Board of Directors Meeting (Public)
To be held on Wednesday 30th November 2022 12.45 – 3.30

AGENDA

All items listed in blue text (throughout the agenda), are to be received for information/ assurance and no discussion time has been allocated within the agenda. These papers can be found in the supplementary pack.

Item No.	Item	Lead	Action	Paper
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs	Discuss	Verbal
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chair	Note	Attached
1.4	**Minutes of the Previous Board of Directors meeting held on 28th September 2022**	Chair	**Approve**	Attached
1.5	**Matters Arising and Action Log**	Chair	Discuss	Attached
1.6	**Overview by the Chair**	Chair	Note	Verbal
SECTION 2: CEO Updates				
2.1	**Chief Executive Report**	Chief Executive	Note	Attached
2.2	**Corporate Risk Register**	-	Note	Supp. pack
2.3	**Board Assurance Framework**	Chief Executive	**Approve**	Attached
SECTION 3: Ambition: Best Quality, Safest Care				
3.1	**Board Assurance Framework: Best Quality, Safest Care**	Director of Nursing, Midwifery and AHPs	Discuss	Attached
3.2a	**Quality Committee Chair's Report November 2022**	Quality Committee Chair	Note	Verbal
3.2b	**Quality Committee Chair's Report October 2022**	Quality Committee Chair	Note	Supp. Pack
3.3	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	-	Note	Supp. pack

3.4	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.5	**Medical Director Report**	Medical Director	Note	Attached
3.6	**Learning from Deaths Q2 Report**	-	Note	Supp. pack
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework: Person Centred; Integrated Care; Strong Partnerships**	Chief Operating Officer	Discuss	Attached
4.2	**Resource Committee Chair's Reports**	Resource Committee Chair	Note	Verbal
4.3	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	-	Note	Supp. pack
4.4	**Chief Operating Officer's Report**	Chief Operating Officer	Note	Attached
4.5	**Director of Finance Report**	Finance Director	Note	Attached
SECTION 5: Ambition: Great Start in Life				
5.1	**Board Assurance Framework: Great Start in Life**	Director of Nursing, Midwifery and AHPs	Discuss	Attached
5.2	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Discuss	Attached
SECTION 6: Ambition: At Our Best: Making HDFT the Best Place to Work				
6.1	**Board Assurance Framework: At Our Best: Making HDFT the Best Place to Work**	Director of Workforce and OD	Note	Attached
6.2	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	Verbal
6.3	**Integrated Board Report –** Indicators from Workforce Domains	-	Note	Supp. pack
SECTION 7 Ambition: Enabling Ambitions				
7.1	**Board Assurance Framework: At Our Best: Enabling Ambitions**	Medical Director	Discuss	Attached
7.2	**Innovation Committee Chair's Report**	Innovation Committee Chair	Note	Verbal

7.3	**Director of Strategy Report**	Director of Strategy	Note	Attached
SECTION 8: Governance Arrangements				
8.1	**Audit Committee Chair's Reports** *(To Note: no meeting has taken place within the Sept-Nov time period)*	Committee Chair		
8.2	**WYAAT Programme Executive minutes**	-	Note	Supp. Pack
8.3	**Collaboration of Acute Providers minutes**	-	Note	Supp. Pack
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next meeting** Wednesday, 25th January 2023			
Confidential Motion – the Chair to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*				

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

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interests
As at 28th September 2022

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing partner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	Date	1. Company director for the flat management company of current residence 2. Chief Executive of the Ewing Foundation
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022	No interests declared	
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Tipton Building Society 2. Chairman, Headrow Money Line Ltd (ended September 2021) 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
Emma Edgar	Clinical Director (Long term & Unscheduled Care)	No interests declared		
Matt Graham	Director of Strategy	September 2021 April 2022	Date Date	1. Director Governor (Chair of Finance & Premises Committee) – Malton School 2. Stakeholder Non-executive Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)	No interests declared		
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)		Date	1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network.

				4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR. 7. Familial relationship with Harrogate GP Vocational Training Scheme 8. Familial relationship within Harrogate & District NHS Foundation Trust
Jordan Mckie	Acting Director of Finance (From March 2022)	August 2022	Date	1. Chair of Internal Audit Provider Audit Yorkshire
Russell Nightingale	Chief Operating Officer	April 2021	Date	Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing Deputy Chief Executive from March 2022	No interests declared.		
Andrew Papworth	Non-executive Director	March 2020	Date	Group Director, Cost and Productivity Insight at Lloyds Banking Group
Laura Robson	Non-executive Director	No interests declared		

Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board 4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. 7. Trustee for the Harrogate District Climate Change Coalition CIO (effective November 2021) 8. Member of Challenge Board for Northumberland County Council.
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	April 2017	March 2022	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018 January 2022 April 2022	Date Date Date	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Member of the Association of Directors of Children's Services 4. Member of Society of Local Authority Chief Executives 5. Local Government Information Unit Associate 6. Fellow of the Royal Society of Arts 7. Stakeholder Non-Executive Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 8. Member of the Corporation of the Heart of Yorkshire Education Group
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	1. Director of ILS and IPS Pathology Joint Venture 2. Familial relationship within Harrogate & District NHS Foundation Trust

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

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Kate Southgate	Associate Director, Quality & Corporate Affairs	Familial relationship with Director in NHS England

Directors and Attendees
Previously recorded Interests – For the 12 months period pre July 2022

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	31 March 2022	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Member of the Yorkshire & Humber NHS Chairs' Network 4. Volunteer with Supporting Older People (charity). 5. Member of Humber Coast and Vale ICS Partnership
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	31 March 2022	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jonathan Coulter	Finance Director Chief Executive from March 2022	November 2017	31 March 2022	(Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Mrs Laura Angus	NExT Non-executive Director	January 2021	March 2022	1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG 2. Chair of York and Scarborough Medicines Commissioning Committee 3. Interim Chief Pharmacist at Humber, Coast and Vale ICS 4. MTech Associate; Council Member PrescQIPP 5. Chair of Governors at Kirby Hill Church of England Primary School
Steve Russell	Chief Executive	March 2020	March 2022	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber (ended July 2021) 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board 3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS 4. Co-Chair of WY&H Planned Care Alliance 5. Chair of Non-Surgical Oncology Steering Group 6. NHS Employers Policy Board Member (September 2020 and ongoing)

				7. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 8. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)
Jordan McKie	Deputy Director of Finance (Until March 2022)	No interests declared		
Richard Stiff	Non-Executive Director		December 2021 February 2022 February 2022	1. Director and Trustee of TCV (The Conservation Volunteers) – ceased December 2021 2. Local Government Information Unit (Scotland) Associate – LGIU has now fully merged with LGIU listed as current interest 3. Chair of the Corporation of Selby College – dissolved 28 February 2022 when it became part of the Heart of Yorkshire Group.
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	April 2017	March 2022	Director of Shepherd Property Ltd
Maureen Taylor	Non- Executive Director		September 2022	No Interest declared0

Board of Directors Meeting - Public
Wednesday, 28th September 2022 from 9.00am – 12.30pm
At the Pavilions, Harrogate

Present
Sarah Armstrong, Chair
Jonathan Coulter, Chief Executive
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Wallace Sampson OBE, Non-executive Director (via Teams)
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Jacqueline Andrews, Executive Medical Director
Matthew Graham, Director of Strategy
Jordan McKie, Acting Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Director of Nursing, Midwifery and Allied Health Professionals and Acting Deputy Chief Executive
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Emma Edgar, Clinical Director for Long Term and Unscheduled Care Directorate (LTUC)
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate (PSC)
Natalie Lyth, Clinical Director for Community and Children's Directorate (CC)
Kate Southgate, Associate Director of Quality and Corporate Affairs

Observing
Four observers were present at the meeting.

Item No.	Item
BD/09/28/1 **1.1** **1.2** **1.3**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies were received from Jeremy Cross, Non-executive Director. The Chair reminded all on the use of acronyms and requested full explanations as members of the Board discussed items. The Chair also reminded all on the use of the supplementary pack of papers provided with the Board agenda.
BD/09/28/2 **2.1** **2.2**	**Patient Story** The Chair noted the importance of the patient story to open the Public Board. Unfortunately, the patient who was due to attend was unwell and could not be in attendance. The Chair also noted that further work was ongoing with the development of the patient story, for example the use of pre-recorded videos.
BD/09/28/3 **3.1** **3.2**	**Declarations of Interest and Register of Interests** The register of interests was received and noted. **Resolved:** The declarations were noted.
BD/09/28/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 27th July 2022** Approved as accurate with 2 amendments: • Page 1 - the date should read 27th July and not 21st July 2022.

	• Page 4 – Should read Associate Director of Midwifery not Associate *Deputy* Director of Midwifery
BD/09/28/5	**Matters Arising and Action Log**
5.1	No open actions.
5.2	No matters arising.
BD/09/28/6	**Overview by the Chair**
6.1	The Chair noted that it was Maureen Taylor's last meeting as our Non-Executive Director after over 8 years of service. On behalf of the Board, the Chair thanked her for all of the hard work, dedication and support.
6.2	Two Non-Executive Directors and Two Associate Non-Executive Directors will be joining the Trust in October 2022.
6.3	The Chair alongside the Lead Governor, has been working closely in recent months to review the work of the Governors. It was noted that NHS Providers had supported the Council of Governors to review its effectiveness. A range of improvements are being action to support and improve the role of our Governors.
6.4	At the last Board Workshop in August 2022, a review and stocktake of the Board governance structure was undertaken. It was noted that work was ongoing to improve our governance arrangements as a result.
6.5	The Chair noted that a wide range of external meetings, workshops and visits had been undertaken in recent months. The Chair made specific reference to the visits undertaken in the North East to meet with our teams.
6.6	**Resolved:** The Chair's report was noted.
BD/09/28/7	**Chief Executive Report**
7.1	The Chief Executive presented his report as read.
7.2	He highlighted the change in Secretary of State for Health since the Board last met. It was confirmed, that the Trust will respond to any new changes in legislation, and noted that organisation would continue to strive forward with our aims and ambitions.
7.3	It was also noted that work continued at a regional level to respond to changes in our local systems and the organisation's approach would be to remain as a strong partner. The focus would also remain on ensuring the safety of our patients when attending our urgent and emergency care setting as well as within the wider organisation.
7.4	Pressures were noted in the 0-19 services, with OPEL levels being 3 for the majority of services. The consultation in respect of the Darlington section 75 agreement have concluded successfully and the arrangements will commence in October 2022. In addition, the transfer of the Wakefield service to the Trust is also due to commence on the 1st October 2022.
7.5	Workforce and wellbeing, including the cost of living crisis and the support the Trust can provide, was highlighted. It was confirmed that the Living Wage Foundation had announced the new living wage and the Trust would continue to be a living wage employer.
7.6	A new management structure, to focus on triumvirate working, was in the process of being implemented and embedded.
7.7	Thanks were expressed to all colleagues involved in the planning and delivery of services and care over the Bank Holiday weekend in September 2022.

7.8	Andy Papworth noted winter planning and queried if anything further needed to be presented and discussed at Board. The Chief Executive noted that operational discussions were ongoing and being managed through SMT. At a strategic level it would be reviewed in the relevant Sub-Committees of the Board and at the next Board an oversight report would be provided.
7.9	Richard Stiff noted that on national radio 4, a patient in the local area had highlighted the positive experience they had received at Harrogate.
7.10	Wallace Sampson queried the place base governance structures and if any emerging priorities had been specified. The Chief Executive confirmed there is a North Yorkshire Place Board which the Trust was a member of, key objectives included: integrating out of hospital care and sustainable workforce across the North Yorkshire place.
7.11	Wallace Sampson queried the selling of annual leave and how this will impact on wellbeing. The Chief Executive confirmed that the Policy was in place for this year only and there is a maximum of 5 days that can be "sold back" to the Trust.
7.12	**Action:** • The Winter Plan to be brought to the Board Workshop in October 2022
7.13	**Resolved:** The Chief Executive's Report was noted.
BD/08/28/8 8.1	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/08/28/9 9.1	**Quality Committee Chair's Report** The Chair of the Committee noted that no governors were present for this meeting. It was also noted that no meeting had been held in August 2022.
9.2	Two presentations were received at the September 2022 meeting. One was in relation to volunteer provision and services and the other was in relation to the AHP workforce improvement project.
9.3	The Committee reviewed the relevant quality and safety indicators via the Quality Report as well as the operational updates from the Quality Governance Management Group (QGMG). Highlights included compliance with NICE guidance, Scan for Safety and mandatory training compliance.
9.4	The Committee gave final approval of the Quality Accounts and the Infection Prevention Control Annual Report.
9.5	The Committee also reviewed and received assurance regarding the maternity and neo-natal safety reports.
9.6	**Action:** • The Associate Director of Quality and Corporate Affairs and the Chair of the Trust to review governor allocation to Committees.
9.7	**Resolved:** The Board noted the content of the report and confirmed final approval of the Quality Accounts 2021-22.
BD/09/28/10 10.1	**Integrated Board Report -** Indicators from Safe, Caring and Effective domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.

10.2	**Resolved:** The Board noted the content of the report.
BD/09/28/11 **11.1**	**Director of Nursing, Midwifery and AHPs Report** The Director of Nursing report was received and taken as read.
11.2	A new Associate Director of Midwifery and Head of Health and Safety have commenced in post. It was also confirmed that the Deputy Director of Nursing, Health Visiting and Safeguarding (Suzanne Lamb) had moved into the Corporate Nursing structure.
11.3	The supplementary papers include the work that has commenced in relation to the national launch of the Patient Safety Incident Response Framework (PSIRF). This would be managed at an operational level via the Quality Governance Management Committee.
11.4	Laura Robson queried if Suzanne Lambs new role would include the continued involvement in mobilisation. The Director of Nursing, Midwifery and AHPs confirmed that this would still be the case.
11.5	Andy Papworth queried the Shared Decision Councils in relation to Care Support Workers, Nutritional Assistants and Theatres and how this would link into the governance structures. It was noted by Director of Nursing, Midwifery and AHPs that the individuals would be involved within the quality governance structures including meetings and committees and throughout the quality programmes.
11.6	The Chair noted the disappointment that the Trust was not successfully in the national bid in relation to international recruitment. The Director of Nursing, Midwifery and AHPS noted that whilst it was disappointing, the Trust still has a strong approach and focus on international recruitment as well successful retention of previous recruits.
11.7	**Resolved:** The Board noted the content of the report.
BD/09/28/12 **12.1**	**Strengthening Maternity and Neonatal Safety** The Director of Nursing, Midwifery and AHPs presented the report, which was taken as read.
12.2	It was noted that the new Associate Director of Midwifery would be focusing on the development of this report.
12.3	The national target and trajectory for Continuity of Care has been removed. It was highlighted that there had been a closure of 12 neo-natal cots at Leeds which may affect availability and transfer times. This is being monitored closely. The first community hub (Leon Smallwood) had been agreed.
12.4	Andy Papworth noted that he would be undertaking a review using 15 Steps during November.
12.5	Maureen Taylor queried if women were opting for “free birth”. The Director of Nursing, Midwifery and AHPs confirmed that the Trust had experienced this with women in our care. It was confirmed that work was ongoing with women that chose to birth outside of guidelines. Richard Stiff queried if staff had been supported from a legal perspective in terms of the interventions they can and cannot do. The Director of Nursing, Midwifery and AHPs confirmed that this had been completed.
12.6	Laura Robson queried the risks on the risk register in relation to midwifery. The Director of Nursing, Midwifery and AHPs confirmed that a Safeguarding Lead for midwifery was in place. In relation to the Polices and sharing Safeguarding

	information across organisation, it was confirmed that integrated systems would be required to fully mitigate this risk. Work was ongoing on this.
12.7	Jeremy Cross, via the Chair, confirmed concern regarding the closure of the neo-natal beds in Leeds. The Medical Director noted that neo-natal cot closure was a short term issue in relation to medical staffing.
12.8	**Action:** • The new Associate Director of Midwifery to attend the October 2022 Board Workshop .
12.9	**Resolved:** The Board noted the content of the report.
BD/09/28/13 **13.1**	**Patient Safety Incident Response Framework (PSIRF)** The Director of Nursing, Midwifery and AHPs took the report as read.
13.2	**Resolved:** The PSIRF report was noted.
BD/09/28/14 **14.1**	**Medical Director Report** The Executive Medical Director noted the content of her report.
14.2	A new consultant-mentoring scheme was now in place and had gained positive feedback. A new Chief Registrar had been appointed and a new leadership post had been created and appointed to – Chief Practitioner for Medically Associated and Advanced Leadership. The Executive Medical Director had been appointed to Humber and North Yorkshire ICS leadership role for Innovation, Research and Improvement.
14.3	It was noted that there were challenges in delays in discharging medically optimised patients. The quality impact of this was been assessed and monitored via the Datix system.
14.4	The Trust is awaiting final treasury sign off of the Electronic Patient Record enablement programme.
14.5	The Chair noted the positive scheme in relation to consultant mentoring programme. Congratulations were passed onto the Executive Medical Director on the new ICS role she had taken on. The Chair queried the electronic patient record funding delay and if there was anything further the organisation could do. It was confirmed that regionally discussions were ongoing with the national team.
14.6	Wallace Sampson queried to progress being made with the Harrogate and District Innovation Hub. The Executive Medical Director confirmed that this was a new initiative and good pace was being seen. Round table regionally and system meetings would be taking place in October and November 2022. Positive buy-in across the system was noted.
14.7	**Resolved:** The Board noted the content of the report.
BD/09/28/15 **15.1**	**Learning from Deaths** The Executive Medical Director noted the content of her report.
15.2	Laura Robson noted the continued level on SHMI and HSMR reporting. The Executive Medical Director confirmed that the extended Learning from Deaths report noted the rich data provided by the Structured Judgement Reviews (SJRs) and how this provided greater assurance. This would continue to be closely monitored.
15.3	**Resolved:** The Board noted the content of the report.

