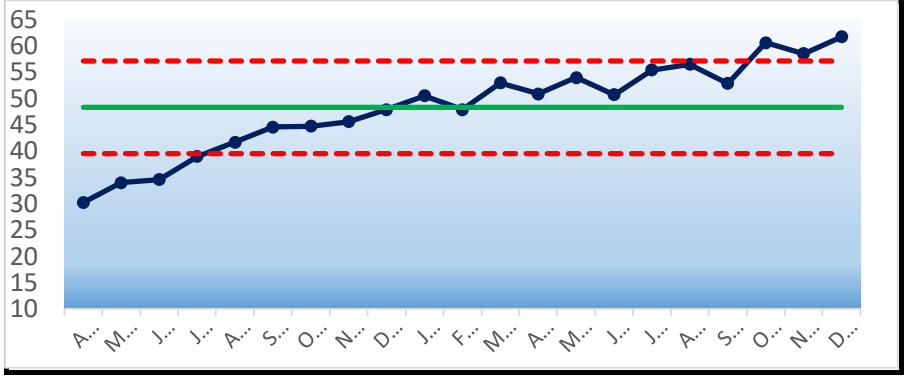
The number of long stay patients (> 21 days) decreased in December but remains above average.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	61.6

Indicator description

The number of occupied bed days expressed per 1,000 population, using the mid-2020 population estimate for Harrogate.

SPC chart



Narrative

As can be seen on the chart, occupied bed days have steadily increased since the start of the pandemic period. By comparison, in the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8 and now the Trust are at 61.6 highlighting some of the flow issues.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	2.8

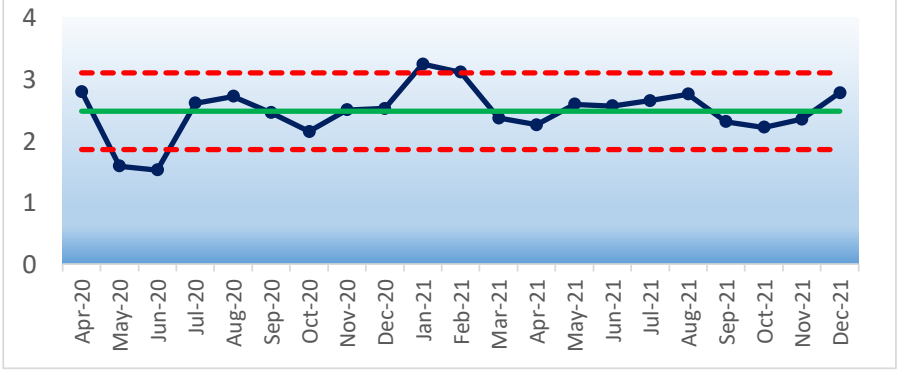
Indicator description

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

Narrative

Elective length of stay increased in December and is now above our local stretch target of 2.5 days.

SPC chart



Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	5.8

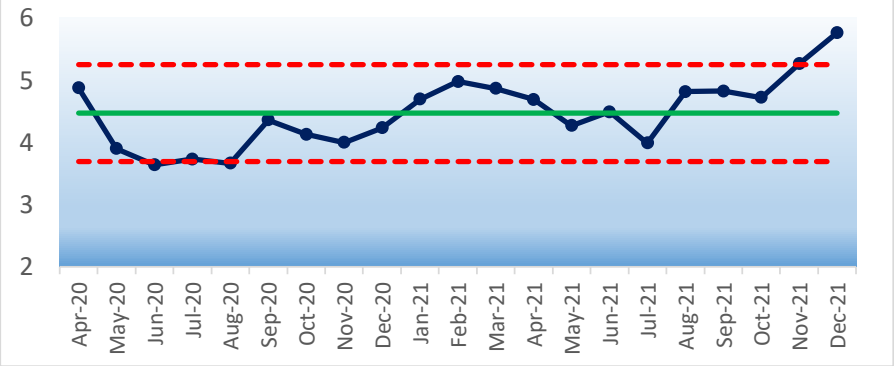
Indicator description

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

Narrative

Non-Elective length of stay increased to 5.8 days in December, mainly impacted by issues with outflow and social care.

SPC chart

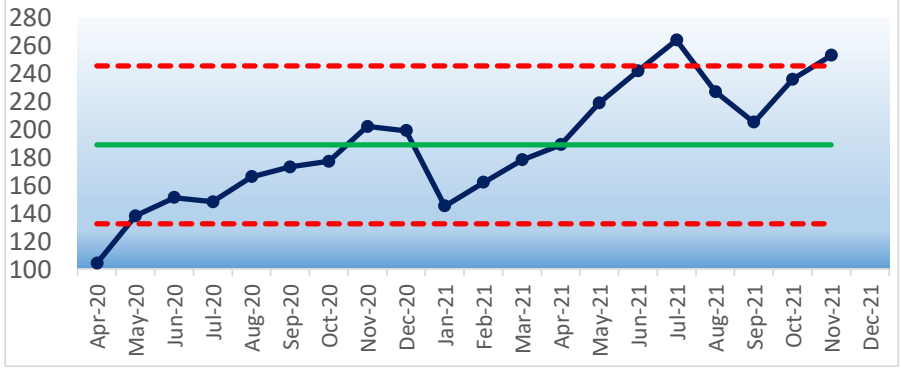


Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-21
Value / RAG rating	253

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 253 avoidable admissions in November. The most common diagnoses were urinary tract infections, pneumonia and gastroenteritis. Excluding children and admissions via CAT/SDEC, the figure was 138.

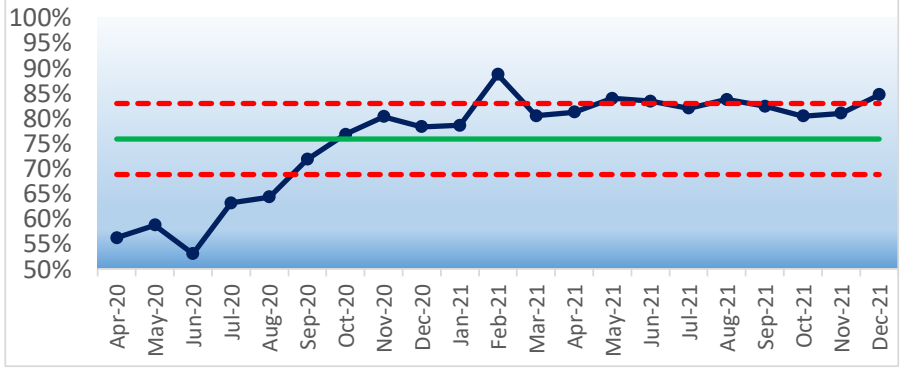
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	84.7%

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 increased in December but remains below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	1.6%

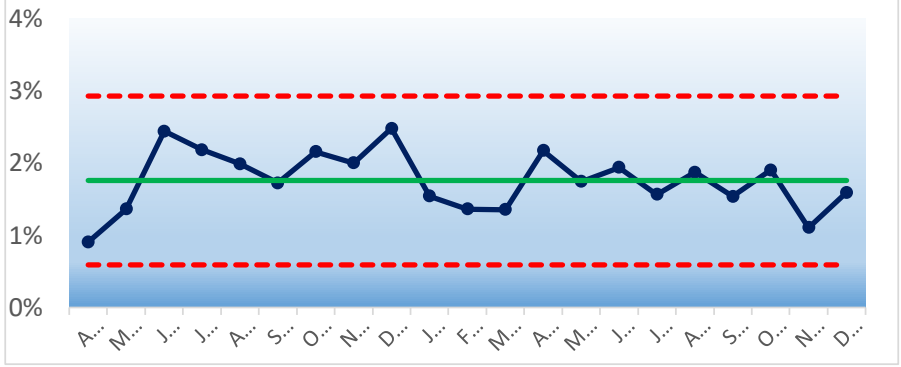
Indicator description

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

Narrative

1.6% (36 patients) of intended day cases stayed overnight or longer in December.

SPC chart



Integrated Board Report - December 2021

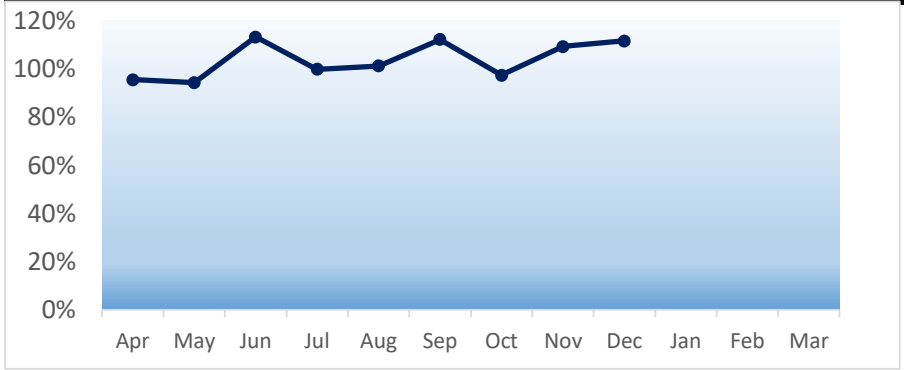
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	111.5%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

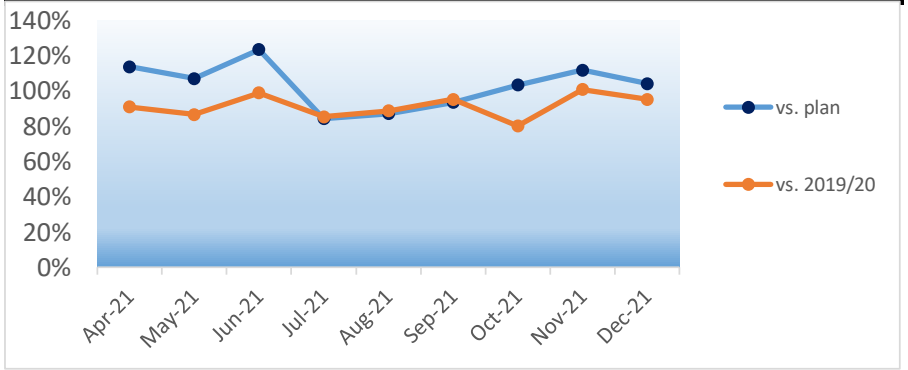
In December, GP referrals were 11% above the equivalent month on 2019/20. On a year to date basis, GP referrals are 3% above 2019/20 levels.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	104.0%

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 4% above plan in December.

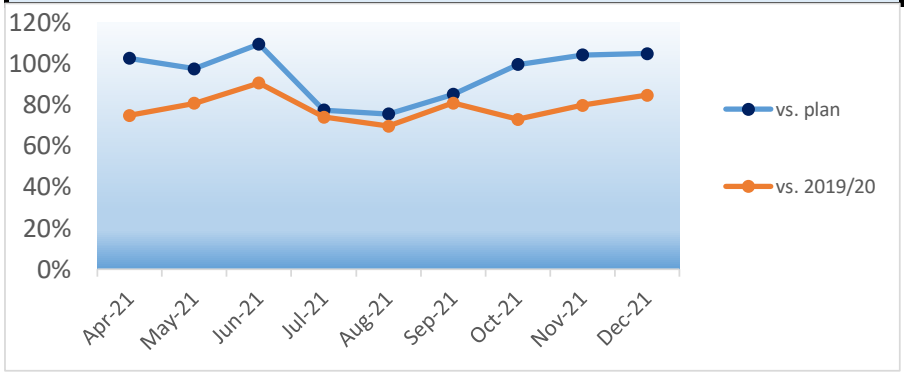
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	104.8%

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 were 5% above plan in December.

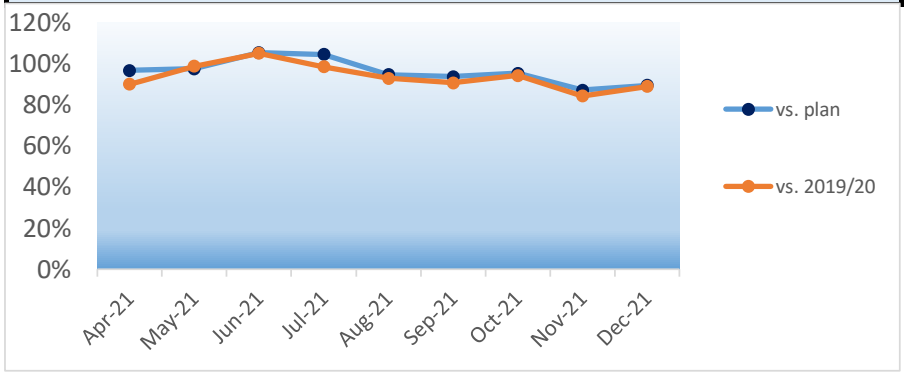
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	89.4%

Indicator description

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

Trend chart



Narrative

Non-elective activity was 11% below plan in December.

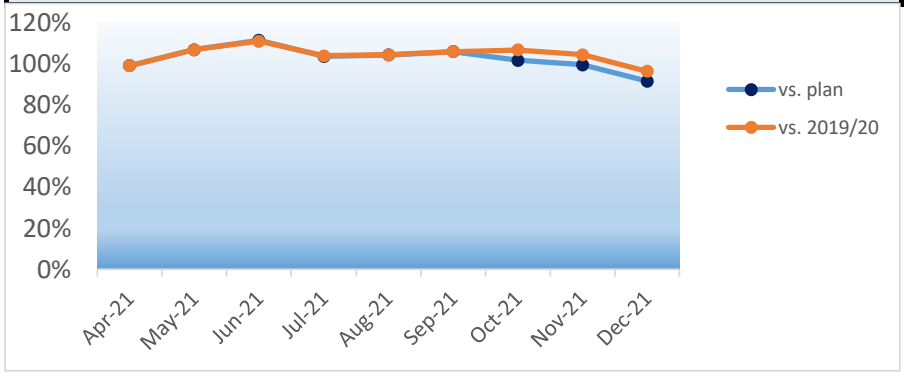
Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	91.4%

Indicator description

Emergency Department attendances against plan and 2019/20 baseline.

Trend chart



Narrative

Emergency Department attendances were 9% below plan in December.

Please note that the plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

3.3

Board of Directors (Public)
26th January 2022

Title:	**Finance Position Month 9**
Responsible Director:	Finance Director
Author:	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 as at the end of October 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	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	
	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	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	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	None	
Report History:	Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.	
Recommendation:	The Board is asked to note and discuss the contents of this report.	

Director of Finance 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
- Agency spend continues in a number of medical specialties
- There is slippage within our capital programme
- The identified efficiency programme for H2 still has c£1.5m of non-recurrent savings at this stage.
- Expected reduction in income of c£9m for 22/23 related to a reduction in CoVid support, the requirement to deliver productivity savings, and a return to a much tighter financial regime next year.

Major actions commissioned & work underway

- Continued focus on delivering our capital programme against the identified resources
- Develop options internally and with the ICS in respect of utilising the full CDEL available
- Refresh the process for use of temporary & agency staff, and the use of off-framework payments
- Financial planning process: resolving the non-recurrent CIP position, review any future CoVid support funding, identifying future productivity, assessing activity plans against ERF, identifying resource availability before undertaking any investment proposals.
- Liaising with the system with regards to allocation of resources for 22/23

Positive news & assurance

- Delivery of the financial plan to date and forecast delivery for H2
- Cash availability and management continues to be positive
- A full efficiency programme has now been identified and is forecast to be delivered (see concern above re level of reliance on non-recurrent measures)

Decisions made & decisions required of the Board

- n/a

Harrogate and District NHS Foundation Trust

Resources Committee
Financial Position – December 2021

1. Purpose of the report

This paper has been developed to update the Resources Committee on progress against the annual Financial Plan. The Resource 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.

2. Introduction

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

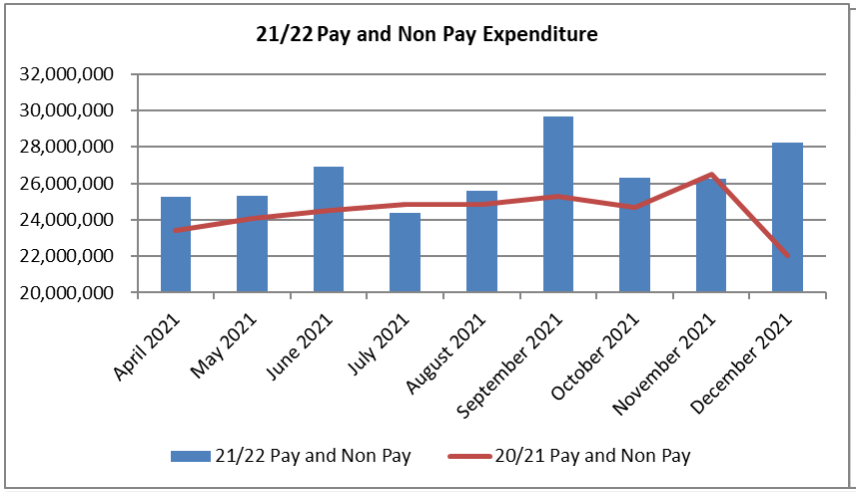
Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.

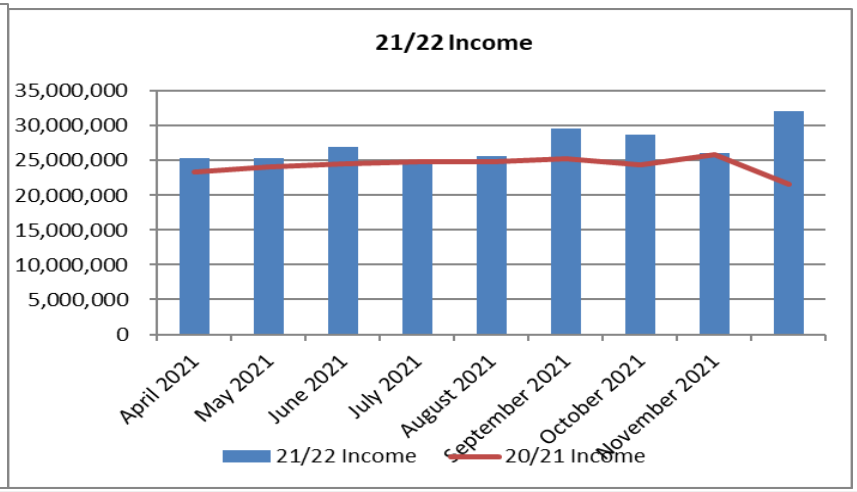
3. Financial Position

High Level Analysis	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's
Commissioner Income	**22,617**	**24,424**	**1,807**	**202,458**	**205,518**	**3,060**
Directorate Income	**3,747**	**7,636**	**3,889**	**32,374**	**38,730**	**6,356**
Pay Costs	-17,685	-17,682	3	-153,040	-151,426	1,614
Non Pay Costs	-9,215	-10,563	-1,348	-82,364	-86,489	-4,125
Expenditure	**-26,900**	**-28,245**	**-1,344**	**-235,404**	**-237,915**	**-2,511**
Surplus / (Deficit)	**-537**	**3,815**	**4,351**	**-572**	**6,333**	**6,905**

Notes *Salix Income of £6.7m included in the position

3.1 Revenue





The position above of a £6.7m surplus is a positive position for the second half of 2021/22. The position includes income associated with the Salix grant. Adjusting for this results in a breakeven position, in line with the plan and expectations set by NHS England and NHS Improvement (NHSEI).

The H2 forecast (October to March) continues to be a breakeven position.

Income reflects additional payments received for Cancer Alliance, Ageing Well and Specialist Nursing.

Directorate spend remains similar to previous months however there is a further increase of £350k in PSC, which is being driven by Critical Care and Theatres.

Premium spend continues across the Trust either via incentive payments/agreed rates outside of A4C or Agency.

Draft annual planning documents have been received and are being worked through.

Community &Childrens	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**1,374**	**1,373**	**-1**
Pay Costs	-46,173	-44,314	1,858
Non Pay Costs	-5,018	-3,930	1,088
Expenditure	**-51,190**	**-48,244**	**2,946**
Total	**-49,816**	**-46,871**	**2,945**

LTUC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**5,068**	**5,266**	**198**
Pay Costs	-44,666	-45,489	-823
Non Pay Costs	-16,383	-17,286	-904
Expenditure	**-61,048**	**-62,775**	**-1,727**
Total	**-55,981**	**-57,510**	**-1,529**

PSC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**597**	**696**	**98**
Pay Costs	-41,106	-41,112	-6
Non Pay Costs	-16,103	-15,220	883
Expenditure	**-57,210**	**-56,333**	**877**
Total	**-56,613**	**-55,637**	**976**

Corporate	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**7,140**	**13,444**	**6,303**
Pay Costs	-13,347	-13,019	328
Non Pay Costs	-28,749	-27,924	825
Expenditure	**-42,096**	**-40,943**	**1,153**
Total	**-34,956**	**-27,499**	**7,456**

HIF	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**15,099**	**14,941**	**-158**
Pay Costs	-7,276	-6,786	490
Non Pay Costs	-7,673	-7,958	-285
Expenditure	**-14,949**	**-14,743**	**205**
Total	**150**	**198**	**48**

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

Directorate performance is outlined to the side.

Within the Directorate positions are some common areas of risk.

These include –

- Ward expenditure positions – £122k overspend in month, £777k overspend YTD. The first acuity review has been concluded and a further one due in February.
- Medical Staffing pressures – Agency continues to be used to cover substantive gaps.
- Significant underspends within Children's Services and Adult Community Services.
- Third party costs for addressing activity backlog ('Gut Care' costs have been recoded to agency from non-pay)
- Delivery of H2 CIP recurrently
- General risk of covering staff in Acute area's from Covid sickness/Isolation - £219k estimated absence cost in month
- Utility pressures.

These areas will continually monitored.

HR and Finance colleagues continue to reconcile vacancies across the directorates.

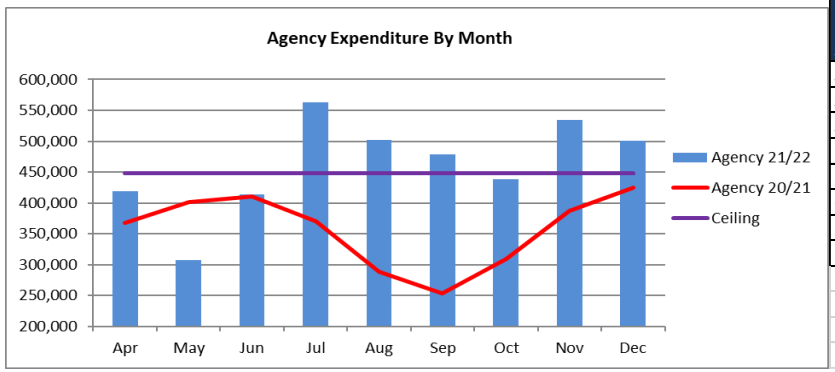
3.2 Agency

Month 9 expenditure on Agency is £500k.

Gut Care (Theatre Ophthalmology) costs are now being included in the Agency spend and the below table has been restated to reflect this.

There are a number of consultant rates over the £100 per hour mark that are summarised below. As part of our governance process, these should be approved by the Chief Executive.

	Actual									
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD
Total Agency	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical	-216	-169	-264	-334	-306	-231	-216	-253	-201	-2,190
Nursing	-123	-100	-110	-146	-113	-157	-124	-178	-197	-1,248
Other Clinical	-17	5	-9	-13	-10	-13	-15	-12	-8	-92
Non Clinical	-63	-42	-30	-69	-75	-78	-84	-91	-95	-628
Total Agency	**-419**	**-307**	**-414**	**-563**	**-503**	**-479**	**-439**	**-535**	**-500**	**-4,158**
Agency Ceiling	-448	-448	-448	-448	-448	-448	-448	-448	-448	**-4,032**
Variance	**-29**	**-141**	**-34**	**115**	**55**	**31**	**-9**	**87**	**52**	**126**



Speciality	Rates £ pr hr	Actual December Actuals	Sustantive Cost (10 PA's)	Excess
SDEC*1	150	39,652	12,000	27,652
SDEC*2	166	36,598	12,000	24,598
SDEC*3	120	19,200	12,000	7,200
ED	120	15,508	12,000	3,508
Radiology	105	29,067	12,000	17,067
Cardiology	144	27,748	12,000	15,748
Respiratory	156	39,893	12,000	27,893
Haematology	110	28,217	12,000	16,217

*Tempre VAT on Service Fee
**Off framework VAT on total cost
***Agency requests normally between 40-50 hour contacts

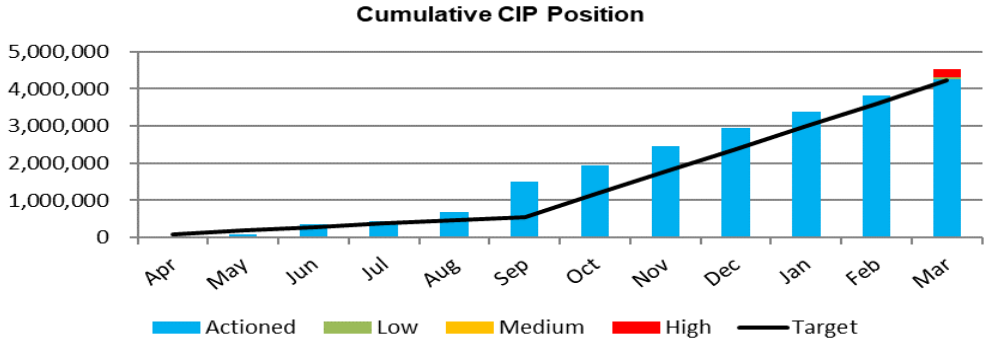
3.3 CIP

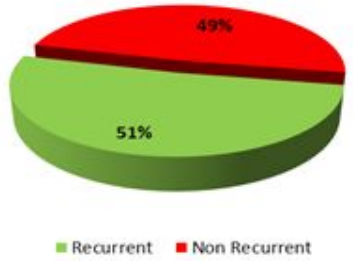
A 3% efficiency programme for the second half of the year was agreed, due to the anticipated income reduction from the CCG, as part of the H2 financial framework. The H2 target is £3.1m, this was in additional to any carried forward targets.

The delivery of the programme is still heavily reliant on NR CIP and Directorates will need to ensure any non recurrent savings are converted into recurrent plans by the end of the financial year.

Directorates continue to make progress with CIP plans, CC Directorate are now over delivering against plan and the biggest area of challenge is within LTUC, 82% risk adjusted to date.

Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age
4,220,300	3,835,612	72,400	0	200,000	112,288	4,108,012	97%	3,944,392	275,908	93%
% of target	91%	2%	0%	5%	3%					





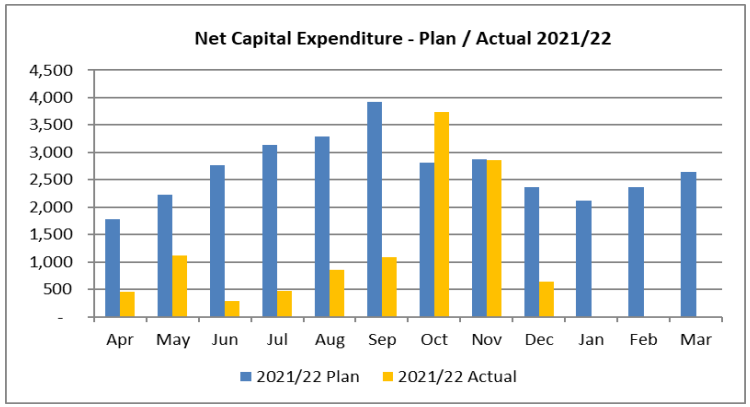
3.4 Capital

As at December £11.4m has been spent on capital against a plan of £25m. There are several material schemes that are weighted towards the end of the financial year that have been assessed however some larger schemes have now slipped in 22/23.

Further capital funding has also been awarded over the past couple of months along with an increase in CDEL allocation from the ICS.

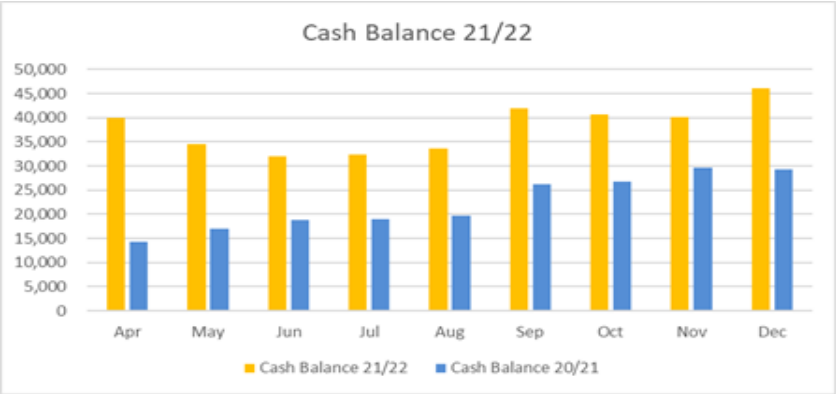
Due to the current forecast, options to utilise the full capital CDEL allocation were discussed at the Resources Committee. These options included bringing forward equipment replacement from future years, and settling outstanding loans early. The outcome of the resource committee discussion will be reported to the Board.

Scheme	Plan	YTD Costs	Further Anticipated Costs	FYE Forecast
Salix	**14,180**	**6,754**	**7,620**	**14,374**
Externally Supported Schemes	**4,848**	**661**	**2,525**	**3,186**
Trust Wide	**12,750**	**3,989**	**6,815**	**10,804**
Total Capital	31,778	11,404	16,960	28,363
Forecast Underspend				3,415
Additional Funding				2,502



3.5 Cash Balance

The Trust cash balance continues to remains positive as at the end of December.



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.

The finances have been agreed for the second half of 21/22 but delivery of a CIP programme will be fundamental to deliver the financial balance in H2.

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 Board of Directors is asked to note and discuss the content of this report.

Jonathan Coulter Deputy Chief Executive / Finance Director

3.4

Board of Directors (Public)
26th January 2022

Title:	**Operational Performance Update**
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 9 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	
Corporate Risks:	CRR41 – RTT CRR61 – ED 4-hour Standard	
Report History:	Reported to January 2022 SMT and Resource Committee	
Recommendation:	It is recommended that Trust Board note the items contained within this report.	

