Board of Directors Meeting (Public)
To be held on Wednesday 31st May 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**	Chair	Note	Attached
1.4	**Minutes of the Previous Board of Directors meeting held on 29th March 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		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	**Learning from Deaths Report Q4 2022-2023**	Medical Director	Note	Supp. Pack

3.5	**Annual Statement – Eliminating Mixed Sex Accommodation**	Director of Nursing, Midwifery and AHPs	**Approve**	Supp. Pack
3.6	**Guardian of Safe Working report**	Medical Director	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
4.2a	**Maternity Action Plan**	Director of Nursing, Midwifery and AHPs	Note	Attached
4.2b	**Maternity CQC Action Plan**	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
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
6.4	**Director of People & Culture Report**	Director of People & Culture	Note	Attached

6.5	**Public Sector Equality Duty**	Director of People & Culture	**Approve**	Attached
6.6	**Modern Slavery Annual Declaration**	Director of People & Culture	**Approve**	Supp. Pack
6.7	**National Staff Survey**	Director of People & Culture	**Approve**	Supp.Pack
6.8	**Freedom to Speak Up Guardian report**	Director of People & Culture	Note	Supp. Pack
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
7.3	**Board Assurance Framework: Healthcare innovation to improve quality and safety**	Medical Director	Note	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	**Going Concern report**	Director of Finance	**Approve**	Attached
8.3	**Annual Report and Accounts Timetable**	Director of Finance	**Approve**	Attached
8.4	**WYAAT Programme Executive minutes**	-	Note	Supp. Pack
8.5	**Collaboration of Acute Providers minutes**	-	Note	Supp. Pack
8.6	**NHS Provider Licence Annual Self-Assessment**	Chief Executive	**Approve**	Supp.Pack
9.0	**Any Other Business**	Chair	Discuss/	Verbal

	By permission of the Chair		Note/ Approve	
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Public Board meeting:** Wednesday, 26th July 2023 12:45-15:45 Venue: Crowne Plaza Hotel, Harrogate			
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 on our website. Minutes of this meeting will also be published in due course on our website.

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interests
As at 31st May 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, 29th March 2023 at 12.45
Held at Crowne Plaza 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)
Richard Stiff, Non-executive Director (RS)
Julia Weldon, Non-executive Director (JW)
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
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
Rebecca a young person who has used youth services attended for the Patient Story at Item 2.
Yvonne Youth Practitioner

Observing
2 Governors (Mike Dunn and Rick Sweeney) and one member of the press were present at the meeting.

Item No.	Item
BD/03/29/1	**Welcome and Apologies for Absence**
1.1	The Chair welcomed everyone to the meeting
1.2	Apologies for absence were received from Wallace Sampson OBE, Non-executive Director (WS), Kama Melly, Associate Non-executive Director (KM) and Emma Edgar (EE), Clinical Director for Long Term and Unscheduled Care Directorate (LTUC).
BD/03/29/2	**Patient Story**
2.1	The Board expressed their gratitude to Rebecca for sharing her story with them. Rebecca shared with the Board her journey and the support she had received from the Youth Forum. She talked to the Board about the services she had accessed including the use of an allotment and the Emotional Resilience Support services. The Youth Practitioner provided an overview of the work she does and the role of the Youth Forum.
2.2	The Clinical Director (NL) asked how Rebecca had become involved with the Youth Group. It was noted that this was through the emotional resilience service that she had accessed.
2.3	The Non-executive Director (LR) noted how important the service that the Youth Forum provides. It was noted that she had visited the allotment and what a powerful source of support this was to young people.

2.4	The Non-executive Director (CD) highlighted the impact of Covid. It was noted that the pandemic has had an impact on children and young people that have been accessing support.
2.5	The Chief Executive queried if there was anything further the organisation could do to support the teams and the young people. It was confirmed that there was more demand than could be accommodated and more work that could be done with more capacity.
2.6	The Board expressed their sincere thanks to Rebecca for being an inspirational individual.
2.7	**Resolved:** The patient story was noted.
BD/1/25/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	The Non-executive Director (JW) noted the declaration in relation to her role as Director of Public Health for the agenda.
3.3	**Resolved:** The declarations were noted.
BD/3/29/4	**Minutes of the Previous Board of Directors meeting held on 25th January 2023**
4.1	**Resolved:** The minutes of the meeting on the 25th January 2023 were approved as a correct record.
BD/3/29/5	**Matters Arising and Action Log**
5.1	The actions were noted as follows: • BD/1/25/10.3 – Integrated Board Report – it was confirmed that work was ongoing to ensure the IBR was fit for purpose. • BD/1/25/23.1 – the Director of Workforce and OD provided an update on the rainbow badge impact on policies – Action Closed.
5.2	The following matters were also noted: • The Executive Medical Director confirmed the Policy on Polices was in line with other NHS Trusts and would be the only policy that would be approved at Board.
5.3	**Resolved:** All actions were agreed as above.
BD/3/29/6	**Overview by the Chair**
6.1	The Chair thanked the Board for their support in her first year as Chair of the Trust.
6.2	It was confirmed that the Non-executive Director, Andy Papworth was confirmed as taking on the role of Vice Chair of the Trust. - Thanks were expressed to him for taking forward the role. Thanks were also expressed to Governors for supporting this.
6.3	Thanks were expressed to Remuneration Nomination and Conduct Committee Governors' for the work they had done on the review of the constituencies. Elections were due to commence shortly
6.4	Thanks were expressed to Mike Dunn and Steve Treece, Public Governors for undertaking the role of Interim Lead Governors.
6.5	Meetings continued with Friends of Harrogate Hospital and Friends of Ripon Hospital, who had been working consistently to help raise money and support the organisation.

6.6	A meeting had taken place with a former Patient Voice member and two ex governors with the Patient Experience Team to look at options on the development of patient engagement programmes and the introduction of Patient Safety Partners.
6.7	It was noted that visits had been arranged for Executives and Non-executive Directors to clinical and non-clinical departments.
6.8	SAS Doctor celebration event had taken place and it was noted as an excellent opportunity to thank this group of colleagues.
6.9	**Resolved:** The Chair's report was noted.
BD/3/29/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read.
7.2	The following points were highlighted: • As the last Public Trust Board of the financial year it was noted that Annual Planning for 2023-24 had been concluded and was included on the agenda for further discussion. • The financial deficit within local systems were noted, which was consistent across the wider NHS. Due to the financial pressures across the system there was a proposal to initiate an ICB-wide productivity programme or Board. • The Electronic Patient Record (EPR) programme across the system was highlighted. • The Care Quality Commission (CQC) report into Maternity Services had been published. • The industrial action was noted including the forthcoming Junior Doctors strike. • The Staff Survey had been published and had been discussed in detail at the February 2023 Trust Board workshop. • Thanks were expressed to colleagues for their hard work and dedication during 2022-23.
7.3	The Non-executive Director (AP) provided further comment on the CQC report and urged colleagues to read the full report and not the ratings in isolation. It was confirmed that the corresponding action plan would be submitted to the CQC in April 2023.
7.4	**Action:** An informal session to be arranged between the Executive Director of Nursing, Midwifery and AHPs and the Non-Executive Director (AP) as Maternity Safety Champions with Governor colleagues to discuss the CQC Maternity report.
7.5	**Resolved:** The Chief Executive's Report was noted.
BD/3/29/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/3/29/9 **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. The Corporate Risks in relation to this element of the BAF were highlighted.
9.2	**Resolved:** The update on Best Quality, Safest Care was noted.
BD/3/29/10 **10.1**	**Quality Committee Chair's Report** The Chair of the Committee noted that two meetings had taken place since the last full meeting of the Board.

10.2	In February 2023, the Committee received an informative presentation on the Pressure Ulcers Quality Priority. Assurance was provided to Board on the detailed and focused action plan that was in place to ensure this quality priority progressed.
10.3	Discussions had been held on cancer waiting times and this would continue to be monitored.
10.4	The Committee had focused on the Serious Incidents open actions and at the March 2023 Committee assurance was received that significant progress had been made.
10.5	The Committee at its February 2023 meeting highlighted a risk regarding the pressures within the Stroke Network.
10.6	It was noted that the Committee had begun to receive escalation reports from the Mortality Committee, Health and Safety Committee and the Infection Prevention Control Committee and assurance was noted.
10.7	In March 2023 the Committee had received an update on the Missed Results Quality Priority. The presentation was informative and the Committee had noted that the project was complex and have work still to be undertaken.
10.8	The Committee had also discussed the recent Maternity CQC inspection report and corresponding action plan. The Committee had noted their significant assurance on the quality and safety of maternity services that had been ascertained from a wider range of sources outside of the CQC inspection report.
10.9	The Committee had discussed the Safer Nursing Care Tool report in detail at the meeting and had supported the recommendations in the report.
10.10	The Non-executive Director (JC) queried if there was a digital solution for missed results. It was confirmed that digital systems can support this issue, however, it was a complex problem and this would not fix the problem in its entirety.
10.11	**Resolved:** The Board noted the content of the report.
BD/3/29/11 **11.1**	**Integrated Board Report -** Indicators from Safe, Caring and Effective domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
11.2	**Resolved:** The Board noted the content of the report.
BD/3/29/12 **12.1**	**Executive Director of Nursing, Midwifery and AHPs Report** The Executive Director of Nursing, Midwifery and AHPs' report was received and taken as read.
12.2	The positive increase in nurse staffing fill rates was noted. It had been agreed via the West Yorkshire partnership that an agreement would be entered into with Kerala Government for Nursing and AHP recruitment.
12.3	The National Deputy Chief AHP had visited the organisation and a positive visit had been noted.
12.4	A 96% trajectory for the complaints position was highlighted for March 2023.
12.5	The Associate Non-executive Director (AB) queried the ethical implications for the oversees recruitment partnership. It was confirmed that this was a reciprocal arrangement and that the government was part of the ethical framework.
12.6	**Resolved:** The Board noted the content of the report.

BD/3/29/13	**Executive Medical Director**
13.1	The Executive Medical Director took the report as read. Thanks were expressed to the support that had been provided during recent industrial action.
13.2	Haematology services had been included as part of the fragile service review that had commenced across WYAAT.
13.3	Acute stroke services had been discussed in detail at the Quality Committee as well as at recent ICB meetings. A deep dive into the stroke network had commenced due to the pressures with the system. Work was also being undertaken internally to ensure pathways were fit for purpose.
13.4	The Board was updated on the Electronic Patient Record project.
13.5	**Resolved:** The Board noted the content of the report.
BD/3/29/14	**Maternity Care Quality Commission Inspection**
14.1	The Director of Nursing, Midwifery and AHPs updated the Board on the organisation receiving the final report of the November 2022 CQC inspection into Maternity.
14.2	The narrative within the report regarding the positive comments regarding the safety of the service were highlighted.
14.3	The Safe Domain had been rated as Requires Improvement, the Well-Led Domain had been rated as Good and the overall Rating was Requires Improvement. An action plan had been produced and would be submitted to the CQC in April 2023.
14.4	The Board were informed that a small number of queries from service users had been received as a result of the report being published.
14.5	The Non-executive Director (JC) queried if the Board would receive the action plan. It was confirmed that the Board would receive the action plan via the Quality Committee.
14.6	The Non-executive Director (JC) queried the mandatory training figures. It was confirmed that a full scale review of the clinical mandatory training programme was underway.
14.7	**Resolved:** The Board noted the content of the report.
BD/3/29/15	**Safer Nursing Care Tool**
15.1	The Director of Nursing, Midwifery and AHPs took the report as read and provided the context that the Quality Committee had discussed the report in detail as highlighted by the Chair of the Quality Committee.
15.2	It was noted that it was mandated that the operational detail was required to be submitted to the Trust Board. It was confirmed that, the details within the report had contributed to the Annual Planning process.
15.3	The Non-executive Director (AP) noted the level of assurance received due to the use of the tool. This was a significant improvement and ensured robust reporting arrangements.
15.4	The Non-executive Director (AP) queried if Continuity of Carer in respect of maternity services was included within the report. It was confirmed that this was not included at this time.
15.5	The Non-executive Director (JC) noted that an executive summary for the report would be useful to help orientate the Board.

15.6	The Non-executive Director (LR) queried if mutual aid would continue. It was confirmed that mutual aid would continue as part of system working. Further work was required across the region to ensure that this capacity was planned and funded effectively.
15.7	**Resolved:** The report was noted and the recommendations supported.
BD/3/29/16	**Guardian of Safe Working Report**
16.1	**Resolved:** The Board noted the content of the report.
BD/3/29/17	**Board Assurance Framework – Great Start in Life**
17.1	The Director of Strategy provided the Board with an update on this element of the BAF.
17.2	**Resolved:** The update on Great Start in Life was noted.
BD/3/29/18	**Strengthening Maternity and Neonatal Safety**
18.1	The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery took the report as read.
18.2	The ongoing risk in relation to safeguarding was noted. It was highlighted that a Lead Midwife for Safeguarding had been recruited to. The availability of home birth cover was discussed including mitigation in place to ensure service provision.
18.3	The Birthrate plus tool was utilised to ensure safe staffing levels. A positive position with no midwifery vacancies was noted. An ongoing recruitment and retention programme was in place to maintain the position.
18.4	Badgernet was noted as having gone live and early feedback was positive.
18.5	Antenatal classes via MS Teams were now in place and a review of capacity would continue as uptake increased.
18.6	The action plan for the CQC Maternity Inspection was in place and progressing well.
18.7	The Non-executive Director (LR) queried the turnover of care support workers. It was noted that feedback had been received that the role was not as they expected. As a result a different recruitment and retention model had been put in place. It was noted that there was a national issue regarding support staff.
18.8	The Non-executive Director (AP) confirmed that staffing levels were above Birthrate Plus requirements and that included elements of Continuity of Carer. The Trust were awaiting the national report that may impact on staffing numbers.
18.9	**Resolved:** The report was noted.
BD/3/29/19	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships**
19.1	The Chief Operating Officer provided the Board with an overall update on the ambition and goals for this area of the BAF.
19.2	**Resolved:** The update on person centred, integrated care, strong partnerships was noted.

