Board of Directors Meeting (Public)
To be held on Wednesday 29th March 2023 12.45 – 3.45pm
Venue: Crowne Plaza Hotel, Harrogate

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 25th January 2023**	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
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**	Quality Committee Chair	Note	Verbal
3.2b	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Quality Committee Chair	Note	Supp. Pack
3.3	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.4	**Medical Director Report**	Medical Director	Note	Attached

3.5	**Maternity CQC report**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.6	**Safer Nursing Care Tool**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.7	**Guardian of Safe Working report**	Guardian of Safe Working	Note	Supp. Pack
SECTION 4: Ambition: Great Start in Life				
4.1	**Board Assurance Framework: Great Start in Life**	Director of Strategy	Discuss	Attached
4.2	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Note	Attached
SECTION 5: Ambition: Person Centred; Integrated Care; Strong Partnerships				
5.1	**Board Assurance Framework: Person Centred; Integrated Care; Strong Partnerships**	Chief Operating Officer	Discuss	Attached
5.2	**Resource Committee Chair's Reports**	Resource Committee Chair	Note	Verbal
5.3	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	-	Note	Supp. Pack
5.4	**Chief Operating Officer's Report**	Chief Operating Officer	Note	Attached
5.5	**Director of Finance Report**	Finance Director	Note	Attached
5.6	**Annual Plan**	Chief Operating Officer/Finance Director/Director of Strategy/Director of People & Culture	Note	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 People & Culture	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
6.4a	**Director of People & Culture Report**	Director of People & Culture	Note	Attached
6.4b	**People Plan**	Director of People & Culture	For Approval	Attached
SECTION 7 Ambition: Enabling Ambitions				
7.1	**Innovation Committee – Chair's Report**	Innovation Committee Chair	Note	Verbal
7.2	**Board Assurance Framework: Digital transformation to Integrate Care and improve Patient, Child and Staff experience**	Medical Director	Note	Attached
7.3a	**Board Assurance Framework: Healthcare innovation to improve quality and safety**	Medical Director	Note	Attached
7.3b	**Continuous Improvement Business case**	Director of Strategy	For approval	Attached
7.4	**Board Assurance Framework: An environment that promotes wellbeing**	Director of Strategy	Note	Attached
7.5	**Director of Strategy's Report**	Director of Strategy	Note	Attached
SECTION 8: Governance Arrangements				
8.1	**Audit Committee Chair's Reports**	Committee Chair	Note	Attached
8.2	**WYAAT Programme Executive minutes**	-	Note	Supp. Pack
8.3	**Collaboration of Acute Providers minutes**	-	Note	Supp. Pack
8.4	**Board Effectiveness Survey**	Chair	Note	Attached
8.5	**HARA S75 Extension**	Director of Strategy	To approve	Attached

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 Public Board meeting:** Wednesday, 31st May 2023 12:45-15:45 Venue: TBC			
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.

Harrogate and District NHS Foundation Trust

Board of Directors Register of Interests
As at 25th January 2023

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Executive Medical Director	June 2020	Date	1. Familial relationship with managing partner of Priory Medical Group, York 2. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board
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
Azlina Bulmer	Non-executive Director	November 2022	Date	1. Executive Director for the Chartered Insurance Institute, 2. Familial relationship for Health Education England 3. Director of Personal Finance Society
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
Chiara De Biase	Non-Executive Director	November 2022	Date	1. Director of Support and Influencing for Prostate Cancer UK 2. Clinical Trustee for Candlelighters (Children's Cancer Charity)
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 Katherine 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
Kama Melly	Non-executive Director	November 2022	Date	1. Kings Council Barrister 2. The Honourable Society if the Middle Templar (Bencher) 3. Director and Deputy Head of Chambers – Park Square Barristers 4. Inns of Court College of Advocacy - Governor
Russell Nightingale	Chief Operating Officer	April 2021	Date	1. 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	1. 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
Julia Weldon	Non-Executive Director	November 2022	Date	1. Director of Public Health / Deputy Chief Executive at Hull City Council and Co-chair of the population health committee for the Humber and North Yorkshire Integrated Care Board.

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
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
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared		

BOARD OF DIRECTORS MEETING - PUBLIC
Wednesday, 25th January 2023 at 12.45
Held at Cedar Court Hotel, Harrogate

Present
Sarah Armstrong, Chair
Jonathan Coulter, Chief Executive
Jeremy Cross, Non-executive Director (JC)
Chiara Debiase, Non-executive Director (CD)
Andy Papworth, Non-executive Director (AP)
Laura Robson, Non-executive Director/Senior Independent Director (LR)
Wallace Sampson OBE, Non-executive Director (WS)
Richard Stiff, Non-executive Director (RS)
Julia Weldon, Non-executive Director (JW)
Kama Melly, Associate Non-executive Director (KM)
Azlina Bulmer, Associate Non-executive Director (AB)
Jacqueline Andrews, Executive Medical Director
Matthew Graham, Director of Strategy
Jordan McKie, Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals and Deputy Chief Executive
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Emma Edgar (EE), Clinical Director for Long Term and Unscheduled Care Directorate (LTUC)
Kat Johnson (KJ), Clinical Director for Planned and Surgical Care Directorate (PSC)
Natalie Lyth (NL), Clinical Director for Community and Children's Directorate (CC)
Leanne Likaj, Associate Director of Midwifery
Kate Southgate, Associate Director of Quality and Corporate Affairs
Lucy Rogers, Macmillan Cancer Information and Support Advisor for Item 2 – Patient Story
Noreen Hawshaw, Lead Cancer Nurse for Item 2 – Patient Story

Observing
5 observers were present at the meeting.

Item No.	Item
BD/01/25/1	**Welcome and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting
1.2	No apologies for absence were received.
BD/01/25/2	**Patient Story**
2.1	The Chair welcomed Mandy, who has Stage 4 breast cancer and colleagues from the Trust to the Board.
2.2	Mandy talked to the Board about her journey with breast cancer and her experience of the care and support she has received. She shared with the Board two photobooks that documented her experiences. Mandy discussed with the Board the care she has received in relation to chemotherapy, ongoing consultations and other treatments. In addition, she discussed the Health and Wellbeing support via Active for Cancer, the "Look Good Feel Better" programme as well as the information and support from the team in the Sir Robert Ogden Centre (Centre for Oncology). Mandy provided a real perspective of living with cancer and the support that was need to live the best possible life.

2.3	The Board expressed their gratitude to Mandy for sharing her story with them. The Board noted how inspirational Mandy was and gave her support for her continued journey.
2.4	**Resolved:** The patient story was noted. *Mandy, Lucy Rogers and Noreen Hawshaw left the meeting.*
BD/1/25/3 **3.1**	**Declarations of Interest and Register of Interests** The register of interests was received and noted.
3.2	New declarations were noted as follows: • Chiara Debiase, Non-Executive Director: Clinical Trustee for Candlelighters • Azlina Bulmer, Non-Executive Director: Director of Personal Finance Society
3.3	**Resolved:** The declarations were noted.
BD/1/25/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 30th November 2022** **Resolved:** The minutes of the meeting on the 30th November 2022 were approved as a correct record, with minor amendments received from the Non-Executive Director (AP).
BD/1/25/5 **5.1**	**Matters Arising and Action Log** The actions were noted as follows: • BOD/09/28/23.8 – Management Restructure – Closed • BOD/11/30/25.8 – Training and Appraisals – Closed • BOD/11/30/26.4 – Innovation – Closed
5.2	**Resolved:** All actions were agreed as above.
BD/1/25/6 **6.1**	**Overview by the Chair** The Chair thanked all for their continued patience and engagement in the pilot of the new Committee and Trust Board approach.
6.2	Thanks were also expressed regarding the Annual Members Meeting, to all that helped the event run smoothly and all who attended. The Chair confirmed that Medicine for Members events would recommence. It was noted that a constituency review was underway with Governors.
6.3	The Chair noted that it had continued to be a challenging start to the year. Thanks were expressed to colleagues for continuing to provide high quality patient care.
6.4	**Resolved:** The Chair's report was noted.
BD/1/25/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read.
7.2	The following points were highlighted:
7.3	Planning guidance had been released shortly before Christmas. The three key areas of focus identified were to recover our core services and productivity, progress in delivery of the long-term plan ambitions and to transform the NHS for the future.
7.4	A new Chief Executive had been appointed to Leeds Teaching Hospitals NHS Trust.
7.5	Performance and flow through the organisation continues to improve and thanks were expressed to all. Work continues to ensure this position improves further.

7.6	It was noted that Industrial Action had taken place in January 2023. It was noted that this was well organised and thanks were expressed to all. Further action was planned in the coming week and contingencies were in place to ensure support for colleagues and the safe delivery of care.
7.7	A draft Maternity CQC report had been received and the Trust had responded on factual accuracy. It was also noted that the National Director for Midwifery had met with the Trust in recent weeks. Discussions were being held with all Trusts on the safety and visibility of Maternity Services. This had been a positive experience and it was noted- by the National Team the level and quality of service provided at HDFT.
7.8	The Non-Executive Director (LR) queried the mortuary capacity. The Chief Executive confirmed that during Covid extra capacity was leased, this had been utilised once more. The speed to release patients from the mortuary had impacted on the need to increase capacity. The Chief Executive also confirmed that capacity had to be used in a neighbouring Trust for some bariatric patients.
7.9	The Non-Executive Director (AP) noted the strike action and thanks were expressed to the Executive Team for continuing to live HDFT's values during this period. The Non-Executive Director is the Maternity Safety Champion and commented on the meeting with the national maternity team. It was confirmed that the national team had already met with over 100 providers before meeting with HDFT. The meeting had been overwhelmingly positive and the high quality service was noted by the national team.
7.10	The Non-Executive Director (JC) noted that there was a balance between being a strong system partner and the impact on HDFT's patients and performance. The Chief Executive confirmed that regionally system plans were being reviewed to consider longer term plans.
7.11	The Non-Executive Director (LR) queried if the ICB and HDFT had planned Board to Board meetings. The Chief Executive confirmed that there were no plans to hold these at the current time, however, other routes of engagement were noted.
7.12	**Resolved:** The Chief Executive's Report was noted.
BD/1/25/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/1/25/9 **9.1**	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an overall update on the ambition and goals for this area of the BAF.
9.2	**Resolved:** The update on Best Quality, Safest Care was noted.
BD/1/25/10 **10.1**	**Quality Committee Chair's Report** The Chair of the Committee noted that no meeting had been held in January 2023. It was confirmed that a meeting was held in December 2022. The focus had been on Improvement Plans for Falls and Pressure Ulcers. The Quality and Safety Report had been received, a discussion had been held on NICE Guidance and it was noted that no Violence and Aggression incidents had occurred in November and December 2022. The Committee had also noted the significant progress made against the Quality Priorities in year.
10.2	The Director of Strategy noted that the Key Performance Indicators in the Board Assurance Framework would be updated for the March 2023 meeting.
10.3	**Action:** The updated Key Performance Indicators to be updated in the Board Assurance Framework for the March 2023 Trust Board.

10.4	**Resolved:** The Board noted the content of the report.
BD/1/25/11 **11.1** **11.2**	**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. **Resolved:** The Board noted the content of the report.
BD/1/25/12 **12.1** **12.2**	**Executive Director of Nursing, Midwifery and AHPs Report** The Executive Director of Nursing, Midwifery and AHPs' report was received and taken as read. It was highlighted that 100% compliance in responding to complaints was noted in December 2023. **Resolved:** The Board noted the content of the report.
BD/1/25/13 **13.1** **13.2** **13.3** **13.4**	**Executive Medical Director** The Executive Medical Director took the report as read. The following areas were highlighted: • Mortality indicators for SHMI had been in normal limits for the last three months. • Medical Appraisal rates were noted as above 90%. • The PSC Directorate were commended for the work undertaken to relocate surgical Same Day Emergency Care to a surgical ward area. • The Quality Governance Agenda and Framework continues to be progressed and strengthened. • West Yorkshire collaborative Non surgical oncology model within the system was under pressure in previous years and this had commenced being addressed through a revised system model. • A national alert had been received regarding knee implants. The Non-Executive Director (CD) queried the communication with patients for knee implants. The Executive Medical Director confirmed the process. The Non-Executive Director (LR) queried how the SHMI results had reduced. The Executive Medical Director noted that these figures were from 12 months previously. It was also confirmed that all deaths were reviewed via the Medical Examiner programme. **Resolved:** The Board noted the content of the report.
BD/1/25/14 **14.1** **14.2**	**Board Assurance Framework – Great Start in Life** The Director of Strategy provided the Board with an update on this element of the BAF. The risk score for autism assessments had increased to a rating of a 16. **Resolved:** The update on Great Start in Life was noted
BD/1/25/15 **15.1** **15.2**	**Strengthening Maternity and Neonatal Safety** The Executive Director of Nursing, Midwifery and AHPs took the report as read. The Associate Director of Midwifery was welcomed to the meeting to provide a further update. The CQC draft report was noted as being received. It was highlighted that a review of provision of home birth services was underway. Recruitment continued in a positive direction and a Perinatal Mental Health Midwife had been appointed. Badgernet "go live" continued at pace with the launch taking place in March 2023. The Non-Executive Director (AP) queried if Badgernet had impacted on the antenatal classes being held. It was confirmed that Badgernet had not directly impacted on the re-launch of antenatal classes. It was confirmed however, that due to the size of

	Badgernet and antenatal classes as projects there they would be a staged approach to launch them.
15.3	The Non-Executive Director (AP) queried what HDFT did when a red flag was noted. It was confirmed that these were reviewed by the senior team. It was noted that these were usually short delays to induction. A full escalation process was in place.
15.4	The Non-Executive Director (CB) queried if the report was for December or September 2023. It was confirmed it was December 2022 report.
15.5	The Associate Non-Executive Director (KM) queried if short term and longer term delays were noted differently as red flags. It was confirmed they were and the red flags for this report, equated to short term delays.
15.6	The Non-Executive Director (LR) queried if babies born before arrival were impacted on by Ambulance Strikes. It was confirmed that discussions had been held with all women that this could impact on in order for women to make informed choices on where they chose to birth.
15.7	The Non-Executive Director (RS) queried the training compliance levels, especially in relation to Safeguarding. It was confirmed that issues had arisen in terms of availability of training. Packages had been revised and had re-commenced. This position would be rectified in the next 6 months. This continued to be managed at a Directorate Risk Register level as mitigation had been effective to improve compliance levels.
15.8	The Non-Executive Director (WS) queried issues regarding sharing information across boundaries. It was confirmed that engagement was improving at a regional level and improved networking due to changes in the management structure of the service. An enhance Safeguarding Service was in development which would also mitigate this risk.
15.9	**Resolved:** The report was noted.
BD/1/25/16	**Maternity Incentive Scheme**
16.1	The Executive Director of Nursing, Midwifery and AHPs took the report as read. The Associate Director of Midwifery provided further context to the report.
16.2	The report noted that there were 10 safety compliance actions. Eight actions were noted as fully compliant.
16.3	Two actions had flagged to be escalate to Board, these related to Safety Action 1 where one late surveillance case had been noted. This was due to a 4 day delay following bereavement which had delayed one submission. It was confirmed that this had no impact on safety of patients. Due to the mitigation it was recommended to Board that this action was noted as compliant.
16.4	The second related to Safety Action 2 which linked to a care professional not recorded on over 70% of the national submission (MSDS – Maternity Services Data Submission). This relates to a local system uploading to the national database. The Board were assured that the information was available to local system and no impact on safety was noted. It was recommended to Board that this action was noted as compliant.
16.5	Compliance against all 10 actions was recommended to Board.
16.6	It was confirmed that the Non-Executive Director (AP) as Maternity Safety Champion had been assured that no safety impacts were highlighted in relation to Safety Action 1 and 2.

16.7	**Resolved:** The Maternity Incentive Scheme was approved for submission with full compliance.
BD/1/25/17 **17.1** **17.2**	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** The Chief Operating Officer provided the Board with an overall update on the ambition and goals for this area of the BAF. **Resolved:** The update on person centred, integrated care, strong partnerships was noted.
BD/1/25/18 **18.1** **18.2** **18.3** **18.4** **18.5** **18.6** **18.7** **18.8**	**Resource Committee Chair Report** The Chair of the Committee confirmed the Committee had focused on finance, operational standards and workforce. A presentation had been received on how Model Hospital data had been used by Radiology. The financial position was reviewed, cost pressures were noted in Oncology, Medicines and a sub-optimal performing CT Scanner. Break even position for 2022-23 was still on track. The position for 2023-24 was noted as potentially at risk, however, further review was being undertaken. Operational performance was reviewed. The Children and Community directorate were highlighted for positive compliance across all metrics. RTT continued to move in the right direction. Compliance with the 4 hour target within the Emergency Department was discussed in depth. December 2022 had been a challenged month, early indications for January 2023 showed a much improved position. In relation to workforce, sickness had increased in December 2022 however, recruitment continued in a positive direction. The Non-Executive Director (LR) queried the 76% national target for 4 hour waits. The Chief Executive confirmed that this was the current national target, however, the Trust continued to strive for 95%. The Non-Executive Director (AP) noted the future proofing for the Emergency Department and the significant work that had been undertaken to ensure this had been strategically focused. Thanks were expressed to all involved in this large scale programme of work. The Non-Executive Director (JW) queried the impact on system support for the Emergency Department and also noted the new Acute Frailty Unit. The Chief Operating Officer provided further information on the introduction of the Acute Frailty Unit as well as revised streaming models and local flow. System partners were invited to take part in the Perfect Two Weeks. This was noted as a success from all partners. **Resolved:** The Board noted the content of the report.
BD/1/25/19 **19.1** **19.2**	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised. **Resolved:** The Board noted the content of the report.
BD/1/25/20 **20.1**	**Chief Operating Officers Report** The Chief Operating Officer presented the report as read. It was highlighted that December 2022 had been a challenged month for performance. It was noted that the Fit to Sit model had been launched, as had the Acute Frailty Unit and revised Same

	Day Emergency Care which would both impact on the future performance and quality of care provide in a positive manner.
20.2	The Clinical Director (EE) noted that focused work continued to proactively assess and action patients regarding discharge.
20.3	**Resolved:** The Board noted the content of the report.
BD/1/25/21	**Director of Finance Report**
21.1	The Director of Finance presented his report as read. It was confirmed that 2023-24 would be a challenged year from a financial perspective. Operational Budgets would be discussed at Board in March 2023.
21.2	The Non-Executive Director (JC) confirmed there would be pressure on capital spend.
21.3	The Non-Executive Director (WS) queried from a capital spend perspective if there was funding allocated to all schemes. It was confirmed that all schemes on the programme had funding allocated, however there was a range of projects that would be moved onto the programme if further funding became available.
21.4	**Resolved:** The Board noted the content of the report.
BD/1/25/22	**Board Assurance Framework – At Our Best Place to Work**
22.1	The Director of Workforce and Organisational Development updated the Board on this element of the BAF.
22.2	**Resolved:** The update on the At Our Best, making HDFT the best place to work was noted.
BD/1/25/23	**People and Culture Committee Chair's Report**
23.1	The Chair of the Committee provided an update on the meeting that had taken place. A Project Search presentation had been well received by the committee. Four interns had been appointed at HDFT. One of the individuals had presented to the committee her positive experience at HDFT. The presentation had made a significant impact on all Committee members.
23.2	The Committee had focused on a review of the People Plan. Alongside the People Plan, there were People Promises which the Committee had also reviewed. The Committee over the following year would continue to seek assurance of compliance and progression against these.
23.3	It was also confirmed that the Staff Survey results had been received and a deep dive would take place.
23.4	The Guardian of Safe Working Report had been received. Further work was required to ensure an action plan against the report was in place. A summary was provided to the Board on the issues that had been raised.
23.5	The Freedom to Speak Up Guardian Report had been received. Charly Gill was thanked for her work in this role and the new Guardian, Jo McCann was welcomed to the role by the Committee. A summary was provided to the Board on the issues that had been raised.
23.6	The Committee had also discussed the changing personal priorities of colleagues and future colleagues and the impact of work life balance had on this. It would be an area of focus for the Committee in the coming year.

23.7	The Associate Non-Executive Director (KM) queried who was providing advice on the impact of the Rainbow Badge Scheme and Trust Policies. It was confirmed that this information would be circulated to Board members outside of the meeting.
23.8	**Action:** The People Plan to be circulated to all members of the Board.
23.9	**Action:** Information regarding advice on the development of Policies in relation to the Rainbow Badge would be circulated to the Board.
23.10	**Resolved:** The Chair's update was noted.
BD/1/25/24	**Workforce Report and Organisational Development Report**
24.1	The Director of Workforce and OD presented her report as read. It was noted that planning for the Industrial Action was the focus for December 2022 and January 2023.
24.2	The Non-Executive Director (RS) queried the phrase used regarding successful delivery of the flu vaccination campaign, due to the lower than normal take up for the vaccination. It was also queried if the sickness absence noted in the report correlated with the lower numbers of vaccination. It was confirmed, that the correlation between sickness absence and vaccination take up had not taken place. The Non-Executive Director (AP) noted that this would be considered further at the People and Culture Committee.
24.3	The Non-Executive Director (WS) noted the new Equality Diversity and Inclusion Manager was in post and the positive contribution that was being made.
24.4	**Resolved:** The Board noted the content of the report.
BD/1/25/25	**Board Assurance Framework – Enabling Ambitions**
25.1	The Director of Strategy updated the Board on the environment enabling ambitions.
25.2	The Executive Medical Director update the Board on the Digital Transformation and Healthcare Innovation enabling ambitions.
25.3	**Resolved:** The update on the Enabling Ambitions was noted.
BD/1/25/26	**Innovation Committee Chair's Report**
26.1	The Chair of the Committee and the Executive Medical Director updated the Board on the development of the new Committee.
26.2	It was confirmed that the Committee had discussed in detail the progress and process with the Electronic Patient Record (EPR). Risks and mitigation were discussed in depth in relation to this area of business and consideration was ongoing regarding including a risk on the Corporate Risk Register. Discussions were also held on the system wide impacts and areas for potential collaboration. It was noted that a collaborative approach to market testing would be undertaken by system partners.
26.3	Research was also discussed by the Committee. A deep dive would be undertaken into research in the NHS and would be presented to a future Committee for further review and education.
26.4	Innovation was discussed by the Committee, it was noted that recruitment to new positions for Innovation was ongoing and moving in a positive direction. The vision and the mission of innovation would now commence development.
26.5	Continuous improvement was noted with work ongoing to procure an external partner to help support the Trust in its development as discussed in depth at the Trust Board workshop in December 2022.

26.6	The Chair of the Committee noted that as the second meeting, it had progressed well further work was ongoing to ensure a clear vision, mission, terms of reference and work programme for the Committee to ensure the full breath of its work was reflected.
26.7	Thanks were expressed to Governors for their attendance and involvement.
26.8	**Resolved:** The Chair's update was noted.
BD/1/25/27 **27.1**	**Director of Strategy Report** The Director of Strategy presented his report as read. It was highlighted that RAAC roofing had been surveyed in the Trust. Remedial works were underway and mitigation was in place. The Trust was now part of the NHS England scheme that looked at an eradication programme of this form of roofing.
27.2	The number of projects underway from a capital programme was highlighted.
27.3	**Resolved:** The Director of Strategy Report was noted.
BD/1/25/28 **28.1**	**Audit Committee Chair's Report** The Chair of the Committee presented his report as read. It was highlighted that a discussion had been held on the Corporate Risk Register and the overlaps between HDFT and HIF.
28.2	The internal audit reports had begun to be received in greater numbers again by the Committee. A Limited Assurance Report had been received in relation to Pressure Ulcers and the Committee noted that this was being actively managed and reviewed at The Quality Committee. A benchmarking report on audit recommendations had been received and it demonstrated that HDFT was in the middle of the benchmarking group. It was noted that as a relative small Trust, HDFT had a relatively large audit programme and therefore a large number of audit recommendations.
28.3	The Committee had discussed the Policy on Policies regarding the need for some policies to be reviewed at a Board level.
28.4	**Action:** To confirm the Trust Policies that required Board ratification.
28.5	**Resolved:** The Board noted the content of the report.
BD/1/25/29 **29.1**	**Use of the Trust Seal** **Resolved:** The Use of the Trust Seal was noted.
BD/1/25/30 **30.1**	**WYAAT Programme Executive Minutes** **Resolved:** The WYAAT Programme Executive Minutes were noted.
BD/1/25/31 **31.1**	**Collaboration of Acute Providers Minutes** **Resolved:** The Collaboration of Acute Providers Minutes were noted.
BD/1/25/32 **32.1**	**Any Other Business** No further business was received.
BD/1/25/33 **33.1**	**Board Evaluation** Any comments to be submitted to the Chair.
BD/1/25/34 **34.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 29th March 2023.
BD/1/25/35 **35.1**	**Confidential Motion**

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

Board of Directors (held in Public) Action Log for March 2023 Board Meeting							
Minute Number	**Date of Meeting**	Subject	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BD/1/25/10.3	25 January 2023	Integrated Board Report	The revised Integrated Board Report (IBR) to be presented at the March 2023 Trust Board.	Director of Strategy	29 March 2023	Work is ongoing - new Lead commenced in post. Update to follow May 2023	Ongoing
BD/1/25/23.1	25 January 2023	Rainbow Badge	Information regarding advice on the development of Policies in relation to the Rainbow Badge would be circulated to the Board.	Director of Workforce and OD	01 February 2023		Ongoing

Board of Directors (Public)
29th March 2023

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)
MARCH 2023

CHIEF EXECUTIVE'S REPORT

National and system issues

1. The significant issue from a national and system perspective for the last two months has been planning for 2023/24. As the Board will be aware, the planning guidance was issued a few months ago, with a requirement that we would collectively recover our core services and productivity, progress in the delivery of long-term plan ambitions, and start to transform the NHS for the future.

2. In more specific terms, there is a requirement to reduce ambulance handover times, improve A&E wait times, reduce elective waiting lists, improve diagnostic access, and improve access to primary care. There are targets in respect of A&E waiting times (76% to achieve the 4 hour standard) as well as reducing maximum waiting times down to 65 weeks.

3. For the purposes of planning and resource distribution, we are very much a part of the HNY ICB, and most of the discussions have taken place across this system. Clearly, our connections into West Yorkshire and the range of local authority services we provide across the North East and Yorkshire, has added a layer of complexity to the process for ourselves, largely about reminding other partners of the extent of our service provision and population.

4. The Board will see the item later in the agenda in relation to our plan for 2023/24 that we are recommending for approval. The key challenge internally and across the NHS has been to deliver a plan that delivers the performance standards and ambitions within the resources available.

5. HNY has a significant planning financial deficit currently, which is consistent across the NHS. The indications nationally are that due to the financial challenges that the planning round will be extended into April and possibly beyond. Whilst this will be important to engage in and influence, for our internal teams it is equally important that we sign off our plans so that we can get on and deliver for the benefit of our patients, the organisation, and the system as a whole.

6. The HNY system plan is currently compliant on other elements of the planning guidance, with a commitment to achieve the ED 4 hour target of 76%, eliminate over 65 week waiters, and reduce bed occupancy. There are varying degrees of risk across the system, but the focus of much discussion at present relates to the financial position. Check and challenge sessions have been undertaken with the ICB, and our position is that we have a plan that is stretching, ambitious, and deliverable.

7. Given the financial pressures across the system, there is a proposal to set up an ICB-wide productivity programme or Board. I have discussed this with both the Chief Executive of the ICB and the Chief Operating Officer as I am keen that any such proposal does not become a burden but genuinely adds value to our productivity delivery. This discussion

could lead to us leading some of this work if we agree how this may or may not be organised. This is still being debated, and I and others of the team will be involved in these discussions.

8. We continue to play a strong and influencing role across the ICB; we currently lead the programme for elective recovery, lead the Urgent Care work as it applies at system level, are part of the system quality committee, and potentially have a role in helping to improve productivity. There are other areas where we are involved as well. It is important that we are influencing the system and importantly the culture and way of working, without losing the fact that most of the improvements will be made locally within teams and organisations.

9. Away from the planning process, we continue to support others with mutual aid, and following recent discussions, we plan to engage in a more structured way with York for joint benefit going forward.

10. In terms of the West Yorkshire system, I have had a helpful discussion with the new Chief Executive of Leeds THT, and we will organise a proper discussion in relation to clinical alliances across the two organisations. We have strong links with Leeds, we are supporting the development of Wharfedale Hospital, and there are opportunities to work closer together in some areas. The WYAAT philosophy of collaborating where it makes sense to do so, and not expecting all trusts to be part of all collaborations, is helpful as we have these discussions.

11. In relation to system delivery in 2022/23, the likelihood is that HNY will not fully achieve the target of eliminating over 78 week waiters by the end of March. This is not unexpected given the position the system has been in over the last few months, and the added challenge of managing recent industrial action. The Board should be aware of our contribution to supporting the best possible outcome for HNY, as well as our leadership of the WY recovery programme.

12. In terms of our provider collaboratives, I mentioned last time that we continue to develop a governance model across the HNY acute collaborative that includes a Committee in Common approach that we are familiar with through our WYAAT collaborative. There remains some development work to do in terms of how we work together, and there is a session being organised for Chairs and Chief Executives in early May to continue these discussions.

HDFT issues

Introduction

13. The operational pressures have eased slightly over the last month or so, and the focus of the teams has been to continue to provide good care to our patients and population whilst also planning for the future. As always, colleagues have been positive and continued to work well together.

14. Our core performance standards (and therefore the quality of care and access we provide to our patients and population) continue to improve in relation to urgent care, planned care and our out of hospital services. We are focusing on cancer recovery to a greater degree, because even though we compare favourably with other Trusts, our performance isn't

where we would want it to be and remains variable. Across all of our services, there is still plenty of opportunity to improve further, and there is also an appetite to do so as well, which is vitally important.

15. The Board will be aware of our commitment to a programme of continuous improvement, supported by funding from our EPR programme. This, alongside our operating plan for next year, and our focus on key objectives, will set the framework and focus of work for the next few years. We will continue to discuss this through our Board sessions and across the organisation as we link our purpose of always putting the patient and child first with what we do and how we do it.

16. This is an exciting period for the Trust, which will also be challenging, but is an approach that we will embrace. Whilst the work across the many systems we are part of is important, the most significant improvements will be made by people working in local teams, focusing on putting the patient first, looking to improve services, and as leaders we need to ensure that where we spend our time and show our interest is reflected in that.

17. 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 we must not 'normalise' some of the difficulties we deal with and accept standards that are not as good as we would want.

18. Also, and to repeat a message that I will never tire of communicating to people, 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. Last week we had the 72 hour strike by our Junior Doctors. We were able to support of junior doctors to appropriately take the action that they wanted to, whilst maintaining the services to patients safely across the three days.

20. Many colleagues were involved in planning, supporting, and delivering the services during the course of the industrial action, and I would like to thank all involved. As with all relatively unusual events, there is also some learning to take from the three days, including how other professions worked to support patients.

21. We hope that the government and the BMA can work a way through the dispute and reach agreement as soon as possible.

22. The Board will be aware that negotiations with the other health unions in respect of pay have concluded with an offer to union members to resolve the current dispute. We await the outcome of the vote by union members.

23. The national staff survey results have now been published, and the Board will be aware of the outcome following our workshop in February. The feedback from colleagues at Trust level is showing positive improvement across most questions, which is encouraging, and we need to ensure that at a very local level teams are reviewing the feedback and discussing how things could be improved for colleagues. As part of our extended SMT workshop in April, we will be working through with teams across Directorates some of the

actions that we could take and to celebrate and learn from areas where colleagues feel most positive and engaged.

24. Earlier this month we had a celebration day for SAS colleagues, to showcase the work that this important group of colleagues undertake and to engage and learn from eachother. This was a really successful event and reinforced how many brilliant colleagues we have across the Trust in all areas.

Our Quality

25. We received the final report from the CQC in relation to their inspection of our maternity services that was undertaken in November. As the Board is aware through previous discussions and the communication that has been publically shared, the narrative of the report was positive even if the rating change was disappointing and not what I would view as a fair reflection of the service we provide.

26. In terms of the next steps, we will be submitting an action plan in April, and we will monitor progress against the improvements we are planning to make through the regular maternity report to SMT, QGMG, and the Board.

27. The team within the maternity unit were positive in their response to the report when we shared it in advance of publication, and as expected, were a credit to themselves and HDFT in their commitment to provide the best possible care to women who use our maternity service.

28. We have discussed the report and the outcomes with the wider SMT and we will take the learning from the process into our improvement work in other service areas.

29. We have declared an SI regarding a delay in stroke care, and we are underway with reviewing both our internal response and response across the stroke network. This will involve colleagues at a West Yorkshire level to ensure that the pathway we have is robust.

Our Services

30. As referenced earlier, our 0-19 services continue to deliver very strong performance across all of our geographic footprint. This is despite the operational and staffing challenges that we have been managing recently.

31. We continued to improve in our delivery of the standards across the urgent care pathway in February, which is particularly illustrated by our performance against the 4 hour Emergency Department standard. A number of improvement initiatives have been implemented and have had a positive impact, and the team is now working in an improved environment as well, with the recent completion of the new ED central monitoring station. We also continue to offer mutual aid to others in the system as and when needed and when we have the ability to support.

32. Our cancer service standard remains below where we would like to see it, and remains a key area of focus. We do have improvement plans and performance has improved in some areas, but as discussed previously, the variability and resilience of our cancer delivery is the concern. We are changing some of the internal management arrangements for cancer management from April as part of our plans to improve outcomes.

33. We continue to deliver our elective recovery plan. We expect to meet the target of having no over 78 week waiters by the end of the financial year, and have provided some support to system partners.

Our money

34. As I have referenced in recent Board meetings, the financial position for the year continues to be a deficit, which reflects the underlying runrate concerns. We will deliver the 2022/23 financial plan and break-even this year, but with some non-recurrent contributions which impact on the financial challenges we face going into 2023/24.

35. Positively, our capital expenditure has increased in the last two months and we will deliver or be close to delivering our full capital programme this year. The planning for next year has also been undertaken earlier than previous years which is helpful as this allows schemes to be planned and delivered in a more timely way.

Other

36. The work on the Electronic Patient Record programme continues, and we will spend a significant sum during 2022/23 as planned. This will continue to be overseen by the Board Committee. There is some pressure within the HNY system to potentially undertake more of this programme across the ICB. There will be benefits of ensuring that EPR systems can work with eachother, and this is part of the Yorkshire Care Record programme. As far as we are concerned, the financial allocation for HDFT reflects our digital maturity and invest requirements as an organisation and we are focused on delivering what we need to deliver within the tight timescales proscribed. We will work with others where helpful to do so, but also ensure that we implement the EPR as is vitally necessary for HDFT.

37. This is the last Board meeting of the financial year, and whilst we will have the opportunity to reflect on our performance in 2022/23 at some point in the future – and formally through our annual reports and annual members meeting – I want to thank all colleagues for the work that has been undertaken in the last twelve months. The Trust has improved in many areas and we are in a strong place going forward thanks to the work that everyone has done this year. Our focus as always will be on the patients and children that we support, and as leaders we will continue to support colleagues across the Trust to create the environment to provide even better care. NHS and care services are delivered to people, by people, and therefore this will continue be our key focus across the organisation.

Jonathan Coulter
Chief Executive
March 2023

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	Number of Theatre Serious Incidents and Never Events	Number of hospital acquired category 3 and above pressure ulcers with omissions in care	Number of inpatient falls moderate and above with omissions in care
Effectiveness	Number of Moderate and Above incidents for Missed results	Number of medication errors	
Patient Experience	Number of complaints		

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

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NHS Harrogate and District NHS Foundation Trust

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 – task & finish group have met to discuss, awaiting Yorkshire audit results who support review to realign with national standard framework, just needs a few tweaks – template now uploaded to tendable, ipads purchased and meeting due to discuss format. • Cleanliness: revised IPC and Cleaning audits implemented – IPC audits on tendable, weekend domestic now in post (feb 2023), no concerns • Safety Dashboard implemented • Implementation of revised Stop Before you Block SOP – Prep-stop,block process under the guidance of Stop Before you block, training delivered to majority of MDT, sessions ongoing to capture anyone missed due to Al.sickness etc. • Implementation of revised Swab Count SOP – all completed and embedded	• Completed – Action Plan in progress • Completed – Implemented, embedding ongoing • Partially Completed – embedding required – 99% compliance for accountable items to reduce. Remove risk of retaining items • 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 The Improvement Programme for Falls has now been formalised. Key activities in month: • Revised governance arrangements are in the process of being developed. This will include new methods of reviewing Falls. Discussion regarding falls risk factors for patients outlined the three we wanted to focus on between	• 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	

			now and March 2023. These are an improvement on completing lying and standing blood pressures on all patients 65 and over as per national guideline. A member of the MDT team assessing a patient for a walking aid within 24 hours (national target). Finally, to ensure that risk assessment are being completed and updated that look at individual risk factors for patients.		
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 The Improvement Programme for Pressure Ulcers has now been formalised. Key activities in month include: • Pressure Ulcer policy has been reviewed and updated following external audit, awaiting ratification • Successful recruitment of 1 WTE B6 TVN with extensive quality improvement experience • Joint working with TVN and theatre team to review and update theatre module to include robust pressure ulcer assessment and care plan.	• 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
			  • Agreed initial focus to be placed on addressing the current unfiled ICE reporting issue
			  • Action/decision log created for specific use in relation addressing the ICE reporting issue
			  • Actions captured in the RPIW action plan relevant to the unfiled ICE reporting issue have been moved across into the new action/decision log
			  • Awaiting up-date from ICE supplier with definite confirmation whether our request for auto-filing can be completed at consultant level – Patient System Specialist leading on this
			  • Automated email reminders set up in Jan & are being sent to clinicians to notify of unfiled reports >6 week with DMD copied in
			  • Automatic report established to generate of numbers of unfiled reports to monitor progress - 12 week review to be completed March
				• 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	

			Matrix in development on measuring progress on the scope of the Medication Error Quality Priority in respect Opioid Safety Group in place - First Safety Group meeting due to take place in March & run alternate months Insulin Safety Group - Insulin meetings have been poorly attended due to winter pressures/staffing issues/sickness etc. Next meeting due to take place in March & run alternate months		

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 Successful recruitment of x2 PET Officers (one FT, one 30 hours), x1 FT PET Co-ordinator and x1 PT PET Engagement Officer New complaints policy and Unreasonable Behaviour Procedure developed and in use PET Volunteer support in place Open concerns records reduced from 150 cases to 32 (Dec – Feb)	• 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)	

Executive Director of Nursing, Midwifery and AHPs

Matters of concern & risks to escalate

- Maternity CQC Report – overall rating reduced to RI, impact on patients and staff
- Complaints – (IBR 2.2.1 & IBR 2.2.2) – increase in number of complaints received by the Trust for Dec/Jan. Response rate 83%.

Major actions commissioned & work underway

- Plans underway to take forward apprenticeships for Nursing, Midwifery and AHP
- National AHP visit planned for 27th March (Steve Tolan Deputy Chief Allied Health Professionals Officer)

Positive news & assurance

- Nurse Staffing – (IBR 1.8.1 & 1.8.2) Overall Nurse staffing fill rates continue on an upward trend (above 95%). Further funding bid to NHSE approved (200k). Increase in CHPPD has increased in line with fill rate increase.
- Partnership with Kerala Government for Nursing and AHP recruitment via West Yorkshire partnerships
- Purchase of Oxleas AHP Preceptorship Package to support newly qualified AHPs aimed at retention

Decisions made & decisions required of the Board

- Support for Safer Nurse Staffing Recommendations

Medical Director Report for Public Board
Date: March 2023
Author: Dr Jacqueline Andrews

Matters of concern & risks to escalate

- Junior Doctor Industrial Action in March- significant impact on elective services to enable capacity to provide safe services for unplanned and emergency services
- Haematology services fragile services review commenced across WYAAT (to add to WYAAT Neurology fragile service review already underway)

Major actions commissioned & work underway

- Clinical services strategy feedback complete and being drafted for publication
- Programme of work to standardise reporting on returns to theatre ahead of IBR inclusion
- New National Guidelines on radiology reporting of abnormal results taken by a Digital Clinical Lead to implement as part of new digital strategy (in conjunction with missed result quality priority)
- EPR Outline Business Case in development and Pre-Tender Market Engagement preparations nearing completion
- A number of EPR readiness and enabling projects nearing delivery, including – Single Sign On, Robot Process Automation, Paper Scanning, IT Infrastructure and Continuous Improvement System
- Children's Public Health research programme- stakeholder engagement underway and roundtable being planned

Positive news & assurance

- SAS Doctor Celebration Event held in March- great attendance and feedback
- EPR funding approved of £8.2m in 22/23 – Spend on track for year end
- Badgernet Maternity System went live 21st March

Decisions made & decisions required of the Board

- SOP for the introduction of a new interventional procedure (NIP) approved by QGMG

Harrogate and District NHS Foundation Trust

Harrogate District Hospital

Inspection report

Harrogate and District NHSFT
Lancaster Park Road
Harrogate
HG2 7SX
Tel: 01423554444
www.hdft.nhs.uk

Date of inspection visit: 15/11/2022
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Good
Are services safe?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Harrogate District Hospital

Good ➔➔

The first 2 pages of this report pertain to the hospital location, from page 3 the report focuses on the maternity service.

We inspected the maternity service at Harrogate District Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

We did not change the rating of the hospital at this inspection. The previous rating of good remains.

How we carried out the inspection

During the inspection we spoke with 20 staff members, and 9 patients. We reviewed 26 patient records and medicines charts and 10 policies.

We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We received 19 feedback forms from women. We analysed the results to identify themes and trends.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

We rated maternity services as requires improvement because:

- Compliance with appropriate safeguarding, life support training and medicines did not meet targets, however there was a plan in place to recover this position. Regular checks on life saving equipment were not always completed. There was no clear system in place to identify prioritise risks to women in the maternity assessment area and there was no record of time to be seen, however, following inspection an action plan has been developed. Medical staffing numbers were not always sufficient, however there were mitigating actions in place.
- Information systems were not always appropriate for the service, however, there was a plan in place to improve this. The service was developing a vision for what it wanted to achieve and strategy to turn it into action. Governance processes were not always robust and there was limited embedded audit in the service.

However:

- The service had enough midwifery staff to care for women and keep them safe. Staff had training in key skills, and worked well together for the benefit of women, understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women in most areas, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent for their role. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed appropriate life support training for their role.

Staff did not always receive and keep up to date with their mandatory training. The trust target for mandatory training was 75%. Data provided as part of the inspection showed nursing and midwifery staff showed compliance for the 8 mandatory core training modules had been met or exceeded the trust target. For the 26 role specific mandatory training modules, data showed the training compliance had been met or exceeded the trust target in 12 modules and 14 had not been met. For the 7 specific maternity training 4 of the modules had been introduced in October 2022 out of the 3 remaining modules training compliance had been met in 2. During the factual accuracy process the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

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Data provided showed medical staff compliance for the 8 mandatory core training modules had not met the trust target. For the 17 role specific mandatory training modules, 4 had been met or exceeded the trust target and 13 had not been met. For the 6 Specific maternity training 4 of the modules had been introduced in October 2022, both remaining modules showed medical staff training compliance had met or exceeded the target. During the factual accuracy process the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Sixty per cent of midwifery staff had current adult basic life support with paediatric modifications training. None of the eligible medical staff members had completed advanced life support training and 30% of medical staff had current adult basic life support with paediatric modifications training. This meant that service leaders could not be assured staff had the correct skills and knowledge to safely treat patients who required lifesaving care or treatment. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Staff had not all completed appropriate advanced life support and neonatal advanced life support training. The trust target was 75%; midwives in the acute hospital had completed neonatal resuscitation training; compliance was 95%. However, medical staff compliance was 33% and nursing and midwifery support staff compliance was 67%. This meant that staff did not always have training to provide lifesaving treatment to women and babies in their care. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

We asked the trust to provide training data for birthing pool evacuation. The service had a policy for using the birthing pool during labour, however there was no specific training module in staff mandatory training, and the policy stated the training was provided to reflect guidelines changes, or when audit, monitoring or incident reporting identified deficiencies in practice. We asked staff during the inspection about the last time there had been a pool evacuation drill and staff could not tell us. The was no clear mechanism for ensuring staff were trained and competent to evacuate patients from the pool in an emergency situation.

Staff completed regular skills and drills training. Records showed staff completed emergency skills training annually, including sepsis, cord prolapse and eclampsia and drills training on scenarios such as shoulder dystocia, maternal collapse and intubation and ventilation. Compliance against the trust target of 75% was 84% for medical staff and 91% for nursing and midwifery staff in maternity services, which was above the trust target.

The mandatory training programme was comprehensive and met the needs of women and staff. Staff told us training was delivered in a multidisciplinary (MDT) way and training was adapted to incorporate learning from incidents and wove throughout the training human factors which were identified during the incident investigation. There was a multidisciplinary approach to planning training as there was a lead consultant for training which demonstrated leadership by example. There was a policy for the provision of multidisciplinary training within maternity services including the training needs analysis and learning development plan; it was version controlled and in date and reflected the training requirements for each role required.

Mandatory training development was led by a practice development midwife and a consultant obstetrician which demonstrated the importance of multidisciplinary training for all grades and disciplines of staff.

Maternity

The service provided training and competency based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 95% in both acute and community services. Medical staff compliance was 100%. All staff groups met the trust target of 75%.

The service provided protected time for newly qualified midwives one day a month to consolidate their pre-registration training. All newly qualified midwifery staff we spoke with valued this time.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. However, not all staff were trained on how to recognise and report abuse.

Staff did not always receive training specific for their role on how to recognise and report abuse. The trust target for safeguarding training was 75%. Medical staff overall compliance with safeguarding children training targets was 55% and 73% for safeguarding adults training. This did not meet the trust target, however, during the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved in line with the action plan.

Nursing and midwifery staff compliance with safeguarding children training targets was 59% which did not meet the trust target and 81% for safeguarding adults training which exceeded the target. During the factual accuracy period the trust provided updated training figures and an action plan, which showed training compliance had improved for safeguarding children level 3 in line with the action plan.

Support staff/unregistered nursing staff compliance with safeguarding children training targets was 90% for level 2, which exceeded the target.

The service had a named safeguarding midwife who provided advice and support to staff regarding any safeguarding concerns identified. We saw safeguarding concerns were also shared during handovers between staff.

Level 3 safeguarding children training was provided to staff in line with national intercollegiate guidelines (2019), however safeguarding adults level 3 training was not provided to any staff role; this was not in line with national intercollegiate guidelines.

The service had a safeguarding action plan which identified training provision, including appropriate levels of training as a risk, the original target date for all levels of training was 31 January 2023. However, during the factual accuracy process the trust provided the final plan which showed an updated date for completion for a final action on 31 March 2023.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service offered training specific for staff roles on how to recognise and report abuse. The safeguarding children's level 3 training covered the expected areas, including scenario based reviews and personal reflections, The training was completed remotely as a workbook with an online reflection session.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We found examples where safeguarding concerns were acted on during the inspection and in patient records we reviewed.

Staff had training on how to recognise and support women who had experienced female genital mutilation and knew how to raise concerns when and if required.

Maternity

Staff followed the baby abduction policy and undertook baby abduction drills. The service had recently completed a live baby abduction drill which was good practice.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were generally clean and well-maintained, however we saw isolated incidents of damaged soft furnishings and grab rails, which meant they were not wipe clean.

Cleaning records were up-to-date in ward areas and reported that all areas were cleaned regularly. The service audited cleaning checks weekly. The trust provided audits for the weeks commencing 10, 17 and 24 October 2022 and these were completed in full. During the factual accuracy process the trust provided the cleaning audits for the weeks commencing 31 October and 7 and 14 November 2022 and these were also completed in full.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned.

The service had processes in place to manage cleanliness and infection control, however we did not see these were completed in all areas, or in a timely way. We did not receive any audit information for the antenatal clinic. We reviewed the infection prevention and control audit outcome between 01 August and 31 October 2022; there had been 3 audits in the time frame on the delivery ward and 2 on Pannal ward and maternity assessment unit. On the delivery ward, compliance averaged 99% across the three months, however the audit deadline was met only 1 in 3 times, which meant it was not always completed in a timely way. There had been no environmental audit on Pannal ward in the timeframe, however, there were 2 cannula insertion audits; compliance was 90% on average across both completed audits, one had been missed in the timeframe.

On the antenatal clinic, we did not see evidence of daily cleaning records. We asked staff but they were unable to provide audits or cleaning records for this area. We found curtains in the antenatal clinic were not dated, so it was unclear how long they had been hung, or when they were due to be changed; they appeared clean. We were not assured there was sufficient oversight of the cleaning that took place, although the department was clean. However, during the factual accuracy process the trust provided cleanliness audit results for antenatal clinic between January and October 2022 which showed scores between 96.8% in May 2022 and 100% in all other months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, regular checks on lifesaving equipment were not completed in line with trust policy.

Women could reach call bells and staff responded quickly when called.

Staff did not always carry out daily safety checks of specialist equipment. We found a number of gaps in daily and monthly checklists for emergency trolleys and resuscitaires across different areas of the service. On one ward, we found daily checks were completed on 11 out of 31 days. We saw gaps in monthly checks of the contents of adult resuscitation

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trolleys on the delivery suite; which had not been documented since January 2022 and antenatal clinic; which had not been documented since March 2022. On 1 trolley we found an item which was identified as missing during a routine audit in August 2022 and was found to be still absent during our inspection, we escalated our findings to staff and the item was replaced. We saw gaps in checks in every month from July to the date of the inspection.

We also found on Pannal ward the obstetric emergency trolley had not been checked 49 out 79 days between 01 September and the date of our inspection on 15 November 2022. In addition, the flow chart for the management of postpartum haemorrhage was out of date and was not aligned to the current policy. This was a risk to patients because the ward staff could not be assured that all emergency lifesaving equipment was available in an emergency situation, and leaders had not identified that there were significant gaps in equipment checks.

We asked ward managers about daily checks on emergency equipment and they told us they were regularly checked by managers and checks were completed appropriately, but this was not in line with what we found.

We checked the fridges for storing patient food and found gaps in temperature checks on the delivery suite between August and November 2022. We also found out of range readings, and these were not always rechecked in line with the trust policy.

The service had suitable facilities to meet the needs of women's families. The environment was suitable, including mood lighting, birthing equipment and appropriate décor. There was a bereavement suite away from the main labour ward area which was appropriately decorated with access to memory boxes and support for patients and their families.

Staff disposed of clinical waste safely. We found waste was appropriately disposed of and sharps boxes were completed in line with guidelines during the inspection.

Assessing and responding to patient risk

On ward areas, staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, there was no clear system in place to identify prioritise risks to women in the maternity assessment area.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately on the ward areas. The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting the seriously ill and deteriorating. The MEOWS chart was used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any women whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016). The trust provided evidence which showed there was a clear process of monitoring and escalation of women’s health and wellbeing.

The service had a maternity assessment centre where women could telephone for over the phone advice from a midwife and if needed, or requested, attend the department for clinical review. The service had two different triage systems; one was a RAG rating (red, amber green) system which provided timescales that women should be seen, depending on the urgency of their concern or symptoms and the other was an acronym, CUSS, which stood for "I am Concerned, I am Uncomfortable, This is a Safety issue, Stop". We did not find evidence of triage categories or prioritisation given to

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women who used the service in the 8 patient records we checked in this area, and when we asked the trust about audits of the triage tool, however none were available. This was a concern as there was no robust assurance mechanism in place to check that women were appropriately triaged, seen by a clinician in an appropriate timescale, and seen in order of clinical need.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Cardiotocography (CTG) used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. When we looked at patient records, we saw that CTG documentation was documented in line with national guidance. The service did not undertake formal CTG audits, however, CTGs were reviewed as part of the professional advisory panel (PAP) and any findings of these reviews were fed back to individuals or communicated to the wider team. However, this meant CTGs which did not meet the threshold for review in PAP were not audited.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. We asked the trust to provide audits of the WHO surgical safety checklist, including findings and actions taken to make improvements. We observed the completion of surgical safety checklists during the onsite inspection and did not find any concerns, audit data between August and November 2022 also confirmed this.

Staff knew about and dealt with any specific risk issues. We found staff discussed patient's holistically during handovers and made appropriate referrals or signposting to provide support to women.

We found staff completed risk assessments for each woman on admission / arrival, using an assessment of risk tool, and reviewed it regularly or after any incident. We found SBAR (Situation, Background, Assessment, Recommendation) tools were used in patient records to handover key information and the same tool was used for shift handovers. The service had not completed any SBAR audits although provided information which showed they were reviewed as part of the PAP review process. This meant SBARs which did not meet the threshold for review in PAP were not audited.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health).

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. The service used SBAR to handover key information. We saw this was documented in patient records.

There had been no pool evacuation simulation since prior to the COVID-19 pandemic. This was a risk because training was only delivered on induction and if there was an identified need, so the service could not be assured staff were competent and confident to evacuate a birthing pool in an emergency situation.

We reviewed the service's maternity quality dashboard. The dashboard provided target figures to achieve for some indicators, however it did not benchmark against national indicators. There was no clear system to use the dashboard as a benchmarking tool, as national figures were not included. Leaders we spoke with told us that the dashboards

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required some development to help identify key themes and trends in a timely way. Leaders stated the introduction of an electronic patient record system would support a more effective maternity dashboard. The dashboard did not include information including sepsis, time from decision to knife to skin or different volumes of post-partum haemorrhage.

The service used the local, regional, and national maternity dashboards collectively to report on clinical outcomes such as mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (cot acuity, preterm delivery), public health information and statistical analysis. It also covered data in regional and national dashboards such as the monitoring of induction of labour. The service provided the local quality dashboard, which included workforce and unit closures, however, this had not been completed in any month in 2022. There were gaps across the dashboard that had not been completed or used. During the factual accuracy process, the trust provided additional information which showed where workforce and unit closures were discussed and monitored.

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Midwifery Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service made sure staff were competent for their roles through an appraisal.

The service had enough midwifery and support staff keep women and babies safe.

The most recent birthrateplus® report from April 2021 showed the service had enough trained midwifery staff. The vacancy rate was low and evidence provided at the time of the inspection showed the total vacancy rate in both midwifery and midwifery support staff was 5.78 whole time equivalents (WTE) overall.

The service managed staffing well, A red flag event is a warning sign that something may be wrong with midwifery staffing of the flow across the maternity unit. There had been 1 red flag event on delivery suite and 22 red flag events on Pannal ward in the last 6 months. There were 13 red flags reported due to delays between admission for induction and the beginning of the process, however there were 3 delays in care, 4 delays in providing pain relief and 1 delay in recognising or acting on abnormal vital signs. We spoke to ward managers about how these events were managed and were told that priority was given to providing one to one care to women in labour on delivery suite. Most instances of short staffing were due to short notice staff sickness or absence. Staff moves did not impact on care delivery on the joint antenatal and post-natal ward.

We looked at the most recent staffing report sent to the trust's board which reported midwifery staffing and absence and planned versus actual staffing in the maternity departments. There was an identified gap in the bereavement midwife position. Staffing was regularly reported to board level, and we saw that actions were taken to mitigate staffing shortfalls both in the short and longer term.

Sickness rates for non-medical staff were 6.55%.

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There were 14.65 WTE midwives in post in the community, against an establishment of 9.9 WTE midwives. This was in preparation for the roll out of the national continuity of carer, however, this was on hold. Community midwives were integrated into the acute workforce and were also utilised during the day as part of the surge process. There were also 3 WTE maternity support workers in the community to support the delivery of care for women outside of hospital.

There were 3 administrative staff to support the antenatal clinic and 0.6 WTE administrative staff for the screening service. Across Pannal ward and the delivery suite, there were 1.5 WTE administrative staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Managers supported staff to develop, however yearly, constructive appraisals of their work did not meet the trust target. Overall, the maternity services achieved 86% of appraisals completed; Compliance for midwifery and maternity support works was staff was 87%. This meant that most staff in the maternity service had received an appraisal in line with guidance and best practice and supported staff in their training, learning and development.

Managers made sure staff received any specialist training for their role. There were 11 specialist midwife roles; 7.86 WTE band 7 specialist midwives were in place and two 0.5 WTE band 6 roles, who were awaiting a start date, to support women in different areas including infant feeding, bereavement, a digital midwife and fetal wellbeing lead. However, 8 of the specialist midwife roles did not relate to specialist clinical provision, for example, there was no specialist midwife to support women with diabetes, perinatal mental health needs, substance misuse or to support teenage pregnancies.

Medical staffing

The service had enough medical staff most of the time with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment, however there were plans in place to mitigate risk and improve staffing.

The service had enough medical staff most of the time to keep women and babies safe.

We reviewed medical staffing numbers which included forecasted medical staffing numbers which would not meet the ideal staffing for the period December 2022 to February 2023. We saw there was the correct number of consultant staff. However there ongoing staffing issues to fill the junior doctor rota which was on the trust risk register. Leaders told us they had a recruitment plan in place and the board report reflected forecasted improvements to the obstetric staffing numbers from March 2023. We saw improvements in provision between the board report in May to September 2022, where the gaps had reduced from 4 middle grade vacancies to one.

Sickness rates for medical staff were 5.51%.

Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. The service used locum medical staffing to fill rota gaps; this supported the out of hours rota gaps that had been a long standing staffing concern in the service.

The service always had a consultant on call during evenings and weekends. Staff told us consultants were available to call for support when they were off site, and they had no concerns with attendance if needed.

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Managers supported medical staff to develop however yearly, constructive appraisals of their work did not meet the trust target. Compliance for doctors was 75%. This meant that most staff in the maternity service had received an appraisal in line with guidance and best practice and supported staff in their training, learning and development.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, records audits were not completed and there was no system in place to document triage assessment and prioritisation outcomes in the maternity assessment centre.

Women's notes were comprehensive, and all staff could access them easily. We reviewed 19 patient records and records were completed in line with trust processes.

When women transferred to a new team, there were no delays in staff accessing their records. The service used paper records and had administrative support to access notes for clinics or assessment. Patient notes were stored in an accessible area to staff during their pregnancy.

Records were stored securely.

However, the service did not document or audit the use of a triage tool in the maternity assessment centre and there was no clear system for this information to be documented.

We asked the trust to provide audit data for patient records for the last 6 months; the trust had no audit available to provide. During the factual accuracy process the trust provided an action plan they had developed following the initial trust feedback to demonstrate they were implementing an audit of triage records and processes.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff training in medicines did not meet the trust target and competency checks were infrequent.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up to date. We reviewed 7 patient medicines records and found they were mostly complete, however patient weights were not recorded in any of the records we looked at. This meant staff could not be sure they were appropriately prescribing medicines based on the weight of the patient.

Staff stored and managed all medicines and prescribing documents safely.

Overall compliance with medicines management training targets was 60%, we were told this was due to disruption of the training programme during the pandemic. This did not meet the trust target. Medical staff average compliance with the two required medicines management training targets was 48%, with one module at 28%. Nursing and midwifery staff average compliance with the two required medicines management training targets was 64%. This did not meet the trust target.

The service did not have effective systems in place to check staff competency when using medicines was in line with trust policy and national guidelines. We saw 53 out of 79 staff had been reviewed and signed off as competent, and 6 staff were not authorised to give intravenous (IV) medicines. However, there were effective plans in place to improve this position.

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Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they felt comfortable raising concerns and felt listened to. We heard examples where staff thought incidents were managed well.

The service had no never events on any wards.

Staff reported serious incidents clearly and in line with trust policy.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Most incidents were investigated and responded to in a timely way; however, there were 2 serious incidents showing as open over 60 days. One from April 2022 was being investigated by an external body following the timely trust investigation. The other from July 2022 was investigated within the time period but was delayed from closure by needing additional sign off as agreed with the local integrated care board and communicated to the patient.

The trust held 48 hour review panel discussions to discuss initial findings relating to incidents. We looked at two recent reviews and found they considered the expected areas, including if the serious incident framework criteria was met, immediate learning and actions and any specific areas to be included in the terms of reference. However, we found relevant sections of the record were not completed, for example no colleagues were recorded as present in one report, no learning or immediate actions had been documented for either incident and one report had no panel date recorded.

In the last 6 months, 3 incidents were referred to the Healthcare Safety Investigation Branch (HSIB) for investigation; one did not meet the HSIB threshold and was returned for investigation in line with local policy, one was ongoing, and the third had recently been completed. We reviewed recommendations from the completed HSIB investigation; however, the trust did not provide its related action plan. Recommendations related to appropriate supervision for medical staff in training and categorisation and escalation of cardiotocography interpretations.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There was a weekly labour ward forum where incidents were reviewed as a team and staff were made aware of themes or trends.

Staff met to discuss the feedback and look at improvements to the care of women.

The service had not reported any neonatal or post-natal deaths from 01 May to 14 November 2022. There were 4 perinatal deaths and the trust reviewed their care by a multidisciplinary team approach who used the Perinatal Mortality Review Tool. We reviewed the perinatal mortality tool for this time frame for the one completed case and saw it was completed fully.

Managers debriefed and supported staff after any serious incident. Staff had access to Professional Midwifery Advocates (PMAs) and the trust offered online access to this service.

Maternity

The service used themes and trends from incidents to inform upcoming training days which were delivered in a multidisciplinary approach; this meant the service had embedded a learning culture into the system.

Is the service well-led?

Good

We rated well led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles. There were clear lines of escalation and oversight from executive leaders.

There was a new leadership structure in place across the trust and roles were being appointed to during the inspection period. We heard about how the new structure would work, and it included clear lines of reporting, dedicated non-clinical time to attend regular meetings and clear roles and responsibilities.

The service was led by an associate director of midwifery, operations director and clinical director. The triumvirate was supported by a maternity services matron, ward manager/coordinators, specialist midwives and a lead midwife for risk and clinical governance. While individuals were relatively new in post, the structure had been established for some time and was well embedded and understood. There was a clear line of reporting into the executive directors and board. There was a governance group in place and regular directorate governance meetings were held. Relevant information was escalated to the trust quality and safety committee.

Leaders told us they felt supported and had direct access to the board level executive and non-executive director safety champions, as well as regular bi-monthly meetings where risks and issues were escalated. Staff told us leaders were approachable and visible.

The service leaders had links with the Maternity Voices Partnership (MVP) and during the inspection we spoke with the MVP chair; despite issues outside of the trust's control, trust leaders, safety champions and the MVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

Mandatory training development was led by a practice development midwife and a consultant obstetrician which demonstrated the importance of multidisciplinary training for all grades and disciplines of staff.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, however leaders had plans in place to develop one.

The service was developing its current strategy, but this was behind schedule. As part of the trust's maternity self-assessment action plan, the development of a strategy had a target completion date of January 2023. Leaders told us that the overarching trust strategy had been developed with an overarching ambition for high quality maternity services, with confidence of women and families. Service level leaders were in the process of developing the service level

Maternity

strategy to link to trust wide objectives. They told us staff would be involved in the co-production but did not describe how they would involve staff in the development of a vision and strategy for the service. The focus was on trust-wide ambitions relating to the best start for children across the footprint of the trust, which included a large geographical area of community services.

The maternity unit had an overall improvement plan which was being used to steer the unit; this was monitored monthly by the safety champion and triumvirate group and any issues escalated at board level monthly. Issues noted included the turnover of leaders in the last year. Leadership roles had been appointed in the new management structure; they had not had time to embed in the service at the time of our inspection. Senior leaders and managers articulated their top priorities for the organisation, which linked to their ongoing plans. These areas were consistent with the gaps we found during the inspection. They included the following:

- Changes to the local population meant the service had recognised a need to engage with the Ukrainian community with the Maternity Voice Partnership (MVP), and joint working had commenced in this area.
- A need to increase the safeguarding specialist midwife role from 0.5 WTE to 1 WTE role. This was anticipated to reflect in addressing safeguards more swiftly and auditing for any trends to inform practice changes or training.
- Recruitment to the mental health midwife vacancy.
- To introduce an electronic patient records system; this was planned to roll out from January 2023.

We found these areas were all in progress and had been identified as risk factors in managing the maternity unit.

Culture

Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

Staff we spoke with felt there was an open culture; they could speak up about concerns and they felt they would be listened to. In the July 2022 staff survey, 73% of staff felt able to make suggestions about their work and the same percentage felt they had opportunities to show initiative. The survey also reflected 93% of staff witnessed and experienced teamwork.

Staff felt there was a no blame culture, and this encouraged conversations or the opportunity to raise any issues. Staff felt the senior management team were visible and they felt able to contact the consultants directly if required. When investigations were completed there was an inclusive approach through a round table format enabling staff to talk as a group and feel supported.

We saw positive and caring interactions between staff, and with their patients. All midwives and staff we observed were friendly and supportive.

The staff survey dated July 2022 also identified areas for improvement. For example, due to staffing shortages, staff responding to the survey said they did not always feel supported to develop their roles or feel supported with their wellbeing needs. These themes had been responded to, with the appointment of a Band 7 midwife to support retention and staff support. Staffing was reviewed regularly using an acuity tool and the actions to maintain numbers to meet the needs of patients was discussed regularly with staff.

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A further survey completed in September 2022 focused on themes around staff wellbeing. The survey showed 53% of staff, felt there could be an improvement in their wellbeing. The Professional Midwifery Advocate (PMA) introduced 'Wellbeing Wednesday' which was open to all midwives and doctors to offer support and information. Staff we spoke with felt this was supportive and staff looked forward to the weekly emails which offered support and offers available within the hospital services or NHS offers.

Women, relatives and carers knew how to complain or raise concerns. The service received no complaints in the 3 months before the inspection. We reviewed complaints from previous months and found they had been addressed. One area which had been identified was communication and a range of options were being considered to improve this area along with opportunities to provide feedback.

Oversight of safety in maternity services was reported to the board monthly. We reviewed the last 2 reports and found appropriate risks and issues and key challenges were escalated, and they were reflected in other reports we reviewed.

The maternity and neonatal safety champions met 4 times in the 7 months prior to our inspection. We reviewed the meeting minutes for the April 2022 and found there was a focus on safety, staffing and national improvement schemes and initiatives. Board safety champions told us there were informal opportunities for safety champions to meet with them or raise concerns.

As part of the national maternity inspection programme women and birthing people are asked to provide feedback on care. Of the 2,226 women and birthing people contacted 19 chose to provide feedback about their maternity care at Harrogate District Hospital. Most praised staff attitude with 12 containing positive responses about the care they received from staff. The concerns raised by some women included delays experienced and some issues with being listened to and fully supported.

Governance

Leaders did not always operate effective governance processes. Systems to embed learning from the performance of the service into improvements were in their infancy. Policies and process used were not always up to date. However, staff were clear about their roles and accountabilities in the new structure

There was a new leadership and governance framework in the service which had only been implemented fully in the weeks before our inspection. The maternity risk management strategy set out the governance structure for the maternity services. Roles and responsibilities were clearly identified in the policy, including responsibility for reviewing incidents at all risk levels. Staff and leaders could clearly articulate this new governance framework for the directorate and how information flowed between maternity services and the board and were clear on their roles in the new structure. However, the structure was not embedded and the evidence we reviewed was in line with the old structure. The new structure had not been in place for enough time to comment.

Staff did not always have access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We found a number of policies and flow charts in the that were not dated, or version controlled, or which had passed the review date during the inspection. There were also sections of guidelines with differing versions and review dates printed together in reference folders in the service.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues. There were clear links to the Local Maternity and Neonatal System (LMNS) and local system.

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Serious incidents were discussed in the local maternity system, including incidents referred to HSIB. Meetings were held monthly and included peer reviews, trust presentations of incidents across the local area and a local learning log which supported shared learning across trusts.

Senior leaders in maternity services met, however we did not see that formal meetings were regular. We asked the trust to provide the last 3 meeting minutes and they provided 2; the senior management team for maternity services met in June and October 2022. There was no set agenda and the minutes covered high level updates. In the most recent meeting, we did not see evidence of discussing themes, incidents, learning or any actions identified.

Internal meetings were not always held regularly. Clinical governance meetings were held bi-monthly. We looked at meeting minutes for the last 3 meetings; they covered topics including safety concerns, incidents, training, feedback, risks, issues, and learning. However, the meeting in July 2022 had not gone ahead, which meant there was a four-month gap between meetings. We saw that low training compliance was discussed at the most recent meeting. However, we did not see that issues we identified during the inspection had been identified through the assurance systems in place, for example out of date guidance and lack of audits. We were not assured that the governance mechanisms were supported by effective assurance systems to identify issues and concerns to be actioned.

The service was represented at the monthly local maternity system serious incident peer review panel where serious incidents were discussed, and actions taken at local area level. Learning was identified and updates were provided on ongoing reviews. During the factual accuracy period the trust provided evidence that serious incidents were discussed as part of the wider directorate.

Following the publication of the Ockenden report (2019) the service completed a benchmarking exercise. We looked at the outputs of the assurance visit in June 2022 relating to the first Ockenden report. We looked at the outcomes of the exercise and associated action plan and found there were 12 areas of positive findings. These included, the environment, quality and effectiveness of multidisciplinary training, effective baby abduction policy, new posts to support the service and positive MVP involvement in service improvements. The service was compliant with the 7 immediate and essential actions. However, the review identified a recommendation, to strengthen governance and audit processes.

The service had 1.2 WTE practice development midwives in place. They were responsible for monitoring and managing staff training schedules. There was a training matrix, and 15 training requirements were developed from local and national drivers and requirements. The training plan also linked to further resources for further reading on some modules.

The service last completed a staffing and acuity review in April 2021 for midwifery staff. It said the service needed 76.21 whole time equivalent staff (WTE) across maternity services to meet the planned needs of women. The service had some vacancies and were addressing this by advertising to over-establish on some roles in order to back fill areas that were difficult to recruit to. There were rota gaps in the middle grade medical rota which had been addressed by recruiting long term locum cover. The service had a plan in place to recruit to vacant posts and it was on the service's risk register.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. There was limited embedded audit in the service, and we were not assured systems were in place to support improvements.

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The service had a risk register in place. We reviewed the risk register and saw one risk scored at 12 which was RAG rated red, 4 rated 6, on rated 8 and one rated 9 which were RAG rated amber, and one rated 4 which was RAG rated green. We found the risk register had clear, regular updates and evidence of risk scores reducing. All risks were progressing within the risk reduction target timelines set by the service.

The trust had a maternity risk management strategy. It was in date and due for review in April 2024. The strategy was clear and included risk escalation and management of incidents, risks, and the governance and meeting structures to support the flow of information. The strategy included incident reporting and escalation process for incidents, including serious incidents and never events and included the governance arrangements around low risk incident management, which was good practice.

There was a robust policy in place to manage the department when it was in escalation which was in line with the national Operational Pressures Escalation Levels Maternity Framework. The policy was based on 7 escalation triggers:

- Ward bed capacity
- Labour ward bed capacity
- Triage breaches
- Unable to give 1:1 care in established labour
- Birth rate plus activity and dependency score on labour ward
- Labour ward co-ordinator not supernumerary
- Delays in elective work includes induction and women booked for elective section.

We saw there were clear actions in place to mitigate risks and manage levels of staffing to the needs of patients, including timeframes for review.

In the last 12 months, suspension of maternity services had occurred 18 times. There had been 4 incidents of suspension of service between March and November 2022, and the 12 incidents prior were largely due to sickness and inability to provide 1 to 1 care to women in labour. The service reviewed all incidents and documented the action as appropriate. We saw in recent incidents the services were suspended for a short period of time which meant that the service re-evaluated the escalation regularly.

The service participated in relevant national clinical audits. The service provided evidence they complied with 3 out of 5 saving babies lives care bundle audits. We found that there were recommendations and outcomes linked to the audits and the service had developed action plans to respond to those recommendations in 2 of the 3 audits. Evidence provided at the time of inspection showed actions in the reduced fetal movements audit was due to be completed by October 2022. During the factual accuracy process the trust provided evidence that all actions had been completed by the required National deadline of December 2022.

We reviewed the trust response to a saving babies lives survey which collected information on the progress of trust progress towards the full implementation of the saving babies lives care bundle in October 2022. The service identified 2 areas in which they had not met the requirements, however, plans were in place which included carrying out improvement activity to reduce smoking in pregnancy and recording of reduced fetal movements. Staff we spoke with identified the planned the introduction of an electronic patient record system, due to commence in January 2023, would enable compliance with reporting requirements they were currently unable to meet.

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We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found perinatal clinical quality was reported through a monthly report to the trust board. The report included emerging challenges, risks and issues, staffing, risk and safety, service user feedback and national priorities.

Managers and staff did not always carry out a comprehensive programme of repeated audits to check improvement over time. The service had an audit programme in place; however, we were not assured there were robust mechanisms in place to check the quality and safety of care provided in the department. There were several audits that were not completed, including records, CTG documentation or fresh eyes, and audits of the triage system. We found the service intended to plan 23 additional audits on areas including completion of records, guidelines, and assessments, but there was no timescale identified to implement these audits and it was unclear how long they were being considered for action. This was a risk because the service did not have established systems and processes in place to support identifying issues, themes, and trends in care delivery to support improvements.

However, we did see completion of some expected audits. The new-born and infant physical examination (NIPE) screens babies for specific conditions, ideally within 72 hours of birth. The service audited the completion of NIPE examinations and achieved 97% compliance between 11 August and 10 November 2022. This meant they monitored screening and we found it was completed in a timely way.

We did not see evidence during the inspection of audits that provided assurance to leaders that policies and processes were followed. We asked the maternity services leadership team about ward-based assurance, audits or rounds and they told us there was a trust wide team who completed checks; however, they could not articulate how regularly they occurred or any recent outcomes. Ward managers we spoke to did not always have access to regular IPC audits or know if they were completed, however, the ward board for one ward contained results of hand hygiene, ward cleanliness and monthly audits. We found gaps in emergency equipment checks that ward managers told us were checked daily.

We were told that the service did not audit SBAR handover completion. There was no audit to monitor time taken to triage against the triage categories and service leaders did not provide additional information to assure us they took place.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with 4 out of 10 safety initiatives for the current year (year 4), and had documented plans in place to provide the remaining assurances required by the deadline of 05 January 2023. We reviewed the final report to board for year 3 from June 2021 and found they had provided sufficient evidence of their compliance to the trust board.

The service was accredited by united nations children’s fund (UNICEF) baby friendly gold award.

The trust evidence showed there were no actions required following the 2020 MBRRACE report. The service had an assurance visit in June 2022 relating to the first Ockenden report. We looked at the outcomes of the exercise and associated action plan and found there were 12 areas of positive findings, including environment, quality and effectiveness of multidisciplinary training, effective baby abduction policy, new posts to support the service and positive MVP involvement in service improvements. There were 7 immediate and essential actions the review identified and 8 recommendations, including strengthening governance and audit processes.

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Information Management

The service did not always collect and analyse reliable data. Staff could not always find the data they needed to understand performance and make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The service had a performance dashboard which collated data and insights about the service, however governance leads told us that updates were needed to streamline dashboards and ensure the outputs were useful in driving improvements.

Most patient records were completed on paper, and the service had delayed implementing some audits until the electronic paper records solution was implemented. This meant that the service was not always collecting and analysing data to make decisions, improvements and monitor care provided. There were plans in place to implement the electronic solution in 2023.

Ward managers did not always have access to information they needed, and we saw limited assurance audits taking place across the service; we did not see an embedded mechanism for collating audit information.

Data which was required by external organisations was collated and submitted in line with requirements.

Engagement

Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.

The service produced and circulated newsletters to staff. We looked at the last 3 editions and found they included incident and risk management information, performance overview, HSIB and internal incident investigation learning and feedback, staff support mechanisms and key facts relating maternity services.

We saw evidence which showed the service engaged with staff to support the maternity workforce strategy and antenatal education.

Maternity voices partnership (MVP) engagement meetings were scheduled bi-monthly and were scheduled up until November 2023. The engagement schedule also included service user coffee mornings to gain informal feedback and provide local support included.

MVP meetings were arranged in different times of the day across the year to provide opportunity to different groups to attend and included alternating morning and evening meetings. We looked at minutes and action plans from the most recent two meetings and saw there was representation from the MVP, trust and local people and organisations. Discussion and actions were driven by service users, service user engagement and seeking feedback to make improvements.

Learning, continuous improvement and innovation

All staff wanted to learn and improve services. There were areas of good practice which allowed staff to explore learning and service development.

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Improvements to the service were discussed at the maternity services forum which was held bi-monthly. We reviewed minutes from the last 3 meetings and found that improvements were discussed in response to feedback, incidents, or complaints. The group noted the need to become more proactive in service improvement.

Staff described a positive level of MDT training and support which was driven by learning from incidents. Human factors were built into the services whole training programme and staff were committed to providing scenario-based training which was measured through PROMPT (PRactical Obstetric Multi-Professional Training). When the service had staffing issues, mandatory training was not cancelled, and specialist midwives facilitated ward based training when staff could not be released.

The service provided dedicated time off the unit for band 5 midwives to complete their preceptorship. They received one day per moth bespoke training with additional pastoral support. This was good practice and had not been found in other units so far in the CQC national maternity services inspection programme.

The service had an online forum with another local trust for case discussion training in CTGs; staff could join from home remotely or watch after the stream.

The service was providing fetal head impaction training based on a live scenario and was the only regional service providing this training at the time of the inspection.

There was specialist support available to mothers; the service had an infant feeding coordinator with 4 days of protected time and midwives and midwifery support workers had received training in breast feeding.

Outstanding practice

We found the following outstanding practice:

- The service identified how all incidents should be managed in the maternity risk management strategy, including low risk rated incidents, and there were clear roles allocated to review all levels of incidents in the structure, which was good practice.
- The preceptorship programme to support newly qualified midwives included giving band 5 midwives a day out of clinical practice monthly. All band 5 midwives we spoke with valued this essential opportunity to reflect and consolidate their training.
- The service had implemented scenario based training in relation to the impacted fetal head. The training included a human factors approach which had seen an increase on the confidence of junior staff to challenge in emergent situations.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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- The service must ensure they embed a system of oversight for women attending the maternity assessment centre to prioritise their care appropriately and monitored. (Regulation 12 (2)(a))
- The service must ensure all equipment is checked and escalated if needed in line with local policy guidance and regulations. (Regulation 12 (2)(a))

Action the trust SHOULD take to improve:

- The service should complete all relevant documentation when incidents are reviewed.
- The service should continue to ensure staff receive appropriate support, training, professional development supervision and appraisal.
- The service should continue to embed systems to assess, monitor and improve the quality and safety of the services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors and one CQC inspection manager. There were two specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director for Secondary and Specialist Care.

Harrogate and District NHS Foundation Trust

Safer Nursing Care Tool Report incorporating: Adult Inpatient Ward SNCT & Emergency Department SNCT

Contents

Harrogate and District NHS Foundation Trust

3.7

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date: February 2023

Author: Brenda Mckenzie (Workforce Assurance and Compliance Matron)

Situation

The Board of Directors are required to receive a Nurse Establishment Review twice a year. This requirement is underpinned by the direction of NHS Improvement (2018) who, in conjunction with the National Quality Board (NQB) (2016), provide a guidance framework containing the key components that should be considered as part of safe staffing review and analysis and in turn enable their nationally endorsed expectations to be met.

The organisation undertook its third adult inpatient safer staffing review using the licenced SNCT during the month of October 2022. Senior colleagues are asked to note the content of the report and support proposed recommendations.