Operational Update January 2022 (December Performance)

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Increase in COVID admissions resulting in requirement to open additional beds and establish extra COVID capacity
- 164 elective theatres lists were undertaken out of a possible 218 (75%)
- Two week wait cancer performance – 87% against the 93% standard *(5.1)* due to increased breast referrals and reduced capacity
- Cancer 62-day standard improved in December but remained below the standard at 83%, with longer waiting patients receiving treatment
- Non-Elective demand remains high and the Trust continues at full capacity (100%+ bed occupancy)
- Demand for new outpatient ECHO test has increased by 40% based on 2019 demand *(5.3)*
- 4-hour ED performance – December performance deteriorated to 69%, significant bed pressures impacting on flow, continued increase in presentations, 10% above 2019/20 levels. *(5.6)*
- 23 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- 3 x 60-minute ambulance handover breaches in December
- Referral to treatment total waiting list increase due to reduction in activity over Christmas period, rate of increase stabilising, (5.1.3); 92nd percentile at 42 weeks (5.1.3)

Major actions commissioned & work underway

- UEC Flow Dashboard now completed and launched across the Trust
- 51-point UEC action plan has been developed with all actions to be completed by March 2022 – business case now completed and in process
- Glaucoma review list action plan developed, and clearance reduced from Q3 to Q1 2022
- Perfect week planned for first week in January

Positive news & assurance

- Cancer 31-day wait target achieved at 97% *(5.1.2)*
- Cancer 28 days faster diagnosis 79%, above the 75% standard (5.*11)*
- H2 M2 plan met 11 of 13 measures for December, routine IP below plan (provisional figures) and increase in 104+ due to IPT of WYAAT patients
- Continuing to support LTHT and YTH with Endoscopy demand c.175 patients per month
- Supporting WYATT with long wait patients (LTHT and BTH) with 50 Ent/Max fax paediatric patients
- Patient initiated follow up identification mechanism implemented
- Supported York District Hospital with acute patient diverts through holiday period
- Continued to deliver planned elective program post Christmas
- Supported primary care with staff testing capacity
- Ambulance handover delays minimised over critical period into New Year

Decisions made & decisions required

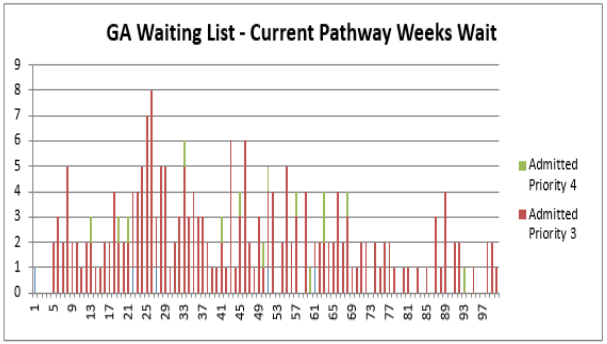
- Fountains ward reverted to green elective beds from 13/12/21
- Additional doors installed into Fountains to allow flexibility between green/yellow capacity
- Stood up Vaccination Hub for covid boosters to general public within 5 days of national guidance
- Revised winter plan in response to national guidance (discharge, covid)
- Opened additional winter bed capacity
- Covid isolation guidance revised and communicated

Children's and Community

Harrogate and District NHS Foundation Trust

Community Dental Services

Waiting List Information				
	Current Week	1 Week Ago	2 Weeks Ago	3 Weeks Ago
GA Priority 2	5	4	4	5
GA Priority 3	209	222	221	219
GA Priority 4	14	15	16	17
Outpatient Treatment	1,137	1,187	1,191	1,221
New Patients	1,551	1,506	1,480	1,474
Total	2,916	2,934	2,912	2,936



Community 0-19 Services

Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	92.6%	90.3%	92.3%	**91.7%**	94.0%	92.5%	89.1%	**91.9%**	91.6%	81.6%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.1%	96.0%	96.3%	**96.1%**	97.6%	96.3%	94.3%	**96.1%**	97.0%	95.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	91.1%	97.6%	97.2%	**95.3%**	93.8%	98.9%	96.2%	**96.3%**	96.2%	97.4%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	96.4%	97.4%	92.7%	**95.5%**	95.8%	94.3%	92.4%	**94.2%**	86.7%	96.6%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	89.4%	89.7%	92.4%	**90.5%**	93.3%	90.5%	86.4%	**90.1%**	93.1%	89.4%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	96.5%	96.2%	97.9%	**96.9%**	98.8%	99.3%	98.7%	**98.9%**	92.5%	96.4%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Sunderland**	98.9%	99.6%	98.3%	**98.9%**	96.2%	99.6%	99.5%	**98.4%**	98.6%	99.6%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	82.6%	85.6%	91.9%	**86.7%**	90.9%	90.1%	90.2%	**90.4%**	84.2%	88.3%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.1%	87.6%	90.4%	**89.4%**	89.8%	90.0%	87.8%	**89.2%**	89.5%	89.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.9%	98.8%	**98.5%**	94.9%	97.7%	98.8%	**97.1%**	97.3%	95.1%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	97.3%	94.9%	94.1%	**95.4%**	94.2%	96.8%	98.2%	**96.4%**	97.3%	93.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	92.9%	94.4%	91.8%	**93.0%**	90.5%	91.9%	93.1%	**91.8%**	87.5%	94.2%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	95.0%	97.1%	97.2%	**96.4%**	95.5%	98.6%	97.2%	**97.1%**	95.4%	95.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	97.8%	97.7%	94.5%	**96.7%**	95.9%	97.5%	92.4%	**95.3%**	94.4%	95.9%
Community Podiatry - % patients seen within 18 weeks	98.9%	99.5%	99.0%	**99.1%**	99.4%	96.9%	92.1%	**96.1%**		
Dementia screening - % eligible patients screened within 72 hours of admission	95.5%	96.7%	96.1%	**96.1%**	95.6%	92.7%	93.8%	**94.0%**	98.1%	94.7%
Dementia screening - % eligible patients having a full diagnostic assessment for dementia	100.0%	100.0%	100.0%	**100.0%**	100.0%	94.4%	88.2%	**94.2%**	95.7%	96.2%
Dementia screening - % eligible patients referred on for specialist assessment	100.0%	100.0%	100.0%	**100.0%**	100.0%	100.0%	90.0%	**96.7%**	91.7%	100.0%

December OPEL Level – 3

Adult Community

Service continues to be very pressured due to increased complexity of caseloads and high vacancy rate, sickness and COVID self isolation

Task and finish group established to progress skill mix review, updated recruitment campaign.

Virtual recruitment event taking place on the 22 Jan and work progressing on skill mix review, with new Senior Community Nurse job description developed to support pressures in District Nursing and retention of Band 5 community Nurses. Looking to go out to recruitment for these new roles end of January.

0-19 Service

In line with OPEL 2/3 level the following actions are being taken:

- Non urgent activity paused, cancelled or re-arranged.
- Flexible approach to timelines for mandated contacts introduced.
- Face to face or virtual contacts based on COVID risk assessment, family health needs assessment and cumulative risk.
- Support required from outside of contract area.

Managing across contracts to minimise impact of staffing gaps due to vacancies and absence levels.

Consultation concluded with unions and 0-19 service will transfer its bank to NHSP from 31 Jan 22. We hope this will allow us to attract more staff onto a 0-19 bank than we have had in the past and give greater options for support to teams for short term absence.

Safeguarding

Staff absence from work within the safeguarding specialist team is impacting on capacity within the team.

Demand for safeguarding remains high within 0-19 and specialist safeguarding teams.

Statutory responsibilities still being delivered

Community Dental

Plans in place to link with clinical teams across HCV to embed best practise and teams have scheduled WLI sessions to target long waiters to ensure all dated before end of March 22. Key risk are those patients that require GA and external anaesthetic support has been commissioned to support additional sessions.

NHS
Harrogate and District
NHS Foundation Trust

Planned Care Recovery

H2 Activity Plan - HDFT

Outpatients

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) Plan	10	10	214	214	214	290
Actual	10	10	230			
Consultant-led first outpatient attendances (Spec acute) Plan	4,435	4,653	4,189	4,809	4,285	4,185
Consultant-led first outpatient attendances (Spec acute) Actual	4,434	5,214	4,176			
Consultant-led follow-up outpatient attendances (Spec acute) Plan	8,747	9,242	8,131	9,780	8,375	9,702
Consultant-led follow-up outpatient attendances (Spec acute) Actual	9,101	10,042	8,637			

Elective Admissions

Total number of Specific Acute elective spells in the period Plan	2,513	2,561	2,292	2,529	2,516	2,605
Total number of Specific Acute elective spells in the period Actual	2,498	2,659	2,401			
Total number of Specific Acute elective day case spells in the period Plan	2,332	2,345	2,094	2,318	2,310	2,388
Total number of Specific Acute elective day case spells in the period Actual	2,317	2,497	2,227			
Total number of Specific Acute elective ordinary spells in the period Plan	181	216	198	211	206	217
Total number of Specific Acute elective ordinary spells in the period Actual	181	162	174			

RTT

Number of Completed Admitted RTT Pathways Plan	866	972	871	961	956	989
Number of Completed Admitted RTT Pathways Actual	970	1,029	838			
Number of Completed Non-Admitted RTT Pathways Plan	3,930	4,020	3,563	4,221	3,661	3,822
Number of Completed Non-Admitted RTT Pathways Actual	4,591	5,064	3,819			
Number of New RTT Pathways (Clockstarts) Plan	7,466	7,334	5,855	7,023	6,122	6,302
Number of New RTT Pathways (Clockstarts) Actual	7,142	7,718	6,626			
The number of incomplete RTT pathways waiting 52+weeks Plan	1,089	1,069	1,049	1,029	1,009	978
The number of incomplete RTT pathways waiting 52+weeks Actual	1,070	1,097	1,177			
The number of incomplete RTT pathways waiting 104+weeks Plan	33	33	30	27	14	0
The number of incomplete RTT pathways waiting 104+weeks Actual	33	34	46			
Incomplete RTT pathways that will breach 104+ wks 31 Mar 22		231	199			
Incomplete RTT pathways that will breach 104+ wks 31 Mar 22 with TCI		76	119			
The total number of incomplete RTT pathways Plan	22,900	22,500	22,350	22,200	22,050	21,900
The total number of incomplete RTT pathways Actual	22,423	22,714	23,464			

Cancer

The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Plan	46	46	46	46	35	27
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Actual	41	36	32			

H2 Plan used from Oct onwards reflecting H1 level outturn, increasing elective admissions to reduce gap to 19/20 continues to be the focus. Dedicated project support continues in theatres to aid recovery.

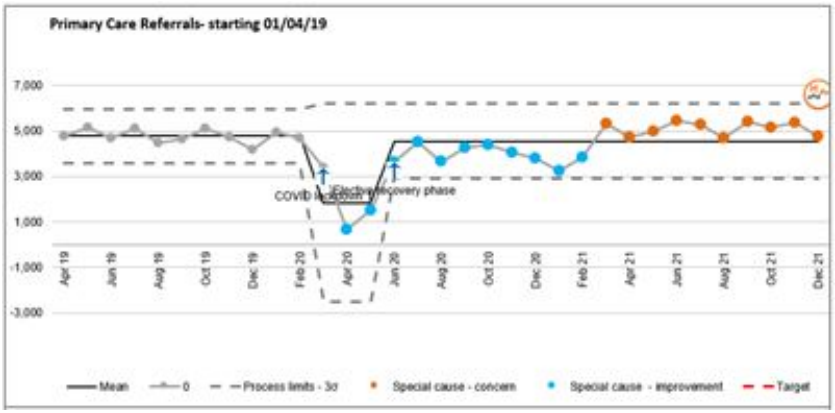
To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered.

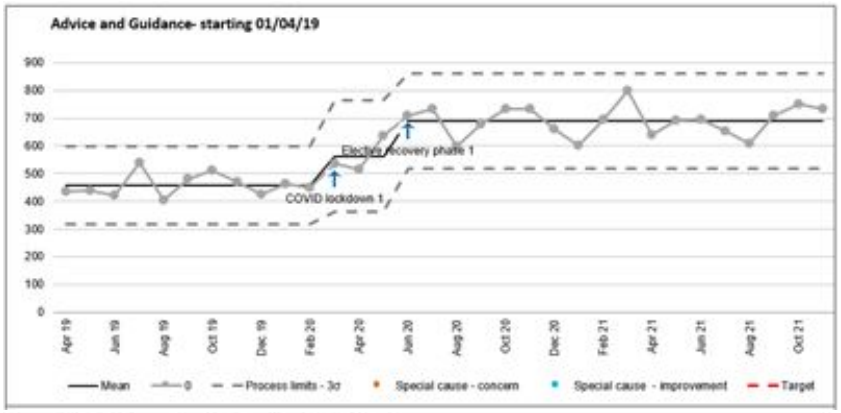
The Trust increased non elective beds on the Elective Surgical Unit, these remain in place to help mitigate increased non elective activity levels. Winter plan with additional capacity being implemented through December to release more beds back to elective care.

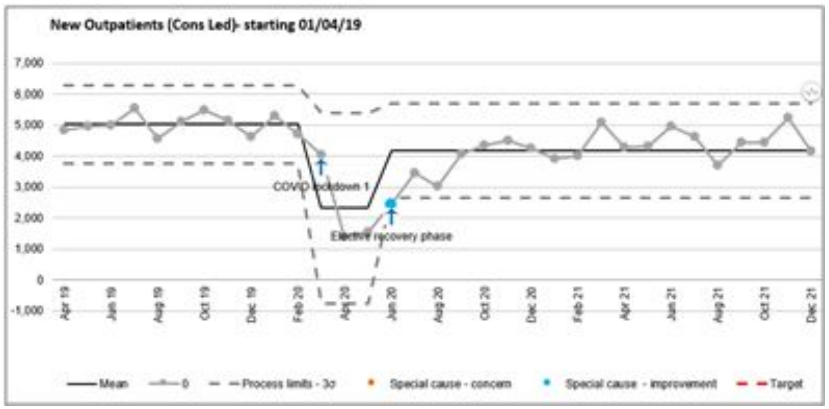
The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, there is currently a reduction in demand for Endoscopy, so HDFT continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels.

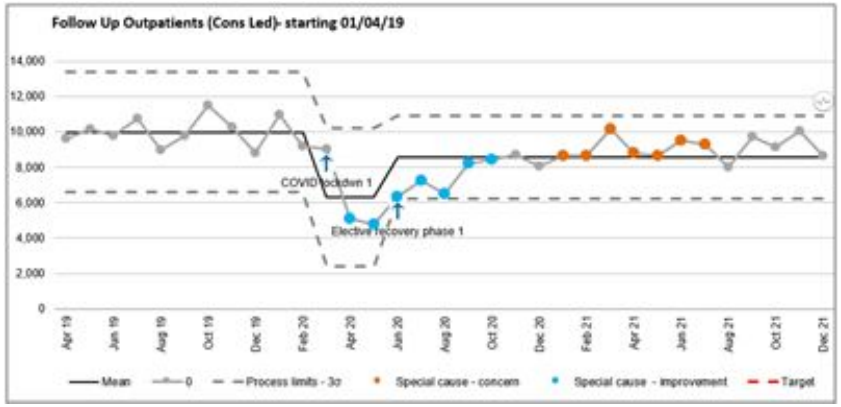
Elective Recovery

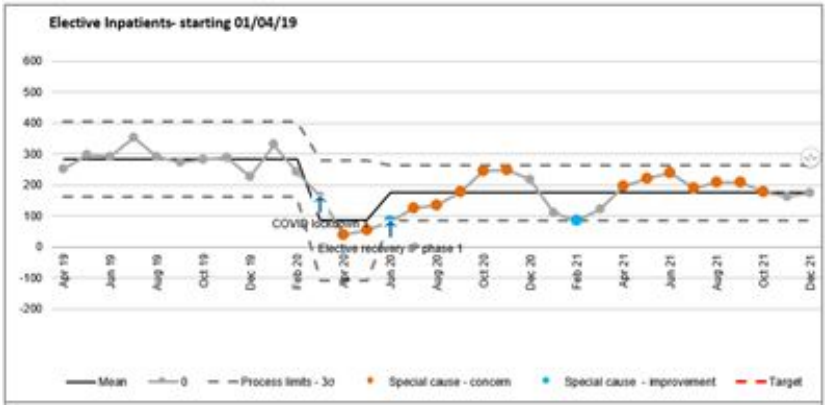
Harrogate and District NHS Foundation Trust

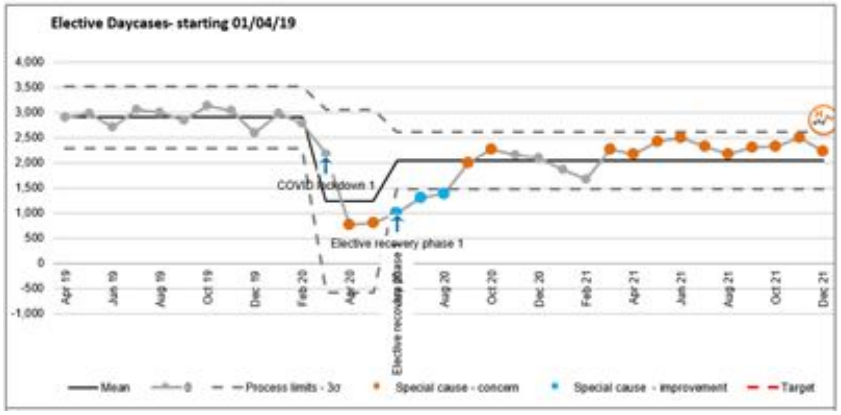








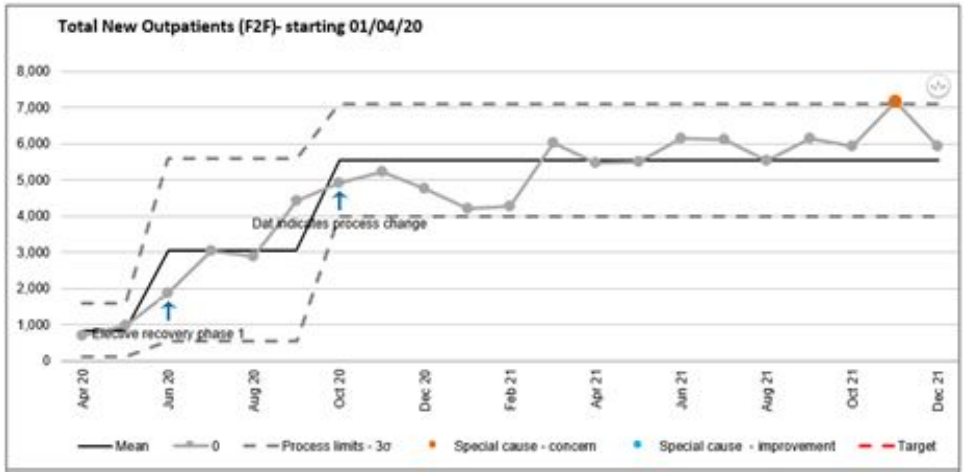


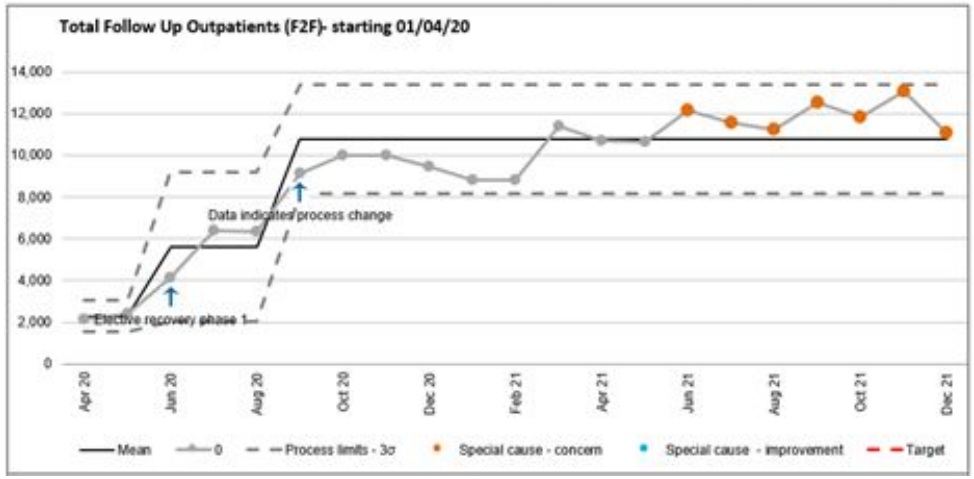


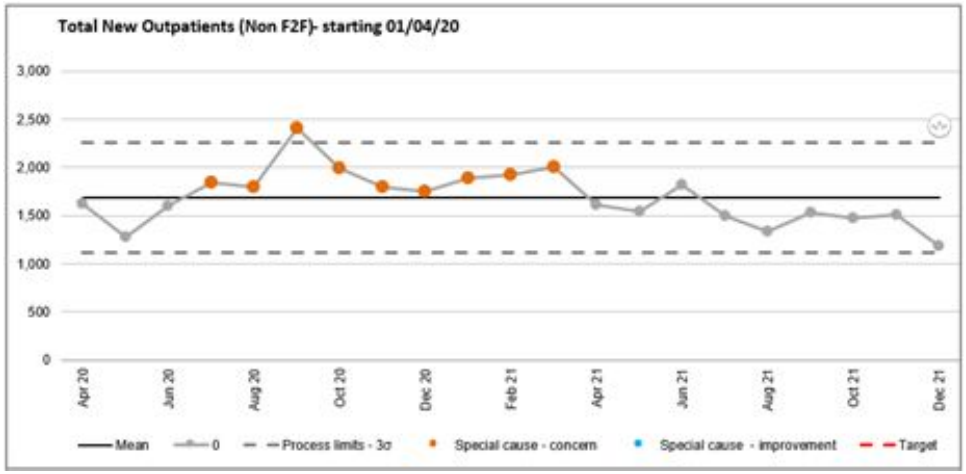
3.4

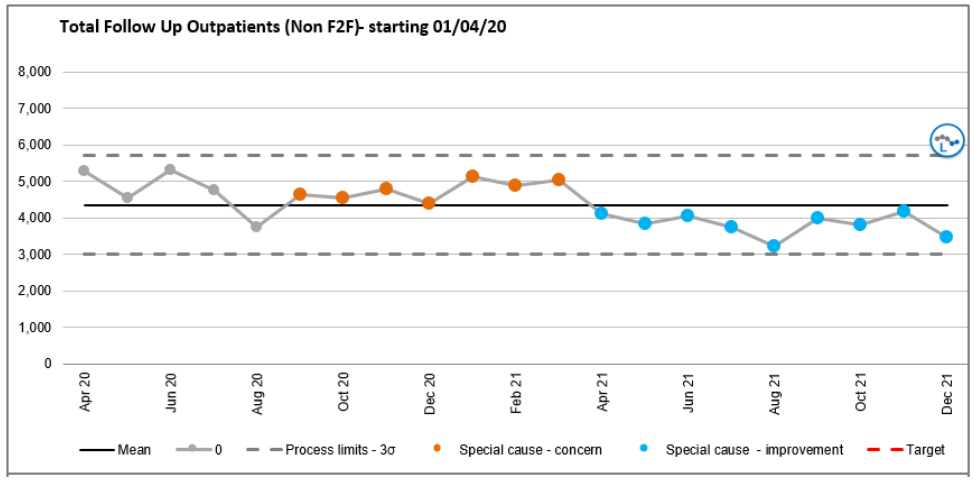
Elective Recovery

Harrogate and District NHS Foundation Trust







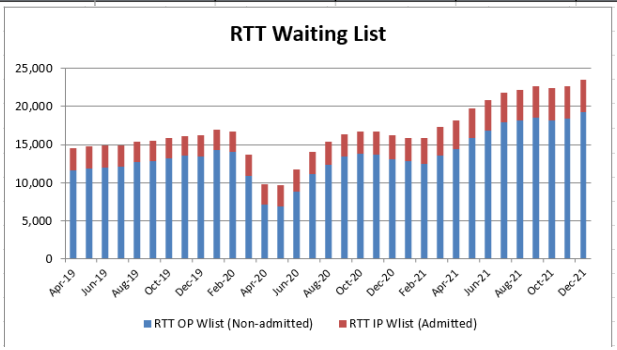


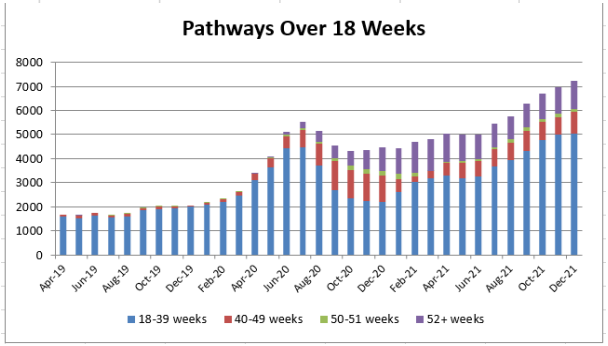
- Elective demand continues to be a challenge with GP Referrals and Advice and Guidance requests both remaining consistently above 2019/20 levels.
- Total New and Follow up outpatient attendances dropped back in December following November's increase, however remain above the average. The Trust continues to deliver around 90% of 2019/20 attendance levels.
- Elective inpatients increased in December reduced in November, day-cases decreased and remain above the average.
- Non face to face first and follow up outpatient contacts have remained below the average since the start of the year, an element of reduction was expected following the change in national guidelines in July 2020. Increasing non face to face contacts remains a focus and is part of the outpatient transformation programme that is working closely with services to increase where appropriate.
- Elective theatres have had a theatre closed for infrastructure works in November and early December, however is now fully operational. Staffing remains a significant challenge as a result of vacancies, sickness and self isolation.
- Focus remains on stepping levels of activity back up to 2019/20 levels.

Referral to Treatment (RTT)

Harrogate and District NHS Foundation Trust

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
No. of pathways 18-39 weeks	2,615	3,047	3,173	3,310	3,168	3,255	3,657	3,922	4,336	4,787	4,880	4,881
No. of pathways 40-49 weeks	527	211	299	521	666	644	735	748	820	743	753	777
No. of pathways 50-51 weeks	219	155	11	21	62	91	90	127	133	104	105	109
No. of pathways 52+ weeks	1,075	1,268	1,345	1,201	1,087	1,006	988	955	1,008	1,070	1,097	1,177
Total >18weeks	4,436	4,681	4,828	5,053	4,983	4,996	5,470	5,752	6,297	6,704	6,835	6,944
Total RTT List	15,877	15,878	17,323	18,182	19,746	20,631	21,785	22,168	22,648	22,423	22,714	23,464





Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	22	0	0	227	207	162	1	15	**634**
3-4	6	0	1	67	201	221	0	6	**502**
5-6	4	0	0	26	115	200	0	1	**346**
7-8	5	0	0	12	103	164	0	1	**285**
9-10	5	0	0	11	52	125	0	1	**194**
11-12	4	0	0	6	51	171	0	2	**234**
13-14	0	0	0	5	44	148	0	1	**198**
15+	0	0	0	16	396	2,097	0	26	**2,535**
Total	**46**	**0**	**1**	**370**	**1,169**	**3,288**	**1**	**53**	**4,928**

RTT - The Trust had 23,464 patients waiting at the end of December, this is an increase of 750 patients on the November position.
There are 1,177 patients waiting over 52 weeks, this is a 7% increase on the November position and due to reduced activity over Christmas period & staff shortages.
The 92nd centile increased from 41 to 42 weeks in December and the median wait remains at 10 weeks.
Of the 4,932 patients waiting for a procedure, 39% are Orthopaedics, 17% General Surgery and 12% Ophthalmology.

Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 99.1% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (2/46) have been waiting <=2 weeks and work continues to ensure these are rapidly coded.
80% 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.

A&E Performance

Harrogate and District NHS Foundation Trust

A&E Attendances & Emergency Admission monthly statistics, NHS and independent sector organisations in England

A&E attendances, performance and emergency admissions

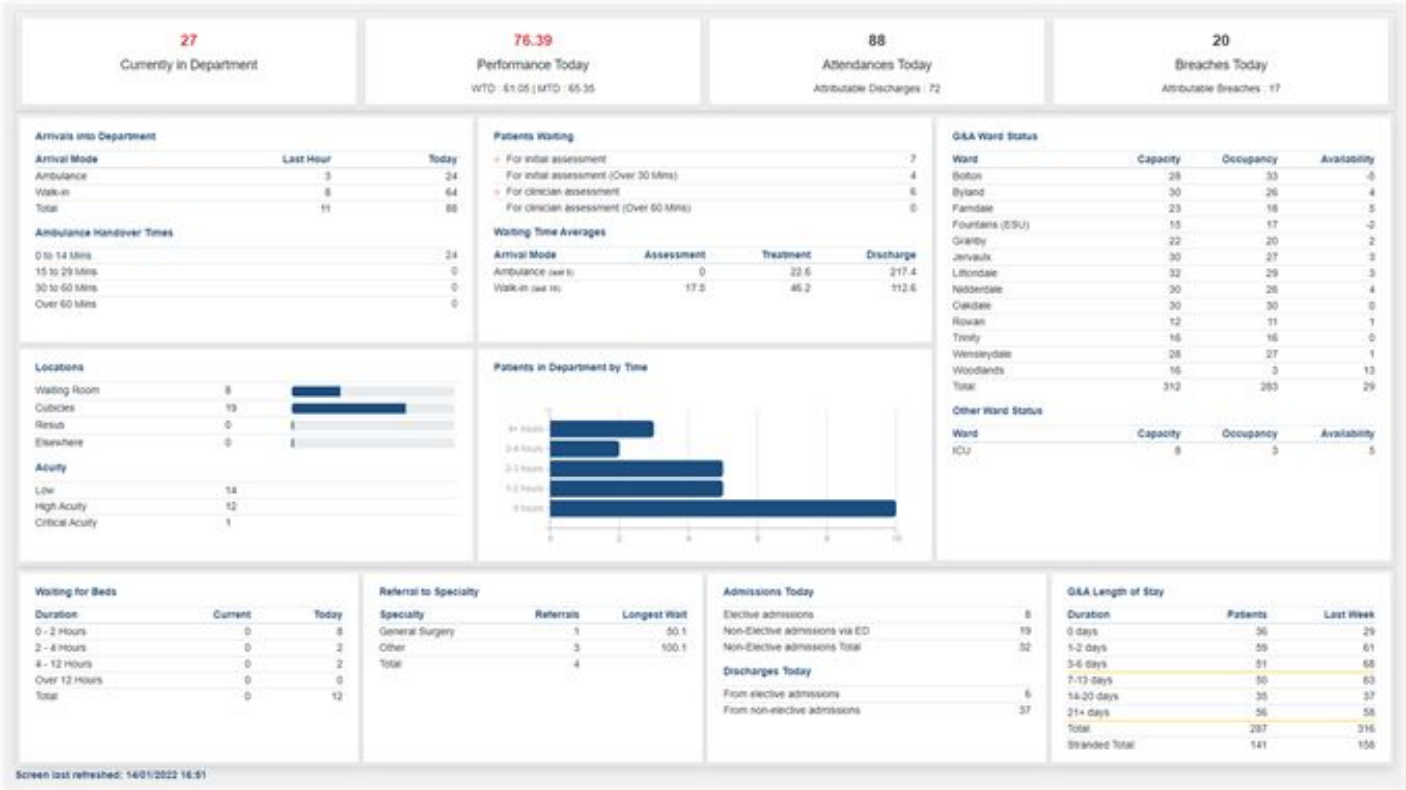
December 2021

SDCS data collection - MSitAE
Provider
13th January 2022

evel Data

		A&E attendances	Percentage of attendances within 4 hours				Emergency Admissions
Region	Name	Type 1 Departments - Major A&E	Percentage in 4 hours or less (all)	Percentage in 4 hours or less (type 1)	Percentage in 4 hours or less (type 2)	Percentage in 4 hours or less (type 3)	Number of patients spending >12 hours from decision to admit to admission
-	England	1,250,669	73.3%	61.2%	97.2%	96.0%	12,986
NHS England North East And Yorkshire	Airedale NHS Foundation Trust	5,646	62.5%	60.4%	100.0%	100.0%	0
NHS England North East And Yorkshire	Bradford Teaching Hospitals NHS Foundation Trust	9,726	73.4%	71.6%	-	100.0%	1
NHS England North East And Yorkshire	Calderdale And Huddersfield NHS Foundation Trust	13,365	73.0%	73.0%	-	-	2
NHS England North East And Yorkshire	Harrogate And District NHS Foundation Trust	4,402	69.0%	65.2%	-	99.4%	23
NHS England North East And Yorkshire	Hull University Teaching Hospitals NHS Trust	8,799	53.0%	53.0%	-	-	2
NHS England North East And Yorkshire	Leeds Teaching Hospitals NHS Trust	16,450	60.0%	50.7%	-	76.7%	63
NHS England North East And Yorkshire	Mid Yorkshire Hospitals NHS Trust	16,173	-	-	-	-	0
NHS England North East And Yorkshire	Northern Lincolnshire And Goole NHS Foundation Trust	11,063	59.0%	59.0%	-	-	165
NHS England North East And Yorkshire	York And Scarborough Teaching Hospitals NHS Foundation Trust	9,086	70.8%	49.3%	100.0%	97.2%	298

ED Dashboard

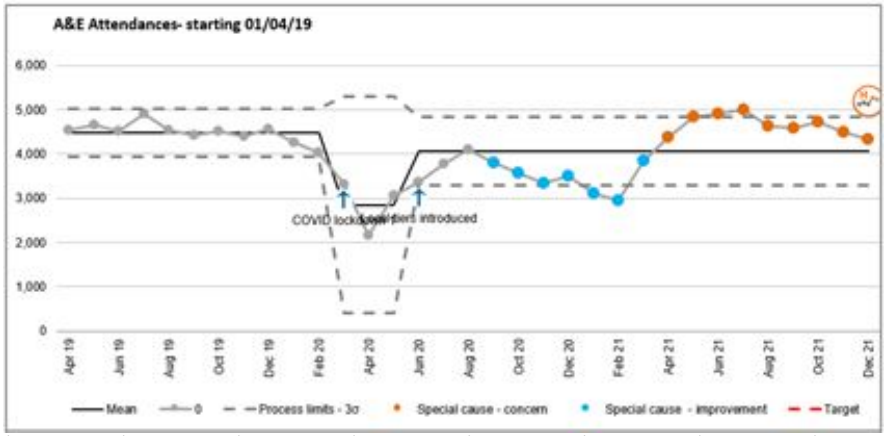


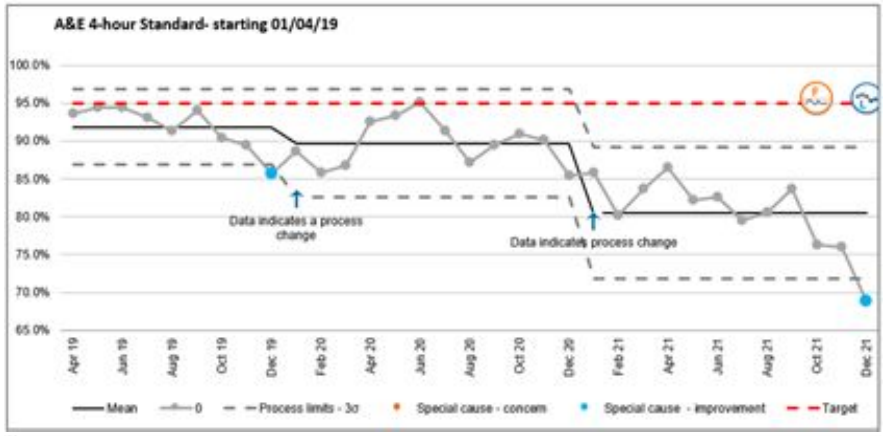
- The table to the left shows the December A&E performance data for HDFT and other Acute Providers in WY&H and HCV ICS'..
- The national performance for the 4-hour standard in December was 73.3% and 61.2% for type 1 - Acute sites.
- HDFT was the second highest performing provider in HCV and third highest in WY&H ICS.