BD/09/28/16	**Guardian of Safe Working**
16.1	The Executive Medical Director presented the report on behalf of the Guardian of Safe Working who was unable to attend the meeting. The content of the report was noted as read.
16.2	The Board expressed their thanks to the Guardian of Safe Working for the work he does in the role.
16.3	The number of exception reports in quarter 2 had increased in trajectory to 88. This was noted as an upward trend across peer organisations. Work was ongoing to ensure senior doctors and doctors in training understood the value of exception report to help improve the working lives of our colleagues.
16.4	The Clinical Director for Planned and Surgical Care highlighted the work that was ongoing with rota coordination. It was also highlighted, the range of actions being undertaken in Same Day Emergency Care (SDEC). This included a new escalation process being put in place, however it was noted that further education and embedding was still required for this. Surgical Care Practitioners had also been appointed and would help to provide support to SDEC.
16.5	The Clinical Director for Long Term and Urgent Care noted the content of the exception reports. It was noted a new staffing model was being implemented and a new junior doctor lead to help support colleagues had been appointed to. Rostering had been a concern, however a secondment had been put in place to help mitigate against the current risks.
16.6	The new Chief Registrar noted they had attended the Junior Doctor meeting in previous weeks. It was noted that it was felt that there was still work to do, but improvements had been made in recent months.
16.7	The Chair thanked all for their comments and noted the helpful context provided by colleagues.
16.8	Maureen Taylor noted that current junior doctors will have had reduced clinical exposure and how was the organisation mitigating this. The Executive Medical Director confirmed that the University had undertaken increased simulation training which has continued within the Trust.
16.9	Maureen Taylor queried the note in the report regarding the potential removal of Junior Doctors in certain areas of the organisation. The Clinical Director for Planned and Surgical Care noted that there was a balance in the staffing model to ensure wellbeing of all staff and the safety of our patients.
16.10	Andy Papworth noted the range of actions in place and how this helped with the context of the report.
16.11	The Chief Executive noted the governance arrangements of this report and suggested that the report is discussed in detail at the People and Culture Committee alongside the relevant actions that were being put in place.
16.12	The Chair noted that following the last Guardian of Safe Working report, the Board had discussed the workforce issues and actions required at a recent Board workshop.
16.13	Wallace Sampson queried the attrition rate of Junior Doctors as well as how other organisations were mitigating against this. The Executive Medical Director confirmed that there was no clear attrition rate for doctors in training and this was a rotational role. The Trust was however, performing well in recruiting and retaining colleagues outside of this trainee programme and positive feedback had been received from undergraduates and postgraduates on the organisation as an employer.

16.14	Jeremy Cross, via the Chair, noted his concern regarding the number of exception reports. He also welcomed the opportunity to discuss the issues and actions in more detail.
16.15	Laura Robson queried if this should be on the risk register.
16.16	**Action:** • The report to be discussed, including appropriate actions being taken, at the People and Culture Committee prior to being submitted to the Trust Board. • The directorates to review their risk registers in relation to staffing and update as required in relation to junior doctors.
16.17	**Resolved:** The Board noted the content of the report.
BD/09/28/17 **17.1**	**Annual Medical Appraisal Statement** **Resolved:** The Board noted the content of the report.
BD/09/28/18 **18.1**	**Infection, Prevention & Control Annual Report 2021-22** **Resolved:** The Board noted the content of the report.
BD/07/27/19 **19.1**	**Resource Committee Chair Report** The Chair reports for the August and September 2022 meetings were noted and taken as read.
19.2	Wallace Sampson, in Jeremy Cross' absence, took the Board through the report. The breakeven position was noted, however it was highlighted that there were significant overspends in certain areas which were being offset by underspends in Children and Community Directorate with some non-recurrent income that was released.
19.3	Operational performance had been reviewed at the Committee specifically concerns regarding two week wait for breast. It was noted that this would be monitored closely by operational teams as well as the Committee.
19.4	A&E performance metrics were highlighted including 12 hour waits and the 4 hour standard. National context was provided as well as improvements that were in place to help rectify these issues including capital works within the Emergency Department.
19.5	RTT was an improving trend and remains on track for delivery of 52, 78 and 104 week waits.
19.6	All metrics for Children's and Community were green for the month of August and the Committee had noted this as a significant achievement given the pressures that the wider system is currently under.
19.7	In relation to workforce, vacancies had decreased as had sickness rates. The Committee continue to monitor "hot spot" areas including Care Support Workers to ensure that the pipeline of new joiners is adequate.
19.8	It was noted that three Business cases, all relating to the Emergency Department were reviewed and approved.
19.8	Thanks were expressed to Maureen Taylor for her significant contribution to the Committee including her previous chairmanship and her wider support. The Committee had benefited from her experience, dedication and commitment.
19.9	**Resolved:** The Board noted the content of the report.

BD/09/28/20	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains
20.1	**Resolved:** The Board noted the content of the report.
BD/09/28/21	**Director of Finance Report**
21.1	The Director of Finance presented his report as read.
21.2	It was noted that the external audit process was continuing with the Annual Report and Accounts due to be signed off by the Audit Committee and Extra-Ordinary Trust Board in early October 2022.
21.3	Highlights from the report included agency expenditure, cost of living schemes and the impacts of the pay award financially and on staff morale.
21.4	**Resolved:** The Board noted the content of the report.
BD/09/28/22	**Chief Operating Officers Report**
22.1	The Chief Operating Officer presented the report as read.
22.2	Cancer performance was highlighted. The area of concern was for two week wait in relation to breast and dermatology. The main tumour site breaching is colorectal. Demand and capacity analysis has been completed and actions being taken to address this shortfall.
22.3	Covid admissions and occupancy remains a challenge with numbers higher than expected. Non-elective demand remains a challenge and the Trust continues to operate at full capacity. Information was highlighted in relation to the Emergency Department capital works as well as performance metrics. In addition, a new 12 bed frailty unit has gone live and further information will be brought back to the Board in future reports. The organisation continues to operate as a strong partner, including accepting acute patient diverts from local system hospitals.
22.4	Richard Stiff queried the background regarding the Duchy Hospital agreement. The Chief Operating Officer noted that access to the Duchy is up to the end of the financial year. It had been agreed that up to 40 patients per month would be cared for through the Duchy, but on average the acceptance of patients is around 20 per month at the moment.
22.5	Andy Papworth queried concerns regarding Glaucoma which was noted at Quality Committee this month. The Chief Operating Officer confirmed that short-term staff absences had caused some impact and it would be monitored at Resource Committee with feedback to the Council of Governors.
22.6	Andy Papworth noted the significant work that Children and Community Directorate had undertaken to achieve a full range of green metrics under current pressures.
22.7	Laura Robson queried the two-week wait in cancer and how compliance increases and decreases regularly. The Chief Operating Officer noted this was a fragile service and it is an area that needs to be considered at a regional level to ensure a long-term solution.
22.8	**Resolved:** The Board noted the content of the report.
BD/09/28/23	**Workforce Report and Organisational Development Report**
23.1	The Director of Workforce and OD presented her report as read.
23.2	It was highlighted that potential strike action could occur and professional groups were currently being balloted. The organisation was looking at mitigation of risk. The People and Culture Committee and the Board will be kept apprised of the situation.

23.3	Recruitment and retention was highlighted including levels of turnover. In addition, the leadership restructure was noted. The vaccination programme had commenced and was progressing well.
23.4	145 nominations had been received for the KITE colleague recognition awards and a celebration event was due to occur in November 2022.
23.5	Work was ongoing with employee casework including timescales and approaches being taken. The focus would be on learning and would follow similar "Just Culture" approach as used in Serious Incident investigations.
23.6	Laura Robson queried the consultation of the restructure of the Pathology Joint Venture and the 4 people noted as being affected, if these were colleagues in the Trust or other organisations. The Director of Workforce and OD confirmed that it was 4 in the organisation, but additional colleagues were affected in the other organisations.
23.7	Laura Robson queried the management structure on who was in scope in the organisation. The Director of Workforce and OD confirmed it was at the management level of Clinical Directorates that would be impacted as part of the restructure. A triumvirate model of working would be introduced and there are no staff "at risk" as a result of the process.
23.8	**Action:** • A full update on the Management Restructure will be provided at People and Culture Committee
23.9	**Resolved:** The Board noted the content of the report.
BD/09/28/24 **24.1**	**WDES Annual Report 2022** The Director of Workforce and OD presented the report as read.
24.2	Andy Papworth noted the structure of the report and the differences between the WDES and WRES. It was highlighted that WDES was more user-friendly.
24.3	Andy Papworth noted the delay in recruitment to the EDI lead and the noted impact this had. It was requested that this be reviewed prior to submission.
24.4	**Action:** • Final review to be undertaken on consistency and review of ratings to be undertaken by the Chair of People and Culture Committee and Director of Workforce and OD. **Resolved:** The Board approved the content and onward national submission.
BD/09/28/25 **25.1**	**WRES Annual Report 2022** The Director of Workforce and OD presented the report as read.
25.2	Andy Papworth noted there were some inconsistencies in the report including targets and it should have a final review before submission.
25.3	**Action:** • Final review to be undertaken on consistency and review of ratings to be undertaken by the Chair of People and Culture Committee and Director of Workforce and OD.
25.4	**Resolved:** The Board approved the content and onward national submission.

BD/07/27/24 **24.1**	**People and Culture Chair's Report** The Chair report for September 2022 meeting was noted and taken as read.
24.2	It was highlighted that Committee commenced with a colleague experience story from Northumberland 0-19 services. A discussion had been held on the Terms of Reference on the Committee and it was noted that as part of the wider governance review to ensure a focus on the elements of the Trust Strategy and Board Assurance Framework which related to the Committee.
24.3	The effectiveness survey had been conducted and positive feedback was received.
24.4	A wider ranging discussion had occurred on the People Plan as well as the national Pulse Survey and results from the organisations Inpulse survey. In addition, updates had been received from the Staff Networks within the organisation and it was noted that the Menopause Network had 70 members with World Menopause Day being held on 18th October 2022
24.5	The Committee reviewed the result of the pilot too address inequalities in recruitment processes relating to BAME characteristics. Interventions have proven to have a positive impact, however these have proven to be manual and time-consuming. Further work is required to ensure a more sustainable solution.
24.6	**Action:** • All Committee Chair's reports to be shared with governors
24.7	**Resolved:** The Board noted the content of the report.
BD/09/28/25 **25.1**	**Integrated Board Report -** Indicators from Workforce Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
25.2	**Resolved:** The Board noted the content of the report.
BD/09/28/26 **26.1**	**Board Assurance Framework (BAF)** The BAF was taken as read with the Chair noting the ongoing work with the development in line with the new Trust Strategy.
26.2	**Action:** • The revised Board Assurance Framework would be presented to the November 2022 Board meeting. •
26.3	**Resolved:** The Board noted the content of the report.
BD/09/28/27 **27.1**	**Director of Strategy Report** The Director of Strategy presented his report as read.
27.2	It was highlighted that a significant amount of planning and capital development was ongoing across the organisation including the Gamma Camera works commencing on 3rd October 2022. Risks were noted with Salix, including the ongoing delays in window replacements.
27.3	The mobilisation of the Wakefield 0-19 service was in process and would go live on the 1st October 2022.
27.4	The number and range of business cases were noted. In addition, the range of Quality Improvement projects were highlighted and it was noted that a full review would be undertaken at the Senior Management Team in October 2022.

27.5	**Resolved:** The Director of Strategy Report was noted.
BD/09/28/28 **28.1**	**Trust Strategy** The Director of Strategy presented the final version of the Trust Strategy for approval by the Board.
28.2	The Director of Strategy discussed the "golden thread" of Board to Ward governance. This included the role of the Board Assurance Framework, the programme of work for the organisations strategic objectives as well as how these will be monitored and developed.
28.3	It was noted that a full communication plan would be implemented following approval of the Strategy by the Board.
28.4	The Chair noted the strong themes and the quality of the document.
28.5	**Resolved:** The Board approved the Trust Strategy.
BD/09/28/29 **29.1**	**Business Development Report 0-19 Services** The Director of Strategy presented the report as read.
29.2	**Resolved:** • The Board approved that the organisation enters into a Section 75 Agreement with Darlington Borough Council • The Board approved delegated authority to the Chief Executive and Deputy Chief Executive for final amendments to the section 75 agreement • The Board approved delegated authority to the Chief Executive and the Chair to sign the final North Yorkshire and City of York Oral Health Promotion Service contract
BD/09/28/30 **30.1**	**Provision of Domiciliary Care Services** The Chief Operating Officer noted that a supplementary paper had been circulated to Board members to provide context to this area of business. The national context was provided in relation to the pressures in the current systems. The Board had previously received a proposal in August 2022 outlining the feasibility of the organisation being a provider of domiciliary care.
30.2	The project proposal to provide a six month pilot of a Back to Home domically service was highlighted. It detailed the specific criteria of the project, the risks and benefits and the financial impacts.
30.3	Richard Stiff expressed his support for the project.
30.4	Andy Papworth expressed his support for the project. He highlighted the need for a strong communication plan.
30.5	Wallace Sampson expressed his support for the project. He noted the potential level of costs for some care packages. The Chief Operating Officer provided some context on the work that had been undertaken on the potential losses and that this would be reviewed as part of the 6 month pilot. Wallace Sampson also queried if recruitment to 6 month posts would be an issue. The Chief Operating Officer confirmed that the members of staff would be recruited to on a permanent basis.
30.6	The Chief Executive noted that the ICB were also supportive of this pilot taking place and the principle of the organisation providing domiciliary care.
30.7	Maureen Taylor confirmed her support of the project.

30.8	Jeremy Cross via the Chair, confirmed his support of the project. The Chair noted that the questions he had on the pilot had already been answered by the Chief Operating Officer.
30.9	The Chair noted that the impact this will have on our patients and our staff will be positive and was proud the organisation was making a contribution to wider system problems.
30.10	**Resolved:** • The Board approved the six month pilot of a Back to Home – Domiciliary Care Service • The Board approved the requirements to register with the Care Quality Commission as a social care provider • The Board approved the requirement to add personal care to the organisations regulated activities • The Board approved the update to the Trust's Statement of Purpose • The Board approved the requirement to appoint a CQC Registered Manager for the service • The Board approved that the organisation would be available on the approved provider list for the provision of domiciliary care for Harrogate and District locality • The Board approved the organisation to become a provider of care to support the Local System with the provision of a domically home care service. •
BD/09/28/31 **31.1**	**Audit Committee Chair's Report** The Chair report for the September 2022 meeting was noted and taken as read.
31.2	A procurement report was received and the impact that global pressures were impacting on the procurement operation. In addition, an update had been received on the work with Harrogate Integrated Facilities (HIF).
31.3	The Treasury Management Policy had been received and approved at the Committee.
31.4	The Committee noted the presence at the meeting of the external audit team and the ongoing work to bring the external audit programme back on track.
31.5	**Resolved:** The Board noted the content of the report.
BD/09/28/32 **32.1**	**Annual Governance Timetable** The Director of Finance confirmed that the Annual Report and Accounts would be received by the Audit Committee and Trust Board in October 2022 in line with the revised timescales.
BD/09/28/33 **33.1**	**WYAAT Programme Executive Minutes – August 2022** **Resolved:** The WYAAT Programme Executive Minutes from August 2022 and the Pathology Business Case were noted.
BD/09/28/34 **34.1**	**Collaboration of Acute Providers Minutes – August 2022** **Resolved:** The Collaboration of Acute Providers Minutes from August 2022 were noted.
BD/09/28/35 **35.1**	**HDFT Treasury Management Policy** **Resolved:** The Treasury Management Policy was reviewed and approved.
BD/09/28/36 **36.1**	**Any Other Business** No further business was received.
BD/09/28/37	**Board Evaluation**

37.1	Laura Robson commented that a wide range of business was discussed and the meeting had been valuable and assurance had been received on all topics.
37.2	Maureen Taylor commented that the structure of the meeting was working well and the focus had been on the right areas of business.
37.3	The Chair confirmed that a board effectiveness survey would be circulated shortly.
37.4	The Chair thanked all for their participation in the meeting as well as expressing thanks to members of the public who had attended.
BD/09/28/38	**Date and Time of the Next Meeting**
38.1	The next meeting will be held on Wednesday, 30th November 2022.
BD/09/28/39	**Confidential Motion**
39.1	**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 (Public)
30th November 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. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

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

CHIEF EXECUTIVE'S REPORT

National and system issues

1. The recent Autumn Statement from the government has implications for the NHS, in terms of future funding and the expectations for delivery. The NHS nationally will be receiving an additional £3.3bn over each of the next two years, which has largely been allocated to mitigate the impact of higher inflation than was planned for earlier in the planning cycle.

2. This funding should allow the NHS to deliver on the key priorities, and it is important to focus on delivery of service improvements. The settlement and statement that this will allow us to deliver on our priorities, is based upon government forecasts of inflation and pay awards, and that any industrial action will not materially affect delivery over the coming months.

3. As part of the agreement with the government, an Urgent and Emergency Care recovery plan will be produced, as will a primary care recovery plan, a long term workforce plan will be produced, and we will continue with the elective recovery plan that was agreed earlier this year.

4. There are specific expectations of the NHS alongside the funding agreement, which focus on improving ambulance response times, improving against the four hour emergency care standard, and improving access to primary care.

5. These are all improvements that we would prioritise and agree with, and it is a helpful settlement for the NHS.

6. Alongside funding for the NHS there is additional funding for social care, in particular to improve discharge from hospitals and reduce the number of patients in hospital that are medically fit to be elsewhere. There is an expectation that we will plan and deliver a reduction in the number of patients in hospital by working with colleagues across the system to increase out of hospital capacity. This funding and emphasis on out of hospital care, in particular social care, completely aligns with our plans going forward – again a helpful development.

7. The final key message relates to productivity, which is the key to the elective recovery work. At a national level the information from the NHS is that we have collectively more doctors and nurses working in the NHS than pre-pandemic, but that we are delivering less patient activity. There will be a number of reasons for this, but the emphasis on getting productivity back to where it was a few years ago is a useful reminder locally.

8. Essentially, the key message is that we will receive resource to mitigate inflation, there is additional funding to support social care and discharge in particular, and therefore it is productivity that will deliver the aim of reducing the backlogs of care.