Background

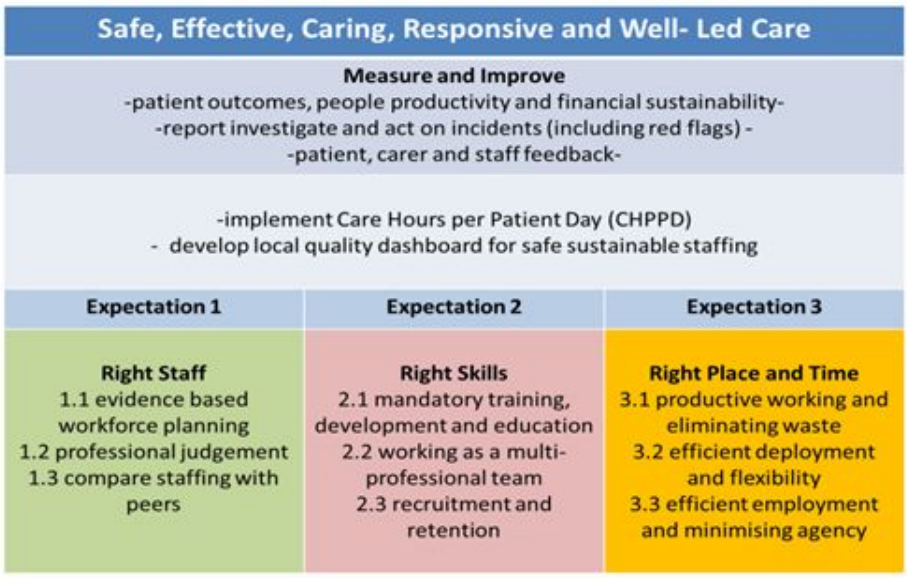
The NQB guidance framework (2016) is central in supporting us to develop a workforce that is fit for purpose in the context of it being safe, sustainable and productive. It comprises of a principle document which is supplemented by a suite of additional publications that collectively act as improvement resources.

The principle structure of the NQB expectations are illustrated below and together form a framework that facilitates and supports care to be underpinned by;

• delivery of the right care, first time in the right place

• minimising avoidable harm

• maximising the value of available resources



Prior to attaining the licence for the SNCT in May 2021 any nurse establishment review was mainly focussed on expectation 3. This report provides an appraisal of the position against historic nursing establishments and further explains the outcome of the most recent evidence based assessment using the SNCT which was undertaken in October 2022 in the general adult inpatient areas.

The trust currently operates an establishment model that was previously agreed in order to reflect seasonal trends and recruitment challenges. Increasing staffing challenges and higher acuity has meant that this model is no longer appropriate to ensure high quality care can be delivered. In addition to this SNCT review, a recent ward reconfiguration has meant that we now have additional unfunded beds, which were initially intended as escalation beds and have now been identified as a more permanent required uplift in speciality beds.

This is the third data collection and shows increased acuity and dependency of our patients. In addition, teams are reporting increasing levels of enhanced care requirements on a daily basis. This report will include enhanced care data *(patients who require an increased level of care to prevent them harming themselves, others or absconding)* for each area as well as compare, where appropriate, dependency data from the first and second SNCT data collection.

Although staffing levels are agreed annually during 'budget setting' prior to the new financial year, these establishments are historical with no real evidence base behind them. The Shelford Group (2018) SNCT is a validated licensed, evidence-based tool (endorsed by NICE), that incorporates acuity and dependency, quality indicators, patient flow information and professional judgement. In May 2021 the organisation purchased the license for the SNCT; the first data collection took place over June and July of 2021 and the second took place over February and March 2022. The scope of this data collection included all adult inpatient wards.

The third data collection ran for the entire month of October 2022. Prior to this collection the Workforce Matron facilitated an extensive training programme; a one and a half hour training session, that was conducted via MS Teams. All attendees were assessed and were required to pass the inter-rater scoring pass levels. This information is stored on the corporate nursing 'shared drive'. It is essential that all scorers are trained to ensure that high quality, reliable data is collected. All the data was peer reviewed by the Matrons to validate and add assurance that the data was an accurate reflection of the patients on the ward and activity during the time of the audit.

The SNCT was used with a 60:40 ratio Registered Nurse (RN) to Care Support Worker (CSW) for all wards with exception of Farndale, our medical admissions ward. For this ward a ratio of 70:30 was used to take into account the additional registered nurse input required when admitting acutely unwell patients, which is recommended by the tool with regards to assessment areas.

Over the data collection period, the hospital bed occupancy was at an average of 96% with a range of occupancy across all 13 areas from 56.1% up to 113.9% with the majority of areas running between 95 and 100% bed occupancy over the study period. The data was collected at the same time each day (15:00hrs).

Assessment

All wards have daily safety huddles where all staff, including medical and AHP colleagues come together on the ward at a set time to discuss any patient safety risks; for example patients who are risk of falls and consider preventative measures to be put in place.

A detailed description of each ward and specific staffing, agency and quality indicators are described in the additional information sections. As recommended by the SNCT; data collected must be triangulated with quality indicators and professional judgement before any changes to establishments are agreed.

The SNCT recommendation is to review the required staffing establishment for each ward on a minimum of three separate study periods. This is to ensure robust data and analysis over different data collection periods/times of the year.

As part of the SNCT process, the Director and Deputy Director of Nursing, Midwifery and AHP's, Head of Nursing (HoN) for Planned and Surgical Care and Long Term and Unscheduled Care, Matron and Ward Manager from each ward and the Matron for Workforce Assurance and Compliance met via MS Teams to review the SNCT results, quality data, patient flow information, environmental factors, and apply professional judgement.

The discussions have been found to be useful in identifying support roles that would enhance patient care and improve the working lives of each team. These are specific to each ward and business cases are being worked up for additional ward clerk hours, nutritional assistants and Nursing Associate roles.

Acuity data was provided via the ward managers and all other supportive data was provided by analytics, sitereps, Tendable, finance, NHSP and ESR

All clinical areas recognised the challenges and understood the results. Where there were perceived anomalies, these were discussed and professional judgement applied. This was pertinent to some smaller wards, wards with more than 50% side rooms, those with assessment areas and those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a high observation/critical care environment at HDFT.

Headroom for each ward is calculated at an overall 21% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness

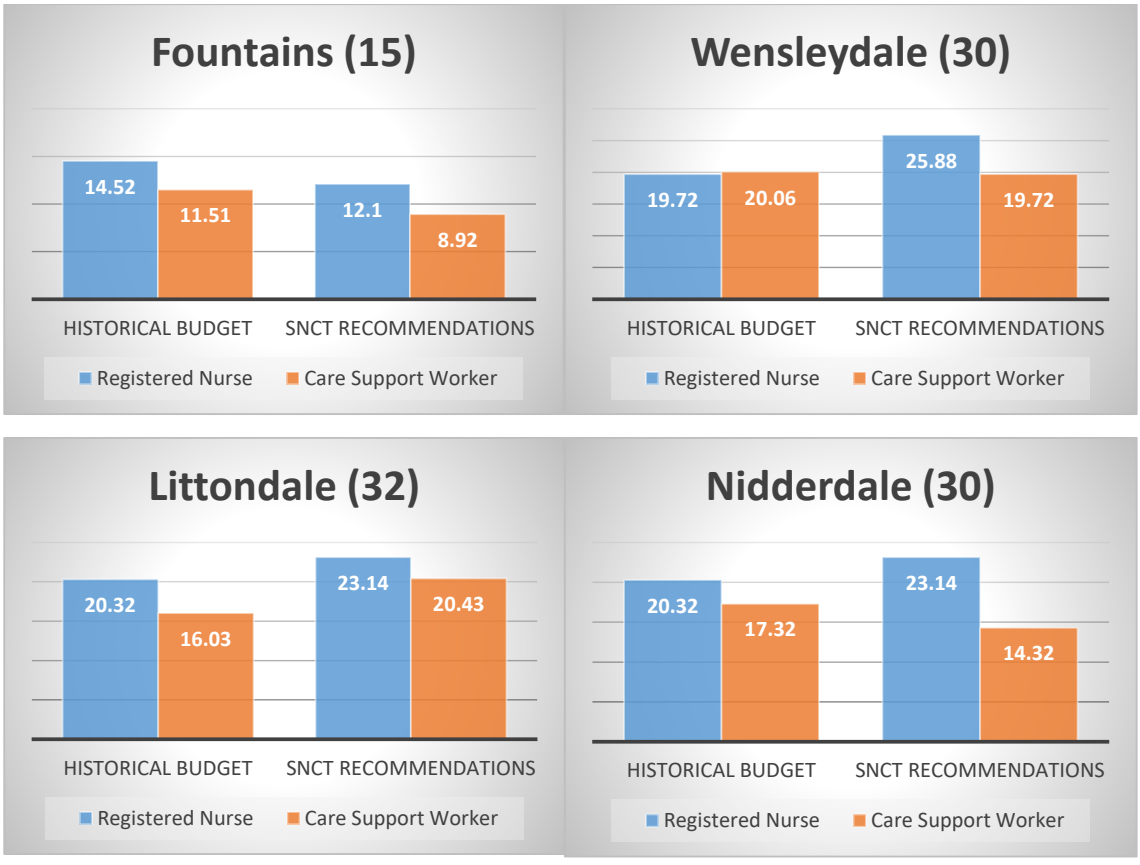
However, the SNCT recommends a minimum of 22% headroom; therefore, the establishment recommendations are calculated at this percentage. During the discussions at the review meetings it was highlighted that the percentage headroom should be reviewed at budget setting.

Results

Proposed Establishments and Staffing Templates PSC

The table charts below show the current budgeted establishments (WTE's) against the proposed staffing establishments following the SNCT review process.

Ward	Historical Budget wte RN's	Historical Budget wte CSW's	SNCT wte Recommendations RN's	SNCT wte Recommendations CSW's
Fountains	14.52	11.51	12.1	8.92
Wensleydale	19.72	20.06	25.88	19.72
Littondale	20.32	16.03	23.14	20.43
Nidderdale	20.32	17.32	23.14	14.32



The SNCT recommended WTE's translate into the staffing templates illustrated below and include 22.5 hours of ward manager, management time.

Nidderdale: Female Surgical & Gastro 30 beds

	Early	Late	Night
RN	5	5	3
CSW Band 2	3	3	2
MD	22.5 hours (0.6 WTE)		

Littondale: Male Surgical & Gastro 32 beds (24 beds & Surgical Assessment Unit)

	Early	Late	Night
RN	5	5	3
CSW Band 2	3	3	2
CSW Band 3	1	1	1
MD	22.5 hours (0.6 WTE)		

Fountains: Elective Surgery 15 beds

	Early	Late	Night
RN	2	2	2
CSW Band 2	2	2	1
MD	22.5 hours (0.6 WTE)		

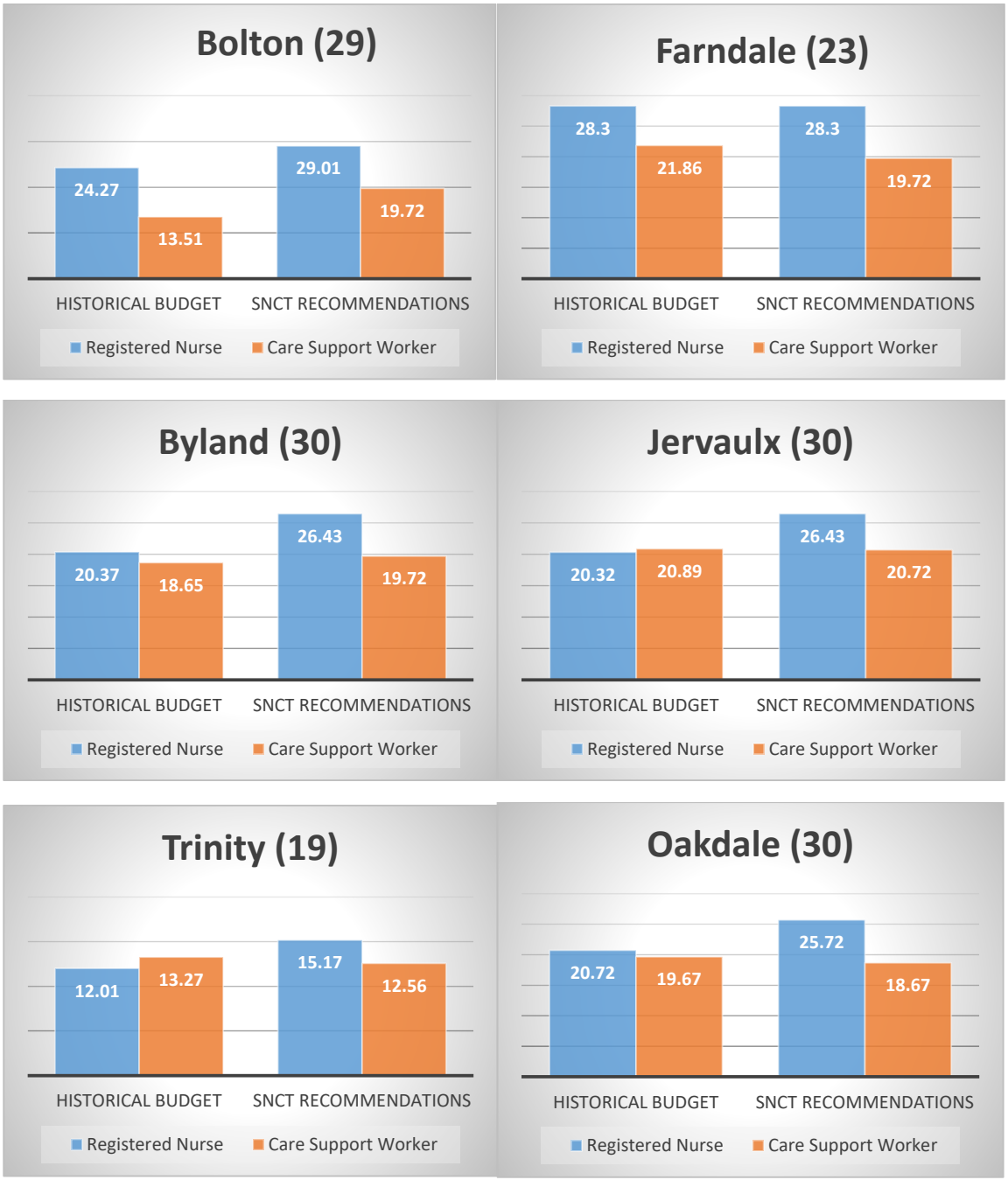
Wensleydale: Non elective 30 beds

	Early	Late	Night
RN	5	5	4
CSW Band 2	4	4	3
MD	22.5 hours (0.6 WTE)		

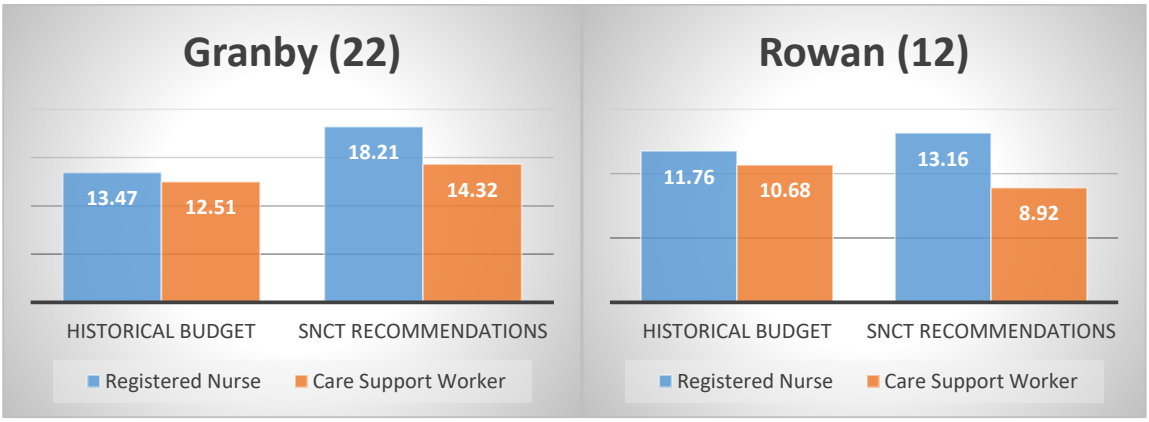
Proposed Establishments and Staffing Templates LTUC

The table charts below show the current budgeted establishments (WTE's) against the proposed staffing establishments following the SNCT review process.

Ward	Historical Budget wte RN's	Historical Budget wte CSW's	SNCT wte Recommendations RN's	SNCT wte Recommendations CSW's
Bolton	24.27	13.51	29.01	19.72
Farndale	28.3	21.86	28.3	19.72
Byland	20.37	18.65	26.43	19.72
Jervaulx	20.32	20.89	26.43	20.72
Trinity	12.01	13.27	15.17	12.56
Acute Frailty Unit	0	0	22.9	14.07
Oakdale	20.72	19.67	25.72	18.67
Granby	13.47	12.51	18.21	14.32
Rowan	11.76	10.68	13.16	8.92


Bolton (29)
24.27
13.51
29.01
19.72
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker
Farndale (23)
28.3
21.86
28.3
19.72
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker
Byland (30)
20.37
18.65
26.43
19.72
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker
Jervaulx (30)
20.32
20.89
26.43
20.72
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker
Trinity (19)
12.01
13.27
15.17
12.56
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker
Oakdale (30)
20.72
19.67
25.72
18.67
HISTORICAL BUDGET
SNCT RECOMMENDATIONS
Registered Nurse
Care Support Worker

NHS
Harrogate and District
NHS Foundation Trust



The SNCT recommended WTE's translate into the staffing templates illustrated below and include 22.5 hours of ward manager, management time.

Farndale: Medical Admissions Unit 23 beds

	Early	Late	Night
RN	5	5	5
CSW	4	4	3
MD	22.5 hours (0.6 WTE)		

Bolton: Respiratory, Cardiology & CCU 29 beds

	Early	Late	Night
RN	5	5	5
CSW	4	3	2
MD	22.5 hours (0.6 WTE)		

Byland: Frailty 30 beds

	Early	Late	Night
RN	5	5	4
CSW	4	4	3
MD	22.5 hours (0.6 WTE)		

Jervaulx: Frailty 30 beds

	Early	Late	Night
RN	5	5	4
CSW	4	4	3
MD	22.5 hours (0.6 WTE)		

Trinity: Rehab 19 beds

	Early	Late	Night
RN	3	3	2
CSW	3	2	2
Additional RN on a Wednesday	1 LD		
MD	22.5 hours (0.6 WTE)		

Acute Frailty Unit: Frailty 20 beds

	Early	Late	Night
RN	4	4	4
CSW	3	3	2
MD	22.5 hours (0.6 WTE)		

Oakdale: General Medical, Oncology, Haematology & Endocrine 30 beds

	Early	Late	Night
RN	5	5	4
CSW	4	3	3
MD	22.5 hours (0.6 WTE)		

Granby: Stroke & Neurology 22 beds

	Early	Late	Night
RN	3	3	3
CSW	3	3	2
MD	22.5 hours (0.6 WTE)		

Rowan: Rehab 12 beds

	Early	Late	Night
RN	3	2	2
CSW	2	2	1
MD	22.5 hours (0.6 WTE)		

Staffing Ratios and CHPPD

The minimum skill mix recommended by the Royal College of Nursing (RCN) is a ratio of **65/35** The SNCT recommends and calculates a **60/40** split for registered nurses/clinical support workers. The **current overall** for HDFT is an average ratio of **54/46** registered nurses/clinical support workers across all inpatient areas.

Skill mix continues to evolve due to the development and introduction of new roles within the Nursing workforce. In many areas where the acuity and dependency of patients has increased and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision. Indeed the SNCT outputs have highlighted that HDFT's current skill mix requires adjustment by increasing the registered nurse establishment.

Focus will continue on reviewing the overall registered to unregistered ratios every six months to ensure that changes in establishments are linked to planned model of care changes. The ratio of registered nurses to care support workers may be lower in some less acute areas such as Rehabilitation, or where other staff are involved in delivering care, for example, Allied Health Professionals contribute significantly towards meeting

patient needs. The outputs of this establishment review will undoubtedly impact on our existing registered nurse vacancies. However, this has been considered and accounted for within our workforce planning. Primarily, the planned international recruitment, which is being supported and part funded by NHS England and our vision to commence CSW to RN apprenticeships.

Work continues, to gather robust information regarding the impact on the workforce in caring for patients who require 1:1 supervision to minimise risk of harm. The anticipated SNCT version 2023 will provide guidance and data capture regarding the staffing of this patient cohort. Observational reports suggest that the general condition of patients has deteriorated as a result of the pandemic, resulting in increasing risk of harm from falls or skin damage. This additional need for 1:1 care can be seen in the demand for bank staff (especially on nights). As the SafeCare functionality of Health Roster is rolled out across the Trust, these requests will be formally captured in real time providing further intelligence on changes in patient dependency and staffing requirements. The acuity of these patients is not currently captured fully by SNCT multipliers and therefore professional judgment is used in terms of recognising the need for 1:1 care or bay cohort nursing.

Trust wide we continue to see an increase in the complexity of patients particularly in relation to mental health need, including dementia and patients remaining in the acute setting for prolonged lengths of time whilst awaiting appropriate placements or arrangements to facilitate discharge.

The overall nurse to patient ratio based on the current Trust establishment is 1 RN for every 7.32 patients during the day and 1 RN for every 8.70 patients at night. These ratios vary between each directorate and are influenced by the ratios of care required on individual wards. To note, this calculation includes the nurse in charge caring for patients.

The ratios below were guided from the SNCT and influenced by quality data and professional judgement. The ratios vary between each directorate and are dependent on the level of care required on individual wards. To note, this calculation includes the nurse in charge caring for patients.

Proposed staffing ratio across LTUC and PSC (following SNCT review) would be;

- 1 RN to **5.96** on a day shift
- 1 RN to **7.48** on a night shift

Proposed staffing ratio for LTUC

- 1 RN to **5.81** on a day shift
- 1 RN to **6.93** on a night shift

Proposed staffing ratio for PSC

- 1 RN to **6.29** on a day shift
- 1 RN to **8.91** on a night shift

The proposed ratios (from SNCT) and Maximum Care Hours per Patient Day (CHPPD) by ward and split by Registered nurse and Care Support Workers, would be as follows:

Ward	Bed Base	RN/CSW ratios	Total max CHPPD	RN max CHPPD	CSW max CHPPD
Wensleydale	30	57/43	**6.6**	3.7	2.9
Nidderdale	30	62/38	**5.4**	3.3	2.1
Littondale	32	54/46	**5.8**	3.1	2.7
Fountains	15	58/42	**6.0**	3.4	2.6
Bolton	29	60/40	**7.4**	4.3	3.1
Byland	30	58/42	**6.6**	3.7	2.9
Acute Frailty Unit	20	62/38	**8.2**	5.0	3.2
Oakdale	30	58/42	**6.4**	3.7	2.7
Farndale	23	59/41	**9.2**	5.4	3.8
Rowan	12	60/40	**7.9**	4.6	3.3
Jervaulx	30	56/44	**6.6**	3.7	2.9
Granby	22	56/44	**6.3**	3.4	2.9
Trinity	19	55/45	**6.2**	3.3	2.9

The average maximum CHPPD for these adult inpatient wards would be **6.8**.

The above calculations are based on 100% bed occupancy and are the optimum CHPPD required to deliver high quality patient care, based on the current acuity and dependency of each wards patients. Each area should continue to undertake a six monthly SNCT based establishment review to maintain staffing requirements in line with any fluctuation in acuity and dependency.

Financials

To support the increase in establishments as outlined in this SNCT report, additional recurrent funding of £656,327 is required.

SNCT Impact		WTE	Budget
RN	Band 7	-1.60	-88,525
	Band 5	-16.66	-591,549
CSW	Band 2	-2.08	-171,454
Nursing Associate	Band 4	5.80	195,200
		-14.54	**-656,327**

It should be noted that some wards opened escalation beds many years ago; however these beds have never been funded in the ward budgets. Therefore, funding would need to be supported for these additional beds, as below. Any further increases in bed base, following this report, would require additional funding (see recommendations).

Additional Beds		WTE	Budget
Respiratory	Mgt	-0.60	-33,197
	RN	-12.26	-482,557
	CSW	-8.92	-244,758
Granby	Mgt	-0.60	-33,197
	RN	-18.21	-716,816
	CSW	-14.32	-392,901
Acute Frailty	Mgt	-0.60	-33,197
	RN	-22.90	-901,684
	CSW	-14.07	-385,885
Oakdale (Stroke)	Net Impact	-2.76	-173,000
		-95.24	-3,397,190

Recommendations

1. To support the uplift in establishment required to adequately staff the wards with their current bed base, acuity and dependency.

2. HoN, Matrons, AHP Leads and Ward Managers to contribute to the business cases being taken forward for;

   - Ward Clerk hours
   - Nutritional Assistant
   - Nursing associate and RN pipeline (development posts)

3. Ensure non clinical management time amongst Band 7 managers is consistent across both directorates; it is recommended that each ward manager gets 22.5 hours (0.6WTE) management time to enable them to undertake their roles, as detailed in the national Ward Leaders Handbook. This time has been incorporated in to the establishment review.

4. To ensure further governance of safer staffing and the daily safe deployment of staff the adult inpatient wards need to have live and accurate rosters (Health Roster). The ‘SafeCare’ module of Health Roster will be rolled out across the inpatients wards in May 2023. This will enable improved oversight of safer staffing across our inpatient wards and assist in the reduction in agency spend.

5. It is recommended that the annual ward budget and annual establishment setting, continue to be modelled from the outputs of the SNCT data collections. These required establishments changes have been through the review meeting process (twice yearly) and match the acuity of the new ward reconfigurations.

6. For the newly established wards, where there is no specific data, the review meeting panel have used comparative data to support the establishment setting process. Continued, bi annual SNCT data gathering should continue to ensure these comparators have been applied correctly.

7. Once the new establishments and skill mix have been agreed for each ward, the max CHPPD will be compared against the actual (calculated and split down in to Care Support Workers and Registered Nurses). This will allow improved board reporting on CHPPD and adequate fill rates.

8. Once new establishments and skill mix have been agreed, staffing templates on health roster will be updated. This will allow the successful implementation of SafeCare.

9. To review the provisions within the 'Headroom' on an annual basis, when budget setting, to reflect the current ward position.

10. To feedback themes to the professional forum, workforce governance, recruitment and retention groups for consideration.

11. To note the content of this report and support the proposal to continue to run the SNCT bi-annually (April and October). It is recommended that future data collections should continue to be undertaken for a full calendar month.

12. Since completing the third SNCT data collection, two wards have increased their bed bases. There is a requirement to understand what our future baseline bed base will be and what our surge capacity/escalation beds are.

- Fountains is currently opened at 28 beds (additional 13 beds form SNCT).
- Bolton is currently opened at 34 beds (additional 5 beds from SNCT).
- Respiratory ward is currently closed (12 beds). No SNCT data collected for this ward.

Emergency Department SNCT

Date: February 2023

Author: Stephanie Davis (Matron)

Department Description

The Emergency Department (ED) is open 24 hours a day delivering unscheduled care for acutely ill/injured adults and children. The department has a range of cubicles spread over two adjoining areas. The department has expanded into an area previously used for fracture clinic to create Emergency Department 2 (ED2). This created much needed space, however the cubicles in ED2 do not have piped oxygen or wall-based suction within them, and are not visible from the main work base in ED. Currently the ED is undergoing building works as part of the reconfiguration of the department. There is a rolling closure programme of cubicles and general workspace due to these works, with reduced services (Oxygen, electrics, water).

There is no dedicated space for patients who are awaiting transfer to a ward and no appropriate area (except an egress corridor) for a cohort of patients awaiting handover from ambulance crews.

The ED is led by a new Triumvirate leadership structure, which was launched in December 2022. The Triumvirate team consists of an ED Consultant Clinical Lead, Service Manager and Matron, and is clinically supported by 2 WTE Band 7 Lead Nurses. There is a cohort of Band 6 Sister / Charge Nurses, who will lead each shift as Nurse in Charge. Additionally, there are Band 6 Emergency Nurse Practitioners (ENP's) who are autonomous practitioners assessing, diagnosing, treating and discharging patients with minor injuries. The team of ENPs has recently expanded to include a cohort of trainee practitioners. Once trained, these Urgent Care Practitioners (UCP) will be able to manage patients with minor injuries/illness.

The management time allocation for the Band 7 lead nurse has increased from 15 hours / week to 37.5 hours / week and will be split across two WTE Band 7 nurses who will work clinically for their remaining hours. There is no formal allocation of management time or allocated CPD time allocated within the budget for Band 6 roles. The department has a budget for a Band 6 Practice Educator for 22.5 hours per week.

The Nurse In Charge (NIC) of each shift allocates staff to patient care areas (department plan in Appendix 1) on a shift basis:

- Streaming (previously Triage)
- Resuscitation room (2 enclosed cubicles and 1 curtained cubicle),
- Cubicle areas 1-4 (4 cubicles),
- B-9 (6 cubicles),
- 10-15 (6 cubicles),
- ED2 (currently up to 7 cubicle spaces) and
- “Fit to Sit” patient area (up to 8 spaces)
- Rapid Initial Assessment Treatment team with 4 curtained areas (RIAT).

The NIC will consider staff experience, skill and competence when allocating staff to work areas, and will re-allocate during the day as required, considering skill mix, workload, clinical priorities and patient dependency. The NIC is responsible for overseeing the team of Registered Nurses (RN’s) and Care Support Workers (CSW’s) band 2/3, ED reception clerks, patient flow in and out of the department (supported by a non-clinical patient flow coordinator 1500-0100 and ED senior doctor: EPIC), and having an overview of patient acuity within the department. The NIC works closely with the EPIC and can escalate any concerns regarding prioritisation of patients to be seen. The ENP’s/UCP’s are based in ED2 and when 2 are available per shift (10:00-22:00) patients with minor injuries are streamed directly to ED2 for them to see. There is a wider plan to increase the allocation of UCP’s/ENP’s to 3 per shift from February 2023. This is to improve the flow of minor injuries and illness.

Background

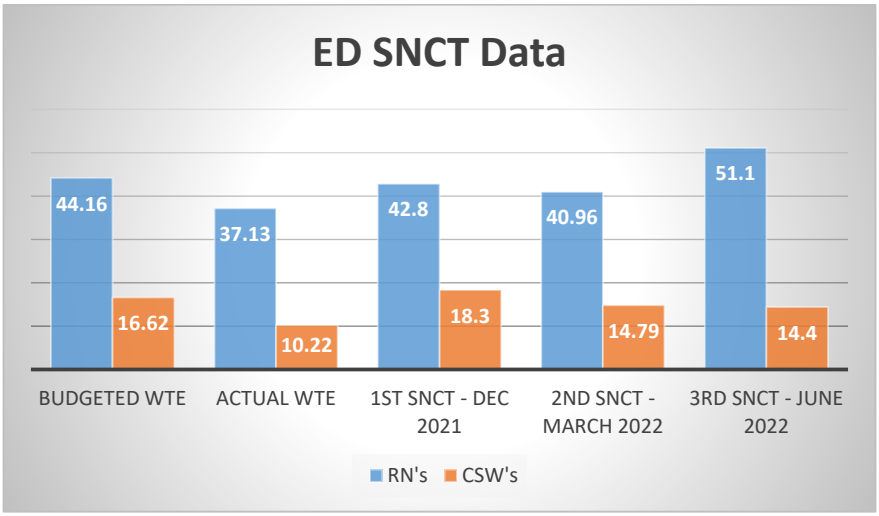
The ED has faced significant challenges throughout the past 24 months during the COVID-19 pandemic. During this time the workforce has adapted considerably to enable delivery of safe and effective care. Following initial phases of the pandemic, patient attendance figures have returned to near pre-COVID levels, however ED performance against the 4-hour standard has not recovered. There is a high proportions of patients over 70 years old attending the department compared to the national position (GIRFT

data). The department has also experienced regular 12 hour trolley breaches due to high bed occupancy in the trust. These delays have resulted in ED having long stay patients and bedding down patients overnight, which means the ED team need to conduct medicine rounds, meals service, washing patients and specialist consultant ward rounds.

Key changes to have taken place during past 24 months include:

- Increase in department size to incorporate ED2 area (previously fracture clinic). The layout of department hinders visibility and a higher number of nursing staff is required to oversee the whole area.
- Streaming of patients with minor injury to ENPs.
- Development of additional ENP/ UCP's to support a full 24/7 streaming service, and development of those roles so that practitioners have training and competency to see patients with minor illness (in progress).
- Segregation of resuscitation room spaces to form 2 enclosed cubicles with increased ventilation to enable safe environment for Aerosol Generated Procedures. There are three beds within resuscitation room, but each patient potentially requires an RN due to lack of visibility and appropriate support for level 2 and level 3 patients.
- Doors added to the area with cubicles 1 to 4 to enable a closed area for patients with respiratory illness or probable COVID/Flu.
- Long stay patients and bed waits within the ED requiring additional staff and resource.
- Reduced flow out of ED is having an impact on the flow of patients coming in to ED (ambulance off-loads and waiting room patients) as patients can deteriorate while waiting to be seen.
- The current building works impact on working lives as well as patient experience (noise, dust, space).
- Streaming of all patients arriving in ED to most appropriate location and service (commenced 3/1/23).
- Shift time change to allow for MDT safety huddle and handover. (pilot for 3 months from 3/1/23).

Establishment and SNCT results:



The table below is the current staffing template for ED from the 3rd Jan 2023.

The 3rd SNCT results indicate an increased RN staffing requirement. This could be due to a number of factors ranging from increased attendances to reduced flow out of the department. Due to the long waiting times patients are waiting long period to be seen, and long waits for beds, both leading to deterioration of condition.

ED are also taking ambulance diverts from hospitals in Yorkshire and Humber region. This is obviously increasing HDFT attendances that would otherwise be seen elsewhere.

Current shift pattern (commenced 3rd January 2023)

	Day					**Night**			
from 07.00am (staggered starts)	from 07:00am(staggered start)	From 1130 am	From 11:30	0900-2200		19.00 (staggered Start)	From 19.00	1800-0200	1800-0200
RN	CSW	RN	CSW	ENP / UCP		RN	CSW	RN	CSW
7	4	8	4	3		6	2	1	1

This shift pattern is covered by the current staffing budget, which includes non-recurrent Covid funding. This funding is due to end after March 2023 at which point the funded establishment will decrease by 1 RN per shift and 1 CSW per shift. This shift pattern does not include additional staff numbers for bedding down.
In order to deliver a responsive and flexible service that covers the areas outlined below we would require a further increase in establishment, above the current position.

Admission Avoidance

Implementation of “Streaming” model 24 hours a day, led by a senior RN or ENP/UCP. Streaming consists of a <5 minute assessment/review to determine the most appropriate pathway for each patient. Observations are only undertaken at this point if clinically indicated to inform priority category and investigations are requested at this stage.

Ambulance arrivals

Implementation of RIAT model (Rapid initial assessment and treatment) led by Clinician, supported by RN and CSW, assessment, instigation of initial investigations and treatment.

Cubicles and Fit to Sit Area

Patients allocated to cubicles for ongoing assessment and treatment.
Fit to sit area enables the decanting of patients from cubicles to an area where they can safely wait for investigations, results and review.

Resuscitation Rooms

The resuscitation room cubicles/ space are segregated for isolation purposes; each then usually requires one nurse per patient when in use. The resuscitation room is located in a low visibility area some distance from the main department work area.

ED2/ Minor Injury / Illness

Patients with minor injury/illness are “Streamed” to ED2 to see an ENP/UCP. Additionally patients waiting for beds are managed in this area but this requires staff allocation to support.

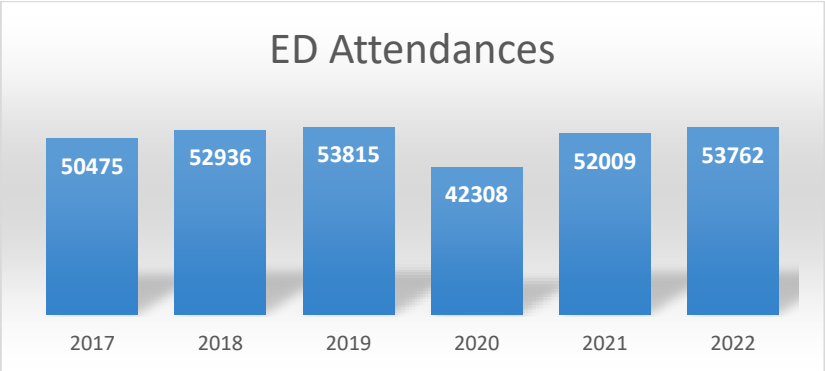
Nursing Workforce

Within the current workforce model it is difficult to maintain the ED CPD plan without risk of cancellation. There is a need to improve mandatory training compliance, allow time for service/quality improvement, allow rostered management time to Band 6 Sister / Charge Nurses to support role development and succession planning and enable dedicated management time for Paediatric lead.

Additionally nurse/ CSW’s are out of the department regularly transferring patients from the department to radiology and wards, all CT transfers out of hours now require a member of the nursing team to escort.

There is great reliance on agency nurses to cover vacancy and sickness gaps and to fill the additional shifts required to care for ‘bedded down’ patients who are spending a long time in the department.

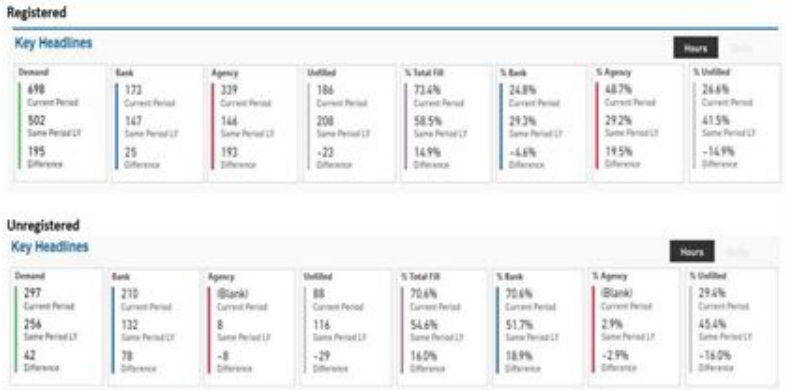
ED attendances year on year



Agency use

Agency use has increased during the same period last year. This correlates with the vacancy gap, short and long term sickness in addition to providing additional care for long stay patients. Additional shifts are put out to increase the RN and CSW numbers

by one per day shift and 2 additional RN's per night shift to support long stay patients in the department. These shifts are inconsistently filled.



Summary

In summary, three episodes of data collection have taken place. All data sets show a requirement to increase the budgeted establishment of RN/CSW's. The third set of data shows the greatest requirement change which is predominantly felt to be due to the increase in patient's length of stay in the department and the requirement for their ongoing care.

The level of agency ratio to substantive is high in part due to inability to recruit and retain experienced nurses into substantive posts, short and long-term sickness cover and also due to their use to cover additional shifts to support care of long stay patients.

Issues impacting on the workload for staff additionally to patient acuity and dependency are:

- The layout of the department and ongoing building works impact on staff requirement due to the large footprint.
- Design of resus area and requirement of 1:1 nurse patient ratio for majority of patients
- Infection / Deep clean waits and high levels of respiratory infections
- Acuity/dependency of patients
- Public expectation
- No Urgent Treatment Centre provision within the Harrogate/Wetherby area
- Datix themes (staffing / workload)

- Level of nursing staff
- Waiting room patients - area of greatest risk
- Ambulance patients – delay to offload and handover
- Storage of decontamination and Major Incident and decontamination equipment in the storage area is cramped leaving other equipment potentially without a safe storage area.

Financials

The table below shows the difference in WTE and difference in budget for each band required, to increase the nursing establishment and deliver the 'new model' of care with a flattened shift pattern and a nurse covering each area. The uplift includes increasing the 'headroom' to 27% in line with national recommendations.

This model of nursing care would require an additional 23.11 RN's and 7.94 CSW's are required at a total additional cost of **£1,301,514**

However the recently increased ENP/UCP establishment consists of 3.47 WTE band 6 (£182,130) and 6.39 WTE band 7 (£394,902). Total ENP / UCP establishment is 9.86 WTE at a cost of £577,032. Therefore reducing the registered nurse WTE to 13.25. These practitioners would support streaming and reduce the number of patients in the main department and so could be considered as a possibility to offset this additional cost.

	WTE Budget			GBP Budget		
Grade	**Dec.22**	**New Model**	**Difference**	**Dec.22**	**New Model**	**Difference**
RNs						
B7	1.00	2.00	- 1.00	68,000	123,600	- 55,600
B6	9.15	12.11	- 2.96	526,200	635,615	- 109,415
B5	23.98	43.13	- 19.15	1,099,800	1,923,598	- 823,798
RN Total	**34.13**	**57.24**	**- 23.11**	**1,694,000**	**2,682,813**	**- 988,813**
CSWs						
B3	0.80	7.48	- 6.68	17,300	275,366	- 258,066
B2	13.71	14.97	- 1.26	451,200	505,835	- 54,635
CSW Total	**14.51**	**22.45**	**- 7.94**	**468,500**	**781,201**	**- 312,701**
Grand Total	**48.64**	**79.69**	**- 31.05**	**2,162,500**	**3,464,014**	**- 1,301,514**

Band 7	2.0
Band 6	9.15
Band 5	23.98
ENP / UCP Band 6	3.47
ENP / UCP Band 7	6.39
Total	**44.99**

ED currently is budgeted for 35.13 WTE RN's, 14.51 CSW's and 9.86 ENP/UCP's. Additional to this was, 4.79 CSW temporary uplift which was supported with non-recurrent funding streams giving a total of 19.2 wte CSW's.

Options

The third SNCT suggested that we require **51.1 WTE** registered nurses and **14.4 WTE** care support workers. Since the latest SNCT data collection there has been an ongoing reconfiguration of the department and new ways of working have been implemented. It is unclear exactly what staffing levels will be required once the reconfiguration is complete, and further SNCT data collections are required to confirm the recommended establishment required.

Option 1: Fund the current establishment whilst working to the 'new ways of working with the Streaming model' and 'Rapid assessment of ambulance patients (RIAT) and Minor Injury/Illness model'. In addition to undertaking a further three SNCT data collections to inform if there is a staffing gap. This option would require the continued support of bank and agency staff and will be funded by additional monies within LTUC for 6 months until the further data collections are complete.

Option 2: Implement the increase in establishment recommended by the third set of SNCT data. With a decision to be made about the uplift required and a plan to repeat the SNCT data collection from March 2023 (alternate months).

This would require an increase of RN establishment to 51.1 WTE, an increase of **6.11 WTE** from the current funded RN establishment inclusive of ENP/UCP's. We would recommend recruiting to these vacancies in a phased approach, in line with our predicted recruitment pipelines, therefore negating the need to use additional agency. This would take place alongside ongoing SNCT data collections bi monthly.

Option 3: Implement staffing based on the modelling below; the 'new ways of working in the department' (see Table 1). This would require **57.24 WTE** registered nurses and **22.45 WTE** care support workers, a further increase above SNCT recommendations. To note, this includes the 6% uplift in headroom as discussed earlier in this paper (total of 27%).

RN Workorce Pattern - 9x RN 24 hours/day

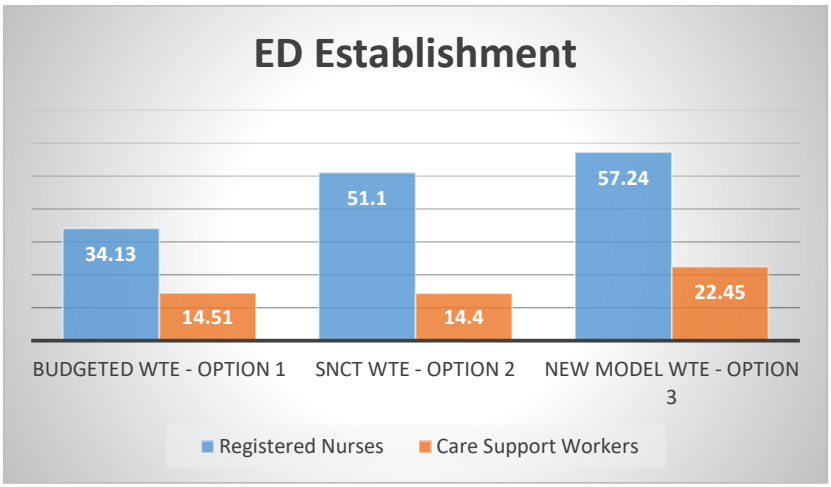
		Time	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	23	1	2	3	4	5	6	Shift	Hours	
	ZONE	Band																											
	Clincal Leadership	7																										8	
	Office																											8	
DAY TEAM	NIC	6																									07:00 - 19:30	11.75	
	STREAMER																										07:00 - 19:00	10.25	
	Majors RIAT	5																									07:00 - 19:30	11.75	
	Cubicles 1-4																										07:00 - 19:30	11.75	
	Cubicles B-9																										07:00 - 19:30	11.75	9x
	Cubicles 10-15																										07:00 - 19:30	11.75	
	Resus																										07:00 - 19:30	11.75	
	Resus																										07:00 - 19:30	11.75	
	FLOAT																										07:00 - 19:30	11.75	

3 x ENP / UCPs running Minors stream 9am – 10pm

NIGHT TEAM	NIC	6																									19:00 - 07:30	11.75	
	STREAMER																										19:00 - 07:00	10.25	
	Majors RIAT	5																									19:00 - 07:30	11.75	
	Cubicles 1-4																										19:00 - 07:30	11.75	
	Cubicles B-9																										19:00 - 07:30	11.75	9x
	Cubicles 10-15																										19:00 - 07:30	11.75	
	Resus																										19:00 - 07:30	11.75	
	Resus																										19:00 - 07:30	11.75	
	FLOAT																										19:00 - 07:30	11.75	

Table 1

The graph below summarises the establishment changes for each option



Recommendations

1. To review ED requirements and agree which option is preferred including source of funding.
2. Repeat ED SNCT data collection alternate months, commencing in March 2023. Train all Band 6's in SNCT data collection, ensure staffing support adequate to be able to collect live data and not to score retrospectively. Embed practice in scoring using SNCT.
3. Consider uplift in headroom from 21% to 27% to align with national recommendation due to complexity of training requirements within the ED.
4. Propose management time of 15 hours per month for Paediatric lead and 7.5 hours per month for other band 6 leaders and CPD time for ENP/UCP's (propose 7.5 hours per month).
5. Review flow coordinator working hours to support patient flow and release of nursing time, review roles and responsibilities.
6. Develop career pathways within department including support roles opportunities (nursery nurse, AHP's, nutritional assistant, apprenticeships) to improve retention

Additional Ward Information and Data Packs

The ward data packs listed below contain the quality data, agency spend, fills rates, flow data, enhanced care data, ward layout plans, vacancy data, skill mix, support roles, CHPPD and previous SNCT data. These assisted the triangulation and guided the professional judgement piece in agreeing the optimum staffing templates, skill mix and wte establishments to meet the acuity and dependency of each specialities patient group. In addition they have informed business cases currently in progress, which demonstrate the requirement for additional support roles.

Farndale: Medical Admissions Unit (23 beds)

Farndale ward is 23 bedded medical admissions and COVID ward. There are two three bedded bays with en-suite facilities and 17 en-suite single rooms.

The ward is “L” shaped leading off the short entry corridor is the staff room and storeroom. There are three staff bases spread across the ward. Behind the central staff base is a fire exit corridor where the ward kitchen is located. Opposite the central staff base are the two three bedded bays which provide limited visibility. The remaining single rooms have very limited or zero visibility from any staff base. Storerooms, linen cupboard and ward managers office are located along the main corridor of the ward.

The ward is led by a dedicated Ward Manager (0.78wte) and experienced Matron, there are a mixture of experienced and junior Band 6 Ward Sisters. The ward manager has a budgetary allocation of two 9.5 hour management days per week, however this is often not the case and the ward manager can be pulled to provide direct patient care.

The patients that are admitted to the ward are usually acutely unwell and require enhanced nursing intervention in the first instance until the patient is stabilised. This includes 4 monitored telemetry beds, in theory monitored by the nurse in charge. Throughout the pandemic there are patients who require Non-Invasive Ventilation (NIV) and as well as the nursing intervention that is required with this there are also the additional requirement of donning and doffing of PPE. There are also additional requirements for the monitoring and observations of these patients. As mentioned, the ward is primarily single rooms, which creates challenges with the visibility of these patients.

Patient care is allocated:

Ideally the patients are split into four teams however when there are only four RNs on duty they are split into three to allow a Nurse in Charge.

Team 1 consists of single room 1,2,3,4,5,6,23

Team 2 consists of Bay 1 (3 BEDS) Bay 2 (3 BEDS) and single rooms 13 &14

Team 3 consists of single rooms 15,16,17,18,19,20,21,22

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team. It should be noted that although the establishment requires 5 RN's, due to staffing challenges there are 4 RN's on the early and late shifts. Therefore, the Nurse in Charge (NIC) takes an allocation of patients in addition to co-ordinating this busy admissions unit.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	72%	70%	85%	92%

The **budgeted** establishment is for 23 beds is 28.3wte RNs and 21.86wte CSW

Contracted for the time of data collection was 23.38wte RN and 14.35wte CSW

Vacancies: 4.92wte RN's and 7.51wte CSW's

Current staffing template:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
5	4	5	4	5	3

The bed occupancy was **97.8%** during the time of the study

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Farndale	905	£34,377	487	£21,425	2327	38.9%	20.9%	40.2%

CHPPD

Max CHPPD 11.9

1st SNCT	**12**
2nd SNCT	**9.1**
3rd SNCT	**9.2**

Turnover %		Sickness %	
RN	CSW	RN	CSW
4.21%	0%	2.43%	5.29%

Quality indicators

Falls	9
Hospital acquired pressure ulcers	3
Medication incidents	7
Staffing Datix	4
Formal Complaints	0

Enhanced care: There were a total of **35** enhanced cares. This averages at **1.2** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	414	13.35
Discharges	107	3.45
Transfers In	17	0.54
Transfers Out	243	7.83
Deaths	13	0.41

Admin Support:

	Establishment	**Contracted**
Band 2	2.07 wte	2.00 wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.00 wte	5.58 wte (B5 budget)

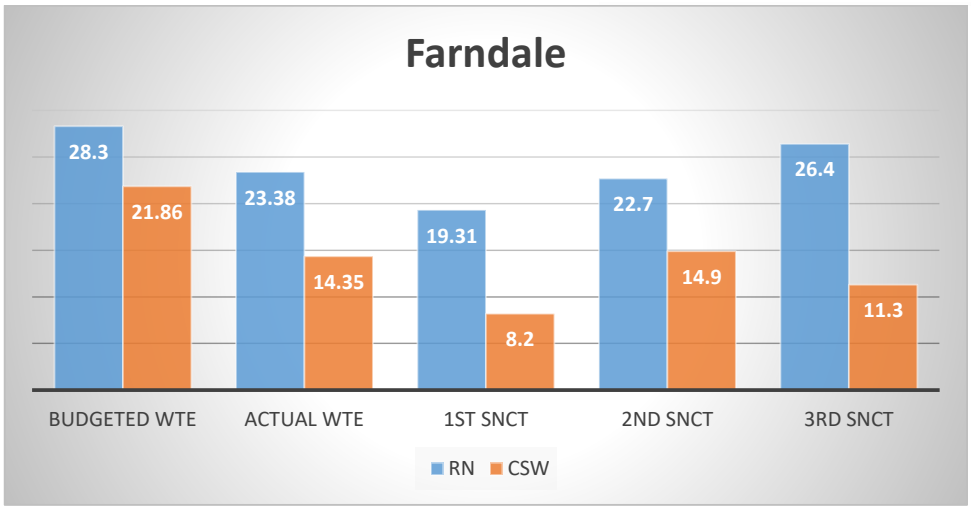
Nutritional Assistant:

	Establishment	**Contracted**
Band	1.00 wte	0.00 wte (post out)

SNCT for acute admission units and based on a 70:30 ratio
The bed occupancy in October was 97.8%

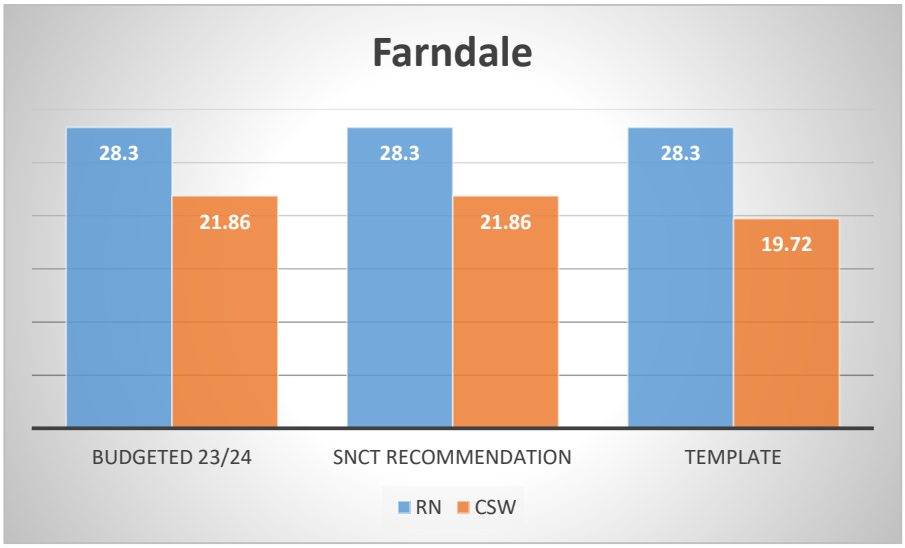
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st, 2nd and 3rd SNCT are based on 23 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Farndale (23 bedded Medical Assessment ward).

Management time will need to be added to the RN WTE, within the SNCT recommendation.



Due to being an acute medical admissions ward and to maintain flow, it is not recommended that this staffing template is changed.

Agreed SNCT recommendation with professional judgement:

- RN 28.3
- CSW 21.86

Proposed Staffing Template (including management time)

- RN 28.3

- CSW 19.72

	Early	Late	Night
RN	5	5	5
CSW	4	4	3
MD	22.5 hours (0.6 WTE)		

Additional requirements:

The blurring of roles and the increased dependency on nursing staff to contribute to:

- Cleaning
- Portering
- Hostess duties
- Advanced clinical skills, that were once deemed a doctors role (cannulation, catheterisation, phlebotomy, ECG's etc)

Considerations:

- Admissions unit
- 17 single side rooms
- NIV recommended nurse patient ratio is 1:2 (British Thoracic Society, 2022).
- Reduced fill rates linked to reduced flow through ED and poor patient outcomes.
- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- Associate nurses are not a replacement 'like for like' for registered nurses. They are being used to mitigate the registered nursing gaps, supplementing the registered workforce.
- Telemetry (monitored bay); ideally should have a registered nurse monitoring these (usually the NIC).
- The registered nurse/care support worker staffing ratio for this admissions ward is 70/30. The CSW WTE includes band 2-4 and therefore the associate nursing establishment for Farndale.
- Farndale has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.
- Although the SCNT indicates a reduction in RN and CSW establishment for Farndale, it doesn't reflect the triangulated professional judgement required to care for the patients within this environment (see above considerations).

Recommendations:

- The new staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient flow through the admissions unit (business cases in progress).
- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To calculate the 'planned' CHPPD for Farndale, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (business cases in progress).

Bolton: Respiratory, Cardiology & CCU (29 beds)

Bolton ward is a Medical Short Stay and Coronary Care Unit with 28 beds funded beds. At the time of data collection 6 escalation beds were opened, using bays from the neighbouring ward (Maternity), increasing the bed base to 34. There are four bays of 6 (Bay1, 2, 4 and escalation), CCU is a 4 bedded bay and a single room and there are 6 further single rooms.

The layout and footprint of the ward is large and long and is an "L" shaped ward. Along the entry corridor is the day room, ward office, linen room, staff room, Doctors office, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area. The kitchen is just to the side of the apex opposite bay 1.

The staff base is at the apex of the "L" and the dirty utility is immediately adjacent. There is some visibility of bay 1 and bay 2 and limited visibility of one single room from the staff base but the remaining bays and side rooms have no visibility.

None of the bays have patient bathroom facilities; shared facilities are located opposite each bay. Two of the side rooms have en-suite. The escalation bay has a toilet.

The CCU is in bay 3 where an RN is designated to work. That nurse also cares for the patient in the CCU single room, which is across the corridor from CCU and also monitors up to four more patients on telemetry (maximum 9 patients on cardiac monitoring). A maximum of 8 patients should be monitored by 1 nurse.

The ward also takes patients who require NIV, and therefore there is an increase in time spent providing intense care and the time spent donning and doffing of PPE.

The ward has significant turnover of patients; in the study period there were (see admissions, discharges, transfers in and out below), however patient's numbers have varied due to COVID cases and subsequent isolation.

There is also often a requirement for an RN to escort a patient to neighbouring hospital for cardiac and other care; this often means the RN is out for the entire day.

The RN NIC working on the ward is required to support the CCU nurse with double checking medication, break relief and infusion preparations.

High Numbers of discharge planning and coordination also needs to be done by the Nurse in charge.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

Patient care is allocated by:

Bay 1 and escalation bay (12 beds) – 1 RN

Bay 2 and single rooms 1, 2, 3, 5 & 6 (11 beds) – 1 RN

Bay 3 (CCU) and single room 4 (5 beds) – 1 RN

Bay 4 and single room 7 (7 beds) – 1 RN

On the Early shift there is a nurse in charge (NIC) to direct flow, plan and complete discharges and support CCU, however when staffing gaps occur the NIC will have a bay allocated to them.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Coronary care staffing ratios across the country have varied throughout the pandemic with organisations having to effectively deploy staff with specialist skills and knowledge to meet the rising numbers of CCU patients whilst meeting infection prevention and control guidelines and maintaining patient safety, within a pandemic situation. Additionally, guidance for Non-invasive Ventilation (NIV) staffing ratios are dependent on the environment, skills set of the nurse and how long the patient has been on NIV. A report by the British Thoracic Society (2022) 'A respiratory workforce for the future' highlights multifactorial challenges within this speciality and although a ratio of 1:2 would be preferred; mitigation of risk can be addressed when staffing challenges are met. For example, introducing CSW support and cohorting patients within the same bay.

Over the data collection period the fill rates were (based on 34 beds):

Data collection period	Day		Night	
	RN	CSW	RN	CSW
October 2022	92%	86%	95%	105%

The **budgeted** establishment is for 34 beds is 24.27wte RNs and 13.51wte CSW

Contracted for the time of data collection was 19.20wte RN and 10.86wte CSW

Vacancies at the time of data collection were: 5.07wte RN and 2.65wte CSW

The current staffing template on Bolton, including CCU staffing is as follows:

Day				Night	
Early		Late			
RN	CSW	RN	CSW	RN	CSW
5	3	4	4	4	1 + twilight

The bed occupancy was 98.3% during the time of the study based on 34 beds.

Bank and Agency usage:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Bolton	1605	£60,897	598	£24,236	2812	57.1%	21.3%	21.6%

CHPPD

Max CHPPD on the current staffing template is 7.5

1st SNCT	**7.5**
2nd SNCT	**5.8**
3rd SNCT	**7.0**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	5.81%	2.51%	10.70%

Quality indicators:

Falls	7

Hospital acquired pressure ulcers	7
Medication incidents	7
Staffing Datix	6
Formal Complaints/SI's	Fall x 1 (SI)

Enhanced care: There were a total of **54** enhanced cares. This averages at **1.8** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	84	2.70
Discharges	119	3.83
Transfers In	135	4.35
Transfers Out	94	3.03
Deaths	6	0.19

Admin Support:

	Establishment	**Contracted**
Band 2	2.07 wte	2.99 wte

Nurse Associates:

	Establishment	**Contracted**
Band 4	0.00 wte	0.00 wte

Nutritional Assistant:

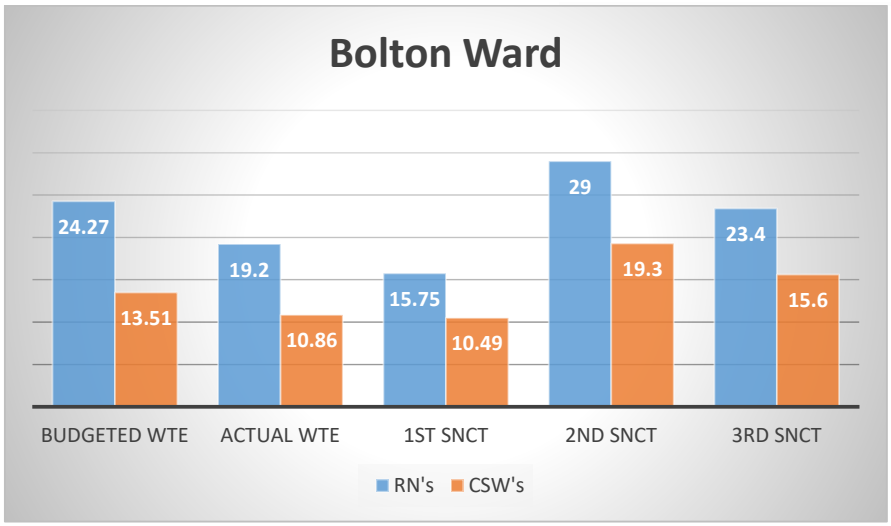
	Establishment	**Contracted**
Band	1.00 wte	0.00 wte

This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

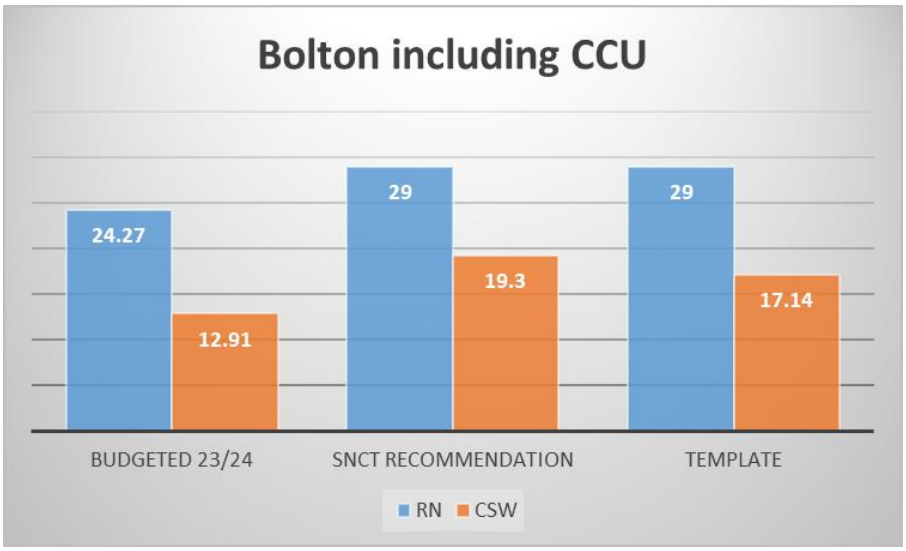
The 1st SNCT data not comparable due to ward moves.

The 2nd and 3rd SNCT are based on 38 beds

Max CHPPD on current staffing template: 7.5 (inc CCU)



The table below indicates the 2023/2024 budget against the SNCT recommendations for Bolton (34 bedded Respiratory, Cardiology and CCU ward). Management time will need to be added to the RN WTE.



Respiratory, Cardiology & CCU (29 beds). Take direct admissions in to the late evening/night. **The template below does not include and escalation beds.**

Agreed SNCT recommendation with professional judgement applied:

- RN 29.0
- CSW 19.3

Proposed Staffing Template (inc management time)

- RN 29
- CSW 17.14

	Early	Late	Night
RN	**5**	**5**	**5**
CSW	**4**	**3**	**2**
MD	**22.5 hours (0.6 WTE)**		

Additional requirements:

The blurring of roles and the increased dependency on nursing staff to contribute to:

- Cleaning
- Portering
- Hostess duties
- Advanced clinical skills, that were once deemed a doctors role (cannulation, catheterisation, phlebotomy, ECG's etc)
- Admin tasks, normally attributed to the ward clerk role, to be undertaken at weekends.
- Bolton take direct admissions (increased registered nurse requirements)

Considerations:

- Escalation beds with no establishment and reliance on agency.
- CCU bay; specialist skills
- NIV recommended nurse patient ratio is 1:2 (British Thoracic Society, 2022).
- High patient to staff ratios becoming the 'norm'; linked to poor patient outcomes.
- Enhanced care patients.
- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this
- RNs can sometimes be required to escort the patients to scans, X-rays and appointments.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.
- Bolton has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.

Recommendations:

- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes.

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (business cases in progress).
- To calculate the 'planned' CHPPD for Bolton, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.
- Increase ward clerk hours to cover 8-8, 7 days a week.

Byland: Frailty (30 beds)

Byland ward is a 30 bedded elderly care ward that can increase to 31 with one escalation bed. There are four bays of six and six single rooms, three of which are en-suite.

The ward is an "L" shaped ward. Along the entry corridor is the ward office, kitchen, linen room, staff room, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area.

The staff base is at the apex of the "L" and the dirty utility is immediately adjacent to the staffroom. There is some visibility of bay 1 and 2 and side rooms 2 and 3 are visible to the nurses' station. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.

The ward is led by Ward Manager who has one years' experience and an experienced Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

Due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward requests a daily CSW to support with the enhanced care needs of patients. Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this. Additionally, the ward RNs are often required to escort the patients to scans, X-rays and appointments.

Patient care is allocated by:

Team 1- bay 1 (6 patients and single-rooms 1,2,3) = 9 patients + Masons Suite = 10 Patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay due to support with the enhanced care needs of patients

Team 2- bay 2 (6 patients and single-rooms 4,5,6) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay to support with enhanced care needs

Team 3- bay 3 and 4= 12 patients

1 RN and 1 CSW allocated to this team

The 4th CSW is allocated the 6 single-rooms and support team 3
The 4th RN on duty who acts as the coordinator will also help support nurse in team 3 with 12 patients.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Byland ward have recently implemented Omnicell which is a new pharmacy system, this has had an impact on workflow as the staff are adapting to a new way of administering medications.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	81%	86%	100%	133%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	3	3

At the time of the study the ward had 30 beds opened and the bed occupancy was 100% as a result of using the one escalation bed.

The **budgeted** establishment is 20.37wte RNs and 18.65wte CSW

Contracted for the time of data collection was 15.06wte RN and 17.82wte CSW

Vacancies of 5.31wte RN and 0.83wte CSW at the time of data collection.

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Byland	1085	£38,031	612	£20,532	2234	48.6%	27.4%	24.1%

CHPPD

Max CHPPD 5.9

1st SNCT	**No data collected**
2nd SNCT	**5.3**
3rd SNCT	**6.0**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	5.85%	4.99%	1.38%

Enhanced care: There were a total of **268** enhanced cares. This averages at **8.7** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	4	0.12
Discharges	38	1.22
Transfers In	64	2.06
Transfers Out	16	0.51
Deaths	12	0.38

Admin Support:

	Establishment	**Contracted**
Band 2	1.0	37.5 hrs/week (1.0)

Nurse Associates:

	Establishment	**Contracted**
Band 4	0	0

Nutritional Assistant:

	Establishment	**Contracted**
Band	1.0	22.30 hrs/week (0.6)

Harrogate and District NHS Foundation Trust

3.7

Quality indicators

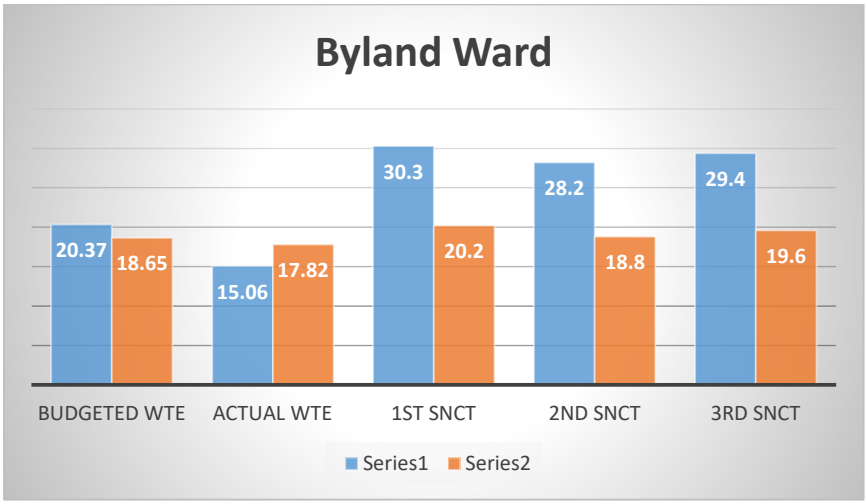
Falls	6
Hospital acquired pressure ulcers	7
Medication incidents	1
Staffing Datix	1
Formal Complaints	Fall (SI) x1

As a summary of the SNCT study period

Bed occupancy was 100% based on 30 beds.

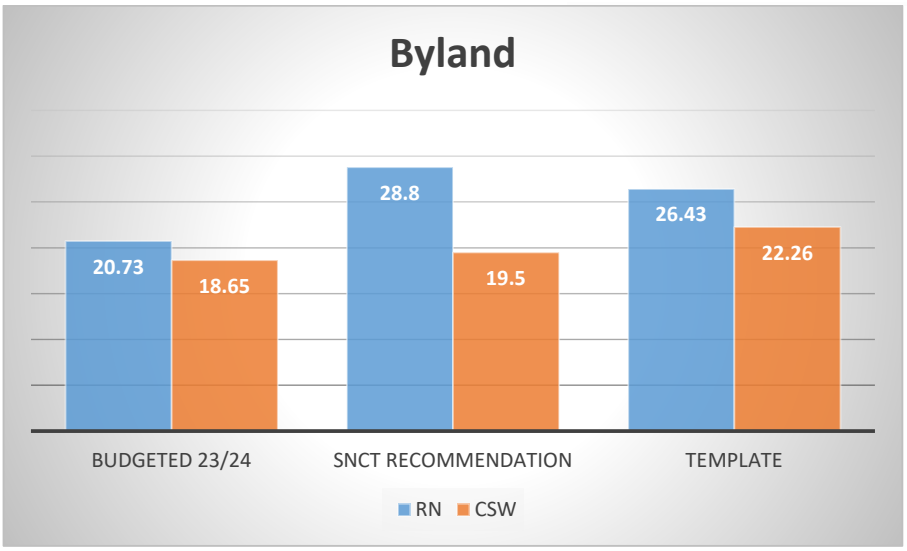
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st, 2nd & 3rd SNCT was based on 30 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Byland (30 bedded Frailty ward).

Management time will need to be added to the RN WTE, within the SNCT recommendation. Within the CSW budget are 2.60wte for trainee RNA's (band 3).



30 beds (Frailty)

Agreed SNCT recommendation with professional judgement:

- RN 28.8
- CSW 19.5

Proposed Staffing Template (including management time)

- RN 26.43
- CSW 22.26

	Early	Late	Night
RN	5	5	4
CSW	4	4	3
MD	22.5 hours (0.6 WTE)		

Additional requirements:

The blurring of roles and the increased dependency on nursing staff to contribute to:

- Cleaning
- Portering
- Hostess duties
- Advanced clinical skills, that were once deemed a doctors role (cannulation, catheterisation, phlebotomy, ECG's etc)

Considerations:

- Average of 8.7 Enhanced Care Patients each day.
- Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this.

- RNs can sometimes be required to escort the patients to scans, X-rays and appointments. High patient to staff ratios becoming the 'norm'; linked to poor patient outcomes.
- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.
- Byland has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.
- 2nd SNCT was the first data collection for this ward.

Recommendations:

- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes. (Business cases in progress).
- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- Increase Nutritional Assistant cover, to support the full 7 days.
- Increase Ward Clerk hours to cover the evenings and weekends.
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To calculate the 'planned' CHPPD for Byland, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (business cases in progress).

Jervaulx: Frailty (30 beds)

Jervaulx ward is a 30 bedded elderly care ward. There are four bays of six and six single rooms, three of which are en-suite.

The ward is an “L” shaped ward. Along the entry corridor is the ward office, kitchen, linen room, staff room, and two single rooms out of sight of the main staff base and around the corner from the main ward area. At the bottom of the ward there is a treatment room where the new Omnicell medication machine is located and where all medication is prepared and stored appropriately.

The staff base is at the apex of the “L”. Bay 1 and 2 are visible to the staff base as are the single rooms 2 and 3. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week (7.5 hours). It was discussed that more management time is required and acknowledgement made that a ward manager review is currently being undertaken, which will address this.

Due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward requests a daily CSW to support with the enhanced care needs of patients. Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this. As well as this the ward RNs and care support workers can often be required to escort the patients to scans, X-rays and appointments, which could be multiple times a day.

Over the last two months since beginning of December there has been a significant improvement with social care allocation for inpatients. Jervaulx ward prior to December had between 10-20 patients that were deemed medically fit and awaiting social care for discharge. Currently the ward has around 2-8 patients who are medically fit, therefore meaning the workload of the nursing staff has increased as more patients are acutely unwell and requiring more nursing intervention.

Jervaulx ward have recently implemented Omnicell which is a new pharmacy system, this has had an impact on workflow as the staff are adapting to a new way of administering medications.

Patient care is allocated by:

Team 1- bay 1 (6 patients and single-rooms 1,2,3) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay due to support with the enhanced care needs of patients

Team 2- bay 2 (6 patients and single-rooms 4,5,6) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay to support with enhanced care needs

Team 3- bay 3 and 4= 12 patients

1 RN and 1 CSW allocated to this team

The 4th CSW is allocated the 6 single-rooms and support team 3
The 4th RN on duty who acts as the coordinator will also help support nurse in team 3 with 12 patients.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were: (Based on establishment for 30 beds)

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	86%	91%	100%	124%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	3	3

The bed occupancy 99.5%

The budgeted establishment is for 30 beds is 20.32wte RNs and 20.89wte CSW

Contracted for the time of data collection was 17.32wte RN and 20.30wte CSW

Vacancies of 3.0wte RN and 0.59wte of CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Jervaulx	1347	£45,964	627	£17,156	2403	56.1%	26.1%	17.9%

CHPPD
Max CHPPD 6.3

1st SNCT	**6.5**
2nd SNCT	**5.8**
3rd SNCT	**6.1**

Turnover % for data collection period		Sickness % for data collection period	
RN	CSW	RN	CSW
0.0%	0.0%	4.29%	5.98%

Quality indicators

Falls	10
Hospital acquired pressure ulcers	5
Medication incidents	2
Staffing Datix	1
Formal Complaints	0

Enhanced care:
During the data collection period there were a **total of 356** enhanced cares on Jervaulx, averaging **11.5** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	8	0.25
Discharges	38	1.22
Transfers In	53	1.70
Transfers Out	12	0.38
Deaths	10	0.32

Admin Support:

	Establishment	**Contracted**
Band 2	1.00	1.00

Nurse Associates:

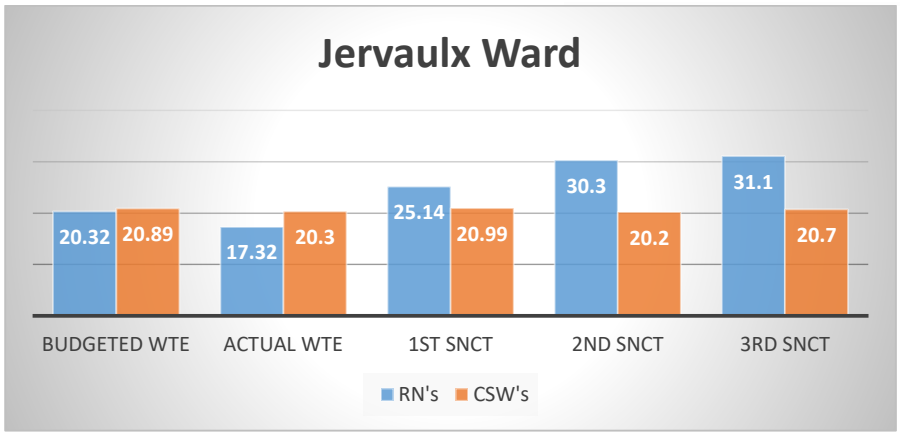
	Establishment	**Contracted**
Band 4	0.00 (from band 5 budget)	2.00

Nutritional Assistant:

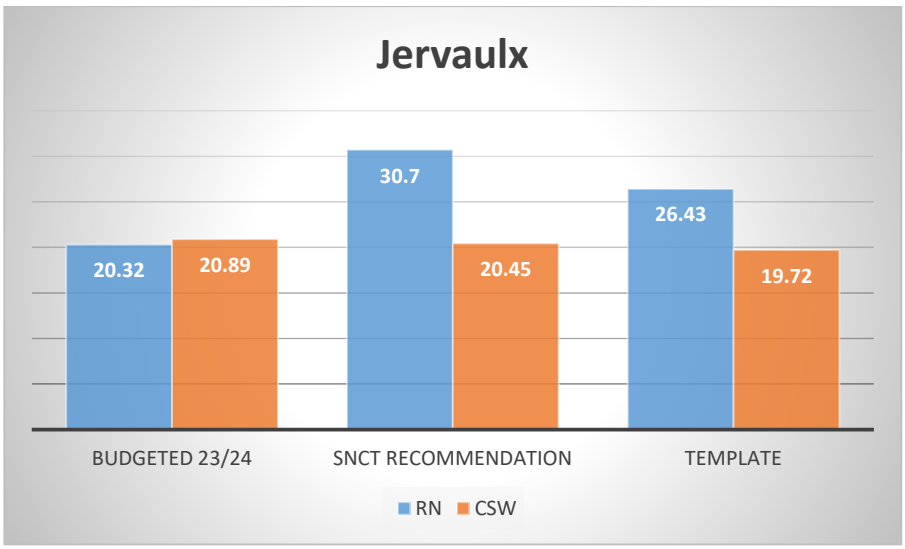
	Establishment	**Contracted**
Band	0.6	1.00

This Table shows the 22/23 budget against the 'in post' **WTE** and the three SNCT recommendations. Bed occupancy was 99.5%

The 1st SNCT incomplete data collection. The 2nd and 3rd SNCT are based on 30 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Jervaulx (30 bedded Frailty ward). Management time will need to be added to the RN WTE, within the SNCT recommendation.



Frailty (30 beds)

Agreed SNCT recommendation with professional judgement:

- RN 30.7
- CSW 20.45

Proposed Staffing Template (including management days)

- RN 26.43
- CSW 19.72

	Early	Late	Night

RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
MD	**22.5 hours (0.6 WTE)**		

Additional requirements:

The blurring of roles and the increased dependency on nursing staff to contribute to:

- Cleaning
- Portering
- Hostess duties
- Advanced clinical skills, that were once deemed a doctors role (cannulation, catheterisation, phlebotomy, ECG's etc)

Considerations:

- Average of 11.5 Enhanced Care Patients each day.
- Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this.
- RNs can sometimes be required to escort the patients to scans, X-rays and appointments. High patient to staff ratios becoming the 'norm'; linked to poor patient outcomes.
- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.
- Jervaulx has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.

Recommendations:

- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes.
- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- Increase Nutritional Assistant cover, to support weekends.
- Increase Ward Clerk hours to cover the evenings and weekends.
- To include the appropriate allocation of management time within the staffing template.

- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To calculate the 'planned' CHPPD for Jervaulx, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.
- To continue to closely review incentive payments for additional hours. These have been extended until 4th September. However, staff are burnt out and feeling the pressure of this current wave of the pandemic.
- To increase International Recruitment and domestic pipelines (business cases in progress).

Trinity: Rebab - off site, Ripon (19 beds)

Trinity Ward is a 19 bedded ward which takes primarily patients with rehabilitation needs but can take up to 2 palliative care patients. The ward is based at Ripon Community Hospital and is the only inpatient facility there. Patients are normally transferred from the main HDFT site but the ward occasionally takes direct admissions from other hospitals or as requested by the GPs.