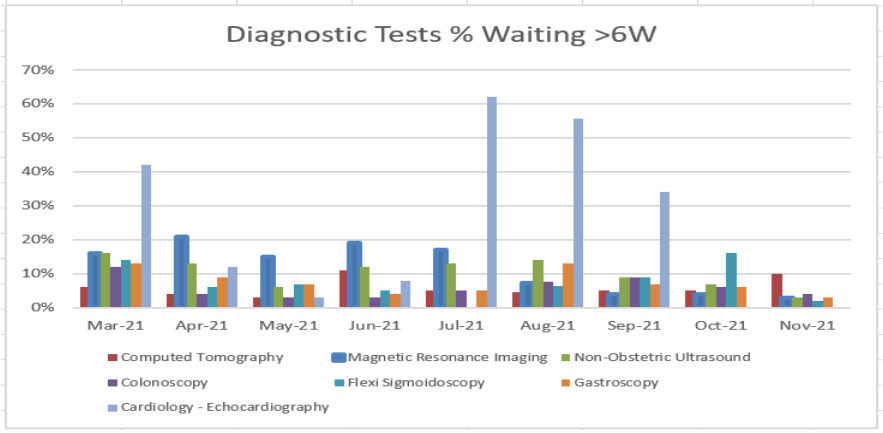
- The ED dashboard is now live and on screens in ED as well as other operational locations on the hospital site, increasing visibility of the current position to enable active support.

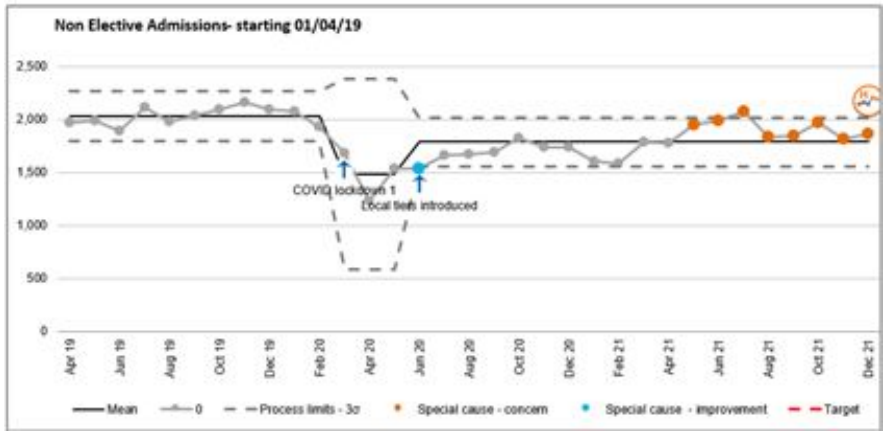
3.4

Urgent Care and Diagnostics





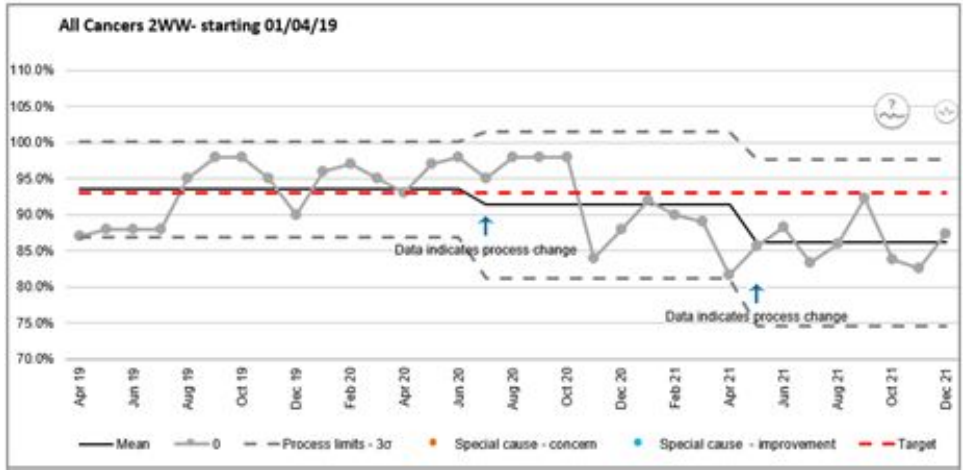


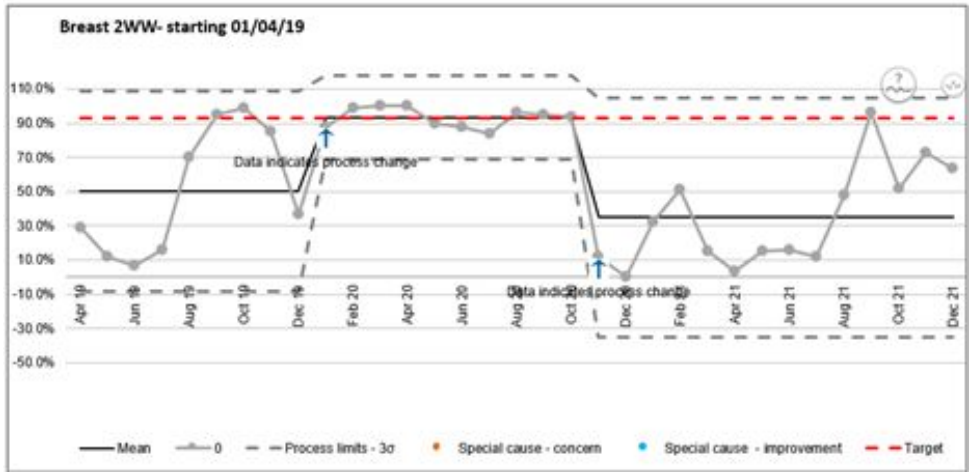


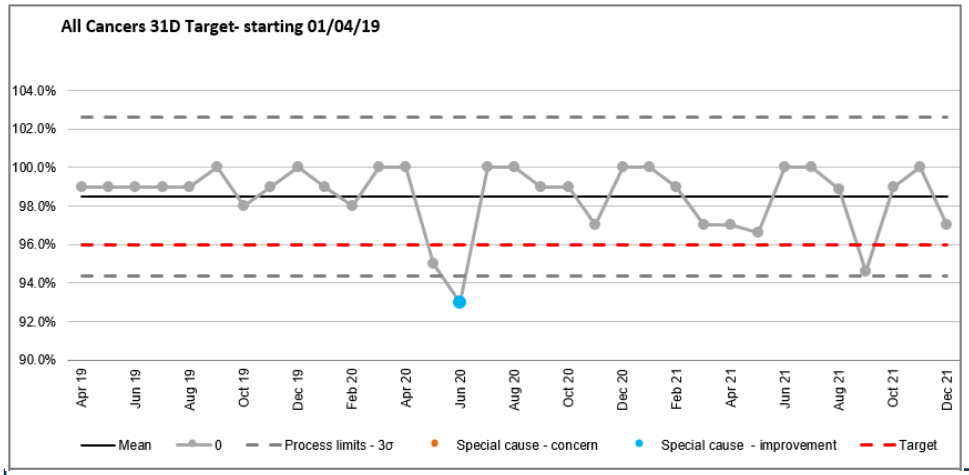
- Performance against the A&E 4-hour standard remained below 95% in December at 69%. The 95th percentile wait was 9-hours 55-minutes.
- There were twenty-three 12-hour breaches in December.
- There were 23 x 30-minute handover breaches and 3 x 60-minute ambulance handover breaches in December.
- ED attendances continue to remain above 2019/20 levels, this combined with the high occupancy levels in the hospital makes flow through the department a significant challenge.
- A UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- A live ED dashboard is now in place with screens visible in a number of hospital operational areas.
- Diagnostic waits beyond 6-weeks continue to decrease with focus maintained on reducing the backlog, echocardiography continues to experience staffing challenges, countered with a short term increase in IS support.

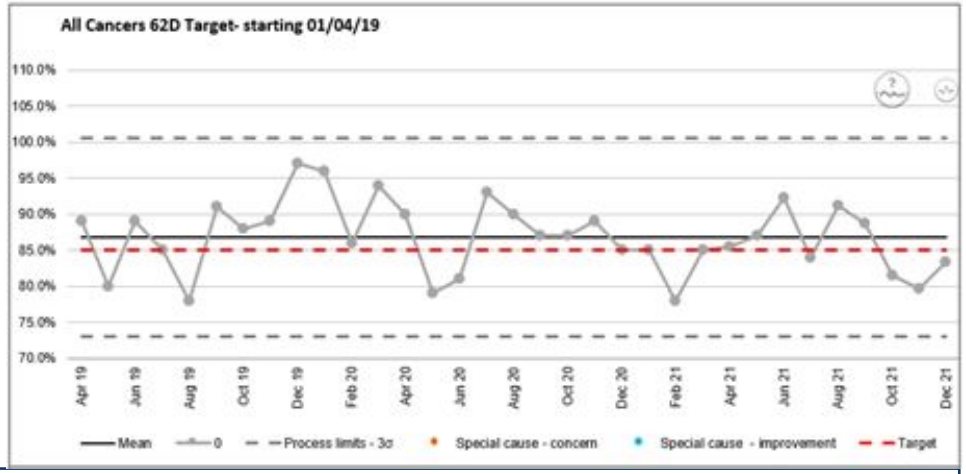
Cancer

Harrogate and District NHS Foundation Trust









- The 62-day standard improved in December but remained below the standard with a performance of 83%
- The 31-day standard was met in December with a performance of 97%
- The 2-week wait standard was not delivered in December with a performance of 87%
- The 2-week wait breast symptomatic standard was not met with a performance of 64%
- At the end of December 25 patients remain on an open cancer pathway over 62 days and 4 patients over 104 days. This has reduced since November and remains a key focus, it is also one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis has been completed and actions being taken to address the shortfall. The colorectal pathway has now resumed 'straight to test'.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics in place.

3.5

Board of Directors (Public)
26th January 2022

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

Purpose of the report and summary of key issues:	This report details Workforce priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
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	
	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	CRR5 – Nurse Staffing	
Report History:	Report discussed at January 2022 SMT and Resource Committee	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

Director of Workforce and OD Report

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Demand and capacity imbalance continues to impact upon service delivery across Recruitment campaigns, occupational health, EDI, HR operations and in particular in relation to ER Casework. Interim HRBP support currently being arranged along with support from external resources.

Sickness Absence

- The Trust's sickness rate hit a peak of 5.79% in October 2021 following an increasing trend since April 2021, however the data shows that sickness has decreased each month since and is at 5.42% for the current month. The Trust remains above the threshold rate of 3.90%.
- Excluding Covid sickness the Trust sickness rate for December is 4.73%, which is a decrease from 5.16% last month.
- Long term sickness has seen a further decrease in December from 3.88% to 3.31%, however short term sickness has seen an increase to 2.11% from 1.58% in November.

Turnover

- Following an increasing trend in turnover rates in recent months, turnover has continued to see a decrease for the second consecutive month from 13.80% in November to 13.70% in December, this remains below the Trust threshold of 15%.
- The breakdown of turnover in December is 3.33% due to involuntary terminations and 10.36% due to voluntary terminations. Voluntary turnover rates have decreased from the previous month, however involuntary turnover has increased by 0.15%.

Major actions commissioned & work underway

- Line Manager webinar's held with 68 attendees. Led by the Senior HR Team to inform managers of Agile Working an Flexible Working policy changes, Covid Guidance, Xmas & New Year pay arrangements, Exit Interviews and tips on using Manager Self Service. Well received by Line Managers
- Theatres Investigation ongoing – draft report being reviewed by the oversight group. Conduct issues highlighted are being managed in accordance with Trust Policies and Procedures
- Mandatory Vaccines – Line Managers are being supported to:
  - confirm roles in scope
  - confirm vaccination status of staff members
  - Provide guidance and resources to encourage the uptake of vaccinations
  - hold the conversations, through Thrive discussions and sign-posting to clinical psychology support where necessary.
  - identify redeployment opportunities
- Mandatory Vaccines - Key Actions underway:-
  - Letters to be sent to staff who have confirmed objections to being vaccinated, informing them that line managers will be arranging to meet with them imminently
  - Operational Directors notified of staff who have objected and advised to ensure line managers meet with staff immediately
  - VCOD Procedure and Manager Guidance documents available to support line managers
  - Data from NIMs being downloaded
  - Details of staff within each category to be shared with line managers
  - VCOD action plan developed and actions being implemented and regularly monitored by Steering Group
- Covid guidance continues to be updated and implemented

Director of Workforce and OD Report

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

Appraisals

- The appraisal rate in December is 59.83%, which is an increase from November which saw an appraisal rate of 58.16%.

Recruitment

- Recruitment activity continues to be busy with an average of 76 live adverts out per week and an average of 271 candidates going through the recruitment process at any one time.
- The pre-employment check process will be amended to align with new ruling relating to mandatory vaccines.

Major actions commissioned & work underway

E-Rostering and MSS

- The HealthRoster rollout to migrate all planned areas is drawing to a close, with eight units remaining which will conclude by February.
- To date, there are currently 290 managers and supervisors live on the system who are actively managing employee records and there are 1,996 employees who have the functionality to request and record annual leave.

Positive news & assurance

- Manager Self Service - Managers/Supervisors live as at 1st Dec = **247.** Employees transferred to MSS as at 1st Dec = **1,874 employees**
- Christmas and New Year pay arrangements have been well received.

E-Rostering

- The strategy to migrate clinical areas more at risk of winter flu and Covid by late autumn was successfully achieved.

Decisions made & decisions required of the Board

Decisions made

NIMS to be accessed in order to identiy vaccination records

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

4.1

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	15th December 2021
Date of Board meeting this report is to be presented	26th January 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Doug Masterton, Public Governor.
- The meeting began with a presentation from Dave Earl in his role as Medical Examiner. He gave a brief introduction to the role but concentrated his presentation on the progress that has been made and the plans for the future. It is intended to expand the process to include deaths in the community. This will be a significant challenge for the small team and more people are required to assist. Recruitment is taking place and it is hoped that a GP will be included in the team. Dave assured the Committee of the robust work that is being undertaken and the successful implementation of the process.
- Jackie Andrews gave an update on the outcome of the two recent inquests, concentrating on the case that has resulted in a huge amount of action and change within the Trust.
- The Committee were appraised of the current operational pressure in the Hospital and community services. We concentrated on the safety of patients and the support for colleagues in these difficult circumstances.
- The requirement to step up the vaccination programme was discussed and the impact this may have on current activity. A requirement to give booster doses to the 12-15 year olds was discussed.
- No internal audits were received but we discussed delay in completion of the Audit programme and the impact this could have on the Trust. The committee will review outstanding actions and ensure progress is evident.
- A number of items from the IBR were discussed. As previously noted the committee receives a draft version so discussions are in depth to seek clarity and assurance.
  Issues raised and discussed were –
  Safe Staffing levels
  Sepsis Screening
  Ratio of low harm: moderate harm incidents
  Stranded and Super-stranded patients
  The committee would like to see an analysis of follow up patients and how long they are waiting. Waits for initial visits and waits for treatment are visible but not

waits for follow up as demonstrated by the recent numbers of Glaucoma patients waiting for follow up.

- Quality Governance Management Group 7th December note was received and discussed. The group had commissioned a deep dive into recent events in ITU. The investigation was to ensure that no thematic issues were evident. The outcome will be reported to the next Quality Committee along with the outcome of a recent peer review of ITU.
- Member of the committee were concerned about the apparent poor attendance at Quality fora and sought assurance that all important issues were being addressed and people prioritised Quality meetings.
- Suzanne Lamb gave a detailed report of pressures in the 0-19 services. An OPEL system has been introduced and the service was running at level 2 which is high but stable.
- The surge in safeguarding cases has not stopped Across all contract areas there was increase in severity and complexity of cases. Increase in cases of injury to babies under 12 months. More neglect and child exploitation. The Trust is well tied into local safeguarding partnerships. The committee was informed that all systems were working well and colleagues were prioritising keeping children safe.
- Updates were also received from LTUC and PSC detailing the mitigation in place to deal with the current operational pressure. This included reconfiguration of wards. Changes to levels of staff and changes to roles and responsibilities.
- The committee received an update on the Caring at Our Best Programme and the achievement of objectives. Some appear to be behind schedule but more data collection and validation is underway.
- The committee was presented with a policy for Clinical Validation Risk Stratification and Harm. This ensures that patients waiting were appropriately managed to minimise the risk of long waits. The committee welcomed the policy as it has been a concern to ensure that the process was robust.

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

Pressures in the services provided by the Trust provide a risk to quality and safety
Stranded and Super-stranded patients who are at risk when they stay in a hospital environment.
Pressures to deliver the vaccination programme

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

Visibility of those patients waiting for follow up appointments.

Integrated Board Report - December 2021

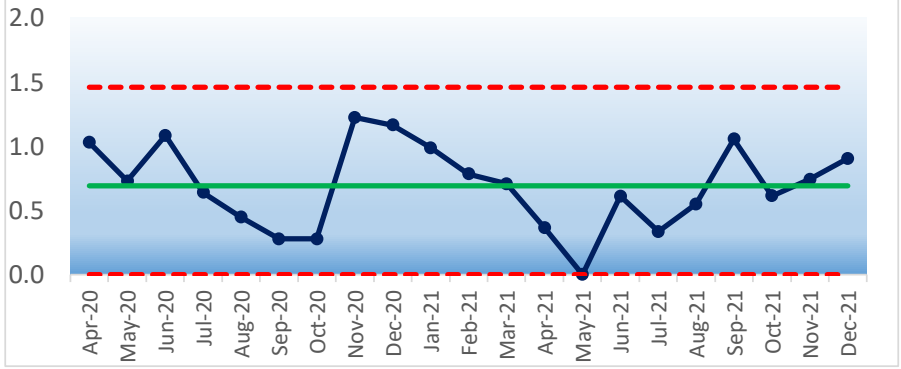
Domain 1 - Safe

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	Dec-21
Value / RAG rating	0.90

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

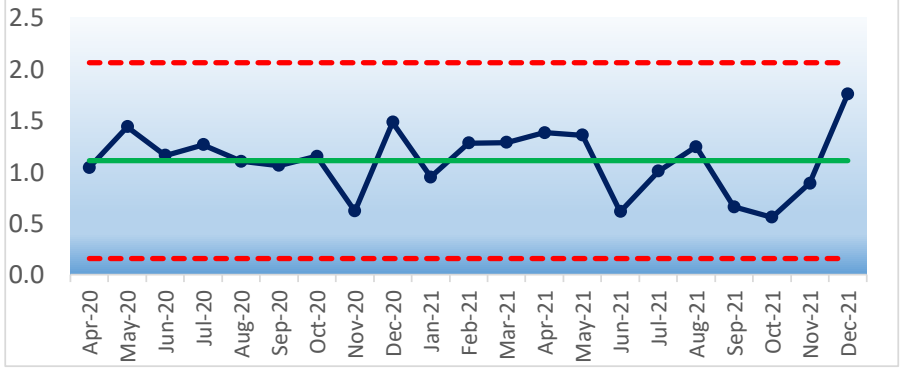
Increase noted for the month of December, likely due to the increased acuity and frailty of patients on the inpatient wards. From late December, the TVN team have been working on specific wards (allocated daily dependant on need) to support with fundamentals of care but to also clinically advise, support and deliver appropriate plans of care to patients who have compromised skin integrity.

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	Dec-21
Value / RAG rating	1.76

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

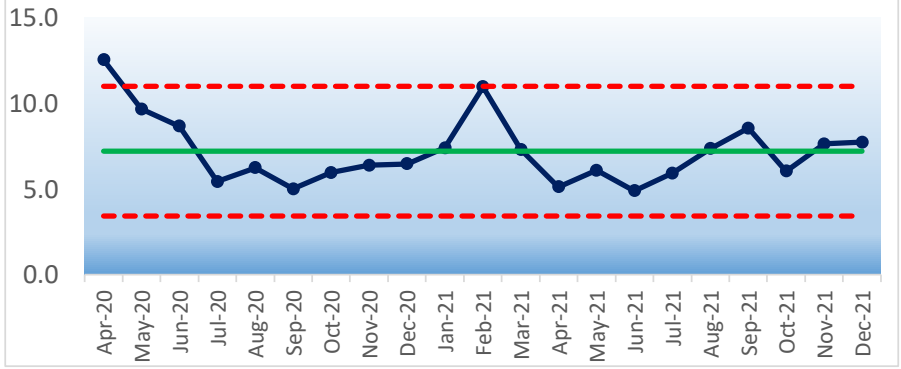
Sharp increase in community acquired cat 3 and above pressure ulcers; likely due to the increased acuity and frailty of patients on the District Nursing caseload, as well as in Care Homes. Adult community services have been at OPEL 3 and had significant staffing challenges for most days in December, therefore some regular reviews of patients will have been postponed; although not definitiv,e this is thought to have had an impact. The TVN team and Matron for Adult Community Services are completing a deep dive review to ensure approporiate plans of care are in place.

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	Dec-21
Value / RAG rating	7.73

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

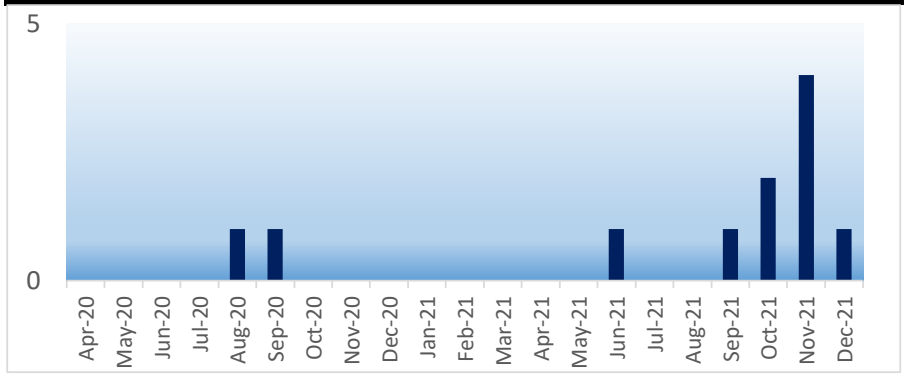
Inpatient fall rate has remained static. There have been instances where the same patient has fallen more than once. The Falls prevention coordinator is scoping ways to address this. Falls sensors have been purchased and training is being delivered throughout the coming weeks. Delays in discharge has been a prevelant factor in RCAs of patients who have fallen.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Dec-21
Value / RAG rating	1

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

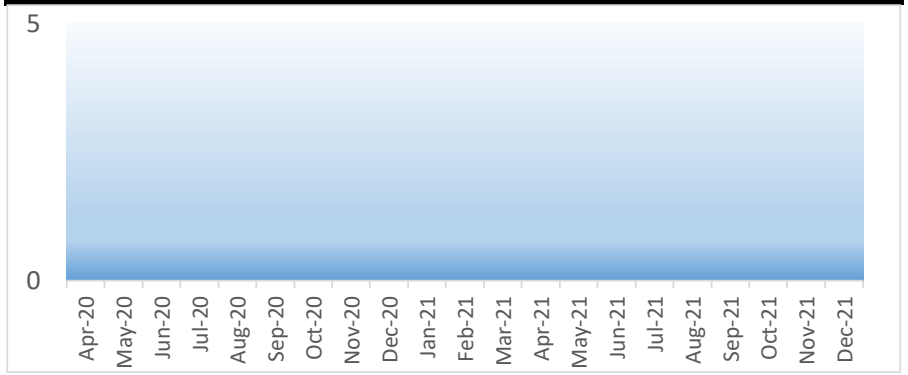
1 case was reported in December where non-contributory lapse in care (lapse in care that did not directly lead to the development of CDI but lapses in the management of the case i.e. delay in stool sampling or isolation) was identified. This related to a delay in stool sampling and isolation.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Dec-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

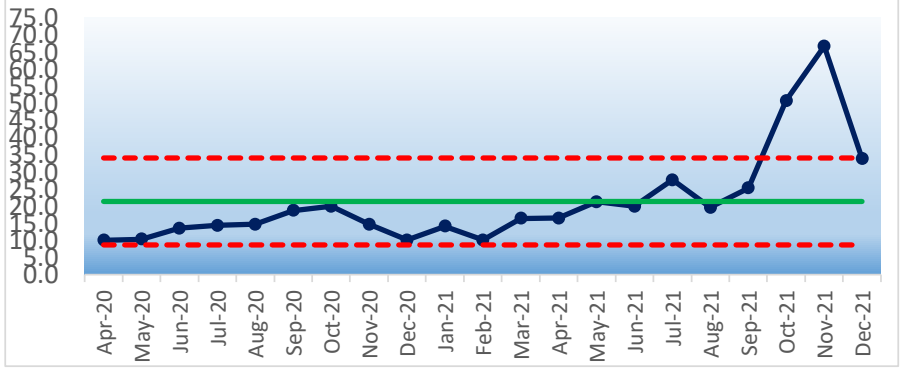
No MRSA cases where lapse in care identified in December.

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	Dec-21
Value / RAG rating	33.9

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

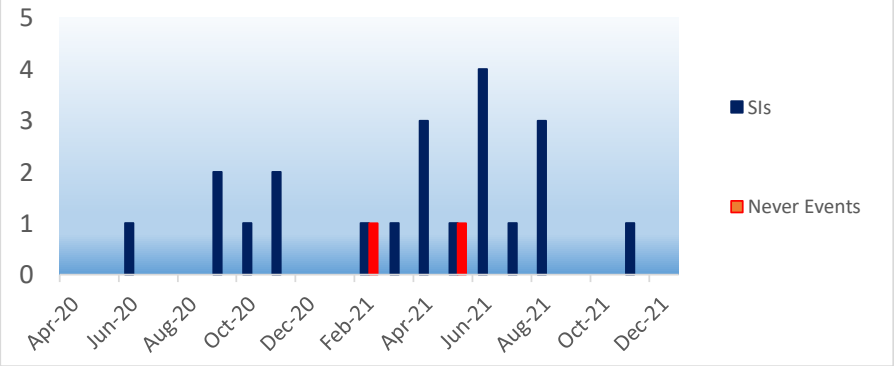
Data from October and November saw a sharp rise in the number of low harm incidents reported. This increase was associated with the reclassification of the 'present on admission' pressure ulcers. Data for December shows a gradual return to the expected levels of reported low harm incidents as the numbers are just on the upper control limit of the SPC chart.

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	Dec-21
Value / RAG rating	2 (SI), 0 (Never Events)

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

There were two new Serious incidents declared in the month of December 2021. From June 2021, we have seen an ongoing overall increase in the reporting of serious incidents. The implementation of a 48 hour review process means these incidents are reviewed in a more timely way and early identification of those incidents likely to meet the serious incident criteria are identified.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Dec-21
Value / RAG rating	88.0%

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

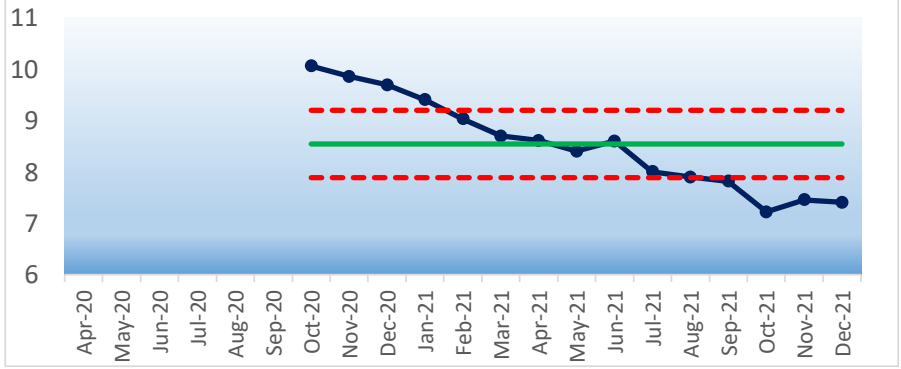
The fill rate for registered and unregistered nursing staff decreased slightly in December with an average of 88% fill rate. This reflects the continued impact of sickness absence seen amongst Clinical Teams, as well as increased isolation as a result of Covid, in particular household contact isolation. Nurse staffing is reviewed at the daily bed meetings where mitigation is put in place by matrons and the site management team. Each morning the Matrons carry out an assurance walkaround that includes validation of enhanced care requests and this helps inform where mitigation support is needed most. The bi-weekly meeting attended by the Heads of Nursing, Clinical Site Operations Manager and the Deputy Director of Nursing continues and reviews nurse staffing for the current week and projected rostering for the following week. Fill rate continues to be more challenging as the flexible workforce pool has reduced for similar reasons. The Corporate Nursing Team continue to explore ways to help attract flexible workers including an increased bank rate and engagement with new nursing agencies. Work continues to increase the Clinical Support Worker workforce to provide additional hands on care for patients and to support front line staff. Plans are in place to increase compliance with Healthroster to achieve the maximum benefits realisation from the system. Business case being completed to purchase Safer Care Module to support robust reporting and visualisation of staffing and its impact on safer care and to support senior teams with identification of risk and support associated decision making.

Indicator	**1.8.2 - Safer staffing - 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	Dec-21
Value / RAG rating	7.4

Indicator description

The chart shows the care hours per patient per day (CHPPPD). This is caclulated by comparing the total hours worked by reigstered and unregistered nurses and midwives and comparing these to the number of patients on the wards during the month.

SPC chart



Narrative

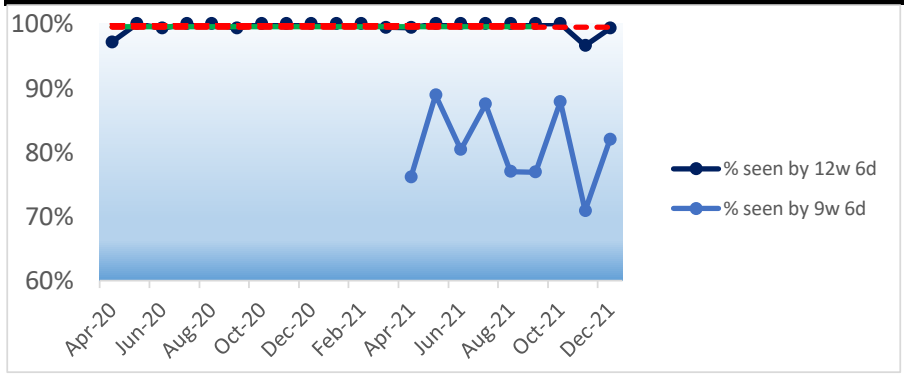
CHPPPD has fallen slightly in December due to a reduction in the number of registered and unregistered nursing staff available to deliver care due to various absence reasons, including increased absence due to isolation. Acuity of patients continued to be consistently high and this has been reflected in the rise of enhanced care requests made, particularly across our elderly and complex care wards. Work continues to increase the Clinical Support Worker workforce to provide additional hands on care for patients and to support front line staff. Plans are in place to increase compliance with Healthroster to achieve the maximum benefits realisation from the system. Business case being completed to purchase Safer Care Module to support robust reporting and visualisation of staffing and its impact on safer care and to support senior teams with identification of risk and support associated decision making.

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	Dec-21
Value / RAG rating	99.3%

Indicator description

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

SPC chart



Narrative

% women seen by a midwife (or healthcare professional) by 12+6 remains high.

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

We continue to submit 0% compliance with this model, as we are providing continuity during the antenatal and postnatal periods but not intrapartum care to women. This is due to reduced midwifery staffing levels and the need to maintain safe staffing levels across the unit.

A new CofC project lead midwife has now started in post in November and we plan to implement one integrated team in March 2022 who will aim to provide continuity for the whole patient journey. This team will consist of existing CofC midwives who are able to work in all areas of the department.

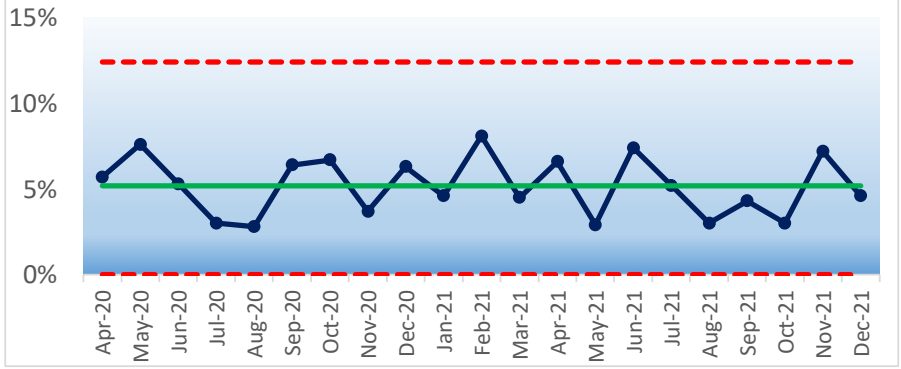
The department are having weekly CofC meetings and implementing a plan for CofC to be the default model of care for all women by March 2023 providing safe staffing levels allow this.

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	Dec-21
Value / RAG rating	4.6%

Indicator description

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

SPC chart



Narrative

% women smoking at time of delivery is 4.6%. Percentages are not high compared to other units in the region. This will be a key work stream for 2022/23.