9. None of the messages and priorities outlined above that have come through recently are a surprise or in any way different from what we ourselves would identify, which is helpful,

and our focus is on delivery against our plans. For ourselves though, we constantly need to remind others that a significant proportion of our organisation relates to the provision of Local Authority commissioned services (our children's public health services), which operates under a different sphere of policy and guidance.

10. In addition to the Autumn Statement, the government has announced a review into how ICS's and NHSE operate, which will be led by Patricia Hewitt. We will await the outcome.

11. Since the last Board meeting, the CQC have issued their annual report on the state of care. Again, this highlights the challenges across the NHS, with particular focus on the current 'gridlock' in the urgent care pathway, the less than timely access to all NHS services, workforce constraints, and the reducing public satisfaction with the NHS.

12. We would recognise the issues raised by the CQC in this report, but are focused on the positive things that we can do to address concerns and improve what we do and what our patients and staff experience. These actions are highlighted in accompanying reports.

13. At a more local level, in our region and local ICS's, there are a number of developments to highlight.

14. A regional elective recovery event was held at the end of October, to share and learn about improvements to assist elective recovery. This included key messages in relation to productivity and sessions for ICS's to demonstrate improvement projects and discuss what further can be done. Russell presented the work done in WYAAT very positively, and demonstrated how we work across a number of systems for mutual benefit, which was positive for HDFT.

15. In terms of our provider collaboratives, we are developing a governance model across the Humber and North Yorkshire acute collaborative that includes a Committee in Common approach that we are familiar with through our WYAAT collaborative. In terms of WYAAT, key developments include a model for collaborative working in relation to aseptic services, and development of a business case with Leeds Teaching Hospitals in relation to expanding theatre capacity at the Wharfedale Hospital site in Otley.

16. It should also be noted that Julian Hartley, CEO of LTHT, will be leaving LTHT in the New Year to become the CEO of NHS Providers. Julian has been a strong supporter of the WYAAT collaborative and HDFT's part of it, and his leadership in the local system will be missed.

HDFT issues

Introduction

17. We continue to operate in a local system that is under pressure, in terms of managing the urgent care demand, managing the safeguarding demand, and delivering improvements in our access times for elective care. This is alongside some staffing challenges and in particular the impact on colleagues of the current economic situation.

18. At all times we re-emphasise to our colleagues that whilst there are challenges, there are things that we all can do to improve services, and that what is vitally important is that 'how' we deliver our services – reflecting our values – is a focus that we don't lose.

Our people

19. We are coming towards the end of our staff vaccination programme, with the final sessions in Harrogate Hospital taking place in December. We have currently achieved a 60% take-up of the CoVid vaccine (2nd out of 34 organisations regionally) and 57% take-up of the flu vaccine (3rd out of 34 organisations regionally).

20. Whilst we are performing well in comparison to other organisations, we are keen to promote this further, and we are focusing on encouraging uptake over the final few weeks. Having the vaccines is an important measure that all staff can take to help protect themselves and therefore our patients and the wider community, as we enter the winter period when respiratory infections are more likely to circulate.

21. Following on from the implementation of the new management arrangements within the clinical directorates, we had an extended SMT workshop this week, focused on team development, sharing information, and introducing colleagues to service data as a route to productivity and quality improvement. It was excellent to engage with so many of our leaders who are positive and enthusiastic about what we can deliver in the future.

22. We continue to support colleagues with cost of living initiatives, and we will be reviewing what we should be doing next year very shortly. We have had around 500 hardship grant applications over the last two months, and this is an area in particular that we need to assess in terms of future support and what our approach could be. There is no doubt that colleagues have appreciated both the practical support and the recognition that this programme has delivered.

23. As the Board will be aware, the Royal College of Nurses has voted to take industrial action during a window of November through to May 23. HDFT is an organisation where staff have elected to take action, and we are working with trade union colleagues to plan for any strikes that are yet to be announced.

24. We have been notified by a number of other trade unions of their intent to ballot members, and we are awaiting the outcome of these ballots to see whether any further unions might be involved in industrial action in the future.

25. In parallel with these discussions with our trade unions, we have engaged them positively through a workshop in relation to our Employee Relations processes, with a view to improving the process and experience for all, particularly including colleagues who are in such processes.

26. We have our KITE and long service awards this week, and I am looking forward to celebrating with colleagues all of the contributions that people make each day for the benefit of our patients.

Our Quality

27. We have recently been visited by the CQC who have assessed our maternity services. We await a draft report, but we have received positive feedback about how we welcomed the CQC team into the service, and also the interactions that were witnessed between colleagues and patients. There will no doubt be some things that we can improve on, which we welcome, but I'd like to personally thank the maternity team, colleagues who supported the team, and those who organised the visit. As we know from recent reports into maternity services elsewhere, the most important factor in safe and effective care is the culture of the department and the attitude and approach of colleagues, and it was a positive experience last week.

28. We will receive a draft report before Xmas which will allow us to comment and engage with the CQC before any final report is issued.

29. We have further communication from NHSE in respect of winter planning, and we are continuing to deliver the winter plan that we brought to the Board workshop last month. A national collaborative event was attended by Jackie early in November, with a focus on delivering rapid improvement in the urgent care pathway to assist us over the winter period.

30. The quality impact of delays in the urgent care pathway is significant, particularly for our frail elderly population, and we continue to focus on delivering a service that will assist us in appropriately discharging people into alternative care provision.

Our Services

31. In our 0-19 services, the majority of areas are operating consistently at OPEL 3, which reflects the operational pressures and demands on the service. Safeguarding demand remains high, especially in Middlesbrough, where we are looking to strengthen further our provision of support. Delivery of the mandated contacts remains really strong.

32. We continue to struggle to deliver the standards we would want to deliver across the urgent care pathway, which is illustrated by our performance against the 4 hour Emergency Department standard. This is indicative of concerns across the whole pathway, but for HDFT the key constraint remains the number of patients who remain in our hospital beds due to packages of care not being readily available. On a positive note, we continue to perform comparatively very well in relation to ambulance handovers, and continue to offer significant system support, with regular ambulance diverts accepted into Harrogate (approaching 1000 such diverts so far this year).

33. Our ED streaming model will be fully in place in the New Year, in line with the completion of the initial capital works within the department.

34. Our cancer service standards remains below where we would like to see it, with demand outstripping capacity in a number of areas. Improvement plans are in place in a number of areas, and we are in dialogue with system partners around potential mutual aid.

35. We continue to deliver our elective recovery plan, and the number of people waiting over 78 weeks and over 52 weeks continues to fall. We expect to meet the target of having no over 78 week waiters by the end of the financial year.

Our money

36. The financial position for the year continues to be a deficit, which reflects the underlying runrate concerns. The expectation is that for 2022/23 the financial plan will be delivered, but with some non-recurrent contributions, so the planning for 2023/24 which is underway is the important activity to complete across the Trust.

37. Our agency costs remain a key driver, with some additional usage combined with increasing rates resulting in our agency ceiling being breached. Work is ongoing with Directorates to reduce demand and improve controls.

Other

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

39. The importance of having sufficient and appropriately trained people in roles, working in an environment that is supportive of their work, and where their contribution is valued and appreciated, remains my key focus.

Jonathan Coulter
Chief Executive
November 2022

HARROGATE & DISTRICT NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK

30 November 2022

AMBITION: BEST QUALITY, SAFEST CARE

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

GOALS:

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

Governance:

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

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

Goal	Metrics		
Safety			
Effectiveness			
Patient Experience			

Related Corporate Risks

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

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

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

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

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

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

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

AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

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

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

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

AMBITION: GREAT START IN LIFE

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To embed the "Hopes for Healthcare" principles in all HDFT services	Better patient experience for children Improved safety for children		• Establish Great Start in Life Programme Board – Jan 23 • Further actions to be determined through programme board – TBC	• On Track • TBC	

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

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

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

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

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

GOALS:

- **Looking after our people: physical and emotional support to be "At Our Best"**
- **Belonging: teamHDFT – teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**
- **New ways of working: education, training and career development for everyone**
- **Growing for the future: the right people, with the right skills, in the right roles**

Governance:

- **Board Assurance:** People and Culture Committee
- **Programme Board:** People & Culture Programme Board
- **SRO:** Director of Human Resources and Organisational Development

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

Goal	Metrics		
Looking after our people			
Belonging			
New ways of working			
Growing for the future			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR6	The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of both short and long term mental health impacts on staff	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: New ways of working: education, training and career development for everyone

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Growing for the future: the right people, with the right skills, in the right roles

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Reconfiguration: Fit to Sit, Majors Area	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete - Jul 22 • Contract award - Aug 22 • Fit to Sit Phase 1 start - Sep 22 • Fit to Sit Phase 1 complete - Dec 22 • Majors Area Phase 2A start - Jan 23 • Majors Area Phase 2A complete - Mar 23 • Majors Area Phase 2B start - Mar 23 • Works complete - Apr 23	• Complete • Complete • Complete • On Track • On Track • On Track • On Track • On Track	
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Design complete – Aug 22 • Tender & Contract award – Mar 23 • Build complete – Jun 23 • Commissioning complete – Aug 23 • In service – Sep 23	• Complete • On Track • On Track • On Track • On Track	
Radiology Reconfiguration Phase 1-2 – XRay & CT	• To improve reliability and capacity of imaging services		• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Tender & Contract award - TBC • Build complete - TBC • Commissioning complete – TBC • In service – TBC	• Complete • Complete • On Track • Further milestones dependent on phasing of overall capital programme for 23/24)	
ED2 (UTC) Reconfiguration	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build start – Mar 23 • • Build complete – Aug 23 • Commissioning complete – Sep 23 • In service – Sep 23	• On Track • On Track • On Track • At risk (may be delayed by ED Majors completion) • At risk • At risk • At risk	
Wensleydale Ward Refurbishment	• Dedicated cardiology and respiratory ward, including High Observation/Non-invasive Ventilation Beds		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build Start – Apr 23 • Build complete – Oct 23 • Commissioning complete – Nov 23 • In service – Dec 23	• On Track • On Track • On Track • At risk (needs coordination with window replacement completion) • At risk • At risk • At risk	

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

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

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

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

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

AMBITION: BEST QUALITY, SAFEST CARE

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

GOALS:

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

Governance:

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

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

Goal	Metrics		
Safety			
Effectiveness			
Patient Experience			

Related Corporate Risks

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

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

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

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

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

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

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

Title: Trust Board Report
Date:30th November 2022
Report: Executive Director of Nursing, Midwifery & AHP's.
Author: Emma Nunez

Matters of concern & risks to escalate

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Nurse staffing fill rates remain challenging linked to opening of Acute Frailty beds, however CHPPD has improved for the month of October. Specific challenges remain in relation to Qualified in Specialty (QIS) Registered Nurses for Paediatrics/Special Care; mitigation plans in place
- Pressure Ulcers – (*IBR 1.1 & 1.2*) - improvement plans being updated. Process for PULT and FILT's being reviewed. Internal Audit Report received with Limited Assurance. Development of monthly ward audits by peers. Review of Tendable audits and the reporting process with a view towards local accreditation frameworks. Working party established to commence in January.
- Safeguarding – Maternity named midwife capacity (plan in place to mitigate). Adult safeguarding team review due to retirements therefore roles out to advert.

Major actions commissioned & work underway

- Benchmarking underway against the new standards for food and drink in healthcare
- AHP Staffing - international recruitment for OTs underway with interviews over next 2-3 weeks.
- New Health Roster KPI's to be introduced in Jan to provide assurance around the allocation of staff across a 24 hour period to reduce risk.
- Safeguarding - National Recommendations from Arthur and Star - new roles included in some contract areas, including in new model in Wakefield. Consideration to inclusion of new roles in all contract areas.

Positive news & assurance

- Final SNCT now complete and the process of reviewing the data has commenced to form the basis of the establishment reviews that will start in December. Including a separate review for ED with the new team.
- Development of QIS /Paediatrics workforce strategy in conjunction with the team and the ODN.
- Migration of long standing, high cost agency nurses to NHSP.
- International recruitment – NHS England bid approved to support 20 international nurses. AHP's and Midwives included in the overall strategy. Further business case in development to support the top up of the recruits with ambition is for 60 in the first instance then an additional 20 to bring us in line with our vacancy position.
- CQC Maternity Announced Inspection (15th November 2022) positive experience for the Maternity Teams, draft report expected within 28 days of the visit

Decisions made & decisions required of the Board

Title: Medical Director Report
Date: 30th November 2022
Report: Public Board
Author: Jackie Andrews

Matters of concern & risks to escalate

- Treasury sign off of Frontline Digitisation fund remains outstanding, proceeding with agreed 22/23 at risk funding but challenges around multi-year spend
- Challenge of no criteria to reside patients in acute sector continues and unlikely to be resolved this winter

Major actions commissioned & work underway

- Draft Clinical Services Strategy presented to November SMT-further work with new group clinical leads to agree local priorities and implementation plan
- Extensive working with ICB and Regional NHSE colleagues to perform deep dive of HDFT mortality indicators, no additional actions recommended
- Monthly mortality review group now established to share learning and good practice
- New Innovation Board subcommittee established from Nov- brings together digital, research, innovation and continuous improvement
- WYAAT led fragile service reviews continue in neurology, haematology again being considered for review and HDFT flagging urology as a service of concern meriting networked approach as per GIRFT recommendation

Positive news & assurance

- Engagement visit by Professor Sir Stephen Powis (National Medical Director NHS England) planned for 2nd December
- The initial phase of SARD e-job planning implementation is complete. All medical teams have received training and good progress being made on switch to e-job planning.
- Successful appointment to new SAS Advocate role (Dr Essameldeen Ali) and applications open to SAS doctors for SAS Academy personal development programme.
- Estate for HDFT Research and Innovation Hub secured (St James Business Park Knaresborough), new Innovation Manager and Innovation Clinical Lead posts created to facilitate real world testing, adoption and spread of healthcare (including digital) innovations.

Decisions made & decisions required of the Board

To approve funding of substantive appointments from Frontline Digitisation 22/23 budget

AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

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

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

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

Operational Update

October 2022

Russell Nightingale
Chief Operating Officer

Operational Update November 2022 (October Performance)

Matters of concern & risks to escalate

- Occupancy remains a challenge with numbers higher than expected or planned
- Cancer 62-day wait target not achieved at 66.7% (5.9.1)
- Cancer 2WW performance was below the 93% target at 56% (5.10)
- Non-Elective demand remains a challenge and the Trust continues at full capacity
- A&E 4-hour performance in October remains below the standard but improved on September at 68%, significant bed pressures impacting on flow, continued increase in presentations and divert support provided to York FT. (5.6)
- The Trust had sixty-four 60-minute ambulance handover breach in October
- 72 x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- TIF2 delivery timescales and concern regarding planning approval and electrical infrastructure works

Major actions commissioned & work underway

- TIF2 internal business case being prepared.
- Reset for Outpatient Transformation Board continues to go well with positive clinical engagement and progress – highest PIFU rates in WYATT
- LUNA product with AI to support RTT validation to allow easier focus on our waiting lists making good progress, technical handover in line with plan later this month (Oct) – some 'snagging' work to be completed into November
- Additional manual validation of RTT commissioned alongside LUNA project
- Interim AFU in place and operational, supporting current challenging occupancy position
- Major ED reconfiguration works started and progressing well. ED team coping well with pressure
- Recruitment underway to domiciliary care project underway
- Operational Restructure on plan with development program ready to commence
- Focus on GIRFT productivity in surgical specialties
- Discharge process and methodology planned for December (R2G) with a 'Perfect Week' scheduled for January

Positive news & assurance

- LLP continues with lists taking place in September and October, over 70 patients now treated
- 198 elective theatres lists were undertaken out of a possible 220 (90%) despite challenging circumstances, 88% previous month last month
- Cancer 31-day wait target achieved at 100% (5.1.2)
- Continued reduction in >78-week RTT waiters for surgery ahead of plan
- RTT 92nd percentile at 45 weeks (5.1.3)
- Top quartile national performance for Ambulance handover delays
- Continued to support York District Hospital with acute patient diverts
- COVID admissions have stabilised and gradually reduced
- Winter planning complete- next phase aligned to re-opening of Wensleydale ward – mid December
- Dermatology responded and resolved 2WW issue- now back under 2WW
- TIF2 – bid gained national approval
- 11% increase on DM01 performance compared with previous month

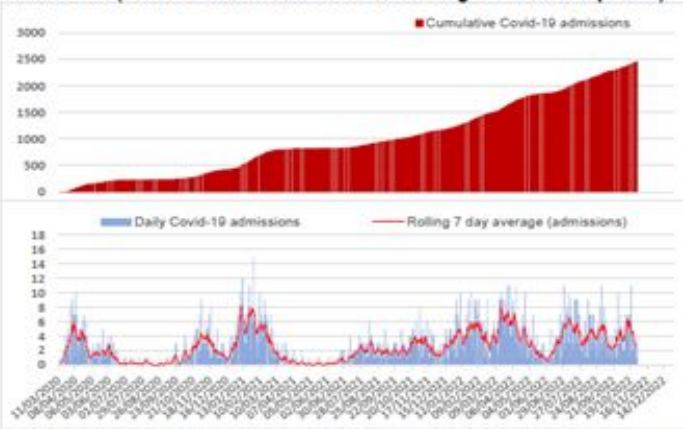
Decisions made & decisions required of the Board

- Solution implemented to create ring fenced orthopaedic capacity on Fountains ward with non-orthopaedic electives being safely placed in other surgical wards
- Continue to maintain escalation capacity open to support 70+ patients per day in hospital not meeting criteria to reside
- MOU agreed with LTHT regarding data warehouse support and power BI reporting functionality