The ward is "T" shaped. The ward managers office and ward kitchen are beyond the Minor Injury Unit (MIU) on the entrance corridor to the ward. On entering the ward there is the staff base with an adjoining clinical utility room. To the right of the ward is a four bedded female bay with a direct link through to a three bedded female bay, a female single room with ensuite facility, leading to a two bedded female bay with en-suite. The supporting patient bathroom facilities and dirty utility are out of site of the ward.

On entering the ward to the left, there is a male single room with en-suite, a male partitioned bed space leading directly to a six bedded male bay. The supporting patient bathroom facilities and dirty utility is out of sight at the end of the ward.

On entering the ward and straight ahead there is a link corridor to the one bedded palliative care room. This has en-suite facilities. There is also a small day room leading from the link corridor to the palliative care room.

At the time of the study the ward was led by an experienced Ward Manager and Matron, there were also 2 experienced Band 6 Sisters with a further due to be appointed. The budgetary allocation for the Ward Manager is two management days (15 hours per week) with only one budgeted. SNCT recommendations should be used cautiously for small wards as at least 2 RN are required per shift and professional judgement should be used to inform staffing levels. It is also to note that due to fire regulations there needs to be at least four members of staff on site on each shift on the case of evacuation being required.

The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised, this is considered when reviewing patients who are suitable for transfer and rehabilitation at Trinity Ward. Criteria has recently been extended and the ward has taken many patients outside the criteria to aid capacity on the main site.

Clinical oversight of the patients is provided by local GPs and an elderly care physician and ACP are on site once a week. In an emergency, as there is no medical cover 24/7, 999 is used for medical support. The ward nursing staff closely work with therapy when available to maximise patient rehabilitation potential. At the time of the study and over the past year there has been less consistent therapy cover due to significant staff vacancies. There are weekly MDT meetings that the RN in charge is required to attend.

Between 18:00 and 08:00 the ward staff are the only staff in the building of Ripon Hospital. It is worth noting that the ward manager has site responsibilities at Ripon Community Hospital in addition to Trinity and therefore needs protected management time.
It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	97%	96%	100%	100%

The current shift establishment is (for 16 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	2

At the time of the study the bed occupancy was 113.9% Based on 16 beds

The **budgeted** establishment is 16 beds is 12.01wte RNs and 13.27wte CSW

Contracted for the time of data collection was 8.84RN and 11.71wte CSW

Vacancy: RN's 3.17wte and CSW 1.56wte

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Trinity	602	£23,713	36	£1,468	675	89.2%	5.3%	5.6%

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	8.69%	17.14%

CHPPD

Max CHPPD 6.6

1st SNCT	**8.0**
2nd SNCT	**5.9**
3rd SNCT	**6.0**

Quality indicators

Falls	5
Hospital acquired pressure ulcers	3
Medication incidents	1
Staffing Datix	1
Formal Complaints	0

Enhanced care: There were a total of **0** enhanced cares. This averages at **0** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	5	0.16
Discharges	22	0.70
Transfers In	19	0.61
Transfers Out	0	0
Deaths	2	0.06

Admin Support:

	Establishment	**Contracted**
Band 2	Ward Clerk 25 hours Discharge support worker 20hours	25 hours 20 hours

Nurse Associates:

	Establishment	**Contracted**

Band 4	0	0

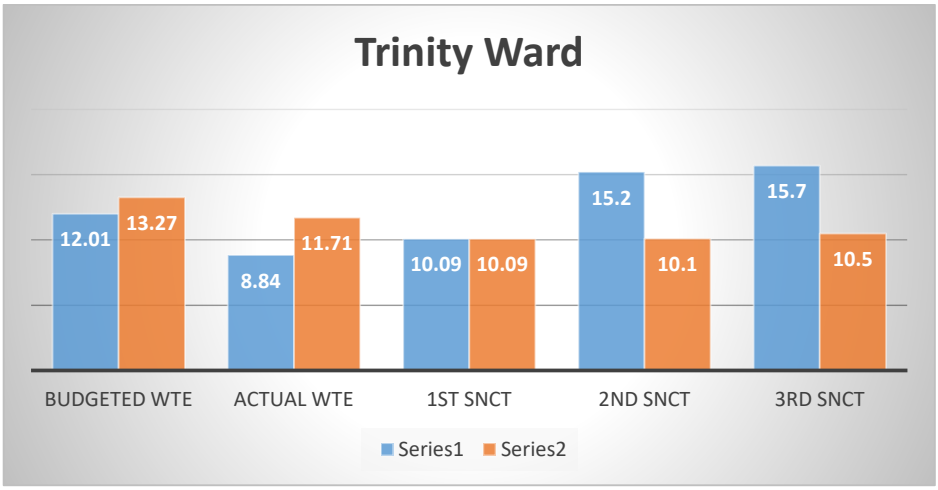
Nutritional Assistant:

	Establishment	Contracted
Band	0	0

Bed occupancy was 113.9% due to escalation beds being used (up to 3 additional beds in use throughout the data collection period).

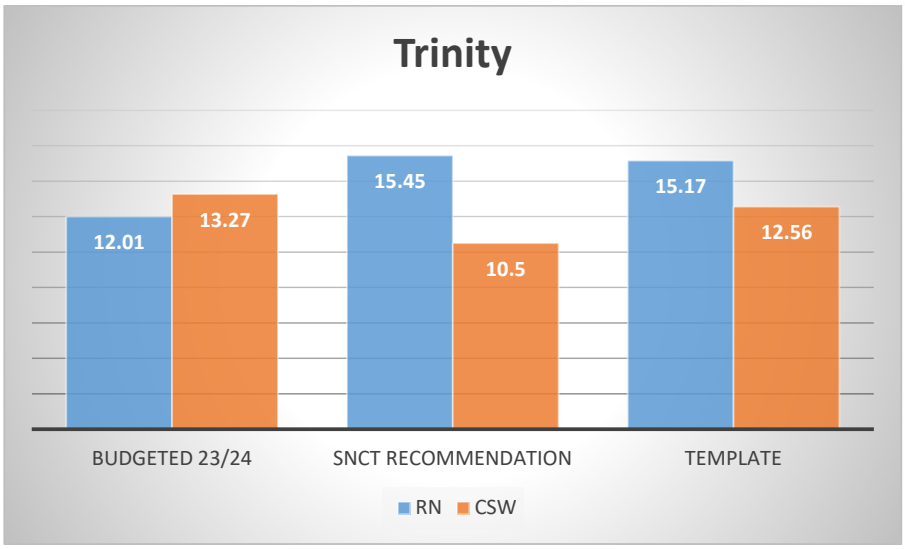
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st SNCT possible fault with the data. The 2nd and 3rd SNCT are based on 19 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Trinity (19 bedded Rehab and stepdown ward).

Management time will need to be added to the RN WTE, within the SNCT recommendation.



Rehab (19 beds)

Agreed SNCT recommendation with professional judgement:

- RN 15.45
- CSW 10.5

Proposed Staffing Template (including management days)

- RN 15.17
- CSW 12.56

	Early	Late	Night
RN	**3**	**3**	**2**
CSW	**3**	**2**	**2**
Additional RN on a Wednesday	**1 LD**		
MD	**22.5 hours (0.6 WTE)**		

Considerations:

- Trinity is based within Ripon Hospital
- Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this
- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.

Recommendations:

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should befunded; ensuring consideration of all necessary support roles which would contribute to improved patient flow through the admissions unit.
- Increase Ward Clerk hours to cover the evenings and weekends.
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- To calculate the 'planned' CHPPD for Trinity, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (Business cases in progress).

Acute Frailty Unit: (12 beds)

There were 12 beds at the time of data collection.

At the time of data collection the Acute Frailty Unit consisted of 2 bays: 1 bay of 6 beds and a second bay of 4 beds.
There were 2 side rooms.
There is a patient bathroom / toilet facilities; 2 toilets. A third toilet is being used as a temporary sluice area.
Shared facilities were with other wards: the store room was shared with Bolton ward, with a separate area allocated for the Acute Frailty Unit.

Escalation Beds: all 12 considered escalation beds

Admin Support: ad hoc and when available.

Staffing Template for 12 beds.

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	2	2	2	2	2

The bed occupancy was 96.8% during the time of the study based on 12 beds.

Bank or Agency Fill:

All N&M								
	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Frailty Unit (Harlow)	1121	£43,817	349	£14,379	1885	59.5%	18.5%	22.0%

Registered								
	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Frailty Unit (Harlow)	502	£25,226	337	£14,109	929	54.0%	36.3%	9.6%

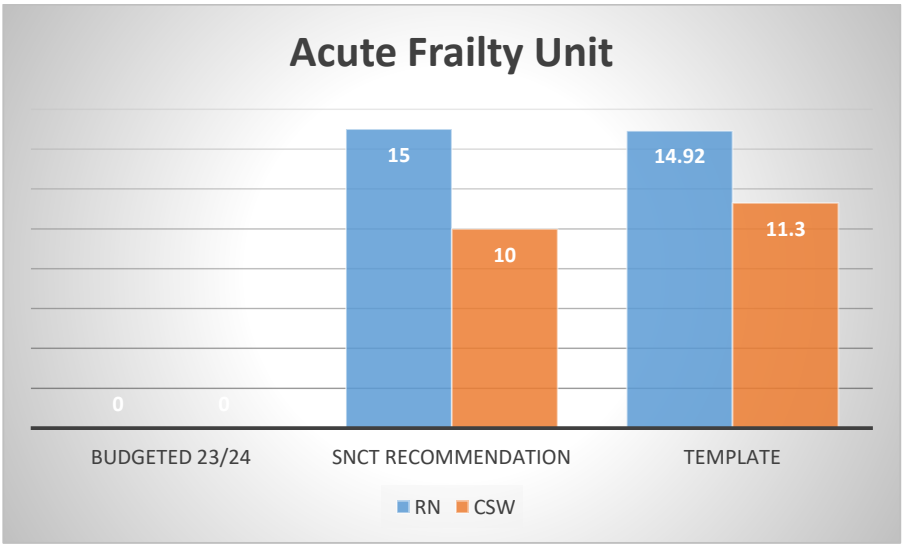
Unregistered								
	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Frailty Unit (Harlow)	619	£18,591	12	£270	956	64.8%	1.3%	34.0%

Quality indicators

Falls	7
Hospital acquired pressure ulcers	2
Medication incidents	1
Staffing Datix	0
Formal Complaints	0

Enhanced care: There were a total of 49 Enhanced Cares.

	Total in data collection period	Average per day
Admissions	12	0.38
Discharges	34	1.09
Transfers In	71	2.29
Transfers Out	24	0.77
Deaths	1	0.03



The results from the SNCT above are based on 12 beds. The review meeting discussed that the ward has now moved location and has increased its bed base to 20. Also taking direct admissions. The modelling for the staffing template below has been agreed using professional judgement and based on the acuity and dependency scores from the frailty patients seen during the data collection period. This ward will require a further three data collections prior to making and significant staffing changes. In addition the directorate will need to find funding for these beds after the 31st March 2023.

Agreed SNCT recommendation with professional judgement based on 12 beds:

- RN 15
- CSW 10

Proposed Staffing Template based on 20 beds (including management time)

- RN 22.90
- CSW 14.07

	Early	Late	Night
RN	**4**	**4**	**4**
CSW	**3**	**3**	**2**
MD	**22.5 hours (0.6 WTE)**		

To note, there is no funding agreed for any part of this establishment after 31st March 2023.

Oakdale: Endocrine, General Medicine, Oncology & Haematology ward (30 beds)

Oakdale ward is a 30 bedded Endocrine, General Medicine, Oncology & Haematology ward, that also administers inpatient SACT. There are three, six bedded bays, one four bedded bay and eight single rooms. The ward is not uniformly laid out. Bay 1, room 12 and the Haematology/Oncology single rooms are out of sight and distant from the main staff base. Room 1, day room, ward manager office, kitchen and staff room are distant to the remainder of the ward. The six bedded rooms (4 & 5) and four of the single rooms are located around the main staff base. There is a further staff base located within line of sight of the four bedded (room 12) and the four oncology single rooms. The six bedded bays (4 & 5) have a toilet and six single rooms have en-suite facilities.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is one management days per week.

During the data collection period a RN from Oakdale held the 'Acute Oncology Helpline' bleep from 18:00 to 0800 every evening and 24 hours over the weekends and bank holidays. This is a helpline for patients to get immediate advice and in necessary, treatment for symptoms relating to their cancer or side effect of their treatment. Each call can take up to an hour and can only be taken by a competency assessed RN; usually the Nurse in charge. Advice will be given or the patient will be signposted appropriately/admitted to the hospital. From June 2022 The Acute Oncology Team will hold bleep on weekends between 08:00-16:00, leaving Oakdale RNs to cover from 1600 on weekends, 1800 week days and all day on bank holidays.

When patients are on the ward receiving inpatient Chemotherapy, staffing numbers need to be maintained with the appropriate skill mix of staff, as this requires intensive periods of level 2 care. When this is not achievable the SACT Unit supports by sending RN's over to check and administer the Chemotherapy. The Lead SACT Nurse also provides extensive training for the RN's on Oakdale to ensure knowledge and skills are kept up to date.

The ward is required to manage the Botox Clinic which requires three RNs six hours each to do so, a total of eighteen hours per month. However, for the data collection period this was reduced to two RNs. This requirement comes directly from the nurse establishment on the ward. The ward is a multi-speciality ward and therefore the nurse in charge is required to attend multiple ward rounds and MDT discussions.

This ward often has a high level of patients who are confused, an absconding risk or require enhanced care. The patients on the ward usually require intense rehabilitation and this may need more than two members of staff to support with this. The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised. Due to this, there is a daily request for an additional CSW overnight and sometimes for the additional long day shift.

Oakdale ward has its own speciality allied health professionals; they support with the ward huddle daily. The geographical location is next to Granby Ward, therefore mutual aid is often provided from each ward.

Patient care is allocated by:

Days:

Bay 1: 6 patients, usually the least dependent patients

1 x RN and 1 X CSW – normally during the day that nurse is the nurse in charge.

Single room 2 & 3 and bay 4 : 8 patients in total.

1 X RN and 1 X CSW

Single room 6 & 7 and bay 5: 8 patients in total.

1 RN and 1 CSW

Single rooms, 8, 9, 10 & 11 and bay 12: 8 patients in total

1 RN and 1 CSW

As a contingency during the day if there are 3 RNS or 3 CSWs the divide is:

Bay 1 and bay 4: 12 patients

Bay 5 and single room 2, 3, 6, 7: 10 patients nurse in charge

Bay 12 and singleroom 8, 9, 10, 11: 8 patients.

Many shifts have just 2 RN's; therefore the patients are divided equally, being responsible for 15 patients each.

Nights:

2 RNS and 2 CSWS allocated to bay 1, bay 4, bay 5 and single rooms 2, 3, 6, 7

1 RN and 1 CSW allocated to bay 12 and single rooms 8, 9, 10, 11

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	79%	92%	98%	118%

The current shift establishment for the funded 26 beds is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	3	3	3

At the time of the study the bed occupancy was 99.8%, data collected at 15:00hrs.

The budgeted establishment based on **30 beds** is: 20.72wte RNs and 19.67wte CSW

Contracted for the time of data collection was 13.7wte RN and 18.94wte CSW

Vacancies at the time of data collection: 7.07wte RN and 0.73wte CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Oakdale	1023	£34,873	947	£32,549	2575	39.7%	36.7%	23.5%

CHPPD

Max CHPPD 6.4

1st SNCT	**6.5**
2nd SNCT	**5.4**
3rd SNCT	**6.0**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0.0%	10.24%	12.3%	5.41%

Quality indicators

Falls	7
Hospital acquired pressure ulcers	1
Medication incidents	5
Staffing Datix	6
Formal Complaints	Poor patient care x 1 (complaint)

Enhanced care: There were a total of **210 enhanced cares**. This averages at **6.8** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	37	1.19
Discharges	52	1.67
Transfers In	39	1.25
Transfers Out	22	0.70
Deaths	2	0.06

Admin Support:

	Establishment	**Contracted**
Band 2	1.73 wte	1.73 wte

Nutritional Assistant:

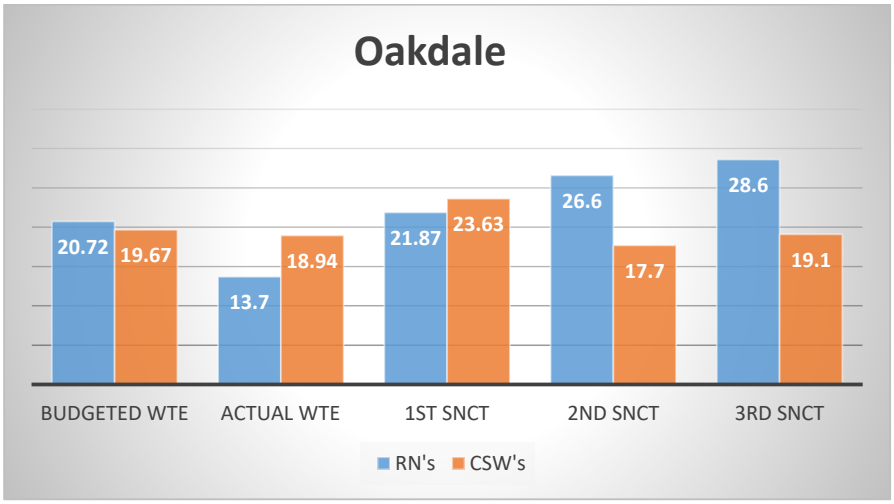
	Establishment	**Contracted**
Band 2	1.0	1.0

Bed occupancy was 99.8%

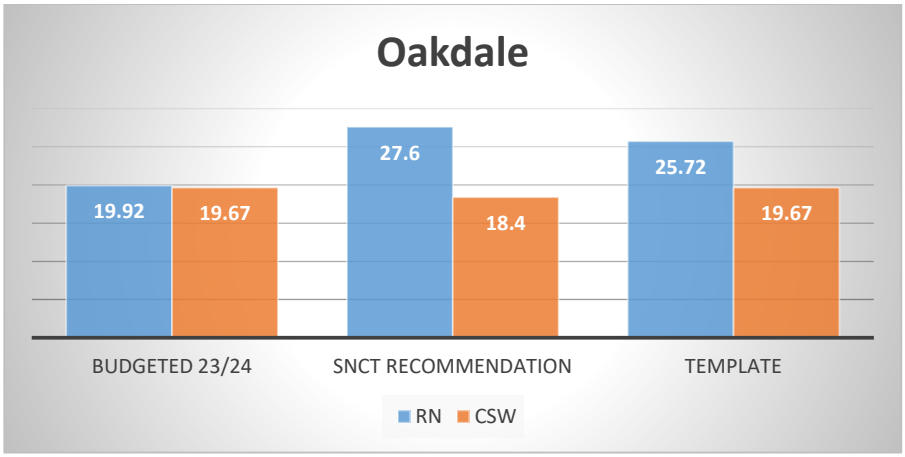
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st SNCT possible fault with the data

The 2nd and 3rd SNCT are based on 30 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Oakdale (30 bedded Endocrine, General Medicine, Oncology & Haematology ward). Management time will need to be added to the RN WTE.



Agreed SNCT recommendation with professional judgement:

- RN 27.6
- CSW 18.4

Proposed Template (including management days)

- RN 25.72
- CSW 19.67

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**3**	**3**
MD	**22.5 hours (0.6 WTE)**		

Considerations:

- Mixed speciality ward
- Administration of SACT
- Out of hours Acute Oncology Helpline Service
- Complex ward layout
- Average 6.8 Enhanced Care Patients each day
  HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this speciality ward is 60/40.
- Oakdale has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.

Recommendations:

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes on this speciality ward. (Business case in progress)
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.

Granby: Stroke and Neurology (22 beds)

Granby ward is a 22 bedded Stroke and Neurology ward. It currently doesn't have a dedicated ward manager; however there is oversight from the Oakdale ward manager.

The ward is a "Z" shaped ward. There are three six bedded bays, and four single rooms, two of which are en-suite. Two of the bays have toilet facilities. Upon entering the ward immediately on the left is the six bedded escalation bay which is out of sight of the remainder of the ward. Therefore, care is taken when assigning patients to that bay. The entry corridors to the main area of the ward have a therapy kitchen, patient shower facilities, staff kitchen, linen cupboard, dirty utility, and staff room. The main area of the ward has a central staff base surrounded by the two bays and four single rooms. The visibility of patients, except for the escalation bay, is good. Granby Ward request one to one enhanced care in exceptional circumstances.

Anecdotally there are frequently complex discharges required of the ward. The ward frequently transfers patients to neighbouring hospitals which requires a RN escort, who can then be absent from the ward for the majority of the shift. The ward often cares for patients with Learning Disabilities; this often requires complex discharge planning and additional care requirements.

The geographical location is next to Oakdale Ward, therefore mutual aid is often provided from each ward.

The budgetary allocation for the Ward Manager is two management day per week (15 hours). The ward managers' office is on the corridor that connects on to Oakdale ward.

Patient care is allocated by:

1 Bay and 2 single rooms – 1 RN

1 Bay and 2 single rooms – 1 - RN

Bay 1 to the Nurse in Charge as these patients are usually the least dependant.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	81%	83%	100%	116%

The current shift establishment is:

	Day				**Night**	
	Early		**Late**			
	RN	CSW	RN	CSW	RN	CSW
22 beds	3	3	3	3	2	2

At the time of the study the ward had 22 beds open and based on the bed occupancy was 99.7%.

The budget establishment is 13.47wte RNs and 12.51wte CSW

Contracted for the time of data collection: 11.43wte RN and 12.15wte CSW

At the time of SNCT data collection there was a vacancy of: 2.04wte RN and 0.36wte CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Granby	734	£24,970	761	£25,999	1950	37.7%	39.0%	23.3%

CHPPD

Max CHPPD 6.2

1st SNCT	**6.7**
2nd SNCT	**5.2**
3rd SNCT	**5.6**

Turnover %		Sickness %	
RN	CSW	RN	CSW
0.0%	0.0%	4.36%	10.48%

Enhanced care: There were a total of 42 enhanced cares. This averages at 1.4 enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	5	0.6
Discharges	61	1.96
Transfers In	69	2.22
Transfers Out	10	0.32
Deaths	5	0.16

Admin Support:

	Establishment	**Contracted**
Band 2	0.92	0.92

Nutritional Assistant:

	Establishment	**Contracted**

Band	1.0	1.0

Quality indicators

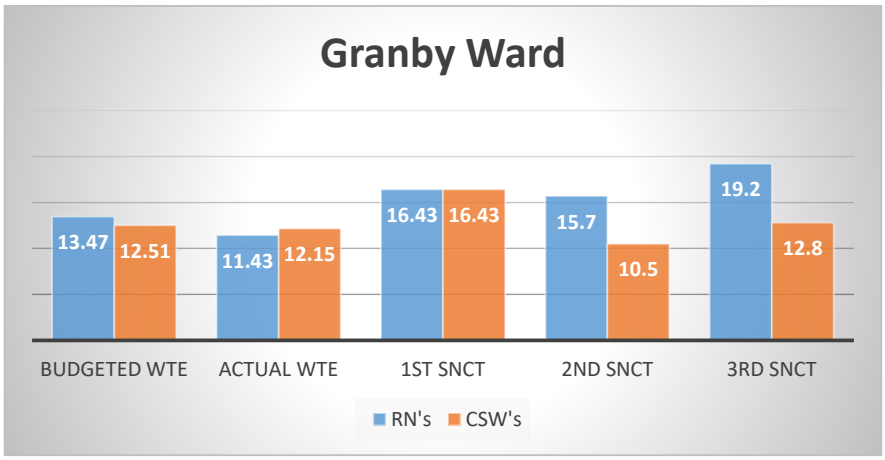
Falls	9
Hospital acquired pressure ulcers	5
Medication incidents	1
Staffing Datix	6
Formal Complaints	0

Bed occupancy was 99.7% based on a bed base of 22.

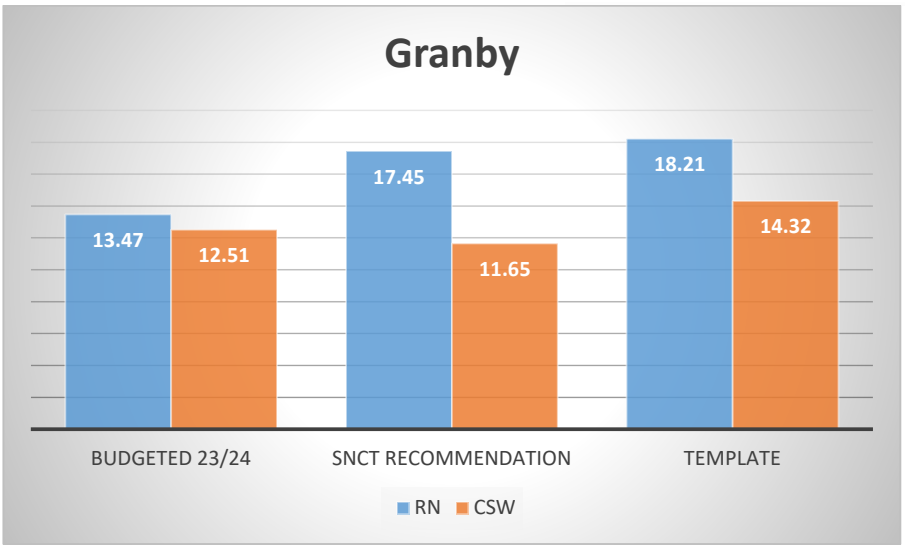
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st SNCT possible fault with data

The 2nd and 3rd SNCT are based on 22 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Granby (22 bedded Stroke and Neurology ward).



Agreed SNCT recommendation with professional judgement:

- RN 17.45
- CSW 11.65

Proposed Staffing Template (inc MD)

- RN 18.21
- CSW 14.32

	Early	Late	Night
RN	**3**	**3**	**3**
CSW	**3**	**3**	**2**
MD	**22.5 hours (0.6 WTE)**		

- Granby has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.
- These is a requirement for registered nurses to escort patients for scans, X-Rays and appointments. In addition there are frequent transfers patients to neighbouring hospitals which requires a RN escort.
- The ward often cares for patients with Learning Disabilities; this often requires complex discharge planning and additional care requirements.

Recommendations:

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes.

- Increase Nutritional Assistant cover, to support weekends
- Increase Ward Clerk hours to cover the evenings and weekends.

Rowan: Rehab (12 beds)

Rowan Ward is a 12 bedded neuro rehab ward specialising in neurological conditions such as Parkinson's disease, Multiple sclerosis, Motor neurone disease and Guillain-Barre syndrome. During the first data collection period the ward had 1 escalation bed open, increasing the bed base to 13. This is planned to reduce back down to 12 beds at the end of May 2022. The staff also have additional skills and often manage up to two patients who are at the end of their life and who can be cared for in a quieter environment than an acute ward.

Although on the main hospital site, it is in a separate wing to all other wards and has no neighbouring wards. The ward is a "L" shaped ward. With two four bedded bays and four single rooms. All bays and rooms are in the same area of the ward. Immediately adjacent linen room, patient toilets and staff room. There are no en-suites. The staff base is at the apex of "L" shape. Other supporting areas such as the ward office, dirty utility, assisted bathroom and storerooms are off the entry corridor; all of which are a distance from the patients. The ward also has a large rehabilitation therapy room, ward education room where a practice educator is based, outpatients clinic room often utilised over the weekends and the radiology department use the ward for access to a CT Scanner – this increases footfall on the ward and often requires ward staff to answer the door as appropriate. The ward has a dining room (of which half is used as a store room) and a quiet room and a small outdoor area for patient use; this means that often patients are located in numerous places across the ward. During periods of increased demand, the ward admit patients who are awaiting complex discharges and also has a 13th bed for escalation – however this reduces clinic capacity if this is used.

At the time of the study the ward was led by an experienced Ward Manager, supported by an experienced Matron, there is one experienced Band 6 Ward Sister. The Ward Manager gets one 9-hour management day per week. Professional judgement by the Matron of the ward is that the ward management days would be adequate at two days per week (18 hours) due to the lower staffing levels with regard to HR management and reduced patient numbers.

The patients on the ward often require assistance of two (or more) to support with the delivery of their care needs; this might be due to mobility or end of life care needs. The patients at the end of their life often need additional intensive support, both physical and psychological for themselves and their families. As this is a rehabilitation ward, the intensity of rehab available to the ward has a direct impact on the length of stay on the ward.

In addition, patients have complex needs which creates complex discharge planning. There will be a number of meetings required (goal planning, best interest meetings, discharge planning meetings) to determine the level of care input or care facility that is

required on discharge. Multi-agencies are often essential (District Nurses, Continence Teams, Social Workers) and the allocation of funding for the required care packages can often take many weeks, extending the patient's admission.

Rowan used to be based on Lascelles, where their environment was appropriately equipped for rehabilitation of patients (they had ceiling tracks for/with hoists, appropriate bathrooms, grab rails for patients to utilise at the bed spaces). This meant that some of the care needs could be performed safely by one member of staff. Because of the environment on Rowan, patients are reliant on two staff members, which puts the SNCT dependency scores higher.

Patient care is allocated by the nurse in charge, who also takes an allocation of patient. The nurse in charge will have oversight of all patients and will support the CSW with personal care requirements of the patients.

Over the data collection period the shift fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	96%	84%	98%	206%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	1

The budgeted establishment is for 12 beds is 11.76wte RNs and 10.68wte CSW

Contracted for the time of data collection was 10.76wte RN and 8.6wte CSW

At the time of data collection there were vacancies of 1.0wte RN and 2.08wte CSW.

Bank & Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Rowan	599	£20,275	553	£16,632	1551	38.6%	35.7%	25.7%

Max CHPPD 8.8

Turnover %	Sickness %

RN	CSW	RN	CSW
0%	26.32%	4.97%	14.65%

Enhanced care: There were a total of **50** enhanced cares. This averages at **1.6** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	1	0.03
Discharges	13	0.41
Transfers In	18	0.58
Transfers Out	3	0.09
Deaths	4	0.12

Admin Support:

	Establishment	**Contracted**
Band 2	0.0	Used band 2 money to fund 16 hours a week

Quality indicators

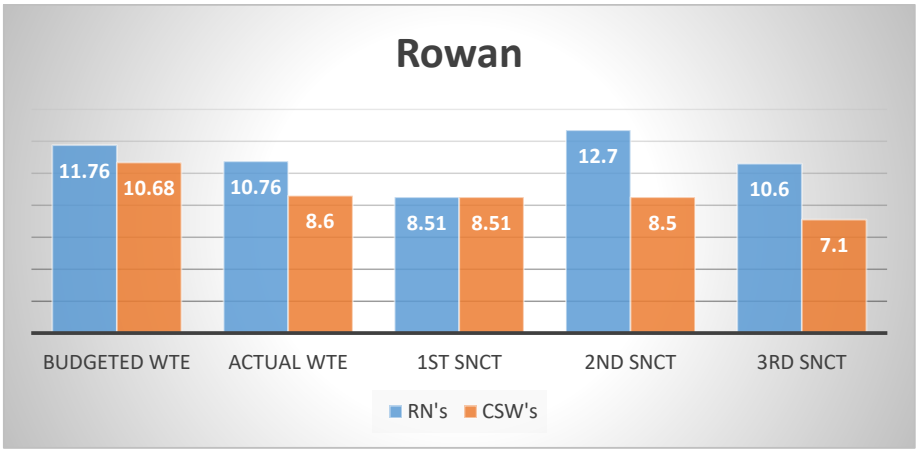
Falls	2
Hospital acquired pressure ulcers	0
Medication incidents	1
Staffing Datix	0
Formal Complaints	0

Bed occupancy was **96%**

This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

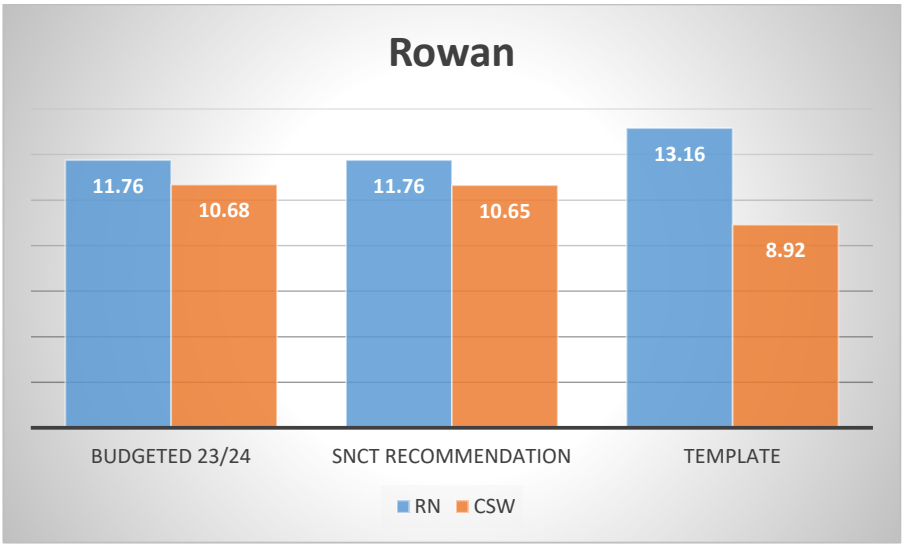
The 1st SNCT possible fault with the data

The 2nd and 3rd SNCT are based on 12 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Rowan (12 bedded Rehab ward).

Management time will need to be added to the RN WTE, within the SNCT recommendation.



Agreed SNCT recommendation with professional judgement:

- RN 11.65
- CSW 8.5

Proposed Staffing Template (including management days)

- RN 13.16
- CSW 8.92

	Early	Late	Night
RN	**3**	**2**	**2**
CSW	**2**	**2**	**1**
MD	**22.5 hours (0.6 WTE)**		

Considerations:

- Average of 1.6 Enhanced Care Patients each day.
- Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this
- RNs can sometimes be required to escort the patients to scans, X-rays and appointments. High patient to staff ratios becoming the 'norm'; linked to poor patient outcomes.

- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.

Recommendations:

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should be funded; ensuring consideration of all necessary support roles.
- Increase Ward Clerk hours to cover the evenings and weekends (business case in progress).
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To calculate the 'planned' CHPPD for Rowan, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on monthly.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (Business cases in progress).

Littondale: Male Surgical and Gastroenterology (24 beds) & Surgical Assessment Unit (8 beds)

Littondale is a 32 bedded for male surgical and gastroenterology ward, which houses a surgical assessment unit.

The ward is a "T" shaped ward. With four adjacent bays and one double side room and six single rooms, all of which are not in sight of the main staff base. Single room 1 and 2 are opposite bay 3 and 4 and single room 8 and 9 are opposite bay 6. Room 5 is opposite the central staff base but visibility is still limited. The double side room is adjacent to room 6 at the far end of the ward. Two single rooms one with ensuite are on the entry corridor to the main ward. The bathrooms, staff base, linen room, and storage room face the bays. Other rooms include the ward office, dirty utility room, ward kitchen,

treatment room, doctors' office, quiet room, therapy storage and staff room, which are all located a distance away from the main patient areas along the entry corridor.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Managers supervisory time for management and alternative leadership responsibilities and duties is three management days per week, however this is often not the case and the ward manager can be pulled to provide direct patient care.

Whilst this is a surgical ward there are mainly gastroenterology patients who can present with delirium and confusion and can be challenging to manage and require one to one enhanced care. These patients are often on very complex intravenous treatment courses which require two nurses to check and administer. Frequently patients require a nurse escort to neighbouring hospitals for treatments. The ward is the only ward in the Trust with the skills to administer TPN and this adds an additional pressure to the ward. As a direct result of the COVID pandemic many of the regular patients that were admitted with alcohol associated illness have not been presenting until 'crisis'. These patients are deconditioned beyond normal limits and therefore increasing their symptoms and length of stay.

Patient care is allocated by:
The ward is split into three, each having an RN and CSW (Band 3 CSW in the SAU)
2 x 6 bedded bays
1 x 6 bedded bay and four single rooms
1 x 6 bedded bay, double side room and two single rooms

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	90%	96%	102%	168%

The current shift establishment is (for 32 beds):

Day		**Night**	
RN	CSW	RN	CSW
4	3	3	2

At the time of the study the bed occupancy was 97% based on 32 beds.

The budgeted establishment is for 32 beds is 20.32wte RNs and 16.03wte CSW

Contracted for the time of data collection was 14.62wte RN and 13.24wte CSW

At the time of data collection there were vacancies of 5.7wte RN and 2.79wte CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Littondale	1540	£49,611	1009	£32,427	2950	52.2%	34.2%	13.6%

Max CHPPD 5.4

Turnover %		Sickness %	
RN	CSW	RN	CSW
0.0%	4.12%	6.60%	2.50%

Quality indicators

Falls	7
Hospital acquired pressure ulcers	3
Medication incidents	2
Staffing Datix	3
Formal Complaints/SI's	1 x fall (SI)

Enhanced care: There were total of **92** enhanced cares. This averages at **3** enhanced care patients per day.

Flow:

	Total in data collection period	**Average per day**
Admissions	37	1.19
Discharges	65	2.09
Transfers In	73	2.35
Transfers Out	41	1.32
Deaths	1	0.32

Admin Support:

	Establishment	**Contracted**
Band 2	1.0	1.0

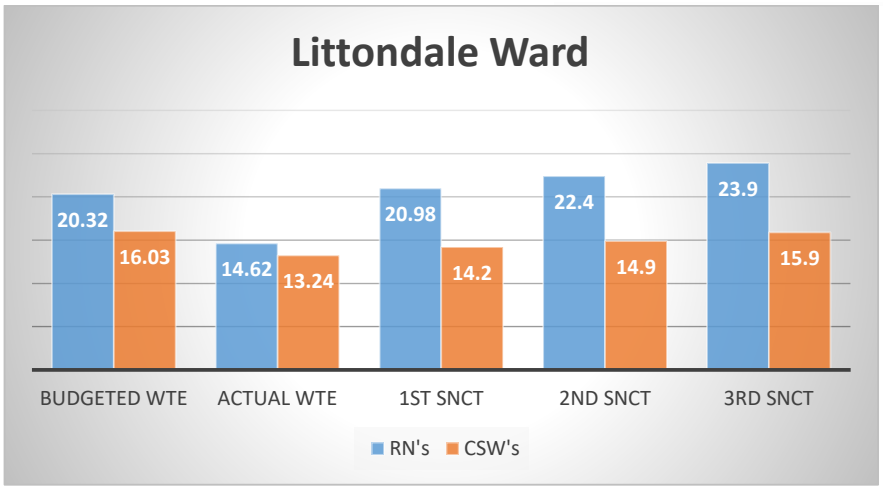
Nutritional Assistant:

	Establishment	**Contracted**
Band	0	1.0

Bed occupancy was 99.2%

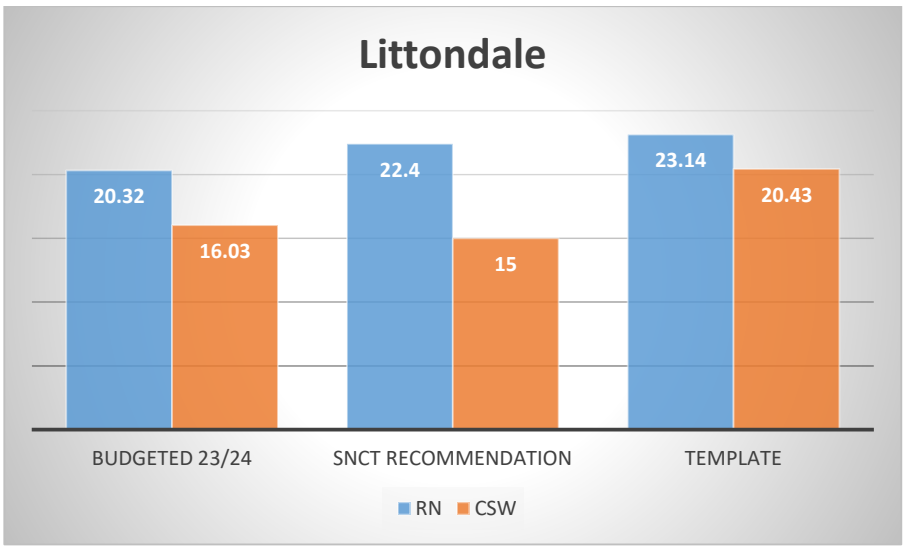
This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 2nd and 3rd SNCT are based on 30 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Littondale (32 bedded non-elective surgical ward with SAU).

Management time will need to be added to the RN WTE, within the SNCT recommendation.



Male Surgical & Gastro 32 beds (24 beds & 8 Surgical Assessment Beds)

Agreed SNCT recommendation with professional judgement:

- SNCT 22.4
- CSW 15

Proposed staffing template including management time:

- RN 23.14
- CSW 20.43 (including band 3's)

To note; professional judgement was applied to model the surgical assessment unit.

	Early	Late	Night
RN	5	5	3
CSW Band 2	3	3	2
CSW Band 3	1	1	1
MD	22.5 hours (0.6 WTE)		

Fountains: Elective Surgery (15 beds)

Fountains ward is an elective surgery ward with 15 beds. Previously this ward had 28 beds; however due to COVID there has been a shift in bed base to allow for escalation beds to be opened on Bolton. The longer-term plan is for Fountains to be moved to a newly refurbished and appropriately designed surgical ward environment. Currently, there are two bays of six and three single rooms, two of which are en-suite. The ward is an “L” shaped ward. Along the entry corridor is the ward office, clean utility, 2 single rooms out of sight of the main staff base and around the corner from the main ward area.

The staff base is at the apex of the “L” and the dirty utility and kitchen are immediately adjacent. There is some visibility of bay 1 and one single room from the staff base but the remaining bays, HOB and three single rooms have no visibility. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay. There are dedicated orthopaedic beds which are required to be separated from the general surgery beds for infection control reasons.

The ward is led by an experienced Ward Manager and Matron.There are also experienced Band 6 Ward Sisters.

Patient care is allocated by:

1 x Nurse in Charge

1 X RN & CSW for orthopaedic patients

1 x RN & CSW for general surgery patients

If there is a patient in the HOB an additional RN is required.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the Data Collection Period, the fill rates were:

	Day	Night

Data collection period	RN	CSW	RN	CSW
October 2022	94%	48%	97%	35%

The current shift establishment is (for 15 beds):

Day				Night	
Early		Late			
RN	CSW	RN	CSW	RN	CSW
2	2	2	2	2	1

At the time of the study the bed occupancy was 56.13% based on 15 beds.

The budgeted establishment is 14.52wte RNs and 11.51wte CSW

Contracted for the time of data collection was 11.55wte RN and 7.89wte CSW

At the time of the data collection there were vacancies of 2.97 RN and 3.53 CSW.

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Fountains	212	£9,731	155	£6,794	621	34.1%	25.0%	40.9%

Max CHPPD 6.6

Turnover %		Sickness %	
RN	CSW	RN	CSW
0.0%	0.0%	1.55%	10.95%

Quality indicators

Falls	0
Hospital acquired pressure ulcers	2
Medication incidents	1
Staffing Datix	1
Formal Complaints	0

Enhanced care: There were a total of **0** enhanced cares. This averages at **0** enhanced care patients per day.

	Total in data collection period	Average per day
Admissions	89	2.87
Discharges	51	1.64
Transfers In	3	0.09
Transfers Out	50	1.61
Deaths	0	0

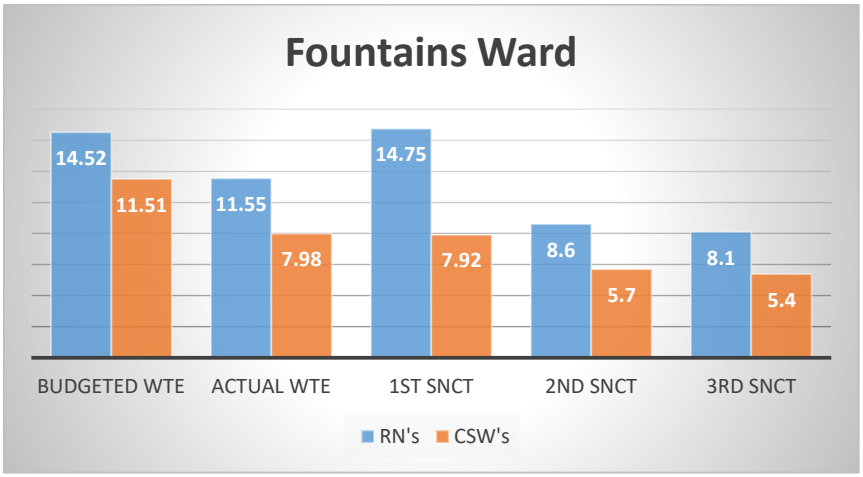
Admin Support:

	Establishment	Contracted
Band 2	1.19	

This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

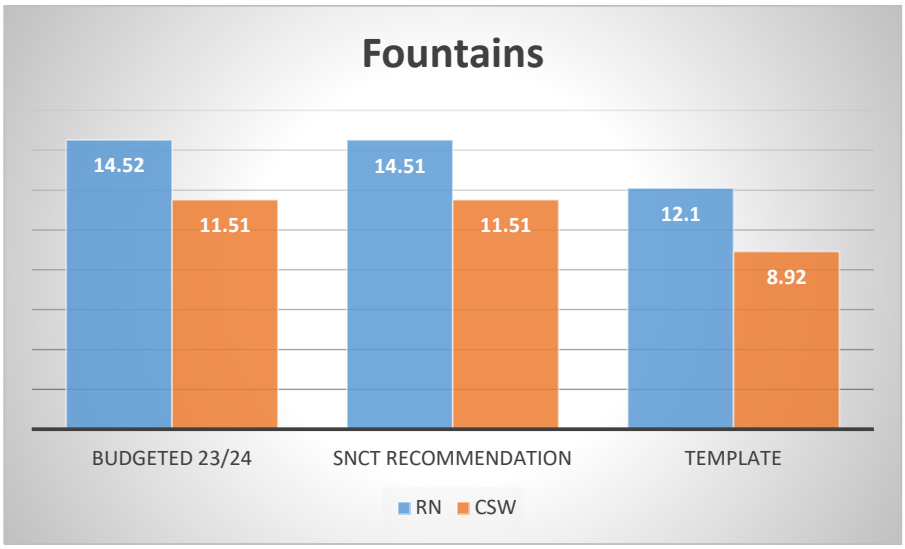
The 1st SNCT was based on 28 beds

The 2nd and 3rd SNCT are based on 15 beds at an average 60% bed capacity during data collection.



The table below indicates the 2023/2024 budget against the SNCT recommendations for Fountains (15 bedded Elective surgery ward). However there are minimum staffing numbers required to ensure that the above staffing template is met. In addition management time will need to be added to the RN WTE.

In addition bed occupancy was just under 60% and it is anticipated that the full bed based will be utilised moving forward.



Elective Surgery

Agreed SNCT recommendation with professional judgement:

- SNCT RN 14.51
- CSW 11.51

Proposed staffing template including management time:

- RN 12.10
- CSW 8.92

	Early	Late	Night
RN	**2**	**2**	**2**
CSW Band 2	**2**	**2**	**1**
MD	**22.5 hours (0.6 WTE)**		

Additional requirements:

The blurring of roles and the increased dependency on nursing staff to contribute to:

- Cleaning
- Portering
- Hostess duties
- Advanced clinical skills, that were once deemed a doctors role (cannulation, catheterisation, phlebotomy, ECG's etc)
- Admin tasks, normally attributed to the ward clerk role, to be undertaken at weekends.
-

Considerations:

- HDFT 'Headroom' is below the national recommended allocation. Currently it is 21% and doesn't include a provision for maternity leave. The minimum recommended 'Headroom' is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- Fountains has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency.
- Fountains ward is an elective surgery ward with 15 beds.

Recommendations:

- Provisions within the 'Headroom' should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes.
- Increase Ward Clerk hours to cover the evenings and weekends; agree hours required.
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To continue to closely review incentive payments for additional hours.
- To increase International Recruitment and domestic pipelines (Business cases in progress).
- To calculate the 'planned' CHPPD for Fountains, if staffing was at 100% fill, so that we can benchmark against 'Actual' and report on this monthly.

Wensleydale: Non Elective (30 Beds)

Wensleydale has one single corridor with a centrally located work base. The ward kitchen and staff room are located at the entrance corridor to the ward out of sight of the patient areas. The top half of the ward comprises three four bedded bays, three single rooms, one of which has en-suite and a two bedded bay. There are patient bathroom facilities centralised opposite the bays. The bottom half of the ward has three four bedded bays and three single rooms. Behind the central staff base is a dirty utility, an MDT room and a clean utility. The Ward Manager's office is located at the entrance to the ward.

There is a fire escape leading to concrete steps at the bottom of the ward, the fire doors lock and alarm if opened. Only one patient in one single room is visible from the central staff base, no other patients are visible from the staff base. No bays have a base for staff. Off the centre of the ward are storage areas.

The ward layout is compounded due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers. As a result of the COVID pandemic these patients are being admitted in a deconditioned state which had directly impacted on the raising numbers of patient requiring enhanced care and increasing length of stay. The length of stay is also impacted by the unavailability of continuing care, also caused by implications of the COVID pandemic.

At the time of the study the ward was led by an experienced Ward Manager and Matron. There are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is 3 management days (22.5 hours) per week. However these are not always taken due to clinical commitments, resulting from staffing pressures.

Patient care is allocated by: (Currently at 30 beds)

Bay 1 and 2 and annex (10 patients) 1 nurse

Bay 3 and 4 single rooms 1, 2, 3 (10 patients) 1 nurse

Bay 5 and 6 single room 4, 5, 6 (10 patients) 1 nurse

The 4th nurse is the nurse in charge and supports RNs and with all of the complex discharges that are required. It is extremely rare that there is a forth nurse; although planned and rostered, staffing challenges on the neighbouring escalation result in this forth nurse being redeployed. In addition, two escalation beds are used on an adhoc basis for 'ward attenders', these additional patients are the allocated responsibility of the nurse in charge.

When patients require scans 'out of hours' an escort is required. The acuity of the patient dictates the need for this escort being a CSW or RN. Escorts can be absent from the ward for 30-40 minutes at a time.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	78%	97%	96%	152%

At the time of the study the bed occupancy was 96.4%

The current shift establishment is:

Day	**Night**

RN	CSW	RN	CSW
4	3	3	2

The budgeted establishment is for 30 beds is 20.32wte RNs and 18.32wte CSW

Contracted for the time of data collection was 9.72wte RN and 13.91wte CSW

At the time of the data collection these were vacancies of 10.6wte RN and 3.41wte CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Nidderdale	1639	£59,715	941	£33,841	3351	48.9%	28.1%	23.0%

Max CHPPD 5.9

Turnover %		Sickness %	
RN	CSW	RN	CSW
0.0%	7.98%	9.0%	14.61%

Quality indicators

Falls	7
Hospital acquired pressure ulcers	5
Medication incidents	4
Staffing Datix	1
Formal Complaints	Poor patient care x1 complaint

Enhanced care: There were a total of **136 enhanced** cares. This averages at **4.4** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	54	1.74
Discharges	42	1.35
Transfers In	35	1.12
Transfers Out	38	1.22
Deaths	5	0.16

Admin Support:

	Establishment	**Contracted**

Band 2	1.0	1,0

Nutritional Assistant:

	Establishment	Contracted
Band	1.0	1.0

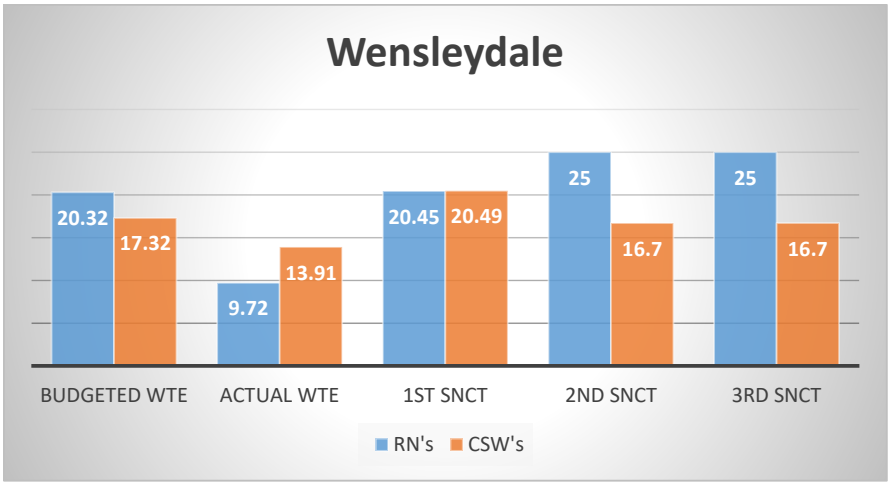
Bed occupancy was **96.4%**

The **budgeted** RN establishment is **20.32wte**

This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

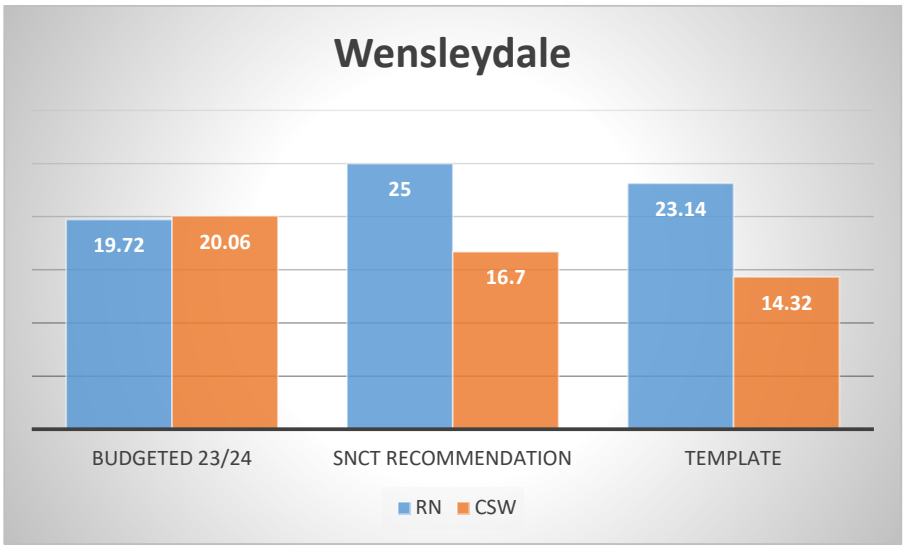
The 1st SNCT possible fault with data

The 2nd and 3rd SNCT are based on 30 beds



The table below indicates the 2023/2024 budget against the SNCT recommendations for Wensleydale (30 bedded non-elective surgical ward).

Management time will need to be added to the RN WTE, within the SNCT recommendation.



30 beds (Non elective)

Agreed SNCT recommendation with professional judgement:

- RN 25.0
- CSW 16.7

Proposed Staffing Template (including management days)

- RN 25.88
- CSW 19.72

	Early	Late	Night
RN	**5**	**5**	**4**
CSW Band 2	**4**	**4**	**3**
MD	**22.5 hours (0.6 WTE)**		

Nidderdale: Female Surgical and Gastroenterology (30 beds)

Nidderdale is a 30 bedded Female Surgical and Gastroenterology ward. The ward is a "T" shaped ward. With four adjacent bays and six single rooms, all of which are not in sight of the main staff base. Single room 1 and 2 are opposite bay 3 and single rooms 27 and 28 are opposite bay 6. The two remaining single rooms are out of sight off the entry corridor. The bathrooms, staff base linen room, and storage room face the bays. Other rooms include the ward office, dirty utility room, ward kitchen, treatment room, doctors' office, quiet room, therapy storage and staff room, which are all located a distance away from the main patient areas along the entry corridor.

At the time of the data collection the ward was led by an experienced band 7 ward manager. The leadership of the ward was overseen by an experienced Matron and supported by experienced Band 6 Ward Sisters. The budgetary allocation for the Ward

Manager is three management days per week; although these frequently change to clinical days due to staffing pressures.

A significant number of patients are frail and elderly. They often experience a post-operative delirium and have an increased risk of falls. Due to this there is a daily request for an additional CSW overnight and increasingly for the additional long day shift. The ward exits by single room 2 and single room 27 are swipe card activated to prevent at risk patients leaving the ward. At risk patients are cohorted in bay 5 and 6 as these bays are the closest to the staff base. As a direct result of the COVID pandemic many patients that are admitted to Nidderdale have been found to be deconditioned. This has increased their care needs and impacted on length of stay.

Patient care is allocated by splitting into three teams of ten. Each team consists of the single rooms and bays. For example: Team 1 includes single room 1 and 2 and B3 - B10.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is sometimes done to support junior nurses who require a less acute team. The nurse in charge overarches all the patients and provides support as needed. If there are 3 RN's on shift the nurse in charge overarches and cares for a team of 10 patients.

Over the data collection period the fill rates were:

Data collection period	**Day**		**Night**	
	RN	CSW	RN	CSW
October 2022	69%	52%	69%	72%

The current shift establishment is (for 30 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	4	3

At the time of the study the bed occupancy was 95.6%

The budgeted establishment is for 30 beds is 19.72wte RNs and 20.06wte CSW

Contracted for the time of data collection was 14.61wte RN and 10.95wte CSW

At the time of the data collection there were vacancies of 5.11wte RN and 9.11wte CSW

Bank or Agency Fill:

	Nhsp Use		Agency Use		Demand and Fill			
	Hours	Cost	Hours	Cost	Demand Hours	NHSP fill%	Agency Fill %	Unfilled %
Wensleydale	1393	£47,476	425	£18,604	2330	59.8%	18.2%	22.0%

Max CHPPD 6.6

Turnover %		Sickness %	
RN	CSW	RN	CSW
0%	0%	2.77%	3.02%

Quality indicators

Falls	0
Hospital acquired pressure ulcers	2
Medication incidents	1
Staffing Datix	0
Formal Complaints	Patient self-discharged – long wait for op and staff attitude (complaint) x 1

Enhanced care: There were a total of **10** enhanced cares. This averages at **0.3** enhanced care patients per day.

	Total in data collection period	**Average per day**
Admissions	184	5.93
Discharges	160	5.16
Transfers In	158	5.09
Transfers Out	154	4.96
Deaths	4	0.12

Admin Support:

	Establishment	**Contracted**
Band 2	1.0	1.0

Nutritional Assistant:

	Establishment	**Contracted**
Band	1.0	1.0

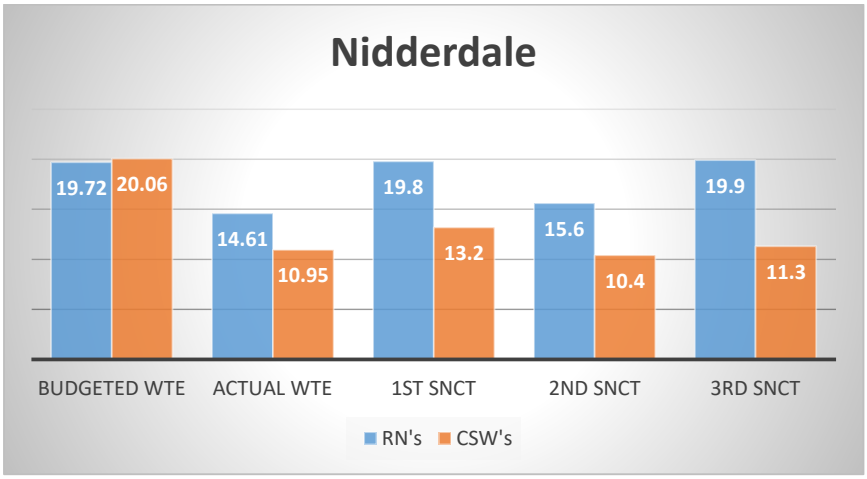
As a summary of the SNCT study period

This Table shows the 22/23 budget against the 'in post' WTE and the three SNCT recommendations.

The 1st SNCT was based on 30 beds

The 2nd SNCT are based on 15 beds

The 3rd SNCT are based on 25 beds



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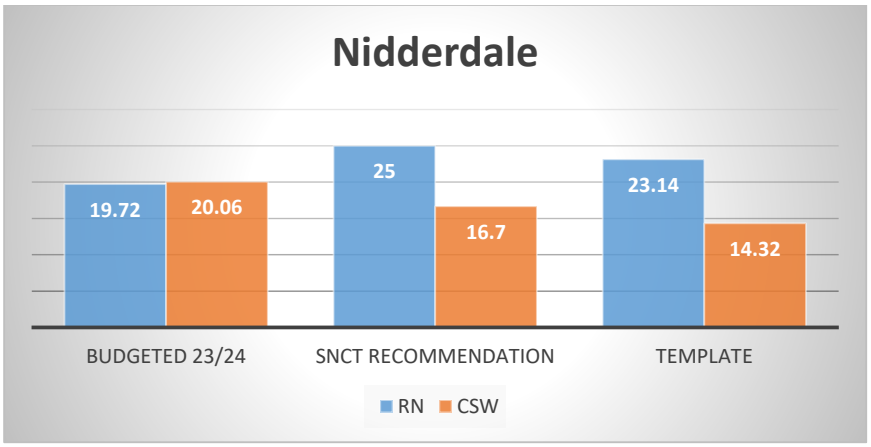


Agreed SNCT recommendation with professional judgement:

- SNCT RN 25.0
- CSW 16.70

Proposed staffing template including management time:

- RN 23.14
- CSW 14.32

	Early	Late	Night
RN	**5**	**5**	**3**
CSW Band 2	**3**	**3**	**2**
MD	**22.5 hours (0.6 WTE)**		

Considerations:

- HDFT ‘Headroom’ is below the national recommended allocation. Currently it is 21% and doesn’t include a provision for maternity leave. The minimum recommended ‘Headroom’ is 22%. Note: The SNCT calculations are based on a minimum of 22%.
- The registered nurse/care support worker staffing ratio for this base ward is 60/40.
- Nidderdale has some significant registered nursing gaps with a turnover equal to recruitment. Therefore heavily reliant on its own staff to work extra shifts in addition to agency and require NIC redeployment from other wards to assist with the imbalance of skill mix within the RN establishment.

Recommendations:

- Provisions within the ‘Headroom’ should be reviewed on an annual basis, when budget setting, to reflect the current state. For example medical isolation during COVID, including maternity leave, increased sickness, known development programmes (study leave), carry over annual leave.
- The proposed staffing template should be funded; ensuring consideration of all necessary support roles which would contribute to improved patient outcomes.
- Increase Nutritional Assistant cover, to support weekends
- Increase Ward Clerk hours to cover the evenings and weekends (8-8).
- To include the appropriate allocation of management time within the staffing template.
- Rollout of Safecare to enable evidence based decision making in the redeployment of staff.
- Monitoring of staff that are redeployed, to review the impact of being moved. This will enable improved understanding of reasons for staff reluctance to move so that these issues can be addressed/mitigated.
- To continue to closely review incentive payments for additional hours
- To increase International Recruitment and domestic pipelines (Business cases in progress).
- To develop communication skills training with support from learning and development.
- To calculate the ‘planned’ CHPPD for Nidderdale, if staffing was at 100% fill, so that we can benchmark against ‘Actual’ and report on this monthly.

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 • Complete • 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 – Q3 23/24	• Complete • Complete • On Track	
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 23	• Complete • Delayed – work ongoing • Complete	
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 • Delayed – lack of capacity delayed to end QI 23/24 • Delayed – lack of capacity delayed to end Q1 23/24 • Delayed – lack of capacity delayed to end Q1 23/24 • Delayed - lack of capacity delayed to end Q1 23/24	

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 • Review of previous work on Hopes for Healthcare – May 23 • Stakeholder review of Hopes for Healthcare ambitions – Jul 23 • Relaunch of updated Hopes for Healthcare ambitions – Sep 23	• Complete – First board held on 21 Feb • On Track • On Track • On Track	

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 • 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	• Compliant • Compliant • 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 • Compliant • Compliant • Compliant • Compliant	

Harrogate and District NHS Foundation Trust

4.2

Strengthening Maternity and Neonatal Safety Report

SMT

February 2023

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), 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 February 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 February 2023 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

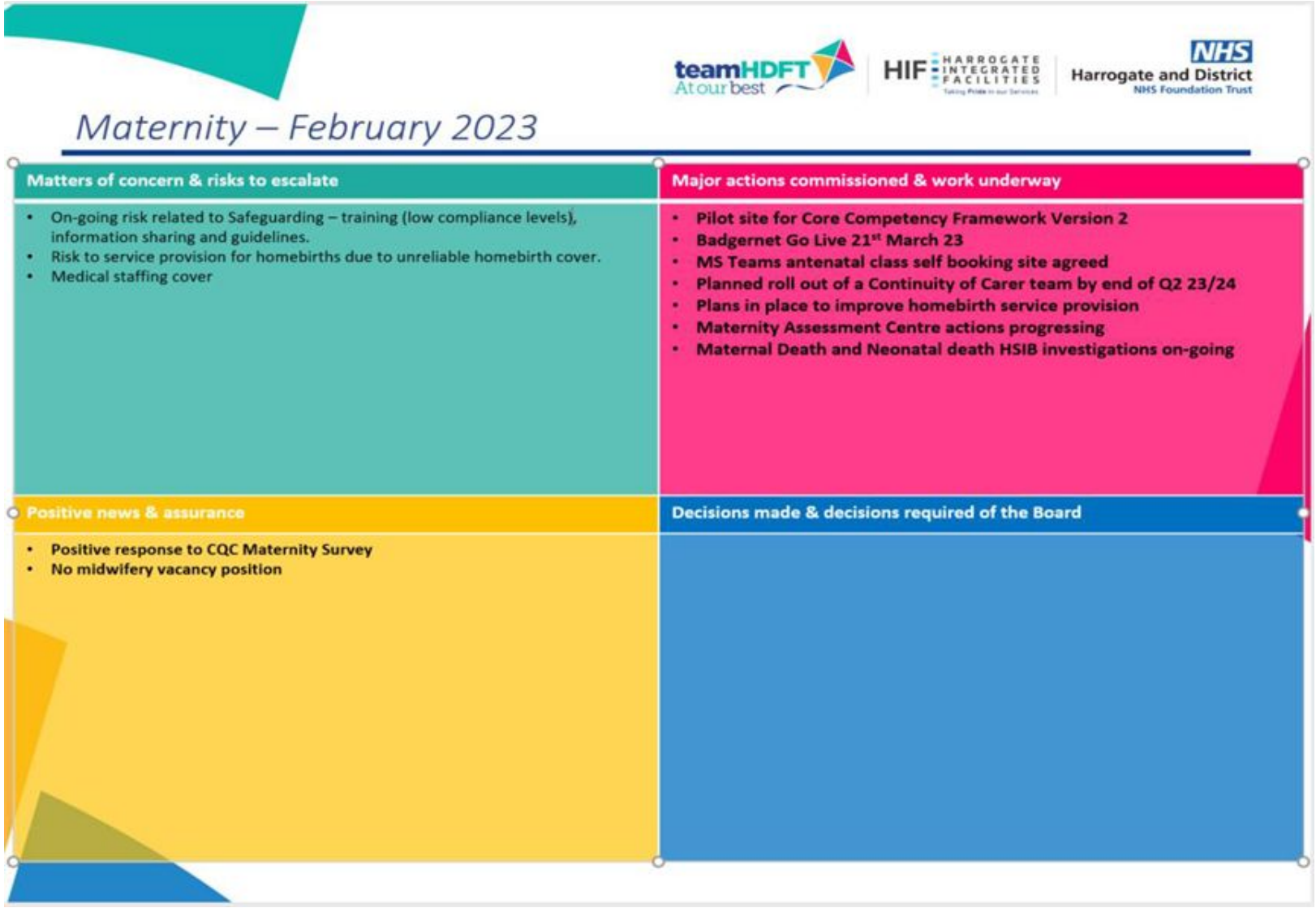
4.1 Not applicable

5.0 Risks and Mitigating Actions

5.1 Safeguarding training, communication and guidelines
5.2 Homebirth service provision
5.3 Maternity Assessment Centre risk assessment and documentation

6.0 Recommendation

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


teamHDFT
At our best
HIF
HARROGATE INTEGRATED FACILITIES
NHS
Harrogate and District
NHS Foundation Trust
Maternity – February 2023
Matters of concern & risks to escalate
On-going risk related to Safeguarding – training (low compliance levels), information sharing and guidelines.
Risk to service provision for homebirths due to unreliable homebirth cover.
Medical staffing cover
Major actions commissioned & work underway
Pilot site for Core Competency Framework Version 2
Badgernet Go Live 21st March 23
MS Teams antenatal class self booking site agreed
Planned roll out of a Continuity of Carer team by end of Q2 23/24
Plans in place to improve homebirth service provision
Maternity Assessment Centre actions progressing
Maternal Death and Neonatal death HSIB investigations on-going
Positive news & assurance
Positive response to CQC Maternity Survey
No midwifery vacancy position
Decisions made & decisions required of the Board

Narrative in support of the Provider Board Level Measures – February 2023 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

The maternity unit has been staffed to minimum safe staffing standards at all times during February 2023. There remains one vacant slot on the middle grade night and weekend rota. This slot is vacant pending appropriate sign off of competency to work with a consultant off site. In addition there are vacant shifts on the first on call rota due to maternity and a doctor working less than full time. The vacant shifts have all been covered by a combination of doctors undertaking additional adhoc sessions (including consultants acting down) or agency locums. The unit has been safely staffed at all times during the reporting period.

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.

3.1 Absence position

Total hours lost to sickness 712.75 hours (4.4 WTE)

Midwifery hours lost across maternity services –
367.5 hours (2.26 WTE) sickness absence
5.6 WTE maternity leave

Maternity support worker hours lost across maternity services –
345.25 hours (2.12WTE) sickness absence

3.2 Vacancy position

0 WTE Midwifery vacancy (Band 5-7). One Band 6 midwife awaiting start date.

5.4 WTE Maternity support worker vacancy (Band 2-3) – 4.6 WTE have been recruited and will start throughout March 2023.

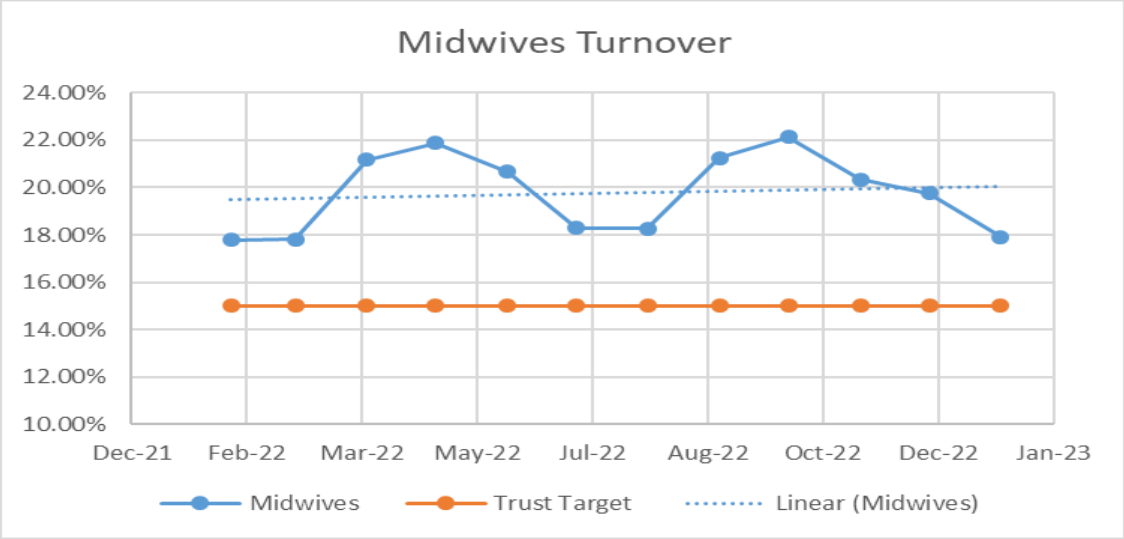
No Maternity Assessment Centre MSW band 3 cover at present. Recruited band 2 MSW's following review of turnover and roles undertaken. There has also not been available staffing to consistently add a third midwife to night shifts on Pannal in this period. This was a recommendation from the Birthrate plus review however there have been no incidents from there being only two midwives on a night shift. Bed occupancy at night is rarely at full capacity.

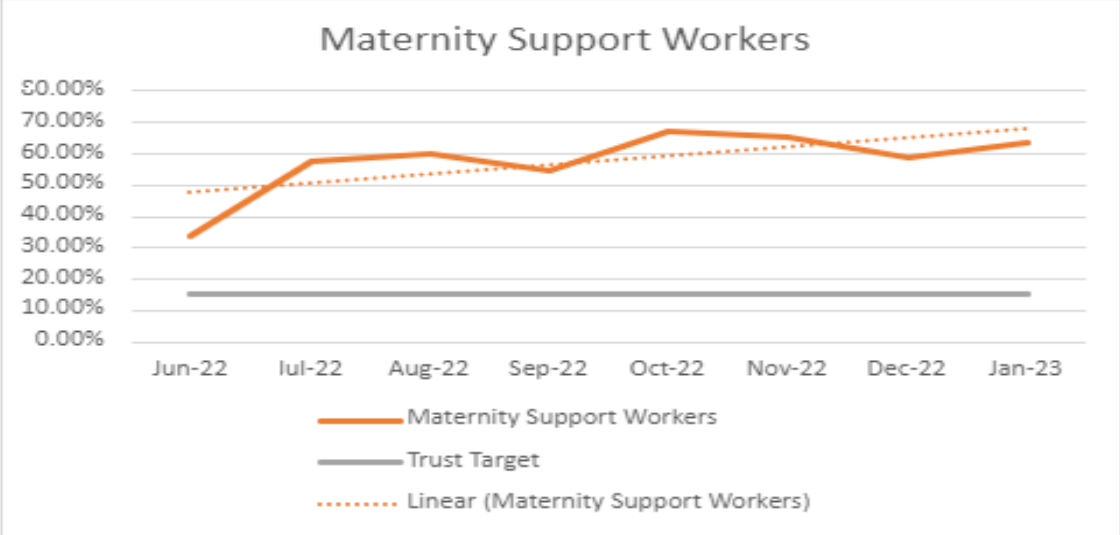
3.3 Use of NHSP

1.47WTE NHSP midwifery staffing across Maternity services.

2.38WTE NHSP maternity support worker staffing across Maternity services.

3.4 Staff Turnover





3.5 Homebirth provision

Home birth provision is covered by a first and second on-call midwife every night between 17:00 – 08:00.

Two homebirths were booked for the month of February 2023. Two homebirths were attended at home, one woman progressed to birth at home, and one woman had a labour assessment at home. No homebirths were transferred to hospital due to a cancelled service.

In the period 1/2/23 – 28/2/23, the home birth provision was suspended on six occasions (21.4%). The service was suspended due to:

- Six ongoing Friday and weekend cover issues

A review of the organisation of on call cover is on-going with a pilot planned for April in which the weekends will be covered by a community midwife working a night shift on Pannal who is able to be released to attend a homebirth.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Neonatal absence position

Current maternity leave – 0.69 WTE B6
0.14 WTE nurse short term absence
No long term absence

4.2 Neonatal Vacancy

1.22 WTE remaining vacancy to be recruited into

4.3 Neonatal Recruitment

- 1 WTE Start date May 2023 (QIS)
- Remaining 1.22 WTE out to advert at Band 5

4.4 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. The ODN have clarified that the QIS compliance is based on staff in post excluding any vacancy.
78.9% compliance (8.05WTE QIS/10.19WTE overall).
Staff nurse 0.61 WTE is currently undergoing QIS course – will have qualification by May 2023.

5.0 Birthrate Plus Acuity Staffing Data

The Birthrate Plus score system is based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. Using the Birthrate Plus classification system the tool provides an assessment of women's needs during their episode of care in the delivery suite and on Pannal, recorded in real time on a 4 hourly basis to enable managers to ensure safety for women and babies during this period. The score sheet provides a research-based method to enable the midwife to assess the midwifery workload required to care for a woman at any time in the intrapartum and immediate post delivery period. Workload is based on

• A minimum standard of one to one care for all women in labour

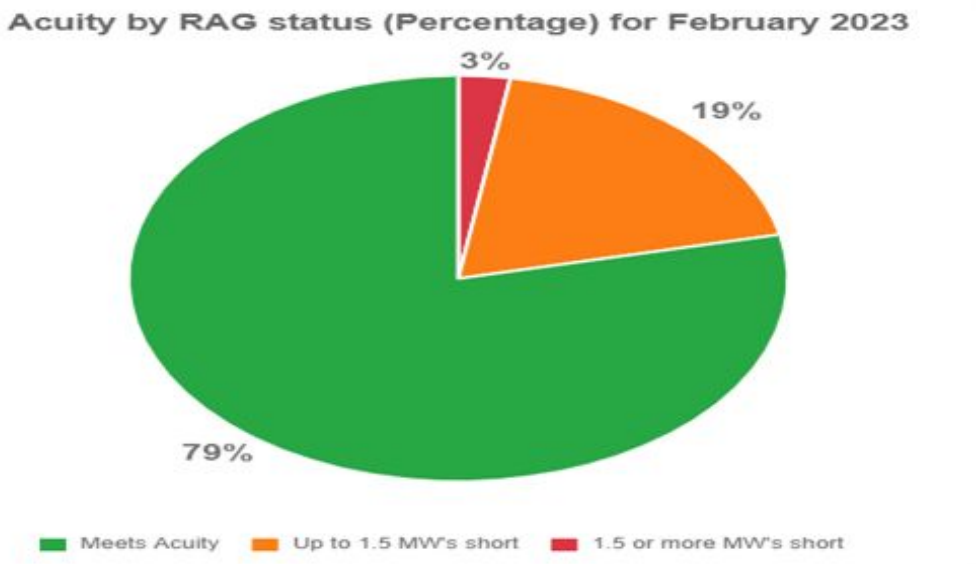
• Increases in this standard for women with higher care needs (Categories III to V)

5.1 Delivery Suite Staffing

The following graph highlights that the provision of staff during February 2023 on Delivery Suite has met the acuity 79% of the time. 79% of the time no clinical actions were required. 21% of the occasions clinical actions were required, these included:

· Delay in continuing IOL - 24 occasions (67%)
• Delay in LSCS- 2 occasions (6%)
· Postponed IOL - 1 occasion (3%)
· Coordinator not supernumerary – 10 occasions (28%)

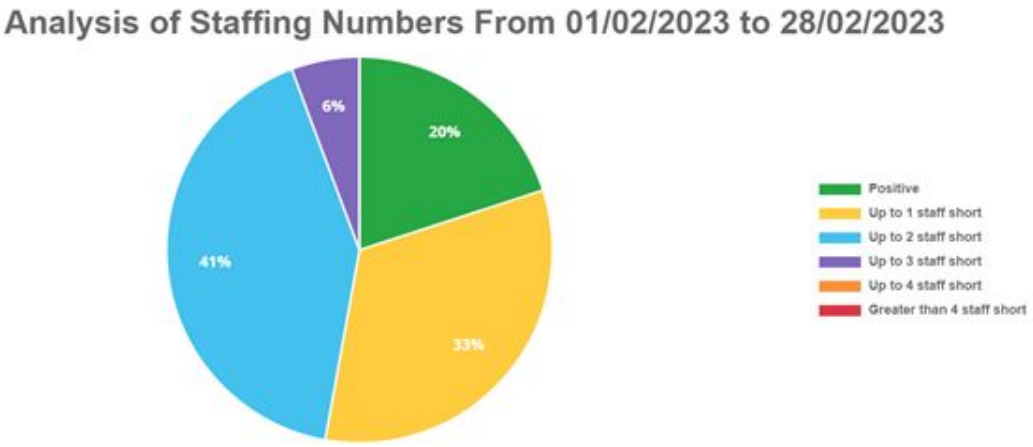
These percentages do not add to 100% as more than 1 action could have been taken at any one time.