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	Dec-21
Value / RAG rating	85.9%

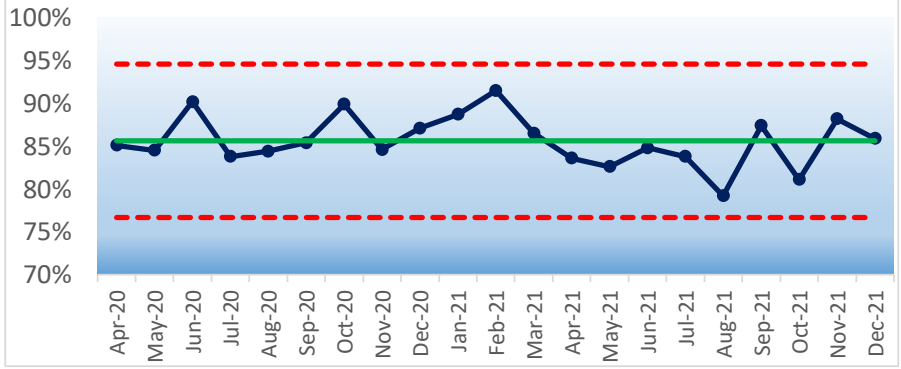
Indicator description

The % of women initiating breastfeeding

Narrative

% women initiating breast feeding remain consistently high and the highest in the region.

SPC chart

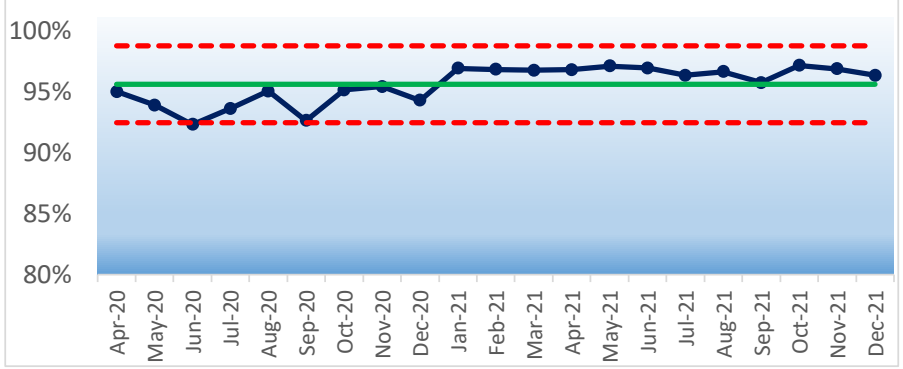


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Dec-21
Value / RAG rating	96.3%

Indicator description

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

SPC chart



Narrative

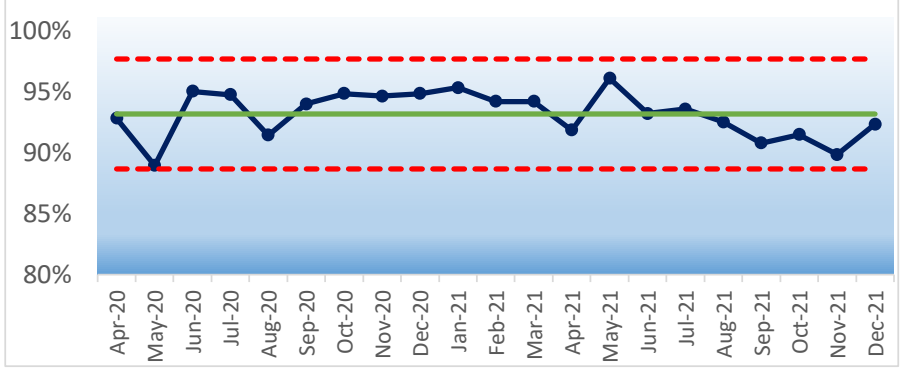
VTE risk assessments continue to meet the 95% standard.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Dec-21
Value / RAG rating	92.3%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

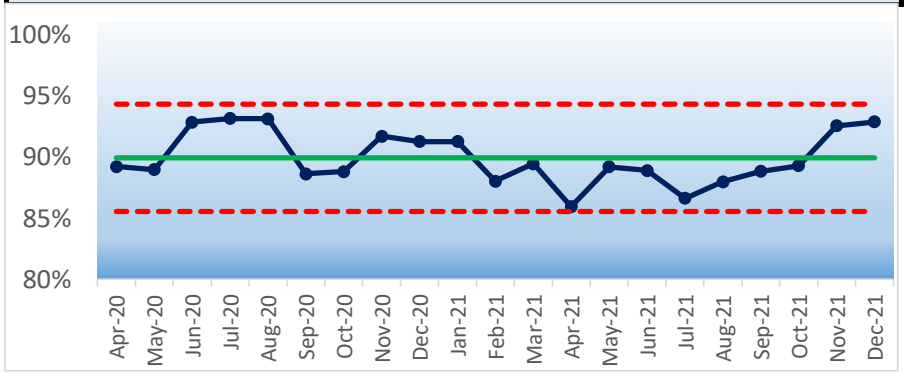
Compliance with the sepsis screening standard has increased this month. Ongoing monitoring of this standard at ward and matron level continues to ensure this is timely and appropropriately captured.

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	Dec-21
Value / RAG rating	92.9%

Indicator description

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

SPC chart



Narrative

Sepsis screening in ED has improved following the focused improvement work in this area.

Integrated Board Report - December 2021

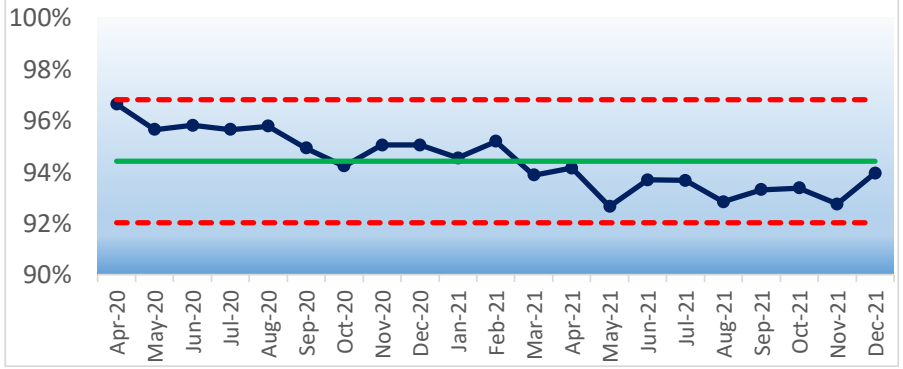
Domain 2 - Caring

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	Dec-21
Value / RAG rating	94.0%

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

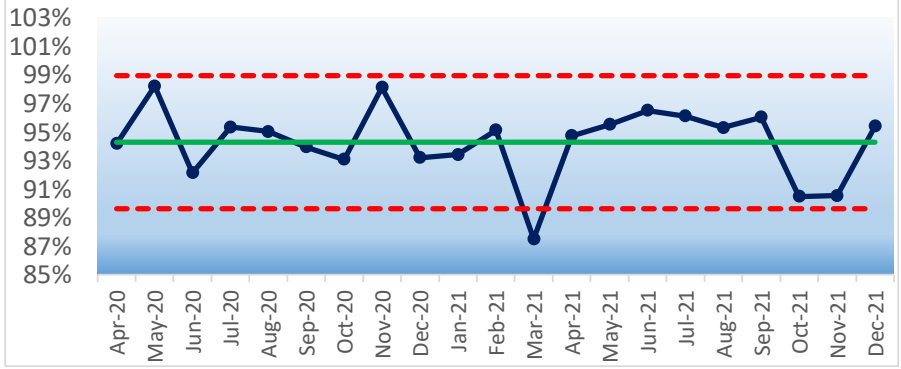
FFT response is positive and improved in December. Monitoring of FFT is via Making Experience Count Forum and linked to the Patient Experience benchmarking work.

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	Dec-21
Value / RAG rating	95.4%

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

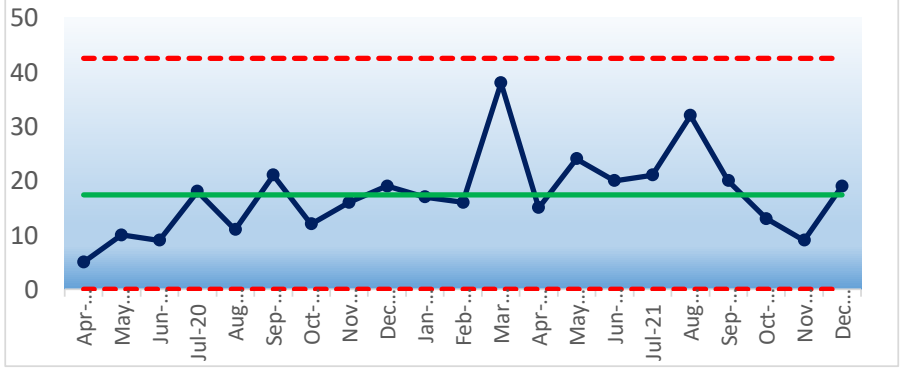
FFT response for community services is positive and improved in December. Monitoring of FFT is via Making Experience Count Forum and linked to the Patient Experience benchmarking work.

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	Dec-21
Value / RAG rating	19

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

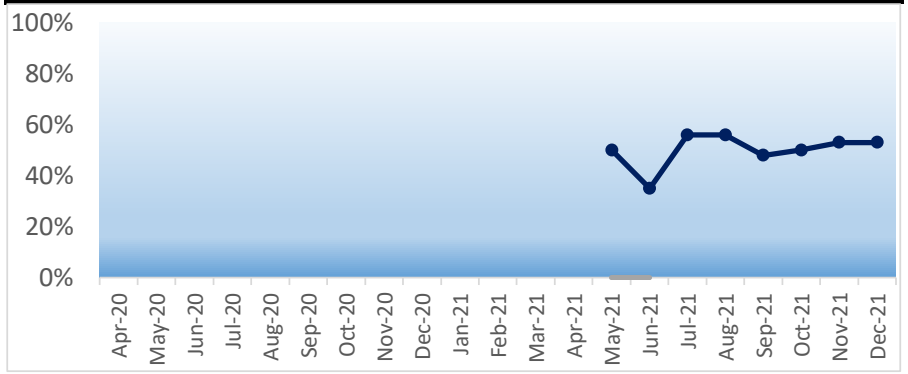
In December HDFT received 19 new complaints, of these 8 are multi agency complaints.

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	Dec-21
Value / RAG rating	53%

Indicator description

The number of complaints responded to within 25 days, shown as the year to date position. The Trust's improvement trajectory for 2021/22 is to respond to 95% of non-multi-agency complaints on time by December 2021.

Trend chart



Narrative

The position on the complaints trajectory for December was to deliver the agreed Trust standard of 95%. This was not achieved and the end of December position was reported as 53%. The work to achieve and maintain the agreed Trust standard of 95% continues and remains high on the Trust's agreed quality priorities.

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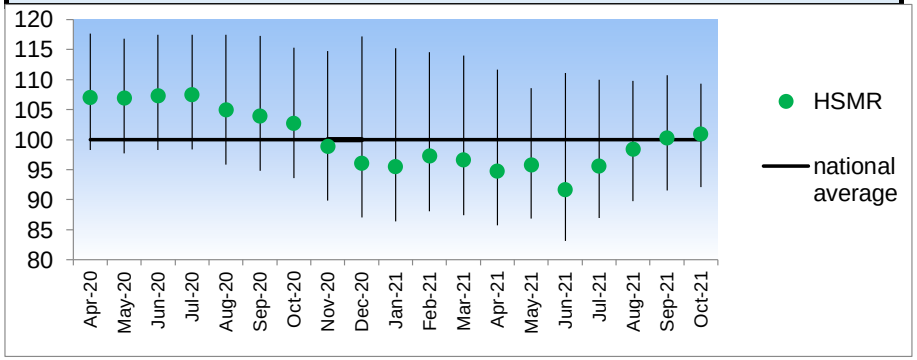
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	100.92

Indicator description

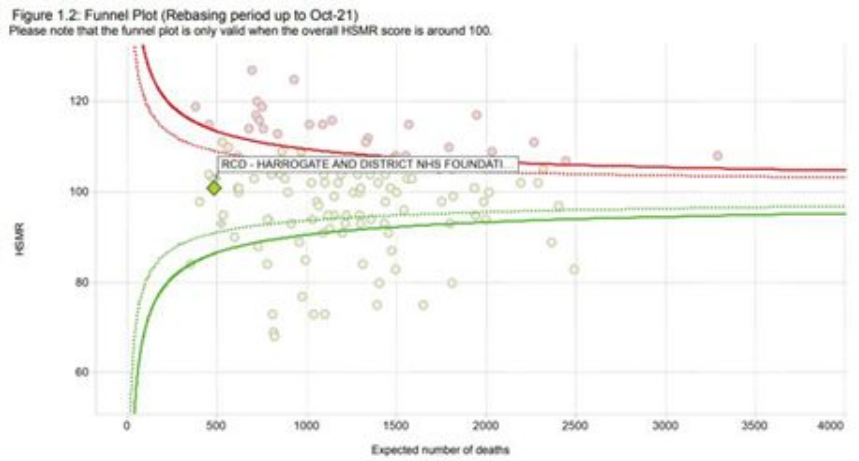
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

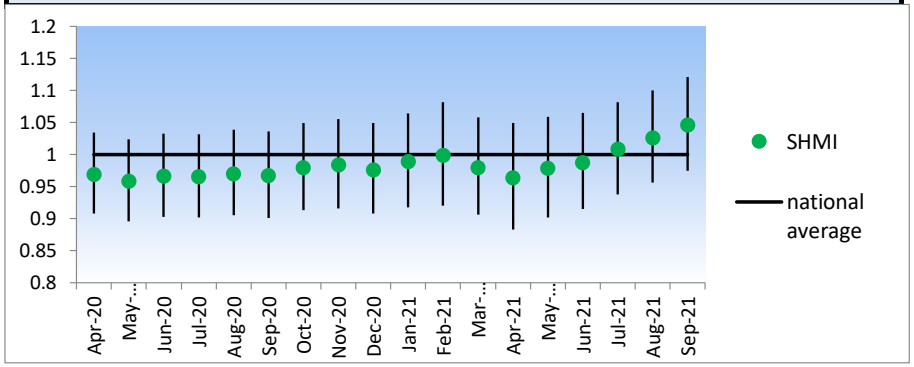


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Sep-21
Value / RAG rating	1.05

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

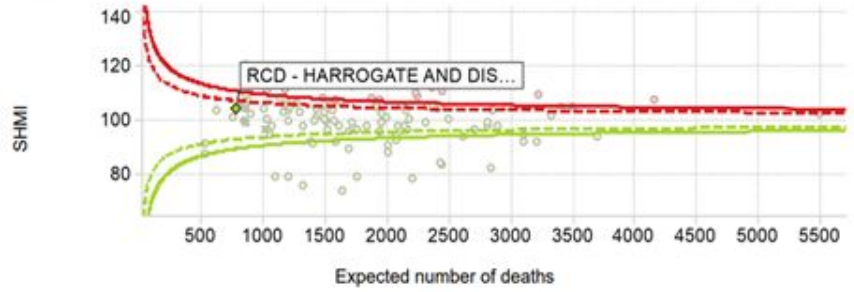


Narrative

National average is 1. HDFT remains within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

Figure 1.2: Poisson Distribution (PD) Funnel Plot

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

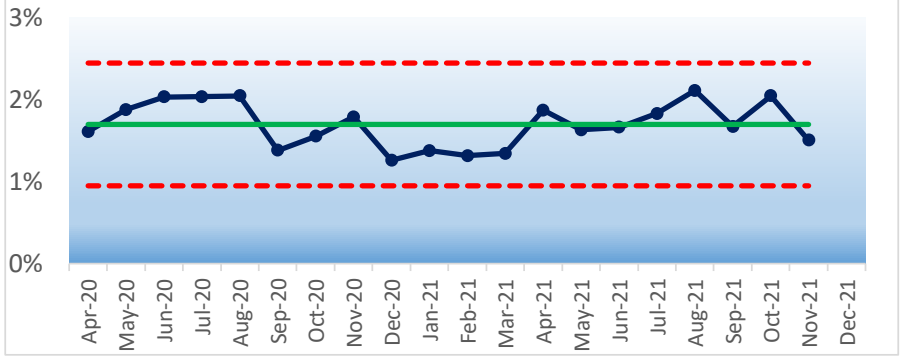


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-21
Value / RAG rating	1.5%

Indicator description

The percentage of 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

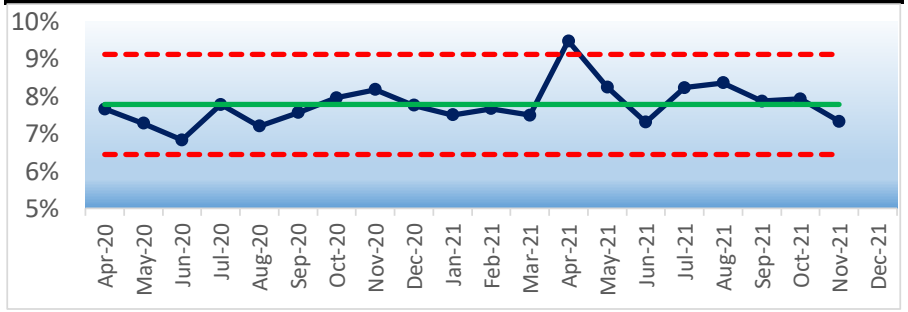
Readmissions following an elective admission decreased in November to 1.5%. This remains within control limits and less than national average.

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	Nov-21
Value / RAG rating	7.3%

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

Readmissions following a non-elective admission decreased in November to 7.3%. This remains within the control limits and in line with national average.

Indicator	**3.4 - Returns to theatre**
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

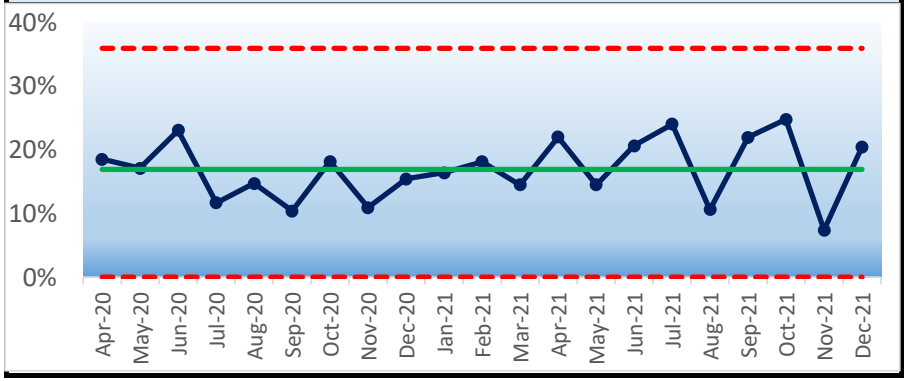
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-21
Value / RAG rating	20.4%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep.

SPC chart



Narrative

Delayed transfer of care reduced in November. The Trust have now purchased a system using funding from NHSE that will allow the ward teams to electronically capture the criteria to reside of every patient. Roll out and training in December 2021.

This will enable real time viewing of delayed patients, however the major blockage with hospital outflow currently is the social care crisis. The reduction reflects higher acuity of patients thus more meeting criteria to reside rather than a significant change in 'delays'.

Board of Directors (Public)
26th January 2022

4.3

Title:	**Caring At Our Best**
Responsible Director:	Executive Medical Director
Author:	Project Manager, PMO and Digital Delivery

Purpose of the report and summary of key issues:	To provide an update on the Caring at Out Best Programme and the specific workstream progress.	
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 Corporate Risks	
Report History:	Report submitted to the SMT in January 2022	
Recommendation:	The Trust Board are requested to note the content of the information contained in the update.	

Matters of concern & risks to escalate

- The current workload of staff with Covid and winter pressures is impacting on the delivery of key milestones and causing delays in implementation.
- Ward daily checklists are currently paper based until Tendable is live. This impacts on our ability to review actions should any incidents occur.
- Issue with the supply of materials has delayed the roll out of the quality dashboards.
- Duplication of milestones with the 'at our best' programme means there is a risk that work is duplicated and/or responsibility for delivery unclear- Director of Strategy undertaking review of all corporate programmes

Major actions commissioned & work underway

- Tendable (previously perfect ward) is fully customised to the requirements for HDFT, familiarisation meetings have taken place with ward staff and planned roll out is end Jan 2022.
- RPIW starting 28th Feb to scope Model Ward and Stage 3 of the CAOB programme.
- Ward Manager review underway now Workforce and Assurance Matron in post. Mtg planned for 15th Feb with Ward Managers to discuss plans and process. Agreement that the role will include protected leadership time to support assurance/accountability and drive quality.
- Triumvirate leadership model, performance and quality reviews in development.
- Patient feedback baseline assessment being undertaken by Interim Associate Director of Nursing to report to Board and Patient Safety Forum in Feb.
- First Learning Summit meeting in Jan to establish the process for dissemination of learning from incidents/complaints/patient feedback.

Positive news & assurance

- Daily ward checklists in place and updated to reflect the learning from SI4474. Daily safety huddles established to review issues highlighted on checklists to ensure plans in place and escalate if needed.
- Comms on Caring at our Best shared with clinical teams and others as part of World Patient Safety day.
- Recruitment to key posts: - Project Manager, Workforce Assurance matron
- CSW induction and preceptorship programmes revised and updated in response to SI.
- Design and procurement of quality dashboards.
- Recruitment of 2 x Clinical Leadership Fellows and a Chief Registrar to promote leadership for clinical staff.
- Making Experience Count Forum refreshed and TORs agreed.
- Launched Inpulse survey to gather regular staff feedback.
- Mandatory training review group relaunched to ensure all training is current and relevant.
- Revised Quality Governance structure agreed and meetings established.

Decisions made & decisions required of the Board

- Note progress against the caring at our best programme plan and the current risks against future delivery

Board of Directors (Public)
26th January 2022

Title:	Director of Nursing Update
Responsible Director:	Director of Nursing
Author:	Deputy Director of Nursing

Purpose of the report and summary of key issues:	For noting and information	
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	CRR5: Nurse Staffing	
Report History:	Update previously submitted to SMT	
Recommendation:	The Board of Directors to note and approve	

Trust Board Report January 2022
Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Staffing Fill Rates have seen a decrease in December due to end of December position in particular with Covid related absences, including isolation. Care Hours Per Patient Day has fallen slightly in December following an improved position in November. This relates to the reduced fill rates due to staff absence and increased acuity and dependency of patients.
- Pressure Ulcers – (*IBR 1.1 & 1.2*) have seen an increase across inpatient and community services. Community services undertaking a deep dive to confirm understanding however overall acuity and dependency with reduced staffing levels
- Complaints (*IBR 2.2.2*) – improvement trajectory of 95% for December was not met, (40%) despite achieving 77% in November. Complaints responses impacted by staffing challenges and band holiday periods.

Major actions commissioned & work underway

- Patient Experience (*IBR 2.2.1 &* 2.2.2):Embedding service user experience and engagement across HDFT baseline assessment underway.
- Rebranding of Freedom to Speak Up to align with 'At Our Best' programme – 'Listening at Our Best'

Positive news & assurance

- Healthcare Support Worker programme – Trust has secured funding from NHSE/I to support implementation of a zero vacancy programme aligned with the revised Care Support Worker Development Framework.
- Nursing, Midwifery & AHP Workforce Assurance meeting established including recruitment and retention workstream.

Decisions made & decisions required of Board

Board of Directors (Public)
26th January 2022

4.5

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

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level safety measures for the month of November as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Maternity Services Forum Maternity Risk management Group	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

4.5

1.0 Summary

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

1.0 Introduction

The new quality surveillance model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. To aid implementation there are local, regional and national elements of this model.

At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the Trust board.

2.0 Proposal

2.1 The report covers the provider Board level measures required as part of the perinatal surveillance model. The report now includes additional neonatal measures.

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

3.0 Quality Implications and Clinical Input

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

4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

5.0 Risks and Mitigating Actions

6.1 The middle grade staffing remains a concern however there are plans in place, explained below in the obstetric cover on delivery suite, gaps in rota section of the report.

6.2 Midwifery staffing levels have continued to be a challenge with gaps in the roster due to staff sickness, the impact of Covid (staff Covid positive and requirement to isolate

due to family contacts) and waiting for staff to start in post. Ongoing recruitment continues for midwifery and MSW staff and staff.

6.3 There has been no demonstrable improvement in the compliance levels for safeguarding children level 3 training since the last report in December. There is a plan to improve levels and access to training days for staff in 2022.

7.0 Recommendation

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

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Middle grade obstetric staffing levels • midwifery staffing levels • Community and CofC midwives access to GP surgeries	• Maternity incentive scheme (NHS Resolution) – decision to pause for 3 months recognising current pressures. Trusts asked to continue to apply the principles of the 10 safety actions.
Positive news & assurance	**Decisions made & decisions required of SMT**
• Successful IT bid – currently embargoed • Successful recruitment of an MVP chair • No formal complaints received in December • 2 midwives received Making a Difference awards • OASI2 project launched December 13th – go live January • One escalation and no women diverted in December	

Narrative in support of the Provider Board Level Measures – December 2021 data

Introduction

The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

- A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
- All maternity Serious Incidents (SIs) are shared with Trust Boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

Obstetric cover on the delivery suite, gaps in rotas

The obstetric cover for delivery suite runs 24 hours a day, 7 days a week. There is always an onsite first on call doctor and second on call doctor. The consultant is on site Monday – Friday 08:00h – 16:30h and on call thereafter within 30 minutes of the hospital.

The second on call rota is staffed by permanent specialty doctors (establishment 4 WTE), and doctors in training in obstetrics and gynaecology (establishment 3 WTE). At specialty doctor level one of the permanent posts is filled by a locum appointment because of difficulties in recruitment. Due to clinical skills and experience required a consultant is required to be present on site.

The locum specialty doctor is leaving for a post elsewhere from February. The substantive post is out to advert and the response has been favourable, with interviews scheduled in January. Most candidates have no UK experience, but do have significant experience elsewhere. We are hopeful that we will be able to appoint from this pool and with a robust induction period to compensate for lack of NHS experience.

At the doctor in training level, there is doctor in their third year of training in obstetrics and gynaecology who does not yet have the clinical skills or experience to be on call without a consultant present and again needs a consultant on site. This therefore impacts on the ability to cover nights and weekend on call because there is no resident consultant. They are undertaking long days on labour ward, meaning the consultant is on site until 20:00h when they then return home and are available as required.

The department is working towards consultant on site cover 08:00h – 20:00h seven days per week in line with the recommendations form the Ockenden Report. This would alleviate some of the issues around on site supervision of doctors in training.

An additional two doctors in training, are not currently available for work due to relocation and sickness. We have received word from HEE that they will not be replaced before their intended date of rotation August.

The above set of circumstances leaves the second on call rota particularly vulnerable. This is stabilised by resilience from consistent use of agency. It is hoped that we will be able to recruit more than one specialty doctor at the forthcoming interviews, which will relieve the situation. However, there is anxiety about the length of time it may take to get them in post with visa requirements etc. There is a well understood contingency plan for ensuring that the provision of a three tier on call is maintained which ultimately results in the consultant becoming resident. However, these events have an inevitable effect on the ability of the consultant body to undertake elective work as they take compensatory rest after resident on site duties. In addition, the middle grade and consultant work force are at risk of fatigue with the additional pressure.

To assure the board, with mitigations as described above, the maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below. At the next board we will provide further detail on the success of specialty doctor recruitment and also on the plans for consultant resident seven days a week 08:00 – 20:00.

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	Three doctors working on the middle grade rota are unable to work without on-site senior supervision. ST6 doctor will be leaving on an inter-deanery transfer February 2022 and will not be replaced by the deanery until August 2022.	Internal cover prioritising labour ward cover Internal cover for short term sickness as required Consultants covering shortfall Urgent recruitment to the vacant post required	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
Consultant	No gaps		

Midwifery safe staffing, vacancies and recruitment update

Midwife minimum safe staffing planned cover versus actual prospectively.

Average fill rate

Average fill rate	**Midwives**	**MSW's**
Delivery Suite	92.7%	79.8%
Pannal ward	89.6%	70.2%

Sickness

Delivery Suite	**Midwives**	**MSW's**
Short Term	9 midwives (216 hours) (cold, stress- not work related, gastroenteritis and pregnancy related)	1 MSW (11.5 hours) Cough, cold flu symptoms
Long Term	1 midwife (168 hours fractured foot)	None

Maternity leave	3 midwives (2.5 WTE)	1 MSW (0.5 WTE)
Paid absence/unpaid absence	2 midwives (23 hours paid carers leave & 11.5 unpaid carers leave))	None
Medical Isolation	2 midwives (46 hours both tested positive for Covid not household contact)	1 MSW (23 hours tested positive not household contact)
Non patient facing	0	0
Pannal ward		
Short Term	3 midwives (47 hours respiratory and gastroenteritis)	2 MSW (34.5 hours migraine and stress)
Long Term	1 midwife (92 hours broken elbow)	0 MSW
Maternity leave	5 midwives (4 WTE)	1 MSW (0.9 WTE)
Paid absence/unpaid absence	0	0
Medical Isolation	4 midwives (227 hours 1 Covid positive and 3 household contact)	3 MSW's (45.5 household contact)
Non patient facing	0	0

Common sickness themes in December 2021 have been severe colds (respiratory) and gastroenteritis with two midwives off on long-term sick both with fractures. The inpatient area has lost 273 hours on Covid medical isolation for midwives which equates to 23 long shifts and 68.5 hours for MSW's which equates to 5.95 long shifts. This is a combination of staff being Covid positive and household contact.

Sickness is managed in line with the current HR policies and processes

Staffing and vacancies

Midwives			
Agreed WTE establishment	Staff in post (WTE)	Staff recruited awaiting start date (WTE)	Vacancies out to advert (WTE)
Band 8	2.00	0	0
Band 7	16.71	1	0
Band 6	41.73	3.44	4.16
Band 5	8.32	1.00	2.6
Band 3	5.00	0.90	3.2
Band 2	9.10	0.00	2

1 midwife has retired in December (previous retire and return)
1 midwife has transferred to SCBU as band 5
1 band 3 Maternity Support Worker has left to start her midwifery training
1 band 2 community clerk has left due to childcare commitments and these hours have been converted to a band 3 Continuity of Carer Maternity Support Worker as there was some unused band 3 hours within the budget
There has been no resignations during the month of December.

Use of NHSP for December

Pannal Ward – Midwives 9% of shifts were covered by NHSP (14 shifts), MSW's 0 % of shifts were covered by NHSP

Delivery Suite – Midwives - 8.6% of shifts were covered by NHSP (32 shifts). MSW's 6% of shifts were covered by NHSP (4)

Number of times the maternity unit was closed to further admissions/women diverted and action

Number of times the unit closed to further admissions and women diverted to other maternity units in the region between August - December:

	August	September	October	November	December
No. of times maternity unit closed to admissions	7	8	5	6	1
Reason					
Increased activity	5	8	3	4	1
Staffing below minimum levels	3	8	4	2	1
No. of women diverted to other maternity units	2	2	7	10	0

Due to the increased number of women diverted in the month of November, a more detailed review of these episodes was undertaken by the HOM – reasons for diversion, activity, staffing and next steps. A copy of the report is attached below:

Escalation report (November) 1.doc

Despite continued challenges with midwifery staffing, the maternity unit closed once to admissions in December and no women were diverted to another maternity unit as a consequence of this. This will be closely monitored during 2022.

December data – BR+ acuity tool

1:1 care in labour – 99.5% (November 100%)

Labour ward coordinator supernumerary 73% (November - 73%)

Midwife: birth ratio – 1:28.3 (gold standard 1:28 RCM recommendation)

Percentage of specialist midwives in post – 7.2 WTE (no change)

Red Flag events (Birthrate +)

Delivery Suite

There were 3 Red Flags identified from the Birth Rate Plus Data

- Delay between admission for induction and beginning of process x 2

- Midwife unable to provide 1:1 high dependency care for AN or PN patient x 1

Pannal Ward

There were 5 Red Flags identified from the Birth Rate Plus Data

- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) x 1
- Delay between presentation and triage x 1
- Delay between admission for induction and beginning of process x 3

Safer staffing – neonatal services

1.0 WTE recruited into with QIS commencing 14/2/21. Waiting for official resignation of 1.0 WTE QIS who is leaving, she is moving to YORK where she lives, she has found driving home post nights difficult. Therefore will be back to 1.45 WTE vacancy. Interviewing this week for a further Neonatal nurse.

12% of our workforce in December was covered by agency, this was due to COVID isolation and vacancy.

Qualified in Speciality (QIS) – 87% for December (aim for above 70%)

1.0 WTE QIS due to start in February, however waiting for resignation of 1.0 WTE therefore will cancel each other out. No staff on LTS.

Staff sickness

SCBU	Nurses	Nursery Nurse
Short Term	4 nurses (92 hours, Covid, cold symptoms, stress unrelated to work)	None
Long Term	None	None
Maternity leave	None	None
Medical Isolation	3 nurses (46 hours)	None

Essential training compliance for all staff groups related to the core competency framework and wider job essential training – (maternity and neonatal)

Prompt emergency face-to-face training recommenced in October.