BD/3/29/20	**Resource Committee Chair Report**
20.1	The Chair of the Committee noted that a presentation had been received from the Operational Director for Planned and Surgical Care Directorate in relation to Model Hospital data and its uses.
20.2	From a financial perspective a breakeven position for 2023-24 had been forecasted.
20.3	The operational position was noted with an 81% performance within the Emergency Department noted in February 2023. Cancer performance was noted as not at the compliance level required and further work was required to improve the position.
20.4	From a workforce perspective the vacancy position was stable, with gaps noted in nursing and community services. Turnover by department was now being reviewed by the Committee.
20.5	The Committee had reviewed the Annual Plan for 2023-24 and had commended it to the Trust Board.
20.6	The Non-executive Director (JW) queried the Domiciliary Care project and questioned if further information could be circulated to the Board.
20.7	**Action:** Domiciliary Care will be provided as an update at the May 2023 meeting.
20.8	**Resolved:** The Board noted the content of the report.
BD/3/29/21	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains
21.1	The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
21.2	**Resolved:** The Board noted the content of the report.
BD/3/29/22	**Chief Operating Officers Report**
22.1	The Chief Operating Officer presented the report as read. Further information was given on the current Cancer position.
22.2	The Non-executive Director (LR) queried ambulance handover and trolley waits. Further context was provided and an update provided on the new streaming model in the ED as well as the improvement in the environment. This was anticipated to impact moving forward,
22.3	**Resolved:** The Board noted the content of the report.
BD/3/29/23	**Director of Finance Report**
23.1	The Director of Finance presented his report as read. The cash position was highlighted to the Board.
23.2	**Resolved:** The Board noted the content of the report.
BD/3/29/24	**Annual Plan**
24.1	The Director of Strategy took the report as read and noted that discussions had been held previously at Board Workshops and the relevant Sub-Committees of the Board.
24.2	The Non-executive Director (AP) noted that a review had been undertaken into staff wellbeing provision with significant work being undertaken in 2022-23.
24.3	The Chief Executive noted the currently planned financial deficit position for 2023-24 and it was confirmed that this would continue to be monitored through the Resource Committee and escalated to the Board as required as system discussions continued.

24.4	The Board expressed their thanks to all involved in the annual planning process.
24.5	**Resolved:** (i) The Board noted the content of the report (ii) The strategic objectives of the organisation for 2023-24 were confirmed and approved (iii) The Breakthrough Objectives for 2023-24 were confirmed and approved (iv) The performance targets for 2023-24 were confirmed and approved (v) The financial plan for 2023-24 were confirmed and approved (vi) The Board noted the directorate activity plans, workforce establishments and financial plans (vii) The Board noted that discussions continued with Humber and North Yorkshire ICB regarding funding for 2023-24
BD/3/29/25 **25.1**	**Board Assurance Framework – At Our Best Place to Work** The Director of Workforce and Organisational Development updated the Board on this element of the BAF.
25.2	**Resolved:** The update on the At Our Best, making HDFT the best place to work was noted.
BD/3/29/26 **26.1**	**People and Culture Committee Chair's Report** The Chair of the Committee noted a positive meeting had taken place. The Terms of Reference of the Committee were reviewed and approved.
26.2	Mandatory training was noted at 94% compliance rates, appraisals 77% and work was ongoing to increase further. The Committee had noted the changes to pension arrangements. The HR function had implemented a new governance system to track progress on HR cases. The impacts and learning from the recent strikes were discussed, this included operational and cultural learning that would be disseminated via the appropriate Sub-Committees of the Board.
26.3	The staff survey results had been received and discussed in detail. Across all 9 People Plan areas there were no areas behind the benchmark. There were actions to be taken to improve the results further and this would be monitored via the Committee. The recent Inpulse survey results had also been received.
26.4	The Committee identified no new risks.
26.5	The Committee had received the People Plan and recommended it to Board for approval.
26.6	**Resolved:** The Chair's update was noted.
BD/3/29/27 **27.1**	**Workforce Report and Organisational Development Report** The Director of Workforce and OD presented her report as read.
27.2	**Resolved:** The Board noted the content of the report.
BD/3/29/28 **28.1**	**People Plan** The Director of Workforce and OD presented the People Plan. The governance arrangements were noted and the processes that had enabled the development of the People Plan.
28.2	The Board thanked the all involved in the development of the Plan.
28.3	The Non-executive Director (RS) noted that the images were focused on clinical colleagues in the acute hospital and queried if further representative of other

	colleagues could be involved. It was confirmed that this was possible and would be actioned.
28.4	**Resolved:** The Board approved the People Plan.
BD/3/29/29 **29.1**	**Board Assurance Framework – Enabling Ambitions** The Director of Strategy updated the Board on the environment enabling ambition.
29.2	The Executive Medical Director update the Board on the Digital Transformation and Healthcare Innovation enabling ambitions.
29.3	**Resolved:** The update on the Enabling Ambitions was noted.
BD/3/29/30 **30.1**	**Innovation Committee Chair's Report** The Non-executive Director (CD) had chaired the Committee in the absence of the Chair. The Committee had not been quorate however strong discussions had taken place.
30.2	The Committee had reviewed the work plan and terms of reference of the Committee.
30.3	The Clinical Research programme had been discussed in detail and a space had been designated for clinical research facilities. Two patient stories were received and it was recommended that these could be included on a future Trust Board meeting.
30.4	Discussions had been held of the development, implementation and funding for the Electronic Patient Record (EPR).
30.5	**Action:** To circulate the deep dive on clinical research that had been received at the Committee to the Trust Board.
30.6	**Action:** A patient story to be included on the Trust Board regarding clinical research.
30.7	**Resolved:** The Chair's update was noted.
BD/3/29/31 **31.1**	**Continuous Improvement Business Case** The Director of Strategy presented the business case for continuous improvement to the Trust Board.
31.2	**Resolved:** The Board: (i) Noted The Business Case for Continuous Improvement (ii) Approved the use of the EPR capital funding to the value of £999,093 to deliver the Business Case as outlined (iii) Approved the entering into a contract to provide consultancy support with Catalysis (iv) Noted the alignment of the business case to the wider EPR programme
BD/3/29/32 **32.1**	**Director of Strategy Report** The Director of Strategy presented his report as read.
32.2	The Non-executive Director (JC) queried if a review of the wider estate would be covered in 2023-24. It was confirmed that an acute Estate Strategy was in development and a review of the 0-19 northern provision of estate was also in the plan for 2023-24.
32.3	**Resolved:** The Director of Strategy Report was noted.
BD/3/29/33 **33.1**	**Audit Committee Chair's Report** The Chair of the Committee presented his report as read. It was highlighted that:

	• The Annual Counter Fraud Plan was received, considered and approved at Committee. • The Internal Audit Programme had been received and further discussions would take place at the next meeting. • The HIF Internal Audit report was also discussed in terms of the appropriate ways to review audit activity for HIF and within HIF. • External audit highlighted the extended timeline to submit the Annual Accounts by 31st August 2023.
33.2	**Resolved:** The Board noted the content of the report.
BD/3/29/34 **34.1**	**WYAAT Programme Executive Minutes** **Resolved:** The WYAAT Programme Executive Minutes were noted.
BD/3/29/35 **35.1**	**Collaboration of Acute Providers Minutes** **Resolved:** The Collaboration of Acute Providers Minutes were noted.
BD/3/29/36 **36.1**	**Board Effectiveness Survey** The Chair thanked those who had completed the survey. The Chair, the Chief Executive and the Associate Director of Quality and Corporate Affairs would meet to review any actions to be taken.
36.2	**Action:** Discussions to be held at the August 2023 Board workshop regarding further developments as a result of the survey.
BD/3/29/37 **37.1**	**HARA Section 75 Extension** The Director of Strategy noted the report as read. It was highlighted that this had been reviewed at the Resource Committee who had recommended it for approval at Board.
37.2	**Resolved:** The Board approved the extension to the HARA Section 75 agreement.
BD/3/29/38 **38.1**	**Any Other Business** No further business was received.
BD/3/29/39 **39.1**	**Board Evaluation** Any comments to be submitted to the Chair.
BD/3/29/40 **40.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 31st May 2023.
BD/3/29/41 **41.1**	**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 May 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 Head of Performance and Planning has commenced in post. Experience from continuous improvement programmes in other trusts is that there is often significant change to their integrated board report as the strategy deployment process identified breakthrough objectives and driver metrics for improvement. Therefore the Readiness Assessment (due to complete in Jul 23) and Strategy Deployment will drive the revised IBR. As update will be provided in September 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	Update to be provided at the meeting	Overdue
BD/3/29/30.5	29 March 2023	Clinical Research	To circulate the deep dive on clinical research that had been received at the Committee to the Trust Board.	Executive Medical Director	31st May 2023	Completed following the meeting	Closed
BD/3/29/30.7	29 March 2023	Clinical Research	A patient story to be included on the Trust Board regarding clinical research.	Executive Medical Director	31st December 2023	Not Yet Due	Ongoing
BD/3/29/36.2	29 March 2023	Board Effectiveness Survey	Discussions to be held at the August 2023 Board workshop regarding further developments as a result of the survey.	Associate Director of Quality and Corporate Affairs	31st August 2023	Not Yet Due	Ongoing

2.1

BOARD OF DIRECTORS (PUBLIC)
31ST May 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.	
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	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)
MAY 2023

CHIEF EXECUTIVE'S REPORT

National and system issues

1. On 18 May, the Board of NHS England announced that the NHS would be stepping down from its level three incident (regionally led) response to CoVid-19. This came one year after the national level four incident was stepped down and follows the World Health Organisation's recent announcement that CoVid-19 is no longer a Public Health Emergency of International Concern.

2. This is a significant milestone for all of us and good news for the NHS and the whole population. How the NHS responded over the three years since the outbreak in early 2020 has been magnificent, from the initial response, through the various waves, and onto the ongoing management of the virus.

3. This is not to forget the impact that this has had on so many people, or the legacy that remains in terms of delayed treatments, mental health concerns, safeguarding levels, long CoVid, and other issues across society, but we should recognise that without the NHS responding as it has done, the impact would have been even more severe.

4. At this significant moment, I would like to thank all colleagues across HDFT for their contribution and commitment in what has been an unprecedented health emergency.

5. Two significant publications have been issued since our last Board meeting. These are the maternity delivery plan, and the primary care recovery plan, both of which were trailed in the government's autumn statement settlement for the NHS. These sit alongside the planned care and unplanned recovery plans, with the final document promised last autumn – the long term workforce strategy for the NHS – due to be issued shortly.

6. We have also heard this week the outline aims of the Labour Party in respect of the NHS, which focus on improving access, reducing deaths, prevention and out of hospital care, integration of health and social care, and reform alongside any resource commitments.

7. All of these proposals and issued plans are absolutely in line with our agreed strategy and strategic objectives, and give us the continued confidence that our focus on improving health, supported by our ambitions, and underpinned by our KITE values, is what we should be looking to do over the coming months and years.

8. The final piece of recent correspondence for the Board to be aware of is a letter in respect of delivering improved elective care standards and asks Boards to be assured about the actions we are taking. We will review this checklist and present this to Resource Committee next month.

9. In relation to our local systems, there have been a number of significant leadership changes recently. Hull University Teaching Hospital Trust (HUTH) and North Lincolnshire and Goole NHS Foundation Trust (NLAG) have appointed Jonathan Lofthouse as their

joint Chief Executive. Jonathan is currently a site Chief Executive as part of Kings College Hospitals Trust in London.

10. Rod Barnes has announced that he is leaving his role as Chief Executive of Yorkshire Ambulance Service (YAS). He is to be replaced in the interim by Peter Reading, formally Chief Executive of NLAG.

11. York and Scarborough Teaching Hospitals Trust (Y&SFT) have announced that their Chair, Alan Downey, is stepping down. He has been replaced in the interim by Mark Chamberlain whilst they recruit a permanent replacement.

12. These are some fairly significant leadership changes in a short space of time, and we will continue to offer support to all across the system whilst recognising the impact in the short term of some of the understandable disruption.

13. We have been part of discussions in both of our acute collaboratives about the future role and strategy of these partnerships. A recent timeout for the ICB has also informed discussions about the future operating model of the system. The ICB has now set up a senior leadership forum as a regular way of bringing people together, and I'll be attending the first session in early June.

14. We have submitted a final system financial plan for 2023/24 as we discussed at our Board workshop last month. This has a level of financial risk for the system but has been agreed by the national team.

15. In practical developments, we have now agreed the permanent boundary divert between Harrogate and York, which will mean that YAS will bring people to Harrogate from an extended geography. It is estimated that this will represent around 800 ambulances a year, and should therefore reduce significantly the level of ad hoc requests that we have experienced over the last year. This is an example of strong partnership working that will ensure improved patient outcomes and experience.

16. We have also now started theatre lists at Wharfedale Hospital, with the first list at the end of April. This is part of our WYAAT partnership with Leeds Teaching Hospitals Trust, and will improve access times for patients as part of the elective care recovery programme.

17. We have had discussions with a number of Local Authorities in respect of funding available to meet the recent pay award costs. There are national concerns about the impact that this could have on the Public Health Grant funding. We have raised this through NHS Providers and also the NHS regulatory system, and will endeavour to use the fact that we are the largest 0-19 service provider nationally to influence a fair funding outcome.