100% of women received one to one care in labour within the unit. There were two babies born before arrival (BBA).

5.2 Pannal Ward Staffing

There were 84 scheduled assessment periods of these 70 were completed, giving a confidence factor of 83%. The data over the last month shows Pannal ward to have met acuity 73% of the time. During the month the data reports that 27% of shifts being at least a midwife short or staff being redeployed.



30% of shifts recorded a relevant staffing factor

· Unexpected MW absence - five occasions
· MW redeployed elsewhere - ten occasions
· Unexpected support worker absence – four occasions
· Unable to fill vacant support staff shift – four occasions

From the data collected from Birth Rate Plus, no clinical actions were required on 91% of occasions during the reporting period. On 9% of occasions, actions were required. These included:

· Delay in IOL > 24 hours – one occasion

· Delay in discharge > 2hrs- one occasion

· No beds – two occasions

· Delay in continuing IOL – two occasions

6.0 Red Flag events recorded on Birthrate Plus

6.1 Red Flags

According to NICE (2017) *a midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed. Examples of Red Flags are -*

• Delayed or cancelled time-critical activity.
• Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
• Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
• Delay of more than 30 minutes in providing pain relief.
• Delay of 30 minutes or more between presentation and triage.
• Full clinical examination not carried out when presenting in labour.
• Delay of 2 hours or more between admission for induction and beginning of process.
• Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
• Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.
• Other midwifery red flags may be agreed locally.

6.2 Delivery Suite Red Flags

Delivery Suite record when the following Red Flag events occur –

RF1	**Delayed or cancelled time critical activity** MROP Em LSCS (Cat 1,2 as per National guidance) 3rd/4th degree tear Delay in continuing with IOL process (in-patient)
RF2	**Missed or delayed care** >60 minutes for suturing (except after pool birth) See unit crib sheet
RF3	**Missed or delayed mediation > 30 mins** Medication not given within 30 mins of prescription Low molecular weight heparins, anticoagulants Pain relief following surgery Antihypertensives Epileptic meds Glycaemic control IV Abx - mum or baby
RF4	**Delay in providing pain relief > 30 mins** Delay of > 30 mins in providing pain relief where requested
RF5	**Delay between presentation and triage >30 mins**
RF6	**Full clinical examination not carried out when presenting in labour**
	Delay between admission for induction and beginning of process

RF7	
RF8	**Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)** Where the midwife has not escalated within 30 mins (not delay due to medical response time)
RF9	**Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour** 'labour' defined as 'any woman on a partogram'
RF10	**Midwife unable to provide 1:1 high dependency care for AN or PN patient**

There were two Red Flag identified from the Birth Rate Plus Data.

- Midwife unable to provide 1:1 high dependency care for AN or PN patient
- Delay between presentation and triage >30 min

The following management actions were taken to ensure these clinical red flag situations, and staffing situations described above, were promptly resolved without the occurrence of harm.

Number & % of Management Actions Taken from 01/02/2023 to 28/02/2023

MA1	Redeploy staff from Pannal	**11**	**52%**
MA2	Staff unable to take breaks	**1**	**5%**
MA3	Review of staff on management time	**2**	**10%**
MA4	Use of specialist midwife	**6**	**29%**
MA5	Use of staff on training days	**0**	**0%**
MA6	Use of ward/department managers	**0**	**0%**
MA7	Staff sourced from wider Trust (theatre & CSW's)	**0**	**0%**
MA8	Use of hospital MW on call	**0**	**0%**
MA9	Use of community MW	**0**	**0%**
MA10	Unit on Divert	**1**	**5%**
MA11	Patient diverted	**0**	**0%**
	Total	**21**	

Note

There has been an increase in elective caesarean section work in the theatre on delivery suite due to a lack of theatre slots despite running extra elective caesarean section lists on a Saturday.

6.3 Pannal Ward Red Flags

There were two occasions where Red Flags identified from the Birth Rate Plus Data which were:

· Delay between admission for induction and starting the process – one occasion

· Any occasion when a midwife is not able to provide one-to-one care to a woman in established labour – one occasion

The following management actions were taken to ensure these clinical red flag situations, and staffing situations described above, were promptly resolved without the occurrence of harm.

From 01/02/2023 to 28/02/2023

MA1	Redeploy staff internally	**4**	**31%**
MA2	Staff unable to take allocated breaks	**3**	**23%**
MA3	Redeploy staff from training	**0**	**0%**
MA4	Specialist MW working clinically	**1**	**8%**
MA5	Manager/Matron working clinically	**2**	**15%**
MA6	Utilise on call MW	**0**	**0%**
MA7	Redeploy from community	**0**	**0%**
MA8	Maternity Unit on Divert	**0**	**0%**
MA9	Staff sourced from bank/agency	**0**	**0%**
MA10	Staff stayed beyond rostered hours	**1**	**8%**
MA11	Escalate to manager on call	**2**	**15%**
	Total	**13**	

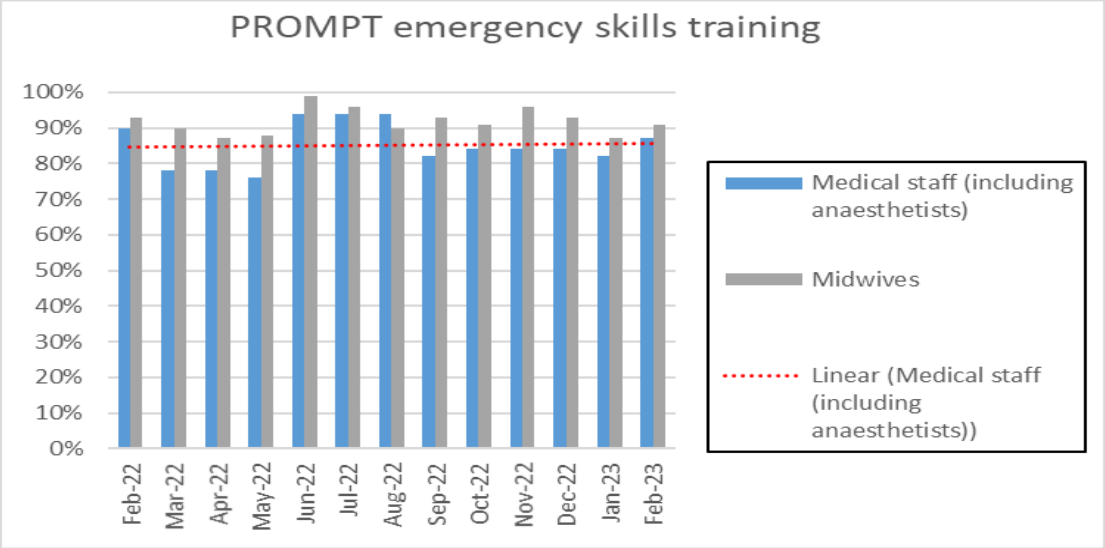
7.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

7.1 Mandatory training

Maternity Area	***Headcount***	***Compliance***
Maternity staffing	51	82.5%
Community Midwifery	27	82.4%
Ante Natal Clinic	11	89.9%
Pannal Ward	21	80.3%
Obs and Gynae Medical	26	88.6%
EPAU	4	70.4%

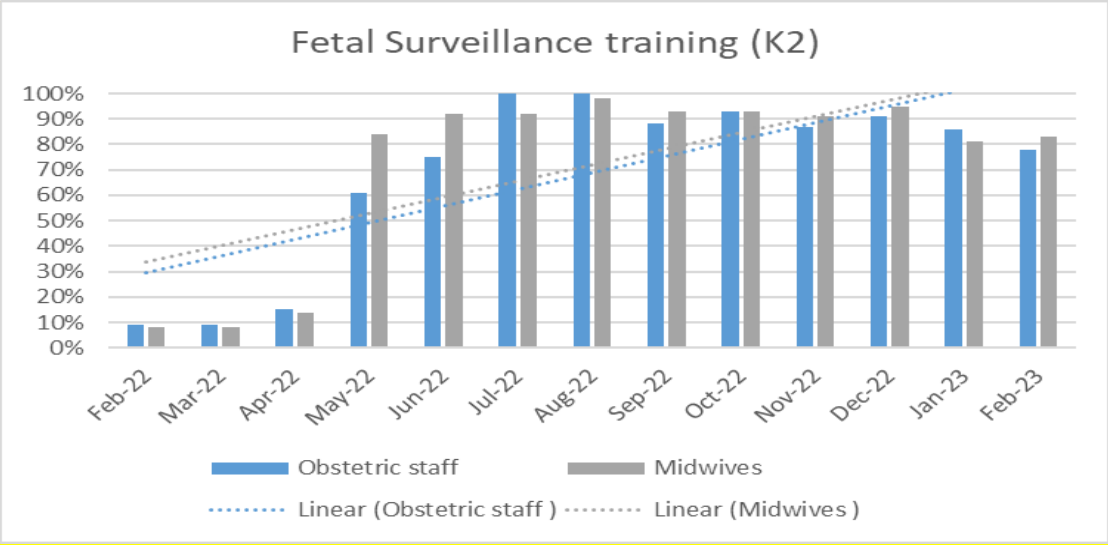
7.2 Prompt emergency skills training

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



7.3 Fetal surveillance training (K2 online training package)

There has been a slight decrease in compliance with midwifery compliance with K2. This is due to a number of midwives expiring at the same time. All relevant staff members have been contacted by their manager to ensure the package is completed as soon as possible. Staff who are not in date with their training are unable to work on Delivery Suite until their training is complete.



7.4 Safeguarding Children and Adults training

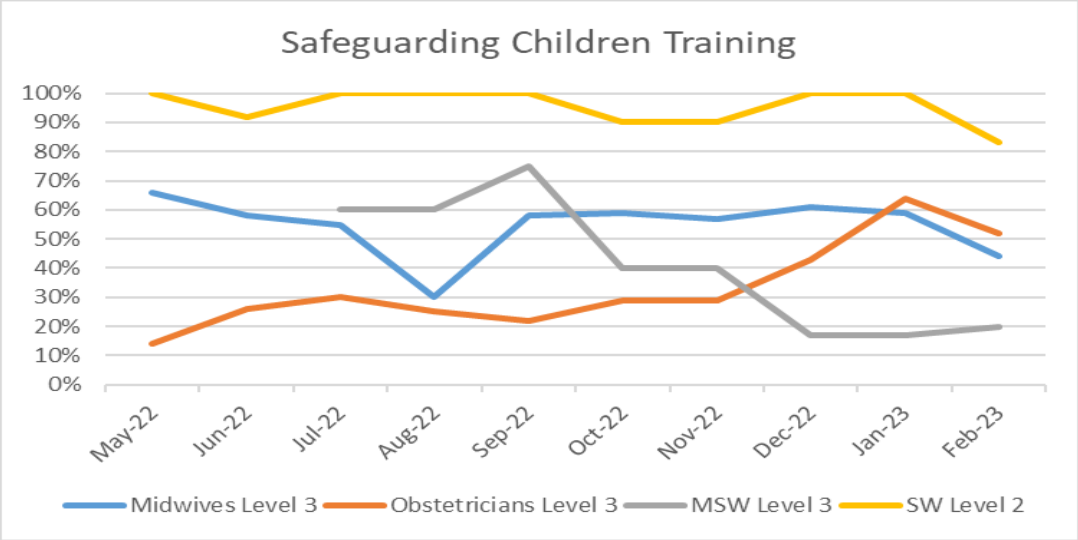
Updated figures for safeguarding training are not currently available. It is recognised that the staff compliance with Safeguarding Children training is not meeting the required standards. This has been added to the Risk Register and an action plan has been created. A Band 8A

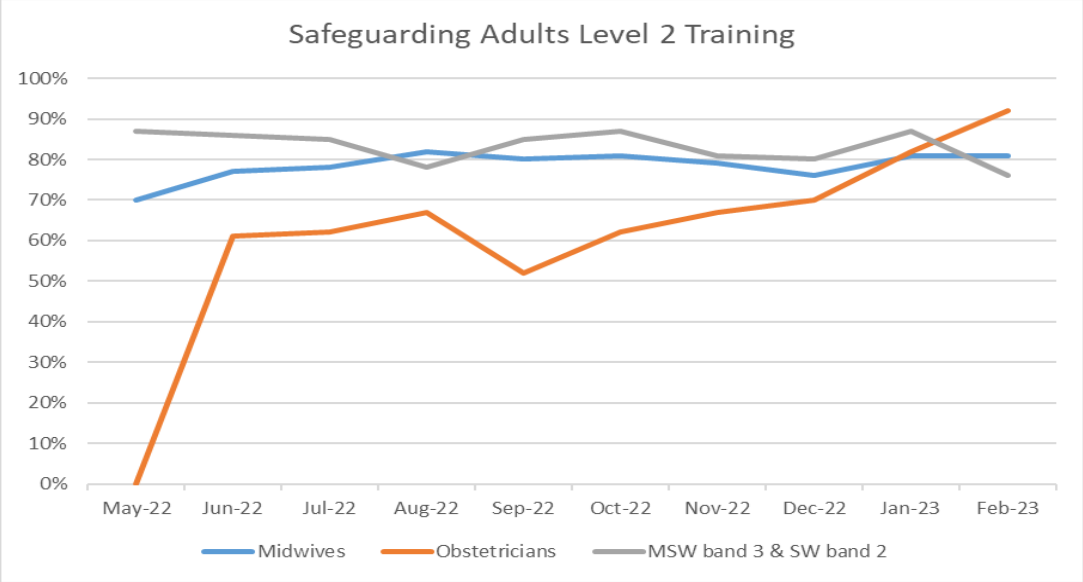
Named Midwife for Safeguarding job is in post from 6th March 2023. We have streamlined Safeguarding Children level 3 training to align to the National Core Skills Training Framework (CSTF). This change:

- Allows training completed at another NHS Trust aligned to CSTF to transfer to Learning Lab record.
- Allows completed training to be transferable to other NHS Trusts aligned to CSTF.
- Alters the renewal period for all staff who require safeguarding children level 3 to annual.

Work is underway to improve compliance with training between January and March 2023. Maternity Support Worker compliance levels have been affected by a recent high turnover rate and work is in progress to improve this situation.

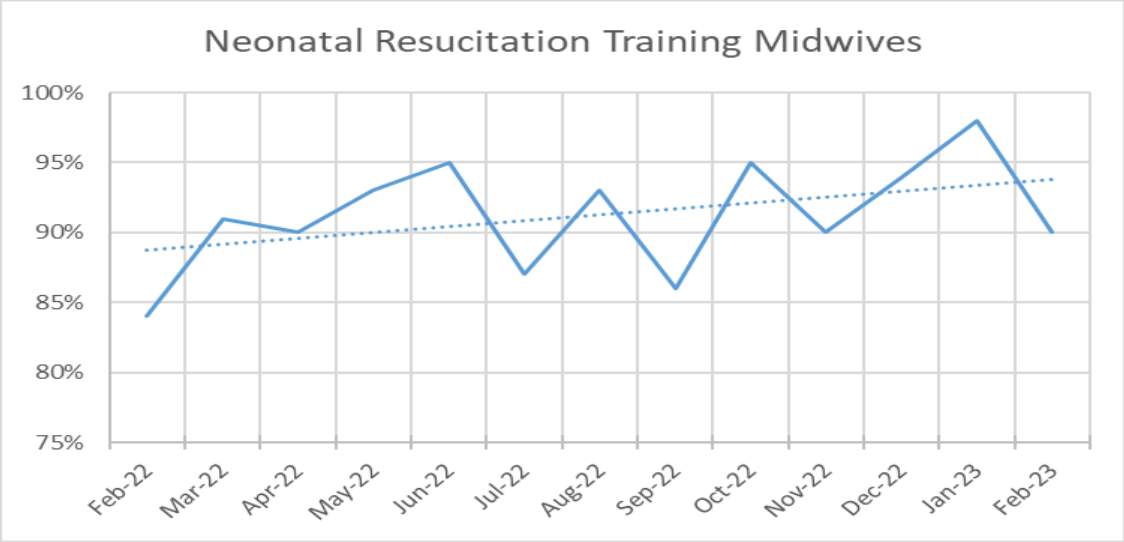
A new package of Safeguarding training will be in place from April 2023. Staff will be prioritised for attendance based on their current compliance. Consideration of multi-agency training is also in progress. Work is also on-going to improve compliance of Adult Safeguarding training and supervision.





7.5 Neonatal resuscitation – Midwives

Unfortunately we are currently unable to report true compliance for neonatal resuscitation. The Resuscitation Lead has stated that we are in a transition period whilst we await approval to change the expiry date of the previous newborn basic life support to 6 months to ensure that we are able to get everyone through the updated training which aligns with Resuscitation Council UK and Maternity Incentive Scheme before December 2023. This action is with the Resuscitation Lead.



7.6 SCBU Training Compliance

Overall Learning Lab training compliance for SCBU staff is 87%.

Three staff members attending NALS March 2023
NLS update completed with two key trainers on SCBU and resus team – to roll out new training sessions this year to update all members of staff.

8.0 Risk and Safety

8.1 Maternity unit closures

One closure listed in February 2023 (for five hours) due to high acuity and no on-call midwife. No patients diverted.

8.2 Maternity Risk register summary

No new risks have been added to the risk register in February.

9 current risks:

- **Risk to patient safety, and lack of compliance with national recommendations due to inadequate provision of Named Midwife: Safeguarding oversight (Score 12).** Full time Safeguarding Lead appointed. For downgrade and archive
- **Risk to compliance with national strategy, MSDS, and patient safety due to lack of end-end electronic record system (Score 9).** Go-live date deferred to March 2023. No further change in risk level at present. For downgrade and archive once implemented following Go-live

- **Risk to patient care due to current lack of Perinatal Mental Health Midwife role (Score 8).** Recruited to role. For downgrade once commenced in post. Risk currently remains the same.
- **Risk to service provision for homebirths due to unreliable homebirth cover (Score 8).** Difficulties experienced in providing cover for homebirths due to staffing model and sickness issues. Some work ongoing to aid support for homebirth service. Risk remains the same.
- **Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 6).** Action plan in place and updates being completed by Named Midwife for Safeguarding. No current 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. Digital Midwife working on appropriate solution with Badgernet implementation. No current change.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance improving and action plan in place. Risk level currently remains unchanged.
- **Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 6).** Pressures remain within the service. No change
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 4).** Service now set up. For downgrade and archive once commenced.

8.3 Maternity Incidents

In February 2023 there were 55 total incidents reported through Datix (but four rejected as a duplicates). There were no incidents recorded as Moderate Harm or above. However there were two 48h reports completed:

- One incident relating to missed opportunity for cervical length scan and cervical cerclage, resulting in extreme preterm labour and subsequent fetal loss
- One incident relating to a twin-twin transfusion and fetal demise following delayed fetoscopic laser ablation after missed 16 week appointment is under discussion (currently No Harm)

Additional incidents of note include:

- Seven readmissions of mother/baby (Five babies with jaundice/weight loss/feeding issues; two maternal readmissions)
- Five fetal losses below 24 weeks
- Four Unexpected Term Admissions to SCBU (includes one admission for social reasons)
- Four incorrect treatment/tests/procedures
- Three 3rd degree tears
- Three reactions to iron infusions
- Two in utero transfers

8.4 SCBU Incidents

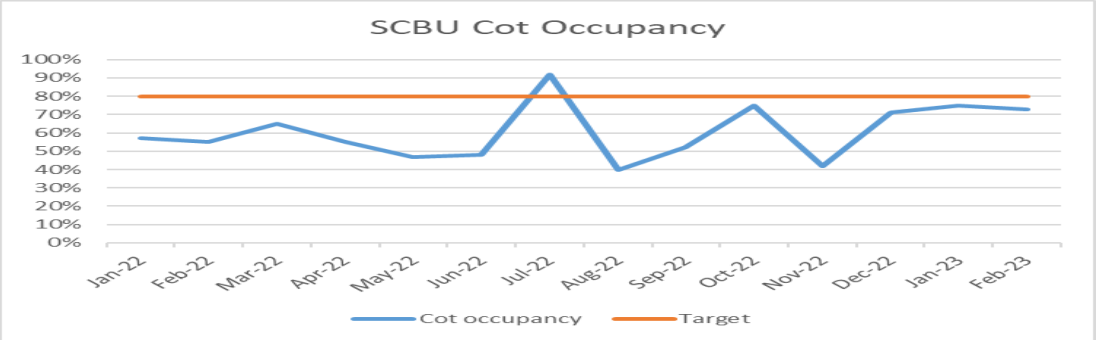
1) Four ATAIN cases
2) No moderate harm incidents
3) One incident where COVID positive parent attended unit
4) Three incorrectly plotted SBR results

5) One baby with multiple haemolysed samples leading to delayed treatment for jaundice – exchange level.

8.5 SCBU Risk Register

No new risks.
QIS staffing remains on the risk register however QIS cover has improved and this is likely to be removed at next risk register review.

8.6 Cot occupancy and babies transferred out



8.6.1 No babies transferred out in February.

9.0 Perinatal Mortality Review Tool (PMRT)

9.1 Principles for the conduct of local perinatal mortality reviews:

- There should be comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight.
- Such reviews should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes;
- A multidisciplinary group should review each case at a meeting where time is set aside for doing the work;
- There should be scope for parental input into the process from the beginning;
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report which should be shared with families in a sensitive and timely manner;
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements;
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6;
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22+0 to 28 days after birth;

- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

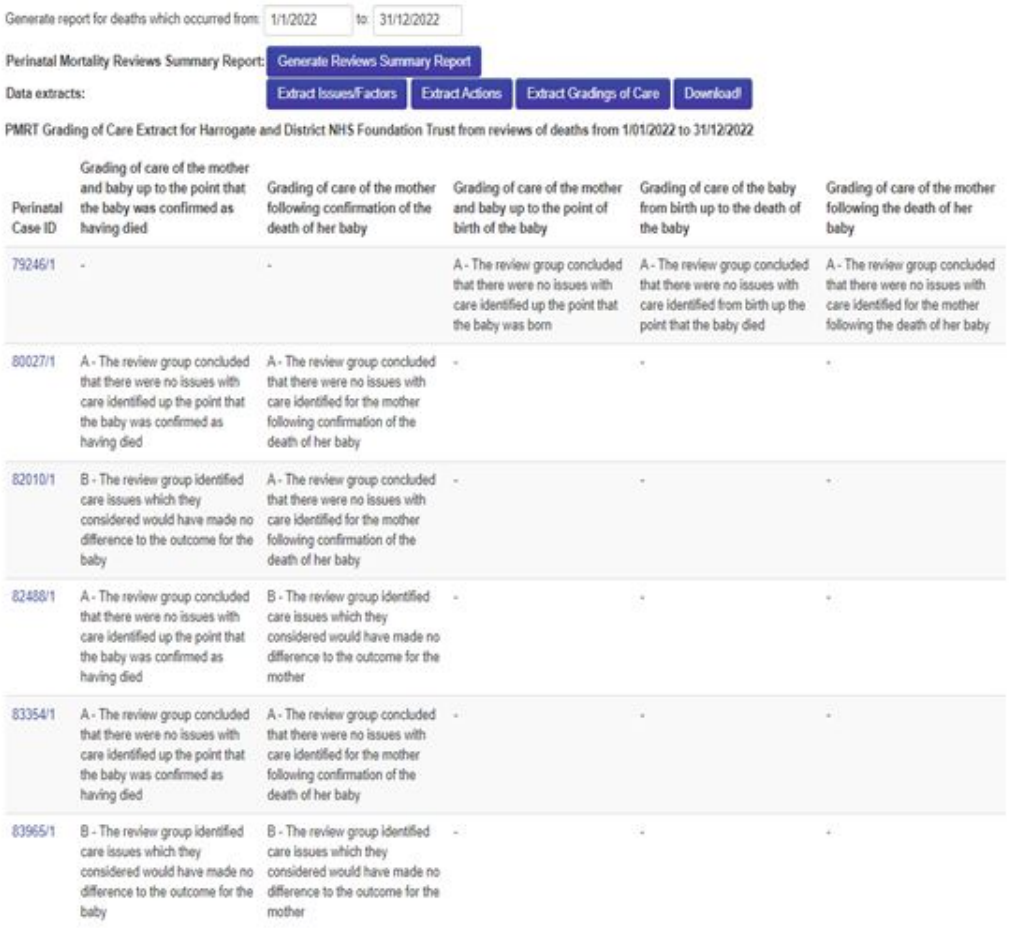
The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation;
- Babies who die in the community 28 days after birth or later who have not received neonatal care;
- Babies with brain injury who survive.

9.2 HDFT PMRT Information

No new PMRT reviews completed in this period.
One new reportable case has been notified in February. Four cases are awaiting review.

A summary of the findings of the grading of care during 2022 is seen below.
The gradings options are:
A - The review group concluded that there were no issues with care identified
B - The review group identified care issues which they considered would have made no difference to the outcome
C - The review group identified care issues which they considered may have made a difference to the outcome
D - The review group identified care issues which they considered were likely to have made a difference to the outcome



Generate report for deaths which occurred from: 1/1/2022 to: 31/12/2022

Perinatal Mortality Reviews Summary Report: Generate Reviews Summary Report

Data extracts: Extract Issues/Factors | Extract Actions | Extract Gradings of Care | Download!

PMRT Grading of Care Extract for Harrogate and District NHS Foundation Trust from reviews of deaths from 1/01/2022 to 31/12/2022

Perinatal Case ID	Grading of care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby	Grading of care of the mother and baby up to the point of birth of the baby	Grading of care of the baby from birth up to the death of the baby	Grading of care of the mother following the death of her baby
79246/1	-	-	A - The review group concluded that there were no issues with care identified up the point that the baby was born	A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
80027/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-	-	-
82010/1	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-	-	-
82488/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	-	-	-
83354/1	A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	-	-	-
83965/1	B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	-	-	-

10.0 Service User feedback

10.1 CQC 2022 Maternity Survey

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The NPSP is commissioned by the Care Quality Commission (CQC) and as part of the NPSP, the 2022 Maternity Survey is the ninth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2022. A total of 45,621 mothers were invited to participate in the survey across 121 NHS trusts. Completed responses were received from 20,927 respondents, an adjusted response rate of 46.5%.

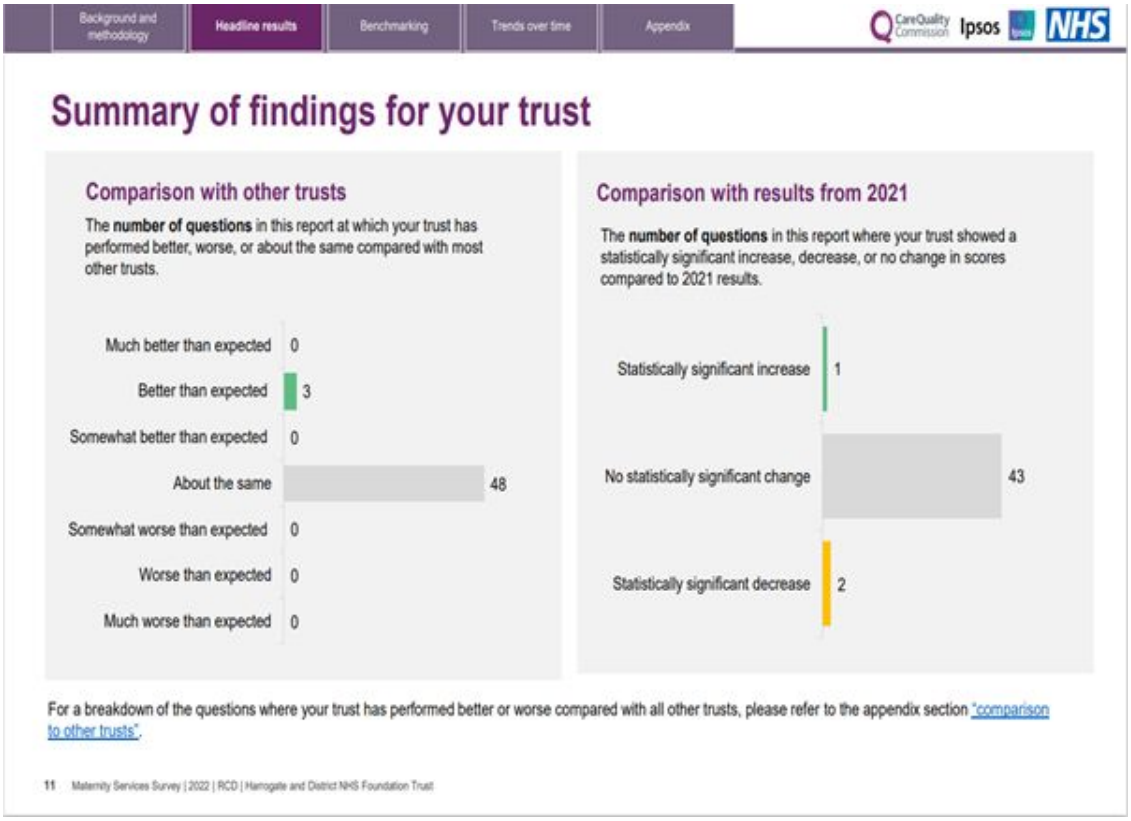
The results show that HDFT is not an outlier organisation (positively or negatively). An action plan has been created to address the areas where mothers' experience could be improved.

There was a significantly significant increase from the 2021 survey noted in the response to the question *"During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?"* This situation will hopefully continue to improve also with the implementation of Badgernet.

The two statistically significant decreases relate to the following two questions –

- *Thinking about your stay in hospital, how clean was the hospital room or ward you were in*?
- *On the day you left hospital, was your discharge delayed for any reason?*

The actions for these two questions will be picked up as part of the local action plan.



10.2 Feedback gained via Maternity Voices Partnership (MVP)

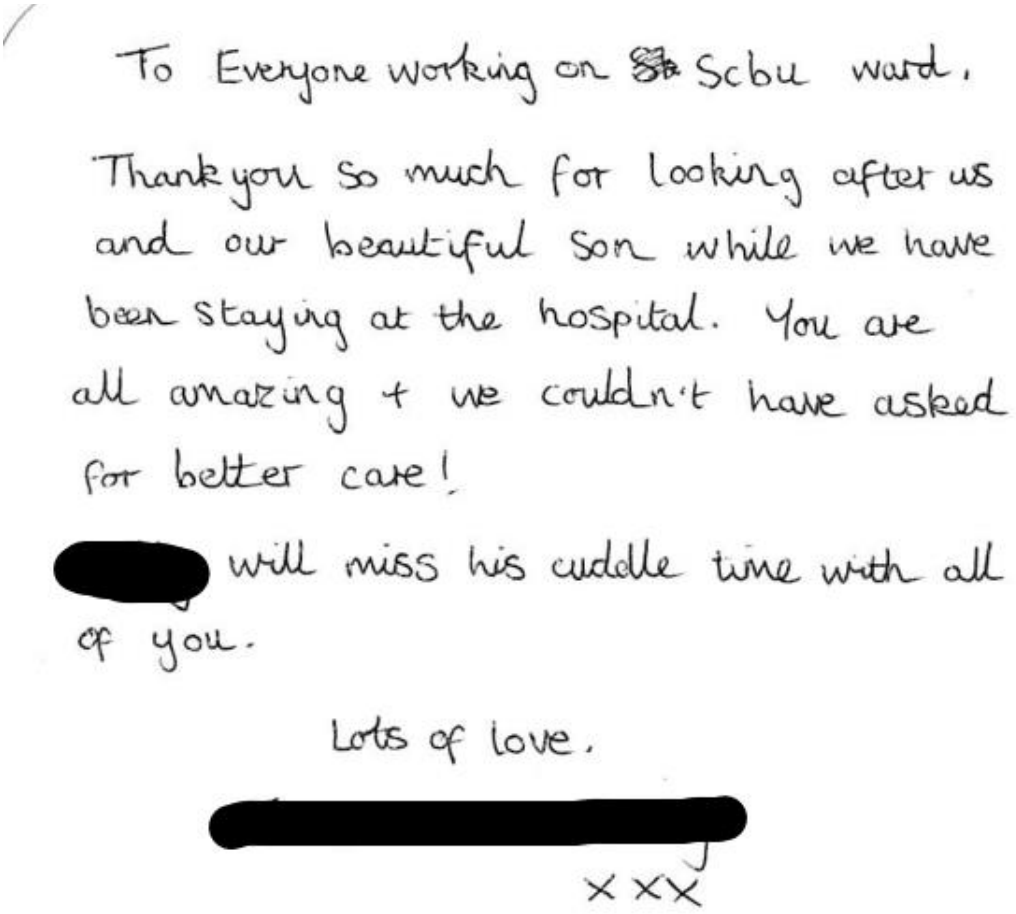
What do you think could have been done differently or could be developed or improved? 6 responses

1. Give appointment times for postnatal community midwife visits. It's not good for new mums to be stuck inside all day, on several days, waiting for someone to appear.
2. See previous answer.
3. Continuity of care. I only met 1 midwife twice and seeing same team would have been nice rather than giving my life story every week. Would have been nice to have support o MY partner more. Maybe doing lateral flow so he could support me at such a hard time.
4. The anaesthetist was absent for three hours after a failed epidural, which was an agonisingly long time to wait. I felt slightly pressured to have a student midwife during the latter stages of my labour (despite making it clear in my birthing notes I did not want one, so it felt inappropriate to ask when I had been in labour for 24 hours snd was too exhausted to say no).
5. We would of loved too see the midwives that helped us personally over the days we were in to get there names be able to thank them personally before we went home!
6. Nothing

Please use this box to tell us about your experience. 6 responses

1. Inconsistent care, waiting in all day for midwife who sometimes failed to appear. GP appointment at 8 weeks was virtually useless - checked baby, showed almost no interest in me.
2. I gave birth at Harrogate Hospital in June 2022. I was induced at 39 weeks following advice from a consultant that my baby was measuring big and that coupled with being borderline for gestational diabetes meant that they would prefer me to have my baby by my due date. My experience of induced labour at Harrogate was overwhelmingly positive. The midwives are all incredible, so empathetic and supportive. I felt like I had choices every step of the way and was helped to make decisions about timing and procedures that felt right for me. I had said I was happy for student midwives to attend. Again, this was a really positive experience. I liked having additional people to talk to at what was a completely new experience as a first time mum. The student midwives I saw were all really calm and in control and when they were unsure of anything they asked for support from more senior midwives. The midwife we had with us during labour (Wendy) was amazing. I felt incredibly supported by her. She let labour how I wanted whilst always being vigilant and on hand to make suggestions and jump in when she needed to. Care on the Pannal Ward following delivery was also great. I felt sorry for the midwife who had to spend 30mins trying to wrestle compression socks back onto my swollen legs but she was cheerful and said it was no bother! The only time during my pregnancy when I felt that something could have been approached better was in relation to the discussions about gestational diabetes and connection suggestion of induction at 39 weeks. I had to ask for a gestational diabetes test, despite having a BMI of over 30. This test was carried out twice and both times I was borderline (7.6 and 7.7). Because it was 'normal' no one contacted me with my results I ended up speaking to my community midwife about it and she suggested cutting sugar from my diet - which I did. 3 weeks after my second test the consultant rang me to suggest that I cut out sugar. I was a bit miffed it took them 3 weeks to contact me about this I had already been cutting out sugar but if I hadn't have asked then that would have been 3 weeks where I could have been helping myself and wasn't. I also felt that the subsequent discussion about induction of labour was very cold and frightened me. Induction of labour has a very negative reputation online and the way this conversation was approached made me unduly anxious. That being said, I followed up this discussion by talking to a variety of midwives who all helped to reassure me and at the end of the day I am pleased that I followed the advice of the consultant.
3. At 21 weeks I got ICP. Then 28 weeks GD. Lots of reduced movements. Towards end struggled with mental health. At 37 weeks I was induced due to mental health, reduced movements and my health. 4 days later she arrived then 2 days on ward on drips or us both
4. I had my son in November 2019. Despite feeling prepared for the birth with the excellent hypnobirthing course at Harrogate hospital, my labour progressed slowly and I ended up having an emergency c-section. My son was 10lbs 10 (!) and had to be whisked off to the NICU shortly after birth. I had a major haemorrhage of 3.5 litres during the operation, so we both had to stay on the ward afterwards for five days. Despite ALL this, the whole experience was transformed by the truly excellent and compassionate care of the midwives, surgeons, Doctors and care assistants during my time in the hospital. I always felt well informed and listened to, as well as supported in my choices. The breast feeding support by Chloe on the ward afterwards transformed my breastfeeding journey. I feel that it was the staff that transformed my labour and son's birth (that had the potential to be traumatic) into a good experience.
5. The Harrogate team we can't thank enough for what you did for us, Wilf was born the early hours of 13th Wednesday morning, both the student midwife (Sophie) and midwife (I wish I remembered your name) kept calm throughout giving me reassurance. The last hour things started to go wrong and an emergency team came in, again everyone reassured us especially Ben telling him everything they were planning on doing. Decisions had to be quickly made for the best interest of myself and Wilf as we both weren't responding well. I was quickly admitted into theatre and again this team looked after me so well as Ben had to stay with Wilf. The midwife looking after Ben came in numerous times whilst I was in theatre to tell me Wilfs progress. It was a scary time for both myself and Ben that we won't forget but The Harrogate Maternity team couldn't of been any better! Your all incredible at your jobs! Hope you enjoyed the Chocolates! Love Wilf, Vicky and Ben Gregg.
6. I wanted to share I had an incredibly positive experience from my community midwife Sarah Hearne and team as well as the entire midwifery department / team at Harrogate hospital. I was treated with dignity, respect and kept well informed throughout my pregnancy journey.

10.3 Feedback for SCBU



To Everyone working on Scbu ward.

Thank you so much for looking after us and our beautiful son while we have been staying at the hospital. You are all amazing + we couldn't have asked for better care!

[redacted] will miss his cuddle time with all of you.

Lots of love.

[redacted]

XXX

11.0 Complaints

No formal complaints received.

- One concern relating to scheduling of elective LSCS
- One concern relating to suggestion of disrespectful behaviour (awaiting further information)
- One concern relating to historic birth in 2019 who feels questions were not answered in previous debrief. Consultant follow up being arranged

12.0 Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received. Two HSIB cases currently with Coroner.

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

No new concerns or request for action received in February 2023

14.0 Healthcare Safety Investigation Branch (HSIB)

No new incidents notified to HSIB.

Two active HSIB cases from October 2022 relating to Maternal Death/Stillbirth and January 2023 relating to neonatal death ongoing.

15.0 Maternity incentive scheme – year 4 (NHS Resolution)

Maternity Incentive Scheme Board Declaration form submitted in January 2023. No further update has been received regarding this. Year 5 Maternity Incentive Scheme details are expected in quarter 2 2023/2024.

16.0 National priorities

16.1 Continuity of Carer

NHS England have stated **-** *While we have announced that there is no target date for services to deliver MCoC as the default model of care to all women, NHS England will continue to support maternity services to pilot enhanced MCoC teams where safe staffing is in place to continue. This decision should be made by trusts, with ongoing consideration given to the local workforce situation.*

Consideration has been given to starting a continuity team given the current zero vacancy position. Plans are now progressing to start a continuity team in the area of Harrogate identified as being within the UK's 10% most deprived population. The target date for commencement is quarter two 2023.

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

NHS England will publish a single delivery plan for maternity and neonatal services in spring 2023. This will consolidate the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent. Further details on the expectations on Local Maternity and Neonatal Systems will be set out in this plan.

16.3 Update on Ockenden (December, 2020)

- Work continues with the Maternity Voices Partnership (MVP) group to review and update the HDFT maternity webpage
- HDFT are to be part of the pilot area for the Advocacy roles
- An Ockenden assurance visit by the LMNS, supported by the regional senior midwifery team, is planned for September 2023.

17.0 Clinical Indicators – Yorkshire and Humber Regional Dashboard

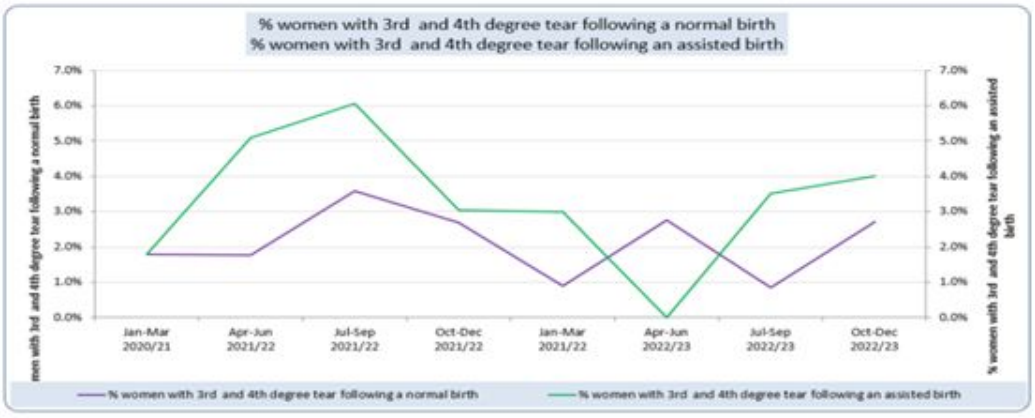
The Yorkshire and Humber Dashboard for quarter three 2022 is included in Appendix A. The data shows that over the region Harrogate isn't currently a negative outlier for any of the measures. In summary for Quarter 3:

- Bookings less than 10 weeks are 79.1%. Rates are amongst the highest in the region (range 43.0-82.9%), and well above the Y&H average (66.8%). No Y&H Trust has yet met the 90% target.
- 1:1 care in labour was 98.8%, a slight increase from the previous quarter. This is comparable with other Trusts in the region (regional average 96.8%).

- BBA rate 1.0% is comparable to the Y&H average of 1.3%.
- Homebirth rate currently 0.5%, slightly below Y&H average of 0.8%
- Normal delivery rate was 53.9% in this quarter (a slight decrease from Q2), against a regional average of 54.4%.
- Total Caesarean section rate was lower than the regional average 34.0% in this quarter (compared with the regional average of 36.0%). Of these, there were 17.2% elective Caesarean sections (compared with 15.0% regional average).
- Induction rate was lower in this quarter to 33.7%, and this is currently lower than the Y&H average (36.8%), with the highest induction rate in the region being 56.1%.
- Significant PPH rate in this quarter (3.2%) remains below the regional average (3.9%).
- Preterm birth rate <37 weeks in this quarter (6.3%), was lower than the regional average (8.9%).
- There was one case reported as stillbirths at HDFT in Q3. Annual stillbirth rate is currently 4.8 per 1000 births compared with the Y&H average of 4.0 per 1000.
- Breastfeeding initiation rates remain high at 86.6% compared with the regional average of 66.5%.
- Smoking rates at booking and time of birth are 5.2% and 5.3% respectively, compared with Y&H average of 10.6% and 11.3%

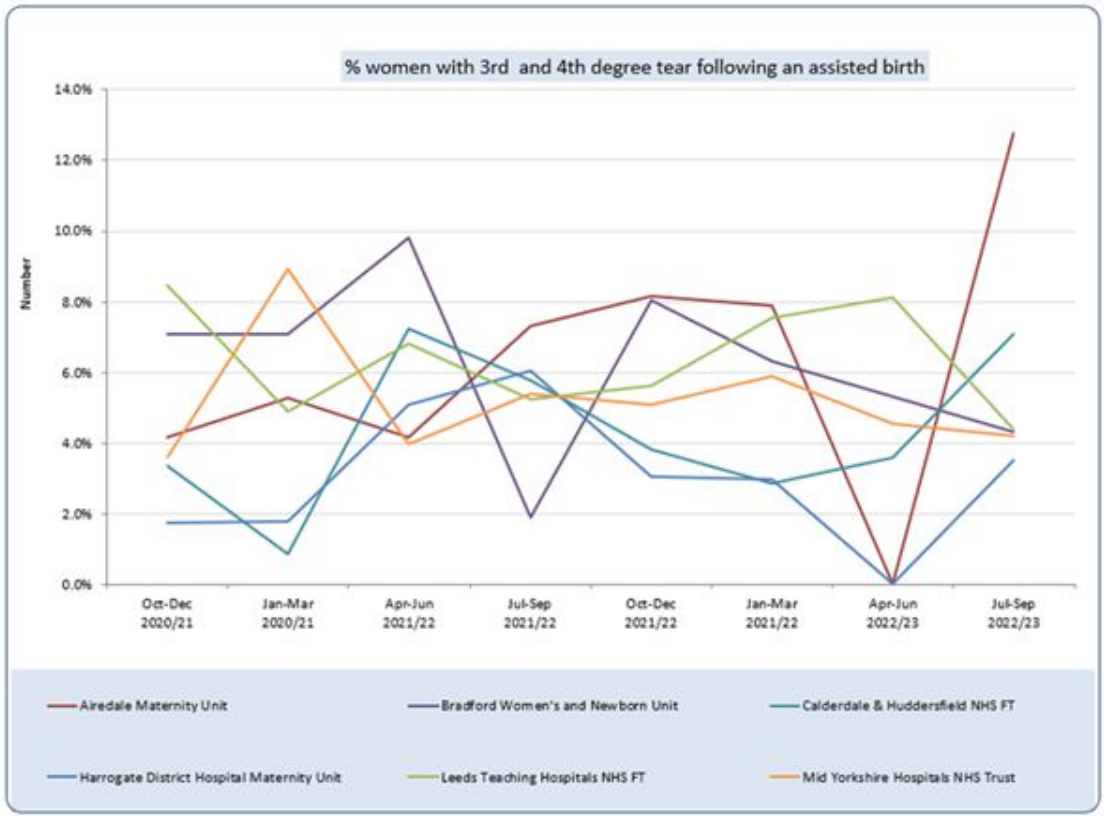
All of the indicators appear to remain stable with the exception of 3rd and 4th degree tears (see section 18 and graph 17.1).

17.1. Harrogate percentage of women with a 3rd and 4th degree tear following a normal and assisted birth.

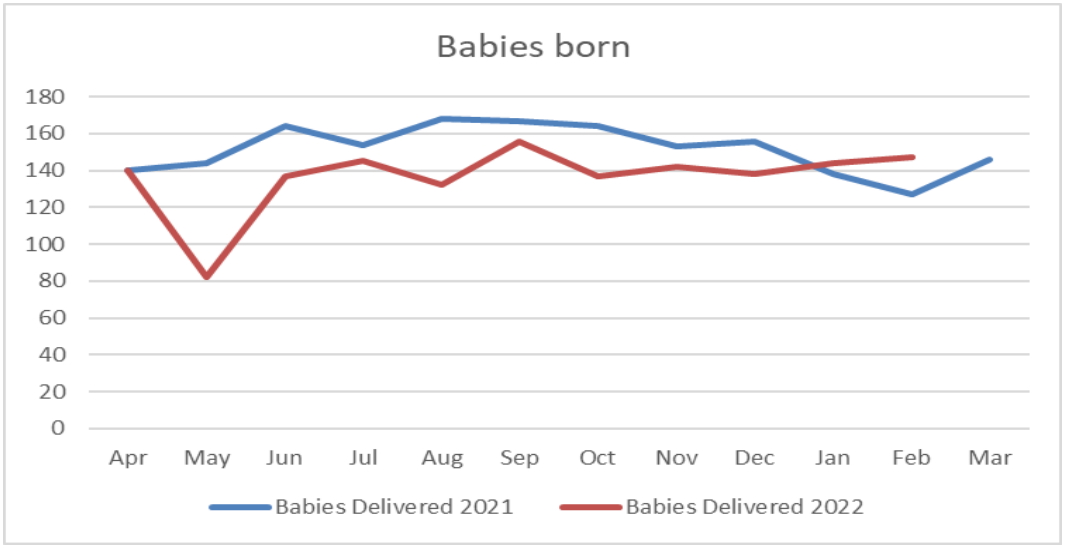


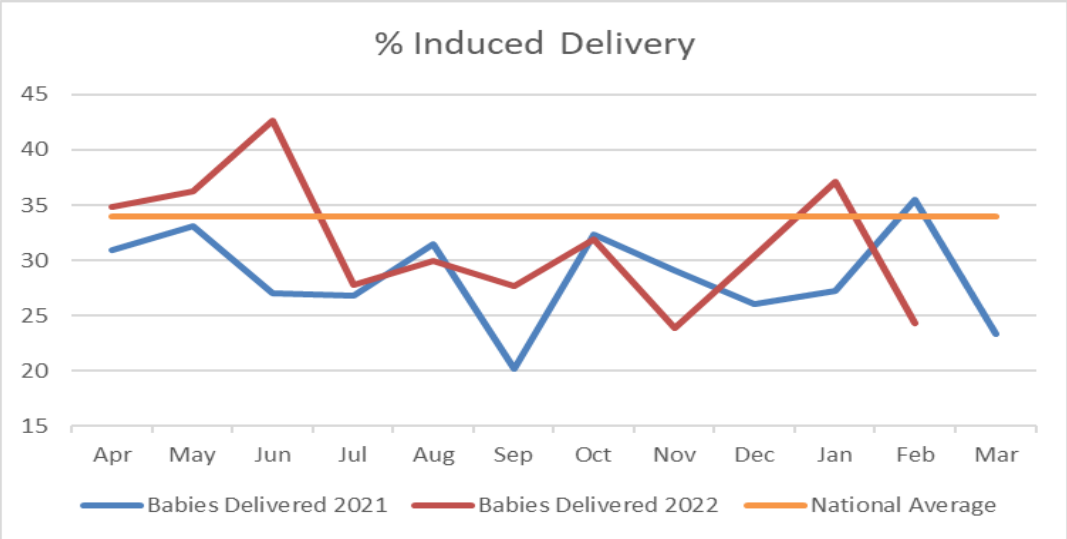
The fluctuations in rates may be related to the small numbers however further investigation may be indicated. The rates of 3rd and 4th degree tears are still within the norm within West Yorkshire and Harrogate Local Maternity and Neonatal System as show in the graph below (17.2).

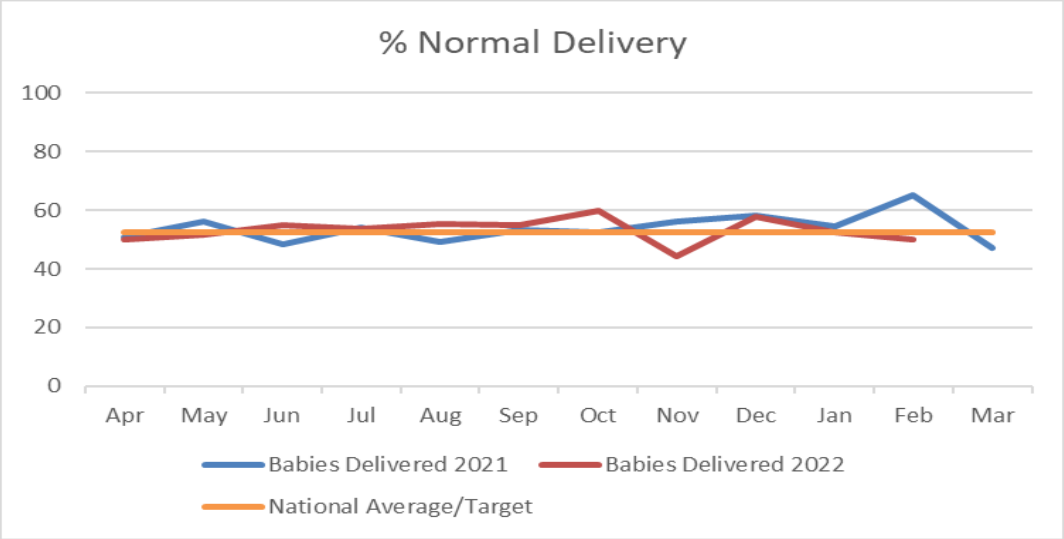
17.2. West Yorkshire and Harrogate percentage of women with a 3rd and 4th degree tear following an assisted birth.

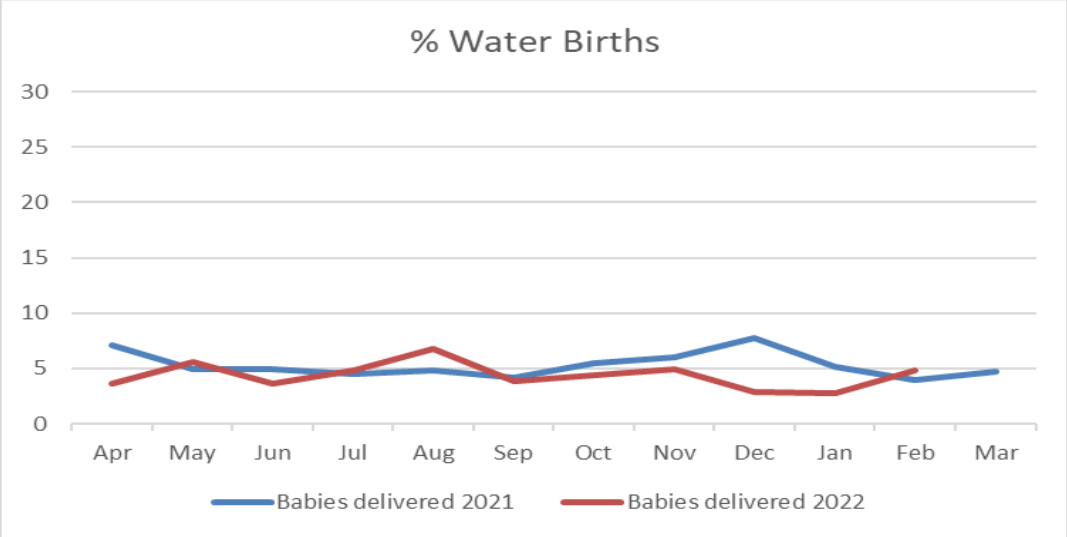


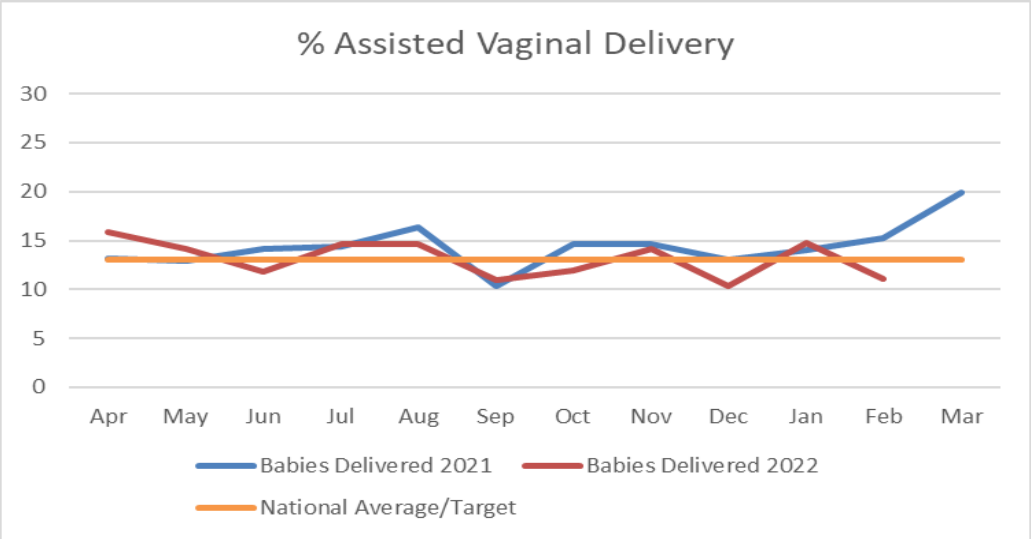
18.0 Local HDFT Maternity Services Dashboard January 2023

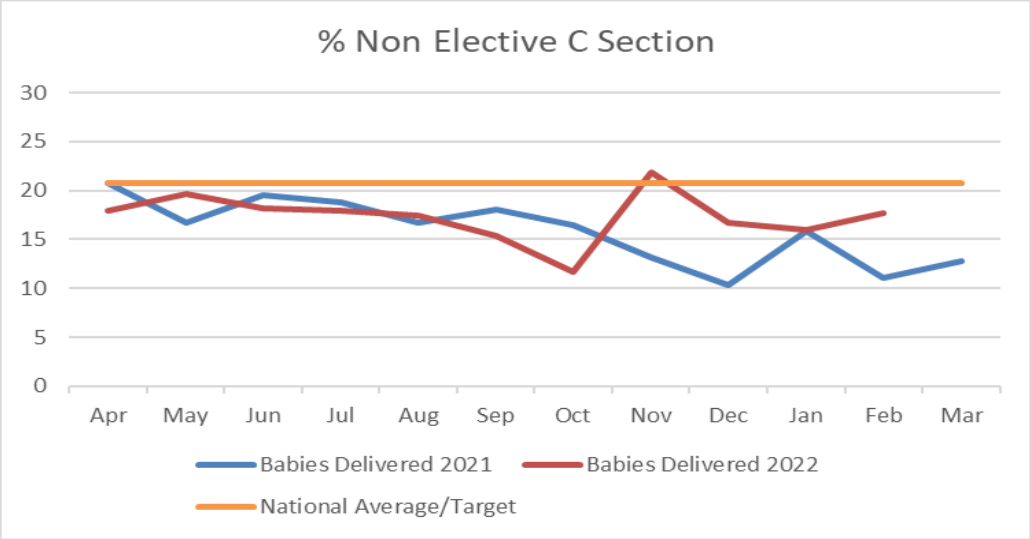


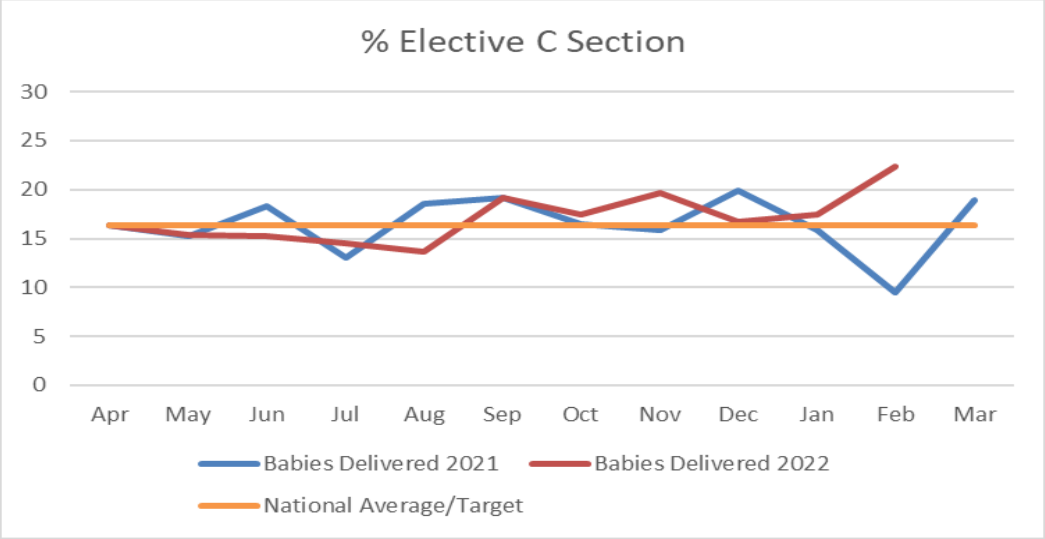

% Induced Delivery
45
40
35
30
25
20
15
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies Delivered 2021
Babies Delivered 2022
National Average

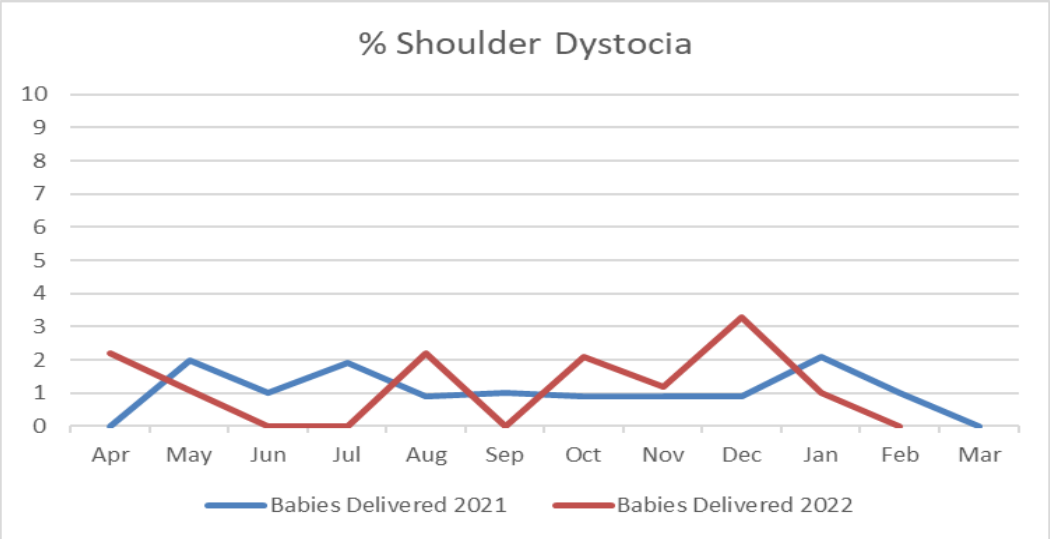

% Normal Delivery
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies Delivered 2021
Babies Delivered 2022
National Average/Target

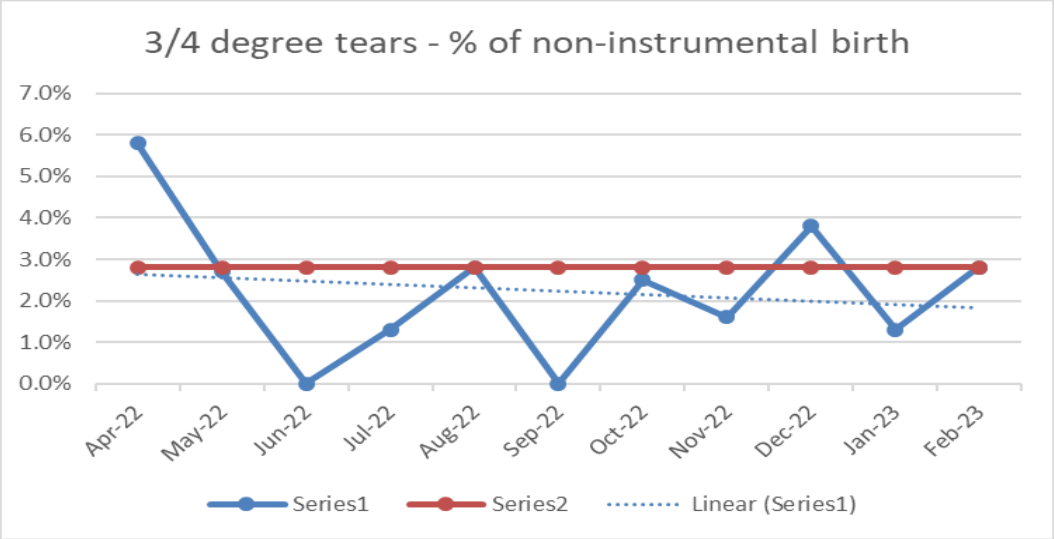

% Water Births
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies delivered 2021
Babies delivered 2022

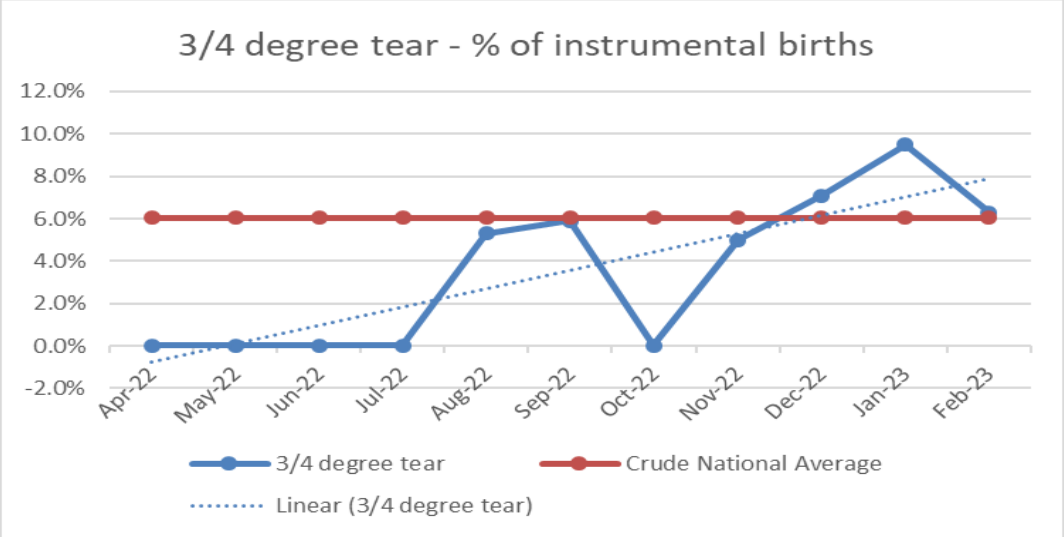

% Assisted Vaginal Delivery
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies Delivered 2021
Babies Delivered 2022
National Average/Target

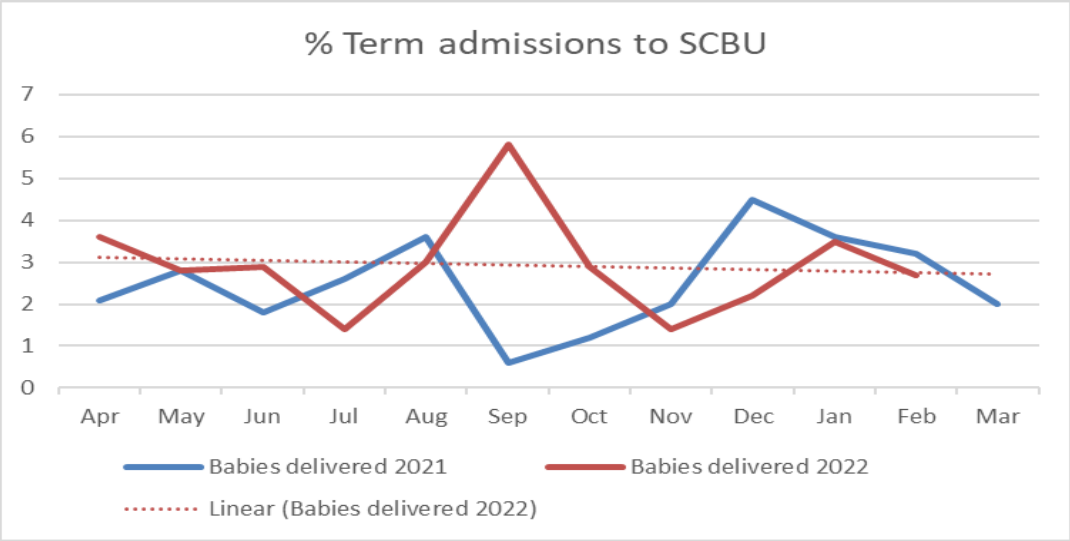

% Non Elective C Section
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies Delivered 2021
Babies Delivered 2022
National Average/Target

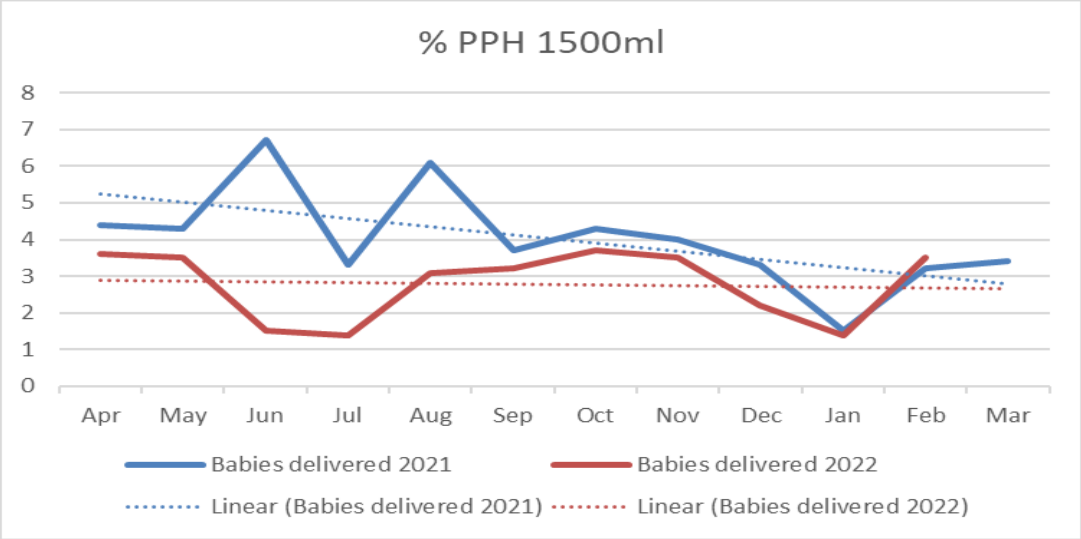

% Elective C Section
30
25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies Delivered 2021
Babies Delivered 2022
National Average/Target

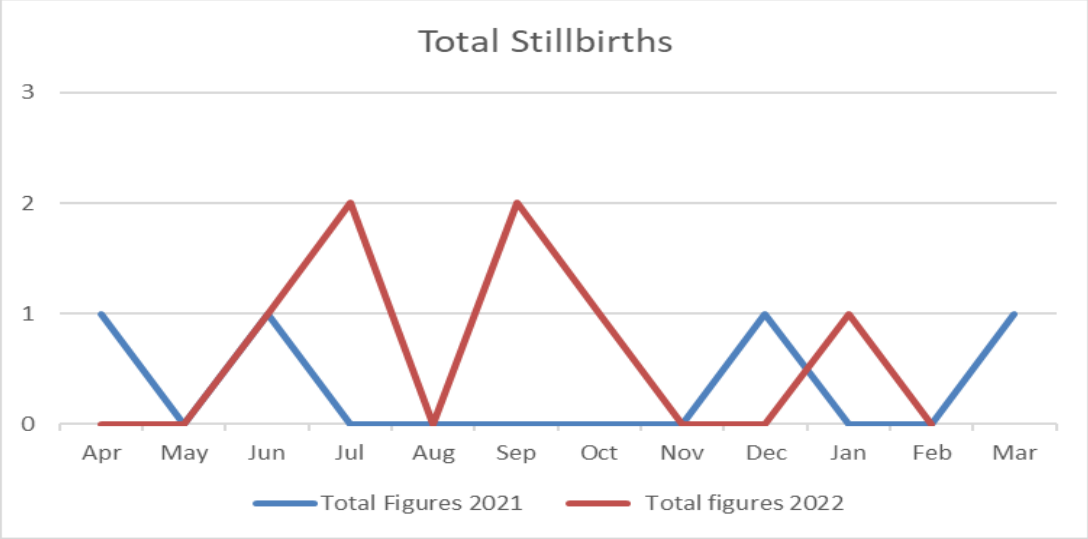

% Shoulder Dystocia
10
9
8
7
6
5
4
3
2
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Babies Delivered 2021
Babies Delivered 2022

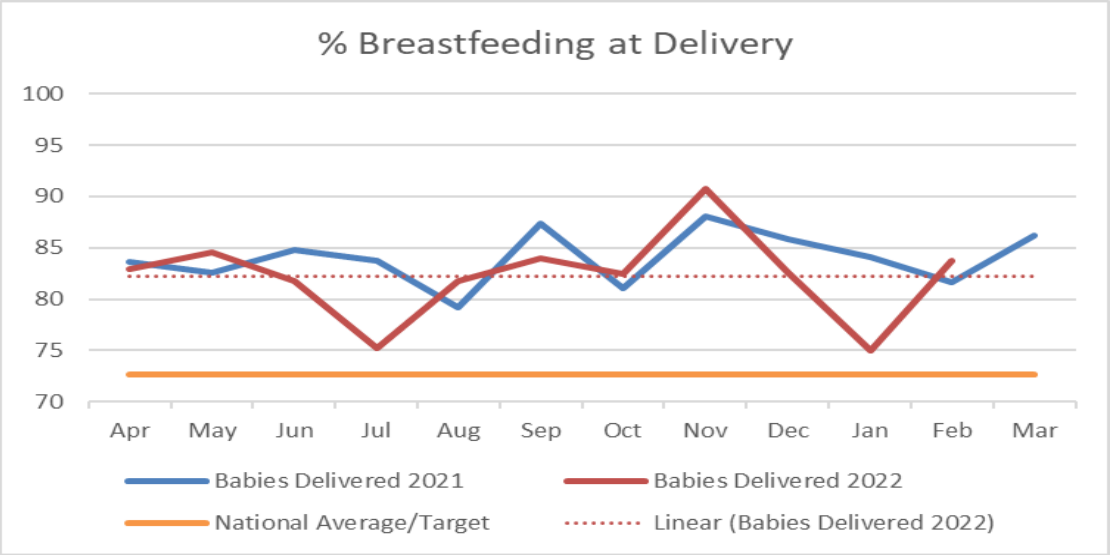

3/4 degree tears - % of non-instrumental birth
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Series1
Series2
Linear (Series1)

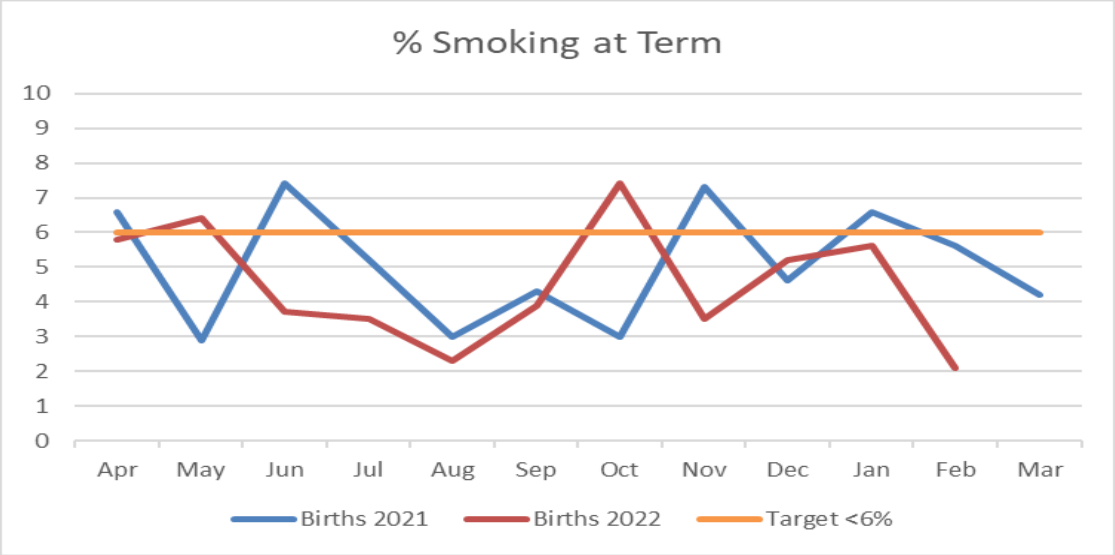

3/4 degree tear - % of instrumental births
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
3/4 degree tear
Crude National Average
Linear (3/4 degree tear)

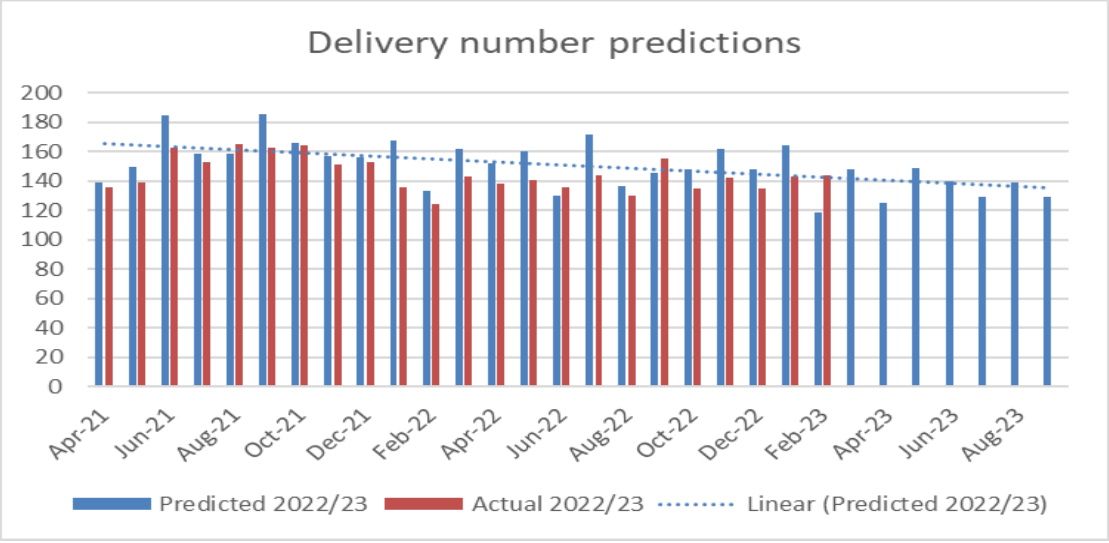

% Term admissions to SCBU
7
6
5
4
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies delivered 2021
Babies delivered 2022
Linear (Babies delivered 2022)


% PPH 1500ml
8
7
6
5
4
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Babies delivered 2021
Babies delivered 2022
Linear (Babies delivered 2021)
Linear (Babies delivered 2022)


Total Stillbirths
3
2
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Total Figures 2021
Total figures 2022


% Breastfeeding at Delivery
100
95
90
85
80
75
70
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Babies Delivered 2021
Babies Delivered 2022
National Average/Target
Linear (Babies Delivered 2022)


% Smoking at Term
10
9
8
7
6
5
4
3
2
1
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Births 2021
Births 2022
Target <6%


Delivery number predictions
200
180
160
140
120
100
80
60
40
20
0
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Predicted 2022/23
Actual 2022/23
Linear (Predicted 2022/23)

19.0 Avoiding Term Admissions in Neonatal Units (ATAIN)

There is overwhelming evidence that separation of mother and baby at or soon after birth can affect the positive development of the mother–child attachment process. Mothers may find it harder to establish and maintain breastfeeding and it may affect their mental health. Preventing separation, except for compelling medical indications, is an essential part of providing safe maternity services and an ethical responsibility for healthcare professionals. There are five main reasons for admitting babies to SCBU and thereby separating mother and baby; infection, respiratory problems, observation, hypoglycaemia and jaundice. There is a lot of cross over between all of the reasons for admission. An ATAIN Audit tool is completed for every baby admitted to SCBU with a birth gestation over 37 weeks to review if the reason for separation was appropriate and if there is any learning to prevent future incidences of separation.

19.1 In February there were four Term newborn admissions to SCBU which are being reviewed at the ATAIN case review meeting. Four Term newborn admission to SCBU which are being reviewed at ATAIN case review meeting (one admitted with low saturations and tachypnoea; one born in poor condition following delivery with initial passive cooling; one with low cord gases; one admitted following a dusky episode).