Training compliance in December

- Fetal surveillance – midwives – 81% and obstetric staff – 86% (November - midwives 87% and obstetric staff 93%)
- Neonatal life support (midwives) – 83% (88% in November)
- Prompt emergency training – midwives 89%, medical staff – 83% and MSW's 70% (medical staff 80%, midwives 87%, MSW's 76%, anaesthetists 100% in November).

Following a meeting with the new named nurse for safeguarding progress on the plan made;

- No improvement in the completion of e-workbooks due to reduced midwifery staffing in December however there is evidence that 20 midwives have commenced the e-workbooks
- There were no new dates for safeguarding level 3 training in December
- The new safeguarding lead midwife starts in post beginning of March
- There is a new practice development nurse on Woodlands ward who is currently arranging the study days and looking at a three hour slot on this training day to do level 3 safeguarding to support compliance, this will be a good opportunity for the midwives to join
- There are also new work books about to come out early 2022 on learning from Serious Case Reviews after staff have completed the current e-workbooks.

SCBU
No change to safeguarding children's training compliance since the last report.

- Safeguarding level 3 - 83% (November 83%)
- Safeguarding supervision – 92% (November 92%)

Risk and Safety

Risk register summary
The Risk Register was reviewed with PSC Quality Assurance Lead on 23rd Nov 2021. Risk Register now transferred to Datix. Currently there are 8 open risks.

- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 12).** Previous gaps in Middle Grade rota and issues with entrustability now worsened by additional issues of Middle Grade post coming to an end, long term sickness, and further staff member relocating. Work ongoing and vacancy advertised. Ongoing issue in recruitment. Agency locum requested. Risk Level upgraded and escalated to Maternity Safety Champions.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 12).** Additional staff in place but ongoing issue with retention. Continuing recruitment and attempts to fill gaps with extras, agency staff and financial incentives. Staff being moved between areas according to need. Managers and specialist midwives working clinically as required. Upgraded on advice of Maternity Safety Champions meeting to align with Directorate
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 12).** Procurement process completed and preferred supplier notified and contract signing. For implementation and downgrade once in place.
- **Risk to patient safety and experience from GP surgeries removing support for midwifery clinics (Score 10).** Situation increasingly challenging and risk score increased. Escalated to CCG and PCN Link GP.
- **Failure to meet national targets in relation to Continuity of Carer (Score 10).** Currently unable to meet targets and zero compliance reported. Local plan in place to build existing teams in community, to recommence in March 2022. Anticipated visit of National Team. Regular discussion about plan ongoing.
- **Lack of local frenulotomy service leading to delays in treatment of neonatal tongue-tie (Score 8).** Infant Feeding Coordinator undergone training and competency training completed. Commissioning of this service is being agreed.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Additional face-face training dates being identified for

new starters Jan 2022. For focused L3 updates for existing acute staff.
Team Leaders providing supervision sessions and uploading to Learning Lab.

- **Postnatal care plans not being filed within hospital notes in timely manner when discharged from midwifery care (Score 6).** Planned use of agency staff to clear backlog. For review of ongoing process.

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

In December 2021 there were 43 total incidents reported through Datix. Of these, there were no incidents recorded as Moderate Harm.

One specific incident of note escalated for 48h report, relating to a termination of pregnancy undertaken under direction of BPAS (British Pregnancy Advisory Service) without prior ultrasound scan to confirm gestational age (due to Covid restrictions). The incident was reported to the Coroner as a possible unlawful termination, and to BPAS who will undertake their own investigation.

SCBU Incidents

Risk Register

Medical Staffing from March 2022 – score 9

Gap 3 WTE middle grades, one is a permanent CESR, Gap 1.6 WTE at junior level.

Mitigation: Locums booked for empty shifts, vacancy control for 1 permanent CESR and 6 month locum middle and junior grade. Not sending any staff to Bradford neonates as part of CESR rotation. 3 part time members of staff have agreed to increase their hours.

Cot occupancy (Cots available on the unit = 7).

December – cot occupancy = 62.2%
Remained open with 7 cots, 2 babies at present.

ATAIN
In December = 5 babies, 1 low harm.

Babies transferred out.

No babies transferred out in December.

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

Perinatal Monitoring Review Tool Report: All PMRTs are completed – none to report for December.

Service User feedback

Maternity Voice Partnership group – after interviews early December we have successfully recruited a new MVP chair, Jen Baldry. This is a paid role by North Yorkshire CCG. We have introduced Jen to WY&H LMS, North Yorkshire CCG, Andy Papworth, non-executive maternity safety champion and have a meeting planned for early January to discuss and agree plans for 2022.

Complaints / concerns to PET / compliments

FFT - 21 responses have been received for Friends and Family (FFT) in December 2021. Of the 21 responses inputted for December 2021 95.24% responses were reported as good or very good (20 responses) and 4.76% responses were reported as poor or very poor (1

response). Feedback is given to the team leaders and individual teams monthly with any negative trends themes disseminated to reduce replication. Individuals named are also given feedback.

No formal complaints received in December.

One concern raised via the Patient Experience team – a patient requested additional information on the documentation of facial bruising to her baby after a forceps delivery, this information was provided. The patient also requested a copy of her hospital notes, on receipt of these may require a further conversation.

Compliments

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

2 midwives received Making a Difference awards in December.

A midwife was nominated by a family who received outstanding care and attention from the team. During their stay, they felt lucky to come under the care of Laila who couldn't have been more efficient, proficient, professional and caring. They were overjoyed when on the morning of the planned delivery, Laila was back on shift and would be with them during the delivery. The family were privileged to have her welcome their new born son into the world and she made the whole thing seem like she was a member of their family. They were sad to say goodbye to Laila at the end of her shift.

Another midwife was nominated by her colleagues for her expert and sensitive handling of a really difficult safeguarding case for a mother and baby. Cory worked with all the agencies involved to gather information and she has been a shining light at meetings. Cory has been outstanding - thorough, proactive, diligent, and so kind and patient focussed throughout this whole case. She has fostered a good relationship with the parties involved despite incredibly challenging circumstances and is an absolute credit to her team and her profession.

Parents feedback received by SCBU

Comments from Parents from Patient satisfaction survey August to October.

Having your first baby is overwhelming and we were made to feel incredibly comfortable by everyone. Thank you so much and keep doing what you're doing, it makes a huge difference to us

Everyone has been so lovely and amazing so I would love to thank everyone for everything they have done

A huge thank you to such a wonderful team, there aren't enough words to express our gratitude to you all. Thank you for showing us all such love whilst here.

Thank you for the amazing support. I feel set up for success, with resilience and a connection to baby. The toilet is not convenient as you have to be buzzed in. It increases stress when you can't get back in - though always for good reason as staff are very attentive.

Thank you so much for all you have done. This was the hardest week of our lives and without the amazing staff on SCBU we would not have coped. Thank you for being there for our little girl and answering our many questions and concerns, supporting us and helping us leave feeling so much more confident to support our baby.

Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in December 2021.

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

In December 2021:

No new cases notified in this period

Action plans from previous cases are being progressed with monitoring of the action plans through MRMG. There are no open HSIB cases.

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

Maternity incentive scheme – year 3 (update)

Following the results of an FOI by Baby Lifeline submitted in December, NHS Resolution are seeking assurance from Trusts to re-confirm in writing whether the minimum training requirements of safety action 6 and 8 of the scheme were achieved. Harrogate did submit the FOI request and re-confirmation was completed in the timeframe requested.

Maternity incentive scheme – year 4 (NHS Resolution)

Key staff in the maternity department continue to work towards compliance with the ten maternity safety actions for year 4 of the scheme.

Update from NHS Resolution (24th December)

In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) **10 safety actions are paused with immediate effect for a minimum of 3 months**. This will be kept under review. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care.

Trusts will be provided with a timetable and revised technical guidance in due course and those will also be shared via your submitted MIS nominated contacts and posted on NHS Resolution's website.

Safety action 5 – midwifery workforce

The bi-annual midwifery staffing report is a requirement of safety standard 5 – demonstration of an effective system of midwifery workforce planning to the required standard:

- A systematic, evidence based process to calculate midwifery staffing establishment is completed
- The midwifery coordinator in charge of labour ward must have supernumerary status (defined as having no caseload of their own during their shift) to ensure there is oversight of all birth activity within the service
- All women in active labour receive 1:1 midwifery care
- Submission of a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every 6 months, during the maternity incentive scheme year four reporting period.

The bi-annual midwifery report is complete covering the period April – September 2021. Please find a copy below.

Bi annual staffing report April 21-Sept

Matters of concern (from the bi-annual staffing report)

- 9.4WTE midwives on maternity leave
- High levels of diversion – 27 occasions over 6 months compared to 15 in previous 6 months – report completed for November)
- DS coordinator supernumerary 81.15% - action plan to be devised
- Continuity of carer on hold – 0% compliance since May – plan in place to introduce an integrated team in March 2022
- High levels of red flags on Pannal ward for delayed or cancelled time critical activity

Positive news and assurance

- Funding received for 5.0WTE additional midwives (Ockenden monies)
- 97% 1:1 care in established labour
- 2.5WTE band 3 MSW's recruited for Maternity Assessment Centre

National priorities

- **Midwifery Continuity of carer (MCofC) update**

We continue to declare 0% compliance, as we are not providing care in labour to women on a continuity of carer pathway. We continue to aim to achieve full midwifery establishment, including the additional 5.0WTE midwives identified in the Birthrate + report. New staff are being recruited to build the existing continuity teams and concentrate on providing continuity in the antenatal and postnatal periods.

Rachel Askey started her secondment in Harrogate until May 2022 and has been concentrating on the implementation of a first team in March 2022 who will provide intrapartum care.

A supportive meeting planned for January 28th 2022 with the regional CofC midwifery leads and regional lead midwives to discuss implementation of our local plan has been postponed to February due to operational pressures and reduced face to face meetings due to Covid.

Update on local plans for MCofC

Planning has identified we will need 5 teams of midwives to deliver full MCoC for all eligible women by March 2023 as per national targets.

Analysis of the workforce planning tool demonstrates that we will be able to roll out 2 teams and achieve 43% MCoC with our current workforce whilst maintaining stability in both inpatient and community areas. A 3rd team can be rolled out when we are staffed to our current funded establishment taking us to 64%. Additional teams will require investment and recruitment of 7.0WTE midwives (2 for team 4 to achieve 85% and a further 5 for the 5th team taking us to 100%). Work continues on a business case to secure this investment.

All new midwives recruited to the trust have been recruited to work in MCoC models and there is growing enthusiasm for working in this way amongst the workforce. Our first 2 teams will be staffed with volunteers and those currently working in integrated roles.

Work continues with workforce engagement to promote the benefits of MCoC for women, midwives and the service as a whole.

The first team of midwives have been identified with plan to roll out in Mar/ April 2022, this will most likely cover the Mowbray Square PCN as we currently have suitable clinical space at the medical centre. This cohort of women also includes the highest proportion of BAME women in our footprint (6.7% of bookings compared to 3.3% average in other PCN).

Estates

Significant challenges remain in securing suitable accommodation for community hubs for midwives to work from and see women for antenatal care. This is a major risk to achieving full scale MCoC. Work continues to identify suitable sites though additional investment is likely be needed which will form part of our business case.

Clinical space is secured for the first team, with additional available space for antenatal classes and meet the midwife sessions. However no suitable base/ office space for midwives has yet been secured which has the potential to impact on the ability of the midwives to work as a cohesive and effective team.

Update on Ockenden action plan

Work to be completed from the action plan:

- Recruit a clinical audit & effectiveness role (maternity specific) to support the ongoing audits recommended in the Ockenden report – post being advertised
- Review and update patient information leaflets (maternity specific)
- Ratify the patient information leaflet for maternal choice for caesarean section (MRMG 15th January)
- Review NICE guidance and compliance
- Work with the local new chair of the local MVP group to ensure the voices of services users are heard via this forum.

The second part of the Ockenden report is expected in March 2022.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

No new regional update since October.

In summary for Quarter 2:

- Bookings less than 10 weeks are 72.5% and amongst the highest in the region. No Y&H Trust has met the 90% target, with the lowest Trust achieving 36.5%.
- 1:1 care in labour was 96.9%. Again, this compares very well against other Trusts (regional average 94.3%).
- Normal delivery rate is the lowest in the region (52.2%) against a regional average of 58.8%.
- Total Caesarean section rate was 34.1% (compared with the regional average of 31.4%). Of these, there were 16.6% elective Caesarean sections (compared with 13.2% regional average).
- Induction rate (29.1%) was lower than the Y&H average (34.1%)
- Significant PPH rate was lower in this quarter (4.4%), but marginally raised compared with the regional average (3.9%). This will reflect the higher Caesarean section rates.
- There were no stillbirths at HDFT in Q2. Rolling annual antenatal stillbirth rate is significantly lower (1.1 per 1000 births compared with the Y&H average of 3.5 per 1000)
- Breastfeeding initiation rates remain very high at 83.6% compared with the regional average of 69.0%, and are the highest in the region.
- Smoking rates at booking and time of birth are the lowest in the region (6.1% and 4.2% respectively)
- Carbon monoxide testing at booking and 36 weeks remains a challenge.

Local HDFT dashboard information (annual 2021)

For month of December:

- 153 mothers delivered (and 156 babies born)
- Elective Caesarean section rate 18.3% (increase since Nov, 15.8%).
- 10.5% emergency Caesarean section rate (lower than Nov, 13.2%)
- 58.1% normal delivery rate (increase from Nov, 56.6% and the highest rate this year)
- 32.7% induction rate (increase from Nov, 29.6%)
- 3.3% significant PPH ≥1500ml rate (reduced compared to Nov [3.9%]; 5 patients)
- 6 x 3rd degree tears [4 at normal delivery; 2 at instrumental delivery] – OASI2 project commenced (see information below)
- 85.9% breastfeeding initiation rate
- 4.6% smoking rate at time of delivery [7.2% in Nov]
- 2 stillbirths

OASI2 Project

An obstetric anal sphincter injury (OASI), is the combined term for a third- or fourth-degree perineal tear, a severe complication of vaginal childbirth. Long-term outcomes of OASI include chronic pain, sexual dysfunction, and urinary and/or anal incontinence. OASI rates are increasing in many countries. In the UK, OASI rates tripled among primiparous women over a 10-year period. The rise in OASI rates was linked to improved recognition of tears, changes in the characteristics of women giving birth as well as to changes in practice, such as an increased use of a 'hands-poised/hands-off' approach, opposed to a 'hands-on' approach to protect the perineum during childbirth, a reluctance to perform an episiotomy, and gaps in the training of midwives and obstetricians.

In response to rising OASI rates, a multidisciplinary team of national experts, supported by the RCM and the RCOG, developed The OASI Care Bundle. The OASI Care Bundle has four elements: antenatal education of women, manual protection of the perineum during delivery, consent for episiotomy if required and rectal examination following delivery.

Through OASI1, the OASI Care Bundle proved to be acceptable, appropriate, and feasible for clinicians and women and is clinically effective in reducing OASI rates. In this follow-on project – OASI2, the focus is on studying and optimising the implementation of the care bundle for eventual national scale-up in the UK, with the primary focus shifting from clinical to implementation effectiveness.

The OASI2 project was launched in Harrogate on 13th December 2021, facilitated by Andrea Stephenson, Rachael Fawcett (DS team leaders), Louise Wills (research midwife) and supported by Mr. Justin and Mr. Altanis (Consultant Obstetricians & Gynaecologists). We have previously implemented some of the aspects of the OASI care bundle and these elements have become embedded in clinical practice however we have not succeeded in reducing our OASI rate. As a multi-disciplinary team, we have identified that we would benefit from the additional support and training offered within this project.

Conclusion and recommendation

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

Appendix - Supporting information – (applicable to some sections of the report)

This section provides additional information around individual sections in the report.

Birthrate + acuity tool

The Birthrate Plus acuity tool is currently the only midwifery specific, national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services. It provides a valuable resource that can routinely support operational and strategic decision making in maternity services. The tool is a prospective "real time" tool that assesses the numbers of midwives and support staff required to safely operate intrapartum and ward services.
Birthrate Plus can calculate an individual ratio of clinical midwives to births for maternity services by reviewing activity, case mix, local demographics and skill mix.
Using NICE guidance and available evidence and best practice, Birthrate Plus calculates how many midwives would be required to meet the needs of women across the whole service.

Birthrate Plus makes a distinction between midwives who provide direct clinical care and those employed in management, development and governance roles, essential to the safe running of the service but not directly involved in clinical care of women. Birthrate Plus recognises that not all of the clinical work in maternity needs to be undertaken by midwives and that by enriching skill mix to include maternity support workers (MSWs) and nursery nurses, midwifery time and expertise can be better focused and targeted. Individual units will make their own judgement about the proportion of midwifery time that can safely be replaced by other roles.

- The suggested skill mix adjustment is 90:10 for clinical support staff who replace midwifery hours.
- Support staff who assist midwives but do not provide direct care e.g. clerical staff and housekeepers should not be included in this ratio.

Safer staffing – neonatal services (SCBU)

- Each shift has 2 registered nurses on duty one being Qualified in Speciality (QIS) meeting BAPM Professional guidance regarding optimal nurse staffing as described in the BAPM Service Standards for Hospitals providing Neonatal Care (2010)
- The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

Qualified in speciality

In the last five years the response to the National Audit Office report (NAO, 2007) into neonatal care delivered in the UK has resulted in the publication of government and professional standards (DH, 2009; BAPM, 2010, NICE, 2011). Within all these frameworks for care, clear recommendations are made for the role of the QIS nurse as a central member of the nursing workforce. QIS nurses provide a pivotal role in workforce strategy, not only in providing direct clinical care to babies and families. Once qualified they are able to develop further into more specialised clinical practice areas (e.g. stabilisation and transport, breast feeding advisor, outreach nurse), or enhance their practice skills/knowledge (eg intubation, cannulation, surgical nursing), and undertake development to advanced practice

level. They are also vital for supporting the foundation learning of novice nurses in neonatal areas.

National drivers for nursing include standardisation of levels of competence (DH, 2008). Competence in practice relies on the assessment of knowledge and understanding, and in skills performance. At QIS level the expectation is for the neonatal nurse to be able to apply knowledge to practice in terms of rationalising judgements, problem solving and making clinical decisions in order to optimise infant outcomes.

Perinatal Mortality Review Tool (PMRT)

Commissioned in 2016, the national Perinatal Mortality Review Tool places at its core the fundamental aim of supporting objective, robust and standardised review to provide answers for bereaved parents about why their baby died. A further aim of the tool is to ensure local and national learning to improve care and ultimately prevent future baby deaths.

The national PMRT was developed with clinicians and bereaved parents in 2017 and was launched in England, Wales and Scotland in early 2018. Unlike other review or investigation processes, the PMRT makes it possible to review every baby death, after 22 weeks' gestation, and not just a subset of deaths. For 92% of parents the PMRT process will likely be the only review of their baby's death they will receive.

Further refinement and development of the PMRT continued through 2019 and 2020. In addition, the tool was adapted in mid-2020 to enable the impact of SARS-CoV-2 on service delivery be reflected in reviews.

It remains the case that the PMRT is only a tool, and will therefore, only be as good as the information that is inputted into it and the way it is used. If it is to achieve the original vision set out by the Task and Finish Group in 2012, it is up to Trusts and Health Boards to improve the way this process is supported and implemented.

ATAIN

ATAIN (Avoiding Term Admission into Neonatal unit) is a national programme designed to reduce avoidable admissions of Term gestation babies, and reduce the harm caused by separation of mothers and their babies. The work focuses on quality improvement work in four main areas:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

To aid this, all Term admissions to SCBU are reviewed against a standardised proforma through a monthly multidisciplinary panel (midwifery, obstetric and paediatric/neonatal) to determine whether the admission could have been avoided and whether there is any learning or practice changes that could be embedded.

Data for Term admissions is captured through an ATAIN dashboard, submitted through the WY&H LMS, together with an action plan of learning points.

Coroner Reg 28 made directly to Trust

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

Maternity Voice Partnership (MVP)

A Maternity Voice Partnership (MVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. It includes a team of service users, midwives, doctors and commissioners, working together to review and contribute to the development of local maternity services.

A successful MVP needs:

- Structure
- Membership
- Role Descriptions
- Terms of Reference
- Funding
- Women's feedback

The Harrogate MVP launched in November 2018, before this date there was no equivalent group at local level. Since the end of 2018, we have been on an extensive journey.

A chair was nominated at the beginning of this process on a voluntary basis to help set up, develop the group and to chair the meetings. The chair successfully recruited a small number of local women to take part. Apart from close communication with the WY&H LMS senior Midwife, we have had little guidance and support in developing this group. From the beginning, the chair of the group did not request payment for performing this important role. At the time, none of us appreciated the amount of work that would be required and the necessary commitment to the role at both local and regional level.

Since the start of the group in late 2018, we have achieved the following:

- Had quarterly meetings of the main group with sub-meetings arranged for members of the committee and local women in-between
- Before Covid-19, the meetings were held face to face in a local children's centre with attendance by a small number of women, the CCG, the chair, HOM, Matron, the parent education midwife
- The chair is invited to the bi-monthly Maternity Services Forum (MSF) and receives minutes of this meeting if unable to attend
- Agreed TOR for the group
- Before Covid – 19, members of the MVP group completed 15 steps challenge in all areas of the maternity department, walk the patch and worked with the maternity service to survey women's experiences of maternity services during Covid-19. There is an action plan in place monitored by the MVP group and MSF

Healthcare Safety Investigation Branch (HSIB)

HSIB conduct independent investigations of patient safety concerns in NHS-funded care across England. The maternity investigation programme is part of a national action plan to make maternity care safer. The organisation is in a unique position as a national and independent investigating body to:

- Use a standardised approach to maternity investigations without attributing blame or liability.
- Work with families to make sure we understand from their perspective what has happened when an incident has occurred.
- Work with NHS staff and support local trust teams to improve maternity safety investigations.
- Bring together the findings of our reports to identify themes and influence change across the national maternity healthcare system.

All NHS trusts with maternity services in England refer incidents to the teams at HSIB.

Most harm in healthcare results from problems within the systems and processes that determine how care is delivered. HSIB investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. The recommendations made aim to improve healthcare systems and processes in order to reduce risk and improve safety. HSIB, as an organisation values independence, transparency, objectivity, expertise and learning for improvement. Work closely with patients, families and healthcare staff affected by patient safety incidents, they never attribute blame or liability to individuals. HSIB is funded by the Department of Health & Social Care and hosted by NHS England and NHS Improvement.

During the investigations, all clinical and medical aspects of the incident are reviewed, as well as aspects of the workplace environment and culture surrounding the incident.

Criteria for inclusion:

- All incidents that meet the Each baby Counts criteria or defined criteria for maternal deaths
- Eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes
- Where the baby was thought to be alive at the start of labour but was born with no signs of life
- When the baby died within the first week of life (0-6 days) of any cause

Potential severe brain injury diagnosed in the first 7 days of life, when the baby:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) - brain injury caused by the baby's brain not getting enough oxygen.
- Was therapeutically cooled (active cooling only) - when the baby’s body temperature was lowered using a cooling mattress or cap, with the aim of reducing the impact of HIE.
- Had decreased central tone (was floppy) and was comatose and had seizures of any kind.

Maternity Incentive Scheme (NHS Resolution) – Year 4

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

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

1. Can you demonstrate the use of the national PMRT to review perinatal deaths to the required standard?
2. Can you demonstrate submission of data to the Maternity Services Data set to the required standard?
3. Can you demonstrate transitional care services to support the ATAIN programme?
4. Can you demonstrate an effective system of medical workforce planning to the required standard?

5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of Saving Babies Lives care bundle?
7. Can you demonstrate patient feedback mechanism for maternity services and that you regularly act on feedback?
8. Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and Newborn life support, starting from the launch of MIS year 4?
9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme for 2021/22?

Continuity of Carer

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth (Better Births 2017).

The Cochrane Review by Sandall showed that there are significant improvements to the outcomes of mothers and babies when a Continuity of Carer (CofC) model is used (Sandall et al 2017). This model of care (if implemented correctly) provides a mechanism whereby midwives can gain a holistic understanding of women's needs and as such be the vehicle that drives improvements in many aspects of maternity care.

The value placed on continuity of carer is highlighted in key national documents such as the NHS Long Term plan, 'Saving Babies Lives Vs2' (NHS, 2016), and most recently the Maternity Incentive Scheme and the workforce review section of the Ockenden report. There are also indications that CofC will be linked to CQC and maternity tariff requirements. It is therefore essential that as a trust this element of maternity transformation is prioritised.

HDFT maternity has been on an unprecedented journey to achieve the national ambition since late 2018. We have faced a number of achievements as well as challenges along the way. Our workforce understands the national direction of travel and through working closely with Human Resources: we have been able to provide opportunities for staff to share their views and create fair processes to support staff through the change. In early 2019 we started with our willing volunteers, which resulted in the launch of two consecutive continuity teams; Ivy and Willow during 2019, taking us to 24% of women booking onto a pathway. For a period of time these teams worked well and were evaluated positively by women and many of the midwives.

Currently 3 teams of midwives are providing antenatal and postnatal care in the community. Providing intrapartum care is not currently possible due to staffing and skill mix issues within the community and in-patient areas. Whilst we have needed to take a step back, the end goal has remained our focus. In light of COVID-19 and the impact on our local midwifery staffing, our continuity of carer plans were revised and a new rollout plan was proposed, agreed and launched in January 2021. Due to the nature of facilitating a large scale change through a global pandemic it has been essential that the project management takes an agile approach to implementation. The journey we have been on so far demonstrates how

essential it is to have a transformation strategy that will allow us to continually adapt to the unpredictable nature of the current climate, whilst continuing to move towards the national goal. Since the revised rollout was launched in January 2021 the national ambition has been updated again to stipulate that all eligible women must be in receipt of continuity of carer by March 2023.

Our revised plan has meant that the percentage of women in receipt of continuity of care has fallen back to 0% from May 2021 and will sit at this level for some time. However, this will not undo the progress we have made so far. The midwives will continue to work together in the 3 geographical mixed risk teams and will over time increase the number of midwives able to provide the full spectrum of maternity care as we recruit and continue to upskill our existing workforce.

Our continuity strategy will focus on the below key areas, which will provide the building blocks to maintain safe care and drive effective and sustainable change.

The key building blocks:

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

Positive Culture – develop a strategy for positive workforce engagement centered around the trust values of kindness, integrity, teamwork and equality.

Hubs – community hubs will provide an environment that fosters effective teamwork and the enhancement of relational care

'Follow the data' - An action plan for the evaluation of our models and integrating continuity of carer into our new electronic system.

The Health and Social Care Committee provided clear support in its July report for the importance of Midwifery CofC, and the strength of its evidence base. It highlighted longstanding challenges in local implementation, and the need for sufficient resources and support to deliver it. The NHS Operational Planning Guidance for 2021/22 requires that MCoC is established as the default model of midwifery care and offered to all women by March 2023.

Ockenden Report (2020)

This independent maternity review focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at Shrewsbury & Telford NHS Trust. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and newborn babies.

This first report was published in December 2020, the review panel, led by Donna Ockenden identified important themes which were shared across all maternity services as a matter of urgency and have formed Local Actions for Learning and make early recommendations for the wider NHS Immediate and Essential Actions.

The families who contributed to the Ockenden Review wanted answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They were concerned by the perception that clinical teams had failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future. After reviewing 250 cases and listening to many more families, this first report identified themes

and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

Immediate and essential actions

1) Enhanced safety

- Essential action - Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

2) Listening to women and families

- Essential action - Maternity services must ensure that women and their families are listened to with their voices heard.

3) Staff training and working together

- Essential action - Staff who work together must train together.

4) Managing complex pregnancy

- Essential action - There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

5) Risk assessment throughout pregnancy

- Essential action - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway,

6) Monitoring fetal wellbeing

- Essential action - All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

7) Informed consent

- Essential action - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

Comparative summary data from Trusts within with Yorkshire & Humber region is produced on a quarterly basis.

Board of Directors (Public)
26th January 2022

4.6

Title:	**Freedom to Speak Up Guardian Update**
Responsible Director:	Emma Nunez – Executive Director of Nursing, Midwifery & AHP's
Author:	Quality Matron – Interim FTSU Guardian

Purpose of the report and summary of key issues:	To provide The Trust Board with an update on Freedom to Speak Up contacts at HDFT To share the proposed rebranding of Freedom to Speak Up and associated project plan	
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	CRR6 – Wellbeing of Staff	
Report History:	Update provided to People & Culture Committee 17/01/22	
Recommendation:	Trust Board members are asked to receive this report for information and support next steps identified at the end of the paper	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

Freedom to Speak Up Guardian update

1.0 Executive Summary

1.1 Freedom to Speak Up Guardians provide regular, comprehensive reports to their Trust Board so that barriers to speaking up are identified and addressed. This report outlines current work nationally, data and themes relating to local contacts to the Guardians and Fairness Champions, progress with local work and further work to be undertaken.

2.0 Background

2.1 This Board Report follows previous Board Reports, presented bi-annually, which have outlined barriers to speaking up, how they are identified and addressed. This report is presented for information outlining current work being undertaken data and themes relating to local Guardians progress with local work and further work to be undertaken.

3.0 Introduction

3.1 All NHS trusts are required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts.

3.2 There is a risk that poor standards of care can proliferate unless patients and staff are listened to, and their concerns welcomed and acted upon.

4.0 Proposal – this report proposes further action on:

4.1 The proposed rebrand of Freedom to Speak Up at HDFT “Listening at Our Best” and update on the project plan

5.0 Quality Implications and Clinical Input

5.1 There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.

6.0 Equality Analysis

6.1 This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.

7.0 Financial Implications

7.1 Minimal cost implications for rebranding materials

8.0 Risks and Mitigating Actions

8.1 The impact of the Covid-19 pandemic during 2020/2021
8.2 Substantive FTSUG on maternity leave, interim FTSUG in place

9.0 Consultation with Partner Organisations

9.1 This Board Report was created without consulting with partner organisations.

10.0 Monitoring Performance

10.1 HDFT is keen to ensure it has robust FTSU arrangements in place and will continue to report on national and local actions, at least bi-annually to the Board, in relation to developing a culture of speaking up about concerns.

11.0 Recommendation

11.1 The Board is asked to review and comment on the content of this of this Board Report to evaluate the work in relation to embedding a culture of speaking up.

12.0 Supporting Information

11.1 The following paper appended makes up this report:

Report: Freedom to Speak Up Guardian update report to Board of Directors

Date: January 2022

Introduction

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The ambition across the NHS is to affect the cultural change that ensures speaking up becomes business as usual.

Workplace culture is the character and personality of an organisation. It is made up of the organisation's leadership, values, traditions, beliefs, and the behaviours and attitudes of the people working within it. We know that:

"If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement".

(The King's Fund: Improving NHS culture)

National Guidelines on Speaking Up training in the health Sector in England

Freedom to Speak Up e-learning, has been developed in association with Health Education England and freely available for anyone who works in healthcare. 'Speak Up, Listen Up, Follow Up' is divided into three modules, it helps learners understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

At HDFT, as discussed at the last Board we are starting to implement the training across the Trust. All Fairness Champions have been asked to complete the Speak Up and Listen Up training. Following the Mandatory Training Review Panel, all members of HIF and HDFT will be required to complete "Speak Up" and all people in a Line Management or Leadership position will be required to complete "Listen Up". The final module, "Follow Up" will be undertaken by members of the Senior Management Team. This is to raise the profile and awareness of FTSU across the organisation and also provide staff with opportunity to reflect and consider how they can support and promote a Just Culture.

Local work

Freedom to speak up current data

The following table captures the numbers of cases received by the Freedom to Speak Up guardians between October – December 2021, common themes identified and a summary of learning points.

Numbers of referrals to the guardians has seen a slight increase during this quarter, however numbers reported remain fairly low. However, it is evident that FTSU cases are brought to other members of the team, including the Executive Directors and therefore this data is not

always captured and reported directly to the NGO. October 2021 was "Speak Up Month" and additional training was provided to Fairness Champions as well as being promoted on social media and within TeamTalk.

Numbers of cases brought by professional level	Worker Manager Senior leader Not disclosed	5 3 0 0
Numbers of cases brought by professional group	Allied Health Professionals Medical Registered Nurses and Midwives Nursing Assistants or Healthcare Assistants Administration, Clerical & Maintenance/Ancillary	3 0 4 1
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		3
Response to the feedback question; 'Given your experience, would you speak up again?	Total number of responses The number of these that responded 'Yes'	5 5
Common themes identified	HR processes not explained to staff involved adequately – unaware of progress of their concerns which have been raised. Immediate actions were taken by FTSU to support the colleagues in having a clear understanding of the processes in place. Inflexible working arrangements	
Summary of learning points	Communication	

The Freedom to Speak Up Guardian role update

The interim FTSU Guardian is Charly Gill to cover maternity leave of the substantive post holder. Leza Layton is the Associate Guardian and there is currently a vacancy for a second Associate Guardian.