HDFT issues

Introduction

18. As always, there are challenges that collectively we have to manage and deal with on a daily basis. And again, as always, we will try and focus on improvement, being positive, supporting colleagues, and reflecting our values. This is vitally important if we want to deliver improvements to our patients and population. It is also crucial that we continue to

deliver what we say we will deliver, as this will ensure we have the confidence of the system and the freedom to act that results from that confidence.

Our people

19. Since our last Board meeting we have had a further period of industrial action from both our Junior Doctors and our nurses who are a part of the RCN. As before we were able to support our colleagues to appropriately take the action that they wanted to, whilst maintaining the services to patients safely across the strike period.

20. There is a financial cost to the Trust as a result of covering strike action, but the bigger issue is the opportunity cost of the time spent by colleagues ensuring that we can continue to provide safe services during these times.

21. Many colleagues were involved in planning, supporting, and delivering the services during the course of the industrial action, and as well as highlighting the opportunity cost of this work, I would like to thank all involved.

22. There is a further Junior Doctor strike planned for mid-June, and currently the RCN are balloting members about further industrial action. We will continue to support, plan, and organise our services in response to these challenges.

23. The Board will be aware that negotiations with the other health unions in respect of pay have concluded and the pay award for Agenda for Change colleagues has been accepted by the NHS staff council and is therefore being implemented. This will be paid in June. We are offering colleagues who are in receipt of Universal Credit (and for whom receiving a backdated lump sum could cause difficulties in respect of their benefit claims) the option to receive the award in smoother payments.

24. The latest Inpulse survey results have now been received. Staff engagement and positive emotions have improved, but as always, there will be teams within HDFT that require further help and support. This will be reviewed through the People and Culture Committee, and Directorates are using this feedback to target improvement.

25. Earlier this month we had a successful staff network day. Over 200 people attended through the day, and this has helped to raise the profile of our staff networks, which are there to provide support to colleagues.

26. The winter vaccine programme planning has started and we will be aiming to improve the uptake of staff vaccinations this year. We will report progress as we go through the autumn period.

Our Quality

27. Over the last two months we have reviewed both our CoVid testing guidelines and our mask wearing guidelines, in line with new guidance published nationally. Other than in particular circumstances, mask wearing is now significantly reduced, as is testing. This is consistent with the stepping down of the level three incident and in line with managing CoVid-19 as we would any respiratory virus.

28. We have submitted our action plan in response to the CQC Maternity inspection. We are well underway in delivering the agreed actions and we will oversee this through our quality governance processes and the Quality Committee. As you will read in the maternity staffing report, we continue to have a strong level of staffing within our maternity unit, which is positive.

29. Work in respect of Health and Safety continues to be a priority, with a focus on fire risk assessment and any necessary action that follows. Work has also been undertaken in respect of management of contractors and also RAAC assessments. The Health and Safety Committee is now working well and is providing the necessary challenge of the arrangements we have in place. In some areas this is raising risks and issues that need to be resolved, but the significant work of knowing where our risks and concerns are is much more progressed than previously.

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. Recent visits to our newest 0-19 services recently (Wakefield and Northumberland) have been positive and demonstrated the commitment and quality of service within these areas.

31. Our urgent care pathway performance continues to improve. This is particularly illustrated by our performance against the 4 hour Emergency Department standard and the fact that we had no 60-minute ambulance handover breaches in April. As noted earlier, we have formalised our system support and will continue to offer mutual aid to others in the system as and when needed and when we have the ability to support.

32. As reported in previous meetings, 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 again as discussed previously, the variability and resilience of our cancer delivery is the concern. We have changed some of the internal management arrangements for cancer and recently appointed a new clinical lead for cancer, to help us improve our performance.

33. We continue to deliver our elective recovery plan. We have no over 78 week waiters, and we are on track in respect of our reduction to below 65 weeks for all patients, despite some impact of the recent industrial action. Russell continues to provide strong leadership to both the WYAAT and the HNY system in respect of improved elective care performance.

Our money

34. As you will read in the report from the Finance Director, our month 1 financial position is behind plan. We have agreed a financial plan as our recent Board meeting, and it is important that we address any issues that we might have early in the financial year.

35. Whilst the industrial action will have been an additional pressure, there are other areas that we need to focus on with Directorates and Care Groups.

36. Our cash position remains positive and we are making progress against our capital programme

Other

37. Since our last Board meeting we have begun our continuous improvement programme that was identified as one of our key strategic objectives for 2023/24. We have had an extended SMT senior leaders' session to outline the programme, for which there is enthusiasm. A readiness assessment is currently underway which will inform how the programme progresses and is organised to maximise the benefit over the next 18 months.

38. Also in mid-April, there was a national launch of the NHS continuous improvement programme, with the aim of ensuring that all organisations within the NHS have structured improvement methodologies. This completely aligns with the work we have already initiated.

39. In the papers for the private board is the outline business case for our new Electronic Patient Record. This is a significant milestone and once we have had approval from the national team we will begin the process of procurement. In parallel, we have initiated a series of enabling projects and investments so that the new EPR system is aligned to improved processes and robust infrastructure. This EPR programme is a part of the system-wide programme, for which Jackie Andrews is the clinical SRO, alongside Simon Morritt (Y&SFT) as the Chief Executive lead. It is important that we work across the system to enable shared records whilst also ensuring that we as an organisation have an EPR that is fit for purpose, and we are working with colleagues across HNY to ensure that these objectives align.

40. An innovation introduced locally by one of our Trauma and Orthopaedic Consultants has been generating interest both regionally and nationally, and we are in discussions about the potential roll-out across organisations in the NHS.

41. The Royal College of Occupational Therapy visited in early May, and were very impressed with the service, in particular the Adult Community ARCHS team.

42. As you will read through the Board papers and hear from discussions, whilst there are the usual challenges that we need to manage, we are focused on delivering better care and outcomes for the patients and population. Given the national pressure, it is really important that we continue to deliver well for patients and the population and maintain the ability and headroom to continuously improve and focus on the future and well as the now. This has been emphasised very positively through our SMT, and we know that our freedom to act is linked to how we are performing. We don't make any apology for having high standards and being ambitious for the organisation, and we know that by supporting colleagues and living our values we are best placed to achieve our ambitions.

Jonathan Coulter
Chief Executive
May 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	Friends and Family Test	

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
CRR75	Health and Safety	Organisational risk to compliance with legislative requirements due to failure in making suitable and sufficient assessment of risks	4x4=16	4x2=8 (Dec 23)	Clinical Operational	Averse

teamHDFT At our best

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 • Completed • Completed • Partially Completed – action plan outstanding • Partially Completed – audit to be undertaken	
Falls To reduce the number of falls in the acute setting rated moderate and above.	Reduction in Falls rated moderate and above per 1,000 bed days		• Older people routinely risk assessed at all appointments • Those at risk of falls have an individualised multifactorial intervention • Older people who fall during admission are checked for injury • Older people in the community with a known history of recurrent falls are referred for strength and balance training • Older people who are admitted after a fall in the community offered a home assessment and safety interventions	• Partially completed – documentation in place in the community, further work required in Acute • Partially completed – available on WebV, compliance to be assessed • Partially completed – post fall initial assessment available, compliance to be assessed • Not completed – gap analysis to be undertaken and referral process developed • Partially completed – environmental assessments available, however process needs to be created for referral	
Pressure Ulcers To reduce the number of pressure ulcers in the acute setting rated moderate and above.	Reduction in pressure ulcers rated moderate and above per 1,000 bed days		• Pressure Ulcer Improvement Plan developed • PURPOSE T risk assessment tool used on all patients • Reassessment of patients as per revised SOP	• Completed • Partially completed – assessment tool available, training continuing, compliance to be confirmed • Partially completed – reassessment tool available, compliance to be confirmed	

			• 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	• 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

- Incidents (IBR 1.7 comprehensive serious incidents (SI) and Never Events) - 2 Incidents deemed to meet the Serious Incident threshold have been declared in April and investigation processes are underway.
- Complaints (IBR 2.2.2 Response Time) – April performance was 79% against the 95% trajectory. Teams continue to plan delivery of 95% standard, escalating challenges in a timely way so support can be provided

Major actions commissioned & work underway

- Review of Practice Development Team and function, application submitted for preceptorship award following review of HDFT preceptorship programme.
- Patient Safety Incident Response Framework plan shared with ICB and other Provider Organisations. Plan to launch at beginning of August
- AHP Therapists initial workshop (supported by Liz Sargent (OBE)) focused on workforce model design to support Home First and Prevention models of personalised care. Further work underway to develop further.

Positive news & assurance

- Nurse Staffing – (IBR 1.8.1 & 1.8.2) Overall Nurse staffing fill rates continue on an upward trend (above 95%). Increase in CHPPD has increased in line with fill rate increase.
- HDFT Awarded the NHS Pastoral Care Quality Award from NHS England recognising the significant work in International Recruitment
- HDFT hosted a visit by the Royal College of Occupational Therapists on 4th May 2023, particular focus on AHPs and ARCH model
- Revised Nurse Agency cascade process embedded resulting in Nurse Agency savings of 26.5k in April 2023
- Business case approved for apprenticeship CSWs and RNAs to RNs (10 RNA tops ups and 8 CSW years 1-3 run through programme)

Decisions made & decisions required of the Board

- Request for delegated authority for Quality Committee to sign off the Quality Account

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

Matters of concern & risks to escalate

Best Quality, Safest Care
- Junior Doctor rota gaps- especially general medicine

Enabling Ambitions- Digital, Research, Innovation
- Server Room AC failure repairs complete- longer term solution being worked on jointly by digital and HIF
- Indicative timescales for EPR contract award is now March 24 (but if slips all EPR capital costs will land in 2 remaining years)

Major actions commissioned & work underway

Best Quality, Safest Care
- WYAAT fragile services review (Haematology/Neurology)- good progress and clinical engagement
- WYAAT MDs- workplan & shared principles for professional areas such as appraisals, job planning and study leave policies
- T&F group set up to review Junior Doctor rota gaps ahead of e-rostering implementation
- HTA Inspection May 23- Compliance, labs, LTUC T&F
- Annual Clinical Audit programme agreed/awaiting approval SMT

Enabling Ambitions- Digital, Research, Innovation
- Project to optimise effectiveness of Wi-Fi connectivity Trust wide progressing – target completion date end May 2023

Positive news & assurance

Best Quality, Safest Care
- 2nd annual Junior Doctor/SAS Doctor/MAAP Showcase Event June 23
- Medical e-rostering business case approved by SMT
- Returns to Theatre- definition agreed and IBR reporting commencing
- Working Group for refurbished Wensleydale (new medical high dependency area) - clinical model, training, digital innovation
- IPC review of mask wearing & testing complete & changes enacted

Enabling Ambitions- Digital, Research, Innovation
- HNY ICB EPR programme board established- ways of working agreed
- EPR funding approved of £8.2m in 22/23 fully spent
- 4th year of EPR funding likely – spreading allocations over 3 more years
- WebV IP medical referrals (blue slips replacement) went live April 2023- excellent feedback from doctors, ward clerks and secretaries
- Innovation function- estate and people confirmed, significant national NHS interest in HDFT ortho digital innovation

Decisions made & decisions required of the Board

Best Quality, Safest Care

Enabling Ambitions- Digital, Research, Innovation
- OBC for EPR recommended for approval by DMG to Innovation Committee and Board

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 • Complete	
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 • Meeting May 2023 to scope	• Complete • Complete • On Track • 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 • Strategic meetings attendance plan – Jun 23	• Complete • Complete • Complete • On Track	
An operating model to support & enable services outside Harrogate	Improved outcomes for children Improved service delivery Increased staff engagement		• Children's PH Strategy Workshop – Oct 22 • Review of corporate support – Jan 23 • Review of community estate and processes – Mar 23 • Proposal for "Northern Hub" – Mar 23 • Draft Operating Model supported by Children's PH Services Board – Apr 23	• Complete • Delayed – workshop planned for 21 Jun 23 • Delayed – baseline review of community estate completed; planning meeting on 5 Jun 23 • Delayed – potential location being reviewed • Delayed – dependent on the actions above.	

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 – next Hopes for Healthcare board on 23 May • 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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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 **Action is complete – propose closing and replacing with new objectives for 2023/24 (see below)**	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	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG

Embedded immediate and essential actions from Ockenden Report (2020 & 2022)
 	
New objective proposed for 2023/24
	A robustly funded, well-staffed and trained workforce to be able to ensure delivery of safe, and compassionate, maternity care.
	
	Strengthened accountability for improvements in care with timely implementation of changes in practice following incidents and complaints and compassionate investigations involving families.
			• Continue processes already in place for reporting to Maternity Safety Champions, Trust Board and external stakeholders and bodies.
			• Review NICE guidance compliance document to assure guidelines are relevant and met.
			• Pathways of care to be clearly described, in written information in formats consistent with NHS policy and posted on the trust website.
				• Processes in place
				• Obstetrics NICE compliance:
				  ○ Relevant guidelines – 16, of which:
				  ○ Compliant – 3
				  ○ Non-compliant – 3
				  ○ Working towards compliance – 5
				  ○ Guideline under review – 5
				  ○ Not relevant - 5
				• Engagement with MVP on-going to improve the information available on the HDFT Maternity website.	