19.2 ATAIN actions

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

Issue	Action	Status
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
Short admission to SCBU but no documentation by paediatric/SCBU staff in notes or Badgernet	Reminder to staff. Datix when no notes are documented	In progress
Try to monitor babies for longer on CLWS with borderline sats/work of breathing before admitting	Continue to encourage staff to stay with baby for ≈30 mins if conditions allow	In progress
No consultant involvement in decision to transfer baby for cooling (decision made by Embrace Team)	Discuss with neonatal lead	In progress

20.0 Saving Babies Lives' v2 metrics for Board oversight

Saving Babies' Lives version 2 is designed to tackle stillbirth and early neonatal death and is a significant driver to deliver the ambition in the NHS long-term plan to achieve a 50% reduction in the rate of pre-term births and stillbirths in the UK by 2025. Saving babies Lives version 2 brings five elements of care together:

- Reducing smoking in pregnancy
- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movement
- Effective fetal monitoring during labour
- Reducing preterm birth

Each organisation is expected to look at their performance against the outcome measures for any given element in relation to other local providers or comparable peers with a view to understanding where improvement may be required. There is an expectation that as well as reporting on the organisation's performance within each element, there will be complimentary reporting of ongoing improvement work (with associated detail of interventions, and improvement in process measures and outcomes) within each element. An integral component of this improvement work will be a focus on learning from incidents or enquiry. Harm may have occurred in relation to implementation of or non-compliance with an element described in the care bundle. The use of the Perinatal Mortality Review Tool complements the investigation and learning in this context.

	Quarter 3 (Oct-Dec 2022)	
Small-for-gestational age/Fetal growth restriction detection rates	Q3: 36.8% detection (<10th centile; 21 cases) (National average 42.6%, Top 10 average 61.5%) Q3: 54.2% detection (<3rd centile; 13 cases) (National average 60.5%, Top 10 average 74.2%)	
	Quarter 3 (Oct-Dec 2022)	February 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	3.1% (13/417)	3.4% (5/147)
Percentage of babies <10th centile >39+6 weeks' gestation	6.0% (25/417)	5.4% (8/147)
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	0 babies born 16-24 weeks in this period (0/407)	0 babies born 16-24 weeks in this period (0/141)
• Preterm (24+0-36+6 weeks)	4.9% (live, 20/407) 0.2% (stillborn, 1/407)	5% (live, 7/141)

21.0 Conclusion and recommendation

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

Appendix A – Y&H Dashboard

YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - CORE INDICATORS				Trust	Harrogate District Hospital Matern	Quarter/Year	Q3_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								
Number of Bookings	Number of women booked	433	445	826.1	376 to 1665	444.5 to 1158		
Bookings <10 weeks	Number of women booked <10 weeks	327	352	552.2	267 to 1157	309 to 709		
% Bookings <10 weeks	% of women booked <10 weeks	75.5%	79.1%	66.8%	43.0% to 82.9%	61.7% to 77.3%		
Women birthed	Number of all women birthed	429	412	732.6	1 to 1394	387 to 1134.5		
Women who birthed a live baby	Number of women who birthed with a live baby	425	411	728.4	1 to 1384	385 to 1125		
Total births	Number of all babies born	433	417	741.5	1 to 1415	392.5 to 1140.5		
Live births	Number of live babies born	429	416	738.7	1 to 1405	391 to 1138		
Live births at term	Rolling annual number of live babies born at term	1637	1588	2711.3	4 to 5178	1474.5 to 4234.5		
Total births	Rolling annual number of all babies born	1739	1679	2908.9	5 to 5706	1601 to 4337.5		
Planned homebirths	Number of women who planned and birthed a term baby at home	3	2	5.8	0 to 19	1.5 to 6.5		
Planned homebirths	% of planned homebirths	0.7%	0.5%	0.8%	0.0% to 100.0%	0.4% to 1.4%		
1:1 Care in labour	Number of women who have received 1:1 care in labour	415	407	673.4	1 to 1348	386.75 to 1079		
1:1 Care in labour	% women who have received 1:1 care in labour	96.7%	98.8%	96.8%	66.7% to 109.2%	95.8% to 100.0%		
BBAs (Born Before Arrival)	Number of women who have a BBA.	10	4	10	0 to 50	2 to 16		
BBAs (Born Before Arrival)	% of women who have a BBA.	2.3%	1.0%	1.3%	0 to 0	0 to 0		
MATERNAL CLINICAL INDICATORS								
Normal births	Number of women with a vaginal birth	234	222	398.4	1 to 761	226 to 614.5		
Normal births	% of women - normal births	54.5%	53.9%	54.4%	48.2% to 100.0%	53.4% to 57.6%		
Assisted vaginal births	Number of women with an instrumental birth	57	50	74.7	0 to 178	46 to 99		
Assisted vaginal births	% of women - assisted vaginal births	13.3%	12.1%	10.2%	0.0% to 14.8%	8.2% to 12.0%		
Elective C/S births	Number of women - El C/S	74	71	109.8	0 to 220	61.5 to 160		
Elective C/S births	% of women - El C/S	17.2%	17.2%	15.0%	0.0% to 17.3%	14.1% to 16.2%		
Emergency C/S births	Number of women - Em C/S	71	69	153.9	0 to 335	73.5 to 220		
Emergency C/S births	% of women - Em C/S	16.6%	16.7%	21.0%	0.0% to 33.3%	18.0% to 23.1%		
Number of C/S births	No. of women - Total all C/S	145	140	263.7	0 to 548	139.5 to 381		
C/S deliveries	% of women - Total all C/S	33.8%	34.0%	36.0%	0.0% to 43.0%	33.3% to 37.7%		
3rd/4th degree tear - normal birth	Number of women with 3rd and 4th degree tear following a normal birth	2	6	8.1	0 to 27	4 to 10		
3rd/4th degree tear - normal birth	% women with 3rd and 4th degree tear following a normal birth	0.9%	2.7%	2.0%	0.0% to 4.0%	1.1% to 2.6%		
3rd/4th degree tear - assisted birth	Number of women with 3rd and 4th degree tear following an assisted birth	2	2	3.2	0 to 12	1 to 4		
3rd/4th degree tear - assisted birth	% women with 3rd and 4th degree tear following an assisted birth	3.5%	4.0%	4.3%	0.0% to 8.5%	3.0% to 5.3%		
Induction of Labour	Number of women commenced induction of labour	141	139	269.9	0 to 471	158.5 to 399.5		
Induction of Labour	% women commenced induction of labour	32.9%	33.7%	36.8%	0.0% to 56.1%	32.9% to 40.0%		
PPH ≥ 1500ml	Number of women who have birthed with PPH ≥ 1500ml	11	13	28.9	0 to 61	15.5 to 43.5		
PPH ≥ 1500ml	% women who have birthed with PPH ≥ 1500ml	2.6%	3.2%	3.9%	0.0% to 8.2%	3.2% to 4.2%		
NEONATAL CLINICAL INDICATORS								
Preterm births <37 weeks	Number of preterm births <37 weeks	32	26	65.5	0 to 130	28.5 to 107.5		
Preterm birth rate < 37 weeks	% preterm births <37 weeks	7.5%	6.3%	8.9%	0.0% to 33.3%	6.8% to 9.7%		
Preterm births 32 weeks to 36+6 weeks	Number of preterm births 32 weeks to 36+6 weeks	26	24	55.0	0 to 117	26 to 90.5		
Preterm birth rate 32 weeks to 36+6 weeks	% preterm births 32 weeks to 36+6 weeks	6.1%	5.8%	7.4%	0.0% to 33.3%	5.9% to 8.5%		
Number of preterm births 27 weeks to 31+6 weeks	Number of preterm births 27 weeks to 31+6 weeks	4	1	7.5	0 to 19	1.5 to 12.5		
Preterm birth rate 27 weeks to 31+6 weeks	% preterm births 27 weeks to 31+6 weeks	0.9%	0.2%	1.0%	0.0% to 2.2%	0.3% to 1.3%		
Preterm birth <27 weeks	Number of preterm births <27 weeks	2	1	3.1	0 to 12	0.5 to 5.5		
Preterm birth rate < 27 weeks	% preterm births <27 weeks	0.5%	0.2%	0.4%	0.0% to 0.9%	0.1% to 0.5%		
Rolling annual number of low birth weight at term - live births	Rolling annual number of live babies at term < 2200g	8	3	23.1	0 to 67	6 to 40.5		
Low birth weight at term - live births	Rolling annual % live babies at term < 2200g	0.5%	0.2%	0.9%	0.0% to 2.6%	0.3% to 0.9%		
STILLBIRTHS								

1	43	Low birth weight at term - live births	Rolling annual % live babies at term < 2200g	0.5%	0.2%	0.9%	0.0%	to	2.6%	0.3%	to	0.9%		
		STILLBIRTHS												
8	44	Stillbirths - Rolling annual total	Annual number of ALL stillborn babies	9	8	11.6	0	to	33	5	to	17		
7	45	Stillbirth rate - Total	Annual rate for ALL stillborn babies / 1000 births	5.2	4.8	4.0	0.0	to	6.6	2.2	to	4.6		
2	46	Stillbirths	Number of all babies stillborn	4	1	2.8	0	to	10	1	to	3		
3	47	Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	8	7	9.9	0	to	27	5	to	15		
4	48	Stillbirth rate - Antenatal	Annual rate for antenatal stillborn babies / 1000 births	4.6	4.2	3.4	0.0	to	5.4	2.1	to	4.1		
5	49	Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	1	1	1.7	0	to	6	1	to	3		
6	50	Stillbirth rate - Intrapartum	Annual rate for intrapartum stillborn babies / 1000 births	0.6	0.6	0.6	0.0	to	1.4	0.1	to	0.6		
8	51	HSIB reportable births	Rolling annual number of reportable births	1	4	2.2	0	to	5	0	to	4		
9	52	HSIB reportable births	Rolling annual % reportable births	0.1%	0.2%	0.1%	0.0%	to	0.3%	0.0%	to	0.1%		
0	53	Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	9	8	9.2	0	to	25	4	to	12.5		
1	54	Stillbirth rate - adjusted to exclude lethal abnormalities	Annual stillborn babies / 1000 births excluding babies with lethal abnormality	5.2	4.8	3.2	0.0	to	5.0	1.7	to	4.2		
2	55	Stillbirths at term	Rolling annual number of babies stillborn at term	3	3	3.6	0	to	8	1	to	6		
3	56	Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	0	0.3	0	to	3	0	to	0		
4	57	Stillbirths at term with low birth weight	Annual % of stillborn babies < 2200g	0.0%	0.0%	8.7%	0.0%	to	100.0%	0.0%	to	0.0%		
5	58	All losses under 24+0 weeks gestation	Number of all losses under 24+0 weeks gestation	11	7	27	0	to	241	0	to	18		
6		Hold for %		0.0%	0.0%	0	0	to	0	0	to	0		
		PUBLIC HEALTH INDICATORS												
7	59	Breastfeeding Initiation	Number of women who breastfed their baby/ies for their first feed	348	356	465.8	1	to	1102	249	to	704.75		
8	60	Breastfeeding Initiation	% of women commenced breastfeeding	81.4%	86.6%	66.5%	55.2%	to	100.0%	58.1%	to	74.4%		
9	61	Smoking at time of booking - self reported	Number of women who were smokers at time of booking	16	23	87.9	1	to	236	52.5	to	124		
0	62	Smoking at time of booking	% of women who smoke at booking	3.7%	5.2%	10.6%	0.1%	to	17.7%	8.2%	to	14.9%		
1	63	Smoking at time of birth - self reported	Number of women who were smokers at time of birth	14	22	82.6	0	to	179	52.5	to	110		
2	64	Smoking at time of birth - self reported	% of women who smoke at time of birth	3.3%	5.3%	11.3%	0.0%	to	18.7%	9.0%	to	12.7%		
3	65	Carbon Monoxide monitoring at time of booking	Number of women who received CO testing with a measurement ≥ 4ppm at booking	22	82	183.3	0	to	1004	55	to	125		
4	66	Women received CO testing at booking	Number of women who received CO testing at booking	234	422	551.1	0	to	1252	308.5	to	797		
5	67	Carbon Monoxide monitoring at time of booking	% women who received CO testing with a measurement ≥ 4ppm at booking	9.4%	14.7%	33.3%	9.1%	to	827.2%	12.4%	to	17.1%		

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 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 • Complete	
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	Stage1/3 complete. Stage 2/3 underway.	
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	• Complete • Complete • Complete • Complete • Complete	
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 • Complete • 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 • Delayed – Jan 23 • 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) • Complete • 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) • Complete • Complete • Complete • 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 – GRIFT HVLC 6 Specs • Improvement events delivered – TBC • Further actions dependent on outcome of improvement events.	• Complete • At risk	

Operational Update

March 2023

Russell Nightingale
Chief Operating Officer

Operational Update March 2023 (February Performance)

Matters of concern & risks to escalate

- Cancer 62-day wait target not achieved at 78.2% (5.9.1) up from 73.0%
- Cancer 2WW performance was below the 93% target at 59.5% (5.10), down from 71.5% in Jan.
- Cancer (Breast) 2WW target not achieved at 24%, the service are focussed on improving the position.
- Non-Elective flow remains a challenge and the Trust continues at full capacity linked to ongoing system support, Infection prevention difficulties and non criteria to reside delays but has show improvement with the streaming model
- Significant levels of COVID up to 50 inpatients , fortunately flu and RSV have reduced.
- A&E 4-hour performance in February significantly improved to 81% (78% last month) but remains below the standard. (5.6)
- The Trust had 8 over 60-minute ambulance handover breach in February (40 last month).
- 16 x 12-hour trolley waits in ED (89 last month).
- Dermatology 2WW position deterioration linked to sustained demand and medium term workforce issues. Recovery plan is underway
- Non criteria to reside data collection being revised to create a sustainable and lean process with improved data quality
- Wensleydale ward environment continues to deteriorate with closure planned end of March '23

Major actions commissioned & work underway

- TIF2 internal business case being prepared. Turner &* Townsend appointed to project manage TIF2
- LUNA product with AI to support RTT validation in place now , training rolled out to ops team. Final piece of work to enable AI element over next 4-6 weeks
- Recruitment underway to domiciliary care project with aim to be delivering packages of care by March – April 2023
- ED streaming model in place , main department reconfig works in progress
- Focus on GIRFT productivity in surgical specialties.
- Roll out of red to green methodology to wards began in January
- Contingency planning underway for industrial action from ambulance service and royal college of nursing.
- Annual operational planning process continues.
- Engagement with Leeds Teaching Hospitals around shared data reporting model. Agreed data discovery work to take place March –April.

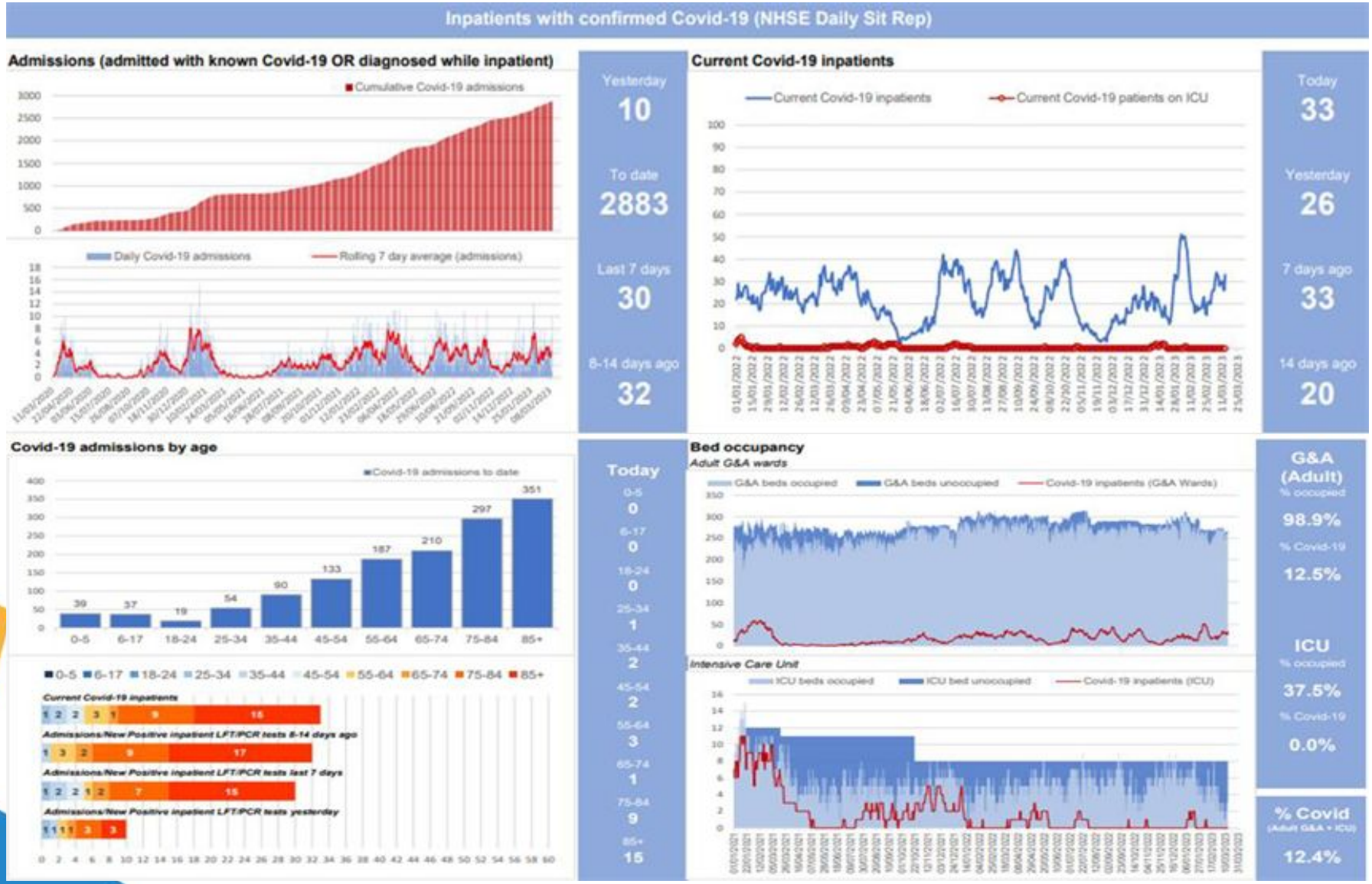
Positive news & assurance

- LLP continues with lists into February
- 199 elective theatres lists were undertaken out of a possible 218 despite challenging circumstances, 91% (88% last month)
- Cancer 31-day wait target achieved at 98% (5.1.2)
- Continued reduction in >78-week RTT waiters for surgery ahead of plan
- Improved ED performance with achievement of a 95% day for first time in 2 years.
- 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
- Progress in ward discharge and patient flow since 1st January leading to reduction in bedded patients in emergency department.
- Frailty Unit delivering frailty turnaround
- Lascelles refurbishment underway to support Wensleydale works later in year

Decisions made & decisions required of the Board

- Continue to maintain escalation capacity open to support 60+ patients per day in hospital not meeting criteria to reside
- Maintained ring fenced orthopaedic elective capacity despite significant non-elective pressures

COVID-19 Management Report



Children's and Community

Performance Indicator Description	Q1	Q2	Q3	Q4 to date (Jan)
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	91.9%	94.3%	94.0%	96.9%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	94.8%	96.0%	95.0%	98.0%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	97.8%	99.2%	99.6%	94.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	91.5%	96.9%	93.9%	96.9%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	93.4%	96.4%	93.4%	93.3%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	97.4%	97.6%	98.4%	100.0%
Health Visiting - % of children receiving a 12 month review by 15 months - **North Yorkshire**	97.6%	98.1%	98.1%	95.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Northumberland**	96.7%	95.6%	93.6%	89.7%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	88.1%	93.5%	96.5%	95.6%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	92.1%	91.5%	90.1%	91.1%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	98.5%	96.9%	98.9%	98.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	93.4%	96.0%	96.6%	95.2%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	91.1%	96.9%	95.5%	94.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	93.8%	96.4%	93.5%	98.0%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	95.3%	95.7%	96.9%	97.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**	93.9%	93.0%	90.8%	89.9%

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 who came into post on 4th December.

Community Dental

No patients breeched 104 weeks RTT wait at the end of December. Ability to have zero 78 weeks wait by end March 23 is a 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

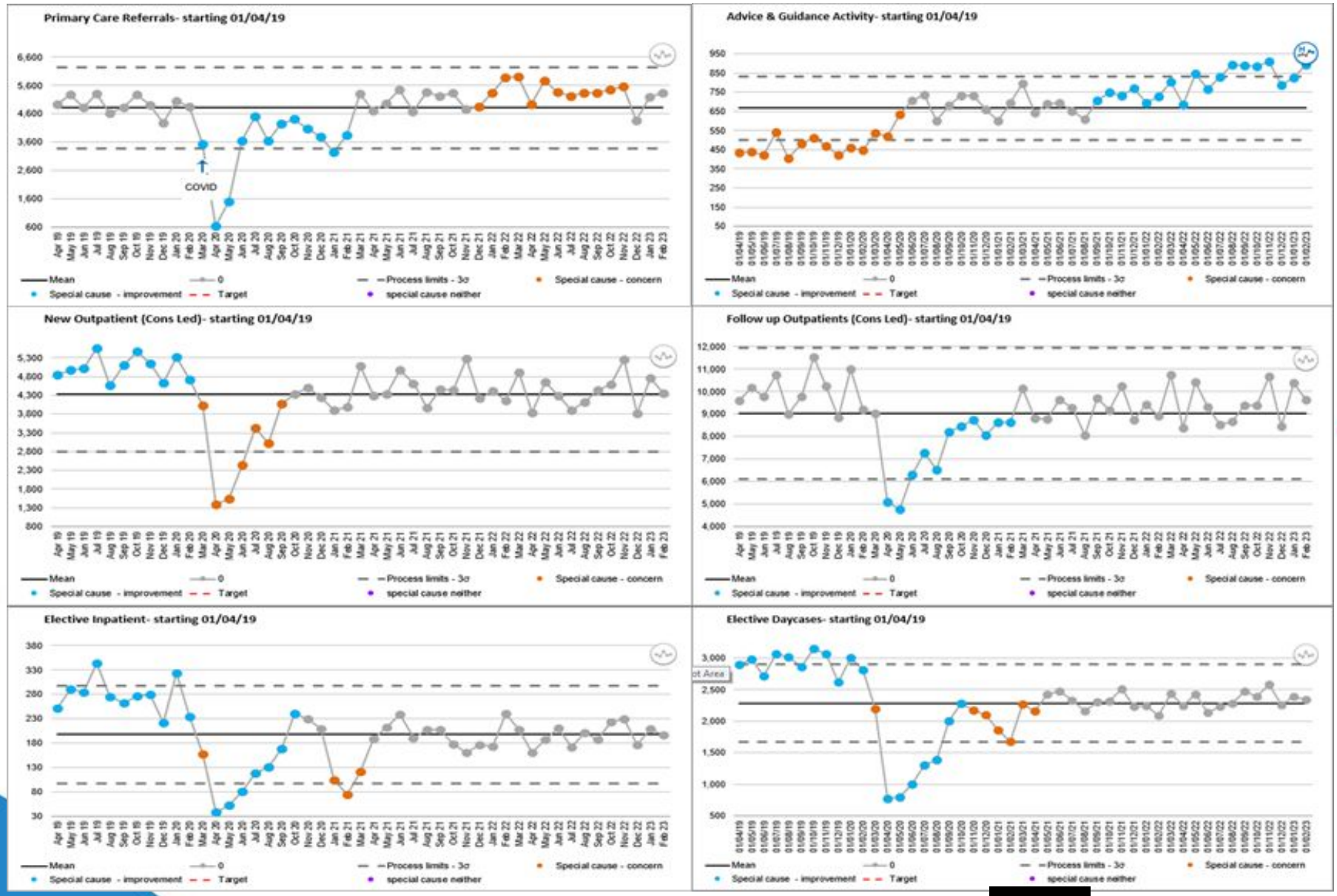
Outpatients	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	450	500	550	600	675	750	825	875	925	1,000	1,050	1,100
Actual	425	451	438	575	677	682	700	766	676	945	862	
Consultant-led 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	4,291	3,907	4,120	4,428	4,583	5,245	3,816	4,759	4,359	
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	8,375	10,432	9,324	8,540	8,676	9,375	9,377	10,666	8,442	10,397	9,635	
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	2,352	2,402	2,483	2,656	2,607	2,814	2,438	2,601	2,539	
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	2,141	2,231	2,282	2,469	2,384	2,585	2,261	2,391	2,343	
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	211	171	201	187	223	229	177	210	196	
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	1,198	1,287	933	1,171		
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	4,456	4,711	3,630	4,340		
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	6,727	6,869	5,202	6,517		
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	1,285	1,201	1,228	1,124		
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	112	100	118	99		
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	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	58	56	76	64	

Increasing elective capacity to 2019/20 levels continues to be the key focus. 12% of 2019/20 was delivered through premium out of core sessions.

Sickness absence, vacancies and some estates issues closing a theatre have caused challenge this month. Activity has grown however we remain below plan. Outpatient clinic templates now returned 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 5% leading the pack in the ICB. Further work ongoing to switch f/u to new activity once all f/u backlogs are clear. Significant increases in advice and guidance activity from 2019/20 which do not get reflected in above figures (baseline of 450/month now up to 825/month)

End of January – all but 6 of the >78 week risk patients now have a date for treatment. In addition supported York with 36 Max-Fax, Urology long waiters requiring outpatients and/or treatment

Elective Recovery

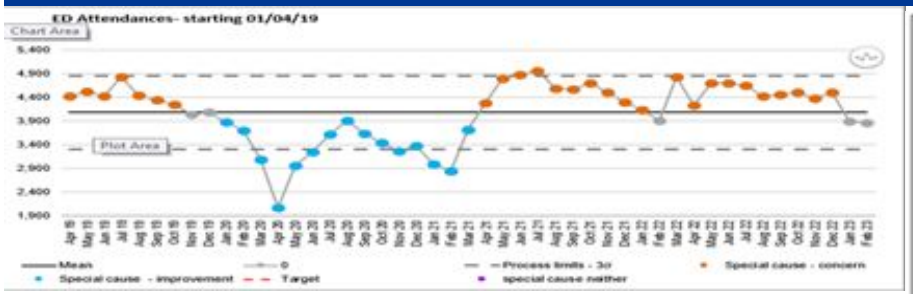


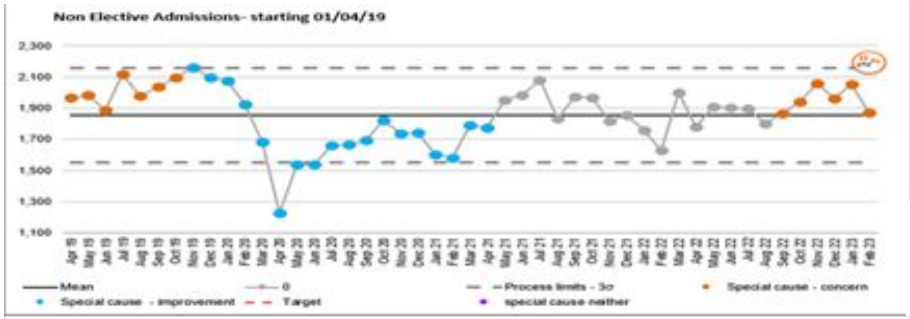
Referral to Treatment (RTT)

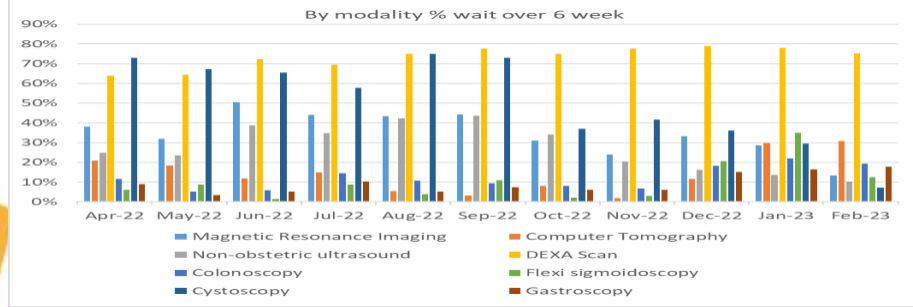
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Total incomplete RTT pathways	24,714	25,384	25,134	25,629	25,564	25,490
Under 52 weeks	23,527	24,188	23,873	24,332	24,267	24,140
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350
> 78 weeks	205	184	169	155	144	133
> 104 weeks	11	3	1	0	0	0
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	
Total incomplete RTT pathways	25,437	25,388	24,951	24,854	25,139	
Under 52 weeks	24,152	24,187	23,723	23,668	24,027	
> 52 weeks	1,285	1,201	1,228	1,186	1,112	
> 78 weeks	112	100	118	101	65	
> 104 weeks	0	0	0	0	0	

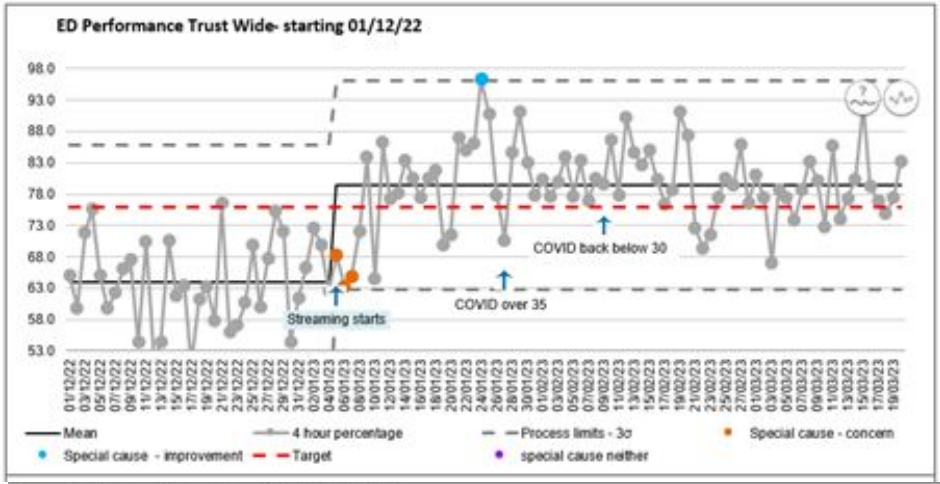
RTT - The Trust had 25,139 patients waiting at the end of February, this is a small climb in RTT pathways for the first time since July. There are 1,112 patients waiting over 52 weeks, continues to fall as we address our longest waiting patients. The AI solution for RTT validation is in place to use manually, some final data imports issues are being resolved before the AI element can start to support validation. Only 150 pathways over 30 weeks are unvalidated.
The number of patients waiting 78+ weeks continues to reduce on plan.
Of the 3,984 patients waiting for a procedure on our waiting list, 41% are Orthopaedics, 13% are Ophthalmology and 9% are Urology.
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.

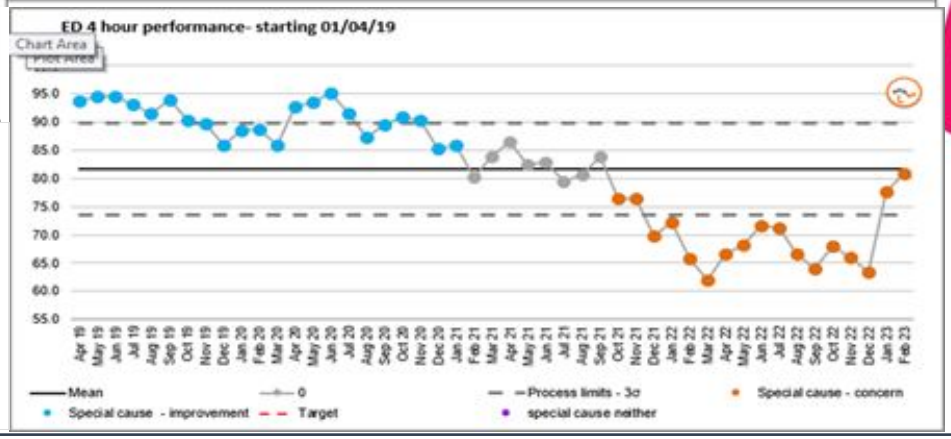
Urgent Care and Diagnostics





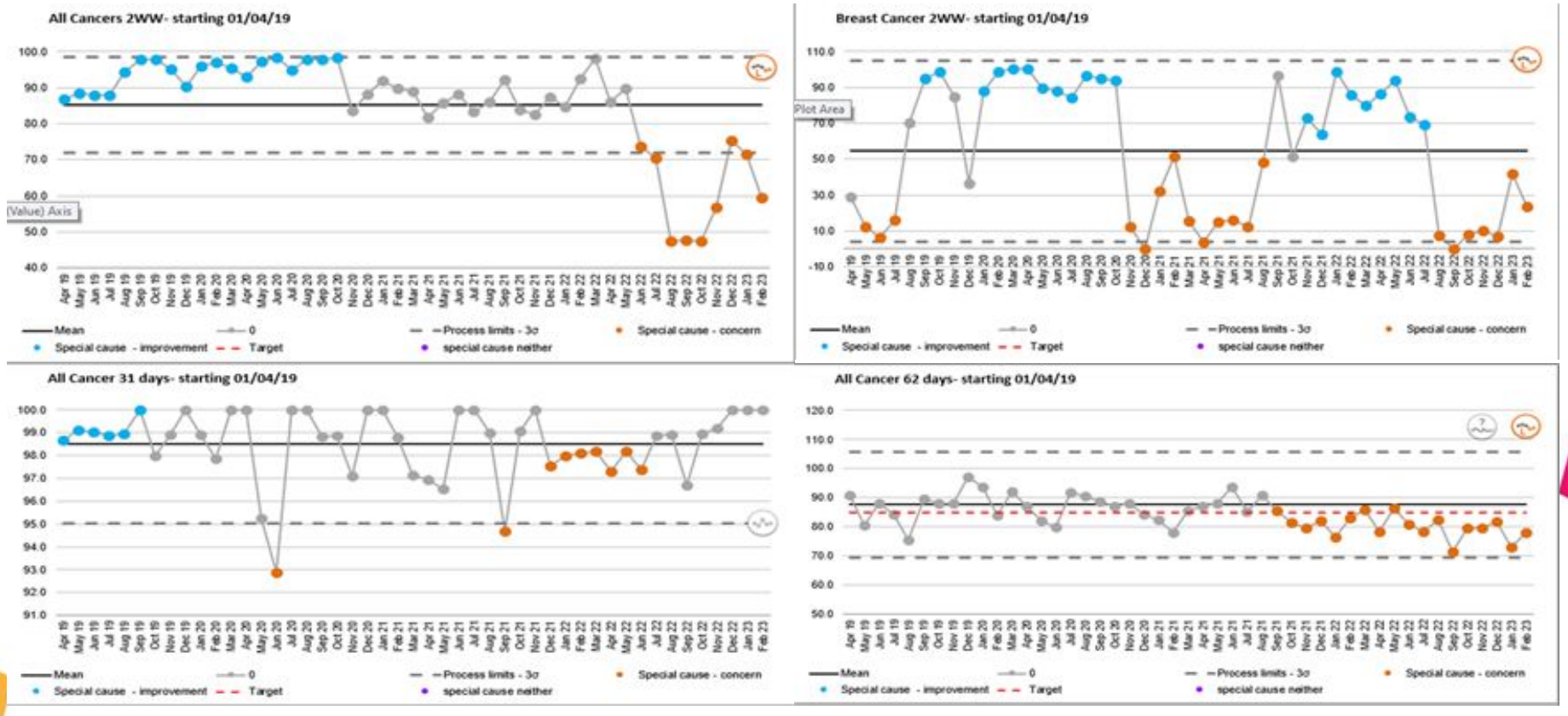






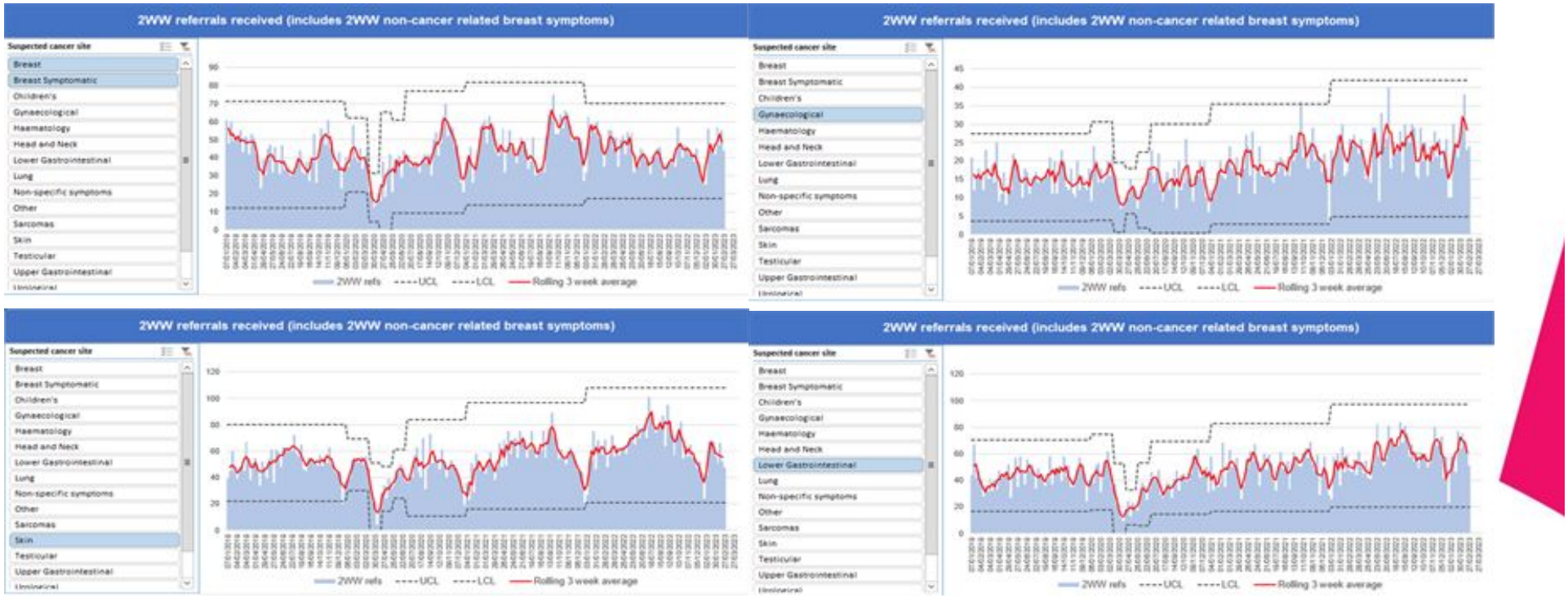
- Performance against the A&E 4-hour standard remained below 95% in February but has improved significantly to 80.9%. ED performance since streaming model commenced has shown a step change. This is also linked to an improved period of bed availability.
- There were 16 x 12-hour trolley wait breaches in February.
- There were 26 x 30-minute ambulance handover breaches and 8 x 60-minute ambulance handover breaches in February.
- ED attendances are now back in line with 2019/20 levels
- UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- Imaging diagnostic activity continues to be maintained despite vacancies, sickness and CT scanner out of action- diagnostic waits reducing or stable in most areas. Significant activity above 2019 baseline is being achieved in MRI & US to reduce waiting times. All modalities are on a recovering trajectory.

Cancer Performance



- The 62-day standard was not met in February with a performance of 78.2% against the 85% standard.
- The 31-day standard was met in February with a performance of 100%.
- The 2-week wait standard was not met in February with a performance of 59.5%. A significant increase in 2WW referrals has been seen in several challenged services (Breast, Lower GI, Dermatology and Gynaecology).
- The 2-week wait breast symptomatic standard was not met in February with 24% 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 February, 64 (76 in Jan) patients remain on an open cancer pathway over 62-days with 11 (11 in Jan) 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



- Performance against the 2WW Cancer standard continues to remain below the standard in February.
- 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.
- 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 skin 2WW positon has deteriorated following from the excellent recovery in November relating to short and medium term work force issues- a recovery plan is underway.

Harrogate and District NHS Foundation Trust
Board of Directors Meeting – 29th March 2023
Financial Position – February 2023

1. Purpose of the report

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

As described below, the Trust Revenue position is a deficit position against a breakeven plan.

2. Introduction

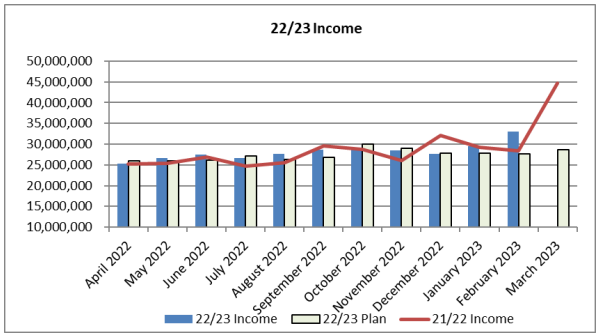
The paper is an update on the Trust Financial Position, and continues the monthly updates received by the Board. The paper aims to provide assurance on the financial position, as well as provide opportunity to discuss the key financial issues across the organisation.

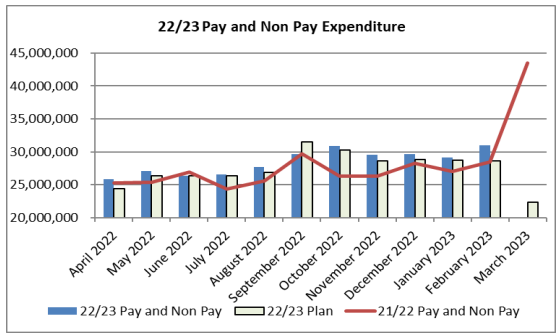
Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.

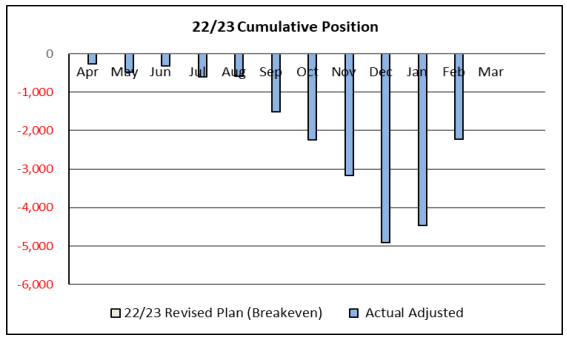
3. Financial Position

High Level Analysis	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's
Commissioner Income	**23,833**	**28,307**	**4,474**	**257,162**	**262,776**	**5,614**
Directorate Income	**3,837**	**4,834**	**997**	**43,436**	**48,691**	**5,255**
Pay Costs	-19,639	-20,797	-1,159	-207,672	-212,159	-4,486
Non Pay Costs	-8,975	-10,162	-1,187	-99,175	-101,002	-1,827
Expenditure	**-28,613**	**-30,959**	**-2,346**	**-306,847**	**-313,161**	**-6,314**
Surplus / (Deficit)	**-943**	**2,182**	**3,125**	**-6,250**	**-1,695**	**4,555**
Salix Adjustment/Depreciation on Donated Assets	**943**	**58**	**-885**	**6,250**	**-532**	**-6,782**
Revised Surplus/(Deficit)	**0**	**2,240**	**2,240**	**0**	**-2,227**	**-2,227**

3.1 Revenue







February's year to date financial position is a deficit £2.2k position against a breakeven plan. This is an improvement of £2.2k to the previous month. The improvement is mainly driven by non-recurring benefits. The underlying pressures previously identified relating to unidentified CIP, inflationary costs in energy and consumables, bank and agency usage to cover vacancies and escalation beds still persists. The current draft plan for 23/24 submitted to the ICB reflects these pressures. Further details of the plan are in section 5.

The trust is forecasting to break even at the end of the year achieve through non-recurring benefits.

Actioned CIPs YTD remain at 77% of the target with only 44% having been delivered recurrently to date.

Community &Childrens	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**1,943**	**1,889**	**-54**
Pay Costs	-67,499	-65,182	2,317
Non Pay Costs	-4,705	-4,076	629
Expenditure	**-72,204**	**-69,258**	**2,946**
Total	**-70,261**	**-67,369**	**2,892**

LTUC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**7,527**	**8,079**	**553**
Pay Costs	-64,295	-69,402	-5,107
Non Pay Costs	-23,151	-28,225	-5,074
Expenditure	**-87,446**	**-97,627**	**-10,181**
Total	**-79,920**	**-89,548**	**-9,628**

PSC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**912**	**935**	**23**
Pay Costs	-47,912	-51,510	-3,598
Non Pay Costs	-13,076	-14,113	-1,037
Expenditure	**-60,989**	**-65,623**	**-4,635**
Total	**-60,077**	**-64,688**	**-4,612**

Corporate	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**7,953**	**10,593**	**2,640**
Pay Costs	-20,336	-20,155	181
Non Pay Costs	-35,461	-36,399	-938
Expenditure	**-55,797**	**-56,554**	**-757**
Total	**-47,844**	**-45,961**	**1,883**

HIF	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**21,042**	**21,280**	**238**
Pay Costs	-9,130	-9,225	-95
Non Pay Costs	-11,727	-12,007	-281
Expenditure	**-20,857**	**-21,233**	**-376**
Total	**185**	**47**	**-138**

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

Directorate performance is outlined to the side.

Within the Directorate positions are some common areas of risk.

These include –

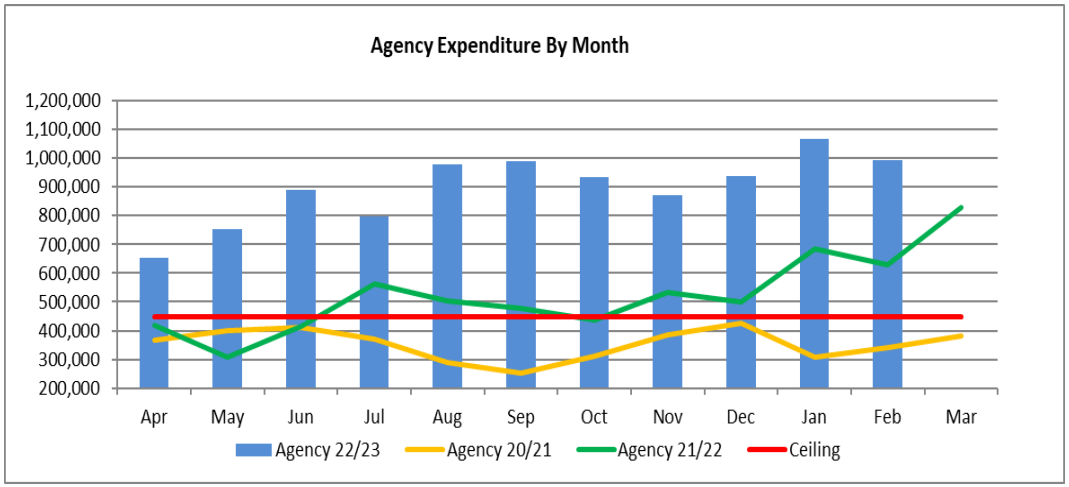
- Ward pay expenditure position – £323k overspend in month, £2.683m YTD. Some of the pay pressures are from wards in escalation. Escalation costs £1m ytd.
- Medical Staffing pressures – £563k overspend in month, £3.16m YTD.
- Main areas contributing to this remain the same as identified in previous months;
  Anaesthetics
  General Surgery
  Obs & Gynae
  ED
  Doctors in Training
  Radiology
- Community Children's Services are underspend by £167k in month on pay. There is some variation at contract level and pressures remain within Paediatrics.
- Significant vacancies across CC, PSC and LTUC in some places offsetting vacancy factors and agency costs.
- 56% of CIP delivered non-recurrently. Section 3.3.
- Third party costs for addressing activity backlog continue.
- Utility prices continue to be a pressure and are being closely monitored. Usage has however not increased.

3.2 Agency

February's expenditure on agency is £993k, Ytd costs are now £9,871k, and this is £4,195k above our annual agency ceiling of £5,676k.

Mitigations identified to date include reduced reliance on expensive off framework agencies in particular for Nursing/OPD in Theatres/Critical Care. Costs however remain high averaging £960k over the last 6 months. Directorates continue to develop actions plans that will also now feed into the cost improvement plan for next year.

Tables below show the breakdown of agency costs by staff groups.



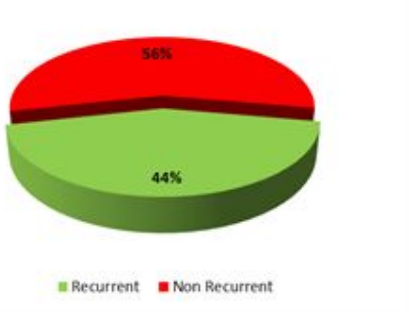
Row Labels	Sum of April 2022	Sum of May 2022	Sum of June 2022	Sum of July 2022	Sum of August 2022	Sum of September	Sum of October 2022	Sum of November	Sum of December	Sum of January 2023	Sum of February 2023
Medical and Dental (Agency)	208,147	306,716	329,189	312,889	264,329	301,927	290,154	312,442	291,812	482,304	432,982
Non-Medical - Non-Clinical (Agency)	113,062	137,310	221,257	183,054	195,810	241,315	205,776	146,718	52,691	365,086	158,376
Registered Nurses (Agency)	264,796	249,970	295,772	253,280	441,232	373,409	370,852	356,408	506,166	191,822	315,078
Scientific, Therapeutic and Technical (Agency)	7,154	5,466	5,558	8,960	1,346	10,275	6,121	2,629	17,430	1,774	16,916
Support To Clinical Staff (Agency)	61,276	52,923	38,379	39,537	77,155	63,885	61,027	54,528	70,126	27,489	69,157
Grand Total	**654,435**	**752,384**	**890,155**	**797,720**	**979,873**	**990,812**	**933,930**	**872,726**	**938,226**	**1,068,475**	**992,509**
Agency Ceiling	473,000	473,000	473,000	473,000	473,000	473,000	473,000	473,000	473,000	473,000	473,000
Variance	**-181,435**	**-279,384**	**-417,155**	**-324,720**	**-506,873**	**-517,812**	**-460,930**	**-399,726**	**-465,226**	**-595,475**	**-595,475**

3.3 CIP

£6,420m has been delivered which is 77% of the target. Currently only 44% of the actioned amount is recurrent.

LTUC and PSC schemes in particular are reliant on significant NR savings. Some of this gap is being addressed via annual planning for 2023/24.

A target of £9.3m for efficiencies has been set in next year's plan. Ongoing discussions within directorates to identify potential schemes. A group has been set up to review the Model Hospital opportunities.



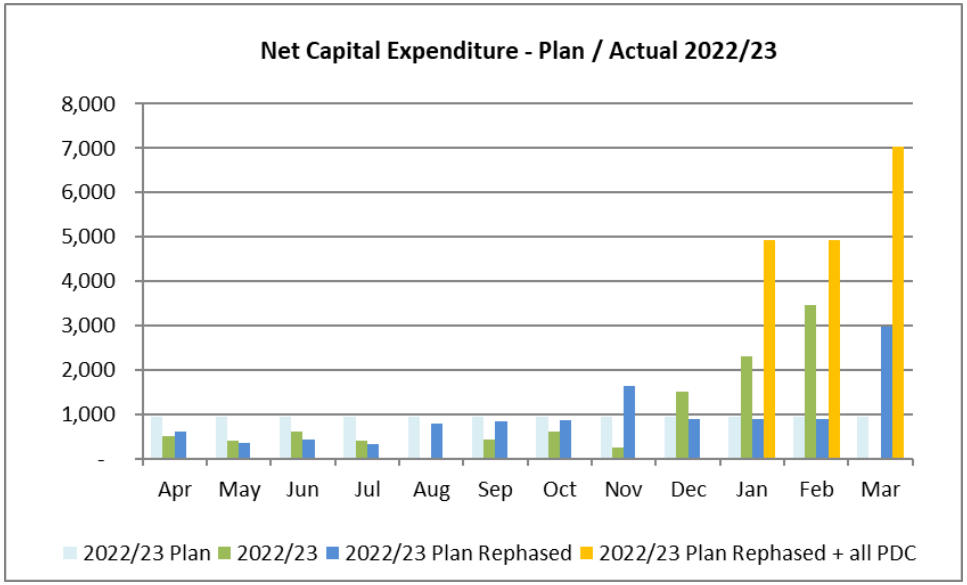
Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age
8,295,500	6,420,092	29,380	488,827	673,694	683,507	7,611,993	**92%**	6,973,803	1,321,697	**84%**
% of target	**77%**	**0%**	**6%**	**8%**	**8%**					

3.4 Capital

The Trust forecast spend is £20.9m and as at February £10.5m has been spent with the balance of this expected to spend in month 12. Given that a month remains before year end there is potential risk of slippage in some schemes.

The main risks relate to the plant room scheme, EPR and TIF2. Other schemes that could potentially utilise some of the slippage have been identified.

Plans for 2023/24 building on the 5 year plan have been developed as part of the annual planning process and reflect wider system discussions.



3.5 Better Payment Practice

The Trust is required to adhere to the Better Payment Practice Code, which targets the payment of 95% of invoices within 30 days.

Actions taken to improve the BPPC include the 'No PO no payment' process and the ongoing review of the authorisers on the system.

Better Payment Practice Code	In Month		YTD	
	Number	£000's	Number	£000's
Total Invoices paid in Period	3,647	9,728	38,742	89,361
Total Invoices paid within target	3,469	8,106	35,965	80,044
% Paid within target	95%	83%	93%	90%

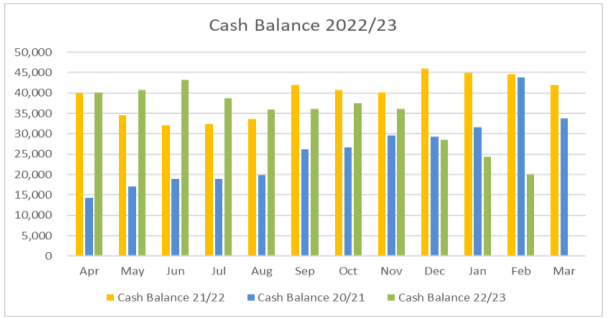
3.6 Aged Debtors

Debtors being reviewed, in particular 31-60 days.

February		
31-60 Days Past Invoice Due Date	61-90 Days Past Invoice Due Date	Over 90 Days Past Invoice Due Date
1,712,455	662,923	817,480

3.7 Cash Balance

The Trust cash balance continues to remains positive as at the end of November and no current concerns.



4. Financial Implication/Risk assessment

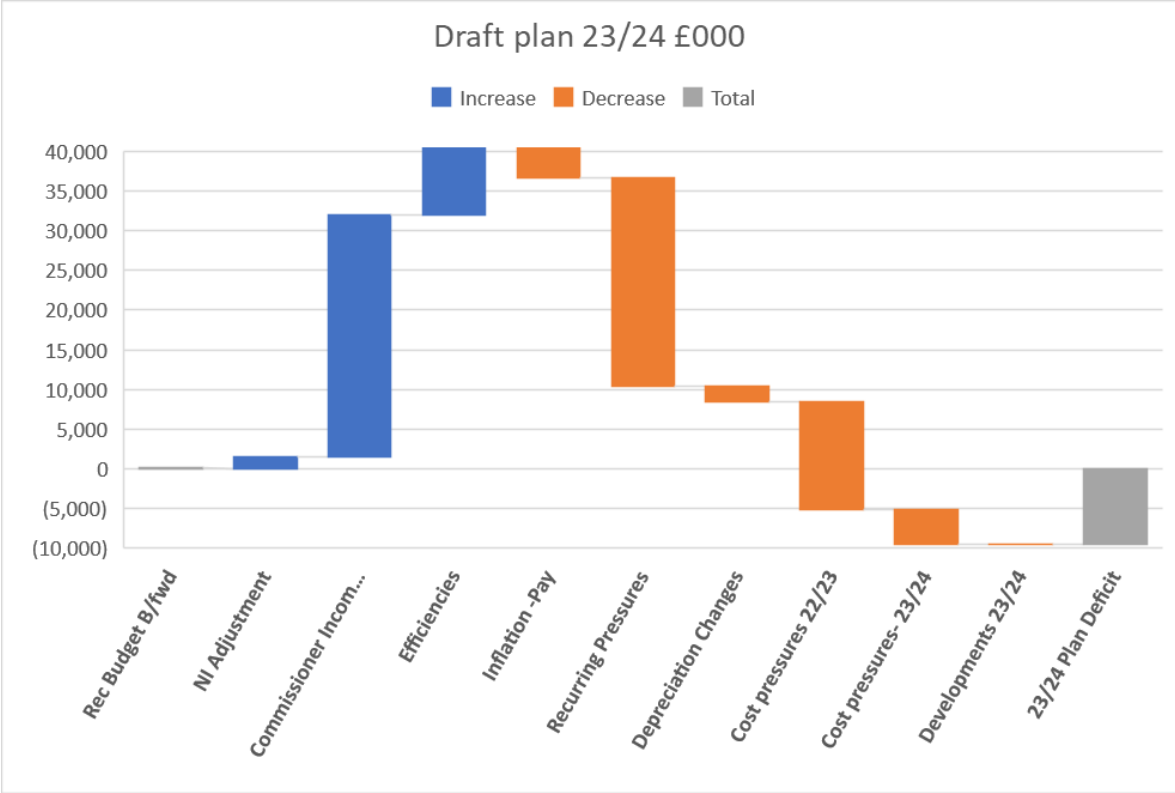
As described within the report. The Trust has a deficit YTD, there continues to be a number of pressures mainly across Medical Staffing and the Wards .Recovery actions are being progressed by the directorates.

5. Draft Plans

Following the initial submission of plans in February, a number of changes have now been made to the plans to incorporate additional income notified from the ICB, review of cost pressures by directorates and additional CIP to align with regional and national expectations. The combined impact of these changes is a reduction in planned deficit from £29.8m to £9.6m. The revised plan has been presented to SMT and will be submitted to NHSE following board approval.

Directorates have also now been asked to formally sign off their budgets. Below is a waterfall showing the revised planned deficit.

Rec Budget B/fwd	0
NI Adjustment	1,464
Commissioner Income changes	30,561
Efficiencies	9,333
Inflation -Pay	(4,691)
Recurring pressures	(26248)
Depreciation Changes	(1972)
Cost pressures 22/23	(13,528)
Cost pressures- 23/24	(4,420)
Developments 23/24	(55)
23/24 Plan Deficit	(9,556)



Risks

There are a number of risks to be updated on the Finance risk register relating to 2022/23. Risks are being managed within local risk registers, and will be escalated when appropriate. Based on the current risks faced by the organisation the following items were escalated to Executive Risk Review Group –

1. Financial Position, risk scoring of 12.
2. Agency Expenditure, risk scoring of 15.

6. Recommendation

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

Jordan Mckie Acting Director of Finance
Tirivake Mutambasere Acting Deputy Director of Finance

Board of Directors
29th March 2023

Title:	Trust Strategic and Operational Plan 2023/24
Responsible Director:	Matt Graham, Director of Strategy
Author:	Matt Graham, Director of Strategy

5.6

Purpose of the report and summary of key issues:	To seek approval of the Trust Strategic and Operational Plan for 2023/24 which consists of: • Strategic Objectives • Performance Targets • Activity Plan • Workforce Plan • Financial (revenue and capital) Plan The Plan has been developed through a comprehensive, iterative planning process with engagement at service, directorate, SMT and Board levels. A key outcome has been a plan which is coherent ie where the finance is sufficient to fund workforce which is sufficient to deliver the planned activity and performance.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	X
	Great Start in Life	X
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	X
	Digital transformation to integrate care and improve patient, child and staff experience	X
	Healthcare innovation to improve quality	X
Corporate Risks	None	
Report History:	SMT, 22 March 2023 NB. Trust Board and Resources Committee have received multiple updates on the progress of the planning process since September 2022.	
Recommendation:	Trust Board is recommended to: • Approve the 23/24 Whole Trust Breakthrough Objectives	

	• Approve the 23/24 Objectives for the Strategic Ambitions and Enabling Ambitions • Note that the objectives are based on the discussion and output of the SMT and Board workshops, and the Planning Process • Approve the 23/24 performance targets, activity plan and bed numbers • Note the directorate activity plans • Approve the 23/24 workforce establishment • Note the directorate workforce establishments • Note the workforce plans showing the expected increase in substantive workforce. • Approve the 23/24 financial plan (revenue and capital) • Note the directorate financial plans • Note that financial plans have been set to fund the workforce establishment which is sufficient to deliver the activity plan and performance targets • Note that discussions continue with HNY ICB about funding for 23/24

HDFT Annual Strategic & Operational Plan 2023/24

29 March 2023

Annual Planning Process

Sep
- Produce Inputs
- Leadership Team review of Inputs

Oct
- Board & SMT Workshop (combined) 26 Oct: Review Inputs, review and confirm Trust Internal Planning Guidance
- Inputs ➔ Trust Internal Planning Guidance: constraints/fixed points; high level priorities, activity & financials

Nov
- Directorate, Corporate Teams, HIF Planning based on Planning Guidance: Directorate Workshop
- Quality Priorities; Demand & Capacity (incl resources reqd, improvement assumptions); Financial Plans (incl CIP)

Dec
- Further development and refinement of Directorate, Corporate, HIF plans: Directorate Workshop
- SMT & Board: update on Outputs: Annual Strategic Objectives, Activity Plan, Financial Plan, Workforce Plan, QIA

Jan
- Further refinement of Trust, Directorate, Corporate Team, HIF plans: Directorate Workshop
- Finalise Outputs: Annual Strategic Objectives, Performance Targets, Activity Plan, Financial Plan, Workforce Plan

Feb
- Directorate, Corporate, HIF Planning Reviews: Directorate Workshop
- SMT & Board Workshop 22 Feb: review and confirm Outputs; identify any remaining areas for refinement

Mar
- Council of Governors planning update and feedback on Strategic Objectives
- SMT & Trust Board sign off of Trust Plan (Annual Strategic Objectives, Performance Targets, Activity Plan, Financial Plan, Workforce Plan) with Directorate Plans to note

Trust Strategic & Operational Plan

An ambitious, deliverable, coherent plan setting out:

- Strategic Objectives (the “must dos” in 2023/24 for each Strategic Ambition)
- Operational Performance and Activity Plan
- Workforce Plan
- Financial Plan (including capital and cost improvement)

In order to provide clarity, common purpose and ownership of delivery from Board, Leadership Team, Corporate Teams, Clinical Directorates and HIF.

NB. Coherent = a financial plan which funds workforce and other resources sufficient to deliver the performance and activity plan

Strategic Objectives 2023/24

OUR PURPOSE, AMBITIONS & ENABLING AMBITIONS

Trust Strategy

Purpose

THE PATIENT AND CHILD FIRST

Improving the health and wellbeing of our patients, children and communities

Ambitions

- BEST QUALITY, SAFEST CARE
- PERSON CENTRED, INTEGRATED CARE: STRONG PARTNERSHIPS
- GREAT START IN LIFE

AT OUR BEST: MAKING HDFT THE BEST PLACE TO WORK

Our KITE Behaviours

KINDNESS | INTEGRITY | TEAMWORK | EQUALITY

Enabling Ambitions

- AN ENVIRONMENT THAT PROMOTES WELLBEING
- DIGITAL TRANSFORMATION to integrate care and improve patient, child and staff experience
- HEALTHCARE INNOVATION TO IMPROVE QUALITY

5.6

Whole Trust "Breakthrough" Objectives

A small number of strategic objectives that the whole (or significant majority) of the Trust can contribute to delivering:

Ambition	Breakthrough Objective
Best Quality, Safest Care	Develop and embed a continuous improvement philosophy and operating model throughout the trust to provide the capacity and capability to improve the quality, safety and efficiency of our services
Person Centred, Integrated Care; Strong Partnerships	Increase health and social care integration through closer working with primary care, social care, VCSE to improve care for our patients and children
At Our Best: Making HDFT the best place to work	Achieving the right number of staff in work, with the right skills to deliver great care for our patients and children (eg through recruitment, retention, wellbeing, efficiency, innovative workforce models)

Strategic Ambitions – 23/24 Objectives

Our priorities for 23/24 to make progress on our strategic ambitions (delivery will be tracked through the Board Assurance Framework)

Best Quality, Safest Care	Person Centred Integrated Care; Strong Partnerships	Great Start in Life	At Our Best: making HDFT the best place to work
To continuously improve our safety and learning culture (including to implement PSIRF)	Health and social care integration – closer working with primary, social and voluntary care	Implementing and embedding Hopes for Healthcare across the Trust	The right number of staff in work, with the right skills to deliver great care
Listening to people to continuously improve our services	Cancer recovery (28 day diagnostic standard; 62 day treatment standard)	Operating model for corporate services to support all community services across all localities	Career pathways – skill mix, role redesign, apprenticeships etc

Enabling Ambitions – 23/24 Objectives

Our priorities for 23/24 to make progress on our strategic ambitions
(delivery will be tracked through the Board Assurance Framework)

Environment that promotes wellbeing	Digital Transformation to integrate care and improve experience	Healthcare innovation to improve quality	Finance
HDH estates strategy	Develop and embed a continuous improvement philosophy and operating model	Invest to grow our R&I function	Autonomy and Accountability to make decisions at the right level (with training and education to support)
Deliver the 23/24 capital programme	Improve our data management & analytics function	Build an academic/university partnership to analyse our datasets	Improve pathway management and clinic administration
Estates and logistics offer for community services	Improve our digital literacy training for patients and staff	Centre of excellence for Children's PH research	Reducing waste, improving processes

Operating Plan

Performance & Activity

Trust Performance Metrics

	Apr 23-Mar 24	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Funded Critical Care Beds	Average 8	8	8	8	8	8	8	8	8	8	8	8	8
% critical care bed occupancy (with increased funding for 8 beds)	Average 75%	75%	75%	75%	75%	63%	63%	63%	75%	75%	88%	88%	88%
G&A Adult + Paeds Beds(17) open	Average 301	301	301	301	301	301	301	301	301	301	301	301	301
% G&A beds occupancy	Average 92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Number of beds occupied by patients no longer meeting the criteria to reside – adult	Average 60	75	70	65	60	55	50	50	50	60	65	60	50
% attendances at all type A&E departments, excluding planned follow-up, departing in less than 4 hours	Average 80%	68%	81%	81%	76%	78%	80%	82%	84%	85%	85%	85%	76%
Number of incomplete RTT pathways of 52 weeks or more active	Average 1,142	1,142	1,200	1,200	1,200	1,190	1,180	1,170	1,160	1,150	1,100	1,100	1,050
Number of incomplete RTT pathways of 65 weeks or more remaining active	Traject to zero	470	470	470	450	440	430	390	370	350	300	200	0
Number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site specific symptoms	Average 55	65	65	60	60	55	55	50	50	50	50	50	50
% of patients receiving a communication of diagnosis of cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days	Average 80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Trust Activity

	Apr 23 - Mar 24 - Total	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Outpatient (all TFC) - first attendances	89,833	6,141	6,200	6,403	8,529	6,908	7,952	8,853	8,358	7,490	8,664	7,675	6,660
Outpatient (all TFC) - follow-ups	162,712	10,717	11,624	10,922	15,231	12,793	13,897	16,581	14,981	13,153	15,863	13,547	13,403
First outpatient attendances - consultant led (Spec acute)	57000	3623	3658	3778	5032	4075	4691	5223	4931	4419	5112	4528	3929
Follow-up outpatient attendances – consultant led (Spec acute)	96,000	6,323	6,858	6,444	8,986	7,548	8,199	9,783	8,839	7,760	9,359	7,993	7,908
Number of episodes moved or discharged to a PIFU pathway	4,985	341	344	355	473	383	441	491	464	416	481	426	370
Number of specific acute elective spells in the period	31600	2103	2480	2270	2977	2878	2711	3035	2957	2499	2944	2691	2057
Total number of specific acute elective day case spells	29000	1944	2283	2076	2687	2644	2491	2795	2711	2307	2664	2485	1915
Total number of specific acute elective ordinary spells	2600	159	197	194	290	234	220	240	246	192	280	206	142
Number of specific acute non-elective spells in the period	23,199	1,792	1,960	1,840	1,950	1,895	1,927	2,020	2,037	2,030	2,033	1,865	1,850
Magnetic Resonance Imaging	10,075	592	793	780	790	786	838	1,019	1,009	1,051	985	733	699
Computed Tomography	17,564	1,697	1,611	1,547	1,503	1,268	1,497	1,574	1,163	1,373	1,452	1,324	1,555
Non-Obstetric Ultrasound	22,927	1,516	1,874	1,681	1,718	1,723	1,795	1,965	2,285	2,205	2,103	1,918	2,144
Colonoscopy	4,160	316	335	349	367	327	420	355	336	356	324	308	367
Flexi Sigmoidoscopy	759	79	54	65	64	70	63	67	69	50	57	58	63
Gastroscopy	2,856	247	239	209	223	218	253	228	215	244	282	239	259
Echocardiography	953	87	72	96	50	82	53	85	77	71	90	91	99

PSC Activity

	Apr 23 - Mar 24 - Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Outpatient (all TFC) - first attendances	68,612	4,523	4,687	4,762	6,512	5,707	6,045	6,905	6,417	5,722	6,627	5,886	4,818
Outpatient (all TFC) - follow-ups	143,483	9,933	10,490	9,798	13,301	11,443	12,221	14,567	13,129	11,447	13,907	11,889	11,359
First outpatient attendances - consultant led (Spec acute)	43,402	2,861	2,965	3,012	4,119	3,610	3,824	4,368	4,059	3,620	4,192	3,724	3,048
Follow-up outpatient attendances – consultant led (Spec acute)	82,540	5,714	6,034	5,637	7,651	6,583	7,030	8,380	7,553	6,585	8,000	6,839	6,534
Number of episodes moved or discharged to a PIFU pathway	10,657	712	752	732	1,003	831	922	1,073	985	871	1,035	896	845
Number of specific acute elective spells in the period	20,717	1,373	1,623	1,491	1,969	1,886	1,776	1,986	1,940	1,633	1,945	1,760	1,334
Total number of specific acute elective day case spells	18,071	1,211	1,422	1,294	1,674	1,648	1,552	1,742	1,689	1,437	1,659	1,549	1,194
Total number of specific acute elective ordinary spells	2,646	162	200	198	295	239	224	245	251	196	286	211	140
Number of specific acute non-elective spells in the period	7,658	592	647	607	644	625	636	667	672	670	671	616	611

LTUC Activity

	Apr 23 - Mar 24 - Total	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Outpatient (all TFC) - first attendances	17,921	1,181	1,224	1,244	1,701	1,491	1,579	1,804	1,676	1,495	1,731	1,538	1,258
Outpatient (all TFC) - follow-ups	30,197	2,090	2,208	2,062	2,799	2,408	2,572	3,066	2,763	2,409	2,927	2,502	2,391
First outpatient attendances - consultant led (Spec acute)	8,770	578	599	609	832	730	773	883	820	731	847	752	616
Follow-up outpatient attendances – consultant led (Spec acute)	18,500	1,281	1,353	1,263	1,715	1,475	1,576	1,878	1,693	1,476	1,793	1,533	1,465
Number of episodes moved or discharged to a PIFU pathway	2,307	154	163	158	217	180	200	232	213	189	224	194	183
Number of specific acute elective spells in the period	10,834	726	853	776	1,005	988	930	1,044	1,013	861	996	928	715
Total number of specific acute elective day case spells	10,740	720	845	769	995	979	922	1,035	1,004	854	986	921	710
Total number of specific acute elective ordinary spells	94	6	7	7	10	8	8	9	9	7	10	7	5
Number of specific acute non-elective spells in the period	10,132	783	856	804	851	827	842	882	890	887	888	815	808

CC Activity

	Apr 2023-Mar 24 Average	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Count of 2-hour UCR first care contacts delivered within reporting quarter	150	139	140	150	155	155	150	155	150	155	155	145	155
The number of people discharged by location and discharge pathway	773	773	773	773	773	773	773	773	773	773	773	773	773
Hospital discharge pathway activity - pathway 0	518	518	518	518	518	518	518	518	518	518	518	518	518
Hospital discharge pathway activity - pathway 1	170	170	170	170	170	170	170	170	170	170	170	170	170
Hospital discharge pathway activity - pathway 2	39	39	39	39	39	39	39	39	39	39	39	39	39
Hospital discharge pathway activity - pathway 3	46	46	46	46	46	46	46	46	46	46	46	46	46
The number of patients on the virtual ward	11	8	8	8	8	8	8	8	8	15	17	20	21
The number of patients the virtual ward is able to simultaneously manage	15	10	10	10	10	10	10	10	10	25	25	25	25
Community services waiting list	8539	8539	8539	8539	8539	8539	8539	8539	8539	8539	8539	8539	8539
Number of CYP (0-17 years) on community waiting lists per system	3333	3333	3333	3333	3333	3333	3333	3333	3333	3333	3333	3333	3333
Number of Adults (18+ years) on community waiting lists per system	5206	5206	5206	5206	5206	5206	5206	5206	5206	5206	5206	5206	5206

Workforce Plan

Planned Establishment 2023/24

Trust Establishment

Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered Nursing, Midwifery & Health Visiting staff	1,626.61	1,619.27	1,625.94	1,622.33	1,631.58	1,632.41	1,644.93	1,645.79	1,651.51	1,641.66	1,649.81	1,640.78
Allied Health Professionals	347.60	351.03	355.86	357.78	356.12	358.08	360.78	362.90	361.20	360.44	362.36	357.53
Other Scientific, Therapeutic and Technical Staff	96.23	97.54	96.54	96.54	95.68	96.48	96.60	96.60	96.20	97.24	97.14	96.64
Healthcare Scientists	56.78	56.78	58.48	58.48	58.98	58.98	58.98	58.48	58.98	60.43	59.93	59.43
Support to Clinical Staff	917.42	914.75	914.34	909.36	910.70	911.47	914.76	914.91	911.03	918.10	929.90	935.16
NHS Infrastructure Support	907.74	906.71	907.00	908.47	907.32	911.34	910.54	910.53	901.33	917.23	920.14	915.95
Any Others	14.00	14.50	14.50	14.50	14.50	14.00	15.50	15.50	15.50	15.50	15.50	15.00
Medical and Dental – Consultants	146.50	147.60	146.56	146.51	146.42	148.73	150.57	150.69	148.90	148.90	148.73	149.00
Medical and Dental – Career Grades	89.85	90.35	91.22	92.15	88.65	92.61	93.11	92.86	92.68	90.04	90.04	89.14
TOTAL	**4,203.73**	**4,199.55**	**4,211.44**	**4,207.11**	**4,210.94**	**4,225.10**	**4,246.76**	**4,249.25**	**4,238.32**	**4,250.54**	**4,274.55**	**4,259.64**

- The table above shows a planned increase to staff in post of 81.16wte between April 2023 and March 2024.
- 60 International Registered Nurses are included in the planned staffing figures. Cohorts of 10 nurses are due to drop into the Registered Nursing, Midwifery & Health Visiting staff group every other month.
- Other planned international recruitment will see 2.00wte Midwives drop into the numbers in the summer and 10.00wte AHPs drop in to the numbers between April and June 2023.
- Medical and Dental – Trainee Grades have been removed from the Workforce Plan submission by HEE as the national plan is to add the doctors in training figures from the Trainee Information System (TIS).

PSC Establishment

Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered Nursing, Midwifery & Health Visiting staff	313.70	310.83	310.31	310.50	313.84	313.05	318.34	319.44	322.81	320.37	325.04	320.40
Allied Health Professionals	94.24	93.24	91.78	93.71	91.86	94.02	96.42	98.82	98.01	97.76	98.96	97.46
Other Scientific, Therapeutic and Technical Staff	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.29	8.49	8.49	8.49
Support to Clinical Staff	189.53	188.37	186.41	184.80	179.63	181.32	181.15	178.33	178.88	179.72	186.30	189.35
NHS Infrastructure Support	89.29	89.33	90.58	89.83	90.24	90.43	90.53	91.83	90.83	90.88	90.66	89.29
Medical and Dental – Consultants	62.11	63.11	61.85	61.85	61.95	63.22	63.68	63.22	63.01	63.01	62.54	63.11
Medical and Dental – Career Grades	39.20	39.20	39.20	39.70	39.20	41.45	40.45	40.45	39.95	39.45	40.45	40.45
TOTAL	**796.36**	**792.37**	**788.42**	**788.68**	**785.01**	**791.78**	**798.86**	**800.38**	**801.78**	**799.68**	**812.44**	**806.25**

- PSC Directorate has seen high turnover in 2022/23, however recent figures show the turnover rate is beginning to decrease, therefore an element of this has been factored into the trends for the Directorate.
- A proportion of the international nurse recruitment that is due to drop into the numbers in 2023/24 has been included within the ‘Registered Nursing, Midwifery & Health Visiting staff group, along with the 2.00wte International Midwives who are due to arrive in the summer.

LTUC Establishment

Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered Nursing, Midwifery & Health Visiting staff	333.26	330.05	334.44	332.50	337.47	333.84	342.78	340.64	346.48	341.13	345.03	340.71
Allied Health Professionals	104.68	109.58	114.78	115.68	115.88	115.68	115.28	114.43	113.98	114.76	114.85	111.21
Other Scientific, Therapeutic and Technical Staff	46.82	46.86	46.60	46.60	47.04	47.54	47.56	47.56	47.56	47.56	47.56	47.06
Healthcare Scientists	56.78	56.78	58.48	58.48	58.98	58.98	58.98	58.48	58.98	60.43	59.93	59.43
Support to Clinical Staff	288.80	289.44	290.83	288.91	289.56	286.70	285.47	283.82	280.95	284.27	286.39	289.19
NHS Infrastructure Support	110.99	110.94	109.84	109.71	110.95	110.34	109.44	108.96	109.41	109.98	109.48	109.30
Medical and Dental – Consultants	70.75	70.75	70.97	70.57	70.37	71.20	72.57	73.15	71.57	71.57	71.87	71.92
Medical and Dental – Career Grades	33.25	33.25	34.42	34.85	33.85	34.85	35.35	35.35	35.67	33.93	33.93	33.93
TOTAL	**1,045.33**	**1,047.65**	**1,060.36**	**1,057.30**	**1,064.10**	**1,059.13**	**1,067.43**	**1,062.39**	**1,064.60**	**1,063.63**	**1,069.04**	**1,062.75**

- A proportion of the international nurse recruitment that is due to drop into the numbers in 2023/24 has been included within the ‘Registered Nursing, Midwifery & Health Visiting staff group.
- The International AHP recruitment is included within the planned workforce figures in the above table. This is a total of 11.00wte who are due to drop into the numbers between April and June 2023.

CC Establishment

Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered Nursing, Midwifery & Health Visiting staff	918.14	917.09	919.21	917.86	918.80	923.44	922.20	924.10	920.92	919.46	919.53	919.97
Allied Health Professionals	144.19	143.97	145.06	144.15	144.14	144.14	144.84	145.40	144.95	143.67	144.30	144.61
Other Scientific, Therapeutic and Technical Staff	34.68	35.94	35.20	35.20	33.90	34.20	34.30	34.30	33.90	34.70	34.60	34.60
Support to Clinical Staff	344.73	344.55	344.92	343.39	349.12	351.88	355.85	360.38	359.62	362.42	364.44	366.08
NHS Infrastructure Support	157.39	156.81	155.77	158.96	157.94	159.04	159.39	157.79	154.12	156.17	156.63	154.93
Medical and Dental – Consultants	11.99	11.99	11.99	12.34	12.34	12.34	12.34	12.34	12.34	12.34	12.34	11.99
Medical and Dental – Career Grades	17.41	17.91	17.61	17.61	15.61	16.31	17.31	17.06	17.06	16.66	15.66	14.76
TOTAL	**1,628.53**	**1,628.26**	**1,629.76**	**1,629.51**	**1,631.85**	**1,641.35**	**1,646.23**	**1,651.37**	**1,642.91**	**1,645.42**	**1,647.5**	**1,646.94**

- We aim to retain the SCPHN students who are in the current cohort when they qualify. This will increase the staff in post within the ‘Registered Nursing, Midwifery & Health Visiting’ staff group from September 2023.