Vicky Innocent has joined the FTSU Team to support with the rebranding and project plan for the relaunch of FTSU at HDFT.

Next steps/Action Plan:

- Regular meetings with Executive Director of Nursing to capture anonymised data from the concerns raised directly to the Director team
- To include the FTSUG role in the current work on the organisational culture, values and behaviours.
- A rebrand of FTSU at HDFT "Listening at Our Best" to embed FTSU into the #teamHDFT values and "At our Best" programme, current project plan:

Action Required	Lead	Date for completion
To formalise and agree a job description for the associate role	Charly Gill	March 2022
Continue with the relaunch and rebranding "Listening at Our Best" as part of "At our Best", including visible "Pledge Wall"	Charly Gill with PM Support from Vicky Innocent and Giles Latham	March 2022
Undertake the NGO Gap Analysis and Just Culture Gap Analysis alongside Deputy Director of OD	Charly Gill & Shirley Sylvester	April 2022
Launch the e - learning package as mandatory training	Learning & Development	February 2022
Scoping exercise around app based reporting system for staff; being mindful of how this will be acted upon and followed up	Darran Miller	April 2022
Ratification of updated Speaking Up policy – taken for comments to People and Culture Committee	Charly Gill	February 2022

Charly Gill
Interim Freedom to Speak Up Guardian
January 2022

Trust Board
26th January 2022

4.7

Title:	**Embedding Service User Experience and Engagement across HDFT**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery and AHPs
Author:	Alison Smith, Interim Associate Director of Nursing

Purpose of the report and summary of key issues:	The key purpose of this report is to provide Trust Board members with an overview of the current work taking place and proposed plans to embed service user experience throughout the organisation. The report if for information at this stage. The plan is to bring a further detailed report to the March Trust Board for approval and assurance which will outline a proposed Service User Experience and Engagement Framework and outline HDFTs commitments to Service User Experience and Engagement. 1. A baseline activity mapping is underway currently across the organisation to assess current strategies being used to capture service user experience and inform service developments. 2. A Trust wide self-assessment is also underway against the NHSEI Service User Experience and Engagement Improvement Framework. 3. Collation of above activities will be shared within planned workshop events in February. The workshop events will be used to develop a proposed Service User Experience and Engagement Framework and HDFTs Commitments. 4. DRAFT Framework / Commitments will be shared through Trust wide meetings for feedback / comments throughout March. 5. Service User engagement / consultation is planned for months of April. 6. Launch of HDFTs Service User Experience and Engagement Framework and Commitments is planned for May 2022. 7. The governance supporting Service User Experience through Making Experiences Count Forum is currently being revised and refreshed with a new Terms of Reference, membership and work plan for 2022. 8. The process for recruitment to a Patient Experience Manager has commenced.	
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	Risk to delivery of Quality Priority regarding development of real time patient feedback.	
Report History:	The report has been discussed with Executive Director of Nursing, Midwifery and AHPs prior to presentation following discussions with SMT related to progress with the Patient Experience Quality priority for the organisation.	
Recommendation:	Trust Board members are asked to read and receive this update report and support the plans to bring a more detailed report as proposed in this paper to the March Board meeting.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

Embedding Service User Experience and Engagement across HDFT

1. Purpose of the report

The key purpose of this report is to provide Trust Board members with an overview of the current work taking place and proposed plans to embed service user experience throughout the organisation. The report if for information at this stage.

The plan is to bring a further detailed report to the March Trust Board for approval and assurance which will outline a proposed Service User Experience and Engagement Framework and outline HDFTs commitments to Service User Experience and Engagement.

The leadership of this agenda is currently being led and coordinated by the Interim Associate Director of Nursing on behalf of the Executive Director of Nursing, Midwifery and AHPs. Future leadership of this Trust priority will sit under the portfolio of the Deputy Director of Nursing. HDFT does not currently have a Head of Patient Experience / Patient Experience Manager and therefore recruitment of a Patient Experience Manager is currently taking place to take forward the operational delivery and coordination of patient experience across the organisation.

2. Introduction

Service User Experience and Engagement is the golden thread throughout each enabling strategy with each describing how patient experience will be enhanced.

“A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of what matters to people. It means working in a system in which people and staff feel in control, valued, motivated and supported” (Health Education England, 2017)

With the required components of “quality” widely accepted as being the combination of safe, effective care and a positive experience for patients HDFT needs now to set out its intention to ensure the best possible experience of person centred/personalised care for all patients. The plan is to develop a Service User Experience Framework which will form part of the developing Quality strategy which will describe how staff will understand their responsibility in ensuring each service user not only receives excellent clinical care, but that it is delivered in a manner that treats them as an individual, recognises their needs and cares for them with empathy and compassion. Current plans are in place to:

1. Establish the baseline
2. Develop and launch a Service User Experience and Engagement Framework
3. Agree a set of key principles / commitments which will support delivery of the Framework
4. Define and implement robust governance arrangements to identify how the Framework will be achieved, how progress will be monitored and within the framework describe a structured approach to involving and engaging with stakeholders in the development of service delivery
5. Identify how the Framework will align to current Trust enabling strategies that outline how HDFT will deliver its Strategic Vision.

3. Plans and activities

The report will now set out the current activities taking place and proposed next steps to take this work forward to embed Service User Experience and Engagement across the organisation.

3.1 Baseline

Following presentation and discussion about the key priorities for developing a Service User and Engagement Framework for the organisation a baseline activity mapping is underway currently to assess current strategies being used to capture service user experience and inform service developments. The current baseline assessment is aiming to capture:

(a) Strategies being used
(b) How data is being captured
(c) How often data is being captured
(d) Themes from the feedback
(e) How feedback is being used to inform service improvements
(f) Who is capturing feedback
(g) How and where the data is being used within Directorate governance processes
(h) How and where the data is being shared within Trust governance processes
(i) Support required from Directorates from corporate team to embed and further develop service user feedback and engagement

3.2 Self-Assessment

The NHS England / Improvement patient experience improvement framework supports NHS trusts and foundation trusts to achieve good and outstanding ratings in their Care Quality Commission (CQC) inspections. It has been developed in partnership with trust heads of patient experience as a response to requests for a patient experience improvement tool. The framework enables organisations to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. It is divided into six sections, each sub-divided and listing the characteristics and processes of organisations that are effective in continuously improving the experience of patients. The framework integrates policy guidance with the most frequent reasons CQC gives for rating acute trusts 'outstanding', as identified in our review of CQC reports in January 2018.

A Trust wide self-assessment is also underway against the NHSEI Patient Experience and Engagement Improvement Framework. The Improvement Framework seeks to understand the current position against the following six key headings:

Leadership (for patient focus)

Almost all NHS organisations profess to put the patient at the centre of everything they do but this principle needs to be clear in the values and behaviours of senior leaders. There should be a clear commitment to equality and diversity ensuring the needs of all are met.

Organisational culture

The organisational culture is patient focused and values behaviour that enhances the experience of patients.

Capacity and capability to effectively collect feedback

The organisation has several routes through which patients can provide feedback.

Analysis and triangulation

The organisation has a systematic and consistent approach to analysing and making sense of patient feedback, and considers it alongside patient safety and patient outcomes data.

Using patient feedback to drive quality improvement and learning

The organisation actively and routinely seeks out patient feedback to be a learning organisation which is underpinned by quality and service improvement work. The organisation can evidence that it uses feedback and staff know that patient feedback is used to drive quality improvement. Patients are actively involved in decision making as equal partners (Participation in the Always events programme is in place)

Reporting and publication

The organisation regularly reports and publishes its patient experience data, and co-produces its quality improvement plans with a range of stakeholders including patients and frontline staff.

3.3 Proposed Next Steps

a) Collation of above activities will take place in the month of January
b) Baseline and self-assessment data will be shared in planned workshop events to take place towards end of February. The workshop events will be used to develop a proposed Service User Experience and Engagement Framework and HDFTs Commitments.
c) Engagement with Healthwatch regarding collaborative working on this agenda
d) Engagement with external organisations to learn from best practice in developing excellence in this area
e) Plans for capturing real time patient feedback as part of developing plans being explored in line with agreed Quality Priorities
f) A DRAFT Framework / Commitments will be developed in March and shared through Trust wide meetings for feedback / comments throughout March.
g) Service User engagement / consultation is planned for month of April.
h) Planned formal presentation to Trust Board in May for sign off
i) Formal launch of HDFTs Service User Experience and Engagement Framework and Commitments is planned for May 2022.

The governance supporting Service User Experience through Making Experiences Count Forum is currently being revised and refreshed alongside the above developments with a new Terms of Reference, membership and work plan for 2022.

4. Financial Implication/Risk assessment

- Financial implications relevant to taking this work forward are linked with the need to support the development of an infrastructure as part of the Corporate Nursing team to lead, coordinate, oversee and assure the organisation of the Board requirements related to Patient Experience and Engagement. Recruitment to a Patient Experience Manager post at Band 7 has been agreed and is currently being taken through the recruitment process.
- The planned clear structure for Patient Experience and Engagement will be shared in the Trust Board update for March`s Board meeting.

6. Risks

Current corporate capacity to deliver on the wider patient experience developments are limited, however with the review of the Quality Team roles and responsibilities it has been agreed to recruit to a Patient Experience Manager to progress this work.

6. Recommendation

The Board/Committee is asked to receive and accept this report and support the plans outlined in the paper to take this programme of work forward.

Name: Alison Smith

Job Title: Interim Associate Director of Nursing

Date: 16th January 2022

Board of Directors (Public)
26th January 2022

Title:	**Medical Director Update**
Responsible Director:	Medical Director
Author:	Medical Director

Purpose of the report and summary of key issues:	For noting and information	
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:	none	
Recommendation:	The Board are asked to note and approve the information contained in this report	

Medical Director Report
Date: January 2022 Public Board

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- Staffing challenges and potential for compromised quality of care across all areas due to COVID isolation
- NHSD "Operation Sawmill" in response to global cyber security alert for Log4j, software building block used in thousands of systems, applications and internet services.
- Fines issued by GSW for surgical trainees exception reports of over hours working in SDEC. Task and finish group reviewing surgical model to optimise patient flow and improve trainee experience.

Major actions commissioned & work underway

- CMDUs (Covid Medicine Delivery Units) being set up for non-hospitalised high risk patients, challenges around geographical distance (Hull/York) for patients – working group set up to develop HDFT model
- External stocktake of new Quality Governance framework completed- no significant gaps identified or alterations recommended
- Review of HDFT policy management and oversight underway- recommendations approved and task and finish group now live
- Paterson Enquiry- government response and recommendations published Dec 2021. Initial HDFT gap analysis complete – working group to enhance patient communications commissioned
- Clinical Lead development programme planned for 2022 alongside survey of current clinical lead experience
- Internal Audit of Research Governance completed and recommendations agreed to ensure safe and secure storage of trial documentation under GCP guidelines

Positive news & assurance

- Successful NHS Digital bid for £250K of cyber security capital funding
- Successful NHS Unified Tech Fund bid for £250K for virtual exemplar ward patient call system
- A number of novel and attractive Clinical Fellow for QI, R&I posts advertised to support clinical services
- Establishment of new Year 2 University of Leeds undergraduate programme at HDFT following invitation to expand placements at HDFT
- £25k funds (from HEE to aid medical training recovery) allocated to : EM Clinical Educator roles; Rheumatology simulation course; Ophthalmology simulation microscope, General Surgery portable laparoscopy simulation devices

Decisions made & decisions required of Board

Board of Directors (Public)
26th January 2022

4.9

Title:	**Guardian of Safe Working Hours Report Q3 2021/22**
Responsible Director:	Executive Medical Director
Author:	Guardian of Safe Working Hours

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous update from the Guardian of Safe Working	
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.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

1.0 Executive Summary

This is the Sixteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st October 2021 to 31st December 2021 - the 3rd quarter of 2021/22.

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

36 exception reports have been submitted in Q3; this is a decrease on the previous quarter (74). This maybe in part due to the new intake of junior doctors and unfamiliarity with the reporting process – there is a repeating pattern of reduced exception reports in each 3rd quarter. There were 3 education exception reports submitted. This brings the total for 2021/22 to 17 (compared to 3 in 2020/21).

Exception reporting remains comparable to other Trusts across the region although it is unclear whether the other trusts are seeing the same increase in educational exception reports.

There have been 6 reported breaches of contract, as such fines totalling £1136.80 have been levied. These breaches relate to working beyond the maximum 13hr shift length, within general surgery on SDEC. National trends in medical post-graduate training and indeed medical workforce numbers overall continue to be adverse.

There has been one regional meeting for Guardians since the last report. Trainee doctors' fora have been held jointly with the Director of Medical Education. These continue in both a face-to-face and virtual capacity but have been reduced to quarterly.

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. The pandemic has had a significant impact on the training delivered and the subsequent progress through the respective training programs of the junior doctors. In turn this is likely to have resulted in a shift of priorities for those junior doctors affected and potentially increasing the likelihood of an exception report being submitted. With the latest wave of the pandemic, plans have been put in place to facilitate changes to junior doctor working to ensure safe working across the hospital site.

This is the key quality assurance statement for the Board:

'The Board is advised that overall working hours across the organisation remain satisfactory, however this quarter has seen the first Guardian fines levied against the trust since the introduction of the new contract. There are concerns over workload on SDEC that have been brought to the attention of the guardian and an action plan has been put in place to manage these.'

2.0 Introduction

All doctors in training posts at HDFT are now employed under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) (hereafter referred to as the New Contract). As part of the new contract, the trust has appointed a Guardian of Safe working, the primary responsibility of which is to:

1. To act as the champion of safe working hours for doctors in approved training programmes within the Trust.
2. Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the new terms and conditions of service.

In accordance with Schedule 6 of the new contract the Guardian of Safe Working should provide the Board with a Guardian of Safe Working Report not less than once per quarter. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This is the Sixteenth quarterly report of the Guardian of Safe Working Hours.

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

The trusts Guardian of Safe Working reports continue to run out of synchronization with the regional quarterly reporting pattern. The Trust's reports are alternately in and out of phase with the quarters. The effect of this is that there is always an incomplete quarter encompassed within the timeframe of the report. Moving forward, the reports will focus on just one quarter at a time.

3.0 High Level Data

3.1 Vacancy information

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty.

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

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

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

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

Junior Medical Rota

Feedback from multiple sources has demonstrated that the junior medical rota has not been functioning well for some time. Attempting to improve this, a working group was established, led by the Chief Registrar and Operational Director for LTUC. Quick improvements have been implemented and in addition to the vacancies described below, there are plans to recruit 4 fellows who will work covering the general medicine rota. Adverts due to close mid-January 2022.

- 1x Quality Improvement Fellow (FY2-CT2, 6 months)
- 3x Clinical Teaching Fellow (FY2-CT2, 6 months)

Changes to Medical Curricula

Changes to several postgraduate medical curricula have come into effect during 2020-2022. Integral to many of these is a requirement for additional supervision for early year registrars. These changes to entrustability (More holistic approach to judging a trainee than simply looking at competencies – "they can do it but are they ready for the responsibility of doing it

on their own"), means that in some specialties, only trainees at ST5 level or above are allowed to be left to do the role unsupervised, out-of-hours.

It is likely that Harrogate will have HEE trainee doctors rotating who are unable to fulfil out of hours commitments to the same level of independence as their predecessors. Specialties particularly at risk are obstetrics and gynaecology, and medicine. The result of this may be increased staffing requirements and/or diversion of consultant activity from elective work to emergency out of hours care. Within obstetrics specifically, this means there will be 3 WTE "gaps" on the senior rota from February 2022.

January 2022

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

The current position is 10 Whole time equivalent (WTE) gaps. There should be 137 junior doctors in the trust. This increases to 166 when GP trainees are included.

The following table explains the breakdown of gaps by directorate.

	Dept	Rotates	Grade	Deanery or Trust	WTE	Recruitment
LTUC	Acute Medicine	6 months	ACCS – CT1	Deanery	1	1 trainee on maternity leave (returns Jan '22). Dept covering with short term locums until then.
LTUC	Cardiology	6 months	ST3+	Deanery	1	Plans to recruit 1 WTE LAS ST1/2 in cardiology/ general medicine currently going through vacancy control.
LTUC	Elderly Medicine	12 months	ST3+	Deanery	1	Advertised twice without success. Instruction from Dept not to re-advertise
LTUC	Psychiatry / Orthogeriatrics / Gastro medicine	12 months	FY1	Deanery	1	Student failed to graduate. No plans to recruit to this gap.
LTUC	Respiratory	6 months	ST3+	Deanery	1	Successfully recruited to this post - candidate withdrew. Re-advertised, due to close in Jan 2022.
LTUC	Emergency Medicine & Acute Medicine	8 months	FY2	Deanery	1	FY2 trainee has had rotations re-calculated due to sickness. No plans to recruit

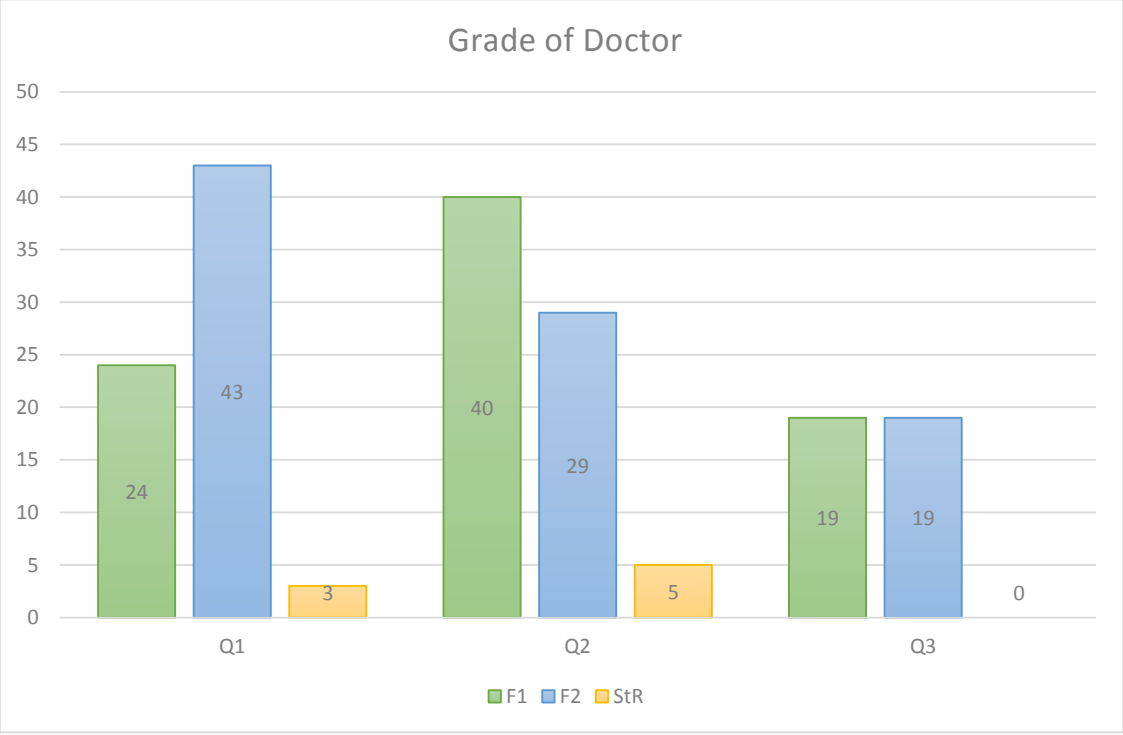
PSC	Gastro Medicine	12 months	CT1 / IM1	Deanery	1	1 WTE gap due to maternity leave. Successfully recruited – Feb 2022 start date
PSC	Anaesthetics	12 months	Fellow (ST3+)	Trust	2	Successfully recruited x2 – Feb 2022 start date
PSC	Dermatology	12 months	ST3+	Deanery	1	Dormant post – no plans to fill

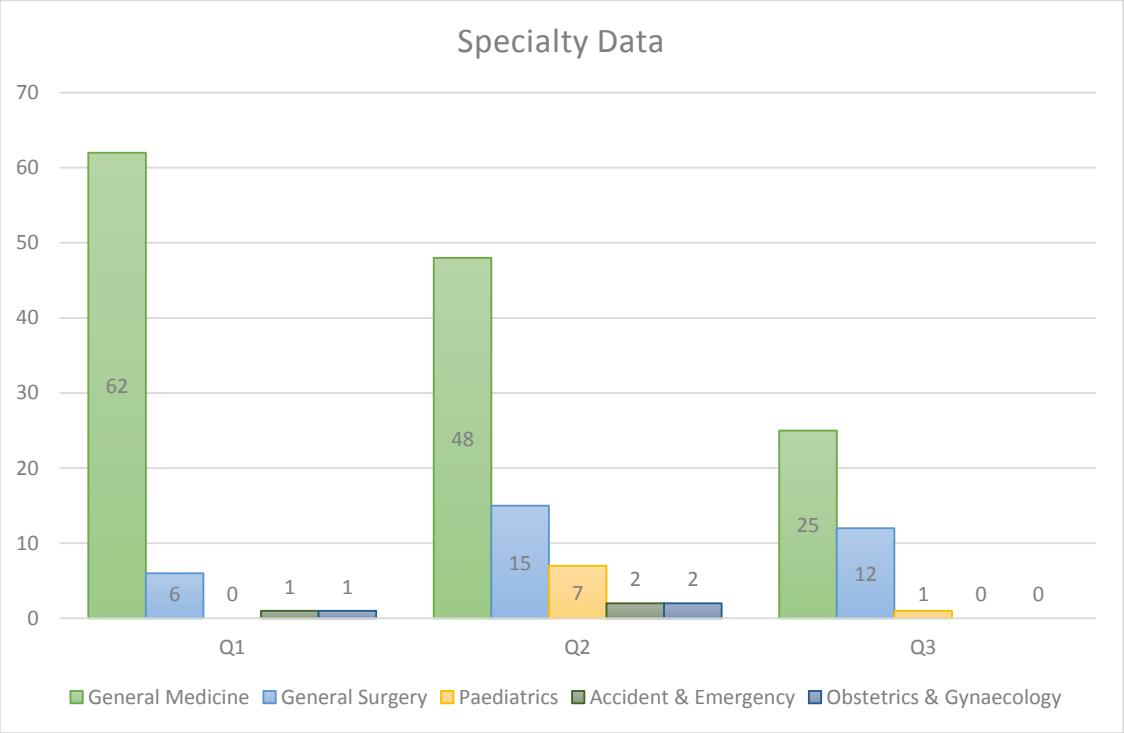
4.0 Exception Reports – Qualitative Analysis

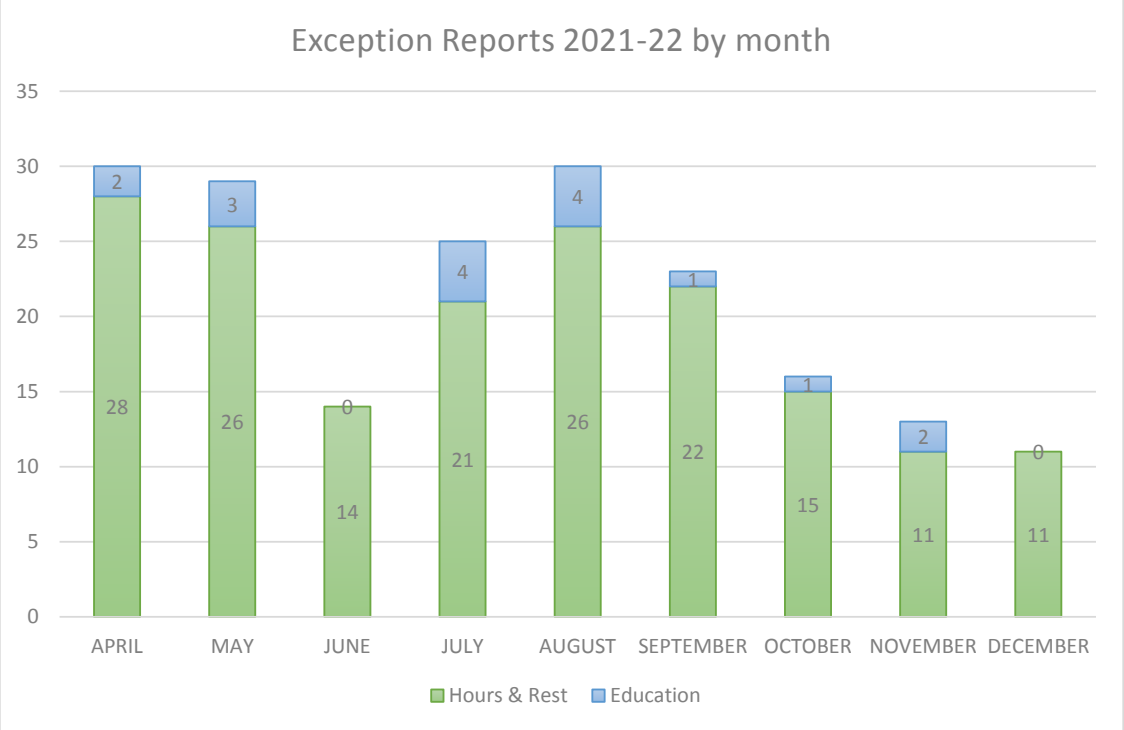
Exception reports are individual notifications to the DRS system by trainee doctors who have experienced an issue causing them to vary their working hours from the contracted work schedule. This may be repeatedly missing breaks during the day, being unable to attend scheduled teaching (either internal or external) or more likely workload requiring them to stay beyond the scheduled hours to complete tasks.

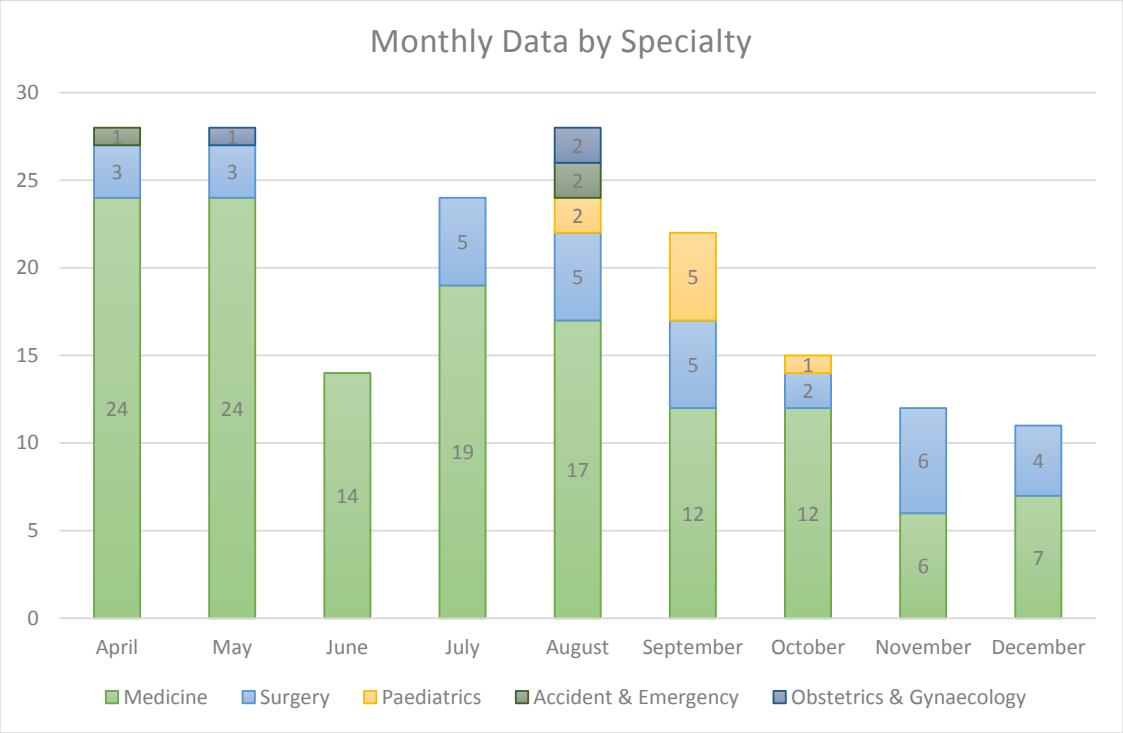
Clinical supervisors are, in most cases, reasonably poor at responding to exception reports within the required time frame. This task was added to the supervisors without consultation by the 2018 review of the New Contract and has never had an enthusiastic response. Significant effort has been put in to try and improve the status quo, most notably weekly reminder emails and participation in the supervisor workshops. Following a role change agreed in V5 of the TCS, any overdue reports must be reviewed and agreed by the Guardian.

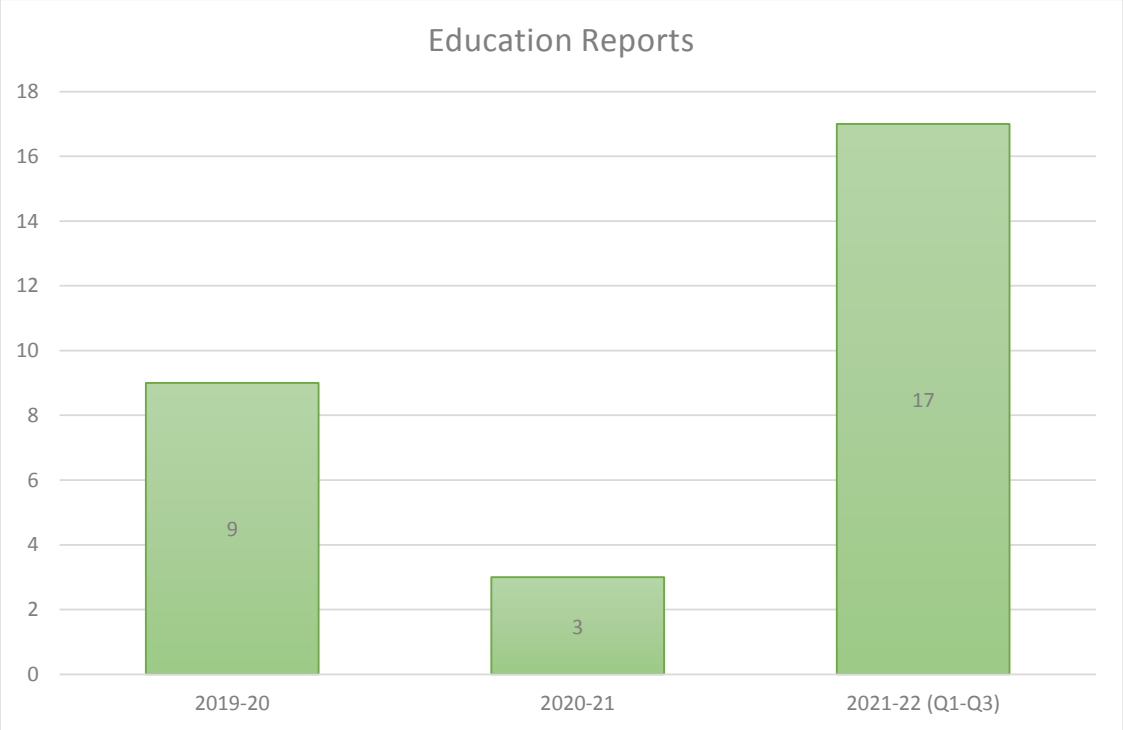
The following pages detail the breakdown of data.




Specialty Data
70
60
50
40
30
20
10
0
62
6
0
1
1
48
15
7
2
2
25
12
1
0
0
Q1
Q2
Q3
General Medicine
General Surgery
Paediatrics
Accident & Emergency
Obstetrics & Gynaecology


Exception Reports 2021-22 by month
35
30
25
20
15
10
5
0
2
28
3
26
0
14
4
21
4
26
1
22
1
15
2
11
0
11
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
Hours & Rest
Education





There were a further 3 education exception reports in Q3, bringing the total to 17 for the year – a significant and troubling increase when compared to the 3 reports for the entire 2020/21 year. In fact, this represents more education exception reports than in the last 3 years combined.

Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine which usually accounts for 65-80% of all exception reports submitted.

[The number of exception reports submitted is known to underestimate the actual amount of routine over-working].

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

4.1 Verbatim exception report excerpts

The following are verbatim excerpts from Q3 exception reports. Due to the publicly available nature of this report any names or other identifiable material have been removed.

Medicine

96238: Hours & Rest

"Very busy Monday - with multiple jobs to do and only 2 doctors on the ward for the 4 Consultant ward rounds of the day. Including one very unwell haematology patient taking up much of one of the Drs time."

Steps taken to resolve

"Handed over jobs appropriate to the on-Call team. But some jobs were not appropriate for this and thus I stayed to execute to keep clinical care at a level I have come to expect for patients."

96516: Hours & Rest; Education

"For the third time on this rotation, I was the only junior doctor covering Oakdale ward. According to the rota, there would be another junior doctor with me to cover the ward, but due to understaffing she was moved to SDEC. I had to stay until 17:00 to finish all the jobs for all the patients on the ward. I don't feel this is safe, because as the only junior doctor being handed over jobs for patients in different teams that are currently in Oakdale (general medicine, stroke, neurology, respiratory, etc) it was difficult for me to know each patient and prioritise safely."