Progress actions towards the Three Year Delivery Plan for Maternity and Neonatal Services (2023) **New objective proposed for 2023/24**	Listening to and working with women and families, with compassion.		• Work with LMNS to improve Perinatal pelvic health services. • Audit of personalised care and equity and inequality	• Planning stage • Audit midwife in recruitment	
	Growing, retaining, and supporting our workforce.		• Implement equity and equality plan actions to reduce workforce inequalities • Develop a recruitment and retention improvement action plan • Maternity and neonatal leads have the time, access to training and development (Core Competency v2)	• In progress • In progress • In progress	
	Developing and sustaining a culture of safety, learning, and support.		• PSIRF implementation • Neonatal leads to participate directly in board discussions	• Planning stage • Under discussion	
	Standards and structures that underpin safer, more personalised, and more equitable care.		• Implementation of version 3 of the Saving Babies' Lives Care Bundle (once released). • Digital roadmap	• Awaiting guidance • In development	

Harrogate and District NHS Foundation Trust

4.2

Board of Directors
31st May 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 (Lead Midwife for Safety, Quality & Clinical Governance), 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 April as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
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	
	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	N/A	
Report History:	Maternity Risk Management Group, Maternity Services Forum, Senior Management Team	
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 April 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 Antenatal Clinic clerical staffing issues impacting on efficiency of the service
5.2 Safeguarding training, communication and guidelines
5.3 Homebirth service provision
5.4 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 – April 2023
Matters of concern & risks to escalate
Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).
Risk to service provision for homebirths due to unreliable homebirth cover (Score 8).
Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 6).
Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).
Risk to patient safety and experience due to shortfall in Middle Grade Obstetric staffing (Score 6).
Major actions commissioned & work underway
Three Year Delivery Plan
Maternity Assessment Action plan – new guidance and RAG rating released.
Embedding of Badgernet electronic patient record
CQC action plan on-going
Business plans in development – Core competency framework, Frenulotomy, Maternity Support Workers
Positive news & assurance
Bi-annual staffing report included.
Quarterly ATAIN report included.
Decisions made & decisions required of the Board

Narrative in support of the Provider Board Level Measures – April 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 April 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 leave 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 bands 5-7 and 13.44 WTE for Band 2 and 3 support staff. A bi-annual staffing report is included at Appendix A.

3.1 Absence position

Midwifery hours lost across maternity services –
602.25 hours (3.7 WTE) sickness absence – 4.67%
4.3 WTE maternity leave

Maternity support worker hours lost across maternity services –
198.5 hours (1.22WTE) sickness absence – 9.42%

3.2 Vacancy position

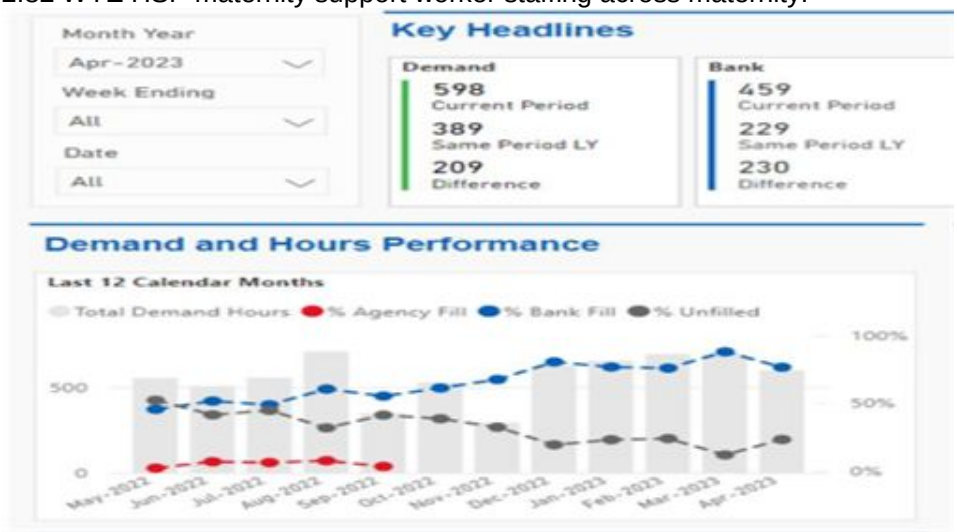
1.0WTE Band 7 ANC Manager and Public Health Specialist Midwife and 1.0 WTE Audit and Clinical Effectiveness Lead Midwife roles are currently in recruitment. 3.5 WTE newly qualified midwives (Band 5) are also being recruited as part of the Local Maternity and Neonatal System (LMNS) recruitment. These are student midwives currently due to qualify in September 2023 and will commence in post shortly after. There are also plans to advertise for a 0.6WTE Band 7 diabetes specialist midwife in the near future to assist with meeting the requirements of Saving Babies Lives version three when it is released.

There is 1.2WTE Maternity Support Worker vacancy.

3.3 NHSP provision
Midwives -
2.78 WTE NHSP midwifery staffing used in April 2023. A ‘Golden Key’ has been added to the NHSP system to require that prior to escalation of an unfilled shift to agency senior

management sign off is sought. In addition to the reduced rate paid to NHSP Bank staff this will improve spend on Bank and Agency.

Support workers –
2.82 WTE HSP maternity support worker staffing across maternity.



3.4 Homebirth provision

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

One homebirth was booked for the month of April 2023. One woman experienced her baby being ‘born before arrival’ (BBA) of the midwife.

In the period 1/3/23 – 31/3/23, the home birth provision was suspended on five occasions (16%). The service was suspended due to:

- three weekend cover issues (prior to new on-call system)

- Two episodes after the new on-call system
  - One due to sickness
  - One suspension by Labour ward manager (Manager of the day) due to acuity and staffing issues on the unit. Anticipated not being able to send on-call midwife in the event of a homebirth. (Datix submitted)

The three month pilot of on call cover is on-going in which the weekends are 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 (due to return May 2023)
1.13 WTE nurse short term absence
No long term absence

4.2 Neonatal Vacancy

2.42 WTE remaining vacancy

4.3 Neonatal Recruitment

1 WTE B5 interviews in May for over recruitment
0.92 WTE B5 QIS recruited March 2023 – Start date TBC

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.

0.61 WTE Staff nurse is currently undergoing QIS course – will have qualification by May 2023.

April 2023 - 78% QIS compliance

5.0 Birthrate Plus Acuity Staffing Data

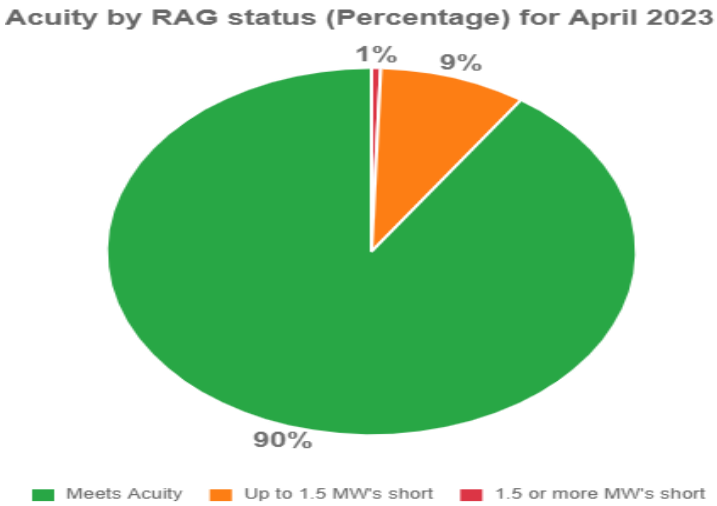
The Birthrate Plus score system is based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. Using the Birthrate Plus classification system the tool provides an assessment of women's 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

There were 160 scheduled assessment periods, of these 180 were completed, giving a confidence factor of 88.89%. Staffing met the acuity 90% of the time.



89% of the time no clinical actions were required.
11% of the occasions clinical actions were required, these included:

- Delay in continuing IOL - 7 occasions (33%)
- Delay in commencing Induction of Labour for inpatients – eight occasions (38%)
- Coordinator not supernumerary – five occasions (24%)
- Delay in elective caesarean section (5%)

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

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

5.2 Pannal Ward Staffing

There were 90 scheduled assessment periods, of these 70 were completed, giving a confidence factor of 77.78%. The data over the last month shows Pannal ward to have met acuity 79% of the time. From the data collected from Birth Rate Plus, no clinical actions were required on 89% of occasions during the reporting period. On 11% of occasions, actions were required. These included:

- Delay in induction of labour – Five Episodes (appropriately delaying an admission to start the induction process later in the day)
- No beds – One Episode (in this situation women remain on delivery suite until a bed on Pannal is available)
- Delay in discharge >2 hours – Three Episodes

31% of shifts recorded a relevant staffing factor

- Unexpected MW absence - 10 Episodes
- MW redeployed elsewhere - 7 Episodes
- Unexpected support staff absence- 2 Episodes
- Unable to fill MW shift – 1 Episode
- Unable to fill MSW shift – 1 Episode
- Admin staff less than rostered numbers – 4 Episodes

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**
RF7	**Delay between admission for induction and beginning of process**
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.

- Delay between presentation and triage >30 mins – one occasion
- Delay between admission for induction and beginning of process - 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.

Number & % of Management Actions Taken
From 01/04/2023 to 30/04/2023

MA1	Redeploy staff from Pannal	6	33%
MA2	Staff unable to take breaks	2	11%
MA3	Review of staff on management time	1	6%
MA4	Use of specialist midwife	1	6%
MA5	Use of staff on training days	0	0%
MA6	Use of ward/department managers	1	6%
MA7	Staff sourced from wider Trust (theatre & CSW's)	0	0%
MA8	Use of hospital MW on call	3	17%
MA9	Use of community MW	1	6%
MA10	Unit on Divert	3	17%
MA11	Patient diverted	0	0%
	Total	18	

Download

6.3 Pannal Ward Red Flags

There were two occasions where Red Flags identified from the BirthRate Plus data on Pannal which were:

· Delay between admission for induction and beginning of process – one episode

· Delay in providing pain relief – one episode

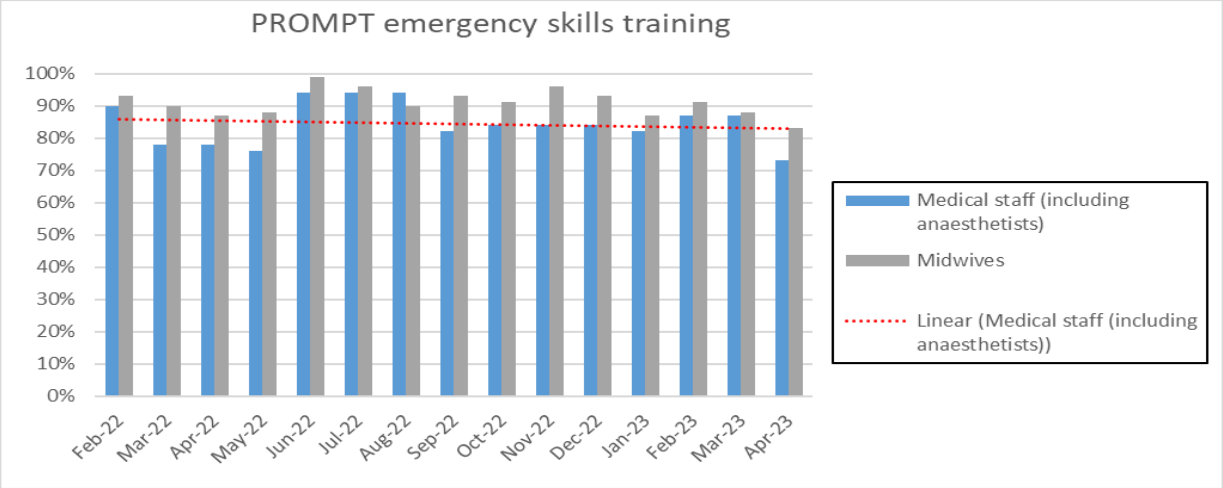
7.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

7.1 Mandatory training

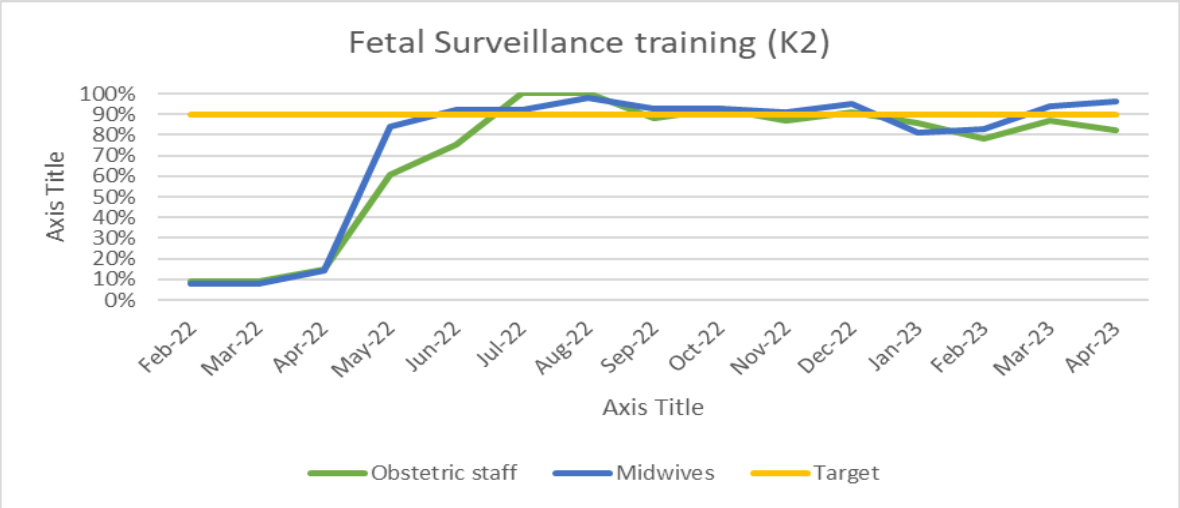
Maternity Area	***Headcount***	***Compliance***
Maternity staffing	53	88%
Community Midwifery	22	83.6%
Ante Natal Clinic	11	91.9%
Pannal Ward	21	89.6%
Obs and Gynae Medical	25	88.6%
EPAU	4	76.8%