Corporate Establishment

Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered Nursing, Midwifery and Health visiting staff	61.51	61.31	61.97	61.47	61.47	62.08	61.61	61.61	61.30	61.20	60.70	61.20
Allied Health Professionals	4.50	4.25	4.25	4.25	4.25	4.25	4.25	4.25	4.25	4.25	4.25	4.25
Other Scientific, Therapeutic and Technical Staff	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.44	6.49	6.49	6.49
Support to Clinical staff	16.97	16.97	16.97	16.97	16.72	16.40	16.40	16.20	15.90	15.90	15.45	16.50
NHS Infrastructure Support	362.82	362.19	362.93	365.10	365.17	368.55	367.22	367.59	363.07	372.46	373.92	375.20
Any Others	10.00	10.00	10.00	10.00	10.00	9.50	11.00	11.00	11.00	11.00	11.00	10.50
Medical and Dental - Consultants	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65	1.65
TOTAL	**463.89**	**462.91**	**464.31**	**465.98**	**465.8**	**469.2**	**468.9**	**469.07**	**463.94**	**473.28**	**473.79**	**475.12**

- The Corporate Services Directorate expected the remain at a relatively static level for 2023/24, with the exception of an additional 10.00wte planned Project Managers within the figures.

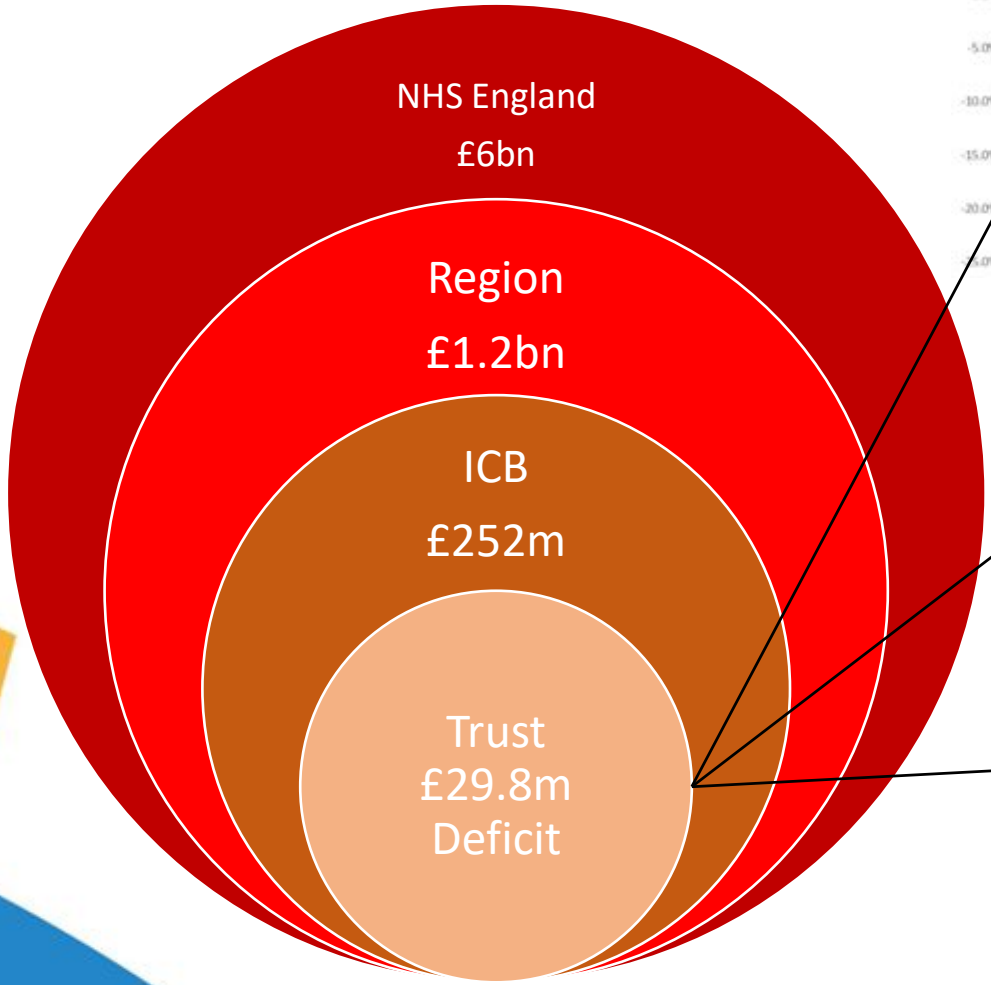
HIF Establishment

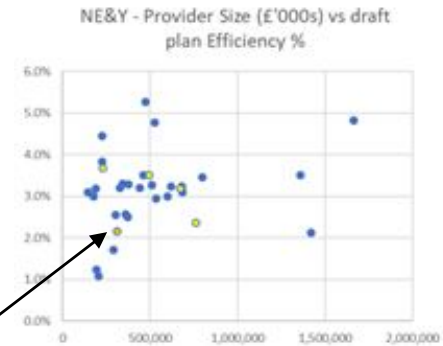
Staff Group	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Support to Clinical Staff	77.39	75.43	75.21	75.28	75.68	75.18	75.90	76.19	75.69	75.80	77.32	76.05
NHS Infrastructure Support	187.24	187.44	187.88	184.87	183.01	182.98	183.96	184.36	183.91	187.74	189.44	187.53
Any Others	4.00	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50	4.50
TOTAL	**268.64**	**267.37**	**267.60**	**264.65**	**263.19**	**262.66**	**264.36**	**265.05**	**264.09**	**268.04**	**271.26**	**268.08**

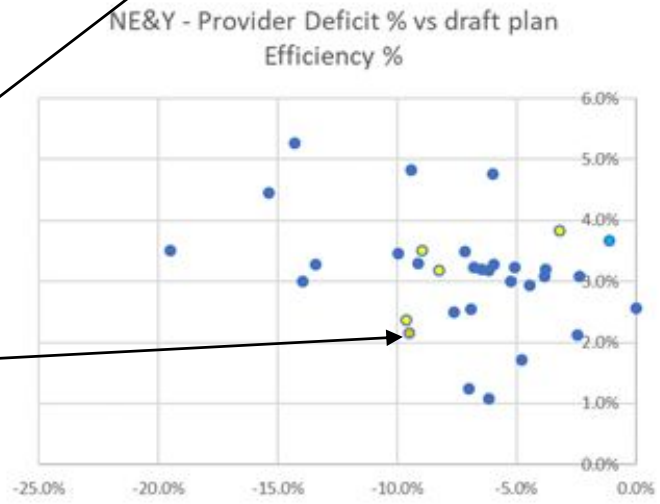
- HIF expected the remain at a static level for 2023/24.

Financial Plan

Financial Plan - Draft







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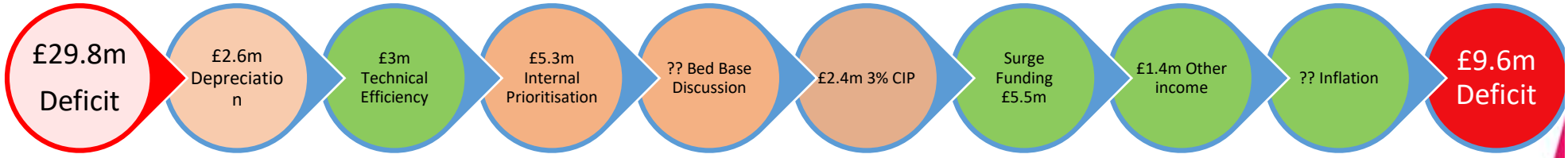
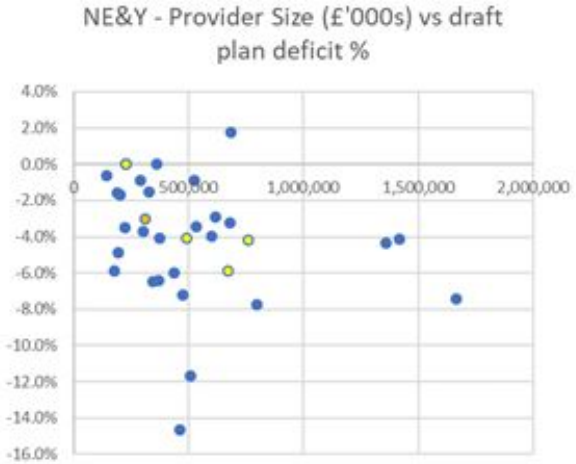
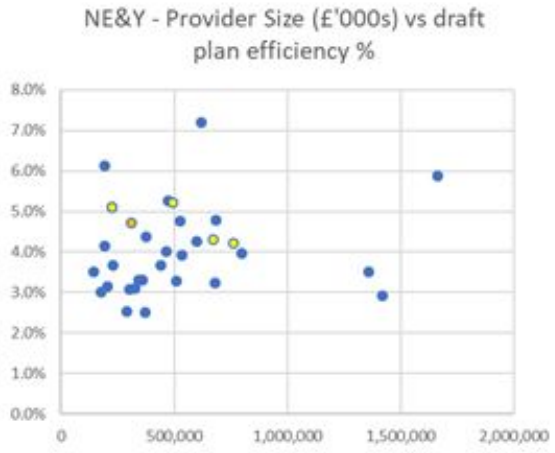
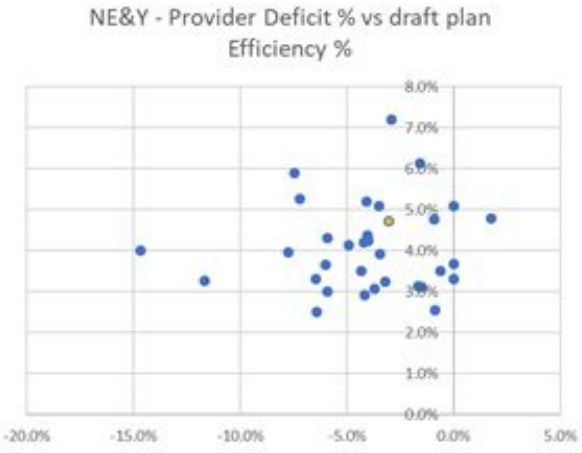
Financial Plan - Progress









Financial Plan – Trust

	£m	
Income from patient care	299	Includes ERF
Other income	22	
Total Income	**321**	
Operating costs – pay	(233)	Include costs for increased G&A and CC beds open throughout 22/23, and significant other cost pressures, developments and undelivered/non-rec savings
Operating costs – non-pay	(94)	
Total Operating Costs	**(327)**	
Operating Surplus (Deficit)	**(7)**	
Finance Adjustments	(3)	
Underlying Surplus (Deficit)	**(9.6)**	

+ve

A&E performance

RTT requirements

Cancer

Bed Occupancy - all

-ve

ERF Performance - Baseline

Financial Plan – Directorate Budgets

HDFT	Opening Budget	Incremental Change/NI Reduction	Cost Pressures	CIP 3% and Carry Forward	Revised Budget
COMMUNITY AND CHILDRENS					
Income	-2,332,400	474,000	151,200		-1,707,200
Pay Expenditure	76,753,900	-1,551,300	215,750		75,418,350
Non Pay Expenditure	5,082,800	554,400	121,850	-2,843,745	2,915,305
	79,504,300	**-522,900**	**488,800**	**-2,843,745**	**76,626,455**

HDFT	Opening Budget	Incremental Change/NI Reduction	Cost Pressures	CIP 3% and Carry Forward	Revised Budget
CORPORATE SERVICES					
Income	-6,392,600		1,000,000		-5,392,600
Pay Expenditure	18,550,100	-175,300	832,300		19,207,100
Non Pay Expenditure	39,465,200	45,500	1,418,600	-1,899,336	39,029,964
	51,622,700	**-129,800**	**3,250,900**	**-1,899,336**	**52,844,464**

HDFT	Opening Budget	Incremental Change/NI Reduction	Cost Pressures	CIP 3% and Carry Forward	Revised Budget
LONG TERM AND UNSCHEDULED CARE					
Income	-6,510,900				-6,510,900
Pay Expenditure	66,101,500	-195,400	7,388,159		73,294,259
Non Pay Expenditure	24,402,600	-255,200	3,130,900	-2,519,796	24,758,504
	83,993,200	**-450,600**	**10,519,059**	**-2,519,796**	**91,541,863**

HDFT	Opening Budget	Incremental Change/NI Reduction	Cost Pressures	CIP 3% and Carry Forward	Revised Budget
PLANNED AND SURGICAL CARE					
Income	-781,700				-781,700
Pay Expenditure	52,689,900	-249,300	1,439,739		53,880,339
Non Pay Expenditure	13,801,400	-65,400	1,614,186	-2,069,982	13,280,204
	65,709,600	**-314,700**	**3,053,924**	**-2,069,982**	**66,378,842**

Financial Plan - Capital

	£m	
Capital Funding		
• General capital funding	9.0	
• TIF2 (HDH Theatres)	10.2	Ring fenced - £2m 22/23, £2m 24/25
• EPR	9.0	Ring fenced
• **Total Capital Funding**	**28.2**	
Programmes		
• Wensleydale/ED2	5.0	£4m build cost
• Imaging Reconfiguration Ph1 & 2	1.0	Excluding CT scanner (already bought)
• Aseptics Refurbishment	1.4	
• HDH Theatres	10.2	
• Plant Rooms	0.5	Carried forward from 22/23
• Lifts	0.3	Carried forward from 22/23
• Backlog Maintenance	0.7	Excluding any national funding for RAAC
• HIF Capital	0.3	
• EPR (including IT)	9.0	
• Contingency	0.5	
• **Total Programme Costs**	**28.9**	**NB Currently £700k over committed**

£700k overcommitted

NB. No funding for wellbeing, equipment replacement and minimal contingency

No uncommitted funding for additional schemes in year

Summary & Board Approval

Summary & Board Approval

Trust Board is requested to:

- Approve the 23/24 Whole Trust Breakthrough Objectives
- Approve the 23/24 Objectives for the Strategic Ambitions and Enabling Ambitions
- Note that the objectives are based on the discussion and output of the SMT and Board workshops, and the Planning Process
- Approve the 23/24 performance targets, activity plan and bed numbers
- Note the directorate activity plans
- Approve the 23/24 workforce establishment
- Note the directorate workforce establishments
- Note the workforce plans showing the expected increase in substantive workforce.
- Approve the 23/24 financial plan (revenue and capital)
- Note the directorate financial plans
- Note that financial plans have been set to fund the workforce establishment which is sufficient to deliver the activity plan and performance targets
- Note that discussions continue with HNY ICB about funding for 23/24

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.

Governance:

- **Board Assurance:** People and Culture Committee
- **Programme Board:** People & Culture Programme Board
- **SRO:** Director of People & Culture

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

Goal	Metrics		
Looking after our people	• **Physical and emotional support to be "At Our Best"**	**Turnover** **Vacancy Factor** **Sickness Absence** **Number of leaders trained** **Appraisal Compliance** **MEST Compliance**	
Belonging	• **Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**	**Staff survey feedback** **Number of ER cases** **WRES data** **WDES data** **Gender Pay Gap** **Ethnicity Pay Gap**	
New ways of working	• **The right people, with the right skills, in the right roles**	**Vacancy Factor** **Agency/locum spend** **Time to Recruit**	
Growing for the future	• **Education, training and career development for everyone**	**Student Feedback** **Number of courses run** **Number of internal promotions**	

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR6	Workforce Risks	Risk to patient care and safety due to potential impacts on staffing levels and increased reliance on agency workers. Potential for lower colleague engagement due to increased workload, post pandemic burn-out and poor working environment. Risk of:	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

		- potential increase in lapses in delivery of safe and effective care to patients and service users. - both short and long term mental and physical health impacts on staff.				

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
To have strong focus on all aspects of health and wellbeing to retain colleagues.	• Increased staff retention. • Reduced vacancy factor. • Reduced sickness absence. • Improved appraisal compliance. • Improved employee engagement via survey scores.		• To work with Health & Safety to deliver a programme to ensure there is a robust model in place to support workplace stress across the organisation. • Continue improve and embed health and wellbeing support to colleagues. • Develop programme to support embedding of KITE behaviours and 'At Our Best' tools to support cultural change. • Run quarterly Inpulse surveys and national staff survey's to gather ongoing feedback on employee experience. • Review National Staff Survey 2022 feedback, develop communications plan and plan to act on feedback. • Plan in place to achieve 90% appraisal compliance across the Trust. • Plan in place to achieve 90% MEST compliance across the Trust. • To work with Trade Union Colleagues to deliver a Fair & Just Culture programme around ER casework management • Review of reasons for people leaving, to ensure any recurrent themes are addressed.	• Managing workplace stress project to be in 3 phases – phase 1 underway. • Health and wellbeing programme in place, more promotion required to ensure all colleagues aware and know 'its ok to not be ok'. • Learning materials and toolkits available across all aspects, KITE included in corporate induction and leadership development programmes – further work required at Directorate and team level. • Quarterly Inpulse surveys embedded and Directorate and team actions taken. • All Directorates working to 90% compliance appraisal – current appraisal 68%. • All Directorates working to 90% MEST compliance – current compliance 87%. • Draft communications plan for National Staff Survey 2022 developed. • Fair & Just Culture work has commenced with Trade Union Colleagues. • Piloting for 12 months with Last Opinion to obtain greater feedback on reasons for leaving.	
To continue to develop employment practices and policies, which support colleague work life balance.	• Improved attraction of staff. • Reduced vacancy factor. • Increased staff retention. • Flexible and agile working environments.		• Review and implement flexible/agile working policy. • Revise and implement Retire and Return policy. • Implement Colleague Wellbeing Passports to support those with caring or disability/long term conditions. • Continue to develop our health and wellbeing services in line with the NHS Health and Wellbeing diagnostic tool.	• Policy review partially completed. • Work to commence on Colleague Wellbeing Passports. • NHS Health & Wellbeing Diagnostic 90% completed.	
To develop our leaders to ensure at compassionate and inclusive leadership is the accepted and expected leadership culture, in line with our KITE values.	• Improvement in responses to question related to leadership in staff survey. • Increased staff retention. • Reduced sickness absence.		• Continue to deliver Pathway to Management and First Line Leader training. • Implement Pathway to Management as a mandatory requirement. • Develop and promote Leadership journey	• Delivery plans in place for both programmes. • Leadership Team discussion required around mandating Pathway to Management.	

	• Improved employee engagement via survey scores.		• Suite of EDI training to be launched. • Access to Coaching and Mentoring Training • Deliver Leading Transformational Triumvirates programme with ILN. • Working with Health & Safety develop models to leaders to manage workplace stress.	• Leadership Journey promotional materials developed and communications plan underway. • EDI training developed and delivery plan being developed. • Leading Transformational Triumvirates programme designed and commissioned with ILN, programme launched 23 November 22 and runs for 12 month period.	

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Belonging: 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
To be an organisation where everyone demonstrates KITE behaviours (Kindness, Integrity, Teamwork and Equality), to care for patients, children and communities who are the focus of everything we do.	• Improved scores on related questions from Inpulse and national staff surveys. • Reduction in employee related matters linked to staff behaviours. • Increased staff retention.		• Develop programme to support embedding of KITE behaviours. • Develop programme to support 'At Our Best' tools – ABC of appreciation, Respectful Resolution, 4 S Appraisal and BUILD Feedback tools.	• Programme to be developed and delivered by Senior OD Practitioner who joined on 09.01.23. • Root Out Racism 'app' developed 80% to be joined with FTSU and rolled out.	
To build strong teams who support each other, work collaboratively and with collective goal of delivering excellent care to our patients.	• Improvement in responses to question related to leadership in staff survey. • Increased staff retention. • Reduced sickness absence. • Improved employee engagement via survey scores.		• Cascade of Inpulse survey feedback and team actions to improve team cohesion. • Development of dashboard to highlight teams where KPI's indicate potential challenges within in team environment. • Adhoc OD support to teams highlighted above.	• Quarterly Inpulse surveys now well embedded with a Behaviour added into the questions each quarter to measure how well embedded our KITE behaviours are. January 23 is Kindness, which will allow direct comparison with the January 22 survey, which was also focussed on Kindness.	

To promote equality and diversity so everyone is valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support networks, leadership development and training of all colleagues.	• Improvement in responses to question related to leadership in staff survey.
	• Increase in number of employees with protracted characteristics.
	• Strong and active staff support networks in place across the Trust.
	• Active Diversity Calendar in place with high visibility of events.
	• EDS22 Assessment Rating of Achieving.
	• Increased staff retention.
			• Deliver WRES & WDES action plans to support HDFT being an inclusive and diverse organisation.
			• Grow membership of staff support networks and develop their role in the organisation.
			• Launch of Equality Impact Assessment policy, process and training programme.
			• Launch pilot unconscious bias training
			• Manage programme of events linked to Diversity Calendar.
			• EDS22 workforce domain action plan developed.
				• Additional training and development is being carried out for BAME leadership, cohort I and Reciprocal mentoring, cohort II.
				• Network Chairs invited to PAG
				• Increased numbers in all staff networks since December 23.
				  ○ Menopause 84 members
				  ○ LGBT+ 40+
				  ○ Disability and long term conditions 50+
				  ○ BAME 30+
				  ○ Mens Health 6
				  ○ Neurodiverse Network – Feb 23 launch
				• Network groups using WRES and WDES from 2023 to inform discussions and feedback points to feedback to Board.
				• Equality Impact Assessment new process and associated training - to be launched during January 2023.
				• Training on Unconscious Bias and Neurodiversity will be rolled out as training	

				available to all staff on Learning Lab. Programme written, to be piloted Feb 23. • EDS22 – external submission by 28 Feb 23 following Equality Reference Group agreed on outcomes from the report then action plan will be developed by end of March 23.	
To seek to increase diversity across our decision making forums.	• Increased equality, diversity and inclusion across all areas of Trust employment practices and wider decision making and recruitment. • Increased staff retention. • Improvement in WRES/WDES data.		• Promote HDFT as an inclusive and diverse employer in our recruitment information. • Review participation in key decision making forum/governance forums and recruitment. • Refresh of imagery to be more reflective of the employees that work here on all media platforms and recruitment sites.	• Recruitment pack under development with statements from Network Exec Sponsors, blogs and vlogs from staff to support. • Signposting information to be included in the recruitment pack to encourage recruitment from outside of the locality.	

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: New ways of working: the right people, with the right skills, in the right roles

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To plan and design our workforce as creatively as possible, to have the right number of skilled colleagues in the right roles.	• Resourcing and workforce numbers aligned to service needs and financial position. • Reduced reliance on agency/locum and other temporary workforce solutions.		• Develop integrated Resourcing & Workforce Plan to ensure we have the right numbers of skilled staff at the right time • Explore skills mix review/new role development and new ways of working • Review Core and Role Specific Mandatory training requirements for each role • Support development of Domiciliary Care subsidiary • Support Clinical Education Fellow Posts across the Organisation • Support Less Than Full Team as guided by HEE • Support Medical Trainees to meet curriculum requirements • Escalate exception reports • Organisational Development programme to support Pathology Services Joint Venture • E-job planning	• Workforce planning underway – 2 workshops held – Activity and Workforce with Finance workshop scheduled for early February. • Directors reviewing MEST requirements for each role across the Trust • There is currently 1 50/50 Clinical Education fellow in Frailty, and 2 colleagues supporting 2 education days in Medicine. Awaiting further interest from other specialities with the intention of supporting 6 from Sept 23-24. • E-job planning - project for implementing e-job planning will go to next workforce systems board. Meeting with ODs and CDs to find a solution regarding final sign off of job plans.	
To recruit great colleagues by building a strong employer brand and implementing effective recruitment practices, making the best use of digital solutions.	• Resourcing and workforce numbers aligned to service needs and financial position. • Reduced reliance on agency/locum and other temporary workforce solutions. • Reduced time to recruit. • Increased number of applicants for all roles.		• Achieve Disability Confident Accreditation Level II • Achieve Rainbow Badge Accreditation • Retain Menopause Accreditation • Publicise diversity of workforce on Intranet Careers page and via social media • Review use of social media in recruitment processes to improve reach • Explore opportunities to attract candidates with protected characteristics • Reach out to wider communities e.g., Care Leavers, Project Search • Review job descriptions, person specifications and job adverts to ensure modernized and appropriate	• Working towards level II of Disability Confident Employer scheme – submitting application with evidence end of Feb. Updating policies, additional training developed and signposting materials. • Rainbow Badge Re accreditation submission end of March 23. Additional resources were created, signposting materials and changes to policies to be more inclusive. • Introducing improved access information and guidance for candidates using google translate, contrast colours and video platforms. • Job adverts going out to third sector job boards focusing on disability and LGBT+ • Working with Project Search to provide core skills and work experience for four interns. Increasing numbers to 10 from September.	

To continue with the implementation of e-rostering to ensure that safe staffing levels can be allocated and managed with maximum efficiency.	• Right staff with the right skills in the right place at the right time.		• Embed Healthroster into business as usual • E-rostering for medical staff project established • Develop e-roster KPIs	• Roster review meetings in place to support compliance and KPIs on a monthly basis. 27/10/22 - E-rostering for clinical staff has been rolled out and project is complete. Next step is to embed and ensure good rostering practices are being followed. E-rostering team have ward review meetings on a monthly basis with a number of non-compliant teams to improve performance. Medical e-roster - awaiting procurement to update us on figures in order to update us on business case. Project team currently identifying suppliers to showcase their products.	

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Growing for the future: education, training and career development for everyone

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To develop career pathways and offer development opportunities to enable colleagues to grow their skills and access career progression at teamHDFT.	• Increased staff retention. • Grow our own talent/succession planning.		• Linking with Corporate Nursing/Professional Development - develop career pathways for all professions. • Develop and implement talent management approach. • Training and development opportunities available to support individual growth and progression. • Appraisal discussions held with all colleagues. • Promote Leadership offering - Compassionate and Inclusive Leadership.	• Leadership Pathway for Managers is live – auto enrolment for all new managers since April 2022. • NHS Elect is live and available for colleagues. • Training and Development opportunities added regularly to Learning Lab. • Appraisal updated to values based, training available via Learning Lab.	
To be a collaborative partner to Health Education England and Higher Education Institutions.	• Positive feedback from HEE Provider Self-Assessment. • Positive feedback received from HEIs on student experience. • Positive feedback from undergraduate learners i.e. NETS. • Number of placements increased.		• Live running document HEE Provider Self-Assessment discussed quarterly prior to Q3 submission. • Regular schedule of meetings in place with HEE and HEI's. • Co-Ordinate the annual HEE Senior Leader visit. • Growing for the Future sub-group in place.	• 1st submission of new style self-assessment Dec 2022. Review due 30th Jan 2023 – GFF. • Regular attendance at DEEF, Acute Trust Meeting, Regional MEM meetings etc. • Potential Senior Leader date for 19th October. • Growing for the Future Sub group 2nd meeting Jan 30th.	
To be an excellent place to learn and develop for all colleagues and students from all professions (international and UK based), offering great placements.	• Positive feedback gained from Guardian of Safe Working. • Positive feedback received from medical and non-medical student evaluation of placements - NETS and PARE. • Competent teams with diverse skill mix.		• Target to recruit 31 international nurses • Support Ward Based Tutors to deliver curriculum requirements. • Review internal offering of training to meet organisational need. • Review of Commissioned Training. • Develop Learning Lab to its fullest potential.	• Current exception report escalations and NETS feedback resulted in a triggered visit by HEE. Currently following action plan on SDEC. • Ward-based Tutors continue to evaluate well from UGME. • Learning Lab hosts all Mandatory Training, a robust leadership and wellbeing offering and is continuing to grow.	

People & Culture

Matters of concern and risks to escalate

Industrial Action
- The BMA Junior Doctors ballot closed and we received confirmation that strike action will be taking place for a 72 consecutive hour period from 06.59am on 13 March to 06.59am on 16 March
- The HCSA have also confirmed its doctors in training will be striking for the same period as the BMA Junior Doctors.

Turnover
- Turnover Rate remains high, however has slightly increased from 15.31% to 15.54%

Sickness
- Sickness has seen a decrease from 5.16% in January to 4.98%

Appraisals
- Appraisal Rate has increased from 71.16% in January to 77.04%

MEST Compliance
- Substantive staff – Core compliance 94%, Role specific 85% and overall 89%
- Bank Staff - Core compliance 81%, Role specific 67% and overall 74%
- Local induction checklist compliance is 74%

Major actions commissioned and work underway

Policy Development
- All HR Policies on the intranet have been reviewed. Work is underway to move all policies from intranet to PolicyStat system

Employee Relations Case Management System
- IT and Procurement documentation completed to purchase case management system to manage all employee relations casework. Awaiting confirmation to process implementation.

Industrial action
- The RCN confirmed it will not be taking industrial action on Wednesday 1, Thursday 2 or Friday 3 March 2023 to enter into discussions with the Government in relation to its Nursing pay dispute
- Work is underway to prepare for the BMA Junior Doctors strikes in March.

Just and Learning Culture
- Working groups consisting of Staffside Reps and members of the Operational HR Team are being assembled to work on the 5 key areas of the Just and Learning Culture Project
- A draft “triage” form to be used by managers when considering if an employee should enter a formal disciplinary process has been developed and has been shared with Staffside to consider and help develop it further
- It is also being shared with the BMA Regional Officer and the Chair of the LNC to discuss how this could be used within the Maintaining High Professional Standards Framework.

Pay and Pensions
- The Medical Additional Rates Group are in the process of costing up some potential new rate proposals and rate changes to help understand the financial impact of proposals discussed to date.

Medical E-rostering
- A Business case was presented to BCRG and was pushed back to review the financing with reference to the resourcing – a further update will be given next month.

Annual Workforce Submission
- The Workforce submission is required to be submitted by 20 March 2023. A number of workshops have been set up to ensure the triangulation between activity, finance and workforce is aligned. Final adjustments will be concluded before submission.

People & Culture

Matters of concern and risks to escalate	Major actions commissioned and work underway
	Corporate Induction • An Induction Improvement Action Plan has been developed to phase improvements on induction and reporting. **EDS22** • EDS22 to be completed and submitted on 28 February 2023. The scoring exercise has now taken place. We are on schedule to produce the action plan and publicise the results by end of February 2023. **Staff Support Networks** • 10 May is National Staff Networks day. An event is planned for the room at the back of Herriots, where all networks will be showcasing the work they do, including the new Neurodiversity staff group and quality improvement as they are keen to link in with the networks. **Occupational Health** • NHS Employers have produced –Growing OH & Wellbeing Together – Our Roadmap for the Future, which plan to review to inform the future development of our OH function. **Health & Wellbeing** • National Health & Wellbeing Diagnostic Tool – we are finalising our self-assessment against this tool, and will produce recommendations for further development within our health and wellbeing offer. **Mental Health Champions** • Mental Health Champions – cohort of 12 new Mental Health Champions are being offered face to face training by OH. Training to be completed by end of March 2023. **Menopause** • Menopause friendly policy has been developed and is in the approval process. **Counselling & Psychology provision** • Referral criteria for in-house counselling and psychology service being redefined to better target this resource to colleagues most in need of in-house expertise and/or longer/more complex support than can be provided by Vivup (EAP) **SAS Grade Doctors** • A SAS Development Programme has been commissioned.

People & Culture

Positive news and assurance

Disability Confident Scheme

- We have been awarded Disability Confident Employer level II.

Pensions

- The NHS Pension Scheme consultation closed on 30 January 2023. It set out proposals to amend NHS Pension Scheme regulations, in line with the announcements made in “Our plan for patients”.
- This included proposals to introduce partial retirement flexibilities to the 1995 Section of the scheme, to remove barriers for staff retiring and returning to work and to facilitate partial retirement for those who wish to do so.
- It also proposes a solution to the Consumer Price Index (CPI) disconnect issue, to reduce the risk that some NHS staff, including senior clinicians, could face an annual allowance tax charge as a consequence of the high rate of CPI for September 2022.
- Thirdly, the consultation proposes amendments to NHS Pension Scheme access policy to allow staff working in primary care networks (PCNs) to continue to access the scheme.
- Finally, it proposes amendments to the member contribution structure to ensure general practitioners pay the correct contribution rate over a full scheme year.
- The responses will now be analysed by the Government.

Nursing and Care Support Worker Bank Rates/Pay incentives

- The Pay Incentives Group and NHS Professionals have developed a proposal for consideration by the Operational Management Group to increase the Trust default bank rates for Band 5 Nurses and Band 2 Care Support Workers to improve fill rate and to help with agency staff migration. It also sets out some proposals for consideration with regards to current and future pay incentives for existing staff groups which are due to cease at the end of March..

Medical Workforce

- CEA 22/23 was concluded this month with all eligible consultants receiving an equal proportion of the allocated funding in their February pay.

Making a difference award

- Our international recruitment project manager, Emily Reid, received a ‘Making a Difference Award’, She was nominated by a few of the international nurses themselves who couldn’t thank her enough for all the support and guidance in their journey into the country.

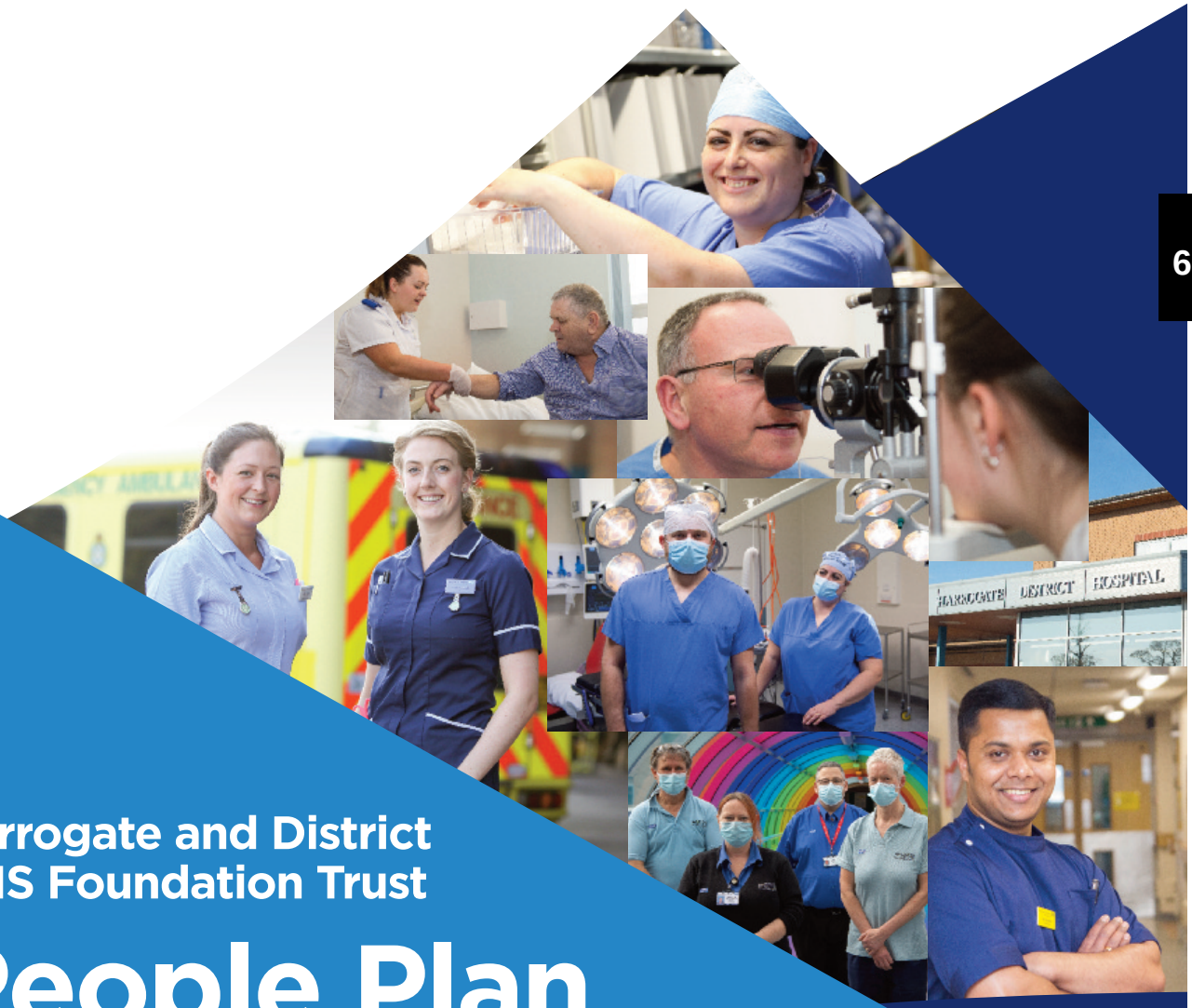
Decisions made and decisions required of Board

People Plan

- Our new People Plan, aligned to the HDFT Trust Strategy, is attached for approval by the Board (Appendix 1).

NHS
Harrogate and District
NHS Foundation Trust

6.5



Harrogate and District NHS Foundation Trust

People Plan

teamHDFT
At our best

WELCOME TO OUR

People Plan for 2023 and Beyond

A welcome from our Director of People & Culture – Angela Wilkinson

Welcome to our People Plan

At HDFT we put patients and children first as our purpose is to improve the health and wellbeing of our patients, children and communities.

To do this, our ambition is to make HDFT the best place to work. We know that if colleagues come to work and are physically and mentally well, fulfilled and connected to their work; patient safety improves and quality of care improves.

Our People Plan sets out our areas of priority and focus to strive towards this ambition...informed by colleague feedback and underpinned by what we value... Kindness, Integrity, Teamwork and Equality. These together with the behaviours we expect that demonstrate these values are what is important to us at HDFT and how we deliver our care.

A C Wilkinson

Angela Wilkinson
Director of People & Culture

OUR PURPOSE, AMBITIONS & ENABLING AMBITIONS

Trust Strategy

Purpose

THE PATIENT AND CHILD FIRST
Improving the health and wellbeing of our patients, children and communities

Ambitions

- BEST QUALITY, SAFEST CARE
- PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS
- GREAT START IN LIFE

AT OUR BEST: MAKING HDFT THE BEST PLACE TO WORK
Our KITE Behaviours

KINDNESS | INTEGRITY | TEAMWORK | EQUALITY

Enabling Ambitions

- AN ENVIRONMENT THAT PROMOTES WELLBEING
- DIGITAL TRANSFORMATION to integrate care and improve patient, child and staff experience
- HEALTHCARE INNOVATION TO IMPROVE QUALITY

Ambition

At Our 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.

As reflected in our Trust Strategy, 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.

LOOKING AFTER OUR PEOPLE:
physical and emotional support to be 'At Our Best'

BELONGING:
teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

NEW WAYS OF WORKING:
the right people with the right skills in the right roles

GROWING FOR THE FUTURE:
education, training and career development for everyone

NHS People Promise

The NHS is an extraordinary, world-class service. Together we have achieved, and continue to achieve, the extraordinary. We should all feel proud of this.

We want our culture to be positive, compassionate, and inclusive – and we all have our part to play.

We are compassionate and inclusive
We do not tolerate any form of discrimination, bullying or violence.
We are open and inclusive.
We make the NHS a place where we all feel we belong.

We are recognised and rewarded
A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution.

We each have a voice that counts
We all feel safe and confident to speak up. And we take the time to really listen – to understand the hopes and fears that lie behind the words.

We are safe and healthy
We look after ourselves and each other.
Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need.
We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology.

We are always learning
Opportunities to learn and develop are plentiful, and we are all supported to reach our potential.
We have equal access to opportunities.
We attract, develop and retain talented people from all backgrounds.

We work flexibly
We do not have to sacrifice our family, our friends or our interests for work.
We have predictable and flexible working patterns – and, if we do need to take time off, we are supported to do so.

We are a team
First and foremost, we are one huge, diverse and growing team, united by a desire to provide the very best care.
We learn from each other, support each other and take time to celebrate successes.

We are more than 1.3 million strong.
We are all walks of life, all kinds of experiences.
We are the NHS.

HDFT KITE Behaviours

We Value

We value kindness, integrity, teamwork and equality. We demonstrate this through our everyday behaviours with colleagues, patients and families.

	I will…	I won't…
KINDNESS		
Compassion	treat people as valued individuals, protect their dignity and privacy with compassion	belittle or dismiss others, be rude, uncivil, or use an abrupt tone of voice, undermine or bully others
Understanding	take the time to understand others' concerns, with empathy, putting myself in their shoes	fail to consider other people's perspectives, be dismissive of others' feelings, stories or journeys
Appreciative	notice what others do to make a difference and say 'thanks' so they feel valued	ignore it when people do great things or 'take the credit' for other people's achievements
INTEGRITY		
Professional	display personal and professional integrity, set and deliver high standards, be responsible for my attitude: calm, patient, reassuring	accept low standards, 'walk past' issues when I see them, come across as 'too busy' or often be late
Honest	be open and honest when communicating with others, build trusting relationships	make no effort to share information, withhold information others need, or leave them 'in the dark'
Positive	welcome change, bring an optimistic, 'can do' attitude, and smile rather than not	focus on the problem rather than the solution, moan, be negative or complain without acting
TEAMWORK		
Helpful	be attentive to other people's needs and feelings, willing to offer help, do what I say I will	not help when I see someone in need, make people feel 'a burden', have a 'not my patient / job' attitude
Listen	listen with curiosity, involve and consult other people and help others to take responsibility	dismiss others' views or ideas without giving them a chance to explain, talk over people as if they aren't there, ignore valid concerns, dictate, interrupt, lecture people or argue rather than discuss
Communicate	communicate clearly and regularly, adjusting communication so others can understand	use language or jargon people don't understand, make no effort to communicate or give mixed messages
EQUALITY		
Respect	treat people equally, embrace diversity and difference, be impartial and open-minded	belittle or dismiss others, be rude, uncivil, or use an abrupt tone of voice, undermine or bully others
Inclusive	be approachable and welcoming, involve people and adjust to different people's needs	fail to consider other people's perspectives, be dismissive of others' feelings, stories or journeys
Fair	act fairly towards everyone, and make it safe and easy for people to speak up, as well as being open to giving and receiving feedback myself as a chance to learn	criticise people for mistakes, stay silent when needing to speak up, be closed to feedback about myself

NHS People Promise

Looking after our people:

Physical and emotional support to be 'At Our Best'

Looking after our people | Belonging in the NHS | Growing for the future | New ways of working and delivering care

We will have **strong focus on all aspects of health and wellbeing** to retain colleagues.

We will continue to **develop employment practices and policies,** which support colleague work life balance.

We will develop our leaders to ensure a **compassionate and inclusive leadership** is the accepted and expected leadership culture, in line with our KITE behaviours.

NHS People Promise

Belonging:

Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

Looking after our people | Belonging in the NHS | Growing for the future | New ways of working and delivering care

We will be an organisation
where everyone demonstrates
our KITE behaviours
(Kindness, Integrity, Teamwork and Equality),
to care for our patients, children and communities
who are the focus of everything we do.

We will **build strong teams who support each other,**
work collaboratively and with collective goal of delivering excellent care to our patients.

We will promote
equality and **diversity**
so everyone is valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support networks, leadership development and training of all colleagues.

We will seek to
increase diversity
across our decision making forums.

NHS People Promise

Growing for the future:

Education, training and career development for everyone

Looking after our people | Belonging in the NHS | Growing for the future | New ways of working and delivering care

We will
develop career pathways
and offer development opportunities
to enable colleagues to grow their skills and access career progression at teamHDFT.

We will be a
collaborative partner
to Health Education England and Higher Education Institutions.

We will be an
excellent place to learn and develop
for all colleagues and students from all professions
(international and UK based), offering great placements.

NHS People Promise

New ways of working:

The right people with the right skills in the right roles

Looking after our people | Belonging in the NHS | Growing for the future | New ways of working and delivering care

We will
plan and design our workforce
as creatively as possible
to have the right number of skilled colleagues in the right roles.

We will
recruit great colleagues
by building a strong employer brand
and implementing effective recruitment practices,
making the best use of digital solutions.

We will continue with the
implementation of e-rostering
and the safe care staffing tool,
to ensure that safe staffing levels can be allocated
and managed with maximum efficiency.

This is how we listen...

We each have a voice that counts...

There are many ways in which colleague voices can be heard. These include staff support networks, HDFT colleague app, employee surveys and everyday conversations.

Carried out every year to improve staff experiences across the NHS

The survey is aligned to the NHS People Promise

Your Voice Colleague Forum

Community of colleagues who are empowered to oversee, support and challenge

not just our "At Our Best" work, but also the wider day-to-day issues that impact HDFT

INPULSE

Surveys carried out on a quarterly basis

to improve culture, engagement and performance within HDFT

STAFF SUPPORT NETWORKS

BAME and Allys Network
LGBT+ Staff Network
Menopause Staff Network
Men's Health Network
Disability and Long-term Conditions Staff Network
Neuro-diversity Staff Network

We have a number of staff support network groups

which give our staff the chance to come together and discuss issues and share experiences, allowing their voice to be heard and to shape our organisation and improve equal opportunities.

Conversations with colleagues...

To understand your development, health and wellbeing needs

Your THRIVE Discussion

We want everybody here to THRIVE at work. And when you thrive - the people we care for THRIVE too.

Evidence shows when healthcare staff are physically well, mentally healthy and feel connected to their work patient safety improves, quality of care improves, outcomes improve.

And that's not all. With better wellbeing of course people take less sickness absence, there's lower staff turnover, people are more engaged.

But the opposite is true too. When people are struggling with their wellbeing at work, quality suffers, productivity suffers, teamwork suffers. And their wellbeing at home suffers too.

Our ambition at HDFT is for everyone in HDFT to have regular wellbeing conversations with their manager. To develop a personalised plan to optimise their wellbeing.

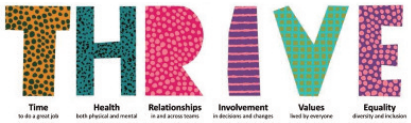
Our response is THRIVE wellbeing conversations.

Your wellbeing conversation

1. How are you?
2. How is your wellbeing?

In our organisation want everybody's wellbeing to

3. How can we help you to thrive?



The Four S's of Appraisal

Great appraisals have so many benefits. As employees they help us understand ourselves better. Our contribution. Our strengths. And where we can develop to achieve more.

You will have an Appraisal discussion with your manager at least annually.

For managers they help you to get to know your people better, to align performance to team goals, and to stay consistent so you give everyone a fair opportunity to develop.

They help create a happier, more engaged team, in an organisation that's achieving its goals.

We will be a Great Partner

We are accessible to, and are here to support, every colleague to be successful in their role.

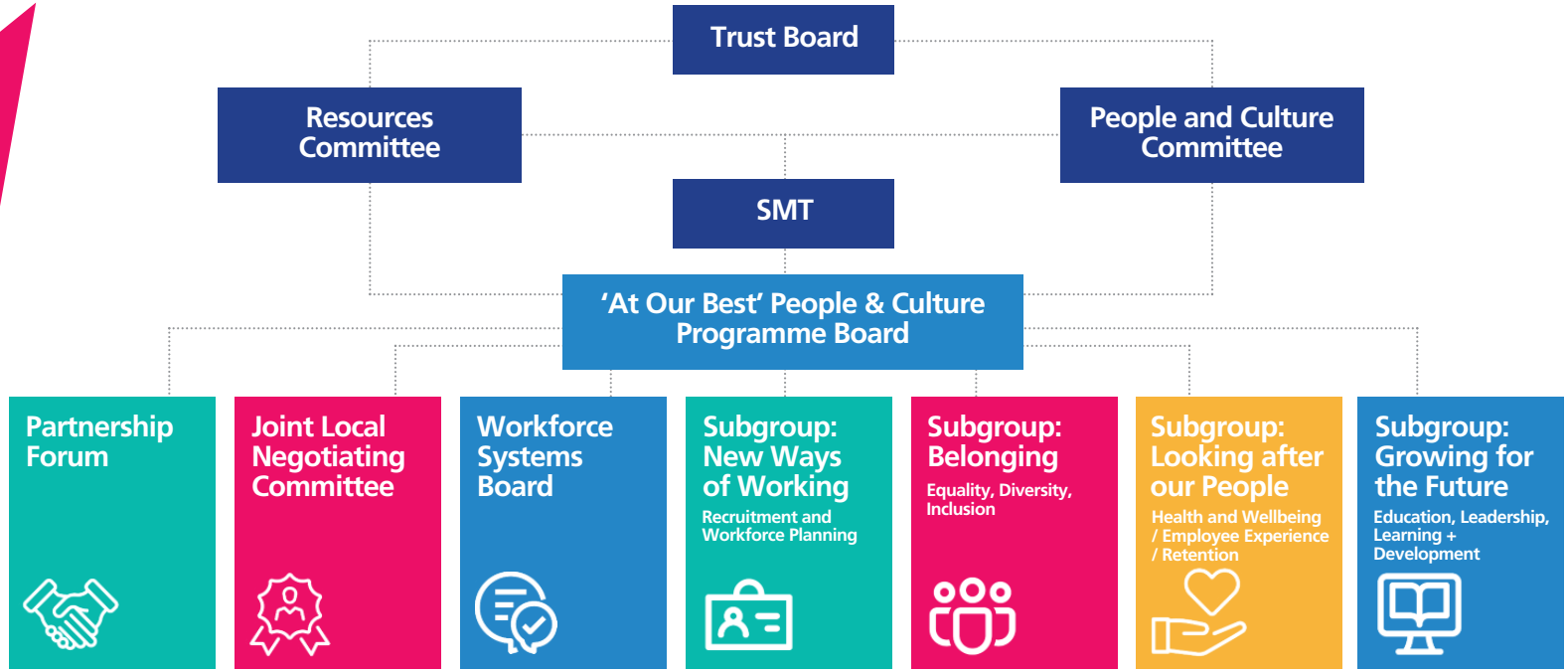
At HDFT we work closely across a range of partners to ensure that our work is well connected, collaborative and is aligned to support the delivery of high quality, safe and patient centred care:

- Clinical and Corporate Directorate Leadership Teams
- Staff Governors
- Trade Union Colleagues
- Freedom to Speak Up Guardian
- Health Education England
- Higher Educational Institutions
- Integrated Care System
- NHS England/ Improvement
- Local Authority
- Public Health

teamHDFT At our best | HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services | NHS Harrogate and District NHS Foundation Trust

People & Culture Governance Structure

This is how we manage our progress against this plan…



www.hdft.nhs.uk

Published February 2023

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

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 – Feb 23	• 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 • Complete	
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 – May 23 • Project complete – Aug 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
Adoption of LTHT Data Platform	To improve decision making by providing more accurate, timely information to clinicians and managers. Reduce cost of delivery by sharing and reusing development assets with LTHT		• Discovery – Feb 23 • HDFT to agree Agilisys proposal - Feb 23 • HDFT and LTHT to agree above proposal – March 23	• On Track • On Track • On Track	
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	• Cancelled • On Hold pending outcome of LTHT discussions • On Hold pending outcome of LTHT discussions	

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 services		• Strategic Outline Case – Aug 22 • Outline Business Case (Internal Approval) – Jun 23 • Outline Business Case (National Approval) – Aug 23 • Full Business Case (National Approval) – May 24 • Contract signed – May 24 • EPR delivery project starts – Jun/Jul 24 • Initial Go Live – TBC, likely Q3/4 25/26	• Complete • On Track • On Track • On Track • On Track • TBC • 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 – Feb 23 • 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	Amber	• Harrogate Innovation Hub Launch event – Oct 23 • Identify Innovation Hub location – Oct 22 • Recruit Innovation Manager – Jan 23 • Appoint Clinical Lead for Innovation – Jan 23 • Further actions to be developed	• On track • Delays due to lease issues due May 2023 • Complete starts 20th Feb 23 • Delays with HR due March 23 • On track	Amber
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 • 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 • TBC • 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 – 1 study open 2 opening by March 23	

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	Amber	• Identify dedicated clinic space within HDH for research clinics – Sep 22	• Ongoing	Amber
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	Amber	• 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 but requires further data so now due end March 2023 • Complete	Amber

Harrogate and District NHS Foundation Trust

Board of Directors, Wednesday 29th March 2023

Review of Continuous Improvement Business Case

Title:	**Review of Continuous Improvement Business Case**
Responsible Director:	Matt Graham, Director of Strategy
Author:	David Plews, Deputy Director of Improvement and Transformation

7.4

Purpose of the report and summary of key issues:	The purpose of this report is to: - approve the Business Case for Continuous Improvement. - approve the appointment of Catalysis (in partnership with KPMG) as a provider of management consultancy services to broaden and deepen a Continuous Improvement Operating Model and philosophy. This paper has been previously reviewed (by Innovation Committee) and its recommendations approved by Resources Committee (13th March, 2023).	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	X
	Healthcare innovation to improve quality	X
Corporate Risks	None	
Report History:	Resources Committee, 13th March 2023 Innovation Committee, 29th March 2023	
Recommendations:	It is recommended that the Board of Directors: 1. Approve the use of EPR capital funding (2022/2023) to the value of £999,093 (plus VAT) to deliver the business case to broaden and deepen a philosophy and operating model for continuous improvement. 2. Approve entering into a contract to provide consultancy support to broaden and deepen a philosophy and operating model for continuous	

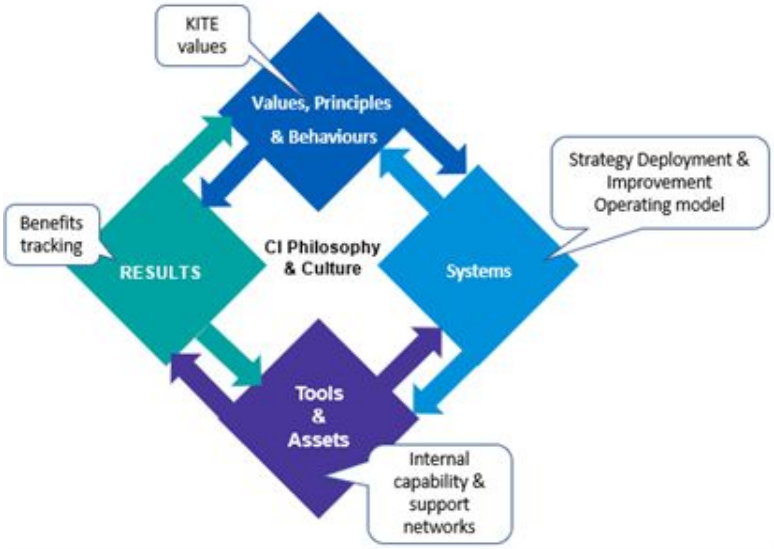
	improvement throughout HDFT with Catalysis (in partnership with KPMG). 3. Note the alignment of this business case to the Trust's wider programme of work in relation to the Electronic Patient Record. 4. Note that the contract will provide consultancy support to HDFT over an 18-month period from 1st April 2023 to 30th September 2024.

Board 29th March 2023

Continuous Improvement Business Case

1. Summary Recommendation

The Board of Directors is asked to approve the awarding of a contract to provide consultancy support to broaden and deepen a philosophy and operating model for continuous improvement throughout the trust to Catalysis (in association with KPMG). This work is part of the wider work on implementing the Electronic Patient Record at HDFT, and the resource to implement this was approved by Board previously. The contract will support the model below by providing support to HDFT over an 18-month period from 1st April 2023 to 30th September 2024. A summary of the model is given here:



The cost of the contract will be £999,093 (excluding VAT).

In outline, the benefits are:

a) timely completion of a thoroughly tested readiness assessment, which will then be used as the basis for further work, including the setting of SMART objectives for the rest of the programme.

b) delivery of a programme of senior leader development to change the way that the organisation is managed.

c) further improvements to strategy deployment and alignment of continuous improvement work.

d) embedding a lean-based improvement operating model.

e) a focus on knowledge transfer and sustainability, including improving capability with more patient-facing colleagues and those in middle management roles. Capacity and capability within HDFT will be built so that the Trust is not reliant on the provider's knowledge or resources to sustain the continuous improvement philosophy and approach beyond the contract term.

f) the facilitation of learning networks.

g) the identification, scoping and delivery of a trust-wide programme of EPR benefits, including the research, training and team coaching necessary to realise these benefits.

The funding of this work has already been agreed as part of the EPR programme but requires a Board decision due to the value of the contract.

This paper presents a summary business case that explains the work needed, provides assurance about the other options that have been considered to deliver this work and sets out a recommendation.

Please note that the procurement outcomes report is “commercial, in confidence” but is available for Board members to view on request.

2. Strategic Case

2.1 What is a Continuous Improvement (CI) Operating Model?

A CI Operating Model provides focus, direction, alignment with strategy and a method of management for daily work. There are a variety of CI Operating Models to choose from. They range from ISO9001, which has been used globally over several decades to newer web-based CIO systems like Qualio and Compliance Quest. There is a whole subset of lean operating models, from which it makes most sense for us to select because there is already some awareness, knowledge and use of the Virginia Mason Production System, the lean-based approach that we use currently.

Prof. Beverly Alimo-Metcalfe’s internationally recognised research[1] into CI operating models/ management systems demonstrates that, in terms of likelihood to achieve success, there is little to choose between the various models. But what is important is to choose an overall approach and stick with it over the longer-term, rather than shifting between models every few years.

A strong lean-based CI operating model contains a number of mutually reinforcing features that are critical for success:

First, a **lean-based philosophy** which puts patients and a respect for people first. This philosophy should be foundational to the trust’s decision-making, collaborations and operational management. It frames “improving quality” as a continuous journey to which it is everyone’s job to contribute.

Second, is an embedded approach to **strategy development, deployment and review**. This is about identifying strategic priorities and cascading them through the organisation.

There should be a **schedule of CI programmes/projects**, and a roster of teams that are working to increase their CI capability.

Fourth, a suitably-resourced **expert CI team** should be in place to support the whole organisation. They should lead on CI training, coaching, facilitation and advice.

The last element is a **management system**, which embeds throughout the organisation a common set of management tools, based on QI methodology. This brings the rigour of scientific method to everyday management challenges. This is the “missing piece” for HDFT.

[1] More information here: Speaker Beverly Alimo-Metcalfe | Leadership Expert | A-Speakers

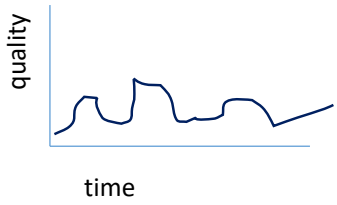
2.2 Aims

HDFT is seeking to broaden and deepen a philosophy and operating model for continuous improvement across the trust. We want to use a continuous improvement philosophy and operating model which is based on lean thinking, has been developed and proven in a healthcare environment and has been co-designed and refined by us to align with the trust's environment, strategy, services and culture.

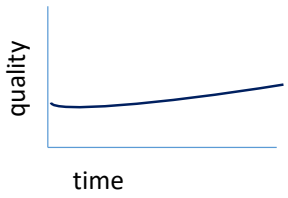
2.3 Options appraisal

There are a number of ways in which this aim could be met:

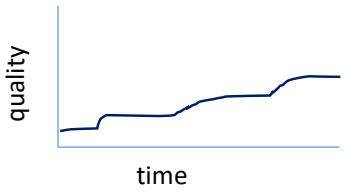
a) **Continue as we are**
QI is used as a set of tools we use to solve problems, but not our "operating model". This leads to an episodic journey where it is difficult to sustain improvement gains into the long-term.



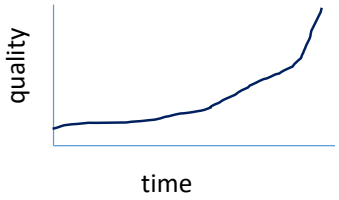
b) **Enhance QI approach independently**
Gradually adopt simple tools and routines (e.g. improvement huddles). The lack of extra resources would necessitate a "slow burn" approach. It would take a long time before sustained improvements were noticed to the current state.



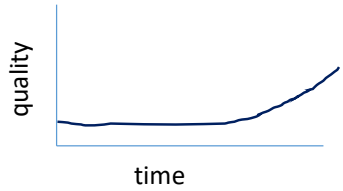
c) **Phased approach with external support**
Commit to a phase at a time, review ongoing. Given low likelihood of funding availability in future financial years, there would be a high risk of taking many years to achieve sustainable improvement gains.



d) **Full implementation with an external partner**
Commit to long-term (1.5-5 years external support, 5+ years full implementation). This approach secures the fastest growing sustainable improvements and can be funded from EPR resources available in the 2022/2023 financial year.



e) **System partnership** (with external support)
ICS agrees a common improvement approach and external support is provider at ICS level to be deployed into providers. There would be initial delay to agree a system approach and then a strong risk that HDFT would not be viewed at system-level as the trust most in need of this support.



2.4 Option taken and next steps

Options a, b, c and e do not deliver sustained and significant quality gains across the organisation quickly enough. *Option d, full implementation with an external partner, is the preferred option because it leads to the largest quality gains in the shortest time.* The timing of delivering this option now brings with it the added benefit of being able to use the delivery of the sustainable benefits of an electronic patient record (EPR) as a transformation programme testbed for the operating model. Linking the operating model to EPR benefits realisation in this way gives leaders a shared initial focus for their improvement work and sends a clear message that senior leaders are committed to hardwiring the operating model into the way that we deliver change.

3. Economic Case

The work needed comprises three related and mutually supportive elements, a readiness assessment; introducing and embedding a continuous improvement operating model; and thirdly, using a continuous improvement operating model to identify and realise a programme of benefits arising from the introduction of an EPR.

3.1 Readiness assessment

It is good practice at this stage is to undertake an objective and external readiness assessment of the trust's current operating model and approach to continuous improvement. This assessment will include elements of self-assessment and triangulate this against other data to bring additional insight to help tailor the subsequent stages of the work. The readiness assessment will cover:

a) the alignment of the philosophy of continuous improvement to the trust's values and behaviours. These values and behaviours are appropriate for the facilitation of any lean-based operating model and it is not recommended that they should be under review as part of this assessment.

b) the alignment of leadership behaviours at Board/Leadership Team, middle management (directorate and clinical group) and frontline leaders to a philosophy of continuous improvement.
c) how the trust Strategy (and supporting strategies where relevant) is deployed through all levels of the organisation so that directorate, team and individual goals form a "golden thread" that links back to the trust's strategy and purpose.

d) the approach to complex, large-scale change projects (e.g. EPR).

e) how operational management processes support strategy delivery and a philosophy of continuous improvement.

f) how support services (including HR, Finance, Quality and Corporate Governance, IT and Information, Strategy and Planning) processes support strategy delivery and a philosophy of continuous improvement.

g) the use of continuous improvement approaches in daily work at all levels and in both clinical and support services across our full geography.

h) the capability and capacity of the existing corporate quality improvement team, other colleagues responsible for delivering improvement/change/transformation (e.g. programme and project managers, digital delivery, quality team, directorate project and improvement leads etc.) and our network of Quality Improvement Champions.

The findings of this readiness assessment will inform the scale and pace of support needed to complete two subsequent phases of work: the introduction and embedding of a continuous improvement philosophy and operating model, and the identification and realisation of a programme of benefits arising from the introduction of an EPR.

3.2 Introducing and embedding a Continuous Improvement Operating Model

Research, including "go and see" visits to a number of trusts already operating a continuous improvement operating model, suggests that facilitation of this will require work and support in five areas:

a) **Senior leader development.** Support to Board, Leadership Team and Senior Management Team to develop and role model a leadership approach and behaviours which promote a philosophy of continuous improvement throughout the trust.

b) **Strategy deployment.** Building on existing strategy and planning processes, support to develop and embed an interactive process to develop, refine, agree and cascade strategic objectives from trust level to frontline teams and individuals, creating the "golden thread" from "board to ward".

c) **Improvement Operating Model.** Support to develop and embed a lean-based Improvement Operating Model, which enables middle and frontline leaders, in both clinical and support services, to empower their teams to take ownership of issues and seek continuous improvement as part of their daily work. The model will support the maintenance of strong corporate and quality governance.

d) **Knowledge transfer and sustainability.** The provider of the support described above will build capacity and capability within the trust so that the trust is not reliant on the provider's knowledge or resources to sustain the continuous improvement philosophy and approach beyond the contract term.

e) **Learning networks.** On completion of the introduction of a continuous improvement operating model, our trust will be provided with ongoing access to international and NHS learning networks of organisations and individuals on similar improvement journeys to enable our leaders and colleagues, to continue and sustain our improvement journey.

3.3 Using a Continuous Improvement Operating Model to identify and realise a programme of benefits arising from the introduction of an EPR

HDFT has been awarded Frontline Digitisation funding to procure and implement a new EPR. The trust recognises that this is not an information technology project, but rather a clinical and business improvement and transformation project, enabled by IT. The benefits of the EPR will be seen in the extent to which it delivers benefit to patients, service users and families - and HDFT colleagues - through improvements in performance, quality and efficiency of the services we provide.

To introduce and embed our continuous improvement operating model, it is important that benefits realisation for the EPR is achieved in line with our philosophy and approach to continuous improvement, and that it demonstrates the value of this philosophy and approach. Therefore, to maximise the impact and value for money of our work on EPR benefits realisation, HDFT will wrap into the external support we will commission to broaden and deepen a philosophy and operating model for continuous improvement, support to:

a) identify and map EPR benefits across all major values streams, including clinical pathways and support services, in both acute and community care service across our geography.

b) develop a strategy to support the realisation of these benefits (including who benefits, who owns each benefit, the type of benefit, and how each benefit will be measured).

c) align the approach to identifying and realising the benefits to the philosophy and approach to continuous improvement.

And lastly, to ensure these two strands of work are mutually reinforcing by:

d) using the readiness assessment and strategy for EPR benefits realisation together to shape and prioritise the approach HDFT will take to broaden and deepen a philosophy and operating model for continuous improvement across the trust.

Wrapping these aspects of the work together into a single contract in this innovative way levers economies of scale, and widens the number of potential providers from a domestic to an international market.

4. Commercial Case

A number of options were considered in deciding how best to purchase the external support needed to achieve full implementation of a Continuous Improvement Operating Model, including a readiness assessment and the identification and realisation of a programme of EPR benefits. These comprise:

a) **Three-stage process: divide the work into three separate tenders, procuring three services separately**. Start with the procurement of a readiness assessment before using the findings of this assessment to specify the detail and procure the support needed to broaden and deepen a philosophy and operating model for continuous improvement across the trust. This would then be followed by the procurement of support to use a Continuous Improvement Operating Model to identify and realise a programme of benefits arising from the introduction of an EPR.

Advantages	Disadvantages
+ Work is delivered in a logical order from those providers best positioned to provide each of the different types of support needed.	- A slower pace of delivery is inevitable. This would be caused by running three separate procurement processes consecutively.
	- There is not enough time to complete all three procurements in the current financial year, meaning funding would only be definitely available for the first of three. This puts the two subsequent pieces of work at high risk of not being affordable and therefore not deliverable.
	- With support potentially being provided by three different organisations there is a high risk that each provider may not trust the other's previous work. Soft market testing has indicated that most reputable companies in the market to provide services to broaden and deepen a philosophy and operating model for continuous improvement would also wish to carry out their own readiness assessment, regardless of whether another company had already provided one.
	- A trusting relationship with one preferred supplier cannot be developed from the outset.

b) **Two-stage process: procure a readiness assessment from a single provider, then use the findings of the assessment to procure the subsequent two stages of work from a single provider** (which may or may not be the same provider from whom HDFT procured the readiness assessment).

Advantages	Disadvantages
+ Work is delivered in a logical order and at a faster pace than in option (a) above.	- With support potentially being provided by two different organisations there is a high risk that the provider of the subsequent stages of the work may not trust the other provider's previous work. Soft market testing has indicated that most reputable companies in the market to provide services to broaden and deepen a philosophy and operating model for continuous improvement would also wish to carry out their own readiness assessment, regardless of whether another company had already provided one.
	- A trusting relationship with one preferred supplier cannot be developed from the outset.

c) Single process: procure a readiness assessment from a single provider through an existing framework agreement. The *same provider* uses the findings of this assessment to deliver the subsequent two stages of work.

Advantages	Disadvantages
+ The fastest pace of work can be obtained.	- "One bite of the cherry", without the ability to mix and match the strengths of different providers.
+ Likelihood of securing maximum value for money through the economies of scale arising from bundling the work into one contract.	
+ Companies with international/global reputations are likely to be interested in this scale of contract.	
+ A trusting relationship with one provider can be built from the outset to help tailor and maximise the impact of the work.	

The slower pace of delivery and risk of duplication in options (a) and (b) and the chance to maximise the quality and impact of the work with option (c) meant option (c) was the preferred one.

A number of key principles for the implementation of option (c) were identified.

4.1 Key principles

These key principles are as follows:

- The philosophy and operating model for continuous improvement must be clearly delivered under the banner of our existing trust Strategy and KITE (Kindness, Integrity, Teamwork, Equality) values and behaviours.

- The name and branding of the model should be aligned to the trust's Strategy and KITE values and behaviours.

- It is essential that the specific philosophy and operating model used at HDFT is co-designed with the trust (its leaders and colleagues at all levels, in all services and roles) so that it aligns with our environment, strategy, culture and services - including acute, community and public health services, across our full geography.

- The delivery approach must build capacity and capability within HDFT so that we are not reliant on an external provider's knowledge or resources to sustain the continuous improvement philosophy and approach beyond the contract term.

- This is the continuation of a long-term improvement journey. To build momentum quickly, we anticipate that the provider will provide more intense support (both capability and capacity) in the first 12 months of the contract, then reduce over the latter six months as the trust's own capacity and capability increases.

- While there will be some elements of this support which can be delivered virtually, at its heart this programme will support the trust's leaders and teams to deliver improvement as part of their daily work. Therefore, the support from the provider must also be provided alongside our colleagues in their place of work and be applied to real-life situations and challenges in their daily work. Previous experience tells us that the majority of the engagement time will be needed working alongside our clinical, operational and support service teams at their place of work.

- HDFT will retain the intellectual property specific to the philosophy and operating model for continuous improvement that is developed for it through this programme of work.

- The relevant regional and sub-regional contexts for this work are relevant to consider. In particular, the Humber and North Yorkshire Integrated Care Partnership and some other trusts in Humber, Coast and Vale and the West Yorkshire Association of Acute Trusts are also considering their approaches to continuous improvement and may wish to extend the support procured for HDFT through a subsequent or related procurement process.

4.2 Procurement process

Taking into account learning from NHS trusts elsewhere who have carried out similar work (through both single and two-stage processes) and following the appropriate procurement advice, a tender for the work was published through an existing procurement framework.

Last week, these submissions were evaluated against the following criteria:

- Service delivery (20%)
- Quality (20%)
- Experience (30%)
- Social Value (10%)

- Price (20% - including a pass/fail element where the bid price must be equal to or less than the specified affordability limit of £1,000,000 [excluding VAT]).

For further information and detailed analysis, see Appendix 2: Procurement Outcomes Report .

5. Financial Case

The affordability of this work has been previously agreed as part of the Frontline Digitisation funding envelope. The funding for this work was included within the wider Electronic Patient Record business case.

The value for money of the recommended provider's bid was tested through the evaluation of their submission. The detailed programme of work follows on from the recommendations of the readiness assessment.

No contingent liabilities are expected as a result of implementing this contract. Any recommendations for business changes, investments or disinvestments would be considered through discussion as part of our usual governance arrangements.

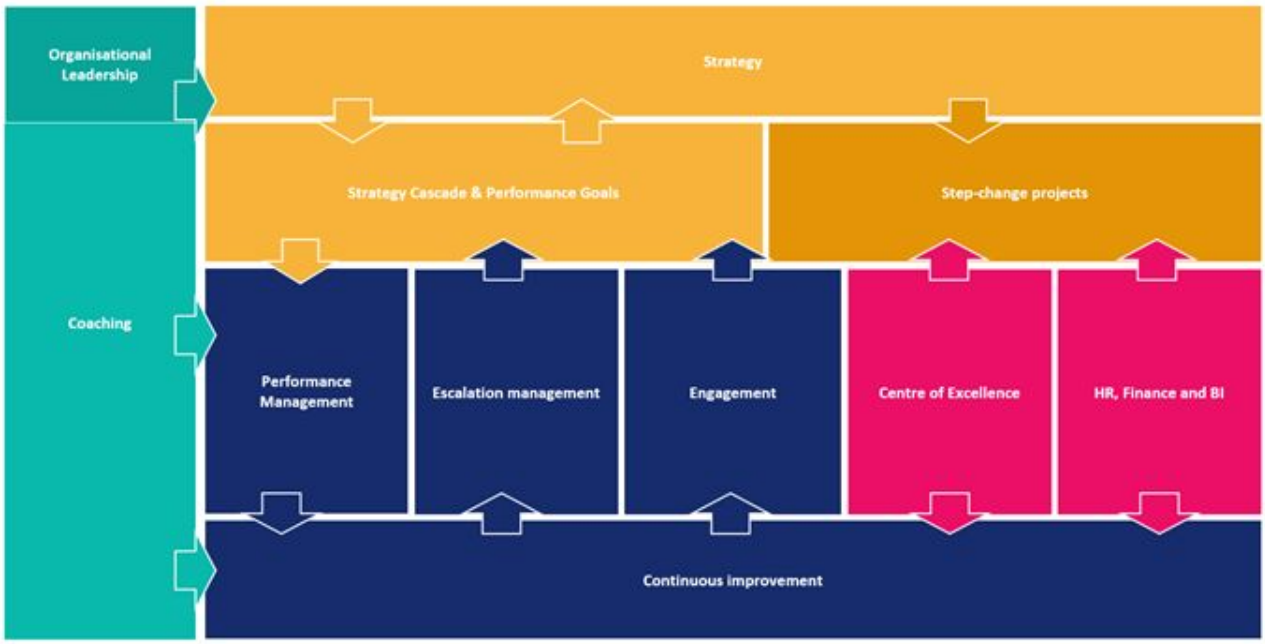
6. Management Case

6.1 What will be delivered and how?

Summary information below explains how the three elements of the contract will be delivered.

6.2 Readiness assessment

The assessment will use this framework:

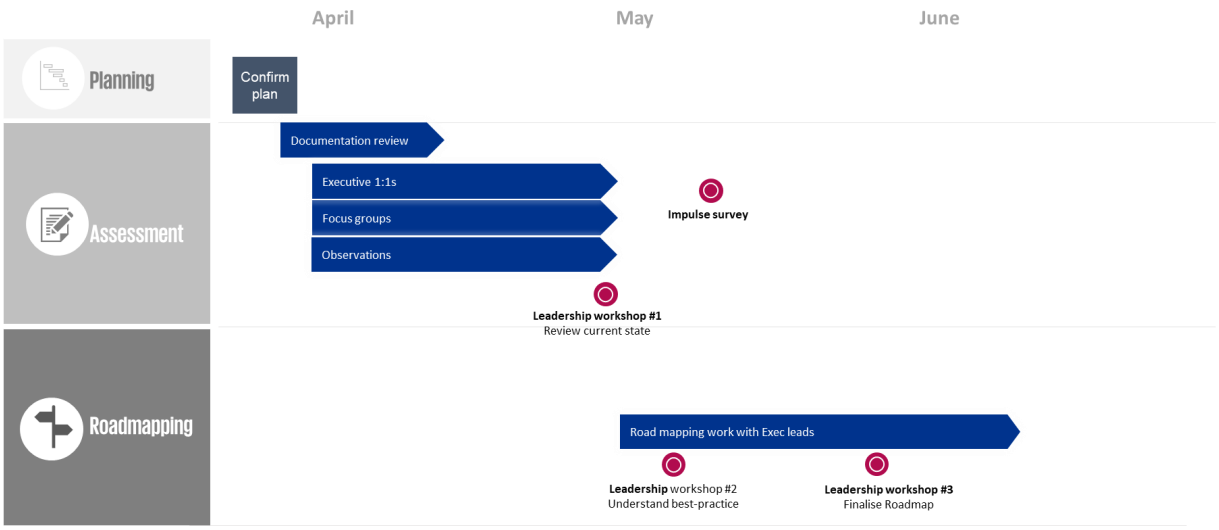


It will include these aspects:

Document review:	1:1 interviews:
• Strategy documents (clinical/people/digital) • Transformation plans • Performance review documents • Induction, talent and succession planning • Staff, Impulse, Patient and FFT surveys • QI team structure • Well led	• Exec, CD, CDIO, and Chair • NED committee chairs • Directorate leads • David Plews • Sam Brown and Rachel McDonald
Direct observations:	**Focus groups:**

• Monthly:
  ○ SMT
  ○ Directorate Review
  ○ QG group
  ○ Board
• Innovation Committee
• Programme Boards
• Directorate Boards
	• Consultants and Junior Doctors forum
	• Frontline medical staff
	• Porters, facilities, etc.
	• Corporate Team
	• Innovation/Improvement teams
	• Ward managers forum
	• Your Voice forum

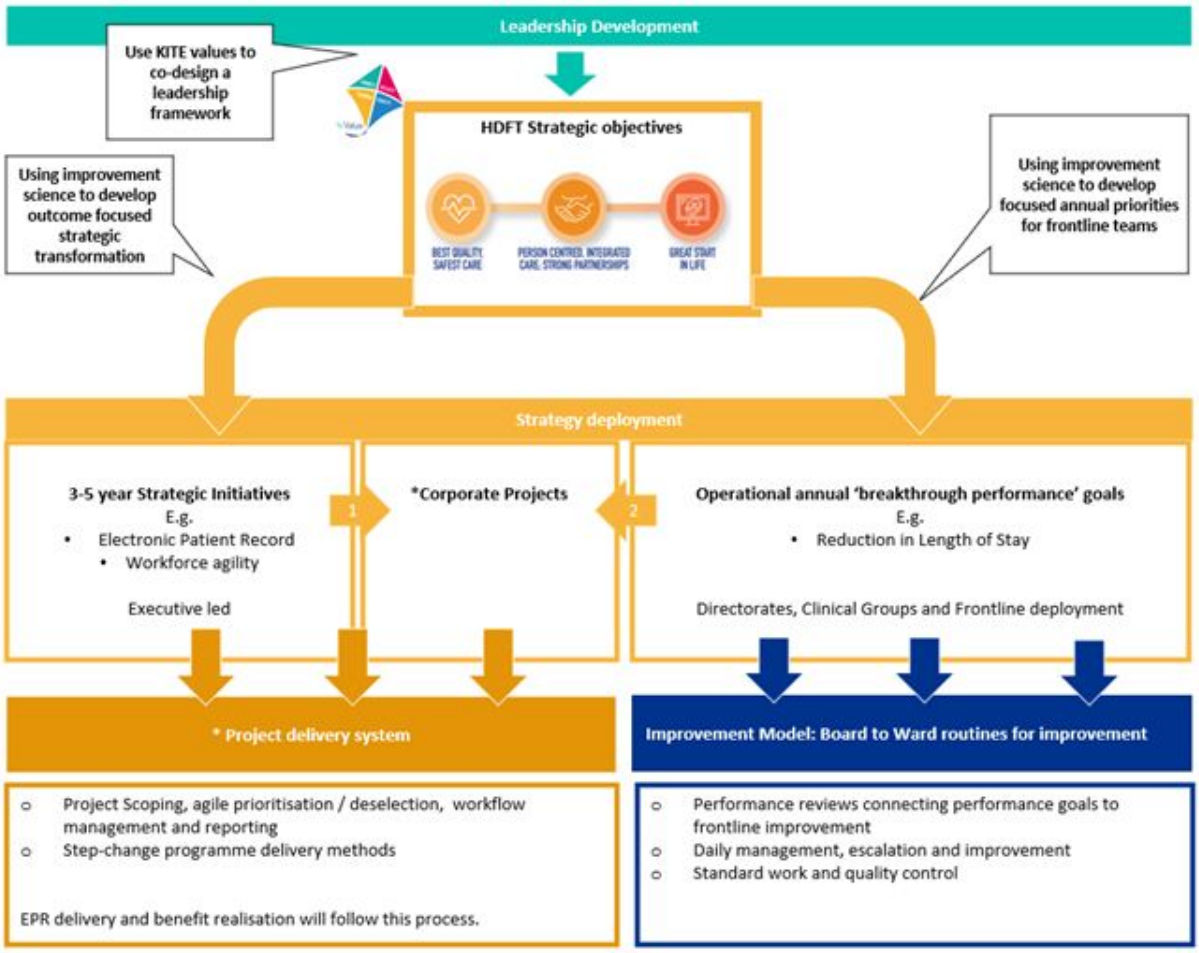
The assessment will run to this timetable:



6.3 Continuous Improvement philosophy and approach

The approach summarised in the diagram below will be based on the Shingo model of change (a lean approach). Outputs from the readiness assessment will be used for Catalysis to co-design with HDFT our

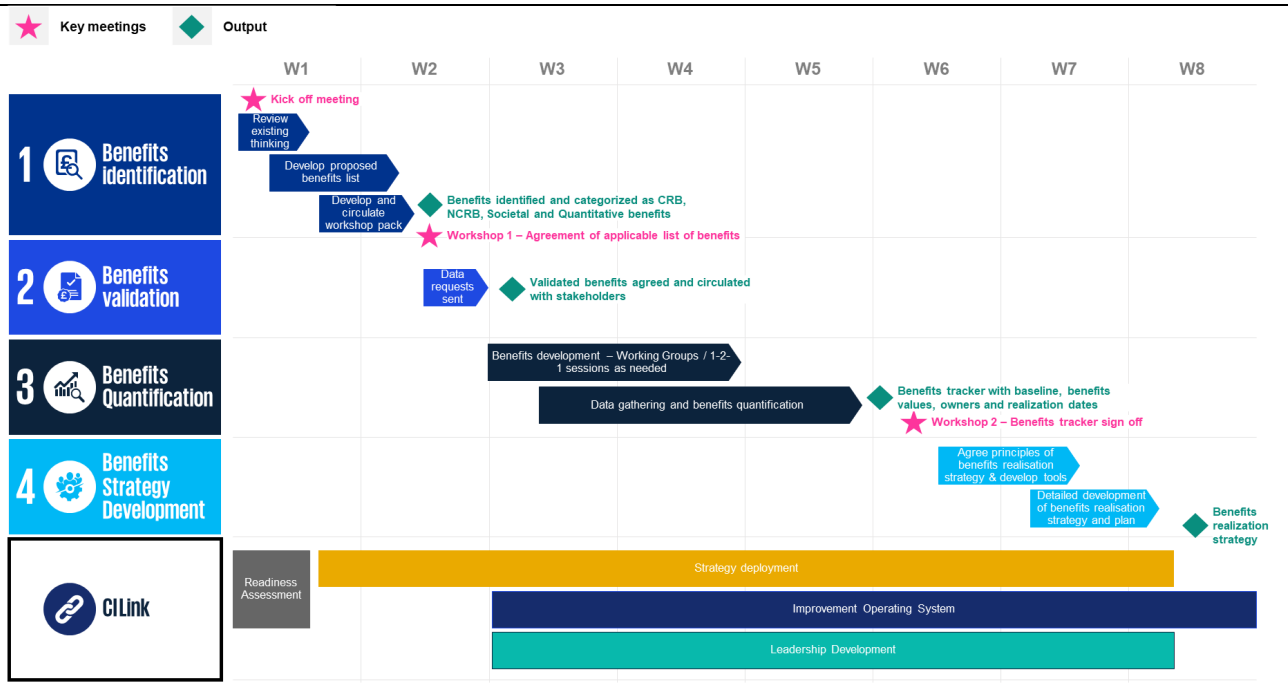
own lean-based Continuous Improvement (CI) Operating Model and required leadership behaviours as outlined in the diagram below. The focus will be on recognising our work to date, including the KITE values and behaviours, and bringing the learning from applying/evolving the approach, which has already been used with 25 similar North American hospitals and 16 NHS trusts.