Steps taken to resolve

"I informed the ward clerk and nurse in charge as soon as I noticed I would be on my own that day. I also informed the consultant doing the ward round that day. Before 9 am, we called the medical rota coordinator to ask about this, she said that she would check the rota and get back to us. We tried to contact her multiple times during the day without any response. No other juniors were sent to Oakdale until the end of the day."

98934: Hours & Rest

"2 juniors on ward initially, phoned rota coordinator for help who sent another junior. Busy day, no consultant cover. Difficulty escalating patients due to no elderly reg support"

Steps taken to resolve

"Escalated to rota coordinator for extra help"

Looking at the supervisor comments for this exception report, consultant cover was via telephone only, and there was no middle-tier support either. "The fact that juniors are having to chase up rota coordinator at the start of the day to ask for more junior support also cuts into the time that they would be otherwise providing patient care."

100139: Hours & Rest

"Only junior on Oakdale ward on 29th. An f2 was also meant to be working on 29th but tested positive for covid. Unable to leave ward for lunch and late finish due to the number of jobs on the ward. Also, no other junior scheduled on the ward for 30-31st without taking covid illness into account. According to medical rota Minimum staffing for Oakdale is 3 juniors. Concerns with being able to manage and patient safety raised with rota coordinator earlier in week but no reply."

Steps taken to resolve

"Raised with rota coordinator before shift but no response and not answering phone"

This report is the only one quoted where staff shortfall was a result of covid-related absence.

Surgery

97811: Hours & Rest

"Very busy day in SDEC! Saw approx. 15 patients during the day with both the General Surgery and Urology registrar being required in theatre all day. This meant that decisions couldn't be made to admit/send home patients until around 4pm. Subsequently became very very busy after 4pm, with the addition of the surgical day teams handing over jobs at 5pm and being on-call to cover the wards. This meant I had to prioritise other things and was required to come back to complete all the discharge letters for SDEC after my shift. This ended up taking me 3 hours (to complete approx. 12 discharge letters) until about 23:30 at night."

Steps taken to resolve

"Alerted senior registrar's to how busy it was in SDEC, but understandably they couldn't attend until late in the day as they were required in theatre."

This report is a prime example of the issues faced by the juniors covering SDEC currently. On attendance patients are clerked by the FY1s and will often then wait until the end of the afternoon before they are reviewed by a registrar, when a decision is then made on management and discharge/admission. As a minimum this would mean all the tasks created from this ward round start at the end of the day – this alone would lead to staying late to complete them. However, the junior covering SDEC is also covering the wards from 5pm. At this point they must prioritise the more urgent ward-based jobs and come back later to finish the SDEC tasks – often after their official finish time. This exception report resulted in a fine being levied against the directorate.

97940: Hours & Rest

"Another very busy day in SDEC where it was very difficult to keep on top of everything. Lots of outstanding jobs from SDEC at the end of the day, including discharge letters for those that have gone home and regular medications and VTE prophylaxis etc for those admitted. At 5pm became busy also covering the wards and therefore it was difficult to finish all the jobs from SDEC. Handed over all of the ward jobs to the night team when they arrived but stayed to finish the jobs from the day in SDEC. Finished at 23:00."

Steps taken to resolve

"The general surgical team were aware that it was very busy and very kindly came to review patient's promptly during the day to help out. However, there was just a lot of paperwork / admission documents / medicines to prescribe that took the additional time in the evening."

This exception report resulted in a fine being levied against the directorate.

98419: Hours & Rest

"Again, another late finish due to working in SDEC. At 5pm when covering the wards, there were more clinically urgent jobs on the wards which I was requested to do. This meant that I was unable to finish the jobs required from SDEC during the day. Handed over lots to the night FY1 at handover at 20:00, however had to finish prescribing regular medications for patients admitted from SDEC, adding admitted patients to the handover list and writing discharge letters for those that have gone home. Finished at 22:30. It is too much work to cover the wards after 5pm whilst still finishing all the jobs from SDEC - you have to prioritise urgent ward tasks, but this means you then have to go back to SDEC after the shift has finished to finish jobs from the day."

Steps taken to resolve

"Asked for help from senior FY2 on-call but unfortunately they were also very busy in A&E."

This exception report resulted in a fine being levied against the directorate.

99290: Hours & Rest

"On call FY1 for surgery in SDEC. Was informed there was discharge letters from two days prior for patients I didn't see which needed to be completed and my own discharge letters from that day however there were multiple sick patients on the wards between 5-8pm. Informed by nurse in charge that legally the discharge letters needed to be done by the next day, so I had to stay late to complete them after attending to sick patients. Stayed from 8am-10:15pm"

Steps taken to resolve

"None"

This exception report demonstrates the pressure juniors can experience to complete discharge letters, often for patients they have never met. This alone is cause for concern as it could lead to transcription errors in paperwork. This exception report resulted in a fine being levied against the directorate.

Paediatrics

97052: Hours & Rest

"Unable to have lunch break and finished after 5.30 1 registrar and 2 juniors down, ward under pressure from number of referrals"

Steps taken to resolve

"None"

It is not uncommon for clinical staff (doctors/nurses/health cares) to forgo breaks to facilitate patient care.

5.0 Work schedule reviews and interventions

5.1 Work schedule review

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

5.2 Interventions

Since the last report, an investigation into a bullying and harassment complaint made by 2 junior doctors has been completed by HR. The cause for the initial complaints remains a concern. The outcome of this process has not been shared with the Guardian, other than a summary or recommendations. It will be up to the directorate management to ensure that the recommendations are implemented.

The Guardian suggests that isolated cases of over-working are to be expected in emergency conditions. The Trust is grateful for trainees' flexibility on occasion and in ensuring patient

safety. However, repeated instances raise the question of whether the rotas and workload are appropriate for the trainees in this specialty. Junior doctors have responded magnificently to the challenge of COVID – as have all health-care staff – but the Trust is contractually obliged to ensure that the trainees balance their service work with educational opportunity and rest.

Previous reports have mentioned the on-going issues with routine overworking within medicine, particularly on the acute medical rotas. Considerable work has been undertaken within LTUC to improve the current situation. This includes ongoing recruitment to short-term posts to cover gaps for 6months. It remains to be seen how the current Omicron wave of the pandemic will affect the implementation of these plans, as well as overall working conditions.

As the exception reports above demonstrate, there is cause for concern regarding the current workload and working patterns of the FY1 doctors covering SDEC. A working group has already been established to look at making changes to help with this. A further issue has arisen regarding the cross-cover of urology patients by general surgical registrars/SAS doctors. Currently these doctors are providing cross-cover during the week only. The result is that there is no senior cover for urology patients at the weekends when the middle tier rota is staffed by a general surgeon. Discussions between clinical leads are ongoing to find a solution.

6.0 Fines

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

This quarter has seen the first fines levied against the trust. There have been 6 reported breaches of the TCS of the new contract caused by the Trust.

Fine number	Directorate	Total Amount	Amount within GOSW Fund
1	PSC	£ 249.48	£ 155.94
2	PSC	£ 249.48	£ 155.94
3	PSC	£ 205.94	£ 128.73
4	PSC	£ 162.40	£ 101.51
5	PSC	£ 118.86	£ 74.30
6	PSC	£ 150.64	£ 94.16
TOTAL		**£ 1,136.80**	**£ 710.59**
	TOTAL DISBURSED		**£ -**
	REMAINING BUDGET		**£ 710.59**

7.0 Meetings

There has been one regional meeting of Guardians in the previous quarter, conducted via MS Teams. The previously reported increase in exception reports submitted by Junior Doctors has continued across the region following a return to normal working patterns. The increase in education exception reports at HDFT has not been seen elsewhere but, our overall numbers are comparable to other trusts (when the data is corrected for junior doctor numbers).

From August 2021, all Foundation doctors were expected to be allocated some self-directed time (SDT), 1 hour per week for FY1 and 2 hours per week for FY2. Other trusts in the region are reporting issues with FY1/2 doctors being allocated their Self-directed time (SDT), this has not been the case at Harrogate.

8.0 Trainees' Forum

Trainees' fora increased to monthly during the pandemic but have now been stepped back to the usual quarterly meetings. The importance of exception reporting has been canvassed to the trainees at each meeting.

The COVID-19 emergency has greatly affected post-graduate medical training. Educational opportunities, assessments, courses, and examinations have been discontinued and the amount of clinical experience in their home specialties has been curtailed due to redeployment. Some trainees will have delayed completion of examinations and completion of training programmes. On the other hand, participation in front-line service in a national emergency is educational in its own way.

The full impact of the pandemic on the training and successful progression through training programmes only became apparent when the first round of ARCPs were completed. Two new ARCP outcomes were created (10.1 & 10.2) to denote trainees whose training has been adversely affected by COVID-19. There are likely to be some trainees that will require additional training time before they can progress (Outcome 10.2) – this may be playing a part in the increasing number of educational exception reports being submitted as the priorities of the Junior Doctors shift and they feel they need to become more vocal to achieve their training requirements.

There is concern at high level within HEE on the impact on future doctor numbers that the pandemic is having. Burn-out, mental health issues, and an increasing trend in working less than full time will all have an impact on the ability to fill trainee posts, rota gaps and overall junior doctor numbers.

9.0 Disclosure

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

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. This information is collated and shared upon request.

10.0 Confidentiality

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

11.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in the previous quarter.

12.0 Extending the scope of the Guardian to the inclusion of SAS Doctors

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce department and unfortunately there are some challenges to overcome before it can take place. The system used by the junior doctors cannot be used for the non-training grades and an alternative system will be necessary. There has been no further progress with this implementation. The Guardian remains committed to bringing this ambition to fruition. Until such time as SAS doctors, working on the same rotas as the junior doctors, have the ability to exception report the extra hours they work, there exists an inherent inequality.

13.0 Issues arising

a) The trust continues in comparable standing to other trusts in the region. Exception report numbers have decreased in the last quarter. It remains to be seen whether this trend will continue through the next wave of the pandemic. It is the opinion of the Guardian that this is unlikely to be the case.
b) There is an on-going problem of over-working and late finishes for trainee doctors owing to colleagues off sick, rota gaps and pressure of clinical work. This is especially true in General Medicine and has now occurred on SDEC.
c) Staff sickness due to covid-19 infection and isolation has had a significant (but hopefully short lived) impact on overall junior doctors staffing.
d) Reluctance of trainees to report exceptions exists regionally and nationally.
e) Exception reports are being received and processed within the accepted time limits. There remains reluctance from supervisors in signing-off the reports. >50% are signed off by the Guardian alone.
f) There are gaps on rotas, but recruitment cycles continue.
g) No national Guardian meeting has yet been announced for 2022.
h) The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed in principle: However, no progress has been made in implementing this since agreement.

14.0 Actions taken to resolve issues

a) 6 fines have been levied against the PSC directorate during this quarter.
b) The Guardian has been involved in several interventions in the last quarter, started as a result of systematic overworking within the respective areas.
    i. Acute Medical staffing improvement work
    ii. SDEC brainstorming event
    iii. Participation in an investigation into a bullying and harassment complaint.
c) At the date of reporting, the Board of Directors is assured from the evidence that:
    i. The exception reporting system is operational for all trainees; they are now all converted to the 2016 TCS Version 5.
    ii. Over-working owing to pressure of workload and rota gaps is a chronic problem in general medicine, currently exasperated by the latest wave of the pandemic.
    iii. The Guardian can only intervene on notified problems.

15.0 Questions for consideration by the Board of Directors

a) The board is asked to receive the quarterly report of Q3 2021-22 and to consider the assurances provided by the Guardian.
b) There are presently no issues outlined in the report which are not being (or cannot be) overcome.
c) Significant pressure on safe staffing is currently being felt across the organisation and is cause for considerable concern. The most recent junior doctor's forum was poorly

attended due to these staffing pressures. As a result, there is limited feedback available.

d) The Guardian currently makes no additional request for escalation, internally or externally, or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future. However, the Guardian asks the board to be aware of the increasing pressures on junior medical staffing and the need for a long-term sustainable workforce model.
e) Issues of medical (and indeed all healthcare professional) workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies in trainee doctor posts; these currently run at 7%.
f) The Guardian asks the board to consider, given the increasing pressures and demand trends, whether medical workforce sustainability should be included on the Trust risk register.

Dr Matthew Milsom

Guardian of Safe Working Hours

18th January 2022

Board of Directors (Public)
January 2022

Title:	**Briefing Report of the Paterson Enquiry**
Responsible Director:	Executive Medical Director
Author:	Executive Medical Director, Deputy Medical Director (Quality and Safety), Responsible Officer

Purpose of the report and summary of key issues:	For information and noting	
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	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 noted	
Report History:	none	
Recommendation:	Board of Directors to note and approve next steps outlined	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

The Paterson Independent Enquiry and the Government Response to its Recommendations

Authors:
Dr Jacqueline Andrews. Executive Medical Director
Dr David Earl. Deputy Medical Director (Quality and Safety)
Mr David Lavalette. (Responsible Officer)

1. Summary of case

Ian Paterson was a breast surgeon who was convicted in 2017 of 13 counts of wounding with intent and three counts of unlawful wounding. He was consequently jailed for 20 years. The Independent enquiry into the issues raised by his case was Chaired by the Right Reverend Graham James and published in February 2020:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf
In his opening statement, report author Bishop Graham James described a "healthcare system which proved itself dysfunctional at almost every level" and criticised the large and uncoordinated group of regulatory bodies and the difficulties in navigating their areas of responsibility. The 15 recommendations in the report (p.223) were:

1. A single database of consultants across England, setting out their practising privileges, critical performance data, including the number of times they have performed a procedure and how recently. This would be publicly accessible and mandatory
2. Doctors in the NHS and independent sector to write to patients outlining their treatment in simple language and copy this letter to the GP rather than the other way round
3. Differences between the organisation of NHS and independent sector care to be explained to patients in the independent sector (including those treated in the sector but funded by the NHS) to also encompass practicing privileges, indemnity and provision of emergency care
4. All patients to be allowed a short period to reflect on diagnosis and treatment options before they consent to any treatment
5. Each patient with breast cancer to have their case discussed at an MDT, whether in the independent sector or the NHS, with the CQC to have responsibility for ensuring compliance
6. Information about complaints pathways to be communicated more effectively in the NHS and independent sector and private patients to have the right to mandatory independent resolution of their complaint
7. The University Hospitals Birmingham NHS Foundation Trust board should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen
8. Spire should check that all patients of Paterson have been recalled, and to communicate with any who have not been seen, and that they should check that they have been given an ongoing treatment plan in the same way that has been provided for patients in the NHS
9. A national framework or protocol with guidance to address recall communication and management
10. Urgent Government reform of discretionary indemnity
11. The system for collaboration of regulators to be reviewed with the Government to ensure that it serves patient safety
12. Hospital investigation of a healthcare professional's behaviour to lead to suspension of the professional if any perceived risk to patient safety

13. The Government to address the gap in responsibility and liability in the independent sector which remains unresolved
14. Apologies from hospitals to be made immediately when things go wrong
15. The Government to ensure that arrangements made in response to the recommendations are applicable across the whole of the independent sector (private, insured and NHS funded), as a qualifying condition for independent sector providers to do NHS work

2. The Government's response to the recommendations.

https://www.gov.uk/government/publications/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson
These were significantly delayed due to COVID pandemic, and only recently published on the 16th December 2021, with no further communication or guidance received from professional bodies to NHS ROs or MDs as yet. **In considering the 15 recommendations of the inquiry the government identified a number of themes which cover the entirety of the patient journey:**

- their initial consultations with clinicians, and the information they receive during their treatment to ensure that they are receiving the highest standard of care
- the fitness of their clinicians to practise
- post-treatment activity ensuring ongoing scrutiny of clinicians' outcomes, pathways for raising concerns and rapid action in all cases where something goes wrong

The government stated that some of their recommendations require further consideration and consultation to ensure they deliver real and lasting change to hospital-based treatment in both the NHS and the independent sector. **There will therefore be a further government response to update on the progress of this plan in 12 months' time. Overall, they responded to 17 recommendations (recommendations 6 and 12 were each split into 2 parts) with the following decisions:**

- accepting 9 recommendations
- accepting in principle 5 recommendations
- not accepting 1 recommendation (immediate suspension if a medical practitioner's behaviour had any perceived risk to patient safety)
- not accepting but keeping under review 1 recommendation
- pending an outcome on 1 recommendation

3. Summary of current HDFT position in response to the government's accepted recommendations:

	Government Recommendation	Sectors affected	HDFT Current Position	HDFT next steps	Estimated time frame
1	A single database of consultants across England, setting out their practising privileges, critical performance data, including the number of times they are performed a procedure and how recently. This would be publicly accessible and mandatory	NHS and Independent Healthcare	Will rely on National Database being created	Once database properties known (accepted in principle), we will need to develop a process to ensure HDFT relevant data is uploaded and regularly reviewed.	Not yet known
2	Doctors in the NHS and independent sector to write to patients outlining their	NHS – HDFT led	Already employed by some HDFT	RPIW planned to develop improved administration by clinicians – will include	Q2 2022

	treatment in simple language and copy this letter to the GP rather than the other way round	action required	teams but no agreed standard model	templates for such communication. National organisations developing support packages to aid transformation. Deputy Medical Director (Quality and Safety) tasked with implementation	
3	Differences between the organisation of NHS and independent sector care to be explained to patients in the independent sector (including those treated in the sector but funded by the NHS) to encompass practicing privileges, indemnity and provision of emergency care	NHS and Independent Healthcare	Compliant for patients treated on HDFT premises.	HDFT will need assurance from external providers that such information is given to patients. Formal regular meetings with SMT of BMI the Duchy Hospital now commenced. Will require further dialogue with other independent providers	Q1 2022
4	All patients to be allowed a short period to reflect on diagnosis and treatment options before they consent to any treatment (accepted in principle- GMC to monitor)	NHS	Two stage process described in HDFT 'Policy for Consent to Examine or treatment'	N/A	N/A
5	Each patient with breast cancer to have their case discussed at an MDT, whether in the independent sector or the NHS, with the CQC to have responsibility for ensuring compliance	NHS and Independent Healthcare	All HDFT cases discussed at the Breast MDT	Establish formal mechanisms with any private provider of breast cancer care for HDFT patients. Regular governance meeting with BMI the DUCHY now established.	Q1 2022
6a/b	Information about complaints pathways to be communicated more effectively in the NHS and independent sector and private patients to have the right to mandatory independent resolution of their complaint	NHS and Independent Healthcare	Patient Experience Team signpost and explain the process	Continuous monitoring of patient and relative feedback required for ongoing assurance	N/A
7	University Hospitals Birmingham NHS Trust should check all Paterson patients have been recalled	UHBT	N/A	N/A	N/A
8	Spire should check all Paterson patients have been recalled	Spire	N/A	N/A	N/A
9	A National framework or protocol with guidance to address recall communication and management	NHS and Independent Healthcare	Will reply on National guidelines	Implementation of guidelines when available	tbc

10	Urgent Government reform of discretionary indemnity	TBC-Response pending	N/A	N/A	N/A
11	The system for collaboration of regulators to be reviewed with the Government to ensure that it serves patient safety	Government/Regulators	N/A	N/A	N/A
12	The Government to address the gap in responsibility and liability in the independent sector. The Government to ensure that arrangements made in response to the recommendations are applicable across the whole of the independent sector as a qualifying condition for independent sector providers to do NHS work.	Government & Independent Health Providers	N/A	N/A	N/A
13	Apologies from hospitals to be made immediately when things go wrong and not hold back for fear of liability consequences	NHS and Independent Healthcare	HDFT complaints policy states immediate verbal apology, regardless of whether need for formal Duty of Candour	Quality Summit already commenced programme of work to imbed and ensure more prompt Duty of Candour conversations and formal communication issued	Ongoing

4. HDFT Governance oversight of recommendations

The Government recommendations on the Paterson Enquiry will be scrutinised by the HDFT Patient Safety Forum and work required to ensure compliance will the report will be overseen by the Deputy Medical Director (Quality and Safety) with Executive oversight by the Medical Director. Subsequent programmes of work arising from the current and future recommendations will be delivered by the Patient Safety Forum, overseen by QGMG with formal reporting of progress and escalation of any concerns or risks to both Quality Committee and SMT.

Dr Jacqueline Andrews
Executive Medical Director
18 January 2022

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Jeremy Cross
Date of meeting:	17th January 2022
Date of Board meeting this report is to be presented	26th January 2022

Summary of key issues

- We ratified the Freedom to Speak Up policy, and had an encouraging update from Charly Gill who is ably covering this role at the moment. Charly noted that communications were significantly increased, and as a result she felt the role was well understood across the Trust
- Helen Law attended from ED to discuss "how things are" in that department at the moment. Clearly ED is under a great deal of pressure, despite the best efforts of all the team – and this is reflected across all of the ICS and beyond. The committee was not looking to provide answers to the issues raised, but more to understand the environment in ED at the moment. Nevertheless we agreed to follow up on three areas.
  1. Security in ED, which is now on the agenda regularly
  2. Internal flow of patients which Helen felt could be improved to allow patients to clear ED quicker. This will form the basis of a future board update
  3. Quality of Care issues that were raised. Helen noted that despite trying hard, the team were not always able to provide the quality of care to patients that they would like. In particular it was not always possible to segregate Covid positive patients as well as we would want. These issues were noted by Laura Robson (Chair of the Quality Committee) and will be followed up there.

  While this was a difficult session to listen to, it is important that the committee hears this sort of feedback.
- We received a comprehensive update from the Deputy Director of Workforce around the People Plan. We have made some progress recently in areas where we have found it difficult previously to recruit – in particular Occupational Health and ED&I lead. It was agreed that we would like to do a deep dive on the Employee Assistance Programme at a future meeting. THRIVE discussions are still not happening which is disappointing to see given the emphasis that was placed on this as part of our future plans. Sickness rates were clearly high as a result of the Omicron variant, but were now on their way back down. Shirley also presented the "Future of NHS HR" work that

had been done centrally, and the team will ensure that the priorities for 2030 that had been agreed would be built into our own local People Plans in the future – both for the Trust and at ICS level. The Trust is soon to appoint an external company to complete Exit Interviews, which will address the concerns raised at the last meeting.

- The CEO presented on the Culture Programme work, which continues to progress well. We received specific updates on the work in Radiology and Theatres.
- There was no representation at the meeting from the LGBT+ network. We will need to try and get input from this group in the future. Nevertheless, we received positive updates from the BAME network, and also from the Disability network, who had been really busy in the last few months and are making themselves well known across the Trust.
- We discussed sickness data for the Deep Dive session – interestingly even with Covid, the level of long term sickness (28 days+) is 1.5x the level of short term. We asked to see data on how these long term absences are being followed up
- Ian Barlow attended the meeting on behalf of the Governors. It was good to see him, and he confirmed he was happy with the way the meeting was run.

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

- The three areas for follow up from the ED presentation should be noted. In particular the Safety in ED will be followed up at P&C committee, but it would be good for the full board to understand the work underway on improving patient flow.

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

- None

Integrated Board Report - December 2021

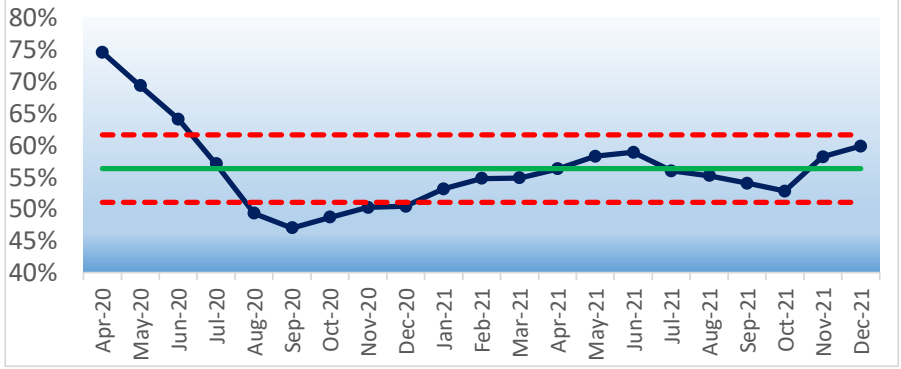
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-21
Value / RAG rating	59.8%

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

The appraisal rate in December is 59.8%, which is an increase from November which saw an appraisal rate of 58.2%.

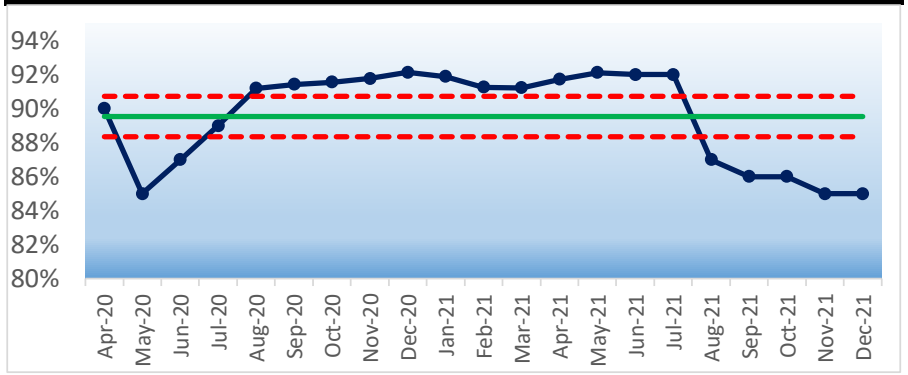
- Non-Medical appraisal % = 59.6% (previous month 57.7%)
- Medical appraisal % = 62.6% (previous month 62.5%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-21
Value / RAG rating	85.0%

Indicator description

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

SPC chart



Narrative

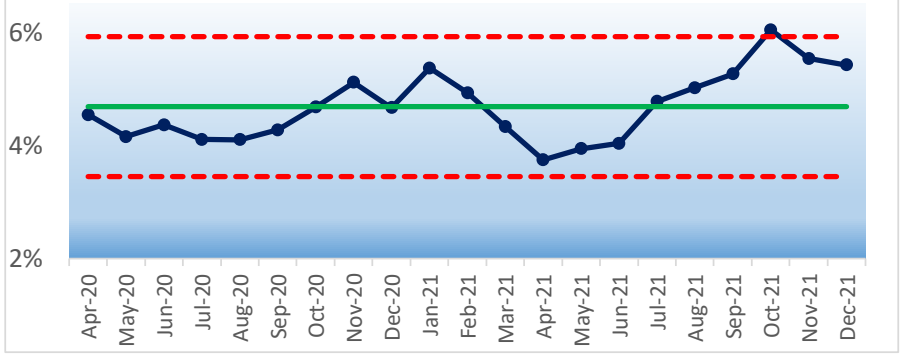
The data shown is for the end of December. The overall training rate for mandatory elements for substantive staff is 85% and has remained the same as the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-21
Value / RAG rating	5.4%

Indicator description

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

SPC chart



Narrative

The Trust's sickness rate hit a peak of 5.8% in October 2021 following an increasing trend since April. However the data shows that sickness has decreased each month since and now stands at 5.2%. The Trust remains above the threshold rate of 3.9%. Excluding Covid sickness, the Trust sickness rate for December is 4.7%, which is a decrease from 5.2% last month.

Long term sickness has seen a further decrease this month from 3.9% to 3.3%, however short term sickness has seen an increase to 2.1% from 1.6% in November.

All Directorates, with the exception of LTUC, have seen a decrease in sickness rates this month. CC Directorate has the greatest sickness levels, with a rate of 6.0% in December, of which 71% is due to long term sickness.

The areas with the greatest increase in sickness in December are Orthopaedic Wards and Day Units, Children's Services – Darlington and Surgical Admissions.

"S10 Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and accounts for 30.1% of the overall sickness in December. "S15 Chest & respiratory problems" is the top reason for short term sickness in December and equates to 12.2% of the overall sickness . This is the sickness reason used for recording Covid related sickness.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-21
Value / RAG rating	13.7%

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

Following an increasing trend in turnover rates in recent months, turnover has continued to see a decrease for the second consecutive month from 13.8% in November to 13.7%. This remains below the Trust threshold of 15%.

The breakdown of turnover in December is 3.3% due to involuntary terminations and 10.4% due to voluntary terminations.

CC and PSC Directorates have seen a decrease in turnover in December.

The 'Additional Clinical Services' and 'Nursing and Midwifery Registered' are the staff groups with the greatest turnover rates, with turnover levels of 15.8% and 15.2% respectively, however these are a decrease on last month's turnover rates.

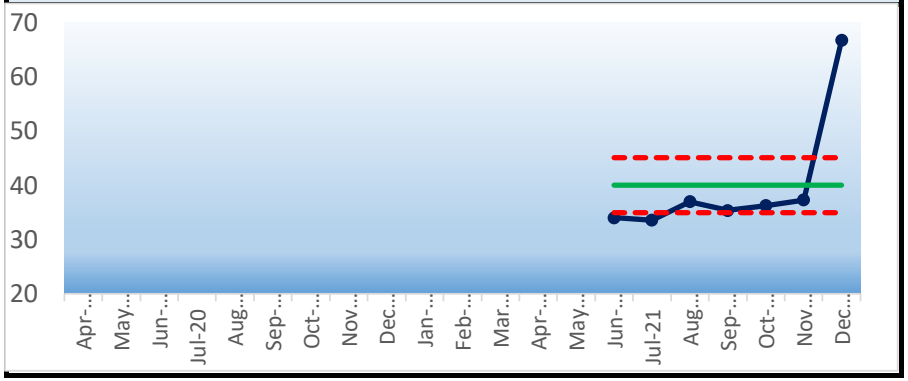
The services which have seen the greatest increase in turnover in December are GP Out of Hours, Information Services and Outpatients - Orthopaedic and Day Units.

Indicator	**4.5 - Children's Services - 0-19 Services - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-21
Value / RAG rating	66.64

Indicator description

The chart shows the total number of vacancies across all localities of the Trust's 0-19 Children's Services

SPC chart



Narrative

The Northumberland staff numbers are now included within the data set for the first time andthis is why the vacancy numbers have seen such a change this month.

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

Board of Directors (Public)
26th January 2022

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

5.3

Purpose of the report and summary of key issues:	This report details Organisational Development priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
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	
	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	CRR6 – Wellbeing of Staff	
Report History:	Report discussed at January 2022 SMT and Resource Committee	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

Director of Workforce and OD Report

NHS
Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- National guidance on reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic

- In December 2021 NHSE/I issued the letter shown in Appendix 1 to all NHS Trusts advising of measure that should be taken to reduce reporting burdens and to release capacity to manage the COVID Omnicron surge. Whist this is welcomed, it will have resulting impacts on rates of medical appraisal, AFC staff appraisal and revalidation for both groups.

Major actions commissioned & work underway

- NHS Elect - To enable us to provide OD support across a wide range of topics and an increasingly large geographical footprint we have invested OD funding to join NHS Elect. This is an arms-length NHS organisation, hosted by Imperial College Healthcare NHS Trust. They have been providing high quality training, coaching and consultancy to the NHS for 18 years. They service over 80 members across England. Each member of their team has extensive senior management experience within the NHS, and they provide a diverse range of services. They give us access to around 140 on-line courses, and our membership also allows us to commission bespoke services from them. This is managed on a token basis – we have 80 tokens and 2 tokens would equate to a half day tailored workshop.
- Our membership commenced on 1 Jan and the L&D team are currently familiarising themselves with the content and commissioning and NHS Elect will be launched at the February SMT.

- NHS Rainbow Badge Accrediation - The Trust have signed up to be included as 1 of 40 Trusts nationally to undertake an assessment to enable us to become Rainbow Badge Accredited. There is an extensive process to undertake, with tight timescales with completion of the process scheduled for 14 June 2022. The benefits of becoming an accredited Trust are:
  - Patient experience improvements.
  - Community engagement facilitated.
  - Staff retention and satisfaction increases.
  - Demonstrates meeting legal requirements to reduce health inequalities.
  - Access to expert support, best practice guidance and case studies

- Menopause Accreditation – The Trust has signed up to become Menopause Accredited in conjunction with our HCV ICS partner organisations

Director of Workforce and OD Report

Harrogate and District NHS Foundation Trust

Positive news & assurance	Decisions made & decisions required of the Board
• The Learning Lab is continuing to receive positive feedback across the organisation, with a number of key milestones achieved in the last 6 weeks The new programme is designed around handling pressure and uncertainty and giving and getting support. The programme is based on emotional intelligence (EQ) • Support to line managers - a toolkit has been developed for line managers to enable them to have supportive conversations with colleagues who have not yet currently had the COVID vaccine. This is based on the Respectful Resolution materials introduced as part of At Our Best culture change programme. • An Interim EDI Lead has been appointed to support this significant and growing programme of work . It is anticipated Krishna Kaur will work with the Trust for a 56 month period commencing in January 2022.. • Colleague Wellbeing Programme Lead - successfully recruited 2 colleagues to job-share this role – currently undertaking pre-employment checks, and anticipate start dates during Febuary 2022. • Mental Health Nurse – successfully appointed, untilising external HCV ICS funding. Anticpated start date during February 2022 and will be able to work pro-actively with colleagues and line managers to support the mental health of colleagues, enabling return to work and supporting colleagues who may be on the cusp of absence to enable them to remain in work, if appropriate. <u>Stat and Mand Training</u> • The overall training rate for mandatory elements for substantive staff is 85% and has remained the same since the previous month.	<u>**Decisions made**</u>

Board of Directors(Public)
26th January 2022

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

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions on the BAF since the previous formal Board on 24th November 2021. Each Board Assurance Framework risk has been reviewed and assessed with the designated responsible Executive Director. Key changes of note are: <u>Changes to lead executives</u> • BAF2.1 – updated with Matt Graham, Director of Strategy as joint lead with Jackie Andrews, Executive Medical Director. • BAF2.2 – updated with Matt Graham, Director Strategy as lead rather than Jackie Andrews, Executive Medical Director. • BAF4.3 – updated with Jackie Andrews, Executive Medical Director as lead rather than Jonathan Coulter, Director of Finance / Deputy Chief Executive. <u>Changes to Ratings</u> • BAF3.1 – current risk rating was updated to 2 x 4 = 8 (from 3x4=12). Target risk score now met. • BAF3.3 – current risk rating was updated to 2 x 4 = 8 (from 3x4=12). Target risk score now met. • BAF4.4 – current risk rating was updated to 2 x 4 = 8 (from 3x4 = 12). Target risk score now met.	
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

6.1

	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.	