COVID-19 Management Report

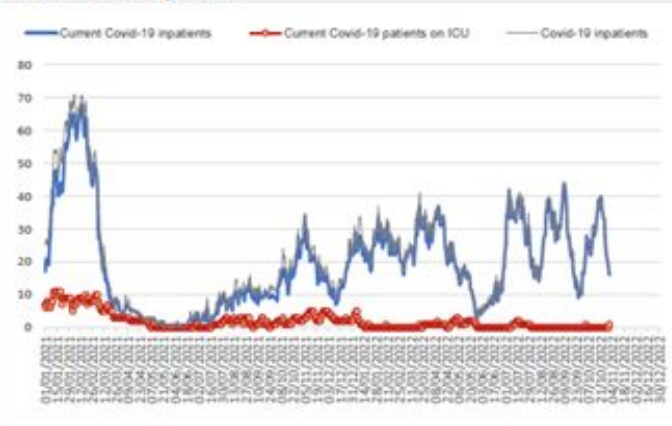
Inpatients with confirmed Covid-19 (NHSE Daily Sit Rep)

Admissions (admitted with known Covid-19 OR diagnosed while inpatient)



Yesterday	To date	Last 7 days	8-14 days ago
4	2461	19	32

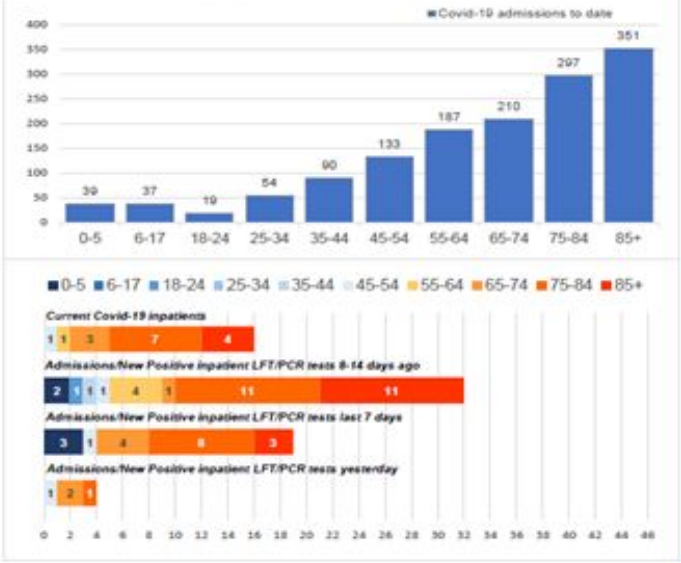
Current Covid-19 inpatients



Today	Yesterday	7 days ago	14 days ago
16	18	33	36

Note: Admission data excludes inpatients whose first positive swab was reported after discharge, and includes patients with a positive result who died in hospital before the result was known

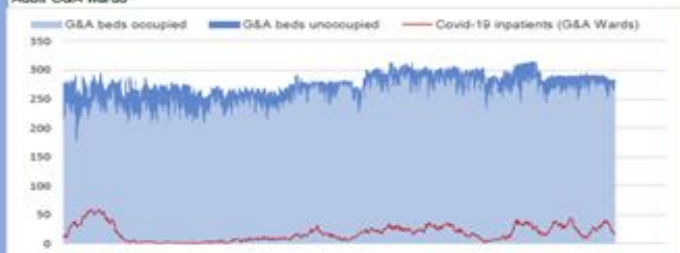
Covid-19 admissions by age



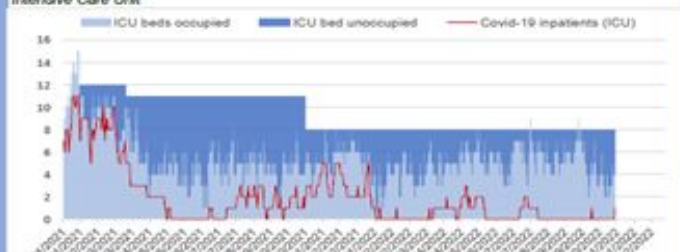
Today	
0-5	0
6-17	0
18-24	0
25-34	0
35-44	0
45-54	1
55-64	1
65-74	3
75-84	7
85+	4

Bed occupancy

Adult G&A wards



Intensive Care Unit



G&A (Adult)	ICU	% Covid (Adult G&A + ICU)
% occupied	% occupied	
97.5%	50.0%	5.3%
% Covid-19	% Covid-19	
5.4%	25.0%	

Children's and Community

Section	Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Community services	Immunisation against Human Papillomavirus, accumulative target								
	Ripon Hospital – Bed Occupancy	99.8%	100.0%	91.2%	**97.0%**	69.8%	95.9%	99.0%	**88.2%**
	Adult Services - Waiting times for Fast Response and Community Matrons/Long Term Conditions Team								
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	90.8%	91.3%	93.6%	**91.9%**	94.2%	95.0%	93.8%	**94.3%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.0%	93.6%	94.7%	**94.8%**	96.3%	96.8%	95.0%	**96.0%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	93.3%	100.0%	100.0%	**97.8%**	100.0%	97.5%	100.0%	**99.2%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	95.4%	90.2%	88.9%	**91.5%**	97.8%	97.7%	95.2%	**96.9%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	93.0%	91.8%	95.3%	**93.4%**	97.8%	93.8%	97.5%	**96.4%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	97.9%	95.7%	98.5%	**97.4%**	98.8%	97.1%	96.9%	**97.6%**
	Health Visiting - % of children receiving a 12 month review by 15 months - **North Yorkshire**	98.0%	97.2%	97.6%	**97.6%**	98.3%	99.0%	97.0%	**98.1%**
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Northumberland**	96.7%	95.8%	97.6%	**96.7%**	95.3%	96.4%	95.1%	**95.6%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	85.5%	86.7%	92.0%	**88.1%**	94.1%	91.8%	94.7%	**93.5%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.4%	93.0%	92.8%	**92.1%**	93.3%	90.1%	91.1%	91.5%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.8%	98.8%	**98.5%**	96.7%	100.0%	93.9%	**96.9%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	99.2%	84.5%	96.5%	**93.4%**	96.4%	98.5%	93.0%	**96.0%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	89.1%	91.1%	93.2%	**91.1%**	97.5%	97.6%	95.7%	**96.9%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	96.0%	95.5%	90.0%	**93.8%**	98.1%	97.3%	93.8%	**96.4%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	95.7%	96.5%	93.8%	**95.3%**	97.0%	95.3%	94.9%	**95.7%**
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**	96.6%	90.4%	94.6%	**93.9%**	93.7%	93.6%	91.6%	93.0%
	Community Podiatry - % patients seen within 18 weeks								

Safeguarding

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

Floating Safeguarding strategy Nurses continue to support most pressured 0-19 contact areas.

Statutory responsibilities still being delivered.

Community Dental

Service has plan to achieve trajectory to see longest waiters in line with Trust recovery plan. WLI sessions to target longer waiters, key risk are those patients that require GA and external anaesthetic support has been commissioned to support additional sessions.

Adult Community

Service still running at OPEL3 due to a 27% vacancy rate in adult community nursing.

A number of initiatives continue to be undertaken to support recruitment including an Adult Community Recruitment Event on the 1st December.

Discussions taking place to review current RCA process for reviewing community pressure ulcers to reduce time required of clinical staff. Jenny Nolan is supporting the service with this review.

0-19

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

Workforce Group

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

Community Dental

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

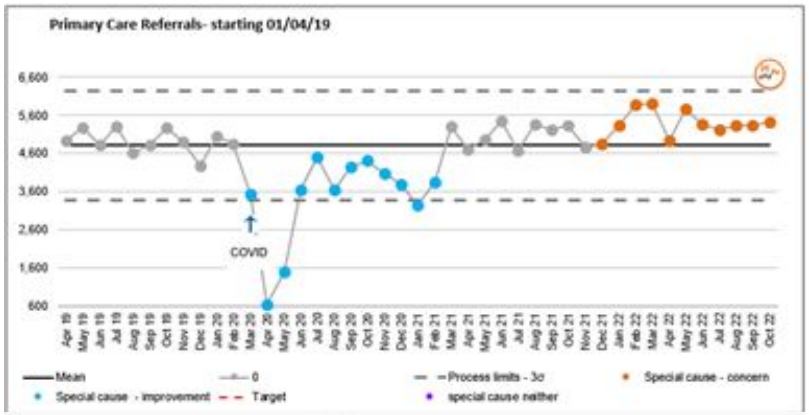
Planned Care Recovery

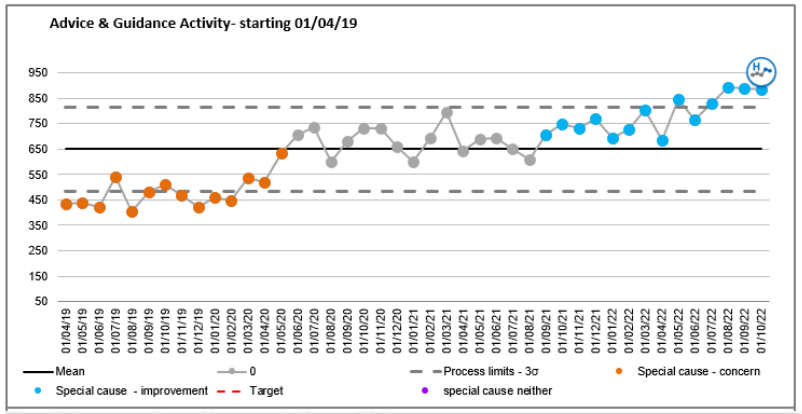
Elective Recovery												
Outpatients												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	450	500	550	600	675	750	825	875	925	1,000	1,050	1,100
Actual	425	451	438	575	677							
Consultant-led first outpatient attendances (Spec acute) - Plan	4,319	4,477	4,548	6,219	5,451	5,773	6,595	6,129	5,465	6,329	5,622	4,601
Consultant-led first outpatient attendances (Spec acute) - Actual	3,829	4,663	4,290	3,897	4,102	4,425	4,507					
Consultant-led follow up outpatient attendances (Spec acute) - Plan	6,493	6,804	6,578	10,078	8,919	9,333	11,051	9,850	8,790	10,380	9,054	8,244
Consultant-led follow up outpatient attendances (Spec acute) - Actual	8,372	10,427	9,323	8,532	8,622	9,347	9,208					
Elective Admissions												
Total number of specific acute elective spells in period -Plan	2,429	2,645	2,120	2,859	2,753	2,578	3,600	3,518	3,039	3,505	3,241	2,574
Total number of specific acute elective spells in period -Actual	2,400	2,613	2,354	2,402	2,485	2,655	2,601					
Total number of specific acute elective day case spells in period -Plan	2,250	2,425	1,904	2,536	2,492	2,333	3,265	3,177	2,758	3,127	2,944	2,353
Total number of specific acute elective day case spells in period -Actual	2,239	2,426	2,142	2,231	2,284	2,468	2,378					
Total number of specific acute elective ordinary spells in period -Plan	179	220	216	323	261	245	335	341	281	378	297	221
Total number of specific acute elective ordinary spells in period -Actual	161	187	212	171	201	187	223					
RTT												
Number of completed admitted RTT pathways - Plan	694	818	749	984	950	895	1,002	976	825	972	888	677
Number of completed admitted RTT pathways - Actual	832	1,057	886	1,011	999	1,083	1,177					
Number of completed non-admitted RTT pathways - Plan	4,442	4,661	4,481	6,099	5,282	5,624	6,604	6,017	5,288	6,317	5,474	4,962
Number of completed non-admitted RTT pathways - Actual	3,458	4,079	4,233	3,879	4,517	4,207	4,210					
Number of New RTT pathways (clockstarts) - Plan	5,330	5,594	5,378	7,319	6,338	6,749	7,925	7,220	6,346	7,580	6,568	5,954
Number of New RTT pathways (clockstarts) - Actual	6,403	7,219	6,382	6,817	6,917	6,669	6,138					
Number of RTT incomplete pathways waiting +52 weeks - Plan	1,181	1,197	1,195	1,180	1,197	1,195	1,150	1,157	1,150	1,147	1,149	1,130
Number of RTT incomplete pathways waiting +52 weeks - Actual	1,187	1,196	1,261	1,297	1,297	1,350	1,334					
Number of RTT incomplete pathways waiting +78 weeks - Plan	229	235	237	229	220	210	215	195	199	150	80	0
Number of RTT incomplete pathways waiting +78 weeks - Actual	205	184	169	155	144	133	123					
Number of RTT incomplete pathways waiting +104 weeks - Plan	5	5	0	0	0	0	0	0	0	0	0	0
Number of RTT incomplete pathways waiting +104 weeks - Actual	11	3	1	0	0	0	0					
Cancer												
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Plan	47	46	45	44	43	42	41	40	39	35	30	20
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Actual	46	39	52	57	76	67	51					

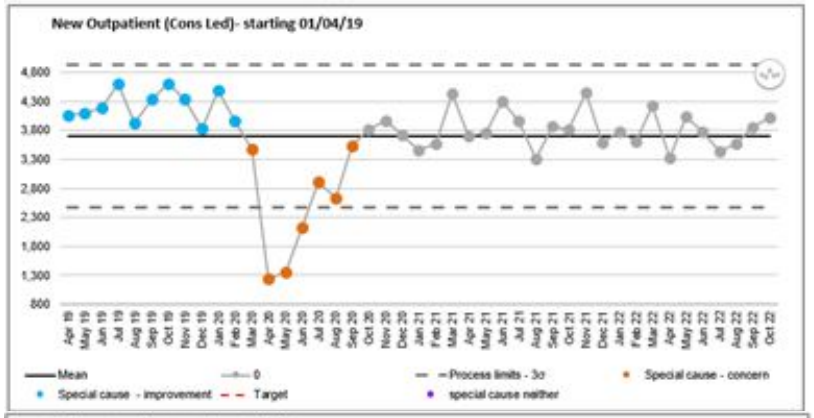
Increasing elective capacity to 2019/20 levels continues to be the key focus. Sickness absence, vacancies and some estates issues closing a theatre have caused challenge this month. Planned numbers taken a significant increase this month and whilst activity has grown we are now below plan. Outpatient clinic templates now returning to pre-covid levels to support an improvement to our current position. LLP process now in place with additional theatre session taking place. PIFU activity as a percentage of activity has reached 3%. Further work ongoing to switch f/u to new activity. Significant increases in advice and guidance activity from 2019/20 which do not get reflected in above figures

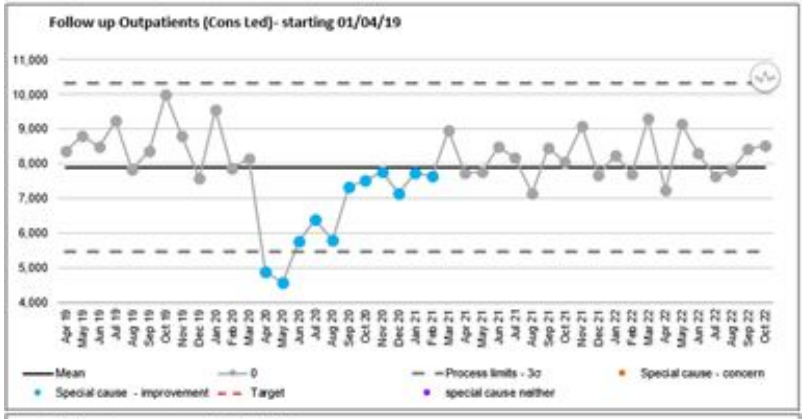
The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, we continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels.

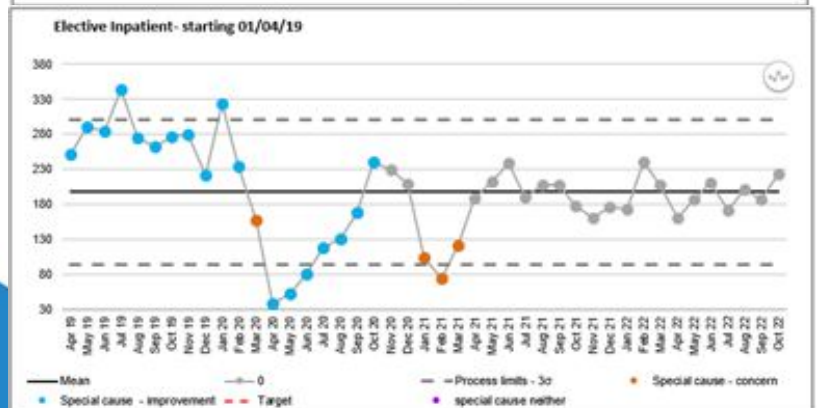
Elective Recovery

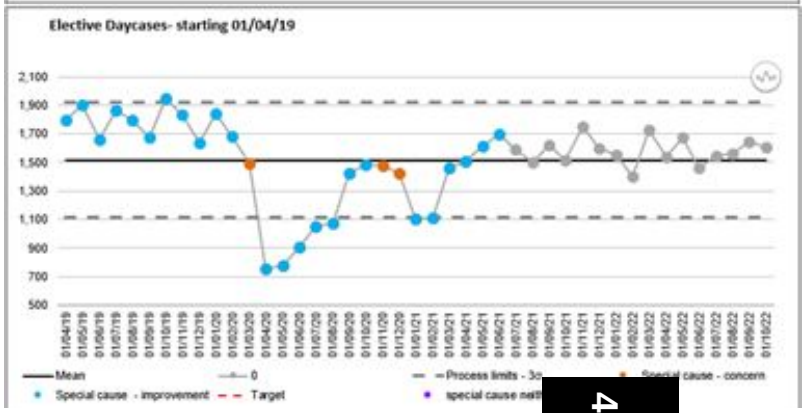












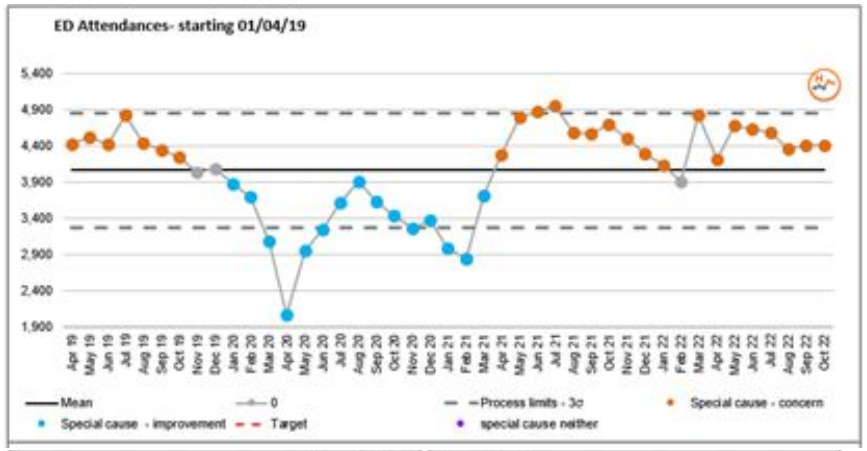
4.4

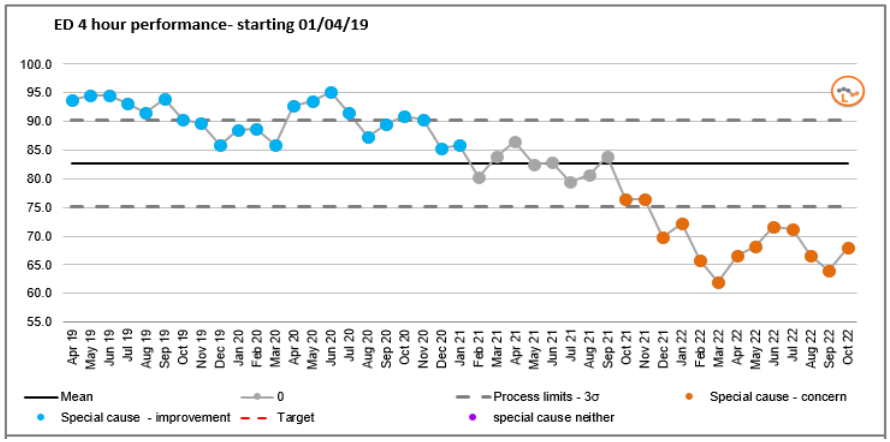
Referral to Treatment (RTT)