6.4 EPR benefits realisation

The programme of work for EPR benefits realisation is as follows:

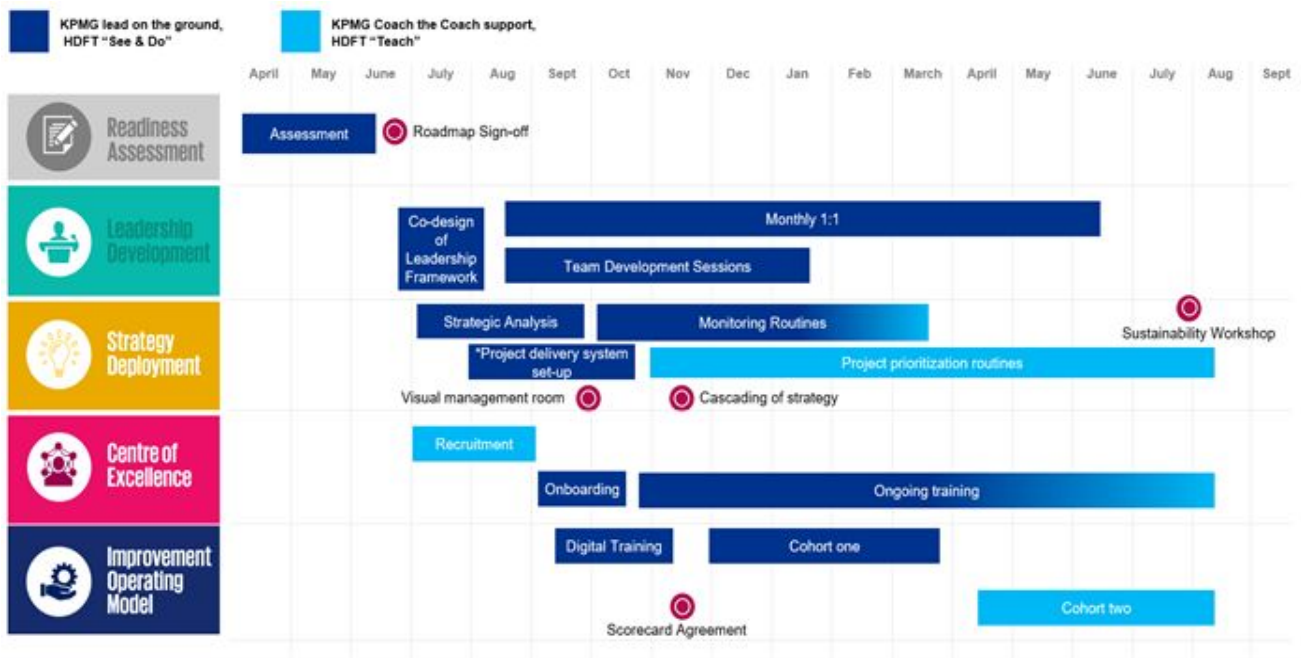
7.4



7.4

6.5 Whole programme

Therefore, the shape of the whole programme looks like this:



6.6 Governance

Senior Leadership Team will provide oversight and initial decision-making for this work. The readiness assessment will make recommendations about any temporary governance arrangements that may be needed to best support the successful achievement of the programme's aims. This may include proposed changes to existing quality improvement and transformation governance arrangements.

6.7 Risks

The two key risks for the readiness assessment are the timely availability of staff and data, and the need to ensure that the assessment builds correctly on all the work we have done to date on continuous quality improvement and transformation. To mitigate these, Catalysis will support our leaders with colleague engagement to maximise availability, and co-design the roadmap based on our strengths e.g. lean capability, Inpulse survey, trust strategy and KITE values and behaviours.

Other key risks for the whole programme of work are explored below:

Workstream	Planned outcome	There is a risk that…	Therefore, Catalysis will…	And we need help from…
Leadership development Support for embedding leadership framework for Exec and Senior Leadership	Leadership role model behavioural framework for leading the organisation	The organisation does not engage with the framework	Co-design the framework with HDFT, building on KITE values, listening to feedback from colleagues across the Trust.	Internal OD lead
Strategy Deployment Cascading the strategy into the operations of the organisation	Strategy is cascaded and routinely managed leveraging a visual management room	The organisation does not understand or recognise the objectives that are cascaded	Build upon HDFT's three ambitions and regularly review feedback	Strategy lead Improvement lead BI Lead
Centre of Excellence Creating an internal team of experts	Internal team is capable and credible in leading the organisation through your CI journey and has a network of peer support	The internal team struggle to understand and develop the core skills to continue the roll out	Embed upskilling methodology of "see one, do one, teach one" and provide on the ground coaching	Improvement team

Improvement Operating Model Embedding a system of routines and necessary toolset	Directorates and Clinical Groups have aligned scorecards in place which drive daily improvement huddles at frontline	Lack of engagement/pace for roll out Insufficient capability is built in frontline teams to sustain routines	Robust engagement plan in place Use recognised "Teach, Train, Coach" approach to focus on capability transfer with Cohort one (60-70 staff), only leaving them once confident.	Improvement team

6.8 Benefits

110 other health and care organisations worldwide have trained their teams in a lean-based operating model and committed to a philosophy of continuous improvement based on evidence from the Shingo Institute[2]. This includes the Catalysis leaders' organisations[3] with whom it is recommended we partner.

This has helped them to make significant quantified improvements. For example:

1. Reduce length of stay across diverse inpatient pathways.

2. Reduce waiting lists for community and acute services.

3. Improve patient safety (e.g. falls reduction).

4. Make productivity gains in community and acute services.

5. Match the number of improvements made in a year to the number of colleagues in the organisation.

6. Increase colleague engagement scores (in some cases to become nationally leading).

7. Colleagues reporting feeling better able to both influence their work and make improvements, even at times of pressure and difficulty.

8. Deliver challenging cost improvements by focusing first on quality.

9. Expedite hospital discharges.

10. Achieve CQC outstanding ratings (e.g. includes the first trust to achieve outstanding in all domains, Western Sussex).

As part of the roadmap sign-off in June 2023 (see schedule in section 6.5 above), the quantifiable benefits of this work will be agreed. This will happen in parallel with the development of the EPR benefits strategy.

7.4

[2] See: About the Shingo Institute - Shingo Institute | Meet the staff!

[3] See: Catalysis | Transforming Healthcare | Healthcare Leadership Coaching | Transformation Journey Assessment and Education | Inspiring Healthcare Leaders – Accelerating Change (createvalue.org)

7. Recommendations

It is recommended that the Board of Directors:

1. Approve the use of EPR capital funding (2022/2023) to the value of £999,093 to deliver the business case to broaden and deepen a philosophy and operating model for continuous improvement.

2. Approve entering into a contract to provide consultancy support to broaden and deepen a philosophy and operating model for continuous improvement throughout HDFT with Catalysis (in partnership with KPMG).

3. Note the alignment of this business case to the Trust's wider programme of work in relation to the Electronic Patient Record.

4. Note that the contract will provide consultancy support to HDFT over an 18-month period from 1st April 2023 to 30th September 2024.

David Plews
Deputy Director – Improvement and Transformation
01423 554481
07500 996603

Appendix 1. Review of Continuous Improvement Business Case: history, context, current state, gaps and drivers

1. How did we get here?

HDFT began its lean quality improvement (QI) journey back in 2013, with several senior colleagues visiting Virginia Mason Healthcare in Seattle, USA to learn from their approach. In the years that followed a range of quality improvements were facilitated across the organisation in a broad selection of clinical and support services, and across HDFT's growing geography. Work focused on both clinical patheays and support services. Our method was and remains based on the Virginia Mason Production System. Our approach withstood the scrutiny of a CQC inspection in 2018, when inspectors observed: *"There was a strong focus on quality improvement throughout the trust which was well embedded. The trust had an innovation and improvement strategy and quality charter which was effective in enabling it to grow skills and capacity in quality improvement and celebrate innovation and quality improvement."*

Since then, (excluding some covid-related disruption in 20-22) the Improvement and Transformation Team has continued to:

a. train over 250 colleagues annually, including doctors-in-training and preceptorship nurses, to give them an introduction to quality improvement (bronze QI champions);

b. train around 130 Silver QI champions annually, and offer each coaching support to progress their own QI project;

c. make 16 QI Team Accreditations at bronze and silver levels;

d. deliver an annual schedule of around 25 improvement events per year, including Rapid Process Improvement Workshops;

e. run newsletter and social media campaigns, publishing recognition for good practice in QI on social media, gaining over 27,000 impressions at peak times during the Quality Conference;

f. provide responsive facilitation, training and one-to-one and small group coaching to colleagues, often where an urgent need for improvement has arisen.

g. establish and support an informal Improvement Collaborative. Those in improvement-focused job roles in directorate teams continue to lead and support directorate-based programmes of work, so the collaborative focuses on sharing, learning and updating each other on QI news. The meetings include input from colleagues across our directorates who are working on the quality improvement and transformation agendas.

2. Where are we now?

Agreed in December 2022, the January-March 2023 schedule for QI projects has been subject to more volatility than usual, which has led to various training sessions and facilitated workshops moving around in the schedule, and some being postponed into the new financial year. Part of the reason for this is that some leaders continue to see QI as a box of tools rather than a "total approach" to managing work. Directorates continue to work differently in how they identify opportunities/ challenges that are suitable for QI work and how they prioritise these into programmes of work.

QI training evaluates really well and improvement events have a track record of being purposeful, productive and achieving most of the targets that are set. But there is an opportunity to better

connect improvement training and facilitation to those services that are most central to the Trust's strategy. Alignment has improved in the last year, with proposed projects being mapped against strategy priorities, but there is still a danger that we are "letting a thousand flowers bloom all over the lawn", rather than cultivating them in the beds that we want them to grow in.

3. What is holding us back?

Some trusts have now moved ahead of HDFT in their full embedding of a continuous improvement operating model, which they have hardwired into their governance and operational management structures. It has been notable that all trusts rated CQC "outstanding" have such an operating model in place. And this embedded operating model is a key gap for HDFT. This gap is

a. preventing us from weaving QI into more colleagues' daily thinking, management and practice to create a culture of improvement.

b. stopping patients from benefiting from the kind of joined-up approaches to QI that we have evidence to prove have such a positive impact on safety, clinical effectiveness and patient experience.

c. felt in the lack of a common language and set of concepts, tools and techniques with which everyone in every team is familiar.

d. seen in the lack of control that some colleagues who associate negative emotions with being at work say they experience. Having a QI operating model in place correlates with higher staff engagement scores. This is because colleagues are empowered to make improvements in their area of work, which mitigates against "learned helplessness".

e. holding us back on the journey from "good" to "outstanding" as an acute and community NHS foundation trust.

4. The Drivers

At the Board workshop on 21/12/23, the Board reflected on the fact that some features of the current state are driving us towards the implementation of a QI/CI Operating Model:

+ Colleagues are impatient for **stronger engagement** and a more agile approach with a faster pace of change, as the Inpulse survey data shows. This will help us to keep ideas and talent within the Trust.

+ At Our Best culture improvement work provides firmer foundation than before. Helps to support having good days at work, and supports a feeling that "we are all in it together"

+ Management restructure for acute services increases likelihood of success. Leaders are ready to further empower their teams.

+ Demand for training in quality improvement has never been stronger. 1,600 people trained over recent years (under 1,000 still at HDFT). Good quality bronze and silver QI projects across the Trust. Supports a "zero waste" approach.

+ Many colleagues feel that **Covid** has shown us that we can change quickly on an organisation-wide footing when we need to. *"We can't carry on running things as we are. Demand is just going up and up."*

+ Good use of **QI tools and techniques**: productive and effective training and workshops. This supports the sustainability and efficiency of services and helps us to make changes that benefit patients.

+ The procurement and mobilisation of a new **Electronic Patient Record** would deliver greater benefits if we manage it as a large-scale transformation programme using a CI operating Model.

But, at the same time, some features are pushing us *away* from the implementation of a CI Operating Model:

- Capacity for QI conflicts with capacity to manage operational pressures when they should be part of the same operating model and philosophy.

- Microcultures exist around quality improvement, not a "whole organisation" approach.

- Change/initiative fatigue arising from **"overwhelm"** is widespread in some teams. Lack of "bandwidth" for what some people perceive as the "additional" work of improvement.

- The most important **priorities are not clear** to the whole organisation.

- Relationships between teams are not always characterised by adherence to **KITE behaviours**.

- We sometimes have more ideas than we can prioritise and implement. This is especially a problem where people feel they need **permission to make changes.**

- Some teams display an aversion to **managed risks**.

- Will we have the **robust data** we need on which to base our improvement science?

- Will we secure the **investment needed** to give us a good chance of success?

- Changes following QI work can be hard to "land" and implement. Need to ensure the right "buy in" is in place for this scale of change.

- **Limited culture of teams owning and solving their own challenges**, with support. Sometimes, a culture of escalation is evident.

- Limited practice of data-driven problem solving - improvement science (using plan, do, study, act cycles)

- Uncertainties about system-wide approaches to CI in our health and care systems.

Knowledge of the history, context, gaps and drivers has been used to inform the business case presented in the main report.

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
CHS3	Managing the risk of injury from fire	Organisational risk to compliance with legislative requirements, with risk of major injuries, fatality or permanent disability to employees, patients and others due to fire hazards.	16 (4x4)	8(2x4)		
CHS4	Control of contractors and construction work	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises.	16 (4x4)	8(2x4)		
CHS5	RAAC Roofing at HDH	Organisational risk to compliance with legislative and NHSE requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with RAAC roofing.	12 (3x4)	8(2x4)		

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 • Completion Mar 23. (50LPR, 19 Wetherby Phase 2, 21 Wetherby Phase 2 to move into 23/24 funding due to scale and complexity)	

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 • Complete • Complete • Complete • On Track • On Track	
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Design complete – Aug 22 • Tender & Contract award and Design – Mar 23 • Build complete – Jun 23 • Commissioning complete – Aug 23 • In service – Sep 23	• Complete • On Track • Oct 23 • Nov 23 • Nov/Dec 23	
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 • Complete • Further milestones TBC by external Design Team	
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	• Complete • Complete - issued Jan 23; returned 8 Mar 23 • On Track • May 23 • Oct 23 • Oct 23 • Oct 23	
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	• Complete • Complete - issued Jan 23; returned 8 Mar 23 • On Track • On Track • Nov 23 expected, possible revised scope to address reduced bed numbers in agreed design • Dec 23 expected • Dec 23	

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 • Summer 23 • On Track – May 23 • On Track • Dec 24 – Engagement with contractors has raised some concerns regarding funding and timescales • At Risk	

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. Expected completion for the scheme is August 23. • Window installation expected completion April 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 • Complete	

Mar 23

Director of Strategy

Matters of concern & risks to escalate

Capital Planning
- RAAC. ongoing survey and monitoring; developing plans to mitigate/eradicate further areas and for overall eradication by 2030

PMO
- CDC: still awaiting approval of NY CDC BC; work started with NHSPS to develop plans for Ripon CH CDC

Major actions commissioned & work underway

PMO
- Projects being supported: OP Transformation (waiting list validation, digital patient letters); UEC (inpatient referrals); Quality (Insulin & Opiates Medicines Errors, Missed Results); Hopes for Healthcare

QI
- Workshops on Enhanced Care and VTE pathways planned for March
- Planning for mobilisation of the Continuous Improvement programme

Capital Planning
- TIF2: Procurement of P23 Principal Supply Chain Partner (PSCP) underway (closes 21 Apr; appoint May); £2m spend for 22/23 underway.
- Aseptics: detailed design work underway; on track to complete Aug 23
- Wensleydale/ED2: Tender evaluation underway; approach to revised bed numbers under development.
- Imaging/CT: Reconfig BC being finalised; detailed design work to begin
- Estates Strategy: tender process started to appoint external consultant to develop HDH Estates Strategy.

Business Development
- Comms: JD strikes, Datix launch, new Intranet,
- Volunteers: attending careers fairs to promote volunteering
- Dom Care: applying for CQC registration, scoping pool cars

Positive news & assurance

PMO
- Prog Mgr starts on 3 April; 1x Proj Mgr appointed
- Inpatient referrals launch planned for 27 March
- Missed results: autofiling enabled in ICE

QI
- EPR engagement support officer in post
- Preferred partner to support Continuous Improvement Op Model programme identified through tender process (6 bids evaluated) and supported by Resources Committee
- QI training: good attendance at Darlington courses; 41 new Bronze QI champions in Jan/Feb; updated Bronze training now on Learning Lab.

Capital Planning.
- 22/23 Programme: Fit to Sit, Omnicell, Gamma Camera completec; Wellbeing, Lascelles, Pod System will be completed by 31 Mar 23
- ED RIAT & Majors: Ph2A handover 17 Mar; Ph2B to complete May
- Wensleydale/ED2: tender returned affordable prices
- Containerised CT Scanner: now operational but for large FOV only

Business Development
- Dom Care: first care assistant roles recruited

Decisions made & decisions required

QI
- Board approval of Continuous Improvement BC and appointment of preferred partner

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	1st March 2023
Date of Board meeting this report is to be presented	29th March 2023

Summary of key issues

The meeting was held via Teams and was well attended. Kathy Gargan and Steve Treece observed and contributed to the meeting on behalf of the Council of Governors. Angie Gillett attended the meeting for the first time to support consideration of HIF internal audit matters.

Key items on the agenda included -

- Terms of Reference and Committee Effectiveness - The Committee undertook the annual review of its terms of reference and agreed minor alterations in relation to attendance by members of the Executive Team. The output from the recent Committee effectiveness survey was considered. It was disappointing that only 4 responses had been received.
- Corporate Risk Register – the current register was considered and noted. Risks related to SCBU, staff engagement and autism assessment were discussed.
- Quality Committee – the Committee received and considered minutes from recent Quality Committee meetings and received a verbal report from the Quality Committee Chair. Discussions at the Quality Committee relating to ED, discharge delays, pressure ulcers, falls, maternity services and health and safety were noted.

- Annual Counter Fraud Plan – fraud and attempted fraud continues to be a significant threat to the NHS and other organisations. The Committee received, considered and approved the proposed plan for counter fraud activity in 2023/24. The proposed programme of work had been designed to address and as far as possible neutralise national and local threats. As in previous years raising staff awareness of threats and risks was at the heart of the plan. The plan provides 65 days of counter fraud activity at HDFT with 15 of those days allocated to HIF and 10 days allocated to investigations.

- 2022/23 Internal Audit Programme - The Committee received a report on the progress of the 2022/23 internal audit programme. A report on management of SI action plans provided significant assurance but a report dealing with RTT data quality offered only limited assurance. A nationally mandated report on financial sustainability was also received. The Committee noted that management requests for changes in the 2022-23 plan appeared to include a number of high priority issues for the Trust and the background and context of these requests will be discussed further at the next meeting. Benchmarking of overdue audit recommendations demonstrated some progress had been made at HDFT, but there is more to be done.

- HIF Internal Audit Reporting – the Committee received a report on the delivery of the 2022/23 HIF internal audit programme. A report on governance and risk management offered only limited assurance but it was noted that these areas were receiving considerable attention from the HIF board and senior managers. A follow up report on food supplies provided significant assurance.

- External Audit – Chris Brown from Azets attended the meeting and provided a verbal report on the progress of the 2022/23 audit. The Trust has been given an extension to 31st August for the submission of its accounts. The national requirement is to submit by 30th June. The extension recognises the period of time that the Trust was without an external audit partner in place and resulting delays in completion of work relating to the 2021/232 financial statements and annual report.

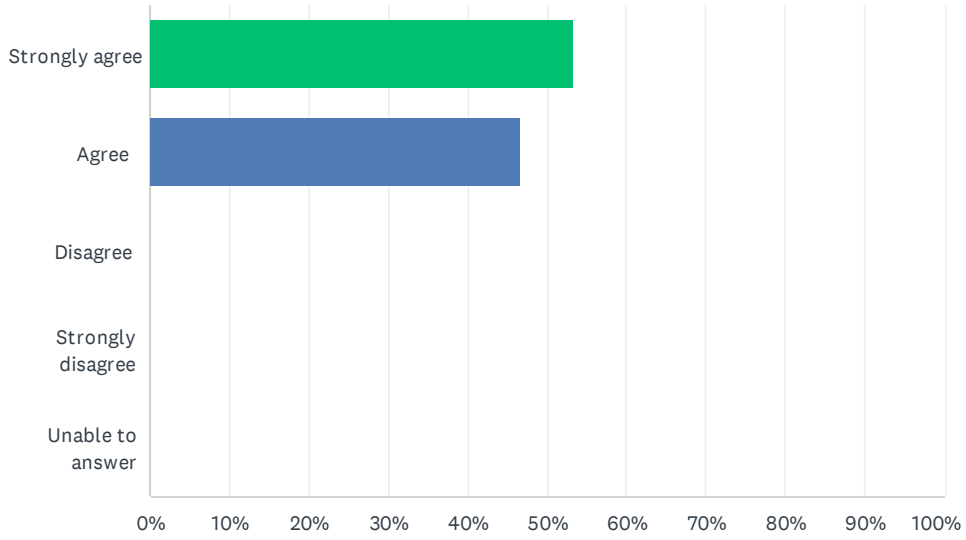
The next scheduled meeting of the Committee is on 25th April, however uncertainty about the external audit timetable may lead to the rescheduling of this meeting or the calling of additional special meetings to consider the

draft financial statements, draft annual report and annual governance statement.
Any significant risks for noting by Board? (list if appropriate)
None.
Any matters of escalation to Board for decision or noting (list if appropriate)
The Board may be required to arrange an additional special meeting to consider the 2022/23 financial statements, annual report etc in order to meet the 31 August submission date.

HDFT Board of Directors - Effectiveness Survey

Q1 The Board has a work plan that adequately focuses on its purpose and role.

Answered: 15 Skipped: 0



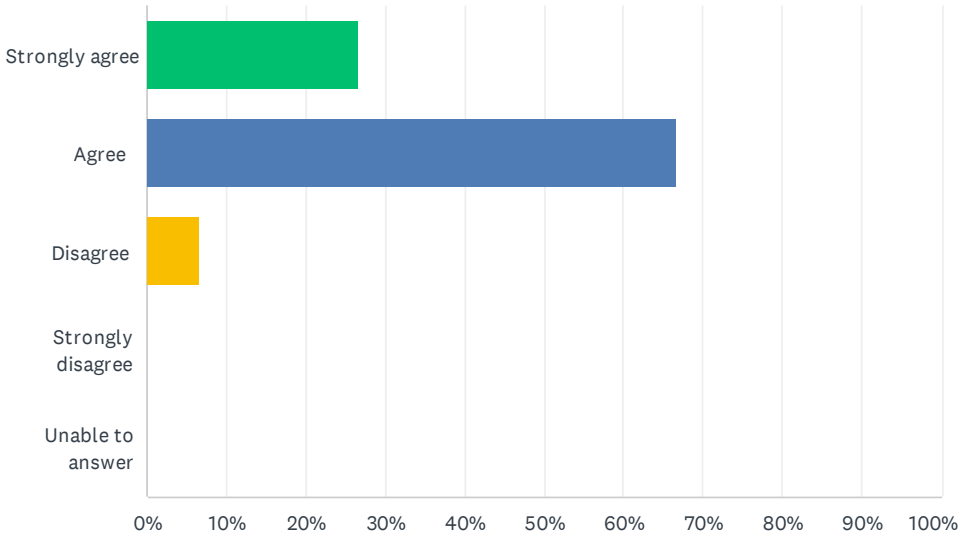
ANSWER CHOICES	RESPONSES	
Strongly agree	53.33%	8
Agree	46.67%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q2 The Board has made a conscious decision about the level of information it would like to receive for each of the items on its cycle of business.

Answered: 15 Skipped: 0

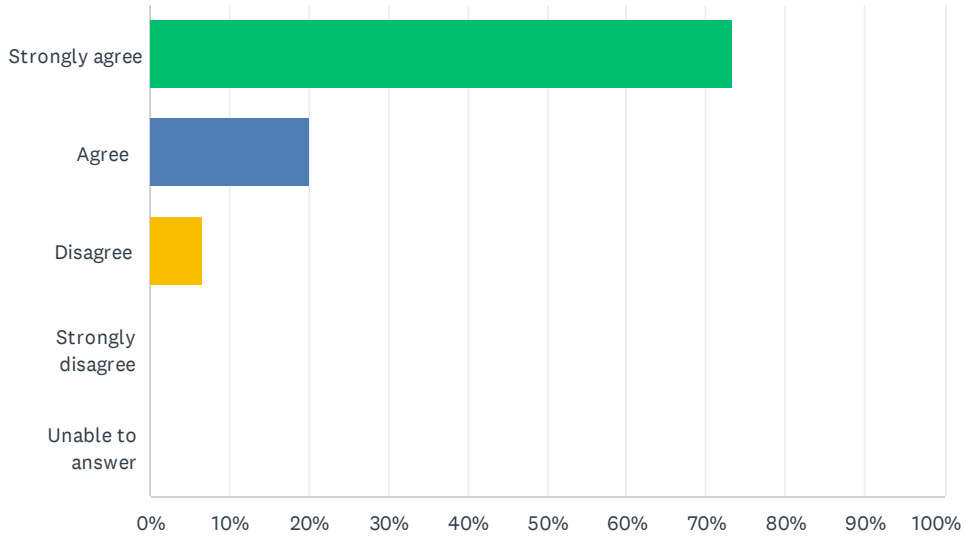


ANSWER CHOICES	RESPONSES	
Strongly agree	26.67%	4
Agree	66.67%	10
Disagree	6.67%	1
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

HDFT Board of Directors - Effectiveness Survey

Q3 Board members contribute regularly across the range of issues discussed.

Answered: 15 Skipped: 0



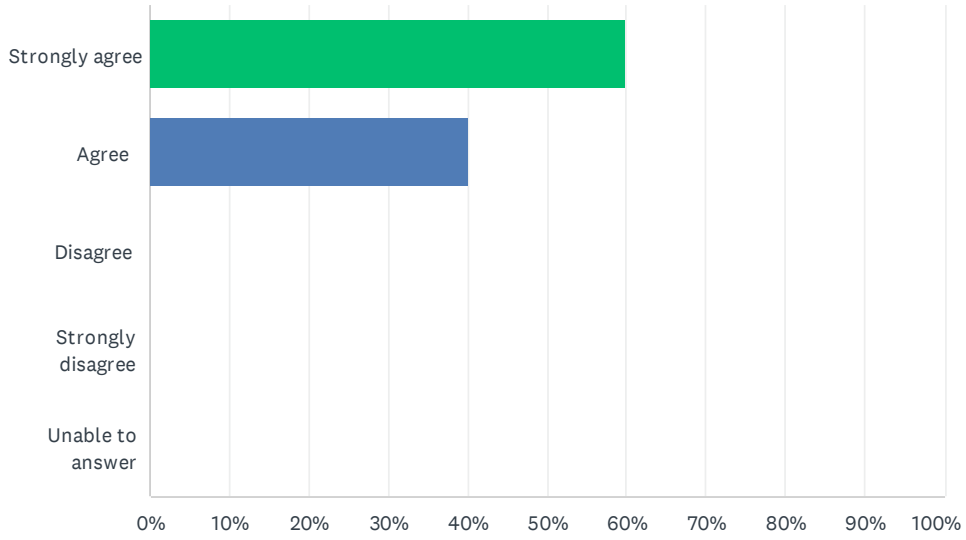
ANSWER CHOICES	RESPONSES	
Strongly agree	73.33%	11
Agree	20.00%	3
Disagree	6.67%	1
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q4 When considering items appropriate emphasis is given to both quality and finance.

Answered: 15 Skipped: 0



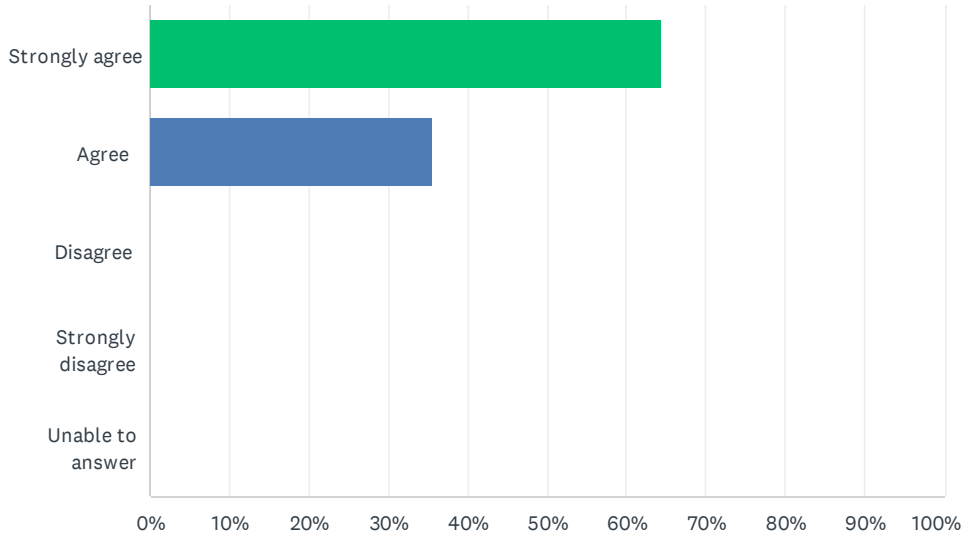
ANSWER CHOICES	RESPONSES	
Strongly agree	60.00%	9
Agree	40.00%	6
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q5 The Board has the right balance of (or reasonable access to) experience, knowledge and skills to fulfil its role.

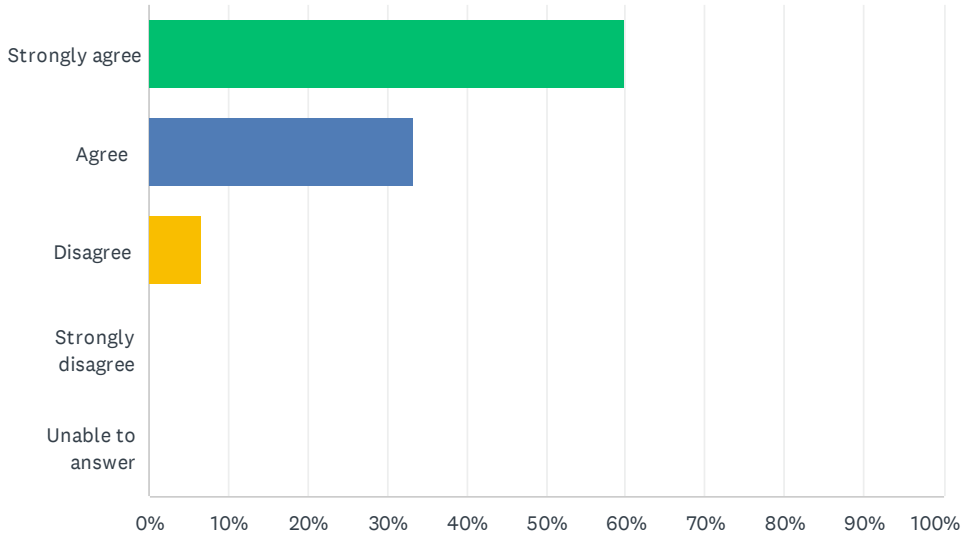
Answered: 14 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	64.29%	9
Agree	35.71%	5
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		14

Q6 The Board ensures that the relevant Executive Director/Deputy Director/Head of Service/Manager attends meetings to enable it to secure the level of understanding of the reports and information it receives.

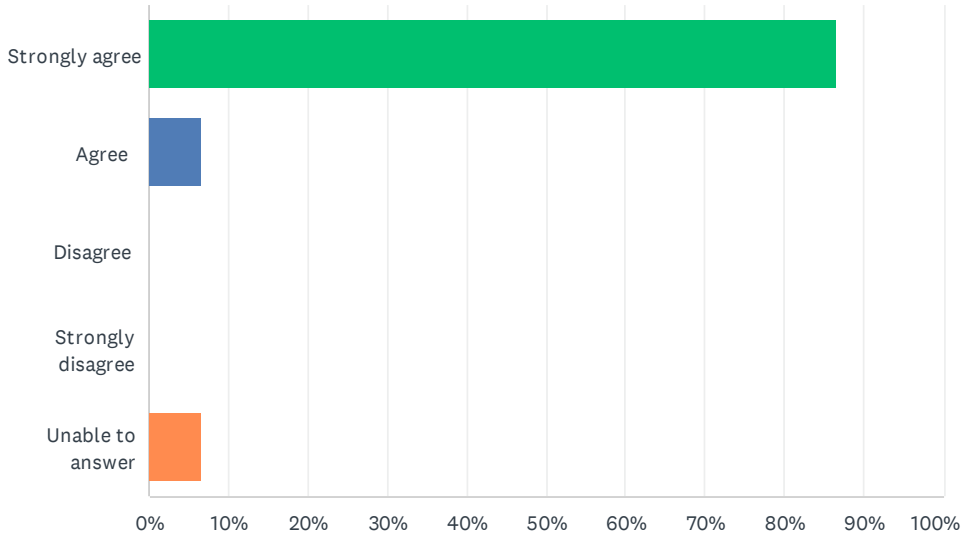
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	60.00%	9
Agree	33.33%	5
Disagree	6.67%	1
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

Q7 I feel sufficiently comfortable within the Board meeting environment to be able to express my views, doubts and opinions.

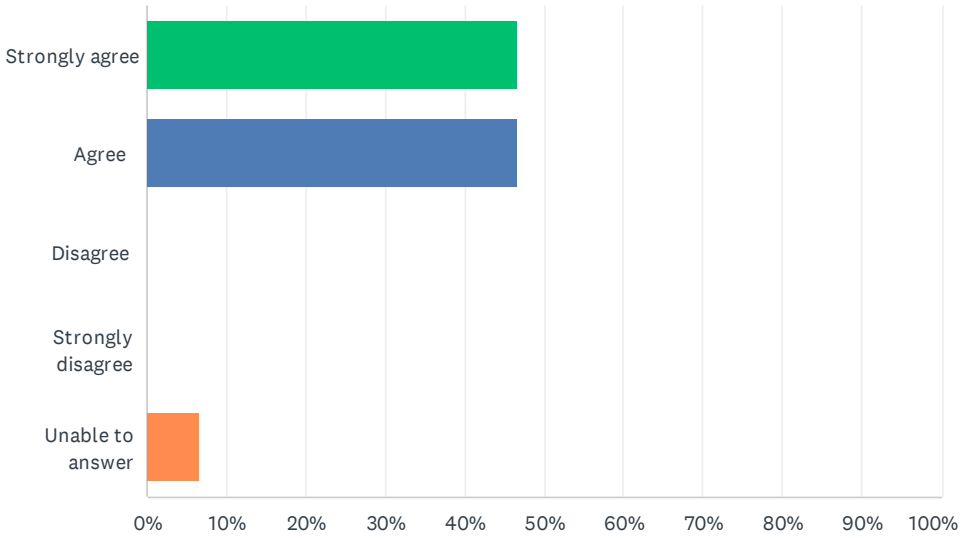
Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	86.67%	13
Agree	6.67%	1
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	6.67%	1
TOTAL		15

Q8 When a decision has been made or action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.

Answered: 15 Skipped: 0

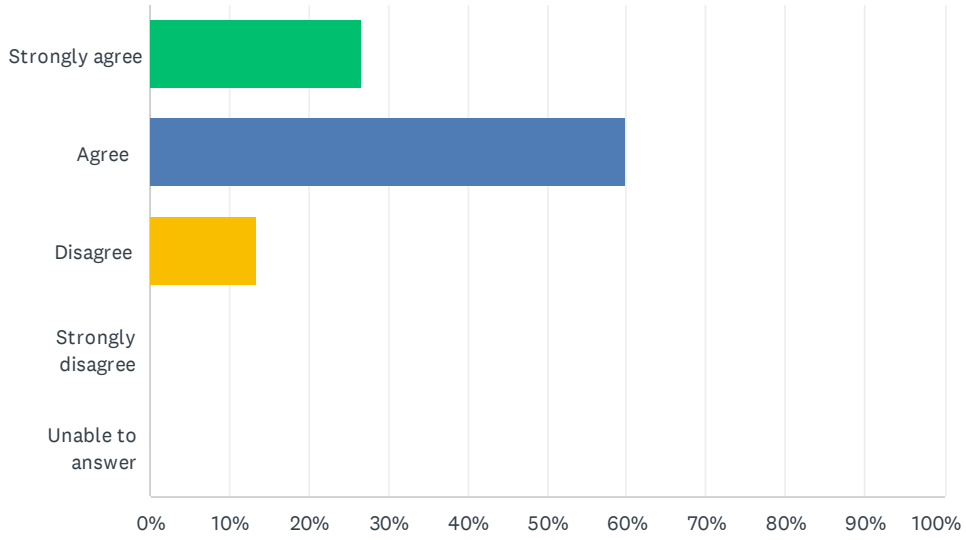


ANSWER CHOICES	RESPONSES	
Strongly agree	46.67%	7
Agree	46.67%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	6.67%	1
TOTAL		15

HDFT Board of Directors - Effectiveness Survey

Q9 The quality of Board papers received allows me to perform my role effectively.

Answered: 15 Skipped: 0

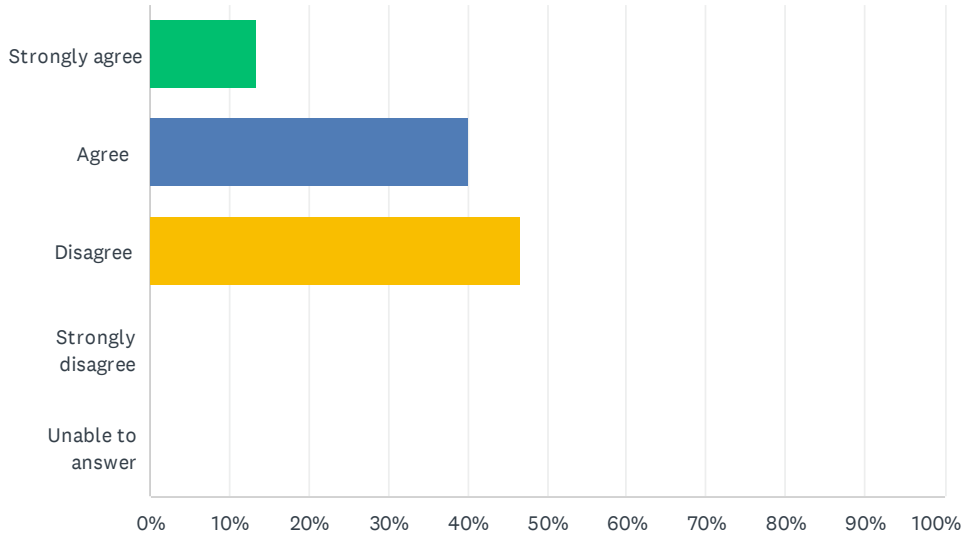


ANSWER CHOICES	RESPONSES	
Strongly agree	26.67%	4
Agree	60.00%	9
Disagree	13.33%	2
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

Q10 I receive papers in enough time to allow me to prepare fully before meetings of the Board.

Answered: 15 Skipped: 0



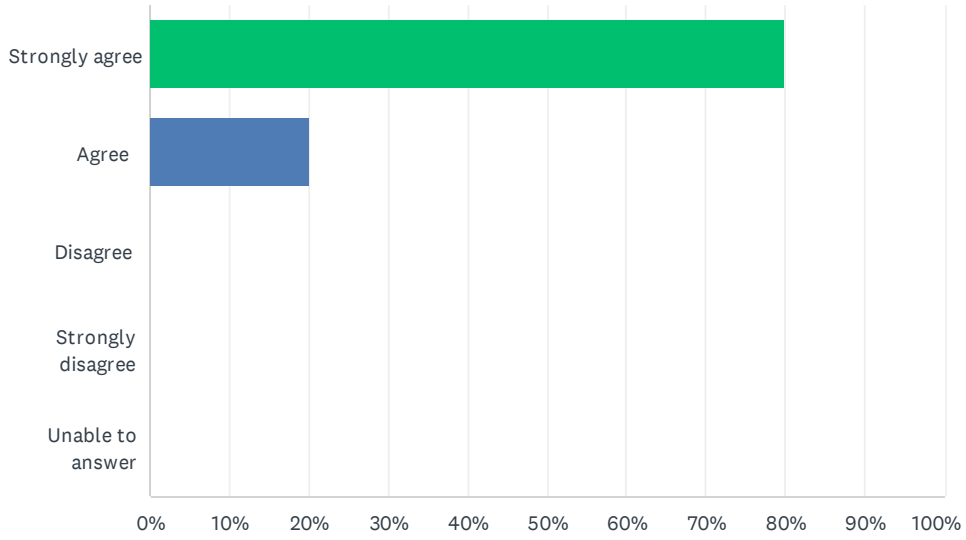
ANSWER CHOICES	RESPONSES	
Strongly agree	13.33%	2
Agree	40.00%	6
Disagree	46.67%	7
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q11 Conflicts are declared at the start of every meeting and appropriate action is taken when relevant matters are discussed.

Answered: 15 Skipped: 0

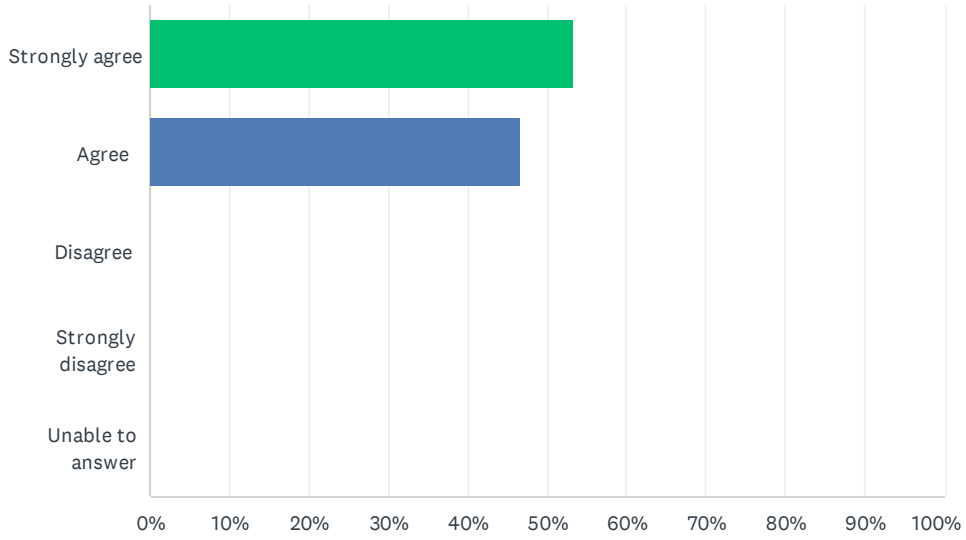


ANSWER CHOICES	RESPONSES	
Strongly agree	80.00%	12
Agree	20.00%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

Q12 Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.

Answered: 15 Skipped: 0



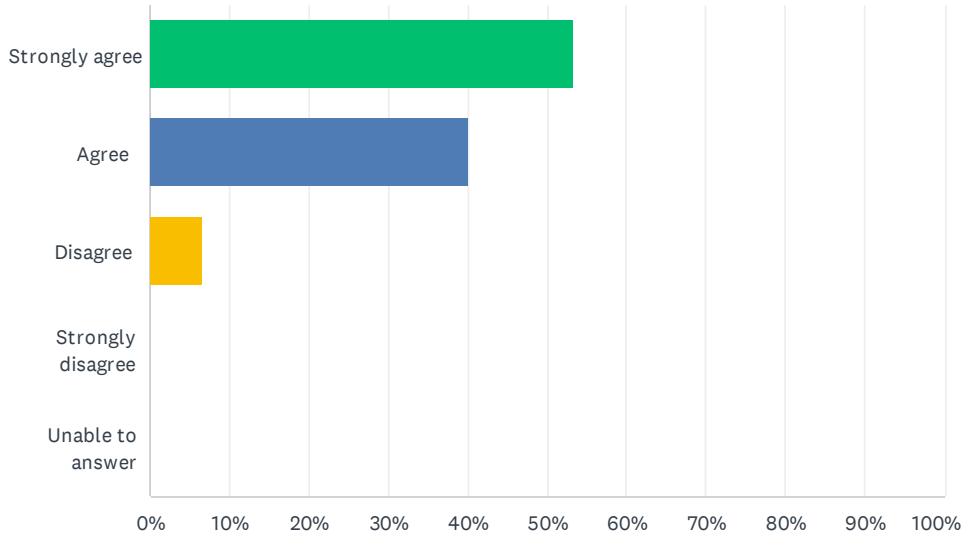
ANSWER CHOICES	RESPONSES	
Strongly agree	53.33%	8
Agree	46.67%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q13 Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.

Answered: 15 Skipped: 0

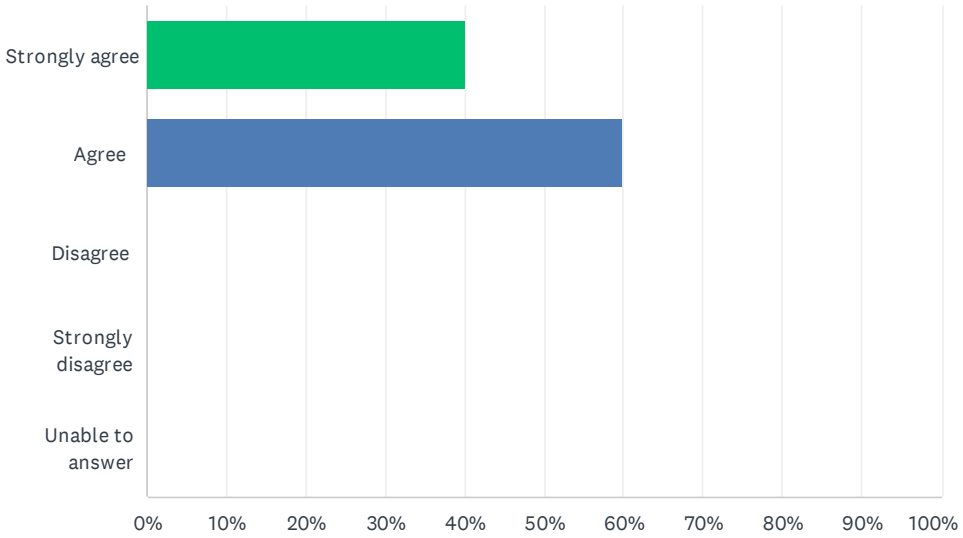


ANSWER CHOICES	RESPONSES	
Strongly agree	53.33%	8
Agree	40.00%	6
Disagree	6.67%	1
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

Q14 Each agenda item is ‘closed off’ appropriately so that I am clear what the conclusion is; who is doing what and what worked well/not so etc.

Answered: 15 Skipped: 0

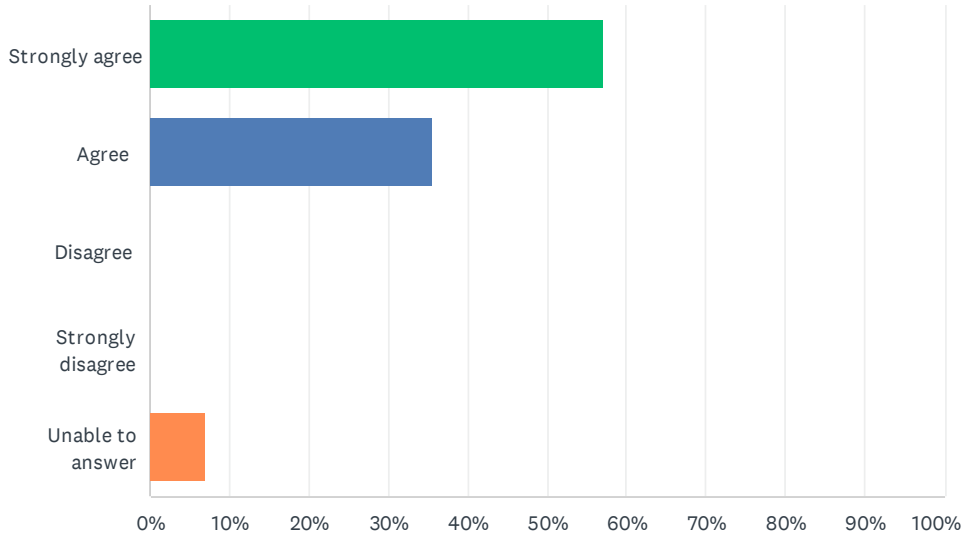


ANSWER CHOICES	RESPONSES	
Strongly agree	40.00%	6
Agree	60.00%	9
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

HDFT Board of Directors - Effectiveness Survey

Q15 The Board actively challenges during the year to gain a clear understanding of its findings.

Answered: 14 Skipped: 1

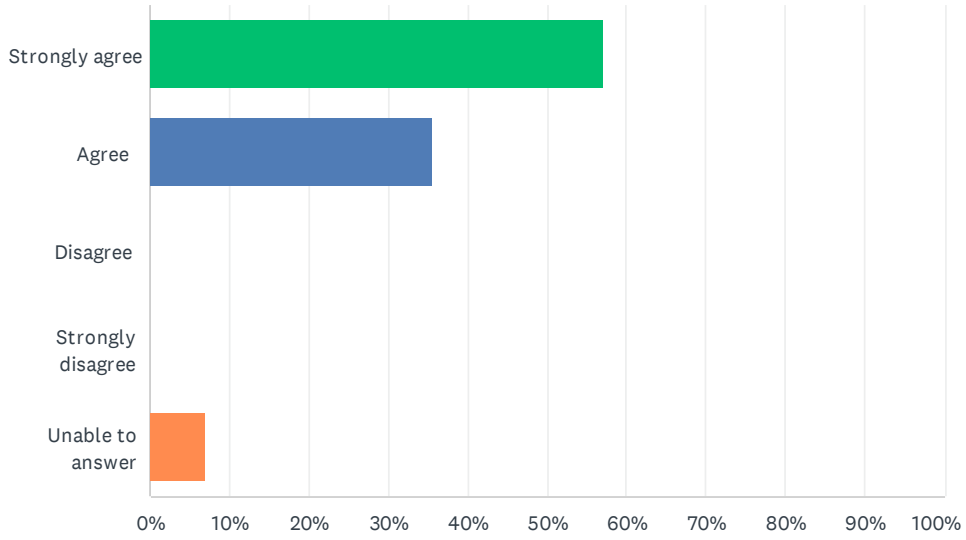


ANSWER CHOICES	RESPONSES	
Strongly agree	57.14%	8
Agree	35.71%	5
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	7.14%	1
TOTAL		14

8.4

Q16 The Board is clear about the complementary relationship it has with sub committees.

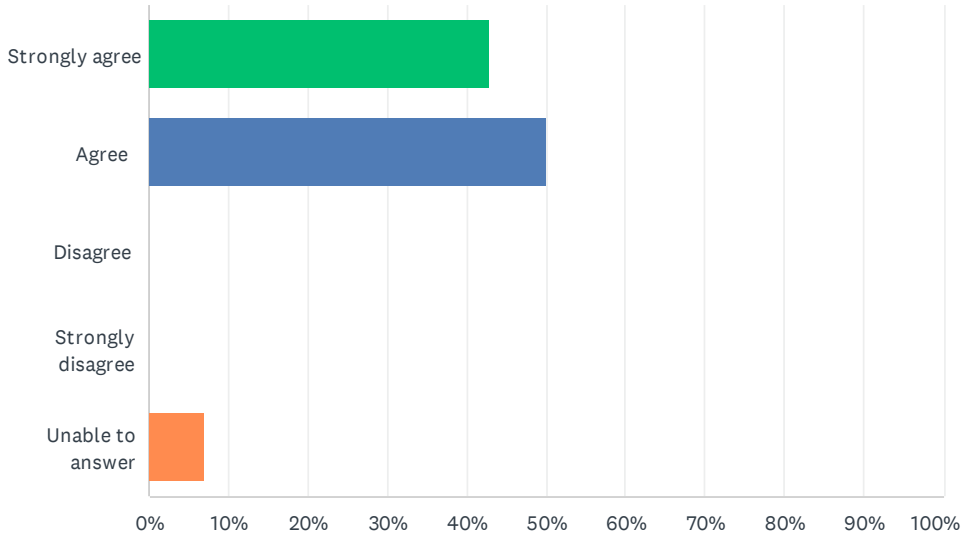
Answered: 14 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	57.14%	8
Agree	35.71%	5
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	7.14%	1
TOTAL		14

Q17 The Board ensures that there is regular and effective communication with key stakeholders.

Answered: 14 Skipped: 1



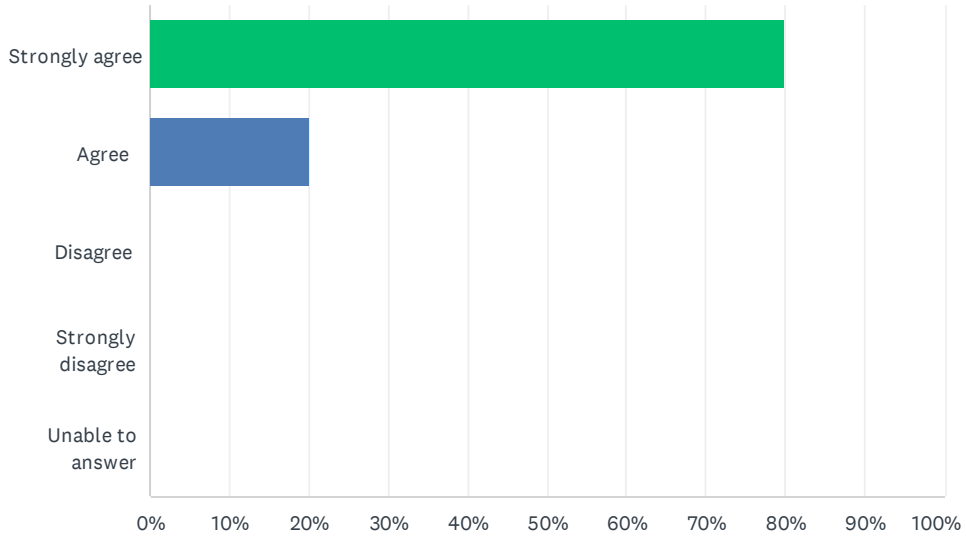
ANSWER CHOICES	RESPONSES	
Strongly agree	42.86%	6
Agree	50.00%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	7.14%	1
TOTAL		14

8.4

HDFT Board of Directors - Effectiveness Survey

Q18 I have a clear understanding of what is expected in my role as a member of the Board.

Answered: 15 Skipped: 0



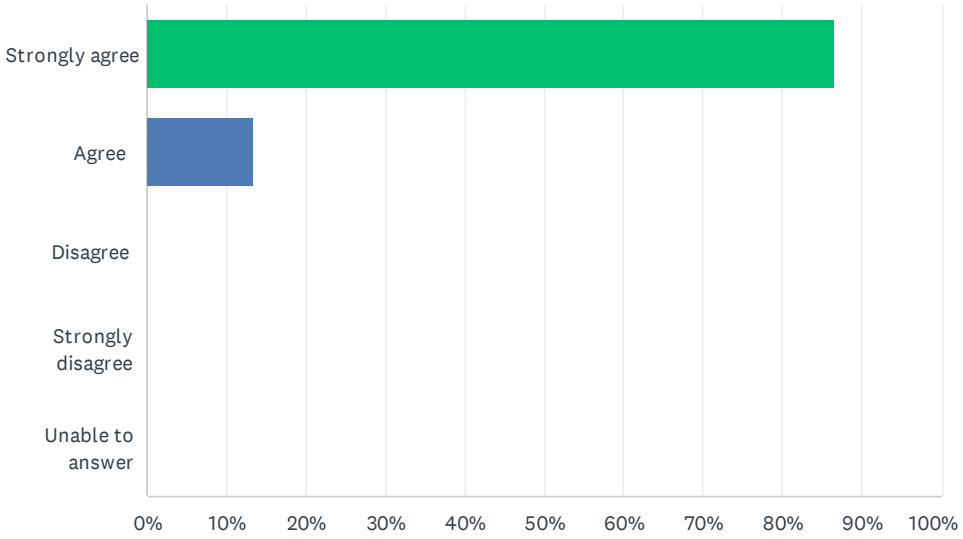
ANSWER CHOICES	RESPONSES	
Strongly agree	80.00%	12
Agree	20.00%	3
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q19 The Chair has a positive impact on the performance of the Board.

Answered: 15 Skipped: 0

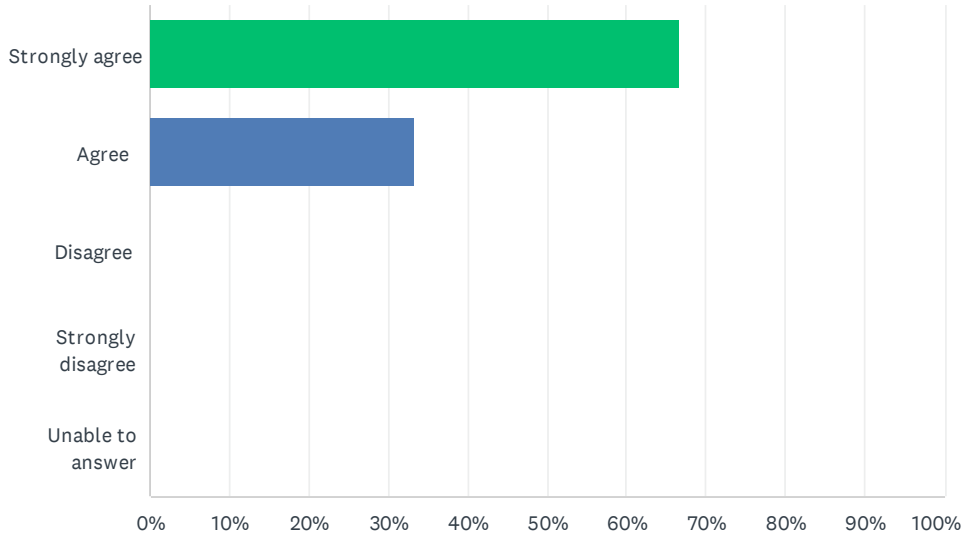


ANSWER CHOICES	RESPONSES	
Strongly agree	86.67%	13
Agree	13.33%	2
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

Q20 Board meetings are chaired effectively and with clarity of purpose and outcome.

Answered: 15 Skipped: 0



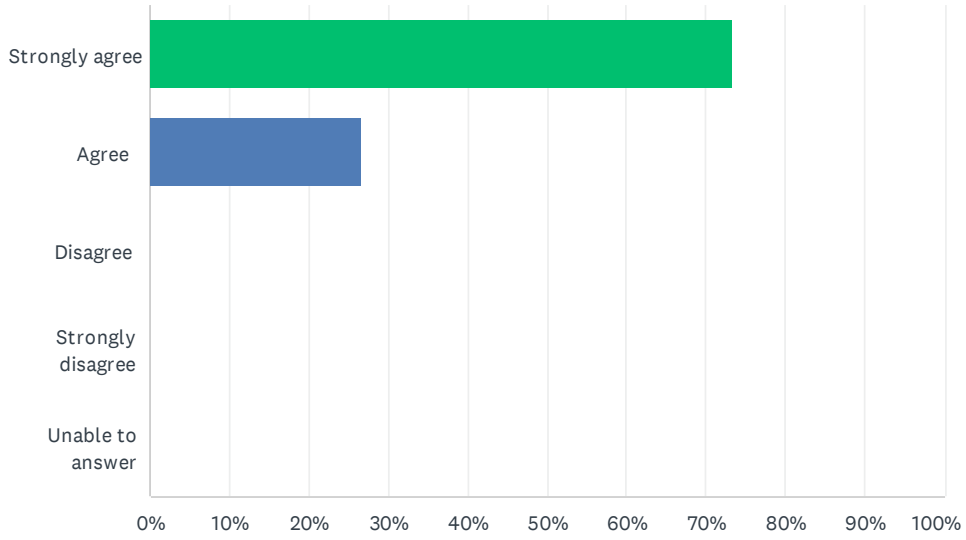
ANSWER CHOICES	RESPONSES	
Strongly agree	66.67%	10
Agree	33.33%	5
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

8.4

HDFT Board of Directors - Effectiveness Survey

Q21 The Chair allows debate to flow freely and does not assert his/her own views too strongly.

Answered: 15 Skipped: 0

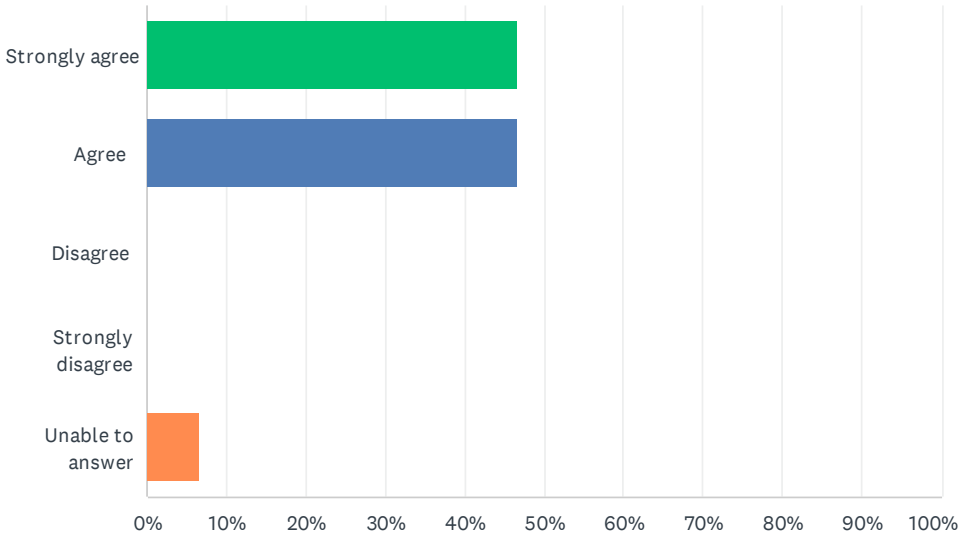


ANSWER CHOICES	RESPONSES	
Strongly agree	73.33%	11
Agree	26.67%	4
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	0.00%	0
TOTAL		15

HDFT Board of Directors - Effectiveness Survey

Q22 The Chair provides clear and concise information to the Board on the activities and the implications of all identified gaps in assurance/control.

Answered: 15 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	46.67%	7
Agree	46.67%	7
Disagree	0.00%	0
Strongly disagree	0.00%	0
Unable to answer	6.67%	1
TOTAL		15

8.4

Q23 Please include any further comments you wish to make

Answered: 4 Skipped: 11

Board of Directors
29th March 2023

Title:	Harrogate and Rural Alliance – Extension to Governance Arrangements
Responsible Director:	Matt Graham, Director of Strategy
Author:	Matt Graham, Director of Strategy

Purpose of the report and summary of key issues:	The current governance arrangements for Harrogate and Rural Alliance (HARA) end on 31 March 2023. This is the Section 75s along with the Alliance agreements. We are asking for an extension to the current arrangements whilst plans for the next five years are developed. These plans need to take account of national and local priorities for the HARA partners. The attached paper has been approved by the NYCC Health and Adult Services Executive. Approval is now sought from the HDFT Board. The proposal is to extend the current arrangements on a six plus six-month basis. This will give us until 1 April 2024 to put new arrangements in place, but with an option to do this on 1 October 2023 if the legal framework can be agreed by then. These proposals along with an outline of the HARA development plans have been recommended by the Harrogate and Rural Integrated Health and Social Care board. Further details on the HARA development proposals will be available early in April.
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities

Best Quality, Safest Care	
Person Centred, Integrated Care; Strong Partnerships	X
Great Start in Life	
At Our Best: Making HDFT the best place to work	
An environment that promotes wellbeing	
Digital transformation to integrate care and improve patient, child and staff experience	
Healthcare innovation to improve quality	

Corporate Risks	None
Report History:	The attached paper has been approved by the NYCC Health and Adult Services Executive.
Recommendation:	Trust Board is asked to approve the extension to HARA s75 and alliance governance arrangements as outlined in the attached paper.

Harrogate and Rural Alliance (HARA): Extension to Section 75 Agreements

1.0 Purpose Of Report

The purpose of this report is to consider, and agree, a further extension, of the existing Section 75 County Council/NHS commissioner and provider agreements for the integrated community health and social care services in the Harrogate district. Previously, these agreements were extended by one year in March 2022

2.0 Background

In Autumn 2019 the Trust Board approved the two Section 75s covering North Yorkshire County Council's involvement in the HARA. The service went "live" from 30 September 2019, bringing together 400 frontline community health and social care staff and managers, employed by Harrogate and District NHS Foundation Trust (HDFT) and North Yorkshire County Council (NYCC), and led by an integrated management team reporting to an Alliance Director who, in turn, is accountable to an NYCC Adult Social Care Assistant Director and an HDFT Operational Director. The aligned spend of the service started at £50m.

HARA is a partnership involving the NHS (Humber and North Yorkshire ICB, HDFT, Tees Esk and Wear Valleys NHS Foundation Trust and Yorkshire Health Network GP Federation and the 4 Primary Care Networks in the Harrogate district) and the County Council and the purpose of the programme is to: "Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets".

The HARA Partners have a shared vision of a timely transformation towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District. The parties believe that co-ordinating and integrating their planning, commissioning and delivery activities will help facilitate the best use of resources to support the local resident and patient population.

The continued ambition for the HARA service is that it has:

- Prevention as the starting point.
- Care anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource.
- Care delivered at home wherever possible
- A focus on population health as opposed to organisations.
- Where possible, a Primary Care Practice Centred Model (currently it operated a hybrid model between practices and geography).
- Primary care involvement and commitment (ideally daily)
- Active involvement from people who use services and carers.

The purpose of the two Section 75s, agreed in 2019, was to put in place the agreements to govern and manage shared planning and commissioning and delivery of integrated services, supported by an indicative set of core and aligned budgets in the geography of Harrogate and Rural District. The Harrogate and Rural Alliance Board (HARAB) was established as the vehicle through which all parties will discharge their shared responsibilities in respect of working together within the defined financial schedules. The Agreements apply to the defined health, public health and social care services supplied to the residents of North Yorkshire County Council and to patients registered with the GP Practices within the former Harrogate and Rural District CCG.

These agreements were extended by one year in March 2022 with the agreement of all parties.

Annex 1 contains a copy of the current commissioner Section 75 and Annex 2 a copy of the current provider agreement.

3.0 Issues for consideration

Extension of the Two Section 75s

The purpose of the further extension is to allow HARA to continue to operate whilst we continue to work on HARA's future operating model. We have developed draft proposals for the future of HARA and these will be shared at a future meeting.

As a reminder, much foundational work has been undertaken. These includes:

- Maturing of relationships between senior leaders
- Establishment of an integrated management structure, with an Alliance Director
- Implementation of Integrated Daily Huddles in the four HARA localities
- Establishment of a framework for monthly Multidisciplinary Team Meetings in each of the four Primary Care Networks
- Developing an integrated hospital discharge function (Community Discharge Hub)
- Development of new services including an Acute Response and Rehabilitation in the Community, Home and Hospital (ARCH) service and Urgent 2 Hour Response Service.

The context in which HARA operates is changing and there are a number of key factors affecting the context. These include:

- White Paper "Health and social care integration: joining up care for people, places and populations
- Local Government Review implementation
- White Paper "People at the Heart of Care: adult social care reform"
- The Health and Care Bill's changes in the Governance and Structure of the NHS with Integrated Care Systems becoming statutory bodies and the abolition of CCGs.

Given this context, this report proposes a simple extension of the Section 75s for a period of up to one year (on a six plus six month basis), which will allow HARA to continue to operate within its current governance framework for a further six months to 31 September 2023 (or March 2024 if the additional six months is needed). During this period work will be completed on the future scope of HARA, taking into account changes in Local Government, Social Care and the NHS noted above.

The requirements for consultation
A formal consultation was undertaken as part of the process for the approval of the Section 75s in 2019, which included the options to extend with the Section 75s.

4.0 Performance Implications

None as it is an extension of current arrangements which are subject to regular service monitoring by both HDFT and Elected Members and officers within the County Council.

5.0 Financial Implications

There are no new financial implications as this is an extension of the current arrangements. Whilst the Section 75 contains the powers to establish pooled funds, to date these powers have not been exercised. At the end of quarter 2 in 2022/23 the HARA budget was in total £55m made up of a NYCC Budget of £45m and a NHS budget of £10m. The parties to these Agreements are not sharing financial risk.

6.0 Legal Implications and Governance compliance

As a recap, Section 75 of the 2006 NHS Act gives powers to local authorities and the NHS to; establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions; to establish integrated commissioning arrangements and to establish integrated management functions in relation to health and social care services.

The proposal is to extend an existing provider S75 and commissioner S75 for 12 months (on a six plus six months basis) which is permitted in the terms of the S75 Agreements.

Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. 617 (“Regulations”) enable NHS bodies to exercise prescribed local authority health-related functions in conjunction with their own NHS functions (provider S75 Agreement) and to establish integrated commissioning arrangements (commissioner S75 agreement).

In relation to the Provider S75 Agreement, under the Public Contracts Regulations 2015 (PCRs) two contracting authorities can enter into a collaboration agreement (co-operation) subject to meeting the tests of Regulation 12 (7) PCRs (known as Hamburg) without the need to undertake a procurement exercise.

7.0 Equalities Implications

The Equality Impact Assessments will be reviewed as part of the extension arrangements, including revised proposals to be presented within the period 2022/23.

8.0 Recommendations

- That the Trust Board approves an up to twelve month (on a six plus six month basis) extension to the Commissioner and Provider HARA Section 75 Agreements.

- That further proposals for future development of the service and any revisions to the Section 75 Agreements are brought back for consideration within the extension period, to enable any decisions and public consultation to take place with respect to longer-term arrangements being agreed beyond the period of this extension.

Chris Watson, Alliance Director, Harrogate and Rural Alliance
March 2023.

Annex 1

Not included for HDFT

Annex 2

DATED 3rd October 2019

Harrogate Rural NHS Foundation Trust (1)

And

North Yorkshire County Council (2)

SECTION 75 PARTNERSHIP AGREEMENT

For the creation of shared service delivery arrangements for Health Care, Public Health and Adult Social Care Service in the geography of Harrogate and Rural District

These arrangements include the use of Section 75 powers to establish core and aligned budgets to support delivery of integrated services to the Harrogate and Rural District population

Harrogate and District NHS Foundation Trust

North Yorkshire County Council

On behalf of Harrogate and District NHS Foundation Trust
Jonathan Coulter, Chief Executive Officer

The Trust's Responsible Officer:
Russell Nightingale, Chief Operating Officer

On behalf of North Yorkshire County Council
Richard Flinton, Chief Executive Officer

The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

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1. The Parties:

1) **HARROGATE AND DISTRICT NHS FOUNDATION TRUST** of Lancaster Park Road, Harrogate, HG2 7SX ("the Trust");

2) **NORTH YORKSHIRE COUNTY COUNCIL** of County Hall, Northallerton, DL7 8AD ("the Council")

2. Background

2.1 The Council has responsibility for commissioning and/or providing public health and social care services on behalf of the resident population of the borough of Harrogate.

2.2 The Trust has responsibility for delivering health services commissioned by NHS Harrogate and Rural District Commissioning Group ("the CCG") pursuant to the 2006 Act for the population of people resident in the Harrogate and Rural District CCG area and patients registered to GP practices within same area.

2.3 Section 75 of the Act gives powers to local authorities and clinical commissioning groups to; establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions; to establish integrated commissioning arrangements and to establish integrated management functions in relation to health and social care services.

2.4 The purpose of the Agreement is to put in place the arrangements required to govern and manage delivery of integrated services, supported by a Pooled Fund in the geography of Harrogate and Rural District. The Harrogate and Rural Alliance Board (HARAB) will be established as the vehicle through which all parties will discharge their shared responsibilities in respect of working together within the defined financial schedules. This Agreement applies to the defined health, public health and social care services provided to the residents of the North Yorkshire County Council and to patients registered with the GP Practices within the Harrogate and Rural District CCG area and whose medical services contracts are managed by the CCG.

2.5 All partner organisations within the geographical scope of the Agreement face significant financial challenges despite delivering cost saving programmes over recent years. The health and social care system overall is challenged in terms of continuing to deliver high quality care within reduced financial envelopes and within the context of austerity.

2.6 The Parties will remain sovereign in line with their statutory duties and responsibilities.

2.7 These Partnership Arrangements have been established pursuant to Section 75 of the Act and pursuant to the Regulations.

3 Joint vision

3.1 The vision for the programme is that it will:

"Deliver an integrated operating model that brings together community health and social care services for adults in Harrogate. Services will be aligned to defined primary care networks to create an enhanced local offer that delivers benefit for the population through maximising the local resource and assets"

3.2 The Parties have a shared vision of a timely transformation towards an integrated approach to commissioning and provision of health care, public health and social care services in Harrogate and Rural District. The parties believe that co-ordinating and integrating their planning, commissioning and delivery activities will help facilitate the best use of resources to support the local resident and patient population.

3.3 The ambition for the programme is that the new integrated service will:

- Have prevention as the starting point.
- Develop a new model, anchored in primary care, based on prevention, planned care and unplanned care, optimising all available resource.
- Provide care at home wherever possible.
- Focus on population health as opposed to organisations.
- Where possible, be a Primary care practice centred model (hybrid model between practices and geography).
- Include primary care daily involvement and commitment
- Have active involvement from people who use services and carers.

3.4 The value of working together as commissioners and providers locally to bring about change in a meaningful way is recognised. There is a clear desire to build on the strength of the provider and commissioner relationships in the Harrogate and Rural area to deliver affordable and sustainable health and care. Therefore, the programme aims to develop and create a new integrated service model. This Agreement reflects the Parties' commitment to the integration of services to be delivered against agreed measures of effectiveness and financial outcomes.

3.5 A Partnership Framework has been put in place to support the formal and legal arrangements between partner organisations. The objective of the Partnership Framework is to improve the outcomes for health and social care users from commissioned services through closer working between the National Health Service and Local Government to the extent (from time to time and subject to the terms of this Agreement) that it is lawful to do so and consistent with the obligations of the Parties to co-operate with each other in the planning, commissioning and delivery of services.

3.6 The Agreement is grounded in the following Principles which have been agreed by the Partners:

Principles to be applied to the integrated care delivery model	
1	Demonstrates an integrated approach to prevention and care to include physical and mental health integrated with social care.
2	Focuses on self-care and prevention to promote independence and reduce pressures on the health and social care system.
3	Clear access points for people to receive modern health and social care services from co- located teams.
4	Ensures people have access to high quality services when needed within a simplified system.
5	Works closely with the community and the voluntary sector.
6	Evidence of Alliance Agreement/partnership to facilitate whole system approach, which is about more than a document or a contract and refer to an alliance style of working, based on constructive, productive relationships.
7	Has effective governance arrangements.
8	Plans to vary the flow of money and resources are identified and agreed underpinned by risk/gain share agreements.
9	Uses whole population budgets and is not based on paying for single events (e.g. “procedures”, “admissions”, “attendances”, “contacts”).
10	Describes how outcomes will be achieved within available resources and timeframe.
11	Any shift in activity between providers within the system needs to be balanced by demonstrable shift in resource where required.
12	The change management plan supports staff through change, identifies and introduces any required new skills and promotes innovation.
13	A clear estates strategy that supports delivery of a modern health and care estate.
14	Has a strategic leadership role for General practice which recognises and develops the full spectrum of primary care service delivery.
15	Enables strong clinical and practitioner operational leadership, including the GP as the expert generalist with the person.
16	To improve the quality and efficiency of services enables the sharing of records, data and information including integrating information management and technology.
17	Enables innovation in service provision using technology.
18	Seeks continuous and effective involvement with public, patient and colleague involvement. Where service changes are proposed, ensure consultation in line with legislation and best practice.