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	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	January 2022 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Mental Health Nurse – recruited Colleague Wellbeing Programme Lead – recruited Quiet room developed in the Education Centre Refreshed wellbeing intranet Mental Health Champions in place Thrive Wellbeing Conversations	Board of Directors Senior Management Team People and Culture Committee Sarah Armstrong – Non-Executive Director for Wellbeing Guardian	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data is being analysed by directorates and managers. Actions are being reviewed and implemented. Presentation was made by each directorate at November SMT. Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF remains outstanding.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated..
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Becoming and Anti-Racist Work programme EDS2 Programme commissioned	Board of Directors SMT People and Culture Committee Wallace Sampson – Non-Executive Director for Inequality and Diversity	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated..

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	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	January 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	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	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy has increased capacity to work with strategic partners	Medical Director Board Report Director of Strategy Board Report SMT	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation. Currently no strategic Harrogate Place Forum – discussions are ongoing to develop forum. Further work required on Harrogate as an anchor institution.	SMT	M Graham, Director of Strategy J Andrews, Executive Medical Director	With the appointment of Matt Graham, the Lead Executive has been updated to include the Director of Strategy. In addition, assurance controls and gaps have been updated to reflect the current position.
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members	Appointment of Director of Strategy Executive Team are key members of strategic groups across the two ICSs.	ICS Groups eg the Provider Collaborative	The required input across the two local ICS may lead to a lack of clarity of funding arrangements. Requirement for HDFT to be members of two ICS means that Executive capacity needs to spread across two structures rather than one.	SMT	M Graham, Director of Strategy	With the appointment of Matt Graham, the Lead Executive has been updated to the Director of Strategy and not the Executive Medical Director. In addition, assurance controls and gaps have been updated to reflect the current position

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	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	January 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement. Governance structure has received a root and branch review and the creation of the three forums above will ensure greater control. Safe Staffing Review completed. Procured Perfect Ward with planned roll out in January and February 2022.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation Weekly Quality Summit and Learning Summit in place Complaints back log cleared	CQC Inspections Bi-monthly Assurance meetings with CCG Internal Audit Report – Board to Board reporting – significant assurance	Do not have consistent quality control in place Workforce challenges impacting	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated.
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	The appointment of the Director of Strategy has given renewed focus and increased resource on the development of the Clinical Strategy and a strategic governance programme is under development	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	Trust and Clinical Strategy under development however they are not yet in place.	Quality Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in assurance have been updated.
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visibility of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports CQC Trust Wide Action Plan – now closed.	CQC Outstanding Report OFSTED Reports JTAI Reports	Metrics required to monitor the embedding of CQC Actions. Paediatric Emergency Department – workforce and environment	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated.
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 23	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings 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, day case and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review Operational Management Group	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	Current controls updated

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	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	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. 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) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures Increased safeguarding activity referrals have continued into 2022 with an increase in workforce pressures. See CRR57 for activity information.		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

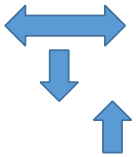
4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

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	Responsible Committee	Lead Executive Director	January 2022 Update
			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	2	4	8	2x4=8	Mar-22	None	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 WYATT – creating financial framework to look at opportunities. The piece of work is being mirrored internally.	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 and the requirement to move to pre Covid levels of activity No new long-term productivity programme currently in place **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed.
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	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS Ongoing discussions with the ICS future allocation Site development group developing plan	Capital Oversight Group H2 efficiency programme	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place with efficiency programme.	**Internal:** No efficiency programme	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Assurance controls and gaps in control update. Noted that the capital is available but potential risks as no long term site development plan currently in place.
BAF#4.3	To provide high quality care and to be a financially sustainable orgnisation	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	2x4=8	Apr-22	None	Digital Strategy Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme Working with digital aspirant programme to create strategic outline case for digital funding.	Capital Oversight Group Digital Strategy Group		Ongoing refresh of the Clinical Strategy and the Digital Strategy	Resource Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in control update.
#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	2	4	8	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	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	Lack of system wide financial plan New financial allocations need to be agreed. Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Current risk rating updated to 8. Target risk met. Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed.

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

Trust Board
26 January 2022

Title:	Director of Strategy Report
Responsible Director:	Director of Strategy
Author:	Matt Graham, Director of Strategy

Purpose of the report and summary of key issues:	To update the Board on the work of the Director of Strategy	
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	None	
Report History:	SMT, 19 January 2022	
Recommendation:	Board is requested to note the content of the report	

6.2

Director of Strategy Report

NHS Harrogate and District

Matters of concern & risks to escalate

- Timescales for refresh of Trust Strategy and development of Clinical Strategy are achievable, but tight.
- Resource required to support implementation of programme structure

Major actions commissioned & work underway

- Trust Strategy
  - Staff & Public Surveys; internal and external stakeholder interviews; engagement with Staff Networks, Your Voice Forum
  - Clinical Strategy development underway: second workshops 19 & 25 Jan
  - SMT and Board Workshops planned for Feb 22
- Programme Governance
  - Identifying programme resource
  - Developing programme plans
- Anchor Institution
  - Assessment of HDFT against the HCV Anchor Institutions Framework underway
  - Project SEARCH (internships for LD&A): engagement with NYCC and college underway
- NYY Community Diagnostic Centres: links made to ICS programme to ensure HDFT can influence the plans.

Positive news & assurance

- Trust Strategy
  - Over 450 responses to Staff Survey (17 Jan 22)
  - First Clinical Service Workshops held on 13 and 14 Dec
- Programme Governance
  - New SMT structure: Current Delivery / Strategy & Improvement; plus 4 half day workshops per year
- Business Cases approved:
  - NPIC Digital Pathology (research phase)
  - Somerset Cancer Information System
  - Looked After Children Capacity
  - Adult Safeguarding Capacity
  - Paediatric Specialist Dentistry
  - 5th Haematology Consultant
- Harrogate Place:
  - Successful Board workshop held with HARA
  - Harrogate agreed as pilot site for NHS Providers / Newton “Place Support Offer”

Decisions made & decisions required of SMT

- Continued support for the approach and timescales for the Trust Strategy and Clinical Strategy work, including SMT Workshop in Feb 22 and sign off in Apr 22.

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	7th December 2021
Date of Board meeting for which this report is prepared	26th January 2022

7.1

Summary of key issues:
The committee continues to meet via Microsoft Teams and be well attended and welcomed Steve Treece observing on behalf of the Council of Governors.
Matters considered included: • Corporate risk – the committee considered the summary report provided by the Ms Southgate, Company secretary and commented that it was a much clearer way of reporting the outcomes from the Executive Risk Review Group. Ms Southgate highlighted that there were two risks due to meet the target risk score in November: Safeguarding Demand (CRR57) and Violence and Aggression in ED (CRR63) and stated that the indication from the October update was that both risks would meet the target risk. • Quality Committee Business – the minutes from the Quality Committee held on 15th September 2021 and 20th October 2021 were received and noted. It was also noted that the Quality Committee had not yet received the Quality account from 2020/21 and there was probably little valuing in receiving it now. • Audit Committee Terms of Reference were reviewed and approved. The committee noted the positive outcome from the Audit Committee annual self-assessment survey and noted the latest staff Register of Interests. • Internal Audit – the committee received and noted the Internal Audit progress report against the plan for 2020/21. Three new reports had been finalised during the period. There is concern that the audit programme is significantly behind plan and there is a lot of audit work to complete in the last quarter of the year. This is largely due to Internal Audit being unable to progress audits and audits taking longer because of pressures within the Trust. This has been escalated to the Executive Risk Group and a way forward has been agreed. Helen Kemp-Taylor (Audit Yorkshire) confirmed that she was confident there would be sufficient progress to enable her Head of Internal Audit Opinion to be provided for the year end.

- The number of outstanding Internal Audit recommendations has reduced significantly since the last meeting in September.

- The committee noted the Internal Audit progress report for HIF which is also behind plan but there is confidence that it will be completed by the year end.
- The Counter Fraud update report was received and noted. The committee queried how the Trust acts upon fraud alerts and an update will be provided.

- The annual review of Internal Audit effectiveness was considered and noted.

- External Audit – Rashpal Khangura attended from KPMG and his sector technical update was noted by the committee. It was confirmed that the 2021/22 accounts deadline has been set at 22nd June 2022 and that External Audit of the Quality Account would not be part of the statutory audit, it would be for Governors to agree the level of assurance required relating to quality.

- This was KPMG's last meeting as External Auditor, Mr Khangura thanked the committee and officers at the Trust for their support and assistance over the last few years. KPMG were thanked for their input to the committee during their contract period.

- The committee received an update of the progress in appointing new External Auditors. There is insufficient capacity in the market at present.

- Approval was given to a report proposing that a number of post project evaluation reports, relating to projects completed in earlier years, would no longer be pursued. The report had previously been considered by Resources Committee where it was agreed that some high value projects would still be reported to the Resources Committee.

- Single tender actions were agreed. There was a discussion about how contracts using the procurement framework could be better presented to the committee in future.

- Helen Kemp-Taylor (Audit Yorkshire) was thanked for her input to the committee over many years as she prepares for her retirement in early 2022.

- The committee will next meet on Tuesday 1st February 2022

Any significant risks for noting by the Board?(list if appropriate)
Ability to recruit new External Auditors due to market capacity.
Any matters of escalation to Board for decision or noting (list if appropriate)
None

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Chaired by Steve Russell, Chief Executive
Date of meeting:	19th January 2022
Date of Board meeting this report is to be presented	26th January 2022

Summary of key issues
Challenges were noted and discussed on current pressures within the local and regional system, including updates on Covid. A discussion took place on Serious Incidents, in both the number and ongoing themes. Learning was also highlighted as an area where further work was required on some elements of our systems and processes. Three key areas of focus were noted on: quality including learning from SIs and Never Events, financial implications and impacts and the reduction in patients with long waits. Key strategic and operational risk were noted as part of the Board Assurance Framework and the Corporate Risk Register. The Community and Children's Directorate provided an update including challenges to staffing, NHSP 0-19 commencing on 31st January 2022, the perfect week had given the opportunity to test new ways of working in relation to a community discharge hub and potential opportunities in relation to domiciliary care. The Long Term and Unscheduled Care Directorate provided an update including SIs and the learning from these for the focus on quality, 12-hour trolley breaches in December and increased temporary mortuary storage. In addition, a new risk had been added to the Corporate Risk Register in relation to Pharmacy Aseptic. The Planned and Surgical Care Directorate provided an update including an update on an SI in theatres, SDEC updates as well as information regarding developments in urology. As part of the Quality update, SMT noted changes in the Quality Impact Assessment Process, a self-assessment was being undertaken against the national Patient Experience Framework, the revised quality governance structure was highlighted and the task and finish group had commenced in relation to policies and guidelines.

The Operational Update noted the constitutional targets and the impact on these of Covid. The UEC Flow Dashboard was completed and launched across the Trust, a UEC action plan had been developed and was due for completion in March 2022. The Winter Plan had been shared with systems partners and it was noted that Perfect Week had been held in January 2022. SMT were also briefed on a Data Quality Review. Thanks were expressed to the Vaccination Team from SMT. A workforce update was provided on sickness absence, the recent line managers webinar, mandatory vaccines as a condition of appointment and the appointment of key posts in relation to an Equality and Diversity Lead, a Colleague Wellbeing Programme Lead and a Mental Health Nurse. A financial update was provided in relation to planning guidance for 2022-23, current areas of pressure that are being off-set by underspend, the slippage in the capital programme as well as the efficiency programme for H2. A strategy update was provided with SMT noting the progress being made on the Trust and Clinical Strategies. A workshop would be held with SMT in February 2022. A comprehensive update was provided on the Caring At Our Best Programme. A comprehensive update was provided on the Elective Recovery Plan. SMT were provided with a brief on the Paterson Enquiry. A report was provided to SMT from the Guardian Of Safe Working. An update was provided on the work that had commenced regarding Violence and Aggression. Further information would be provided at a future SMT.
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

Board of Directors (Public)
26th January 2022

Title:	**Resource Committee Terms of Reference**
Responsible Director:	Chair of Resource Committee
Author:	Company Secretary

Purpose of the report and summary of key issues:	Attached are the Resource Committee Terms of Reference. These were approved at the meeting in November 2021 and are presented to the Trust Board for onward ratification.	
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:	Previously approved at the November 2021 Resource Committee.	
Recommendation:	The Board is asked to note and ratify the Terms of Reference for the Resource Committee.	

Terms of Reference
Resources Committee

1. Authority

1.1. The Resources Committee (the Committee) is constituted as a standing committee of the Trust Board. The Committee is a Non-executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. The Terms of Reference can only be amended with the approval of the Trust Board.

1.2. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.3. The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and may request the attendance of individuals from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2. Purpose of the Committee

2.1. The Committee is responsible for providing information and making recommendations to the Trust Board on financial, workforce and operational performance issues and for providing assurance that these are being managed safely.

3. Membership

3.1. The membership of the committee shall be composed of the following:

- 4 Non-Executive Directors (which can include the Trust Chairman), one of whom will Chair the Committee
- Chief Executive
- Director of Finance
- Chief Operating Officer
- Director of Workforce and Organisational Development

3.2. All Board members outside the core membership have an open invitation to attend any meeting if he/she wishes to do so.

4. Attendance and Quorum

4.1. The quorum for any meeting of the Committee shall be attendance of a minimum of three members of which two will be Non-executive Directors (which includes the Trust Chairman) and one Executive Director.

4.2. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the committee to the Board.

4.3. If an Executive Director is unable to attend a meeting they should nominate a deputy subject to agreement with the Chief Executive and consultation with the Committee Chairman. Deputies will be counted for the purpose of the quorum.

4.4. The Non-executive Director who serves as Chair of the Audit Committee may choose to attend as an observer of the Committee. A Trust Governor may be in attendance as an observer. The Deputy Director of Performance and Informatics, Deputy Director of Finance, Deputy Director of Workforce and Organisational Development and the Company Secretary will also be in regular attendance.

4.5. The Chair may request attendance by relevant staff at any meeting.

5. Frequency of meetings

5.1. The Committee will meet 12 times per year scheduled to support the business cycle of the Trust.

5.2. The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

5.3. Meetings of the Committee shall be set at the start of the calendar year.

Responsibilities

6.1. The specific responsibilities of the Committee are to:

Performance - Resources, Finance and Workforce

- Review the integrated performance of the Trust
- Provide overview and scrutiny in any other areas of financial, operational and workforce performance referred to the Resources Committee by the Trust Board.
- Monitor the effectiveness of the Trust's financial, operational and workforce performance reporting systems ensuring that the Board is assured of continued compliance through its annual reporting.
- Review the Trust's financial performance against its annual financial plan and budgets, both revenue and capital.
- Review the Trust's operational performance against its annual plan and to monitor any necessary corrective planning and action.
- Review the Trust's performance against its workforce plan and to monitor any necessary corrective action.
- Review the in-year delivery of annual efficiency savings programmes

Financial Strategy and Planning

- Scrutiny of the development of the Trust's financial and commercial strategy, both revenue and capital
- Provide overview and scrutiny to the development of both the annual plan and the medium term plan, including scrutiny of assumptions, methodologies, activity modelling and efficiency assumptions.
- Ensure the annual financial plan is consistent with the financial strategy
- Oversee how benchmarking initiatives, such as the Model Hospital, are being implemented within the Trust

- To make recommendations to the Board of Directors on the Trust's financial plan prior to submission to NHS Improvement.
- Review the capital programme in line with the financial plan.
- Provide oversight of the Digital Transformation programme
- Oversee the development and implementation of the Trust's Estates Strategy.
- Have oversight of the Trust's Digital Transformation Strategy.

New Business Developments

- Ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by NHS Improvement
- Scrutiny of business cases for new investment with delegated authority to approve total costs ranging from £500,000 and below £1 million.
- Receive and review post-project evaluations of business cases of £500,000 and above, one year after implementation and provide relevant assurance to the Board on the outcome

Governance and Risk

- Assure the Trust's maintenance of compliance with NHS Improvement.
- Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee, as part of the reporting requirements, and to report any areas of significant concern to the Board as appropriate.
- Produce an annual work plan for the Committee and prepare an annual report at the year end to demonstrate compliance with terms of reference.
- Carry out an annual review of Committee effectiveness and report the outcome through the Committee Chairman's summary report.
- Undertake any other responsibilities as delegated by the Trust Board.

8. Audit Committee

8.1. The Audit Committee will maintain full oversight of the Annual Accounts process and Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

9. Administrative Support

9.1. The Resources Committee will be supported by the Director of Finance as the nominated lead Executive Director. The Committee will be supported administratively by the Company Secretary and Corporate Support Team who will:

- Prepare and agree the agenda with the Director of Finance and the Committee Chairman
- Collate and distribute papers at least five working days before each meeting.
- Take the minutes and prepare a log of actions and matters arising.
- Provide support to the Chair and members as required.

10. Accountability and Reporting arrangements

10.1. The Committee shall be directly accountable to the Trust Board.

10.2. The Committee shall refer to the Board any issues of concern it has with regard to any lack of assurance in respect of any financial, workforce or operational aspect.

10.3 The Chair of the Committee shall prepare a summary report to the next meeting

in public of the Board of Directors, detailing items discussed, actions agreed and issues to be referred to the Board. The Chair of the Committee is also required to inform the Board on any exceptions to the annual work plan or strategy. The Chair will report any specific issues on the risk register to the Audit Committee.
10.4. Approved minutes of the Committee meetings will be submitted to the subsequent meeting in private of the Board of Directors.

10.Review of Terms of Reference
10.1 The Terms of Reference of the committee shall be reviewed at least annually by the Committee and approved by the Trust Board.

Previous Review: July 2021

Reviewed: October 2021

Approved by the Committee: October 2021

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
Opening Items	Patient Story	All	x	x	x	x	x	x	x	x
	Declarations	All	x	x	x	x	x	x	x	x
	Minutes	All	x	x	x	x	x	x	x	x
	Action Tracker	All	x	x	x	x	x	x	x	x
	Chairman Report	All	x	x	x	x	x	x	x	x
Chief Executive	Chief Executive Report	All	x	x	x	x	x	x	x	x
	Corporate Risk Register	All	x	x	x	x	x	x	x	x
Quality & Safety	Quality Committee Chair Report	All	x	x	x	x	x	x	x	x
	IBR Metrics	All	x	x	x	x	x	x	x	x
	Director of Nursing, Midwifery and AHPs	All	x	x	x	x	x	x	x	x
	Freedom to Speak Up	Quarterly	x		X	x	x		x	x
	Strengthening Maternity and Neonatal Safety	All	x	x	X	x	x	x	x	x
	Medical Director Report	All	x	x	X	x	x	x	x	x
	Guardian of Safe Working	Quarterly	x		X	x	x		x	x
	Learning from Deaths	Quarterly	x			x	x		x	x
	Statement – Eliminating Mixed Sex Accommodation	Annually					x			
	Quality Accounts	Annually					x			
	National Patient Survey	Annually				X				x
	Safeguarding Annual Report	Annually		X				x		
	Health and Safety Annual Report	Annually		X			x			
	IPC Annual Report	Annually		X			x			
	7 Day Working Framework	As required								
	Paterson Inquiry	As required			X					
People & Culture	People & Culture Chairs Report	All	x	X	X	x	x	x	x	x
	IBT Metrics	All	x	X	X	x	x	x	x	x
	Workforce Report	All	x	X	X	x	x	x	x	x
	Workforce Race Equality Standards	Annually	x				x			
	Workforce Disability Equality Standards	Annually	x				x			
	Public Sector Equality Duty	Annually	x				x			
	Gender Pay Gap	Annually	x				x			
	Medical Revalidation	Annually	x				x			
	Modern Slavery	Annually				X	x			
	National Staff Survey	Annually				x				x
Strategy & Partnerships	Director of Partnership Report	All	x	x	X	x	x	x	x	x
	Trust Strategy	As required		x		X				
Resources and Finance	Resource Committee Chairs Report	All	x	x	X	X	x	x	x	x
	IBR Metrics	All	x	x	X	X	x	x	x	x
	Director of Finance report	All	x	x	X	X	x	x	x	x
	Chief Operating Officer Report	All	x	x	X	X	x	x	x	x

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
	Organisational Development Report	All	x	x	X	X	x	x	x	x
Governance	Audit Committee Chairs Report	All	x	x	X	X	x	x	x	x
	SMT Chairs Report	All	x	x	X	X	x	x	x	x
	Board Assurance Framework	All	x	x	X	X	x	x	x	x
	Board Reporting Framework	All	x	x	X	X	x	x	x	x
	Annual Accounts	Annually					x			
	Going Concern Review	Annually					x			
	Audit Letter	Annually					x			
	Annual Report	Annually					x			
	Emergency Preparedness Statement	Annually					x			
	Self certification and statement	Annually				X				
	Fit and Proper Person	Annually					x			
	Standing Orders	As Required								
	Use of Trust Seal	As required								
	Board Effectiveness Review	Annually						x		
	Certification on training for governors	Annually				X				
	Board Appointed Non Executive Roles	Annually			X					
	Constitution Review	Annually					x			
	Section 75 Arrangements	As required				x				

Board of Directors(Public)
26th January 2022

Title:	**Enhancing Board Oversight**
Responsible Director:	Chairman
Author:	Company Secretary

Purpose of the report and summary of key issues:	In December 2021, NHS England issued a document *"Enhancing Board Oversight – A new approach to non-executive director champion roles".* This document confirmed that there are a small number of statutory requirements that still require a designated individual, however there are many issues where NHSE/I consider progress will be best made through existing committee structures rather than through individual Non-Executive Champion roles. It is believed that this approach will enhance Board oversight. This approach is recommended but not mandated. If Trusts consider Non-Executive champion roles an effective tool to provide assurance to their Board on specific issues, then they have the flexibility to retain or implement that approach. This report outlines the Trust's approach to each designated role and issue.	
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:	None
Recommendation:	The Board is recommended to review the content of this report and approve: • The appointment of a Non-Executive Director lead for Security Management • The governance arrangements for the management of all highlighted issues in section 2.3 of this report and confirm that these will be managed via the Committee Structure rather than a designated Non-Executive Director.

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
TRUST BOARD (PUBLIC)

ENHANCING BOARD OVERSIGHT

1.0 PURPOSE

In December 2021, NHS England issued a document *"Enhancing Board Oversight – A new approach to non-executive director champion roles".* This document confirmed that there are a small number of statutory requirements that still require a designated individual, however there are many issues where NHSE/I consider progress will be best made through existing committee structures rather than through individual Non-Executive Champion roles. It is believed that this approach will enhance Board oversight.

This approach is recommended but not mandated. If Trusts consider Non-Executive champion roles an effective tool to provide assurance to their Board on specific issues, then they have the flexibility to retain or implement that approach.

2.0 NEW RECOMMENDED APPROACH

2.1 Information Summary

The table below sets out the Non-Executive Director champion roles that were in scope of the review and their status under the new approach:

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

Five roles have been identified as still requiring Non-Executive Champion roles. The following information is provided on the rationale for the role and the named individual for the Trust.

2.2 Retained NED Champion Roles

Role	Type of Role	Legal Basis	Background	Named Individual
Maternity Board Safety Champion	Assurance	Recommended	In response to the Morecambe Bay Investigation (2015), the Safer Maternity Care (2016) and the Ockenden Review (2020)	**Andy Papworth**
Wellbeing Guardian	Assurance	Recommended	In response to the Pearson Report and adopted through the "We are the NHS People Plan 2020-2"	**Sarah Armstrong**
Freedom to Speak Up	Functional	Recommended	In response to the Robert Francis Freedom to Speak Up Report (2015)	**Laura Robson as Senior Independent Director**
Doctors disciplinary champion / independent member	Functional	Statutory	In response to the 2003 Maintaining High Professional Standards in the modern NHS: A framework for the Initial Handling of Concerns about Doctors and Dentists in the NHs and the associated Directions on Disciplinary Procedures 2005.	**A Non-Executive Director is assigned to each case.**
Security Management	Assurance	Statutory	Under the Directors to NHS Bodies on Security Management Measures 2004.	**To be confirmed**

RECOMMENDATION:
It is recommended that the following Non-Executive Directors are designated:

- Security Management – Chair of Audit Committee, Richard Stiff

Additional Roles

The organisation has also determined that a Non-Executive Director Lead for Equality and Diversity is required. This is noted as Wallace Sampson, Non-Executive Director.

2.3 Issues to be overseen through Committee Structures

This section provides information on areas that in the past have been overseen by a Non-Executive Director but are now recommended to review within the Committee Structure:

Quality Committee

Issue / Topic	Detail	Position
Hip fractures, falls and dementia	The focus in on hip fractures and other serious harms resulting from inpatient falls can be linked to dementia. It is suggested that the executive lead for dementia attends the Quality Committee as well as the Dementia Steering Group.	Falls, including themes such as dementia are regularly reviewed in the Patient Safety Forum and escalated through Quality Governance Management Group and on to the Quality Committee. Consideration is being given to if a dementia steering group is required in HDFT.
Palliative and End of Life Care	The focus is on the six ambitions for the improvement of Palliative and End of Life Care as outlined in Ambitions for Palliative and End of Life Care National Framework 2021-26. The Board should be aware of standards of care in PEoLC.	The Executive lead is Emma Nunez, Director of Nursing, Midwifery and AHPs. End of Life feeds into the HDFT Making Experiences Count Forum and is escalated through the Governance Structure as required. A Board workshop will be held in the Summer of 2022 and the Board will receive a formal report on the Framework to the September 2022 meeting.
Resuscitation	The Health Service Circular Services: HSC 2000/028 stated that all trusts should give a NED designated responsibility on behalf of the Board for ensuring the resuscitation policy is agreed, implemented and regularly reviewed within the clinical governance framework. It is suggested that the Quality Committee may wish to discharge this duty rather than a specific Non-Executive Director.	The Resuscitation Policy is managed via the Patient Safety Forum with Annual Reports submitted to the Quality Committee.
Learning from Deaths	All Non-Executive Directors play a crucial role in constructively challenging the executives to satisfy themselves that clinical quality controls and risk management systems are robust and defensible. It is suggested that the Quality Committee should understand the Learning from Deaths review process, champion quality improvement that leads to actions that improve patient safety.	A Medical Examiner is in place and a well established process is in place with Quarterly Reports submitted to the Board with numbers, themes and trends.

Issue / Topic	Detail	Position
Health and Safety	Strong leadership at board level and a strong safety culture, combined with NED scrutiny are essential. The wide range of issues that this encompasses could be better scrutinised within a Committee structure.	Health and Safety is currently under development within HDFT. **ACTION:** The Health and Safety Committee is currently a level 4 committee and needs to be moved to Level 3, reporting to the Quality Committee. This will commence in February and March 2022.
Safeguarding	The Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff suggests that boards should consider the appointment of a Non-Executive Director, however, this could be discharged by a committee in ensuring appropriate scrutiny of the safeguarding performance, all Board members should have Level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents.	The Executive Lead for Safeguarding (Children and Adults) is Emma Nunez, Director of Nursing, Midwifery and AHPs. Safeguarding is managed through the Safeguarding Forum as well as regular reports through the Quality Committee and Annual Reports to the Board,
Safety and Risk	the CQC well led framework notes that a range of Non-Executives will be interviewed who have safety and risk as their priority. It is noted in the report that organisations can determine if they wish to designate the role to a Committee or a specific Non-Executive Director.	A well-established process is in place with reports submitted on a monthly basis to Quality Committee and escalated to Board as required.
Children and Young People	The CQC Children and Young People Framework states that a Non-Executive will be interviewed. This could be a designated Non-Executive Director with this responsibility or the Quality Committee Chair.	A 0-19 Sub Committee of the Board working group was agreed in November 2021 at the Trust Board. The inaugural meeting is due to be held in February 2022. In addition, the Trust has Laura Robson, Non-Executive Director and Chair of Quality Committee as the lead for Children and Young People.

Audit Committee

Issue / Topic	Detail	Position
Counter Fraud	the role is primarily a senior manager within an organisation, however the Audit Committee Chair will be required to ensure that Counter Fraud is considered at the Committee.	The executive lead is Jonathan Coulter, Director of Finance / Deputy CEO. Thomas Morrison, Head of Financial Accounts is the HDFT champion with updates provided at every Audit Committee.
Emergency Preparedness	the NHSE Emergency Preparedness, Resilience and Response Framework sets out the responsibility of the accountable emergency officer (AEO). The Framework suggests that a Non-Executive could have responsibility for holding the AEO to account, however, the Board will want to ensure that they have oversight.	The AEO is Russell Nightingale, Chief Operating Officer. **ACTION:** The Framework will be submitted to Board in May 2022.

Resource Committee

Issue / Topic	Detail	Position
Procurement	this should be overseen by the Resource Committee with escalation to the Board as required.	Well established process of review at the Resource Committee with 6 monthly updates.
Cyber security	each organisation should have a Senior Information Risk Owner (SIRO). The Board or Committee should regularly review cyber security risks. This should include information on the removal of unsupported systems from Trust networks, timely patching of systems and prompt action on high severity Alerts when they are issued and ensuring robust and immutable backups are in place. It is recommended that the Board undertake annual cyber awareness training.	The SIRO is Russell Nightingale, Chief Operating Officer. Cyber Risks are discussed on a monthly basis at the IT Steering Group. **ACTION:** 6 monthly report to be submitted to Resource Committee

People and Culture Committee

Issue / Topic	Detail	Position
Security management - violence and aggression	as set out in the NHS People Plan and the NHS Violence Prevention and Reduction Standard 2020, organisations should commit to develop a violence prevention and reduction strategy that is endorsed by the Board and a senior management review is undertaken twice a year as a minimum to evaluate and assess the Violence Prevention and Reduction programme.	Violence and aggression is overseen by the Quality Governance Management Group and escalated as required to the Quality Committee. **ACTION:** Development of a Violence Prevention and Reduction Strategy to be submitted to Board in September 2022.

3.0 NEXT STEPS

Following review of Non-Executive Director roles, a further review will be undertaken on statutory and regulatory roles required by other colleagues in the Trust, for example, Freedom to Speak Up Guardian, Director of Infection Prevention and Control to ensure full compliance and transparency of these roles. This report will be brought back to a future Board.

4.0 RECOMMENDATIONS

The Board is recommended to review the content of this report and approve:

- The appointment of a Non-Executive Director lead for Security Management
- The governance arrangements for the management of all highlighted issues in section 2.3 of this report and confirm that these will be managed via the Committee Structure rather than a designated Non-Executive Director.

Kate Southgate
Company Secretary

January 2022

Board of Directors (Public)
26th January 2022

Title:	**Non Executive Director Board Committee Membership**
Responsible Director:	Chairman
Author:	Chairman

Purpose of the report and summary of key issues:	The report provides the Trust Board with updates on changes to Non-Executive Directors on Sub-Committees of the Board	
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. The January 2022 report has been reviewed at the Executive Risk Review Meeting (January 2022) and the Senior Management Team meeting (January 2022).	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
JANUARY 2022

Non Executive Director Board Committee Membership from February 2021

In anticipation of the possibility that Maureen Taylor may step down as Non Executive Director within the next few months it is necessary to review Non Executive director membership of Board Committees. The Board is requested to approve the following arrangements from February 2022.

Changes to Committee Chairmanship

Jeremy Cross to become chairman of the Resources Committee
Andy Papworth to become chairman of the People and Culture Committee

Non Executive Director Committee Membership from February 2022

- **Resources Committee**

  Jeremy Cross
  Wallace Sampson
  Maureen Taylor
  Andy Papworth
  Chairman

- **Quality Committee**

  Laura Robson
  Sarah Armstrong
  Richard Stiff

- **People and Culture Committee**

  Andy Papworth
  Laura Robson
  Sarah Armstrong

- **Audit Committee**

  Richard Stiff
  Jeremy Cross
  Laura Robson
  Maureen Taylor
  Wallace Sampson

Angela Schofield
Chairman
December 2021