7.2 Prompt emergency skills training

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



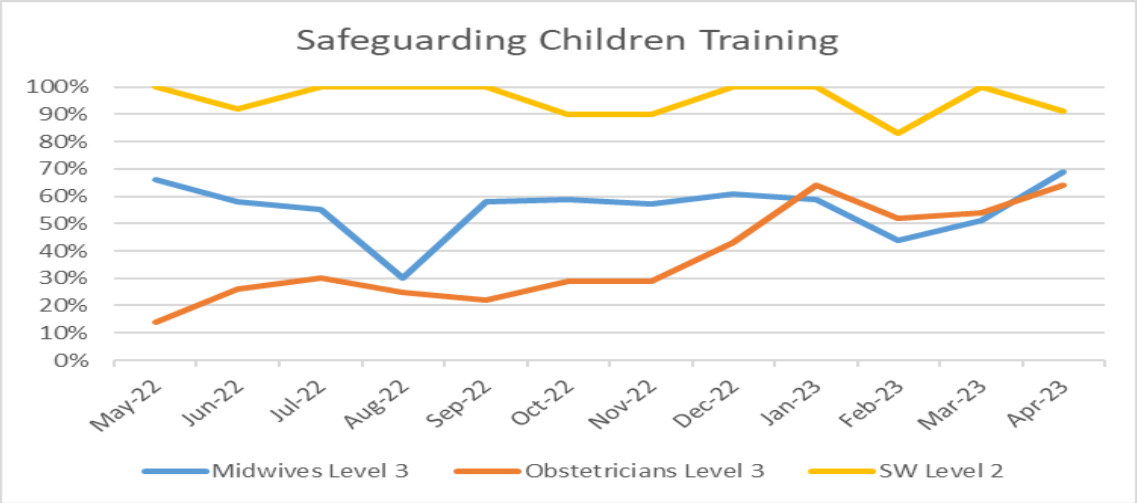
7.3 Fetal surveillance training (K2 online training package)

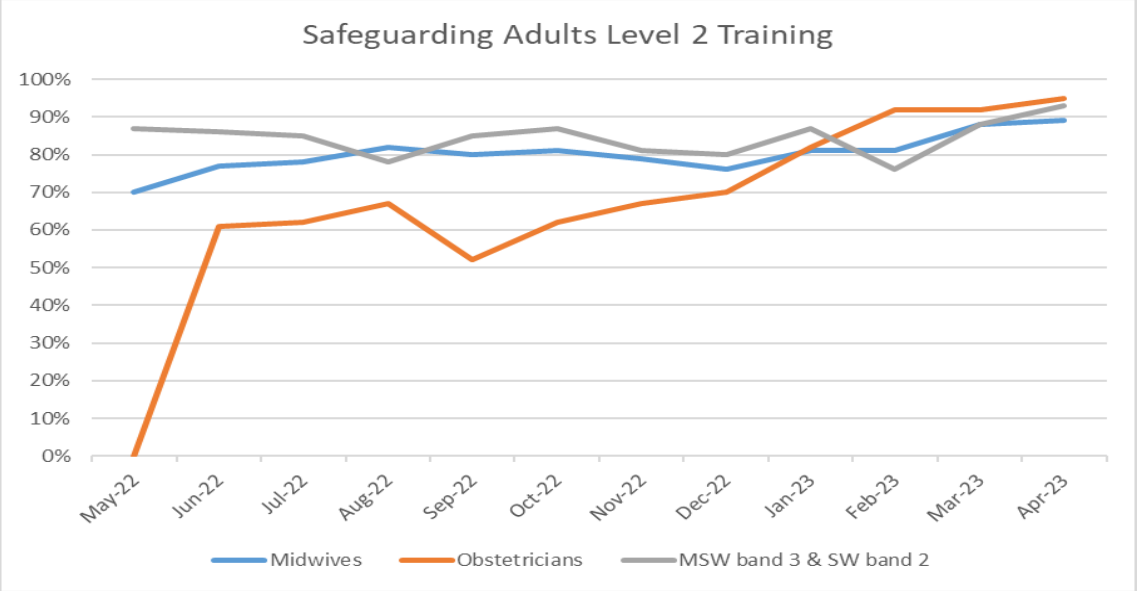


7.4 Safeguarding Children and Adults training

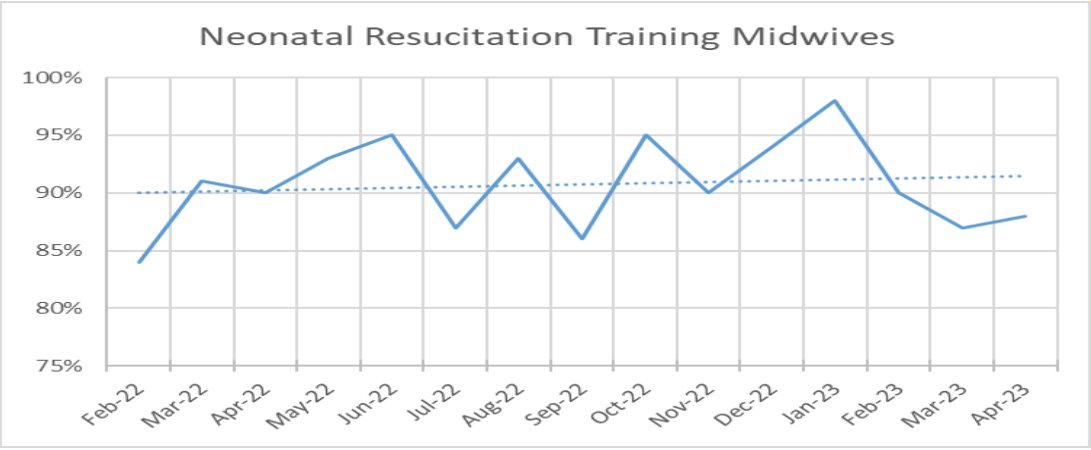
It is recognised that the staff compliance with Safeguarding Children training is not meeting the required standards. This has been added to the Risk Register and an action plan has been created. A Band 8A Named Midwife for Safeguarding job is in post from 6th March 2023. The Safeguarding Children level 3 training has been streamlined 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.





7.5 Neonatal resuscitation – Midwives



7.6 SCBU Training Compliance

Certification Name	Required	Not Achieved	Compliance %
Harrogate Newborn Advanced Life Support (HNALS)	12	5	58%
Harrogate Newborn Intermediate Life Support (HNILS)	1	0	100%
Adult Basic Life Support with paediatric modifications	13	1	92%
RCUK Newborn Life Support Face to Face	3	1	67%

8.0 Risk and Safety

8.1 Maternity unit closures

Two incidents of closure of the unit in April 2023.

One of these related to a lack of night Obstetric first on-call cover (locum non-attendance due to unintended cancellation) and decision by consultant to close unit. This resulted in two patients being diverted to other hospitals.

One related to staff sickness and no midwife on-call cover.

One additional incident report where homebirth service suspended due to inadequate staffing (two midwives sick for night shift prior to Bank Holiday weekend, and no on-call cover).

8.2 Maternity Risk register summary

No new risks added.

Eight pre-existing risks:

- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).** Issues with scheduling pregnancy appointments and missing time-critical appointment deadlines for screening. Meetings ongoing with Medical Records Team Leaders to define actions and support required.
- **Risk to patient safety and CQC compliance due to lack of formal triage risk assessment pathway for pregnant patients (Score 9).** CQC identified lack of formal triage risk assessment rating system. New MAC/triage guideline being rolled out. No current change
- **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. 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. Badgernet implemented and to monitor sharing of information. 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).** No change
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 4).** Service now awaiting required diathermy equipment before clinics can be implemented. No change at present.

8.3 Maternity Incidents

In April 2023 there were 66 total incidents reported through Datix (four were rejected due to being duplicates).

One incident currently recorded as Moderate Harm but is awaiting full review and may be downgraded.

Additional incidents of note include:

- 10 readmissions of mother/baby
  (9 babies with feeding/weight loss/jaundice; 1 maternal postnatal readmission with symptomatic anaemia)
- 4 PPH≥1500ml
- 4 babies Born Before Arrival
- 4 Unexpected Term Admissions to SCBU
- 4 Missed follow up appointments
- 3 patients appointed to wrong clinic
- One IUD<24 weeks
- One in utero transfer
- One baby born <32 weeks at HDFT

Several incidents were reported relating to ANC appointment issues.

Two incidents of closure of the unit in April 2023.
One of these related to a lack of night Obstetric first on-call cover (locum non-attendance) and decision by consultant to close unit. This resulted in two patients being diverted to other hospitals.
One related to staff sickness and no midwife on-call cover

One additional incident report where the homebirth service was suspended due to inadequate staffing as above (two midwives sick for night shift prior to Bank Holiday weekend, and no on-call cover).

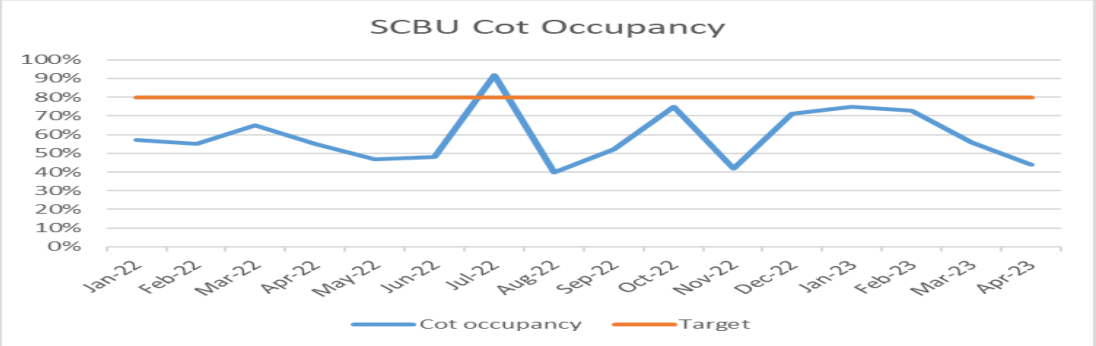
8.4 SCBU Incidents

No moderate harm incidents

8.5 SCBU Risk Register

No new risks. Video laryngoscope has now arrived and blades are available. Training is to be organised and then the risk will be reviewed and considered for archiving.

8.6 Cot occupancy and babies transferred out



8.6.1 One baby transferred out during April 2023 due to prematurity.

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 notifications for PMRT this month. One PMRT review still to complete from February 2023. HDFT are contributing to five perinatal reviews from other Trusts following providing some care to mum/baby but not all care.

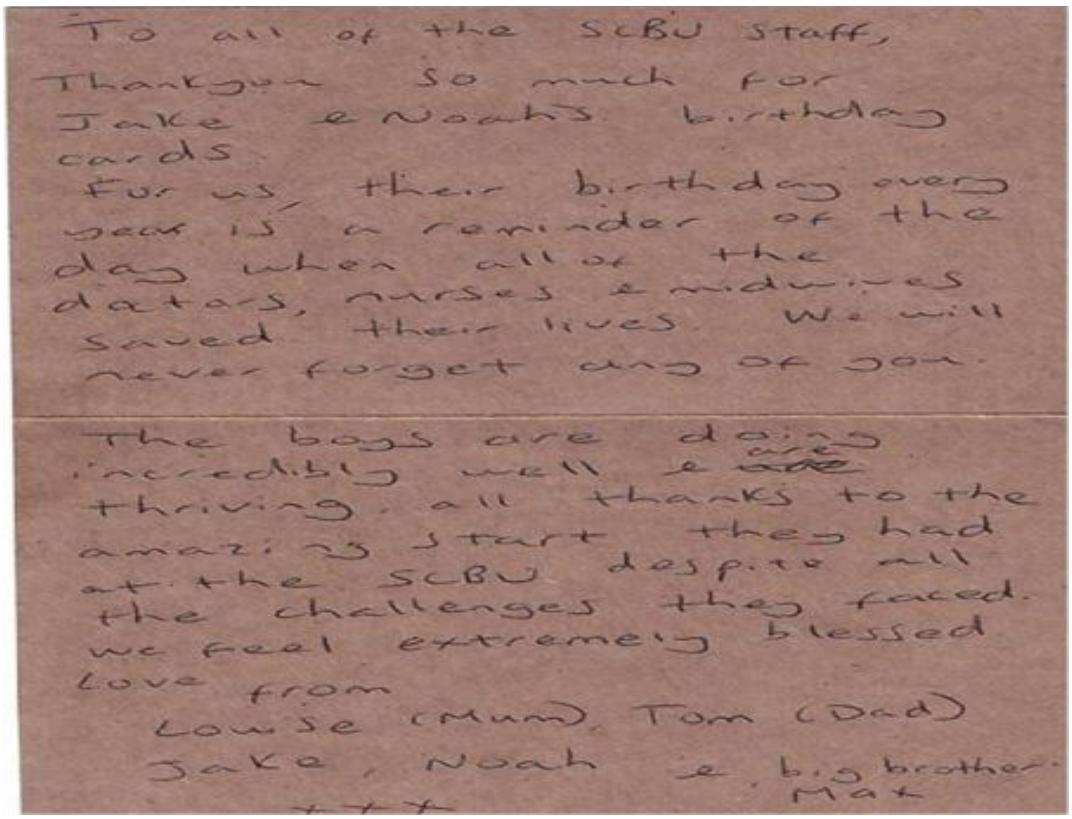
One PMRT completed this month in relation to an on-going HSIB investigation. The findings of the review gave a grading of care as follows:
C - Care issues which they considered may have made a difference to the outcome for the baby
A - No care issues identified from birth up to the point that the baby died
D - Care issues which they considered were likely to have made a difference to the outcome for the mother (already reported as SI and reported to HSIB)

The grading 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

Comprehensive feedback has been received from the family which will be responded to separately. In particular relation to poor communication and counselling, recognition of medical conditions, documentation of discussion, and pressure to undergo induction of labour with subsequent delayed attendance with reduced fetal movements.