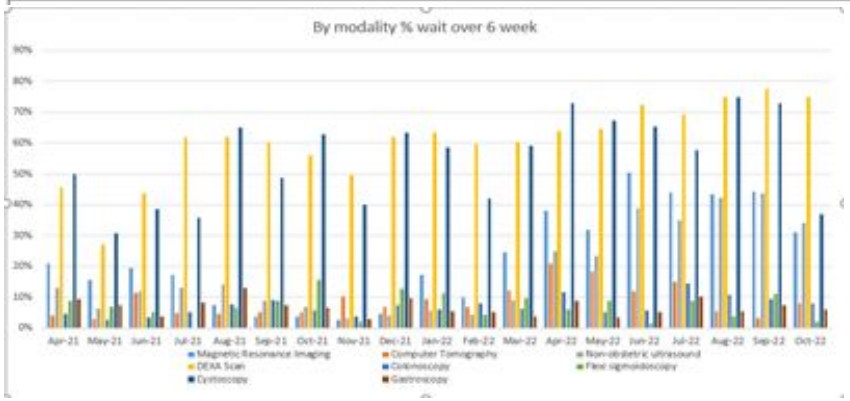
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Total incomplete RTT pathways	23825	22714	24964	24736	25325	25280	24,714	25,384	25,134	25,629	25,564	25,490	25,448
<52 weeks	22456	21372	23511	23375	23950	23953	23322	24004	23704	24177	24123	24007	24040
> 52 weeks	1070	1097	1177	1138	1157	1140	1,187	1,196	1,261	1,297	1,297	1,350	1,285
> 78 weeks	299	245	276	223	218	187	205	184	169	155	144	133	123
> 104 weeks	33	34	47	52	50	22	11	3	1	0	0	0	0

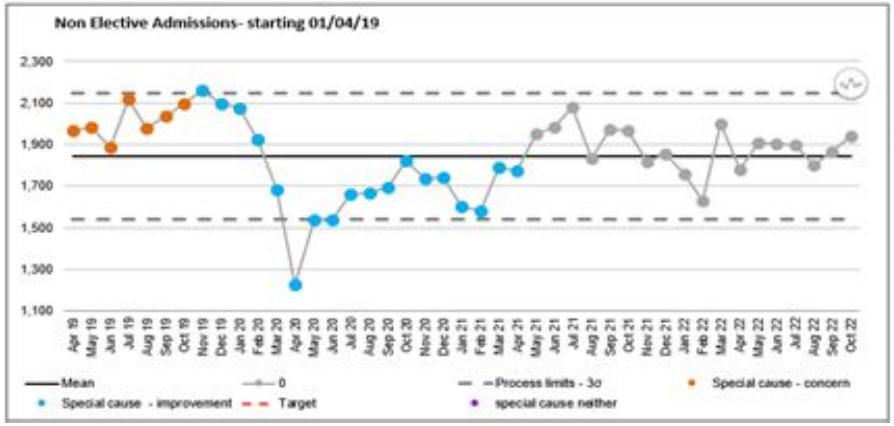
RTT - The Trust had 25,448 patients waiting at the end of October, this the 3rd decrease in a row. There are 1,285 patients waiting over 52 weeks, this is decrease of 65 patients on the previous month. The AI solution for RTT validation is close to being in place, additionally we are buying in some time to support more rapid validation over the next 2 months.
The number of patients waiting 78+ weeks continues to reduce ahead of plan. Of the 4,714 patients waiting for a procedure, 36% are Orthopaedics, 17% General Surgery and 11% Ophthalmology.
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.3% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (45/84) have been waiting <=2 weeks and work continues to ensure these are rapidly coded. 82.7% of P2 patients have been waiting less than 28-days and there is still an element of patient choice. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

Urgent Care and Diagnostics



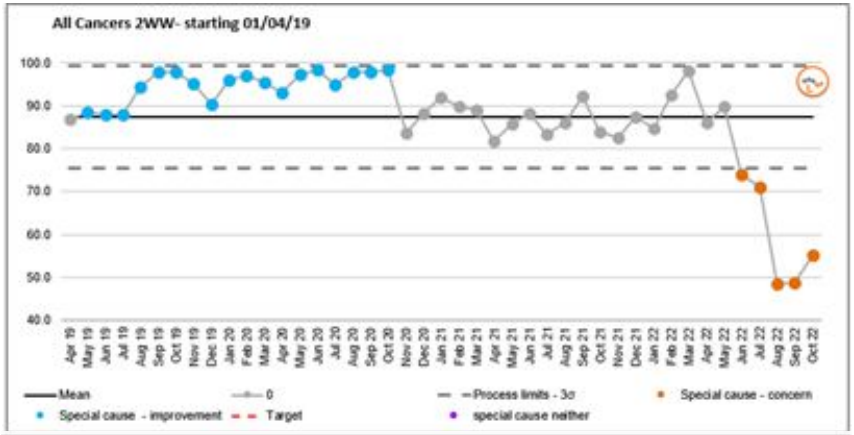


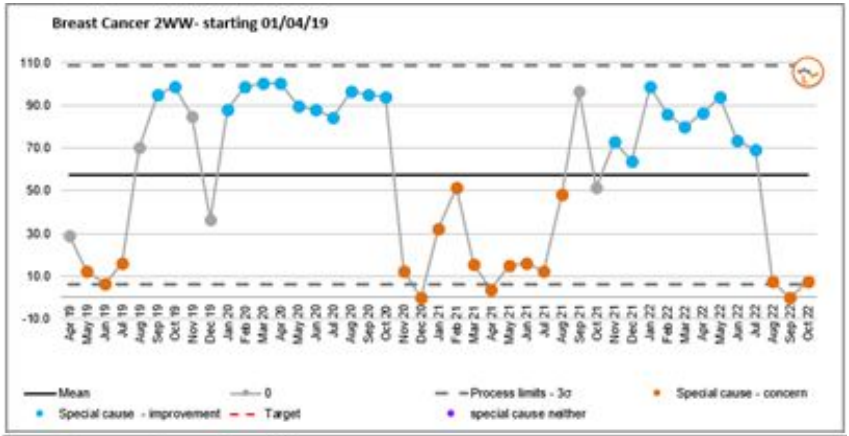


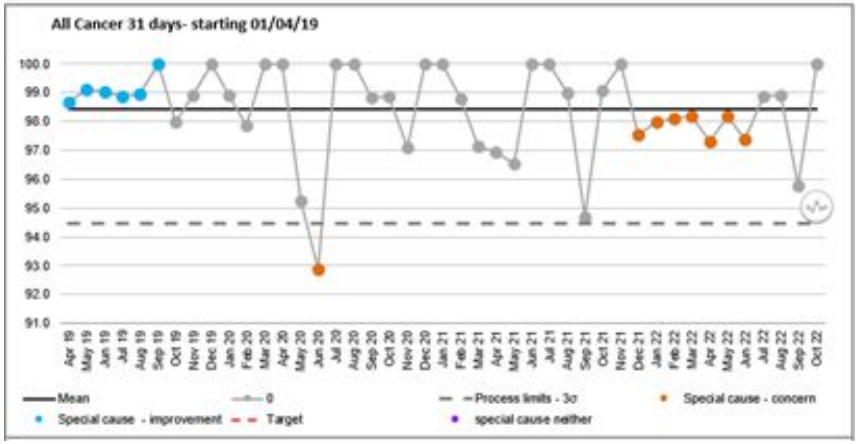


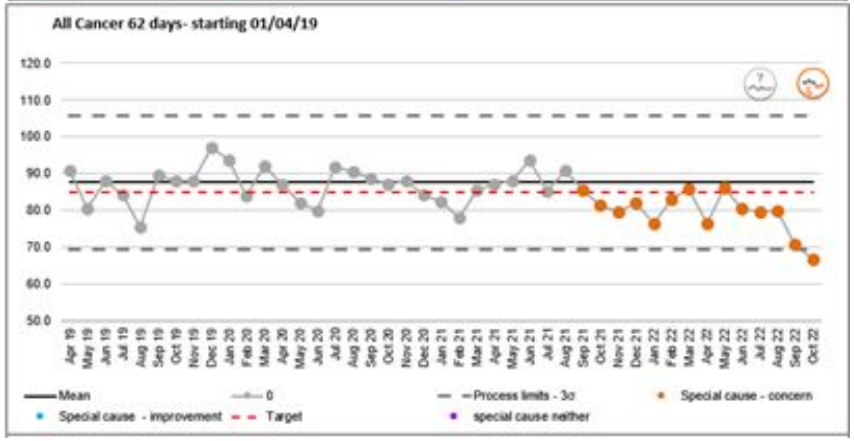
- Performance against the A&E 4-hour standard remained below 95% in October at 68.1%.
- There were 72 x 12-hour breaches in October.
- There were 147 x 30-minute handover breaches and 64 x 60-minute ambulance handover breaches in October.
- ED attendances are now back in line with 2019/20 levels, this combined with the high occupancy levels in the hospital makes flow through the department a significant challenge. There were 2 weeks in October where discharge flow was challenging with high volumes of patients bedded in the ED which translated into the above 12 hour breaches and ambulance handover position.
- A UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- A live ED dashboard is now in place with screens visible in a number of hospital operational areas.
- Imaging diagnostic activity continues to be maintained despite vacancies and sickness, diagnostic waits reducing or stable in most areas. Significant activity above 2019 baseline is being achieved in CT to reduce waiting times. All modalities are on a recovering trajectory.

Cancer Performance





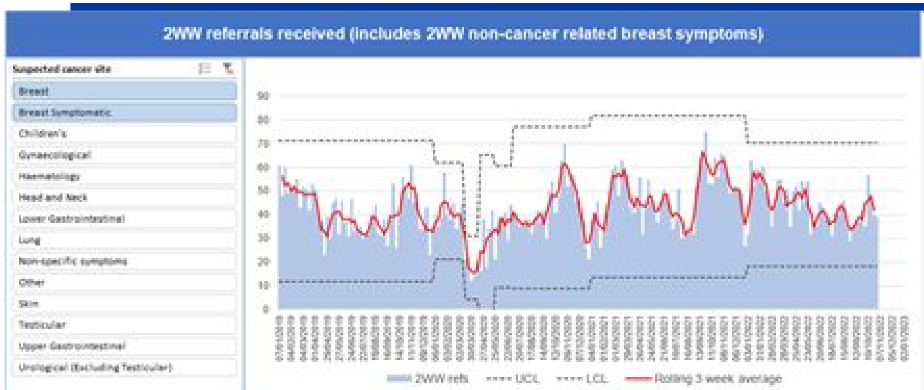


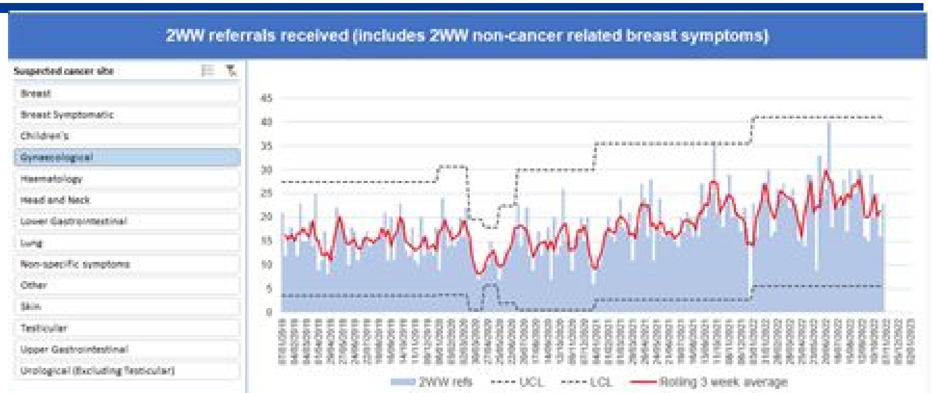


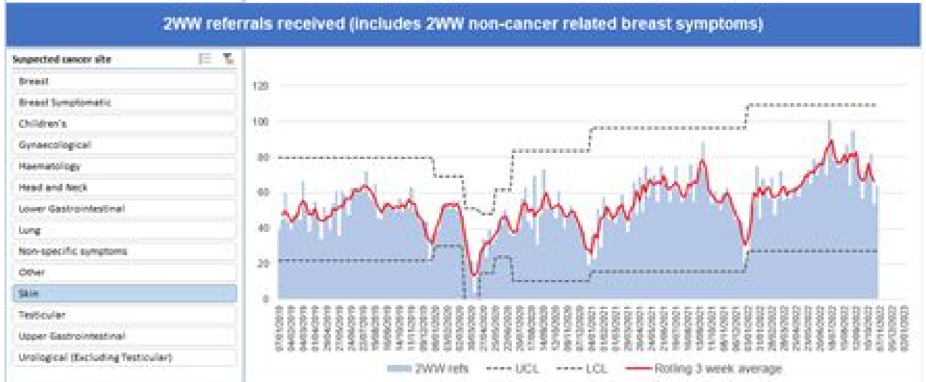
- The 62-day standard was not met in October with a performance of 66.7% against the 85% standard.
- The 31-day standard was met in October with a performance of 100%
- The 2-week wait standard was not met in October with a performance of 56%. A significant increase in 2WW referrals has been seen in several challenged services (Breast, Lower GI; Dermatology and Gynaecology – Dermatology has in month recovered its position, other specialty recovery plans are in progress).
- The 2-week wait breast symptomatic standard was not met in October with 9% of patients being seen within 2-weeks. Work with York to support on going high demand has started as well as insourcing clinics.
- At the end of October 51 (67 in Sept) patients remain on an open cancer pathway over 62-days with 7 (10 in Sept) of these over 104-days. This remains a key focus, it is also one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis has been completed and actions being taken to address the shortfall. The colorectal pathway has now resumed 'straight to test'.

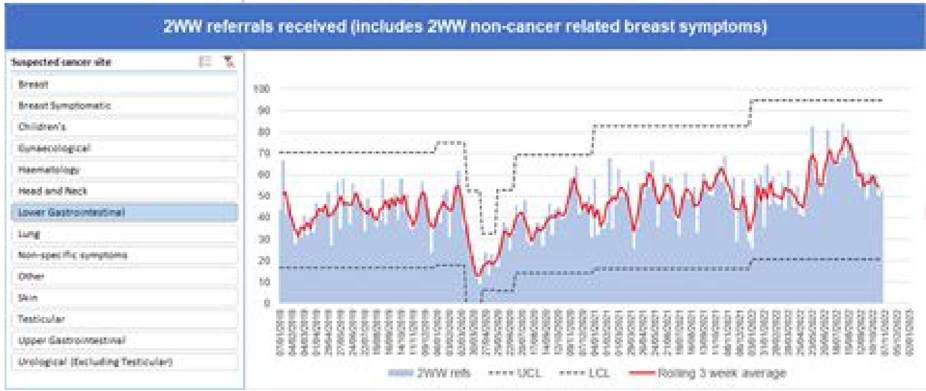
Cancer Performance

teamHDFT At our best | HIF Harrogate Integrated Facilities Taking Pride in our Services | NHS Harrogate and District NHS Foundation Trust









- Performance against the 2WW Cancer standard continues to remain well below the standard in October
- 2WW referrals have seen a sustained increase for a number of the higher volume cancer sites, including Dermatology (skin), Gynaecology and Lower GI, resulting in demand remaining above available capacity and a performance deterioration.
- The Dermatology service have completed a sample audit of the referrals and identified a number of them not meeting the 2WW criteria. The service are meeting with the locality group and primary care to share this information and are hopeful the position improves on the quality of 2WW GP referrals. The team have provided significant additional capacity and recovered the position in month
- Gynaecology and post menopausal bleed capacity has been a challenge owing to staff sickness. The successful recruitment of a Nurse Hysteroscopist will improve this position and improve the diagnostic capacity.
- Successful recruitment of a new General Surgeon will improve the Lower GI position from September. A capacity and demand gap does remain as a result of the significant increase resulting from high profile national media coverage, options to reduce this gap continue to be explored.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work provided by the outsourced private provider ceased in August as a result of them being unable to support clinics over the Summer period.. Short term consultant sickness (2-weeks) has also impacted on capacity available. A further increase in referrals is expected as a result of the national Breast Awareness campaign that starts in October. Work has commenced with York who have a much better position aro aid.