4. Section 75 provider document purpose

4.1 The Parties believe that the integrated delivery arrangements proposed by this Agreement fulfil the objectives set out by: the North Yorkshire Health and Wellbeing Board within the Joint Health and Wellbeing Strategy; the NHS Constitution; the key plans of the NHS locally and nationally; of North Yorkshire County Council and guidance in so far as it relates to local, regional

and national requirements, the Council Plan and the Council's relevant strategic directorate business plans.

4.2 The purpose of this Section 75 Agreement is to:

4.2.2 Record the intentions of the Parties to work together in delivering health, public health and adult social care services.

4.2.3 Allow for the establishment of integrated management arrangements as set out in Schedule Four. These arrangements will be reviewed throughout the mobilisation phase (March 2019 to September 2019) to allow adjustment in line with the objectives of the Programme. Any change to the services after 1 October 2019 will be enacted in line with Clause 35 of this Agreement.

4.2.4 Describe the role of the Harrogate and Rural Alliance Board within the Partnership Framework and to make formal arrangements for its procedures and actions.

4.2.5 Describe the health, public health and social care services, as set out in Schedule Two, to be covered by the Partnership Framework.

4.2.6 Make the necessary delegation, governance, audit and regulatory arrangements to facilitate the purposes listed above as agreed by each organisation within this Agreement. Each organisation will remain sovereign for decision making through its own internal procedures.

5. Definitions and interpretation

5.1 In this Agreement, unless the context otherwise requires, Schedule One pertains.

6. Integrated service delivery

6.1 The arrangements set out in this Agreement shall be how the Parties work in partnership to deliver the services described in Schedule Two.

6.2 During the period of this Agreement the Parties will co-operate with a view to introduce integrated service delivery where appropriate and with the agreement of both Parties. Where this is not appropriate the Parties will co-operate to ensure that service delivery by all Parties is done in a co-ordinated and joined up manner.

7. Integrated service delivery objectives

7.1 The Parties shall seek to achieve the following objectives through the integrated service delivery arrangements set out in this Agreement:

7.1.1 Improved quality of care through integrated service planning and delivery arrangements.

7.1.2 Ensure better investment and spend of public monies to meet the statutory requirements of each agency and to deliver the service and financial imperatives of both parties.

7.1.3 Improved service delivery efficiencies (cashable or non-cashable) through joint planning and delivery arrangements.

7.1.4 Exploration of increased integration of service planning and delivery arrangements.

7.1.5 Progression of any steps required to develop a future procurement strategy for the better integration of services.

8. Integrated service arrangements covered by this Agreement

8.1 The Parties propose to deliver the services described in Schedule Two of this Agreement subject to the governance arrangements set out in Schedule Five of this Agreement.

8.2 The HARA service management structure, as set out in Schedule Four, will facilitate the following:

8.2.1 To oversee the use of HSCA 2012 flexibilities for establishing and then operating a Pooled Fund to support integrated service delivery between the Parties under the terms of this Agreement.

8.2.2 To manage services within the overall Pooled Fund, the component individual service elements and the required Party contributions to the Pooled Fund.

8.2.3 To monitor the Pooled Fund in accordance with NHS England guidance, making use of recommended best practice templates and to report to the Responsible Officers for sign off and in relation to any specific required annual returns relevant to the Parties' statutory duties and responsibilities in so far as they relate to this Agreement.

8.2.4 To receive proposals from the Finance Lead(s) for managing the financial aspects of the Pooled Funds for consideration by both Parties, including the initial separate management of the Parties contributions and then, following any pooling of the aligned resources, the risk management arrangements associated with this.

8.2.5 To inform (as a minimum) HARA performance reports, to include both service and financial information, in a form to be agreed, to fulfil the Parties' performance management requirements and to agree appropriate action resulting from the above reports were necessary.

8.2.6 To effectively deliver integrated service objectives and targets, ultimately demonstrating improved outcomes for service users

and making recommendations to the HARA Board as to any amendment to its functions.

8.2.7 To report to the sovereign organisations, on an appropriate basis, on the integrated service delivery arrangements to ensure appropriate reporting and accountability in line with each Party's internal governance arrangements.

8.2.8 Any other purposes as may be deemed appropriate by the Parties and agreed as set out in this Agreement.

8.3 Where there is agreement on joint service delivery, the service contract(s) will initially be between the Party with responsibility for delivery of that service and the commissioner of the service.

8.4 Following the establishment of integrated service delivery arrangements through the Pooled Fund, service provision may be undertaken by either Party or as otherwise provided for under this Agreement as long as both Parties agree as set out in a written agreement between the Parties.

8.5 Services may be flexed to maximise the opportunities for integrated service delivery where this meets the principles agreed by the Partners subject to Clause 3.7 and/or the integrated service delivery objectives set out in Clause 7 of this Agreement.

8.6 Subject to Clause 8.5, the Alliance Director will be responsible for issuing a revised Schedule Two and/or Schedule Four as a formal amendment to this Agreement.

8.7 The Finance Lead(s) will meet formally on a quarterly basis to facilitate this Agreement and, in particular consider: the forecast financial position compared to the planned financial position; operational and strategic cost pressures of each Party that may impact on this Agreement; any cumulative risk factors that may impact on this Agreement.

9. Delegations

9.1 Under the arrangements the Parties retain individual sovereignty for the specified services. Where it is deemed by the Parties that the objectives of this Agreement can be met through shared service delivery arrangements, the Parties will work together, and with other members of the Partnership Framework, in partnership (but not so as to create the legal relationship of partnership between them), to implement the shared planning and delivery arrangements set out in this Agreement. To support delivery for the services to be provided under Schedule Two the Parties agree that:

9.1.1 In the event that any delegation of powers by any of the Parties provided for under this Agreement shall require obtaining the consent or approval of any Minister of the Crown, Government Department or any other body formally constituted for that (and other) purposes then the Party required to seek such consent or

approval shall use its best endeavours to do so and in a timely fashion, efficiently and without unreasonable delay.

9.1.2 The Parties shall only delegate such powers to each other as are required to implement the terms of this Agreement and through consent and specifically reserve all other statutory powers and functions to themselves.

10. Partial or incomplete delegations

10.1 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant service as set out in Schedule Two. The Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with those statutory constraints subject to 9.1.1 and 9.1.2.

11. Parties mutual responsibilities

11.1 The Parties agree that that, where appropriate and in relation to this Agreement, they shall work together for the purposes of undertaking shared planning and delivery arrangements to achieve the objectives described in Clause 7 and shall:

11.1.1 Co-operate with each other in the conduct of all activities relating to the objectives.

11.1.2 Make the necessary delegations as set out in Clauses 9.1.1 and 9.1.2 including any formal arrangements to give all necessary third-party consents or notifications.

11.1.3 Make all and any agreed contributions into the Pooled Fund as set out in Schedule Three promptly and without deductions for the purposes of providing the services.

11.1.4 Make any necessary arrangements to make payments from the Pooled Fund as agreed by the Parties to provide the services that have been commissioned under this Agreement.

11.1.5 Operate all their related activities and services in a manner that is compatible with the objectives set out in Clause 7 so far as they are not inconsistent with their other legal obligations or formal service delivery arrangements.

11.1.6 Operate the integrated service delivery arrangements set out in Clause 8 and fulfilling all responsibilities relating to them as agreed in this Agreement.

11.1.7 Both Parties shall work in co-operation and shall endeavour to ensure that the services specified in Schedule Two are delivered with all due skill, care and attention through the Partnership Arrangements and in the spirit of the Partnership Framework.

11.1.8 Exercise candour in their dealings with each other and conduct themselves transparently in any negotiations, including

disclosing any reasonable prospect that there shall be a conflict of interest between them.

11.1.9 Unless otherwise specifically agreed in writing, overspends in relation to this Agreement are the responsibility of the relevant provider organisation.

12. Legacy contracts, transitional service arrangements

12.1 All Parties agree that any contracts for the full or partial delivery of the services specified in Schedule Two that are continuing at the date of this Agreement and which are between the Parties and other commissioners/providers (legacy contracts) will be unaffected by this Agreement.

13. Role of the Harrogate and Rural Alliance Board

13.1 The main aim of the HARAB is to deliver care wrapped around primary care networks of c. 30-50,000 population to support strategic delivery of an integrated health and social care model which optimises the Parties' resources to improve health and care outcomes for the defined population.

13.2 The HARAB will provide strategic direction on issues of operational delivery for the services described in Schedule Two of this Agreement. The HARAB will operate within a defined Terms of Reference as set out in Schedule Six of this Agreement.

13.3 Implementation of the decisions taken by the HARAB shall be under the overall direction of the Alliance Director as the lead operational manager, as reflected in the Partnership Framework.

14. Monitoring and review of the Harrogate and Rural Alliance Board

14.1 The Responsible Officers of the Parties shall from time to time agree joint arrangements to monitor and review the way the HARAB exercises it's functions as set out in this Agreement to ensure that they are exercised in compliance with the law and with the terms of this Agreement and that the way they are exercised is both effective and appropriate.

14.2 The HARAB will make any necessary reports to the Health and Wellbeing Board outside the terms of this Agreement as may be required under the HSCA 2012.

15. Financial accountability and risk sharing

15.1 Each party will maintain its existing financial accountability and internal and external audit arrangements and shall bear its own risks in relation to the integrated service delivery arrangements. By way of clarification this means that the Council will follow its Financial Procedure rules and the Trust will

follow its own Standing Financial Instructions and Standing orders as last approved by the Trust Board.

15.2 The approach to bearing risks will remain under continuous review by all Parties in line with the objectives of the Agreement relating to integrated service delivery and the management of the Pooled Fund. The default position (unless otherwise agreed by both Parties in writing) will be that the relevant provider Party who has responsibility for the service in question will be liable for the overspend subject to Clause 19.

15.3 The Alliance Director shall present an annual report to the HARAB which shall include income and expenditure received by or incurred from the Pooled Fund.

16. Pooled Fund

16.1 The Parties agree as follows:

16.1.1 Responsibility for accounting, audit and the financial reporting of the overall Pooled Fund will be the Finance Lead(s) nominated by each party.

16.1.2 The Finance Lead(s) will create a clear identifiable accounting structure within their financial systems to enable effective monitoring and reporting of the Pooled Fund and the budgets of the Individual Pooled Services.

16.1.3 The Finance Lead(s) will be responsible for maintaining an overall accounting structure for the Pooled Fund to be deployed by the Alliance Director.

16.1.4 The Parties will determine delegation of financial responsibility to the Alliance Director who will work through the HARAB to deliver the services set out in Schedule Two of the Agreement on behalf of the Parties and the HARAB.

16.1.5 The level of financial delegation pertinent to the Alliance Director will be set out in a specific Scheme of Delegation to reflect permissions in line with his employing organisation and any associated honorary contract arrangements.

16.1.6 Parties will, through the auspices of the Finance Lead(s) provide the Alliance Director and the Individual Pooled Service Budget Managers with the necessary financial advice and support to enable the effective and efficient management of the Pooled Fund and any Individual Pooled Service Budget.

16.1.7 The Alliance Director will provide information as is deemed necessary by the Parties to enable effective performance management of the Services provided under this Agreement. As a minimum, this information will include budget monitoring, service performance and workforce analysis in accordance with 15.3.

17. Operation of the Pooled Fund

17.1 The Parties will agree the Pooled Fund as set out in Schedule Three for each Financial Year in accordance with this Clause 17.1. The contributions for the Financial Year 2019/20 and indicatively for 2020/21 are as set out in Schedule Three and will be used as a basis for agreeing any future Financial Year contributions from the Parties. Such annual contributions will be evidenced in writing by insertion into the said Schedule Three as an agreed amendment.

17.2 The Parties agree that the annual Pooled Fund will be confirmed by 31 March for the following Financial Year, subject to budget setting processes. HARAB will receive notice of planned contributions within a reasonable timescale and no later than one week after the Parties have formally approved said contributions in line with sovereign organisational budget setting processes.

17.3 The Alliance Director shall ensure that Value for Money is always actively secured in making payments from the Pooled Fund to deliver the services set out in Schedule Two.

17.4 Any monies specifically allocated by the government for particular client groups, services or specific projects shall be considered and put into the relevant Pooled Service Budget subject to such discretions that funding allocations allow to the Parties. The Responsible Officers, or their nominated deputies, shall approve the expenditure plans for such grants and report appropriately for such purposes. The appropriate Individual Pooled Service Budget manager will ensure that the conditions of the grant are met. Where grants are put into relevant Pooled Service Budgets any underspends in the grant will be carried over to the next Financial Year unless this is not allowed by the conditions of the grant.

17.5 For the avoidance of doubt, all funding between the organisations supplied under this Agreement is included in each party's annual contribution to the Pooled Fund.

17.6 Where a change to the Pooled Fund is made to the extent that it is reflected in Schedule Three this should be reported to the HARAB at the earliest opportunity by the Alliance Director.

18. Contributions to the Pooled Fund

18.1 The annual Pooled Fund will normally be calculated as the initial Pooled Fund for the previous year. Annual contributions to the Pooled Fund will be agreed between the Parties and may consider, but not limited to, the following: recurrently rolled forward Funds from previous year

18.1.1 plus, or minus agreed in-year changes where recurrent (overspends or underspends)

18.1.2 plus, or minus agreed inflationary uplift

18.1.3 plus, or minus planned and agreed changes, and

18.1.4 minus planned and agreed efficiency requirements

18.2 The Parties agree that these changes must not have a detrimental financial impact on either Party unless specifically agreed with the Party adversely affected and approved by the Responsible Officers, or their nominated deputies.

18.3 Contributions agreed by Parties will be formally budgeted for prior to the start of the new Financial Year.

18.4 The Parties may not normally vary their annual contributions to the Pooled Fund during the course of the Financial Year to which the annual contribution applies. Any variations to the Parties' annual contributions must be agreed in writing by the Responsible Officers following consideration of information prepared by the Parties' respective Finance Leads.

18.5 The contribution by the Council to the Pooled Fund shall be made upon the gross figure prior to deductions for charges levied on Service Users, or any associated or expenses or as alternatively agreed.

18.6 The services set out in Schedule Two and the relevant budgets in Schedule Three shall set out any non-financial contributions (and the service or services to which they relate) of each Party including staff (Alliance Director), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

18.7 Both Parties may contribute additional resource which supports management and delivery of the integrated service model which is not detailed in Schedule Three. Such contributions will be the responsibility of each individual Party unless a variation to the Agreement is considered appropriate, subject to Clause 35.

18.8 Changes forecast to the total level of agreed Pooled Fund expenditure for the year shall be reported to the HARAB in the first instance through the Alliance Director.

18.9 The Pooled Fund shall only be used for the provision of services as set out at Schedule Two to this Agreement.

18.10 The Parties recognise that there may be scope to develop the Partnership Framework and to bring other budgets and services in addition to those specified in Schedule Two into the Pooled Fund or aligned arrangements from time to time and any such changes will be treated as variations to this Agreement and will be evidenced in writing and scheduled to this Agreement subject to Clauses 8.6 (schedule variation), Clause 35 (formal review and variation to the Agreement).

19. Pooled Fund: Underspends and overspends

19.1 The Parties have agreed that as a general principle the Pooled Fund is a defined budget for each Party as set out in Schedule 3.

19.2 In the context of this Agreement, any underspends or overspends will be the responsibility of the relevant party and not shared.

20. Division of Pooled Fund into Individual Pooled Service Budgets (PSB's):

20.1 The HARAB shall establish suitable arrangements for the purposes of creating pooled service budgets for the individual services to be provided under this Agreement to be operated in accordance with the financial governance arrangements set out in this Agreement and the budgets set out in Schedule Three.

20.2 The Partners shall agree the treatment of each Pooled Service Budget for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

21. Capital expenditure

21.1 No part of the Pooled Fund shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of the Council. While the Trust generates a resource for capital through depreciation, this has a minor impact on the services described. There are no capital budgets within the Trust linked to this Agreement. If a need for capital expenditure is identified this must be agreed by the Parties.

22. Relationship between parties and HARAB, over-arching principle of financial probity

22.1 All Parties shall promote a culture of financial probity and sound financial discipline and control in relation to the arrangements set out in this Agreement.

22.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access by them to any document, information or explanation they require from any employee, member of the Parties to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

22.3 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties respective Standing Orders and Standing Financial Instructions).

22.4 The Trust is subject to NHS Foundation Trust statutory duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the Trust's statutory duties and clinical governance obligations.

22.5 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

23. Data and information sharing

23.1 Information shall be shared between the Parties save that no commercially sensitive information shall be communicated between the Parties in the course of the operation of this Agreement without the express agreement of the Responsible Officer for either Party.

23.2 Any and all agreements between the Parties shall be subject to their duties under the Data Protection Act (the 2018 Act), the Freedom of Information Act (the 2000 Act) and the Environmental Protection Regulations 2004 (the 2004 Act).

23.3 The Parties agree that they will each co-operate with each other to enable any Party receiving a request for information under the 2000 Act, the 2004 Act or the 2018 Act to respond to a request promptly and within the statutory timescales. This co-operation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Parties as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

23.4 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act, the 2004 Act or the 2018 Act. No Party shall be in breach of Clause 23 if it makes disclosures of information in accordance with any of the Acts set out in Clause 23.

23.5 Any processing of data that is undertaken by the Parties, their servants, employees, agents or subcontractors in the course of this Agreement shall comply with the Fair Data Processing principles set out in the 2018 Act. Provisions for Data Processing, Personal Data and Data Subject are shown on Schedule 5A.

24 Confidentiality

24.1 In respect of any Confidential Information a Party receives from another Party (the "Discloser") and subject always to the remainder of this Clause 24, each Party (the "Recipient") undertakes to keep secret and strictly confidential and

shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that

:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law.

24.3 Each Party:

24.3.1 may only disclose Confidential Information to its employees (this includes individuals with Honorary Contract status) and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25. Managing conflicts of interest

25.1 The Parties shall comply with the agreed principles for identifying and managing conflicts of interest via adherence to their own policies ensuring they meet the NHS England Managing Conflicts of Interest Statutory Guidance.

25.2 Where a dispute between the parties occurs this shall be subject to Clause 26 of the Agreement.

26. Resolution of service delivery disputes between parties by mediation

26.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute.

26.2 The Responsible Officers, or their nominated deputy, shall meet in good faith as soon as possible and, in any event, within seven 7 days' notice of the dispute being served pursuant to Clause 25 at a meeting convened for the purpose of resolving the dispute.

26.3 If the dispute remains after the meeting detailed in Clause 26.2 has taken place, then the Parties will escalate the issue to the Chief Officers who shall meet in good faith as soon as possible and, in any event, within 7 days' notice of the escalation by one of the Parties.

26.4 If the dispute remains after the meeting detailed in Clause 26.3 has taken place, then the Parties will mutually agree further action to resolve the issue. If either Party does not agree to any such proposed further action, the Parties will attempt to settle such dispute by formal mediation in accordance with an independent mediation procedure as agreed by the Parties. To initiate mediation, either Party may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to the Centre for Effective Dispute Resolution (CEDR) or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Party will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, Clause 14 of the Model Mediation Procedure will apply (or the equivalent Clause of any other model mediation procedure agreed by the Parties). The Parties will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

27. Liabilities, insurance and indemnity

27.1 Subject to Clause 9, if a Party ("First Party") incurs a Loss arising out of or in connection with this Agreement or in relation to the Services to be jointly commissioned under the terms of this agreement as a consequence of any act or omission of another Party ("Other Party") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the contract under which the Services are to be provided then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

27.2 Clause 27.1 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party or the HARAB.

27.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause then the Party that may claim against the other indemnifying Party will:

27.3.1 As soon as reasonably practicable give written notice of that matter to the Other Party specifying in reasonable detail the nature of the relevant claim.

27.3.2 Not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Party (such consent not to be unreasonably conditioned, withheld or delayed).

27.3.3 Give the other Party and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purposes of assessing the metis of and if necessary, defending the relevant claim.

27.4 Each Party shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential legal liabilities arising in tort from this Agreement.

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

28. Conduct of claims

28.1 In respect of the indemnities given in this Clause 28:

28.1.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

28.1.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

28.1.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

29. Term of Agreement

29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35.

29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.

30. Continued co-operation between parties after end of the Agreement

30.1 The Parties shall continue to co-operate with each other or their statutory successors following the termination of this agreement (for any reason) with a view to ensuring the continuity of delivery of the services relating to them and the continued provision of health and social care to the served populations, subject to the requisite contractual arrangements for services.

31. Continuing contracts and liabilities arising from termination of the Agreement

31.1 In the event that this Agreement is ended then any contracts made under it will be deemed to continue as between the parties to that Agreement and the Parties will seek to co-operate under Clause 12 in relation to the arrangements made under such contracts.

32. Third party rights and contracts

32.1 Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Agreement pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

33. Governing and applicable law

33.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

33.2 Subject to Clause 26, the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arise out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

33.3 Ombudsman - The Parties will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

34. Complaints procedures

34.1 During the term of the Agreement, complaints can be made to any Party to this Agreement and will be dealt with through that Party's usual complaints process in line with the statutory complaints procedure of that Party but where the complaint relates to all Parties, they will work together to provide a joint response.

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

35. Review and variation

35.1 The Parties shall formally review the Section 75 arrangements no later than 12 months (31 March 2021) prior to expiry of the Term (31 March 2022) with a view to varying the Agreement for the period 1 April 2021 to 31 March 2022 subject to Clause 35.1 or termination of the Agreement subject to Clause 46.

35.2 Formal review as set out in Clause 35.1 will be as directed by the Responsible Officers of the Parties and shall comprise:

35.2.1 the delivery of the Functions and any related Functions

35.2.2 the extent to which the objectives of the joint service delivery arrangements are met

35.2.3 compliance with and fulfilment of national and local policies

35.2.4 financial arrangements and continuous improvement in quality of care as determined by the outcomes and benefits agreed by the Parties.

35.3 The review and variation provisions in this Clause 35 shall apply as a means of developing and refining the parties' respective functions in relation to the services and fulfilling the objectives of this Agreement.

35.4 If at any time during the term of this Agreement either Party (First Party) wishes to vary this Agreement, they must set this out in writing and submit a Variation Notice to the Other Party (Second Party) for consideration. The Second Party must confirm their agreement or disagreement in writing fourteen (14) days after the necessary internal governance processes have been undertaken.

35.5 In the event of mutual agreement to the Variation Notice then a Memorandum of Agreement shall be prepared and executed by the Parties and thereafter the variation shall be binding.

35.6 If the Second Party does not agree to the request to vary the agreement, then the variation shall not take place.

35.7 The Parties may determine to renew the Agreement at the end of the Term subject to this Clause 35.

36. Appointment of Legal Advisors

36.1 The Parties shall in all circumstances where it is practicable to do so, and where both Parties are in agreement, take a single advisor approach to seeking legal advice in relation to the implementation of this Agreement, any dispute arising from it or any proposed change to or modification of its terms.

36.2 Agreement to a single advisor approach should be confirmed in writing between the Parties and is at the discretion of the Responsible Officers, or their nominated deputies.

36.3 Where there is potential for a conflict of interest to arise, Parties may obtain separate independent legal advice at their own expense.

37. Appointment of Financial and Audit Advisors

37.1 At all times the Parties shall retain their own financial and audit advisors for their financial and governance arrangements but may make arrangements for a single advisor in relation to specific matters where it is practicable to do so, and where both parties are in agreement.

37.2 Agreement to a single advisor approach should be confirmed in writing between the parties and is at the discretion of the Responsible Officers, or their nominated deputies.

38. Responsibility for public statements, press releases and social media

38.1 The Parties shall co-operate when issuing any public statement, press release or social media communication relating to the terms of this Agreement or any activity undertaken under it or discretion exercised by reference to it to the intent that both Parties agree such statement or release which should represent the agreed position of all parties in relation to such matters.

39. Entire Agreement

39.1 The terms herein contained together with the contents of the schedules constitute the complete Agreement between the Parties with respect to planning and delivery of services as set out in Schedule Two and supersede all previous communications, representations, understandings and agreement and any representation, promise or condition not incorporated herein shall not be binding on any Party.

40. No Partnership or Agency

40.1 Nothing in this Agreement shall create or be deemed to create a legal partnership or the relationship of employer and employee or agent and principal between the Parties.

41. Invalidity and severability

41.1 If any Clause or part of this Agreement is found by any court tribunal administrative body or authority of competent jurisdiction to be illegal invalid or unenforceable then that provision will to the extent required be severed from this Agreement and will be ineffective without as far as is possible modifying any other Clause or part of this Agreement and this will not affect any other provisions of this Agreement which will remain in full force and effect.

42. Counterparts

42.1 This Agreement may be executed in any number of counterparts or duplicates, each of which shall be an original, and such counterparts or duplicates shall together constitute one and the same agreement.

43. Notice

43.1 All formal Notices relating to this Agreement shall be given by hand, pre-paid first class post (or in accordance with the Postal Services Act 2000 if applicable) or facsimile transmission confirmed by pre-paid letter to the addressee at the address given below or such other address as the addressee shall have for the time being notified to the other Party giving notice and such notice shall be deemed to have been delivered either upon delivery if by hand or if by letter at the expiration of forty eight (48) hours after posting or if by facsimile, upon receipt.

44. Addresses

44.1 For the purposes of this Agreement, the address of each Party shall be:

(1) Harrogate and District NHS Foundation Trust:
Harrogate District Hospital
Lancaster Park Road
Harrogate
North Yorkshire
HG2 7SX

(2) North Yorkshire County Council:
County Hall
Northallerton
North Yorkshire
DL7 8AD

45. Force Majeure

45.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party or incur any liability to the other Party for any losses or damages incurred by that Party to the extent that a Force Majeure Event occurs, and it is prevented from carrying out its obligations by that Force Majeure Event.

45.2 On the occurrence of a Force Majeure Event, the affected Party shall notify the other Party as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the affected Party and any action proposed to mitigate its effect.

45.3 As soon as practicable, following notification as detailed in Clause 45.2, the Parties shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 45.4, facilitate the continued performance of the Agreement.

45.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Party shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Party. For the avoidance of doubt, no compensation shall be payable by either Party as a direct consequence of this Agreement being terminated in accordance with this Clause.

46. Termination

46.1 This Agreement shall terminate upon the effluxion of time except where Clause 35 applies, or the Agreement is otherwise renewed on review by the Parties.

46.2 In the event of dispute or disagreement relating to the terms and conditions of this Agreement, which cannot be resolved under this Agreement, then either Party may, by service of 3 months' notice in writing upon the other Party, terminate this Agreement.

46.3 In the event that the Agreement terminates, responsibility for the Trust's Functions exercised under the Agreement will be returned to the Trust and responsibility for the Council's Functions exercised under the Agreement will be returned to the Council.

46.5 Either Party may terminate the Agreement at any time with immediate effect in the event that:

46.5.1 There is a change in law that materially affects the Partnership Arrangements made pursuant to this Agreement under the Regulations or renders performance of any Party's obligations (or the obligations of any other party towards that Party) ultra vires.

46.5.2 One of the Parties is in material breach of its obligations under this Agreement, provided that where the breach is remediable, the non-defaulting Party shall require the defaulting Party to remedy the breach and if the defaulting Party so remedies the breach within one month, such breach shall not give rise to a right to terminate the agreement.

46.6 In the event of immediate termination of this Agreement the Pooled Funds, including underspends and overspends shall be returned to the Parties based on proportions of contributions to the Pool. In the event of assets being purchased from the pool, the Parties will provide proposals to the Responsible Officers, or their nominated deputies, on how these will be dealt with prior to the termination of the agreement. If these proposals cannot be agreed that Parties will refer to the dispute procedure at Clause 26.

46.7 Termination of the Agreement shall be without prejudice to the rights, duties and liabilities of the Parties or any of them that have accrued prior to termination.

47. Transferability of the Agreement

47.1 In the event that any individual role or statutory function of any Party that is a fundamental requirement for the effectiveness of this Agreement shall be transferred to another organisation then:

47.1.1 The remaining Parties shall first seek to negotiate a continuation of this agreement with that organisation and if that shall not prove possible within a reasonable period (to be agreed between the Parties) then this Agreement will be deemed to have ended due to supervening impossibility of performance.

47.2 Should either Party cease to exist or cease to be responsible for the defined functions then, subject to any applicable ministerial direction or delegated legislation, this Agreement shall be deemed to continue with any other organisation that takes over substantially all its role or statutory function with the Harrogate and Rural District boundaries.

47.3 The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the Other Party, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Party's statutory functions.

Schedule One: Definitions and Interpretations of this Agreement

Definition	Means
Agreement	this Section 75 document including its Schedules and Appendices jointly agreed by the Parties for the purposes of providing the Services pursuant to the Regulations and Section 75 of the Act.
All references to any statute or statutory provision	shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.
Alliance Agreement	the separate multi-agency partnership agreement entered into by the organisations that comprise the Harrogate and Rural Alliance Board set within the Partnership Framework
Alliance Director	the nominated officer responsible for operational delivery of the Harrogate and Rural Alliance Board's integrated care operating model and who will be accountable to the HARAB for the management of the Pooled Fund in accordance with the Pooled Fund arrangements.
CCG	the NHS Harrogate and Rural District Clinical Commissioning Group.
Trust functions	means such of those Harrogate and District NHS Foundation Trust functions as may be necessary to provide the Services.
Chief Officers	means the Chief Executive Officer of the Trust and the Chief Executive Officer of the Council.
Commencement Date	1 October 2019.
Confidential Information	information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and: (a) which comprises Personal Data or Sensitive Personal Data or which relates to any Service User or his treatment or medical history; (b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or (c) which is a trade secret
Council's Functions	means such functions of the Council as may be necessary to provide the Services specified in Schedule Two.
Finance Lead(s)	the Section 151 Officer of the Council and the Finance Director of the Trust, or their nominated deputies.
Financial Year	a twelve-month period commencing on 1 April and terminating on the following 31 March.
Gender and persons	words importing any particular gender include all other genders, and the term "person" includes any individual, Partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns

Definition	Means
Harrogate and Rural Alliance (HARA)	the collective name for the services comprising the integrated service delivery model for the population covered by this Agreement.
Harrogate and Rural Alliance Board (HARAB)	the strategic forum established by the Parties and other members of the Alliance to oversee the co-ordination and delivery of the integrated services.
Harrogate and Rural District CCG area	Harrogate and Rural District CCG area within the Boundary of North Yorkshire. It includes areas in which GPs listed by the CCG are practicing and for which commissioning responsibilities exist for the registered population.
Health-Related Functions	the public health functions of the Council under the HSCA 2012 and any other functions that may be exercised by the Council in its delivery of the Services specified in Schedule Two.
In the event of a conflict	the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
Indirect Losses	loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis
Individual Pooled Service Budget Managers	being officers with delegated responsibility (for budgets and the provision of services) within an individual pooled service.
Individual Pooled Service Budgets	the budgets agreed between the Parties within the Harrogate and Rural Alliance Board to provide the services specified in Schedule Two of this Agreement from the Pooled Fund as set out in Schedule Three of this Agreement.
Integrated service delivery	a mechanism by which the Parties jointly operationally deliver a Service. For the avoidance of doubt, an integrated service delivery arrangement does not involve the delegation of any functions outside of this Agreement.
Losses	any and all direct losses, costs, claims, proceedings, damages, liabilities and any reasonably incurred expenses, including legal fees and disbursements whether arising under statute, contract or at common law but excluding indirect losses.
Mode of formal communication	subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.
Money	unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but if pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.
Non-exhaustive lists	Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.
Parties	together Harrogate and District NHS Foundation Trust and North Yorkshire County Council (provider responsibilities).
Partners	the organisations that comprise the HARA Board

Definition	Means
Partnership Arrangements	the arrangements jointly agreed by the Parties for the purposes of providing the services pursuant to the Regulations and Section 75 of the Act.
Partnership Framework	this Section 75 document (providers); a Section 75 document (commissioners) and associated Harrogate and Rural Alliance Agreement (members of the HARA Board).
Pool Host	The service provider that has responsibility for delivery of the services aligned to an Individual Pooled Service.
Pooled Fund	such fund or funds of monies received from separate contributions by the Parties for the purposes of providing the specified services to be delivered through the HARAB and which are set out in Schedule Two of this Agreement.
Pooled Fund Arrangements	means the arrangements agreed by the Parties for establishing and maintaining the Pooled Fund.
Reference to the Parties	shall include their respective statutory successors, employees and agents subject to the provision of Clause 30.1.
References to this Agreement	within its text include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.
Responsible Officers	the named individual as nominated by each Party with responsibility for overseeing this Agreement, as specified in Schedule Four of this Agreement.
Service contract	an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the services in accordance with the relevant service.
Singularity	words importing the singular only shall include the plural and vice versa.
SOSH	the Secretary of State for Health.
Staff and Employees	shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.
The Act	means the National Health Service Act 2006.
The Council	means the North Yorkshire County Council.
The Functions	means the NHS and health related functions and the Council's Functions in so far as they relate to the Agreement.
The headings in this Agreement	are inserted for convenience only and shall not affect its construction and a reference to any Schedule or clause is to a Schedule or clause of this Agreement.
The HSCA 2012	means the Health and Social Care Act 2012.
The NHS Functions	those NHS functions listed in Regulation 5 of the Regulations as are exercisable by the Trust as are relevant to the provision of the services and which may be further described in Schedule Two.
The Regulations	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No. 617 and any amendments and subsequent re-enactments.
The Service User	an individual in receipt of services commissioned under the Agreement.
The Services	the services planned, commissioned and delivered under this Agreement.
Third Party Costs	all such third-party costs (including legal and other professional fees) in respect of each service as a Party reasonably and properly incurs in the

Definition	Means
	proper performance of its obligations under this Agreement and as agreed by the Responsible Officers of this Agreement.
Words importing the singular number	shall include the plural and vice versa and words importing the masculine shall include the feminine and vice versa.
Working Day	means the normal service times for each service provider within the Alliance.

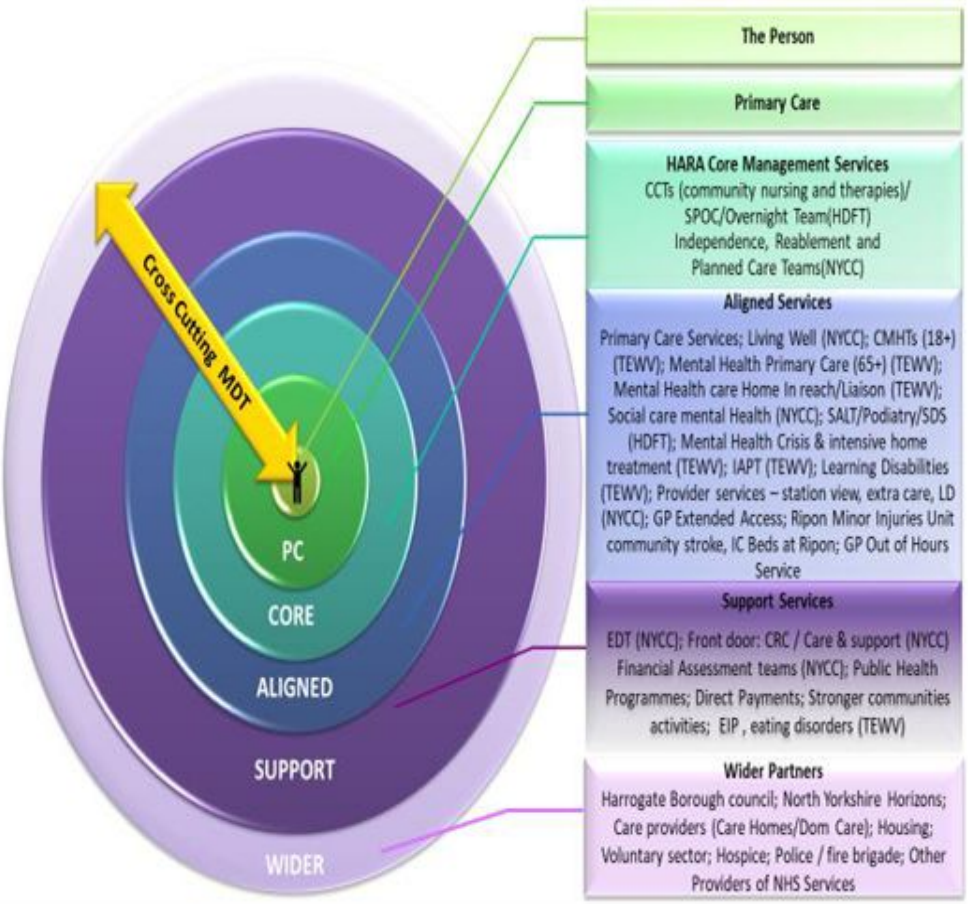
Schedule Two: Scope of services relating to this Section 75 Agreement

For clarity, the services covered by the commissioner section 75 agreement are those described as ‘Core’ and ‘Aligned’ within Figure 1. Other services may, at the discretion of the Parties and in agreement with the Partners, be brought into this Agreement subject to the conditions set out in this Entire Agreement.

In terms of this specific Agreement, it is designed to bring together the provider elements of current services described as ‘Core’, giving the Alliance Director delegated authority through a clear governance structure, as well as enabling the Alliance Director to manage operations of these health and social care services described. This complements the responsibilities of the Alliance Director described in the commissioner agreement.

The Alliance Director and their immediate Alliance Management Team (comprising of two NYCC Service Managers and two HDFT Service Managers) will have the direct responsibility for the ‘Core’ services. They will also influence the ‘Aligned’ services through the daily coordination of huddles and the wider Alliance Leadership Team which includes representatives from the ‘Aligned’ service areas.

Figure 1: Target Operating Model showing service delivery arrangements[1]



[1] Target Operating Model (13/8/19 from subgroup)

Schedule Three: Financial budgets relating to this Section 75 Agreement[2]

For the period 1 October 2019 to 31 March 2020 and indicative budgets for 2020-2021

	North Yorkshire County Council		
	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
Reablement Teams	1,629,400	814,700	1,661,988
Independence Teams	888,900	444,450	906,678
Planned Care Teams			
Pay & Other non-pay	1,909,300	954,650	1,847,486
Care Packages	40,063,800	20,031,900	40,565,076
Direct Payments	3,987,700	1,993,850	3,767,454
Total Core Services	**48,479,100**	**24,239,550**	**48,748,682**
Carers	109,400	54,700	111,588
Equipment	1,385,000	692,500	1,412,700
Senior Management Team	1,047,700	523,850	1,068,654
Living Well	275,000	137,500	280,500
Social Care Mental Health	1,772,300	886,150	1,807,746
Provider Services	2,203,300	1,101,650	2,247,366
Total Non Core / Aligned Services	**6,792,700**	**3,396,350**	**6,928,554**
Total Budget NYCC	**55,271,800**	**27,635,900**	**55,677,236**

	Harrogate and District Foundation Trust		
	Annual budget £	Oct 2019 to Mar 2020 £	Indicative budget 2020-2021 £
Community Care Teams	5,104,000	2,552,000	5,206,080
			-
Total Core Services	**5,104,000**	**2,552,000**	**5,206,080**
Community Stroke	154,000	77,000	157,080
Community Medical Devices	94,000	47,000	95,880
Ripon Community Hospital	1,103,000	551,500	1,125,059
Total Non Core / Aligned Services	**1,351,000**	**675,500**	**1,378,019**
Total Budget HDFT	**6,455,000**	**3,227,500**	**6,584,099**
Total	**61,726,800**	**30,863,400**	**62,261,335**

[2] Schedule 3 – Version 7 (13/8/19 from finance subgroup)

Schedule Four: HARA management structure relating to this Section 75 Agreement

From 1 October 2019-31 March 2021, the following arrangements will be implemented to facilitate this Agreement:

1. A senior manager, the Alliance Director appointed to manage the service and be accountable to relevant partners, as well as the HARAB. The Alliance Director will be responsible for four service managers who manage both community health services and NYCC Adult Social Care Services, with a view to developing a fully integrated management structures across the Harrogate and Rural Alliance from Year 2 onwards.

2. Tactical and operational management will be done through the current organisational leads of each of the Parties to the Agreement. For clarity these are:

    a. Harrogate and District NHS Foundation Trust: Operational Director, Long Term and Unscheduled Care

    b. North Yorkshire County Council: Assistant Director, Care and Support

3. The core services will continue to be managed by their current organisational manager in the first year of service delivery, but this may change from year two onwards. All staff will be employed by their existing employers. However, these managers will have designated locality responsibility as well.

4. The governance arrangements which operate across the HARA structure, and the context of this Agreement in the wider Partnership Framework, are set out in Schedule Five.

5. There will be clinical/practice leadership (not necessarily line management) and decision making based around the operational teams within each of the localities for the population covered by this Agreement.

6. It is the responsibility of the employing organisation to ensure that all colleagues have the required qualification, up to date professional registration (where required), statutory and mandatory training, recruitment checks and clearances (i.e. Identity, Right to Work and DBS checks).

7. Colleagues will be responsible for their own individual practice and must work within their scope of competence, experience and professional code of conduct (as applicable).

8. Clinical liability (including any subsequent claim) and responsibility for the actions of any colleague lie with the employing organisation.

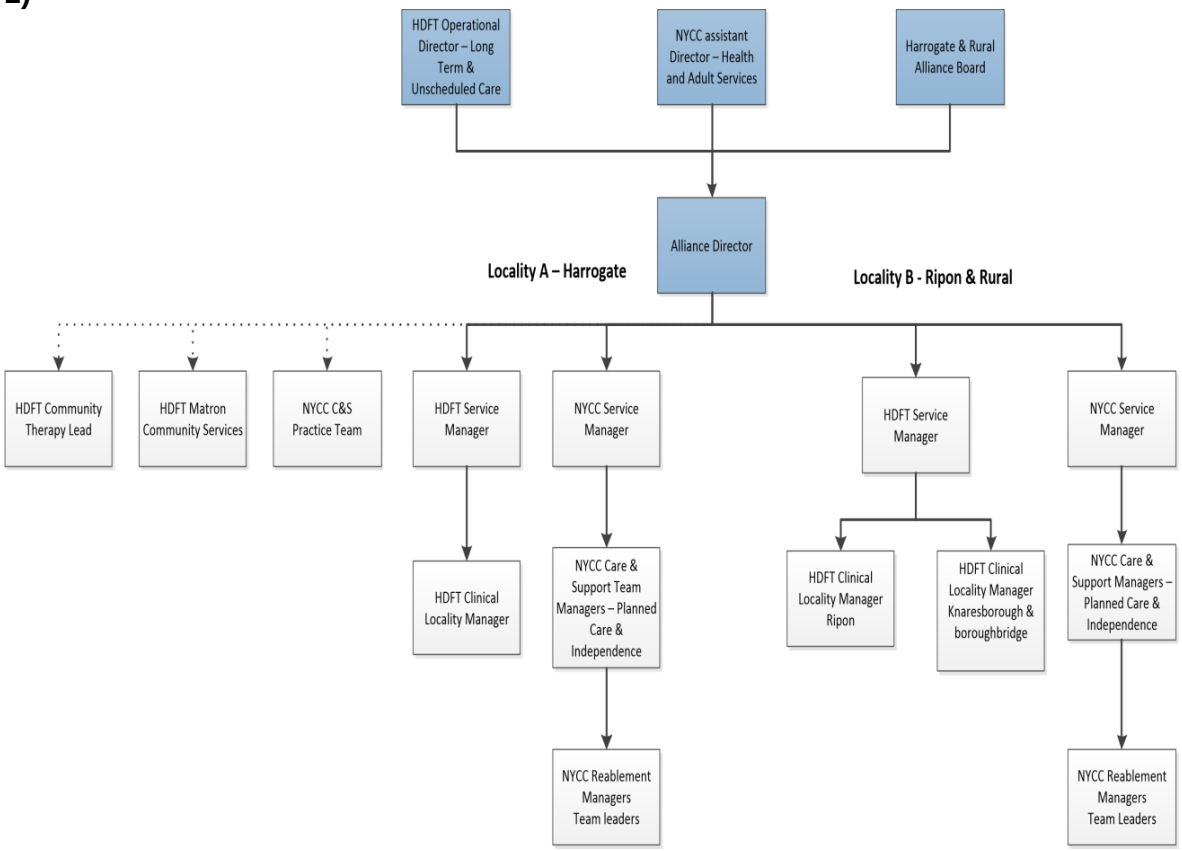
9. Where roles have joint accountabilities, e.g. as part of the integrated management structure, the Parties agree to the exchange of information regarding recruitment checks and clearances (Identity, Right to Work and Disclosure Barring Service), with the

consent of individual colleagues, to support the set-up of honorary contract arrangements, and service delivery as set out in Schedule Two of the Agreement.

10. It will be the responsibility of the employing organisation to investigate any concerns in accordance with their policies and procedures. The policies and procedures of the employing organisation of the colleague to whom the concern relates will have primacy. Where concerns relate to multiple colleagues across different employing organisations, the Parties agree to give consideration to the policies and procedures of the other Party and share relevant information in line with the Alliance Information Sharing Agreements. The Parties will adopt an approach, on a case by case basis, which supports the Alliance objectives and principles.

11. This Schedule will be updated in accordance with revisions to the HARA management structure (see Figure 2 in this Schedule) in line with changes to the service operating model, at the discretion of the Alliance Director and in liaison with the Responsible Officers, subject to Clause 8.5 and 8.6 of this Agreement.

Figure 2: Harrogate & Rural Alliance Integrated Management Structure (Year 1)[3]



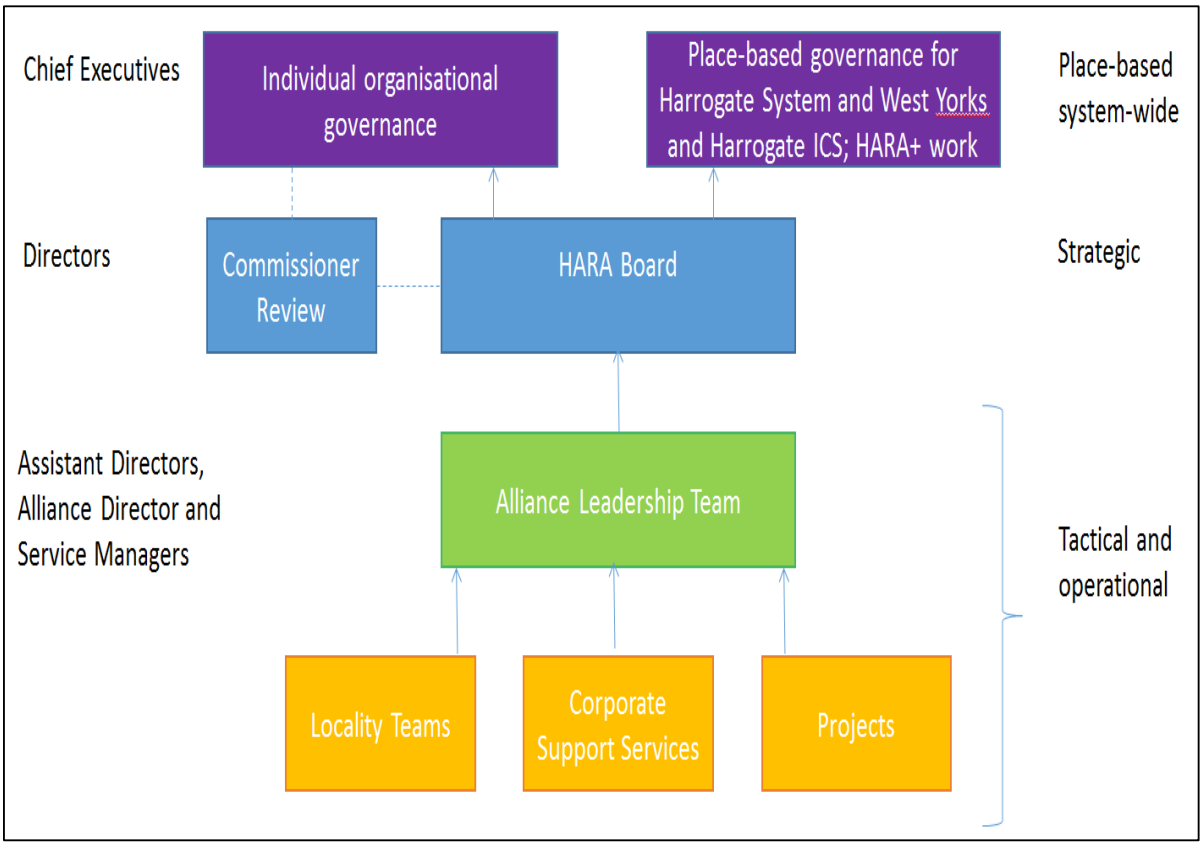
[3] HARA Management structure V4 (13/8/19)

Schedule Five: Governance arrangements relating to this Section 75 Agreement (set within the wider arrangements comprising the Partnership Framework)

(1) The Trust's Responsible Officer:
Rob Harrison, Chief Operating Officer

(2) The Council's Responsible Officer:
Richard Webb, Corporate Director of Health and Adult Services

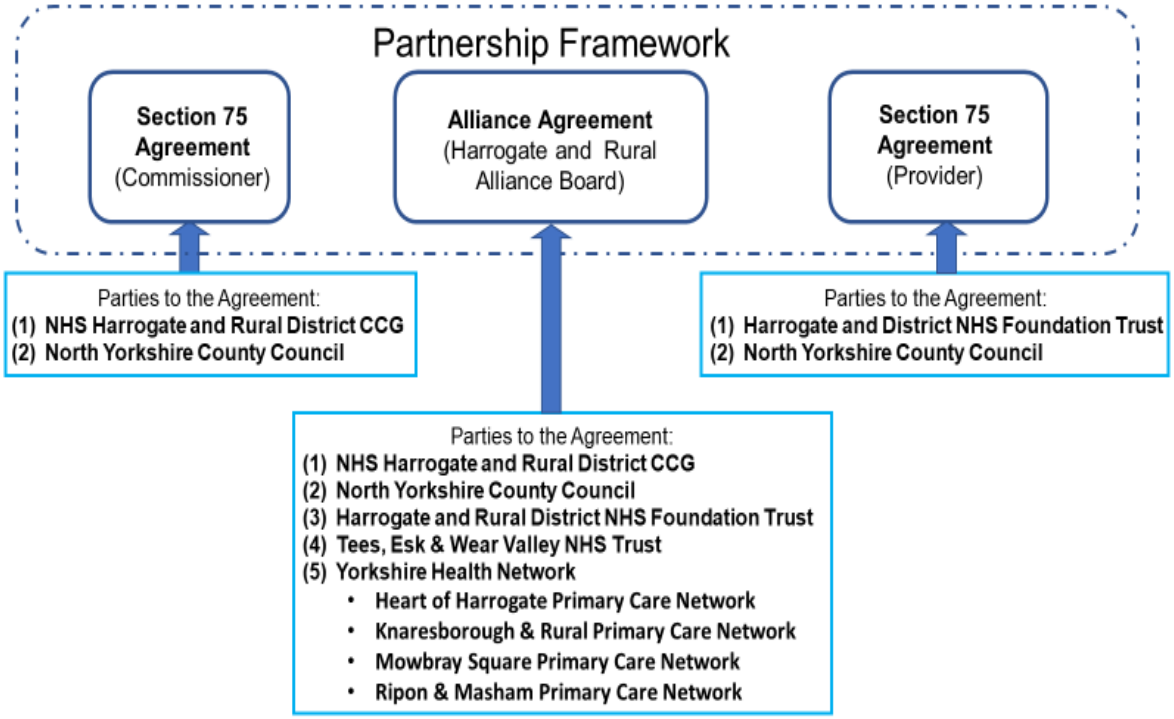
Figure 1: Governance diagram for Harrogate and Rural Alliance arrangements[4]



8.5

[4] Governance diagram as at 16/8/19

Figure 2: Relationship between this Section 75 Agreement and the wider Partnership Framework[5]



8.5

[5] Partnership Framework as at 16/8/19

SCHEDULE FIVE A DATA PROCESSING, PERSONAL DATA AND DATA SUBJECT

1. The Provider shall comply with any further written instructions with respect to processing by the Purchaser.

2. Any such further instructions shall be incorporated into this Schedule 3.

Description	Details
Subject matter of the processing	**Single Point of Access Overflow Service** To provide a continuous single point of access service for HDFT by redirecting calls that would receive an engaged call to the overflow service at NYCC whereby the referral detail are taken and referred to the Admin staff at HDFT. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **Multi Disciplinary Teams (MDT's)** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint. The purpose of the MDT's are to bring Primary Care colleagues together with Community Teams. To have a space to discuss complex cases, to share intelligence across Primary Care and Community Teams and take a preventative approach to supporting people in the community. To try and ensure health and care is more joined up and coordinated around the person and prevent that person being unnecessarily admitted to hospital Each Provider is a Data Controller in their own right. **Huddles** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Where cases are brought to the Operational Huddle discussion, the aim will be to use the professional expertise across the integrated disciplines to support better outcomes for the person in relation to their health and care needs. Each Provider is a Data Controller in their own right.

	Performance Reporting Anonymous summary performance data for each of the HARA partners to enable monitoring and decision making. Each Provider is a Data Controller in their own right. **Workforce Skills Audit** An audit of the skills of each workforce. Each Provider is a Data Controller in their own right. **Population Health Management** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. Each Provider is a Data Controller in their own right.
Duration of the processing	As per Clause 29 of the Section 75 Partnership Agreement. **29. Term of Agreement** 29.1 This Agreement will commence on 1 October 2019 and expire at 31 March 2022. Thereafter it can be extended on a year to year basis at the Parties' discretion and agreement for a maximum period of ten years subject to Clause 35. 29.2 Unless otherwise stated, the duration of the arrangements for each element of service shall be as set out in Schedule Two.
Nature and purposes of the processing	**Single Point of Access Overflow Service** The current process will for the most part remain unchanged, but for the exception where the HDFT SPOA main number is engaged then the caller will be re-routed to a different data controller (an NYCC Social Care Advisor in the customer service centre.) On receipt of the call, the Social Care Advisor will complete the required information on a word document (see below) and on completion email this to a secure HDFT SPOA email inbox. The provider will be the Data Controller and North Yorkshire County Council will be the Data Processor. **Multi Disciplinary Teams (MDT's)** A weekly MDT of 60-90 minutes will be held within the four Primary Care Networks across the Harrogate and Rural District footprint to bring Primary Care colleagues together with Community Teams to ensure

	health and care is more joined up and coordinated around the person by sharing intelligence across Primary Care and Community Teams to enable a preventative approach to supporting people in the community Each Provider is a Data Controller in their own right. **Huddles** The Operational Huddles will be led in each of the 4 areas by the relevant Team Managers from each HDFT and NYCC team. Each Organisation will access their own organisation's systems, to support understanding of capacity and resilience, as well as to share any relevant case updates where a specific person is brought to the Operational Huddle for discussion. Each Provider is a Data Controller in their own right. **Performance Reporting** Sharing of summarised performance information relating to the activities of work within the Harrogate and Rural Alliance with partners, which includes, Harrogate District Foundation Trust – (HDFT) and Yorkshire Health Network (YHN) and Tees, Esk and wear Valley Trust (TEWV). Each Provider is a Data Controller in their own right. **Workforce Skills Audit** Information will need to be gathered about resource / capacity, skill-sets, qualifications, recruitment and retention challenges. The intention is to amalgamate data sets to create a combined view of the workforce profile across the health and social care system, which can be mapped against a view of the activity/ demand in each of the four geographic areas/ networks. The data will need to be reviewed in relation to the strategic priorities and service development objectives identified by Alliance Management Team and the HARA Programme Board for Year 2, to inform the areas for the workforce model to address by developing the skills profile. Each Provider is a Data Controller in their own right.

Type of Personal Data	**<u>Personal data</u>:** General personal information: name, address, identification number, UPN, ULN, date of birth, gender, telephone number (home, mobile), NHS number Family information: parent/carer name, siblings, other family members Resource profile (turnover, vacancies, specific recruitment challenges) GP details In relation to Staff: Capacity (roles & FTE) Skills (qualifications, professional registrations, specialist skills, baseline assessment of common skills areas – to be defined e.g. mental health, motivational interviewing, digital skills); degree of competence (e.g. Basic, Confident, Expert, Can teach others) **<u>Special category data</u>:** Full history of Social Care episodes Full history of Health and Medical episodes Post looked after information Ethnic code
Type of Personal Data	**<u>Population Health Management</u>** Data sharing between HARA Organisations to provide data insights to improve health and wellbeing of the populace within Harrogate and the surrounding areas over the coming decades. This activity will likely develop over a number of phases as data sharing practices are developed and introduced. Each Provider is a Data Controller in their own right.
Categories of Data Subject	Clients, Family Members, plus providers, providers' staff, Local Authority officers, GP's, Other Professionals where applicable.
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	In line with the provider's own retention and disposal schedule.

8.5

Schedule Six: Benefit Framework and Metrics

This schedule comprises:

- Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system
- Figure Y: Operational HARA metrics for core services – day 1
- Figure Z: Harrogate and Rural Alliance Benefits Framework

Figure X: Strategic framework of benefits, metrics and commissioning priorities for HARA and the wider system

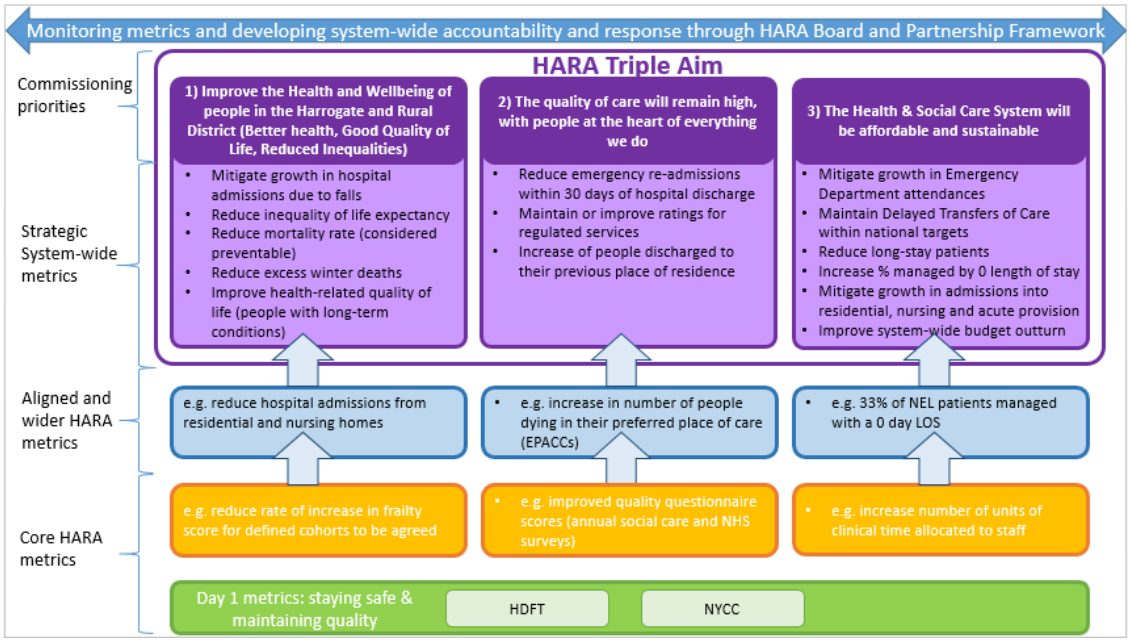


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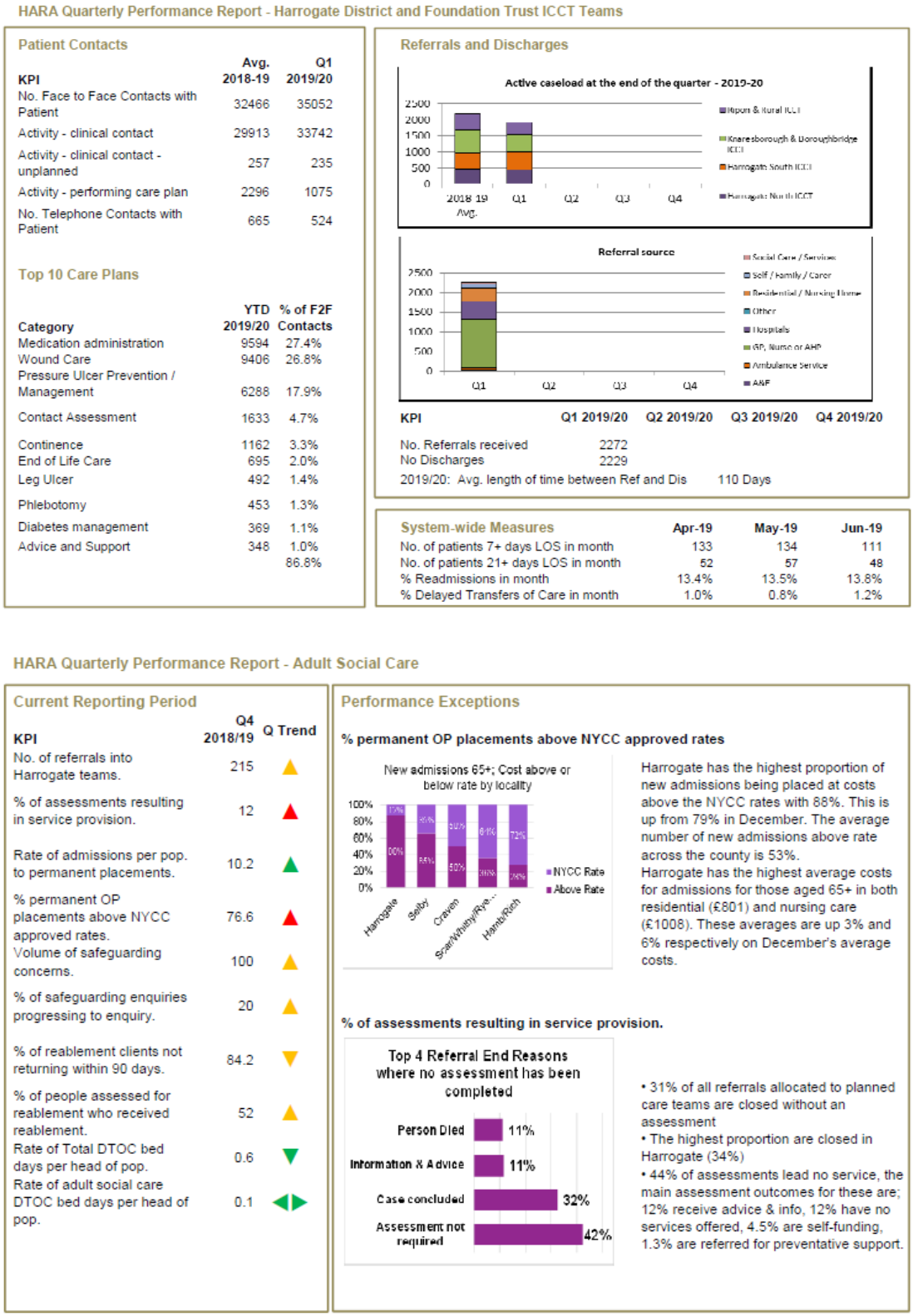
Figure Y: Operational HARA metrics for core services – day 1



HARA Quarterly Performance Report - Harrogate District and Foundation Trust ICCT Teams

Patient Contacts

KPI	Avg. 2018-19	Q1 2019/20
No. Face to Face Contacts with Patient	32466	35052
Activity - clinical contact	29913	33742
Activity - clinical contact - unplanned	257	235
Activity - performing care plan	2296	1075
No. Telephone Contacts with Patient	665	524

Top 10 Care Plans

Category	YTD 2019/20	% of F2F Contacts
Medication administration	9594	27.4%
Wound Care	9406	26.8%
Pressure Ulcer Prevention / Management	6288	17.9%
Contact Assessment	1633	4.7%
Continence	1162	3.3%
End of Life Care	695	2.0%
Leg Ulcer	492	1.4%
Phlebotomy	453	1.3%
Diabetes management	369	1.1%
Advice and Support	348	1.0%
		86.8%

Referrals and Discharges

KPI	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
No. Referrals received	2272			
No Discharges	2229			
2019/20: Avg. length of time between Ref and Dis	110 Days			

System-wide Measures	Apr-19	May-19	Jun-19
No. of patients 7+ days LOS in month	133	134	111
No. of patients 21+ days LOS in month	52	57	48
% Readmissions in month	13.4%	13.5%	13.8%
% Delayed Transfers of Care in month	1.0%	0.8%	1.2%

HARA Quarterly Performance Report - Adult Social Care

Current Reporting Period

KPI	Q4 2018/19	Q Trend
No. of referrals into Harrogate teams.	215	▲
% of assessments resulting in service provision.	12	▲
Rate of admissions per pop. to permanent placements.	10.2	▲
% permanent OP placements above NYCC approved rates.	76.6	▲
Volume of safeguarding concerns.	100	▲
% of safeguarding enquiries progressing to enquiry.	20	▲
% of reablement clients not returning within 90 days.	84.2	▼
% of people assessed for reablement who received reablement.	52	▲
Rate of Total DTOC bed days per head of pop.	0.6	▼
Rate of adult social care DTOC bed days per head of pop.	0.1	◀▶

Performance Exceptions

% permanent OP placements above NYCC approved rates

Harrogate has the highest proportion of new admissions being placed at costs above the NYCC rates with 88%. This is up from 79% in December. The average number of new admissions above rate across the county is 53%.
Harrogate has the highest average costs for admissions for those aged 65+ in both residential (£801) and nursing care (£1008). These averages are up 3% and 6% respectively on December's average costs.

% of assessments resulting in service provision.

- 31% of all referrals allocated to planned care teams are closed without an assessment
- The highest proportion are closed in Harrogate (34%)
- 44% of assessments lead no service, the main assessment outcomes for these are; 12% receive advice & info, 12% have no services offered, 4.5% are self-funding, 1.3% are referred for preventative support.

8.5

Figure Z: Harrogate and Rural Alliance Benefits Framework

Harrogate and Rural Alliance
Health and Social care working together with you

Monitoring metrics and developing system-wide accountability and response through HARA Board and Partnership Framework

HARA Triple Aim	1) Improve the Health and Wellbeing of people in Harrogate and Rural District (Better health, Good Quality of Life, Reduced Inequalities)	2) The quality of care will remain high, with people at the heart of everything we do	3) The Health & Social Care System will be affordable and sustainable
Strategic system-wide metrics	• Mitigate growth in hospital admissions due to falls • Reduce inequality of life expectancy • Reduce mortality rate (considered preventable) • Reduce excess winter deaths • Improve health-related quality of life (people with long-term conditions)	• Reduce emergency re-admissions within 30 days of hospital discharge • Maintain or improve ratings for regulated services • Increase of people discharged to their previous place of residence	• Mitigate growth in Emergency Department attendances • Maintain Delayed Transfers of Care within national targets • Reduce long-stay patients • Increase % managed by 0 length of stay • Mitigate growth in admissions into residential, nursing and acute provision • Improve system-wide budget outturn
Aligned and wider HARA metrics	• Reduction in hospital admissions from residential and nursing homes. • Increase in PAM 'activation' score - Patients who are 'activated' are likely to self-care and improve their own risks. Patients who are less activated should be targeted more. • Population Health Management measures to be identified - as approach is developed • Increase referrals to diabetes prevention programme. [consider as PCNs develop]	• Skills audit work to define training and skills data/metrics • Increase in number of people dying in their preferred place of care (EPACCs)	• Reduction in the number of Stranded/ Super Stranded Patients - patients who have been in hospital more than 21 days (HDFT target is 42% based on April 18 baseline, which HARA will support) • Reduction in Length of Stay for Non-elective admissions for targeted cohorts (over 18s) - beginning with the frailty cohort? • 33% of NEL patients managed with a 0 day LOS (link to Acute Frailty Approach and improve same day facilities)

	• Mitigate increase in prevalence of diabetes, cardio-vascular disease, respiratory conditions, sepsis [consider as PCNs develop] • Mental health metrics - further consideration needed as TEWV become more involved in HARA • Loneliness / isolation metrics [for future consideration in partnership with the voluntary sector as loneliness strategy is developed] • Reduce smoking prevalence to 15% or lower by 2021. • % of patients on repeat medications who have had a medication review in the last 12 months [consider as PCNs develop] • Cases by location and specific need group (eg LD, travellers and homeless population) • Increase service utilisation by different channels including online • Increase number of community contacts in rural areas or identified areas of deprivation		• Mitigate growth in cost of care including CHC (D2A Pathway 3) following discharge [Consider as a development opportunity in future years] • Measures of demand on GP services/extended access offer - to consider development with PCNs
Core HARA metrics	• Reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population. • Reduction in re-attendances at GP within 90 days for people on the HARA caseload [work with PCNs to develop baseline] • Reduce rate of increase in frailty score (moderately and severely frail) for defined cohorts to be agreed • Reduction in number of urgent and scheduled visits (HDFT) for those	• Reduce number of complaints and increase number of commendations received (in relation to the number of people in receipt of a service) • Improved quality questionnaire scores (annual social care and NHS surveys) - Friends and Family test % of responses indicating Extremely Likely or Likely to recommend service; social care questions to be identified • Case file audits demonstrating improved quality of practice against CQC and professional standards	• Reduced budget out-turn / overspend for commissioning organisations (NYCC, CCG) • Reduction in the number of non-elective admissions for patients in target population cohorts (beginning with frailty cohort, further cohorts to be agreed) • Increase proportion of patients discharged to their usual place of residence. • Maintain the average total monthly delayed transfers of care (attributable

	on HARA caseload / target cohorts to be identified • Reduction in number of NYCC open planned care cases • Increase the % of people assessed for reablement who go on to receive a reablement service • Mitigate growth in A&E attendances for targeted cohorts (over 18s - to be defined after PHM work) [cross-reference to affordable and sustainable system] • NYCC - reduction in assessment completion timescale • Reduction in waiting time for therapy services (NYCC and HDFT) • Maintain and improve on 4hr response to urgent clinical need • Decreased % No Further Action and proportion of contacts diverted at the front door (SPOC or CRC) (NYCC) [data and service development of SPOA required to measure this for HDFT patients]	• Increase the proportion of carers/patient groups/representatives who report that they have been included or consulted in discussions - beginning with Therapy Outcome Measure metrics (reablement) • Increase the reporting of low and no harm incidents, evidencing increased awareness and opportunities for shared learning • Reduction in staff sickness • Increase response rate and increase overall staff satisfaction for surveys: annual social work health check; NYCC staff survey; HDFT annual staff survey: questions from all to be identified. • Number of staff in the alliance (FTE) • % of huddles (daily) and MDTs (weekly) held • % MDTs attended by GPs • Increase in remote log-ons for HARA workforce • Progress reporting against agreed milestones for integrated working • Maintaining or improving CQC inspection outcomes for Adult Community Services, Reablement Delivery and NYCC in-house provision (Station View)	to either NHS, Social Care or both) per 100,000 below NHSE targets • Maintain proportion of beds occupied by a reportable delay within target (target is no more than 3.5% of beds) • Reduction in budget out-turn / overspend for provider organisations (HDFT, NYCC) • Improve OPEL levels for HARA services • Increase in number of cases and % of whole caseload aligned to delivery through single co-ordinator (metric to be developed) • Increase in remote log-ons for HARA workforce • Increase in skype and video-conferencing usage for HARA workforce - increase in #minutes per staff member used • Reduction in ratio of desk space to colleague headcount for HARA workforce • Reduced rescheduling of appointments • Staff time efficiency - increase number of units of clinical time allocated to staff (HDFT); NYCC metric to be developed.

Schedule Seven: Terms of Reference for HARAB[6]

1 Purpose

1.1 The Harrogate and Rural Alliance Board (HARAB) has been established to provide strategic direction to the alliance, to provide governance and oversight of risk and to hold to account the Alliance Leadership Team (ALT) for the performance of the alliance such that it achieves the objectives set for it.

2 Status and authority

2.1 The Alliance is established by the Participants, who remain sovereign organisations, to provide a financial and governance framework for the delivery of the Services. The Alliance is not a separate legal entity, and as such is unable to take decisions separately from the Participants or bind its Participants; nor can one or more Participants 'overrule' any other Participant on any matter (although all Participants will be obliged to comply with the terms of the Agreement).

2.2 The Agreement establishes the HARAB to lead the Alliance on behalf of the Participants. As a result of the status of the Alliance the HARAB is unable in law to bind any Participant so it will function as a forum for discussion of issues with the aim of reaching consensus among the Participants.

2.3 The HARAB will function through engagement between its members so that each Participant makes a decision in respect of, and expresses its views about, each matter considered by the HARAB. The decisions of the HARAB will, therefore, be the decisions of the Participants, the mechanism for which shall be authority delegated by the Participants to their representatives on the HARAB.

2.4 Each Participant shall delegate to its representative on the HARAB such authority as is agreed to be necessary in order for the HARAB to function effectively in discharging the duties within these Terms of Reference. The Participants shall ensure that each of their representatives has equivalent delegated authority. Authority delegated by the Participants shall be defined in writing and agreed by the Participants and shall be recognised to the extent necessary in the Participants' own schemes of delegation (or similar).

2.5 The Participants shall ensure that the HARAB members understand the status of the HARAB and the limits of the authority delegated to them.

2.6 The HARAB operates within a Partnership Framework as set out in Figure 2 of this Terms of Reference.

3 Responsibilities

[6] Harrogate and Rural Alliance Board (HARAB) Terms of Reference as at 16/8/19

3.1 The HARAB will:

a) support alignment of service delivery in line with the Harrogate and Rural Alliance vision and objectives;
b) promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Participants;
c) formulate, agree and ensure implementation of strategies for achieving the Alliance Objectives and the management of the Alliance;
d) discuss strategic issues and resolve challenges including those escalated by the Alliance Leadership Team such that the Alliance Objectives can be achieved;
e) respond to changes in the operating environment, including in respect of national policy or regulatory requirements, which impact upon the Alliance or any Participants to the extent that they affect the Participants' involvement in the Alliance;
f) agree performance outcomes/targets for the Alliance such that it achieves the Alliance Objectives;
g) review the performance of the Alliance, holding the Alliance Director and Leadership Team to account, and determine strategies to improve performance or rectify poor performance of the Alliance;
h) ensure that the Alliance Director and Leadership Team identify and manage the risks associated with the Alliance, integrating where necessary with the Participants' own risk management arrangements;
i) generally, ensure the continued effectiveness of the Alliance, including by managing relationships between the Participants and between the Alliance and its stakeholders as set out in Figure 1 of this Terms of Reference (Stakeholder diagram);
j) contribute to the requirements of relevant regulators in respect of the services in the scope of the Alliance and other stakeholders through appropriate means, as determined by the Participants
k) oversee the implementation of, and ensure the Participants' compliance with this Agreement and ensure that Alliance activities do not jeopardise any of the individual Participants' contractual requirements;
l) review the governance arrangements for the Alliance at least annually.

4 Accountability

4.1 The HARAB is accountable to the Participants through the representatives delegated as members on behalf of the Participants.

4.2 The minutes shall be accompanied by a report on any matters which the Chair considers to be material. It shall also address any minimum content for such reports agreed by the Participants.

4.3 The minutes of the HARAB meetings will be sent to the Participants (usually via the HARAB membership) in advance of the next meeting.

5 Membership and Quorum

5.1 The HARAB will comprise:

5.1.1 Harrogate and District NHS Foundation Trust: Chief Operating Officer
5.1.2 North Yorkshire County Council: Corporate Director, Health and Adult Services
5.1.3 NHS Harrogate and Rural District Clinical Commissioning Group: Director of Strategy and Integration
5.1.4 Tees, Esk and Wear Valleys NHS Foundation Trust: Director of Operations for North Yorkshire and York
5.1.5 Yorkshire Health Network: Chair of the Network

5.2 The following persons should attend meetings of the HARAB as observers but will not participate in decisions:

5.2.1 Harrogate and Rural Alliance Director
5.2.2 Harrogate and District NHS Foundation Trust: Operational Director, Long Term and Unscheduled Care
5.2.3 North Yorkshire County Council: Assistant Director, Care and Support
5.2.4 Primary Care Networks: A Clinical Director
5.2.5 Yorkshire Health Network: Chief Operating Officer

5.3 Others may attend on an as required basis to contribute to items.

5.4 The HARAB will be quorate if:

(a) two thirds of its members are present, of which;

(b) at least one commissioner participant, one provider participant and one primary care provider participant.

5.5 Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.6 Subject to the members present being able to represent the views and decisions of the Participants who are not present at any meeting. Where a member cannot attend a meeting, the member can nominate a named deputy to attend. Named deputies must be able to contribute and make decisions on behalf of the Participant that they are representing in accordance with individual Participant Schemes of Delegation. Deputising arrangements must be agreed with the Chair prior to the relevant meeting.

5.7 The HARAB will be chaired by a member of the Board based on a majority vote of the HARAB members on an annual basis.

5.8 The Chair will be held by the nominated member for a period of no more than

two consecutive years.

6 Conduct of Business

6.1 Meetings will be held monthly initially and from time to time as an extraordinary meeting as required by the needs of the Alliance.

6.2 The agenda will be developed in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place before the meeting is scheduled to take place. In the event members wish to add an item to the agenda they need to notify the Chair's nominated representative who will confirm this with the Chair accordingly.

6.3 At the discretion of the Chair business may be transacted through a teleconference or videoconference provided that all members present are able to hear all other parties and where an agenda has been issued in advance.

6.4 At the discretion of the Chair a decision may be made on any matter within these Terms of Reference through the written approval of every member, following circulation to every member of appropriate papers and a written resolution. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

6.5 The HARAB shall receive reports from the ALT at least quarterly.

6.6 In accordance with Clause 18.4 of the Alliance Agreement, a Rectification Notice may be issued by any organisations within the Harrogate and Rural Alliance. The Chair shall be responsible for overseeing the subsequent Rectification Meeting(s) as set out in the Alliance Agreement. In a situation where the Chair is conflicted, the non-conflicted members of the HARAB shall nominate an alternative representative to oversee this process.

7 Decision Making and Voting

7.1 Each member of the HARAB shall have one vote in any decisions and motions will be carried on a majority basis.

7.2 Majority decisions can only be carried if the voting majority include at least one of the Commissioner Participants.

7.3 Decision made subject Clause 7.1 and 7.2 shall be binding all Participants.

8 Conflicts of Interests

8.1 The members of the HARAB must refrain from actions that are likely to create any actual or perceived conflicts of interests.

8.2 The HARAB shall manage Conflicts of Interests in line with the Board's approved protocol for addressing actual or potential conflicts of interests among its members (and those of the ALT).

9 Confidentiality

9.1 Information obtained during the business of the HARAB must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information will be to inform new service models and such information should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

9.2 Members of the HARAB are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Alliance. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items should not be disclosed until such time as it has been agreed that this information can be released.

10 Support

10.1 Secretariat support to the HARAB will be provided by the employing organisation of the Chair.

11 Review

11.1 The HARAB terms of reference will be formally reviewed at least annually.

11.2 Terms of Reference Approved Date 29th August 2019

11.3 Terms of Reference Review Date 29th August 2020

Figure 1: Stakeholder diagram[7] - See Schedule 5 (Governance) of this Agreement

Figure 2: Partnership Framework[8] - See Schedule 5 (Governance) of this Agreement

[7] Stakeholder diagram as at 16/8/19
[8] Partnership Framework as at 16/8/19

8.5