Some actions from other recently completed PMRT reports in relation to twin-to-twin transfusion syndrome (TTTS) and need for increased awareness and patient information leaflet, and listening to patient concerns on MAC. Additional theme in relation to management of ongoing vaginal discharge.

10.0 Service User feedback


To all of the SCBU staff,
Thankyou so much for Jake & Noah's birthday cards
For us, their birthday every year is a reminder of the day when all of the doctors, nurses & midwives saved their lives. We will never forget any of you.

The boys are doing incredibly well & are thriving, all thanks to the amazing start they had at the SCBU despite all the challenges they faced. We feel extremely blessed
Love from
Louise (Mum) Tom (Dad)
Jake, Noah & big brother Max
x x x

11.0 Complaints

No formal complaints received in April.

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 April 2023. Progress continues against the CQC action plan. The Maternity Assessment Centre action plan is progressing. New guidance is in place for the staff working in that area. The Manager of the Day provides oversight of the equipment checks on a daily basis. Compliance with Safeguarding training is improving however this is not progressing as quickly as would have been preferred. This is due to staff being allocated protected time on the roster and face to face sessions. All staff are booked to have completed this within the next two months and therefore compliance will be above 90% by September 2023. An audit midwife has been recruited and will progress actions in relation to audit once in post.

14.0 Healthcare Safety Investigation Branch (HSIB)

No new HSIB incidents were reported in April 2023. There are three active HSIB cases

- October 2022 relating to Maternal Death/Stillbirth
- January 2023 relating to neonatal death are ongoing.
- March 2023 neonatal cooling

15.0 Maternity incentive scheme – year 4 (NHS Resolution)

Maternity Incentive Scheme Board Declaration form submitted in January 2023. Email received confirming submission. Year 5 Maternity Incentive Scheme details are expected in quarter 2 2023/2024.

16.0 National priorities

16.1 Three Year Delivery Plan For Maternity And Neonatal Services

NHS England published a three year delivery plan for maternity and neonatal services on 30th March 2023. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. The Plan aims to deliver change rather than set out new policy and combines a number of existing maternity and neonatal requirements including original Better Births (2016), Long Term Plan (2019), Ockenden (2020 and 2022), East Kent (2022), Saving Babies Lives Care Bundle v2, CSNT requirements, MBRRACE reports, BAPM7 neonatal ambitions and equity/race related guidance. For the next three years services are asked to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

An action plan is being developed to enable progress to meet the requirements of this document is monitored.

16.2 Update on Ockenden (December, 2020)

- Work continues with the Maternity Voices Partnership (MVP) group to 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 November 2023.

16.3 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. The intention is 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. There remains anxiety amongst staff regarding this model of care, the safety of the unit as a whole and their working patterns.

17.0 Clinical Indicators – Yorkshire and Humber Regional Dashboard

The Yorkshire and Humber Dashboard for quarter four 2022/23 is expected in June 2023.

18.0 Local HDFT Maternity Services Dashboard April 2023

For month of April (Badgernet data):

- 118 mothers delivered (and 118 babies born)
- 16.1% elective Caesarean section rate
- 18.6% emergency Caesarean section
- 49.2% normal delivery rate
- 6.1% instrumental delivery rate
- 35.6% induction rate
- 4.2% significant PPH ≥1500ml rate
- One 3rd degree tear
- 83% breastfeeding initiation rate
- 1.7% smoking rate at time of delivery
- No stillbirths in April recorded

Work is on-going with the Head of Performance and Planning, Lead Cancer Manager, and Data Protection Officer to present the dashboard in a more effective way to enable better analysis.

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.

The ATAIN quarterly report is attached as Appendix 2.

19.1 Term Admissions to SCBU

Two term newborn admissions to SCBU which are being reviewed at the ATAIN case review meeting. One baby was admitted for observation after a maternal abruption. This baby returned to mum after three hours; one baby was admitted for respiratory support following a rapid delivery with thick meconium liquor.

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 Delivery Suite with borderline oxygen saturations/work of breathing before admitting to SCBU	Continue to encourage staff to stay with baby for ≈30 minutes 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
No formal observations with T21	Ensure formal observations completed in accordance with guideline and add to proforma	In progress
Follow UK Resus Council algorithm for acceptable saturation limits after birth before delivering oxygen	Disseminate to nursing & medical staff	In progress
If sugar acceptable after delivery, then just to give colostrum instead of formula/IV fluids	Discuss with neonatal lead	In progress
For specific documentation about how quickly oxygen levels should be reduced	Disseminate to nursing & medical staff	In progress
Determine acceptable saturations for babies with a pneumothorax receiving oxygen, to guide oxygen delivery	D/W Embrace and normal saturation limits of 90-95% apply	Complete

Passive cooling commenced in anticipation of need for active cooling	To disseminate to paediatric staff to commence passive cooling only on advice of Embrace	Complete

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 4 (Jan-Mar 2023)	
Small-for-gestational age/Fetal growth restriction detection rates	Q4: 31.5% detection (<10th centile; 17 cases) (National average 43.6%, Top 10 average 62.7%) Q4: 52.9% detection (<3rd centile; 9 cases) (National average 61.8%, Top 10 average 80.6%)	
	Quarter 4 (Jan- Mar 2023)	April 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	3.0% (13/433)	0.8% (1/118) [<2nd, WHO centiles]
Percentage of babies <10th centile >39+6 weeks' gestation	4.6% (20/433)	3.4% (4/118)[WHO centiles]
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)	2 late miscarriages born 16-24 weeks (0.4%, 2/423)	1 late miscarriage born 16-24 weeks (0.8%, 1/118)
• Preterm (24+0-36+6 weeks)	3.8% (live, 16/423) 0.2% (stillborn, 1/423)	2.5% (live, 3/118)

21.0 Conclusion and recommendation

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

Appendix 1

Bi Annual Staffing Report	
	Time Period of data **1st October 2022 – 31st March 2023**
Name & designation of person completing the summary	**Leanne Likaj** **Associate Director of Midwifery**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, BirthRate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (1st October 2022 – 31st March 2023) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the NHS Resolution Maternity Incentive Scheme, safety action 5.

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

- A systematic evidence based process to calculate midwifery staffing establishment and action taken to address staffing shortfall.
- A process in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels. This includes a team leader huddle every week to review planned midwifery staffing levels against the agreed establishment for each clinical area. Daily staffing reviews are also held by the Manager of the Day/Delivery Suite Coordinators to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.
- Action taken to address the findings of BirthRate + report
- Evidence from an acuity tool that demonstrates 100% compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour
- Monitoring of red flag incidents associated with midwifery staffing.

3. The evidence described in this paper provides assurance that Harrogate and District NHS Foundation Trust (HDFT) has an effective system of midwifery workforce planning and monitoring of safe staffing levels in place.

Midwifery Establishment

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake a systematic assessment of workforce requirements since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3). It must however be recognised that one of the Ockenden (2022) recommendations was that

> *The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSEI, RCOG, RCM and RCPCH. Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families and additional mandatory training to ensure trusts are able to safely meet organisational Clinical Negligence Scheme for Trusts and CQC requirements. Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.*

A BR+ establishment review was last completed in 2021 utilising two months data for March and April 2021 and annual data from 2020/21. The total births in 2020/21 was 1725, in 2022/23 the total births remains unchanged at 1718. The Birthrate Plus establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. The 2021 BR+ establishment review recommended a total Clinical, Specialist and Management whole time equivalent (WTE) of 76.21 midwives. The HDFT funding for midwives is 75 WTE (including NHSE funded posts) and there is currently 72.6 WTE in post as at the end of April 2023 (not including those on maternity leave, career break or external secondment). The budget is currently under review with the finance manager for the Directorate and the Operations Director. It is recommended that establishment setting is reviewed every three years unless there are significant changes in the service provision and a BR+ establishment review is therefore scheduled to be completed in 2024.

In addition to establishment setting BR+ also provide an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018 and information from this tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward). It has recently been explored with BR+ whether there is an acuity app for Maternity Assessment Centre (MAC)

further to the CQC inspection in November 2022. Unfortunately there isn't currently any system available to monitor acuity in a triage area like MAC.

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

Establishment Deficits

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

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

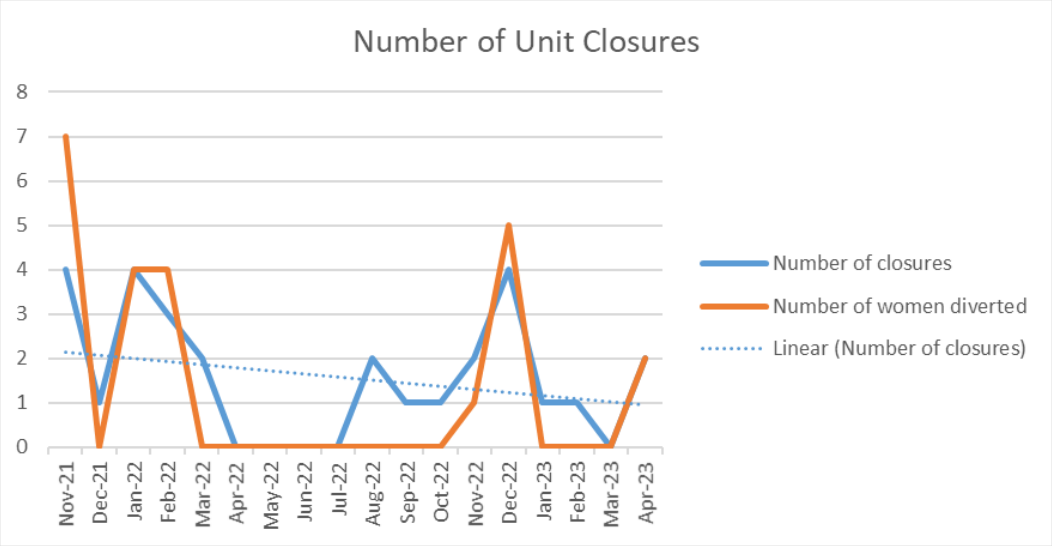
The maternity department continues to actively recruit new staff as required. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between October 2022 and March 2023.

	Midwives	Maternity Support Workers (MSW's)
New Starters	7.2 WTE	2.89 WTE
Leavers	5.83 WTE	4.3 WTE
Career break	1.0 WTE	0
Maternity Leave	6.0 WTE	0.39 WTE
Secondment	1.92 WTE	0

From the data submitted over the six month period there were no relevant staffing factors identified for 74% of the time on delivery suite and 69% of the time on Pannal ward. The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required. Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the Birthrate Plus acuity tool. Due to the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on nine occasions with six women diverted

to another hospital. A Datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All women diverted elsewhere are sent a letter apologising for the inconvenience of the diversion. All closures are reviewed by the Matron with the Labour Ward coordinator to discuss the activity, staffing and decision making before the escalation paperwork is signed off. There is an oversight of staffing issues through Maternity Risk Management Group (MRMG) meetings and monitored through Datix.

	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
No. of times maternity unit closed to admissions	1	2	4	1	1	0
No. of women diverted to other units	0	1	5	0	0	0



Planned Versus Actual Midwifery Staffing Levels

The tables below show the monthly overall fill rate for both Delivery Suite and Pannal Ward. Night and weekend cover is filled as a priority, during daytime hours any shortfalls in staffing levels can be covered with midwifery managers and specialist midwives.

Fill Rates

	Fill Rates			
	Day		**Night**	
	RN	**CSW**	**RN**	**CSW**
October 22	**93%**	**66%**	**95%**	**94%**

November 22	**94%**	**93%**	**94%**	**93%**
December 22	**90%**	**92%**	**100%**	**95%**
January 23	**98%**	**70%**	**102%**	**94%**
February 23	**96%**	**79%**	**101%**	**91%**
March 23	**91%**	**82%**	**97%**	**95%**

A weekly midwifery manager's huddle is in place to review the planned staffing against the agreed establishment for each clinical area with the ability to redeploy staff when required.

Actions have been taken as per the Maternity Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives and team leaders working clinically " as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift. The lower fill rates for MSW's are due to vacancies which are now filled. There is also now a MSW support midwife in place which will hopefully improve retention.

Midwife: Birth Ratio

The monthly midwife to birth ratio is currently calculated taking into account those midwives who are not available for work due to sickness whilst adding in the WTE bank shifts completed in each month. This "worked" calculation shows greater fluctuations in the ratio but provides a realistic measure of the number of available midwives measured against actual births each month. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour. The Associate Director of Midwifery or Matron are not included in the midwife to birth ratio however team leaders have their clinical time included.

HDFT midwife to birth ratio

Midwife to Birth ratio	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
In Post	1:27	1:27	1:24	1:25	1:26	1:25

Specialist Midwives

BR+ suggests 11% of the midwifery establishment are not included in clinical numbers. This includes those in management positions and specialist midwives

The current percentage of specialist midwives employed is 13.8%. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours. This includes posts that are externally funded through NHSE and the Local Maternity and Neonatal System (LMNS).