Finance Position
Board of Directors – 30/11/2022

Matters of concern & risks to escalate

- Month 7 has been a challenging position with an in month deficit of £0.9m. This takes the YTD position to £1.5m deficit
- Key Drivers include performance against Savings programme, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity, inflation and escalation
- Agency expenditure continues to increase month to month, with oversight meeting in place with directorates
- Pay award (Local authority) and ERSF funding (West Yorkshire) remain key risks for this financial year
- Planning for 2023/24 – pressures related to Revenue and Capital. Focus on reducing run rates required

Major actions commissioned & work underway

- Recovery Planning actions being taken forward, including agency review sessions
- Detailed planning process for 2023/24 commenced
- Review of finance structure and processes to support directorate structure
- Understanding workforce and activity movements from 2019/20, with particular focus on the opportunities and risks presented by current planning discussions nationally

Positive news & assurance

- The Trust continues to forecast achievement of this years plan, albeit with the risks outlined above, as well as the issues for 2023/24
- HFMA self assessment checklist submitted for Internal Audit review, initial feedback is positive
- Various cost of living schemes have been put in place to support colleagues at an approx. cost of £700k

Decisions made & decisions required of the Board

- Note the introduction of the NHS England forecast changes protocol discussed at Resource Committee

AMBITION: GREAT START IN LIFE

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To embed the "Hopes for Healthcare" principles in all HDFT services	Better patient experience for children Improved safety for children		• Establish Great Start in Life Programme Board – Jan 23 • Further actions to be determined through programme board – TBC	• On Track • TBC	

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

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

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

Harrogate and District NHS Foundation Trust

Strengthening Maternity and Neonatal Safety Report

SMT

October 2022

5.2

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

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

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of October 2022 as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

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

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

2.0 Proposal

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

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

3.0 Quality Implications and Clinical Input

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

4.0 Equality Analysis

4.1 Not applicable

5.0 Risks and Mitigating Actions

5.1 Sonography provision
5.2 Safeguarding training, supervision and guidelines
5.3 MVP expenses fund

6.0 Recommendation

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

Maternity

Matters of concern & risks to escalate

- Sonography provision
- Maternal death – 32 weeks. Baby stillborn.
- Ongoing risk related to Safeguarding – provision of named midwife and training. Action plan in place
- East Kent report released
- MVP – expenses fund not agreed at ICB

Major actions commissioned & work underway

- Planning to recommence antenatal classes face to face.
- Opportunistic offer of COVID19 vaccine started for maternity patients
- QIS nurses in recruitment process

Positive news & assurance

- New labour ward co-ordinators started at HDFT - improving resilience of co-ordinator team.
- Innovation funds to support CFAM for SCBU – recently highlighted as an issue in HSIB report.

Decisions made & decisions required of the Board

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

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

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

2.0 Obstetric cover on the delivery suite, gaps in rota

RCOG has recognised the challenges with middle grade staffing and published guidance (August 2022) on covering gaps and the process for ensuring any external locums have the appropriate skills and competencies. The maternity unit has been staffed to minimum safe staffing standards at all times during October 2022. There remains one 'gap' on the middle grade rota. This 'gap' is being filled by doctors undertaking adhoc additional sessions or agency locums.

3.0 Midwifery safe staffing, vacancies and recruitment update

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

3.1 October Absence position

Midwifery hours lost -
6.05 WTE sickness absence – main theme - stress
0.05 WTE special leave
7.1 WTE maternity leave.

Maternity support worker hours lost –

0.98 WTE sickness absence
0.05 WTE special leave
0.86 WTE maternity leave

3.2 Vacancy position

3.09 WTE Midwifery vacancy (Band 5-7). This includes 0.80 for perinatal mental health role
3.7 WTE Maternity support worker vacancy (Band 2-3)

3.3 Use of NHSP Midwives

3.87 WTE NHSP midwifery staffing across Pannal and Delivery Suite

1.32 WTE shifts uncovered.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Absence position

Current mat leave – 0.69 WTE B6
4.2 WTE remaining vacancy to be recruited into

As of October the below recruitment was not in place therefore total vacancy for October = 4.91 WTE + 1.53WTE LTS. Overall total vacancy including sickness is – 6.44WTE

4.2 Recruitment

- 0.61 WTE (Internal Trust candidate) – start date November 22
- 0.77 WTE QIS – On maternity leave – start date December 22
- 0.92WTE Neonatal experience but non QIS, no start date as yet, needs sponsorship
- Interviews planned for November.

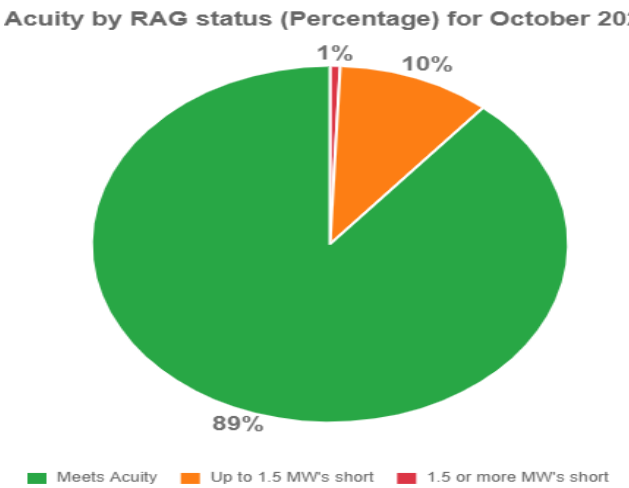
4.3 Qualified in Speciality (QIS)

SCBU budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS = 8.274 WTE.
54% QIS staff in post in October – 6.46 WTE QIS

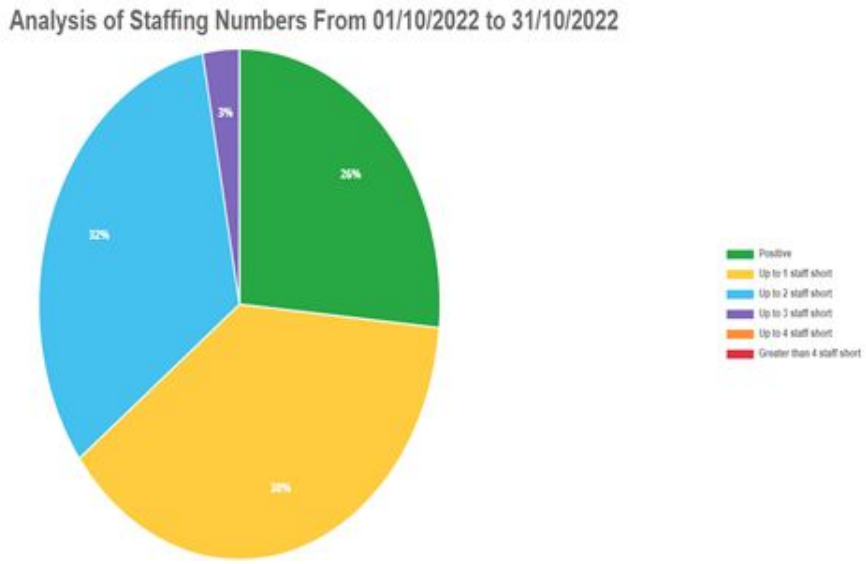
2.32 WTE QIS absence in October resulting in
35% QIS available in October - 4.14WTE QIS

5.0 Birthrate Plus Acuity Staffing Data

Delivery Suite
The following graph highlights that the provision of staff during October 2022 on Delivery Suite has met the acuity 89% of the time. ON the occasions where the staffing hasn't met acuity staff have been redeployed to enable this position to be rectified.



Pannal Ward
Staffing on the antenatal/postnatal ward meets the acuity 60% if the time however completion of the tool can be missed making the quality of the data unreliable. Work is on-going to improve the data collection to enable an appropriate representation of the ward staffing versus acuity. There are occasions on the Pannal where the staffing is up to two or three staff short. This relates to both midwives and support staff. Some of these occasions relate to where staff are moved to meet the acuity on Delivery Suite due to the high acuity.



6.0 Red Flag events recorded on Birthrate Plus

Delivery Suite

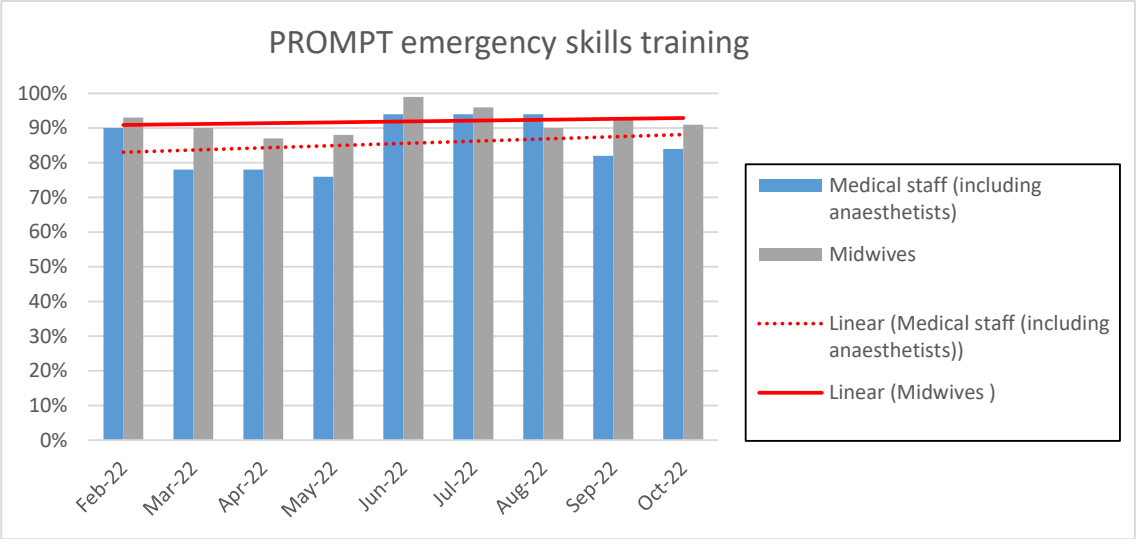
There were no Red Flags identified from the Birth Rate Plus Data.

Pannal Ward

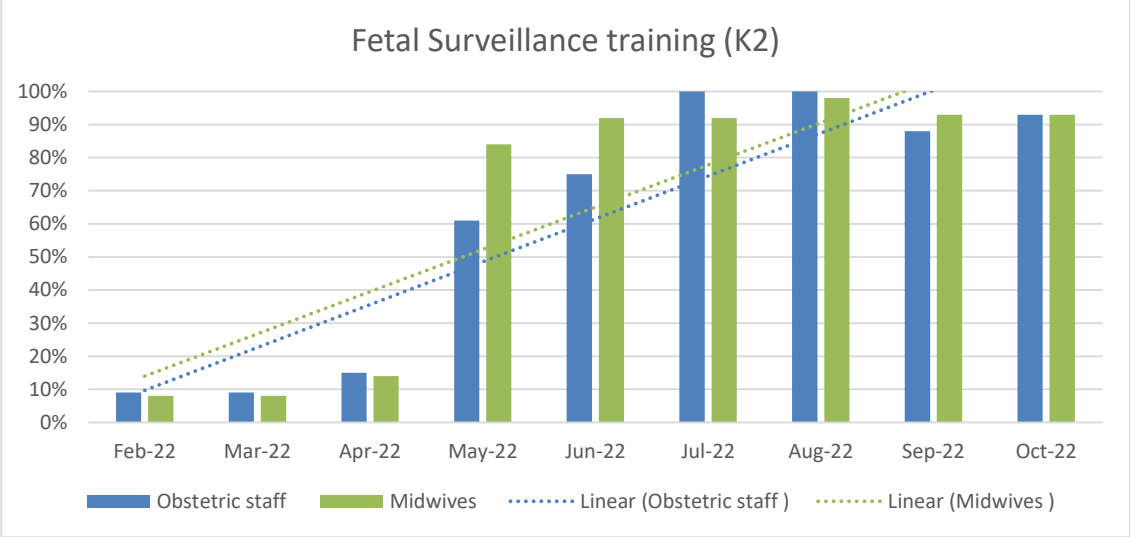
There were 2 occasions where Red Flags identified from the Birth Rate Plus Data which were:
- Delay between admission for induction and starting the process – 1 occasion
- Missed or delayed care >60 mins – 1 occasion

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

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



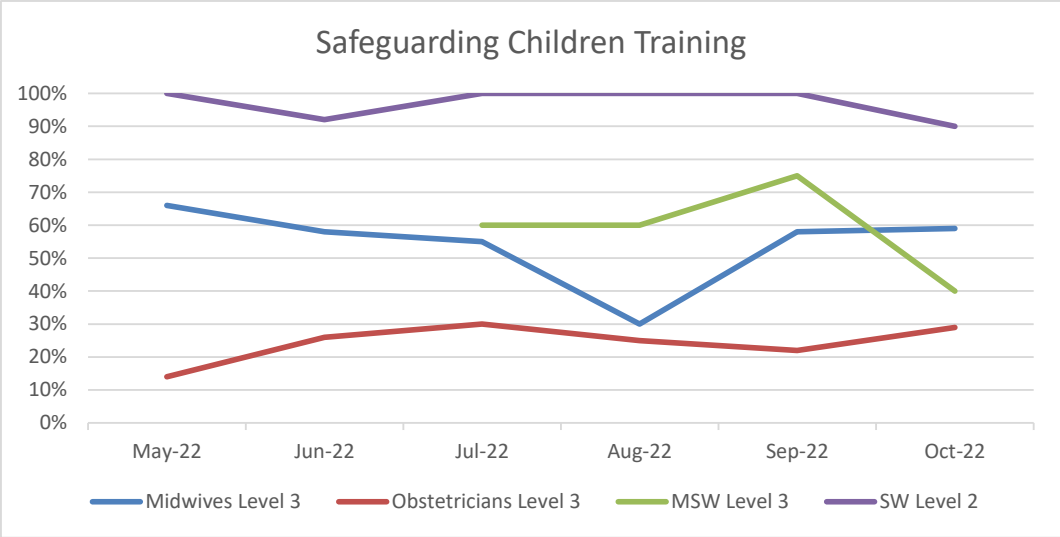
7.2 Fetal surveillance training (K2 online training package)

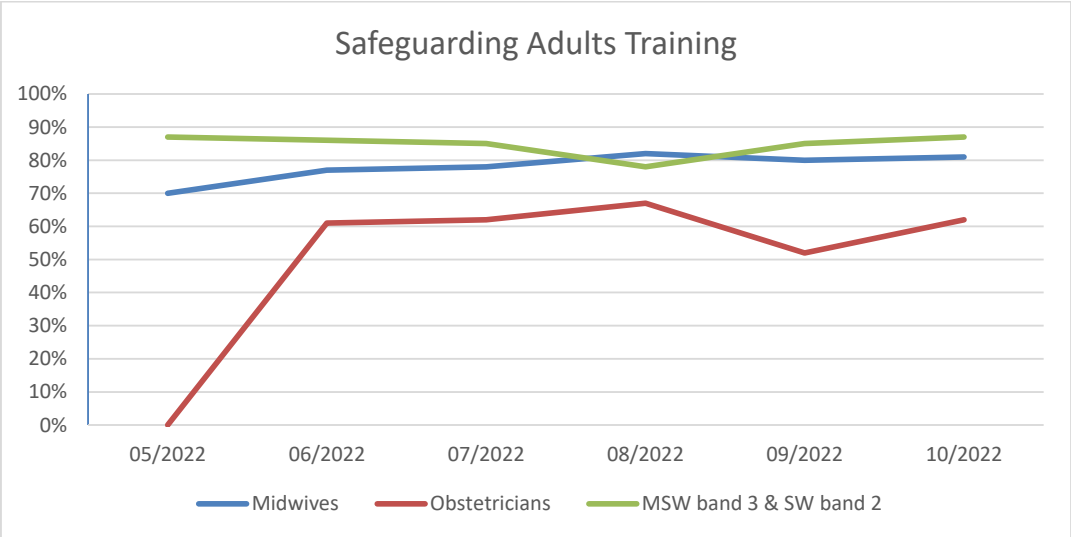


7.3 Safeguarding Children and Adults training

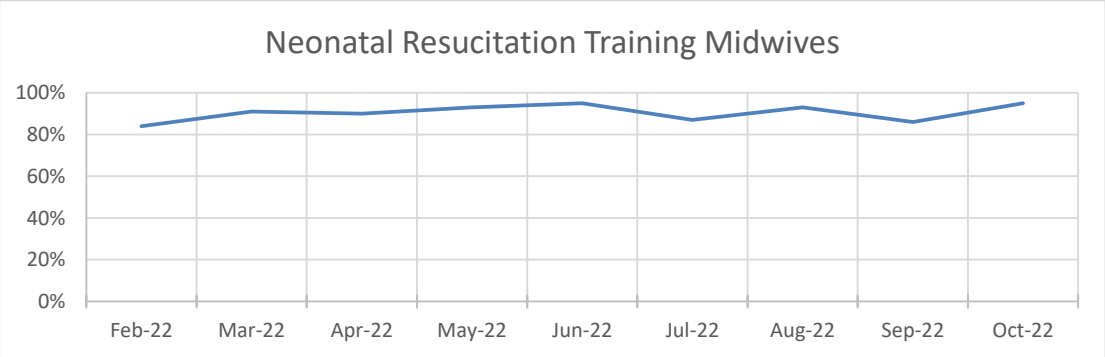
It is recognised that the staff compliance with Safeguarding Children training is not meeting the required standards. This has been added to the Risk Register and an action plan has been created. Conversations are on-going about the Named Midwife for Safeguarding provision in relation to Banding and capacity. Safeguarding training will return to face to face training from January 2023. Staff will be prioritised for attendance based on their current compliance. Consideration of multi-agency training is also in progress.

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





7.4 Neonatal resuscitation - Midwives



7.5 SCBU Training Compliance

Overall Learning Lab training compliance for SCBU staff is 93.3%.

8.0 Risk and Safety

8.1 Maternity Risk register summary

One new risk was added to the Risk Register in October following an NHS England safety alert relating to an incident at another Trust where there was incorrect frequency settings of wireless CTG telemetry resulting in detection of a fetal heartbeat from a neighbouring room.

- **Risk to patient safety due to CTG wireless telemetry being set to the same frequency and resulting in the potential detection of fetal heartbeat from other CTG machines. (Score 6).** Wireless CTG monitoring was temporarily removed until checking completed by Medical Engineering with assistance from manufacturer. Ensured frequencies set correctly and no cross-talk. Equipment now back in service. **Risk now archived.**
- **Risk to patient safety, and lack of compliance with national recommendations due to inadequate provision of Named Midwife: Safeguarding oversight (Score 12).** Named Midwife: Safeguarding provides cover for 0.5WTE funded by Maternity, but requires increased provision of full-time service to ensure effective safeguarding oversight. Further discussions ongoing with Safeguarding Team. No change.
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 9).** Work ongoing towards go-live date in January 2023. No change at present.
- **Risk to patient care due to current lack of Perinatal Mental Health Midwife role (Score 8).** Decision now for role as Band 7. Awaiting job matching and advert. Risk currently remains the same.
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 8).** Commissioning of service has been approved. Still awaiting implementation arrangements for the service with Service Manager. No change at present
- **Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 6).** Current safeguarding policies and procedures not sufficient for need, and do not currently include specific pathways for learning difficulties, child sexual exploitation, asylum seekers. Some lack of awareness of processes by staff. No change.
- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 6).** Difficulties experienced by cross-boundary working, and different IT systems in community and inpatient areas means that relevant information not being shared effectively. Process for checking of Child Protection – Information Service and WebV (e.g. for recurrent ED admissions), and improve sharing of SystmOne information. Plans also under consideration for interfacing with Badgernet Maternity EPR system when implemented. No change.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance rates continue to improve. Plan in place. Risk level currently remains unchanged.
- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 6).** Situation improved and new staff appointed with increased level of entrustible staff. One vacancy remains. **Risk downgraded**

8.2 Maternity Incidents

In October 2022 there were 55 total incidents reported through Datix. Of these, there was one incident recorded as Moderate Harm (buttonhole tear to rectal mucosa), and an antenatal Maternal/fetal death at home (with perimortem caesarean section).

- Duty of Candour is being completed for the buttonhole tear, though labour and delivery care was felt to have been appropriate.
- The maternal/fetal death has been referred for Coroner post-mortem by James Cook Hospital and has been reported to HSIB for investigation. Notification also made to MBRRACE.

Additional incidents of note include:

- 8 readmissions of mother or baby (5 babies with jaundice/weight loss/feeding issues; 3 maternal readmissions [urinary retention/hypertension/endometritis])
- 6 Unexpected Term Admissions to SCBU (4 with low oxygen saturations, increased work of breathing or respiratory problems; 2 for additional care following resuscitation)
- 5 Equipment problems (3 related to CTG issues of faulty pulse oximetry readings/screen freeze; 1 freezer temperature issue; 1 faulty pump leading to air-in-line [no harm to patient])
- 4 Postpartum haemorrhage (≥1500ml)
- 3 Incorrect Treatment/Procedure (one occurring on SCBU; 2 relating to VTE risk assessment)
- 2 Low cord pH
- 2 Shoulder dystocia
- 2 issues with clinical record availability
- 1 Fetal laceration at elective caesarean section (breech)
- 3 Medication incidents
- 1 Born before arrival at hospital
- 1 Stillbirth
- 1 episode of short term closure of the unit due to staffing issue on SCBU with temporary lack of QIS presence

8.3 SCBU Incidents

No moderate harm incidents.

8.4 SCBU Risk Register

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

8.5 Babies transferred out

Two appropriate transfers out for complexity or prematurity.

9.0 Perinatal Mortality Review Tool (PMRT)

One stillbirth reported to MBRRACE. Two additional stillbirths occurred at other trusts but received antenatal care at Harrogate so requiring input into PMRT.

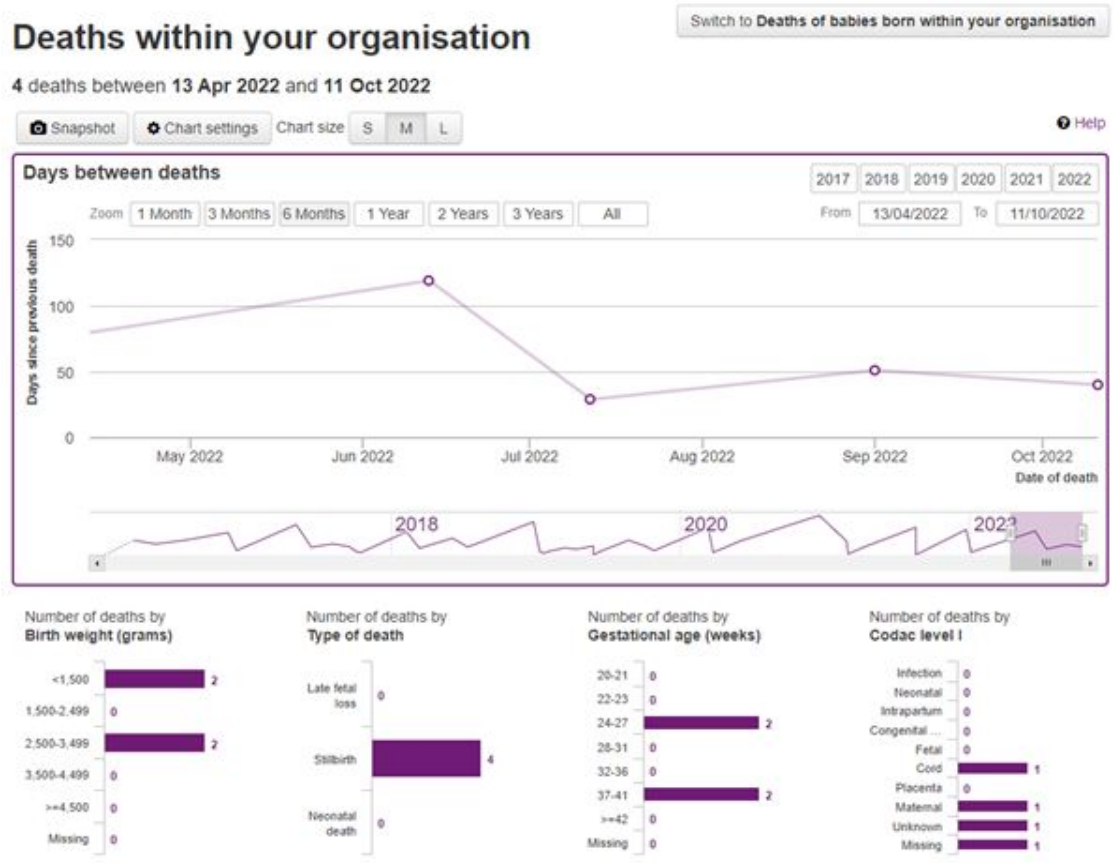
Two PMRT reviews completed in October 2022.

Findings from PMRT include:

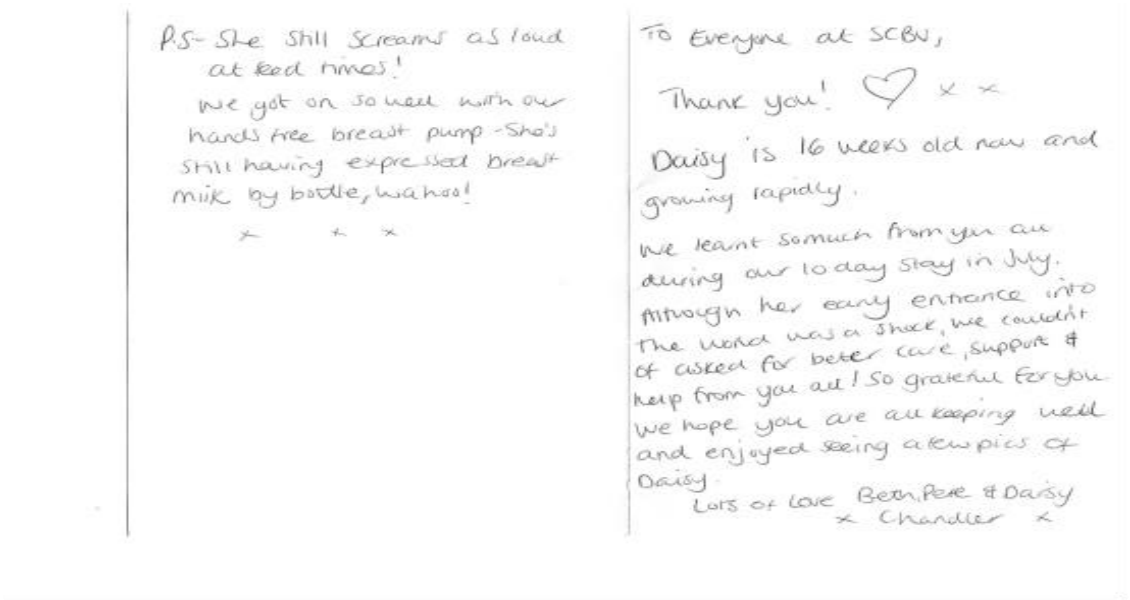
- Lack of CO screening at booking (this related to a prior national supply issue at time of booking)

- Recurrent non-attendance at appointments (appropriate efforts were made to follow up)
- Small for gestational age at birth not detected by scan. Images reviewed and considered to have been satisfactory quality and within the ±20% tolerance of scan accuracy
- Some midwifery staff have limited training in bereavement care and required paperwork [additional training requirement]
- Lack of provision of support information and advice about practical issues following the death [training and guideline update]
- Incomplete bereavement follow up (awaiting new Bereavement Midwife in post)

Reciprocal external involvement in PMRT reviews in place with Airedale.



10.0 Service User feedback



P.S- She still screams as loud at feed times!
We got on so well with our hands free breast pump - She's still having expressed breast milk by bottle, woohoo!
x x x

To Everyone at SCBU,
Thank you! ♡ x x
Daisy is 16 weeks old now and growing rapidly.
We learnt so much from you all during our 10 day stay in July. Although her early entrance into the world was a shock, we couldn't of asked for better care, support & help from you all! So grateful for you. We hope you are all keeping well and enjoyed seeing a few pics of Daisy.
Lots of love Beth, Pete & Daisy x Chandler x

11.0 Complaints

During October there were no new complaints and one new concerns.

12.0 Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in September 2022.

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

No external concerns or requests for action have been made directly to the Trust in September 2022.

14.0 Healthcare Safety Investigation Branch (HSIB)

Findings of review all cases eligible for referral to HSIB

In October 2022:

Final report received following a delay of factual accuracy checking by family.

Two safety recommendations:

- Safety Recommendation 1. The Trust to ensure that midwifery trainees are provided with the level of supervision suitable for their stage of pre-registration training.

- Safety Recommendation 2. The Trust to ensure that CTG interpretation tools support staff with categorisation to ensure correct categorisation and escalation

Actions are being defined to address the recommendations. Awaiting new guidance from NICE relating to new recommendations for CTG interpretation, this is anticipated to be released within the next two months.

15.0 Maternity incentive scheme – year 4 (NHS Resolution)

The revised timeframe for the Year 4 Maternity Incentive Scheme is now February 2023. Key staff in the maternity department continue to work towards compliance with the ten maternity safety actions for year 4 of the scheme.

Current risks identified in achieving the 10 safety actions include Safety Action One – deadline missed by 4 days for completion of the PMRT data. Safety Action Four – achieving 100% supernumerary status for the labour ward coordinator and Safety Action Six – achieving over 80% of women having a CO measurement at 36 weeks gestation.

All other actions are currently on track to be achieved.

16.0 National priorities

16.1 Continuity of Carer – National targets paused by NHS England as of 21st September 2022.

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

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

16.3 Update on Ockenden (December, 2020) action plan

- Maternal medicine centres (MMC) – developments continue within the LMNS. Associate Director of Midwifery and Antenatal Clinic Manager met with recently appointed MMC Consultant Midwife. Host Trust is Leeds Teaching Hospitals and MMC will be based at both Leeds Teaching Hospitals NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust. Principles of care are being developed.
- Work continues with the Maternity Voices Partnership (MVP) group to review and update patient information leaflets and the HDFT maternity webpage
- We are working closely with the MVP chair to ensure the voices of services users are heard via this forum. The MVP chair has met with key staff within and outside the organisation and attends meetings with groups of staff where appropriate.

17.0 Clinical Indicators – Yorkshire and Humber Regional Dashboard

The Yorkshire and Humber Dashboard for quarter two 2022 is included in Appendix B. The data shows that over the region Harrogate isn't currently a negative outlier for any of the measures. The number of stillbirths in quarter two has shown a peak. Two of these stillbirths meet the criteria for PMRT review, two were not reviewed by PMRT due to being terminations for fetal abnormalities. No factors in care have been found that could have prevented the outcome in the two cases that have been reviewed via PMRT.

18.0 Local HDFT dashboard information

For month of October:

- 135 mothers delivered (and 137 babies born)
- 16.3% elective Caesarean section rate (decrease from Sept, 18.7%)
- 11.9% emergency Caesarean section (decrease from Sept, 15.4%)
- 60.0% normal delivery rate (good increase from Sept, 54.8%)
- 11.9% instrumental delivery rate (increase from Sept, 11.0%)
- 34.0% induction rate (increase from Sept, 31.6%)
- 3.7% significant PPH ≥1500ml rate (slight increase compared to Sept [3.2%]; 5 patients)
- Two 3rd/4th degree tear (one small buttonhole rectal mucosa≈4th, both normal delivery)

- 82.5% breastfeeding initiation rate (decrease since Sept, 84.0%)
- 7.4% smoking rate at time of delivery [3.9% in Sept; 10 patients]
- One stillbirth in October recorded

19.0 Avoiding Term Admissions in Neonatal Units (ATAIN)

Three term newborn admissions to SCBU which are being reviewed at ATAIN case review meeting, all babies were admitted due to grunting.

19.1 ATAIN actions

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

Issue	Action	Status
Not to administer high levels of non-humidified low flow oxygen to newborn infants	Educate nursing staff about guideline	In progress
Issue with babies becoming cold in main theatres following elective caesarean section	Decision for application of hats to all newborn babies born in main theatres	Disseminated to staff
ASCOM devices not being utilised routinely by maternity/paediatric staff	Work ongoing to increase use of ASCOM amongst ward staff and by paediatric doctors	In progress

20.0 Saving Babies Lives' v2 metrics for Board oversight

Next update due in January 2023 with Quarter three data

21.0 Conclusion and recommendation

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

Appendix A

Bi Annual Staffing Report	
	Time Period of data **1st April 2022 – 30th September 2022**
Name & designation of person completing the summary	**Danielle Bhanvra** **Matron**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic Continuity of Carer
Sources of data collection	Information obtained from E-Roster, HDFT Staffing Levels, BirthRate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (April 2022 – September 2022) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the Maternity Incentive Scheme, safety action 5.

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

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

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

- Action taken to address the findings of BirthRate + report

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

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

3. The evidence described in this paper provides assurance that HDFT has an effective system of midwifery workforce planning and monitoring of safe staffing levels between April 2022 – September 2022

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

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

Data extracted from BirthRate Plus during this time period show there was a compliance completion rate of the tool of 77.32% on delivery suite and 69.58% for Pannal Ward. There were no relevant staffing factors identified for 61% of the time on delivery suite and 69% of the time on Pannal ward. The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required.

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

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

The tables below show the monthly overall fill rate for both Delivery Suite and Pannal Ward with average fill rates for both midwives and maternity support workers higher at night than during the day. It is a priority to cover nights and weekends as during daytime hours any shortfalls in staffing levels can be covered with midwifery managers and specialist midwives. Covid 19 continues to have an impact on staffing levels with midwives and maternity support workers isolating if testing Covid positive

Fill Rates

Delivery Suite	Midwives	MSW's
April	94%	86%
May	96%	83%
June	96%	85%
July	91%	53%
August	95%	60%
September	93%	85%

Pannal Ward	Midwives	MSW's
April	93%	76%
May	97%	72%
June	98%	75%
July	94%	82%
August	95%	80%
September	97%	76%

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

Actions were taken as per the Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives and team leaders

working clinically " as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift

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

Following the table-top exercise of Birth Rate Plus, completed in June 21. It was identified that an additional 5 WTE midwives were required to ensure the unit remained safe. This would include an additional midwife on the night shift and one on the Maternity Assessment Centre at the weekend (9-5). Funding was secured through the Ockenden bid process and HDFT was successful in securing the additional funds needed to recruit the additional midwives with a commitment from the organisation for future funding of these additional midwives.

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

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

The maternity department continues to actively recruit new staff. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between April 2022 and September 2022.

	Midwives	Maternity Support Workers (MSW's)
New Starters	9.32 WTE	3.4 WTE
Leavers	7.11WTE	6.65WTE
Career break	2.00WTE	0.0WTE
Maternity Leave *	4.6 WTE	1.40WTE
Secondment	0.80 WTE	0.00

*only includes midwives who have started maternity leave in this period

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

Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the Birthrate Plus acuity tool. Due to the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on 8

occasions with 3 women diverted to another hospital. A datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All closures are reviewed immediately by the Matron or Associate Director of Midwifery with the coordinator to discuss the activity, staffing and decision making before the escalation paperwork is signed off. There is an oversight of staffing issues through Maternity Risk Management Group (MRMG) meetings and monitored through Datix

	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
No. of times maternity unit closed to admissions	0	0	0	1	5	2
No. of women diverted to other units	0	0	0	1	2	0

A further review of the staffing establishment requirements for Continuity of Carer (CofC) has identified a further 8.9 WTE midwives are required to enable the full implementation of this model.

Midwife: birth ratio

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

HDFT midwife to birth ratio

Midwife to Birth ratio	**April**	May	June	July	August	September
Funded	26.89	26.89	26.89	26.89	28.89	26.20
In Post	27.87	27.22	27.41	27.41	26.44	26.44

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

The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birthrate + accounts for 8-10% of the establishment which are not

included in clinical numbers. This includes those in management positions and specialist midwives.