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

The service has a wide range of specialist midwifery posts at Band 7 and 8A as detailed below totalling 10 WTE:

- Bereavement 1.0 WTE (funded by NHSE)
- Infant feeding 0.8 WTE
- Quality and Safety Lead 1.00 WTE
- Professional development midwife 0.6 WTE
- Named Midwife for Safeguarding 1.0 WTE
- Antenatal and Newborn Screening 1.00 WTE
- Professional Midwifery Advocate 0.5 WTE (funded by NHSE)
- Fetal Monitoring Lead Midwife 0.4 WTE
- Digital Midwife 1.0 WTE
- Midwife Sonographer 0.60 WTE
- Clinical Practice Support and Retention Midwife 1.00 (Funded by NHSE)
- Community and Continuity Project Lead 1.00 (Funded by NHSE/LMNS)

Compliance with Supernumerary Labour Ward Coordinator Status and Provision of One to One (1:1) Care in Active Labour

Data extracted from BR+ during the six months 1st October 2022 – 31st March 2023 show there was a compliance completion rate of the tool of 76.19% on delivery suite and 79.49% for Pannal Ward. A higher compliance completion rate provides more assurance that the interpretation of the results is accurate.

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

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

There is always a delivery suite coordinator (or suitably experienced band 6 midwife in exceptional circumstances) rostered to be in charge on delivery suite and will aim to be supernumerary in order to provide oversight of all birth activity in the service. Harrogate is a

small maternity unit and there is full recognition of the advantages of the delivery suite coordinator being supernumerary in improving outcomes for both mother and baby but in practice this is extremely difficult to achieve at times of acute sickness and increased activity, this being the nature of maternity services.

All information was collated using the Birthrate Plus acuity tool. During this time period there were 35 occasions when the Delivery Suite coordinator was not supernumerary out of a completed 832 occasions which equates to 95.8% supernumerary status. There were 260 occasions when BR+ acuity app wasn't completed during this six month period. Each completion refers to a four hour period and the occasions of none supernumerary status may only occur for a small amount of time during each four hour period. Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialist's midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

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

- 837 women birthed
- 848 babies born (includes multiple births)
- 9 women experienced a baby being born before the arrival (BBA) of the midwife and one woman birthed on Pannal.

98.8% of women therefore received 1:1 care in labour.

Midwifery Continuity of Carer (MCoC)

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that is evidence-based. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.
In September 2022 NHS England (NHSE) notified Trusts that they are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so. Local midwifery and obstetric leaders have been asked to focus on retention and growth of the workforce and to develop plans that will work locally. The plan needs to take into account local populations, current staffing and more specialised models of care required by some women.

In March 2023 it was recognised that the midwifery staffing at HDFT had reached target levels and as such that it should be possible for one team of midwives (eight headcount as per NHSE requirements) to safely work in a MCoC model. Engagement with the staff is taking place to assess the feasibility of this model being appropriately staffed without impacting on the safety of the inpatient maternity services as this was recognised as an issue with the previous MCoC roll out attempt. MCoC midwives are required to work with caseloads of 1:27 (compared to national caseload of 1:96 for traditional care community midwives) and provide care on Delivery Suite in an as required model. This requires careful planning to ensure that the women not being cared for in the MCoC model continue to receive safe care.

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are available on the BirthRate Plus acuity tool (listed in appendix 1).During the 6-month period between October 2022 and March 2023 the following red flag events were identified;

Delivery Suite 11 red flags were identified -

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)	**1**	**9%**
RF2	**Missed or delayed care** >60 minutes for suturing (except after pool birth) See unit crib sheet	**2**	**18%**
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	**0**	
RF4	**Delay in providing pain relief > 30 mins** Delay of > 30 mins in providing pain relief where requested	**0**	
RF5	**Delay between presentation and triage >30 mins**	**2**	**18%**
RF6	**Full clinical examination not carried out when presenting in labour**	**0**	
RF7	**Delay between admission for induction and beginning of process**	**6**	**55%**
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)	**0**	
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'	**0**	
RF10	**Midwife unable to provide 1:1 high dependency care for AN or PN patient**	**0**	
	Total	**11**	

Pannal ward 35 red flags were identified –

RF1	**Delayed or cancelled time critical activity**	**2**	**6%**
RF2	**Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)**	**8**	**23%**
RF3	**Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)**	**0**	**0%**
RF4	**Delay in providing pain relief**	**4**	**11%**
	Delay between presentation and triage	**2**	**6%**

RF5			
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	17	49%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	2	6%
	Total	35	

The postnatal ward acuity tool is under development by BR+ and is to be paused for three months May 2023 – July 2023.

As can be clearly identified the main red flag relates to delay to induction of labour care. This is an appropriate clinical action to take in the majority of circumstances. The situation is not acute and can therefore be appropriately delayed without untoward impact on outcomes. This does however impact on the service user's experience of maternity care. Work is required to consider the management of induction of labour to endeavor to protect the patient experience whilst ensuring the safety of the service provision. It has been suggested that the following elements should be considered outpatient induction, mechanical induction, an allocated midwife for inductions on Pannal and capacity management.

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

Recommendations

1. Maternity budget review to be completed to ensure the HDFT funding aligns with BR+ recommendations.
2. Continue to engage with the staff regarding the continuity of carer model of working.
3. Update the induction of labour process (including considering outpatient induction, an allocated midwife and capacity management) to reduce delays and improve patient experience.

APPENDIX A

MINIMUM MIDWIFERY STAFFING LEVELS

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	Aug 2010	Initial issue	2013
2.0	Sept 2011	Reviewed and updated	Sept 2013
3.0	April 2013	Reviewed and updated	March 2014
4.0	Oct 2014	Reviewed and updated	Sept 2015
5.0	Oct 2015	Reviewed and updated	Oct 2016
6.0	Nov 2016	Reviewed and updated	Dec 2017
7.0	Dec 2017	Reviewed and updated	Dec 2018
7.1	June 2018	Interim update to include statement on supernumerary	Dec 2018

Status	Active	
Publication Scheme	HDFT intranet	
FOI Classification	Release without reference to author	
Function/Activity	Clinical guideline	
Record Type	Clinical guideline	
Project Name	Minimum midwifery staffing levels	
Key Words	Minimum, safety, skill mix, continuity of carer	
Scope / Location	Maternity Department	
Author	Leanne Likaj	Date
APPROVAL AND/OR RATIFICATION BODY	Maternity Risk Management Group	May 2023

CONTENTS

1. Introduction

1.1. Purpose

Harrogate and District NHS Foundation Trust (HDFT) is committed to the provision of an appropriately staffed maternity service to ensure the safe provision of high quality care to all women who choose to access its services. Appropriate staffing levels and skill mix across midwifery, maternity support staff, admin and clerical staff are essential for providing a safe and high quality maternity service. This document outlines roles and responsibilities of midwifery and support staff working in maternity services, standards and guidelines for planning of off-duty, staffing support mechanisms within the maternity services at HDFT and contingency plans when maternity staffing levels fall below agreed minimum levels. The standards and guidelines have been reached and agreed after a consultation process including Senior Midwifery Team leaders, specialist midwives, Directorate managers and senior medical staff.

Staffing levels are continually reviewed by the Associate Director of Midwifery, Matron and Senior Midwifery Team Leaders and the Planned and Surgical Care Directorate, and consideration is given to projected maternity bookings within the Maternity Services.

The procedure to undertake in the event of insufficient staffing levels due to short term sickness, insufficient beds and staffing capacity for work load or insufficient equipment are all outlined in the Maternity Escalation Policy.

BR+ acuity app workload analysis tool is being used to inform and suggest the appropriate level of staffing within the acute areas (Delivery Suite and Pannal ward).

There has recently been a move away from calculated midwife to birth ratio to providing women in established labour with supportive one-to-one (1:1) care. This is because birth can be associated with serious safety issues, and 1:1 care can help ensure that a woman has a safe experience of giving birth. Regionally and according to BR+ it is accepted that as a minimum the Associate Director of Midwifery and the Matron should be removed from the midwife to birth ratio and the HDFT ratio reflects this. . 1:1 care in labour data is captured in Badgernet and is reported monthly to the trust board in accordance with the Perinatal Surveillance Model.

1.2. Better Births (2016) – Midwifery Continuity of Carer model (MCoC)

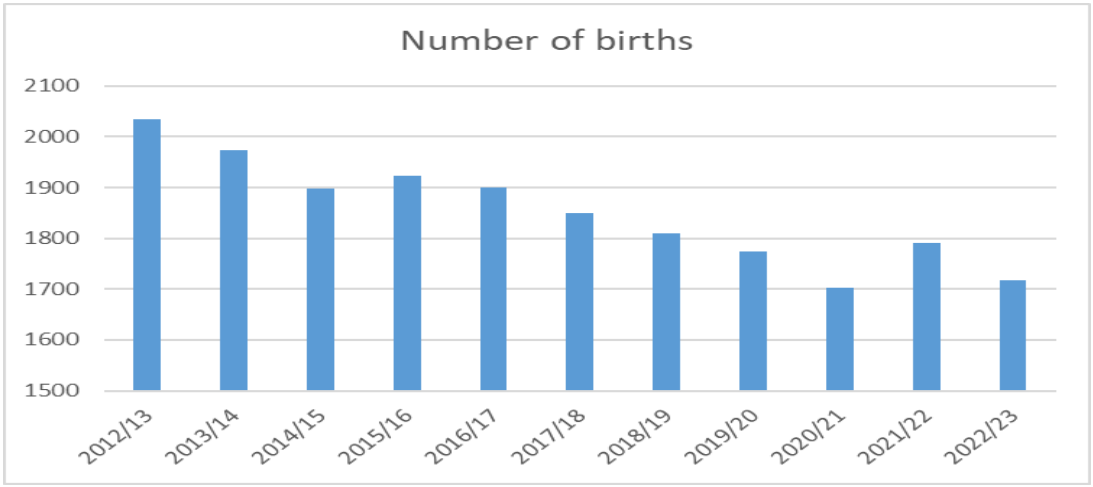
The national document *Better Births, Improving outcomes of maternity services in England* (NHS England, 2016) recommended the implementation of continuity of carer models within all maternity units in England. This model involves every woman having a midwife, who is part of a small team of eight midwives based in the community who know the women and family,

and can provide continuity throughout the pregnancy, birth and postnatal period. This model moved away from the traditional midwifery staffing models and required midwives to work in a very different way across the service. At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It can improve the outcomes for most women and babies and especially women of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. This model of care requires appropriate staffing levels to be implemented safely.

In September 2022 NHS England (NHSE) notified Trusts that they are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so. Local midwifery and obstetric leaders have been asked to focus on retention and growth of the workforce and to develop plans that will work locally. The plan needs to take into account local populations, current staffing and more specialised models of care required by some women.

1.3. Birth rate (women delivered) at HDFT (financial years since 2011 - 2023)

2012/13	2034
2013/14	1973
2014/15	1898
2015/16	1923
2016/17	1900
2017/18	1850
2018/19	1810
2019/20	1774
2020/21	1703
2021/22	1790
2022/23	1718



The birth rate has steadily decreased over the last 5 years which is in line with trends seen in both the regional and national birth rate. Due to the nature of maternity services there is always some variation in monthly projected and actual deliveries and activity levels on a shift by shift basis leading to peaks in some months/shifts and troughs in others. There is also an additional increase in the complexity of health needs for some women; increasing numbers of women

with raised BMI and increasing numbers of women requiring induction of labour (recommendations from Saving Babies Lives care bundle, 2019).

1.4. The Basis of Birthrate Plus® (BR+)

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests BR+ is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake a systematic assessment of workforce requirements since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3). It must however be recognised that one of the Ockenden (2022) recommendations was that the feasibility and accuracy of the BR+ tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSEI, RCOG, RCM and RCPCH. Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families and additional mandatory training to ensure trusts are able to safely meet organisational Clinical Negligence Scheme for Trusts and CQC requirements. Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.

A BR+ establishment review was last completed in 2021 utilising two months data for March and April 2021 and annual data from 2020/21. Data collection included ANC, community midwifery and continuity of carer teams as well as in-patient areas. The total births in 2020/21 was 1725, in 2022/23 the total births remains unchanged at 1718. The BR+ establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

In addition to establishment setting BR+ also provide an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. The BR+irthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period in order to determine the total midwife hours, and therefore staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice. The acuity tool considers the different workloads and working patterns of midwives based in the hospital setting and takes account of the contribution to quality services of midwifery staff not involved in direct hands of care or women such as managers and clinical governance midwives. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018 and information from this tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward).

1.5. Planned and actual staffing numbers

All hospitals are now required to publish information about the number of nursing and midwifery staff working on each in-patient ward. This initiative is part of the NHS response to the Francis report in 2013 calling for greater openness and transparency in the health service. In response to this report, the midwife in charge of the shift wears a red badge making them clearly identifiable for both staff and patients.

Information about actual versus planned nursing and midwifery staffing levels is published on a monthly basis for each inpatient ward area in the Trust, including maternity inpatient areas for midwives and MSW's (Delivery Suite and Pannal ward). This data is available on the NHS choices website as well as the Trust website.

Within the hospital this information is displayed for patients and visitors in all inpatient ward areas on a daily basis showing planned and actual staffing available at the start of each shift. There is a board on both Pannal ward and Delivery Suite displaying this information.

1.6. Scope

This guideline covers all midwifery, maternity support staff and clerical staff working within the Maternity services at HDFT.

1.7. Definitions

- MCoC – Midwifery Continuity of carer
- DS – Delivery suite
- EPAU – Early pregnancy assessment unit
- HDFT - Harrogate and District NHS Foundation Trust
- ADoM – Associate Director of Midwifery
- MSW – Maternity Support Worker
- MRMG - Maternity Risk Management Group
- MAC - Maternity Assessment Centre
- MT - management time
- PAP – Professional advisory panel
- ODP - operational departmental practitioner
- WTE – Whole time equivalent
- WY&H LMS – West Yorkshire & Harrogate Local Maternity System

2. Policy

2.1. Current Staff roles working in maternity services

2.1.1. Associate Director of Midwifery (ADoM)

The ADoM has responsibility for all areas of maternity services, including community midwifery, and Early Pregnancy Assessment Unit (EPAU).