The current percentage of specialist midwives employed is 11.5%, slightly above the 8-10% recommended by BirthRate Plus acuity tool. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours. This includes posts that are externally funded through NHSEi or LMNS

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

The service has a wide range of specialist midwifery posts as detailed below:

- Bereavement 0.4 WTE
- Infant feeding 0.8 WTE
- Risk / governance 1.00 WTE
- Professional development midwife 0.6 WTE
- Safeguarding (part of ANC manager hours)
- Antenatal and Newborn Screening 1.00 WTE
- Professional Midwifery Advocate 0.5WTE (funded from MOU monies)
- Fetal Monitoring Lead Midwife 0.4 WTE
- Digital Midwife 1.0 WTE
- Midwife Sonographer 0.60 WTE
- Clinical Practice Support and Retention Midwife 1.00 (Fixed term for 2 years – funded externally)
- Community and Continuity Project Lead 1.00 (externally funded)

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

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

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

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

All information was collated using the Birthrate Plus acuity tool. Compliance in completion for the 6-month period was 77.32%.

During this time period there were 31 occasions when the coordinator was not supernumerary out of a completed 1098 occasions which equates to 97.18 % supernumerary status Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialist's midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

During this time period 1:1 care in labour was achieved 100% of the time for women admitted to the unit

845 women birthed
854 babies born (includes multiple births)
100% 1 to 1 care in labour for women admitted to unit
98.35% 1 to 1 care for all women including BBA's (Born before arrival) as below
14 women did not receive 1 to 1 care :
-14 BBA's

Continuity of Carer (MCoC)

Better Births (NHS England, 2016), the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised and put the needs of the women, their baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving. At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth.

There is no longer a national target for MCoC. Local midwifery and obstetric leaders have been asked to focus on retention and growth of the workforce and to develop plans that will work local. The plan needs to take into account local populations, current staffing and more specialised models of care required by some women.

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

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

During the 6-month period between April 2022 and September 2022, red flag events identified;

Delivery Suite 2 red flags were identified
Pannal ward 24 red flags were identified

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

Recommendations

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

Appendix 1

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

Pannal Ward - Red Flags	April	May	June	July	August	September
Delayed or cancelled time critical activity	0	0	0	0	0	0
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0	0	1	0	2
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0	0	0	0	0
Delay in providing pain relief	2	0	1	1	0	2
Delay between presentation and triage	0	0	0	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
Delay between admission for induction and beginning of process	1	3	2	0	0	7
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0	0	1	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0	0	0	0	1

YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - CORE INDICATORS	Trust	Harrogate District Hosp... Maternity Unit	Yea...	Q2_2022_2023

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

		Indicator	Measure	Trust/Site Quarterly Data		Y&H Average (Sites)	Y&H Range (Sites)	Y&H Interquartile Range (Sites)	Previous Q	Y&H Avg
				Previous	Latest					
		ACTIVITY INDICATORS								
1	1	Number of Bookings	Number of women booked	448	433	773.5	374 to 1543	484.5 to 1053.75	##	##
2	2	Bookings <10 weeks	Number of women booked <10 weeks	360	327	526.1	267 to 1114	331 to 685	##	##
3	2	% Bookings <10 weeks	% of women booked <10 weeks	80.4%	75.5%	68.0%	56.2% to 75.5%	65.6% to 72.1%	-0	0
4	3	Women birthed	Number of all women birthed	415	429	750.4	1 to 1457	408.5 to 1112	14	##
5	4	Women who birthed a live baby	Number of women who birthed with a live baby	414	425	746.7	1 to 1451	405.5 to 1109.5	11	##
6		Total births	Number of all babies born	421	433	760.3	1 to 1467	415 to 1125	12	##
7	5	Live births	Number of live babies born	420	429	756.7	1 to 1461	412 to 1122.5	9	##
8	6	Live births at term	Rolling annual number of live babies born at term	1693	1637	2773.8	23 to 5666	1510 to 4319.5	##	##
9	7	Total births	Rolling annual number of all babies born	1789	1739	2998.8	24 to 5983	1642 to 4641.5	##	##

10	8	Planned homebirths	Number of women who planned and birthed a term baby at home	4	3	6.7	0	to	22	1.5	to	10.5	-1	-4
11	8	Planned homebirths	% of planned homebirths	1.0%	0.7%	0.9%	0.0%	to	20.0%	0.3%	to	1.3%	-0	-0
12		1:1 Care in labour	Number of women who have received 1:1 care in labour	414	415	685.2	1	to	1432	385	to	1054.25	1	##
13	9	1:1 Care in labour	% women who have received 1:1 care in labour	99.8%	96.7%	95.6%	78.2%	to	100.0%	96.8%	to	100.0%	-0	0
14		BBAs (Born Before Arrival)	Number of women who have a BBA.	-	10	8	0	to	21	4	to	12	-	2
15		BBAs (Born Before Arrival)	% of women who have a BBA.	-	2.3%	1.1%	0	to	0	0	to	0	-	0
	9	**MATERNAL CLINICAL INDICATORS**												
16	10	Normal births	Number of women with a vaginal birth	217	234	432.7	0	to	833	230	to	646.5	17	##
17	10	Normal births	% of women - normal births	52.3%	54.5%	57.7%	0.0%	to	100.0%	52.7%	to	60.7%	0	-0
18	11	Assisted vaginal births	Number of women with an instrumental birth	58	57	74.1	0	to	167	38	to	114.5	-1	##
19	11	Assisted vaginal births	% of women - assisted vaginal births	14.0%	13.3%	9.9%	0.0%	to	14.5%	7.3%	to	11.5%	-0	0
20	12	Elective C/S births	Number of women - El C/S	65	74	109.3	0	to	241	67.5	to	140	9	##
21	12	Elective C/S births	% of women - El C/S	15.7%	17.2%	14.6%	0.0%	to	18.1%	12.7%	to	16.6%	0	0
22		Emergency C/S births	Number of women - Em C/S	75	71	150.8	0	to	337	74.5	to	215.5	-4	##
23		Emergency C/S births	% of women - Em C/S	18.1%	16.6%	20.1%	0.0%	to	33.0%	16.6%	to	20.5%	-0	-0
24	13	Number of C/S births	No. of women - Total all C/S	140	145	260.1	0	to	578	148	to	354	5	##
25	13	C/S deliveries	% of women - Total all C/S	33.7%	33.8%	34.7%	0.0%	to	43.9%	30.8%	to	36.9%	0	-0

26	14	3rd/4th degree tear - normal birth	Number of women with 3rd and 4th degree tear following a normal birth	6	2	6.6	0	to	18	3	to	11	-4	-5
27	14	3rd/4th degree tear - normal birth	% women with 3rd and 4th degree tear following a normal birth	2.8%	0.9%	1.5%	0.0%	to	3.0%	0.8%	to	1.8%	-0	-0
28	15	3rd/4th degree tear - assisted birth	Number of women with 3rd and 4th degree tear following an assisted birth	0	2	4.3	0	to	10	2	to	6.5	2	-2
29		3rd/4th degree tear - assisted birth	% women with 3rd and 4th degree tear following an assisted birth	0.0%	3.5%	5.8%	2.9%	to	14.3%	4.2%	to	8.1%	0	-0
30	16	Induction of Labour	Number of women commenced induction of labour	152	141	250.4	0	to	510	162.5	to	332.5	##	##
31	16	Induction of Labour	% women commenced induction of labour	36.6%	32.9%	34.8%	0.0%	to	50.0%	28.6%	to	40.3%	-0	-0
32		PPH ≥ 1500ml	Number of women who have birthed with PPH ≥ 1500ml	12	11	26.2	0	to	70	11.5	to	35	-1	##
33	17	PPH ≥ 1500ml	% women who have birthed with PPH ≥ 1500ml	2.9%	2.6%	3.5%	0.0%	to	5.2%	2.8%	to	3.8%	-0	-0
	17	**NEONATAL CLINICAL INDICATORS**												
34	18	Preterm births 32 weeks to 36+6 weeks	Number of preterm births 32 weeks to 36+6 weeks	16	26	52.2	0	to	115	27.5	to	73.5	10	##
35	18	Preterm birth rate 32 weeks to 36+6 weeks	% preterm births 32 weeks to 36+6 weeks	3.8%	6.1%	6.9%	0.0%	to	19.6%	5.3%	to	7.8%	0	-0
36	19	Number of preterm births 27 weeks to 31+6 weeks	Number of preterm births 27 weeks to 31+6 weeks	4	4	7.3	0	to	22	3.5	to	9.5	0	-3
37	19	Preterm birth rate 27 weeks to 31+6 weeks	% preterm births 27 weeks to 31+6 weeks	1.0%	0.9%	1.0%	0.0%	to	2.8%	0.5%	to	1.0%	-0	-0
38	20	Preterm birth <27 weeks	Number of preterm births <27 weeks	0	2	3.3	0	to	18	0	to	3.5	2	-1
39	20	Preterm birth rate < 27 weeks	% preterm births <27 weeks	0.0%	0.5%	0.4%	0.0%	to	1.3%	0.0%	to	0.4%	0	0
66		Preterm birth <37 weeks	Number of preterm births <37 weeks	20	32	62.7	0	to	124	39.0	to	90.0	12	##

67		Preterm birth rate < 37 weeks	% preterm births <37 weeks	4.8%	7.5%	2.1%	0.0%	to	21.4%	6.6%	to	8.4%	0	0
40		Rolling annual number of low birth weight at term - live births	Rolling annual number of live babies at term < 2200g	10	8	17.7	0	to	52	8	to	29	-2	##
41	21	Low birth weight at term - live births	Rolling annual % live babies at term < 2200g	0.6%	0.5%	0.6%	0.0%	to	1.2%	0.4%	to	0.7%	-0	-0
	22	**STILLBIRTHS**												
42	22	Stillbirths	Number of all babies stillborn	1	4	3.5	0	to	11	1.5	to	5.5	3	0
43	23	Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	2	8	9.5	0	to	26	3.5	to	14	6	-2
44	23	Stillbirth rate - Antenatal	Annual rate for antenatal stillborn babies / 1000 births	1.1	4.6	3.2	0.0	to	5.2	1.7	to	3.9	3	1
45		Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	1	1	1.8	0	to	5	0.5	to	3	0	-1
46	24	Stillbirth rate - Intrapartum	Annual rate for intrapartum stillborn babies / 1000 births	0.6	0.6	0.6	0.0	to	1.4	0.2	to	0.8	0	-0
47	24	Stillbirth rate - Total	Annual rate for ALL stillborn babies / 1000 births	1.7	5.2	3.8	0.0	to	6.0	2.3	to	4.4	3	1
48	25	HSIB reportable births	Rolling annual number of reportable births	1	1	2.3	0	to	6	1	to	3.5	0	-1
49	26	HSIB reportable births	Rolling annual % reportable births	0.1%	0.1%	0.1%	0.0%	to	0.2%	0.0%	to	0.1%	0	-0
50	26	Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	3	9	10.8	0	to	25	6	to	16	6	-2
51		Stillbirth rate - adjusted to exclude lethal abnormalities	Annual stillborn babies / 1000 births excluding babies with lethal abnormality	1.7	5.2	3.4	0.0	to	5.2	2.3	to	4.1	3	2
52	27	Stillbirths at term	Rolling annual number of babies stillborn at term	3	3	3.9	0	to	8	2	to	5.5	0	-1
53	27	Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	0	0.3	0	to	2	0	to	0	0	-0

54	28	Stillbirths at term with low birth weight	Annual % of stillborn babies < 2200g	0.0%	0.0%	6.8%	0.0%	to	50.0%	0.0%	to	0.0%	0	-0
55		All losses under 24+0 weeks gestation	Number of all losses under 24+0 weeks gestation	-	1100.0%	18	0	to	243	0	to	11	-	-7
56		Hold for %		-	0.0%	0	0	to	0	0	to	0	-	0
	28	**PUBLIC HEALTH INDICATORS**												
57	29	Breastfeeding Initiation	Number of women who breastfed their baby/ies for their first feed	346	346	472.2	1	to	1058	266.25	to	717.5	0	##
58	29	Breastfeeding Initiation	% of women commenced breastfeeding	83.6%	81.4%	66.0%	54.5%	to	100.0%	59.5%	to	72.6%	-0	0
59		Smoking at time of booking - self reported	Number of women who were smokers at time of booking	27	16	104.0	16	to	214	69.5	to	135	##	##
60		Smoking at time of booking	% of women who smoke at booking	6.0%	3.7%	13.4%	3.7%	to	20.6%	11.3%	to	16.6%	-0	-0
61		Smoking at time of birth - self reported	Number of women who were smokers at time of birth	22	14	86.8	0	to	173	49.5	to	120.5	-8	##
62		Smoking at time of birth - self reported	% of women who smoke at time of birth	5.3%	3.3%	11.6%	0.0%	to	20.4%	9.4%	to	13.8%	-0	-0
63		Carbon Monoxide monitoring at time of booking	Number of women who received CO testing with a measurement ≥ 4ppm at booking	35	22	131.625	22	to	944	39.75	to	113.25	##	##
64		Women received CO testing at booking	Number of women who received CO testing at booking	236	234	501.9	108	to	926	381.5	to	660.5	-2	##
65		Carbon Monoxide monitoring at time of booking	% women who received CO testing with a measurement ≥ 4ppm at booking	14.8%	9.4%	28.0%	9.2%	to	874.1%	10.0%	to	20.7%	-0	-0

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

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

GOALS:

- **Looking after our people: physical and emotional support to be "At Our Best"**
- **Belonging: teamHDFT – teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**
- **New ways of working: education, training and career development for everyone**
- **Growing for the future: the right people, with the right skills, in the right roles**

Governance:

- **Board Assurance:** People and Culture Committee
- **Programme Board:** People & Culture Programme Board
- **SRO:** Director of Human Resources and Organisational Development

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

Goal	Metrics		
Looking after our people			
Belonging			
New ways of working			
Growing for the future			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR6	The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of both short and long term mental health impacts on staff	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: New ways of working: education, training and career development for everyone

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Growing for the future: the right people, with the right skills, in the right roles

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Reconfiguration: Fit to Sit, Majors Area	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete - Jul 22 • Contract award - Aug 22 • Fit to Sit Phase 1 start - Sep 22 • Fit to Sit Phase 1 complete - Dec 22 • Majors Area Phase 2A start - Jan 23 • Majors Area Phase 2A complete - Mar 23 • Majors Area Phase 2B start - Mar 23 • Works complete - Apr 23	• Complete • Complete • Complete • On Track • On Track • On Track • On Track • On Track	
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Design complete – Aug 22 • Tender & Contract award – Mar 23 • Build complete – Jun 23 • Commissioning complete – Aug 23 • In service – Sep 23	• Complete • On Track • On Track • On Track • On Track	
Radiology Reconfiguration Phase 1-2 – XRay & CT	• To improve reliability and capacity of imaging services		• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Tender & Contract award - TBC • Build complete - TBC • Commissioning complete – TBC • In service – TBC	• Complete • Complete • On Track • Further milestones dependent on phasing of overall capital programme for 23/24)	
ED2 (UTC) Reconfiguration	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build start – Mar 23 • • Build complete – Aug 23 • Commissioning complete – Sep 23 • In service – Sep 23	• On Track • On Track • On Track • At risk (may be delayed by ED Majors completion) • At risk • At risk • At risk	
Wensleydale Ward Refurbishment	• Dedicated cardiology and respiratory ward, including High Observation/Non-invasive Ventilation Beds		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build Start – Apr 23 • Build complete – Oct 23 • Commissioning complete – Nov 23 • In service – Dec 23	• On Track • On Track • On Track • At risk (needs coordination with window replacement completion) • At risk • At risk • At risk	

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

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

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

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

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

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

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

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

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

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

Director of Strategy

Matters of concern & risks to escalate

PMO
- Lack of capacity in PMO to support delivery of strategic objectives

Planning
- RAAC: Work required to ITU/Farndale corridor, clinical waste store roof, kitchen plant room roof. Therapy Services survey complete, remedial works being designed. 3 remaining surveys to be completed..

Major actions commissioned & work underway

Strategy
- Directorate Planning Workshop held on 4 Nov; further workshops in Dec, Jan, Feb, Mar, Apr
- Draft Clinical Strategy presented to SMT Workshop on 23 Nov

PMO
- Interview for new Programme Manager completed
- OP Transformation: options paper for email communication with patients being developed.

QI
- Developing proposal for Improvement Management System for Dec Board

Planning
- Wellbeing Works: drawings for larger projects provided to HIF to deliver
- Plant Rooms: crane delayed to 26/27 Nov
- Aseptics (23/24): revised tender response requested; remains on programme
- Imaging (23/24): phases and outline costs developed; plans for first phases to replace CT scanner under development.
- TIF2 (23/24): P23 procurement process being developed

Business Development
- Recruitment of Senior Comms Officer commenced
- Dom Care: recruitment, contracting, IT, training, CQC workstreams

Positive news & assurance

PMO
- TIF2: BC approval and confirmation of funding received.
- CDC: bid for diagnostic vans and enhancements to Ripon CH

QI:
- Spotlight on equality for Team of Month and Making A Difference Awards
- Imaging and Antenatal RPIWs held with immediate improvements

Planning.
- Swaledale works complete and handed back to Trust.
- ED Fit2Sit work underway, plan to complete by 12 Dec
- Omnicell: progressing well with pharmacy, Bolton, Farndale, Byland, Day Surgery complete
- Gamma Camera work underway, due to complete 25 Nov

Business Development
- Multiple careers fairs and school/college visits undertaken to promote the Career Enhancement Volunteer pathway.
- Volunteer Handbook published Nov 22
- New volunteer manager appointed

Decisions made & decisions required

Strategy
- Board approval of new Board Assurance Framework

PMO
- Wharfedale Theatres (TIF1) BC to be approved by SMT on 23 Nov

Planning
- Wensleydale & ED2 (UTC) projects to progress together in 23/24
- TIF2: Recommendation for traditional construction route agreed by Environment Board.
- Wensleydale Ward (23/24): decision required on when window replacement work can be undertaken

Business Cases
- Pharmacy Homecare BC
- Haematology Nursing BC