The ADoM is professionally responsible for midwifery practice and care provided by midwives to women and their families within the hospital and community setting. The ADoM works as part of the Trust Corporate Nursing Group and Planned and Surgical Directorate management team advising on professional midwifery issues. The ADoM is directly accountable to the

Executive Director of Nursing Midwifery and Allied Health Professionals and line managed by the Planned and Surgical Care Operational Director. The ADoM has responsibility for the operational management of resources within the acute areas and community midwifery (Delivery Suite, Pannal ward, Maternity Assessment Centre, and Early Pregnancy Assessment Unit) and maternity clinical governance in the Planned and Surgical Care Directorate. The ADoM is accountable for ensuring the highest standards of clinical care are provided within the maternity services and the principles of clinical governance are implemented. The ADoM is available professionally for support and advice.

	Band	Funded WTE
Associate Director of Midwifery, Planned and Surgical Care	8c	1.0

2.1.2. Matron Maternity Services

The Matron is part of the Planned and Surgical Care Directorate management team; line managed both professionally and operationally by the ADoM. The Matron has responsibility for the operational management of resources within Antenatal Clinic, Delivery Suite, Maternity Assessment Centre (MAC), Pannal Ward, community midwifery, and EPAU.

The Matron is accountable for ensuring the highest standards of clinical care are provided and clinical governance processes are implemented within the maternity services. The matron is the interface between the Directorate Management Team and the front line maternity clinical staff, skilfully translating national, organisational and Directorate objectives into operational reality and leading their implementation across maternity services.

	Band	Funded WTE
Matron Maternity Services	8a	1.0

2.1.3. Lead Midwife for Safety, Quality & Clinical Governance

This senior midwife has responsibility for overseeing safety and quality within maternity services and the development of the professional midwifery agenda to achieve consistency of practice, high quality and safe standards of care and innovation with a strong patient safety focus. The Lead Midwife for Safety, Quality & Clinical Governance represents maternity services at Trust, Directorate and regional (West Yorkshire & Harrogate Local Maternity System – WY&H LMS) risk management and governance meetings. This role is predominantly non-clinical but there is scope for clinical shifts when appropriate. The Lead Midwife for Safety, Quality & Clinical Governance is line managed by the ADoM.

The post holder provides a key link between Maternity Services and the Corporate Quality team.

	Band	Funded WTE
Lead Midwife for Safety, Quality & Clinical Governance	8a	1.0

2.1.4. Named Midwife for Safeguarding

The Named Midwife for safeguarding works closely with the ADoM to ensure that the Trust meets its statutory obligation to safeguard adults, children and babies. They also promote the welfare of all children and vulnerable pregnant women who access services within the Trust. The Named Midwife for Safeguarding is a highly visible senior midwife who provides specialist knowledge, advice and clinical expertise to all staff in maternity services in all areas of safeguarding including children, young people and adults of concern. They are a key member of the wider Safeguarding Children and Adult Harrogate and District Foundation Trust (HDFT) Team.

	Band	Funded WTE
Named Midwife for Safeguarding	8a	1.0

2.1.5. Delivery Suite and Maternity Assessment Centre (MAC) Team leader

The Delivery Suite and MAC manager is responsible for the efficient management of the Delivery Suite and MAC, providing regular advice, support and guidance to all staff working in this area. This includes:

- Ensuring a high quality service through evidence based guidelines and a robust risk management framework, safe and effective resourcing of equipment and support systems for mentoring new and junior midwives and students
- Delivery Suite coordinators reporting directly to the Delivery Suite and Maternity Assessment Centre (MAC) Team leader
- Working predominantly Monday - Friday with a combination of clinical and managerial shifts (MT)
- Working closely with the Obstetric Clinical Lead, Neonatal Clinical Lead, and Consultant Anaesthetic Lead.
- Overall responsibility for the Maternity Assessment Centre, supporting midwives within this area in providing high quality, safe care.
- Line managed by Matron.

	Band	Funded WTE
Delivery Suite Manager and MAC Manager	7	1.0

The Maternity theatre on Delivery Suite is staffed with a team consisting of a registered general nurse, a care support worker and an operational departmental practitioner (ODP) who provide scrub/theatre cover for the maternity unit theatre to be used as and when required over 24 hours a day, seven days a week. This team are part of the wider main theatre team and not included within the maternity establishment. This ensures that midwives are not being utilised for work in theatre and are always available to care for and support those women and their partners having emergency procedures in the maternity theatre on delivery suite.

2.1.6. Band 7 Delivery Suite coordinators (shift coordinators)

For each shift on delivery suite there is a designated Delivery Suite coordinator providing 24-hour cover with managerial, leadership and supportive responsibilities including:

- Day to day management of the team on duty providing leadership, advice, supervision and coordination of staff within the multi-disciplinary team
- Assist in the supervision and development of junior midwives and other members of staff
- Provision of specialist advice to midwives and other members of the multi-disciplinary team
- At weekends, bank holidays and night duty the delivery suite coordinator is the most senior member of midwifery staff on duty and has overall responsibility for the efficient management of the delivery suite and Pannal ward providing advice, support and guidance to all staff on duty
- Line managed by the Delivery Suite Manager.

A senior midwife (Delivery Suite coordinator or equivalent) is to be present on duty on Delivery Suite 24 hours a day, 7 days a week and should aim to be supernumerary to other midwives who are providing one to one (1:1) care to women in labour. The majority of the time being supernumerary will be achievable however there will be occasions when, due to increased workload, it is not possible to remain completely supernumerary. This is a Red Flag event captured on the BR+ acuity tool. Red Flags are monitored closely by Matron and the Delivery Suite Team leader. It is important that the Delivery Suite coordinator remains as accessible and visible as possible to provide leadership, management and supportive responsibilities to all members of the multi-disciplinary team. If this is not possible due to increased activity and/or the acuity of the women the coordinator will request additional help, as stated in the Maternity Escalation Policy

	Band	Funded WTE
Delivery Suite Coordinator	7	6.9

2.1.7. Pannal Ward Team leader

The Pannal Ward Team Leader has responsibility for the overall management of the clinical area, including elective caesarean sections and inductions of labour. They are accountable for ensuring the highest standard of clinical care is provided on Pannal Ward. They are easily identifiable to patients, providing strong, visible leadership and have the appropriate level of authority to provide support, advice and assistance required by women, their partners and families. Pannal Ward Team leader is line managed by Matron.

	Band	Funded WTE
Pannal ward	7	1.0

2.1.8. Community Midwifery and Midwifery Continuity of Carer (MCofC) Team Leader

This senior midwife is responsible for community and continuity of carer midwifery services in Harrogate and District. The midwives and maternity support workers in community report directly to the Community Midwifery Team Leader. The role is predominantly a managerial capacity with a small amount of clinical care when required. The Community/CofC Midwifery Team leader is line managed by Matron.

	Band	Funded WTE
Community and Continuity of Carer team leader	7	1.0

2.1.9. Antenatal Clinic team leader and Public Health Specialist Midwife

The ANC team leader provides clinical leadership and operational management of the antenatal clinic team. They are responsible for leading and managing the activities of midwives and other members of the multi-disciplinary team in the antenatal clinic setting and providing leadership, support and expert clinical advice pertinent to antenatal care in the hospital setting. The ANC team leader is also responsible for the antenatal public health agenda.

	Band	Funded WTE
Antenatal Clinic Team leader and Public Health Specialist Midwife	7	1.0

2.1.10. Specialist Midwives

There are a number of additional specialist roles within maternity services, detailed below. All of these specialist midwifery roles are currently included in the overall midwifery establishment but not all rostered to work clinically:

Title	**Band**	**Funded (WTE)**
AN and Newborn screening coordinator	7	1.0
Deputy AN and newborn screening coordinator	6	0.2
Infant feeding coordinator	7	0.8
Professional development midwife (includes 0.4 for fetal monitoring lead)	7	1.0
Bereavement Midwife	7	1.0
Digital Midwife	7	1.0
Lead Professional Midwifery Advocate	7	0.6
Total	7	5.6
Clinical Practice Support & Retention Midwife	***7***	1.0 (Fixed term until April 2024)
Total	**8**	**6.6**

Infant feeding coordinator

This role is a senior midwife who works closely with all staff working in maternity services in line with the Baby Friendly Initiative Accreditation process and maintaining evidence to continue the work required for reaccreditation of the recently acquired gold award. This midwife works collaboratively with neonatal and paediatrics services within the Trust.

The infant feeding coordinator works closely with the team in providing formal teaching to staff on all aspects of infant feeding and facilitating antenatal and postnatal breastfeeding workshops. They ensure that all clinical guidelines are evidence based and up to date to support and guide staff working within the clinical environment.

They have a thorough knowledge of the UNICEF Baby Friendly Initiative and current government policies on breastfeeding, and represent the maternity department at local and regional meetings (infant feeding specific).

	Band	Funded WTE
Infant feeding coordinator	7	0.8

Professional development midwife and fetal wellbeing lead

The Professional Development midwife facilitates the continuing professional and personal development of midwives and maternity support workers (MSW) within the department and links closely with the Trust Education Department. This encompasses local and national recommendations. The role also has a particular focus on quality and safety providing expert clinical support and advice that will enhance care whilst acting as a champion of best practice to support the midwifery, support worker and medical team.

This senior midwife is responsible for the planning and delivery of all maternity mandatory and role specific training and regular review of the content of study days with the support of the ADoM and Matron.

	Band	Funded WTE
Professional development midwife	7	0.6

Fetal Monitoring Lead Midwife

The Fetal Monitoring Lead Midwife strives to improve the standard of intrapartum risk assessment and fetal monitoring, in accordance with element 4 of the Saving Babies' Lives Care Bundle. They provide comprehensive training for all midwives and obstetricians to increase their knowledge and competence in identifying fetal well-being, potential fetal compromise in all clinical settings and improve clinical decision making. The Fetal Monitoring Lead Midwife develops and maintain policies, procedures and practices with regard to all fetal monitoring (both intermittent auscultation and electronic fetal monitoring) and ensures all relevant assessments and standards are complied with.

	Band	Funded WTE
Fetal Monitoring Lead	7	0.4

Bereavement Midwife

The post holder has responsibility for the provision of care, support and practical advice to women and their families following the loss of their baby. This midwife is an expert resource in pregnancy bereavement, a positive role model and providing sound professional knowledge and leadership to all members of the multidisciplinary team within the maternity service. The midwife ensures the provision of statistical data for local and national reports.

Providing training events and updates on mandatory training on how best to support families and exploring effective communication, supporting informed choice and offering appropriate advice. The bereavement midwife works with families to explore how the service can be planned to meet their needs and is the link between the other professionals being a constant presence by offering information from other sources and helping to “translate” the data into what it means for the parents. There has been a recent increase to hours for this role as a recognition of the responsibilities of the role.

	Band	Funded WTE
Bereavement midwife	7	1.0

Digital Midwife

The role of the Digital Midwife enables safe, effective and efficient maternity care through the best use of information and information technology. Digital record keeping streamlines local and national data collection, supporting the delivery of safer care and improving women’s experience through pregnancy and beyond. Improving the sharing of information will reduce the need for women to repeat information to different professionals.

	Band	Funded WTE
Digital Midwife	7	1.0

2.1.11. Rotational Midwives

Regular review of staffing levels takes place between the ADoM, Matron and ward managers, with the support of the Finance Manager within the Directorate.

Band 6 midwives
Band 6 midwives working in the maternity unit rotate between Pannal ward (postnatal and antenatal ward) and Delivery Suite on a regular basis.

Band 5 midwives
Newly qualified midwives new to the maternity unit have an 18-month preceptorship period. During this process band 6 and 7 midwives in each area of the maternity unit support these midwives whilst they complete this package. During their preceptorship, they will work on Delivery Suite and Pannal ward. Band 5 midwives complete part of their preceptorship time working in the Community/MCofC teams.

The move from Band 5 to 6 is agreed by a senior midwife after a minimum period of 18 months based on:

- Successful completion and sign off of the competencies and experience in the preceptorship package
- Completion of an annual appraisal and personal development plan
- Attendance and completion of all mandatory training/e-learning
- Evidence of completion of the workbook to become a practice supervisor in line with SSSA standards (Standards for student supervision and assessment, NMC, 2018)
- Experience and achievement of agreed competencies of being the midwife in charge on Pannal ward

2.1.12. Midwives in the Maternity Assessment Centre (MAC)

MAC is staffed by Band 5/6 midwives who complete telephone triage of women in early labour as well as pregnant women referred by GP's, community midwives or self-referral with pregnancy related conditions. This allows swift treatment for women in an area that is separate from Delivery Suite allowing women in established labour on Delivery Suite to receive one to one care by midwives; this has shown improved outcomes for women and to improve patient satisfaction.

The opening times are seven days per week (08.00-20.00).

2.1.13. Community midwives

These are a number of midwives based in the community who provide a full range of community midwifery care including a homebirth service. Midwives working in the community work between 08.30 - 17.00, seven days a week. Outside of these hours there is an on call service for home births only.

On call
The first and second on call midwife for home births are provided by the community midwifery team.

There is a hospital midwife on call rostered every night of the year to support the maternity unit at times of escalation.

2.1.14. Community Maternity Support worker

The MSW in community was employed to support the midwives to deliver high quality care to women, babies and their families within the community setting (the home, GP surgeries and children's centres).

	Band	Funded WTE
Community maternity support workers	3	1.6

2.1.15. Professional Midwifery Advocates (PMA)'s

The Professional Midwifery Advocates (PMA's) provide support to develop, progress and strengthen the capabilities of the midwifery workforce. There is a Lead Professional Midwifery Advocate who is required to lead the team and enable actions to be completed and driven forward. There is no agreed caseloading number of midwives for individual PMA's. Currently

there are eight PMA's. These are non-funded posts with no allocated time to perform the role being incorporated within the PMA's existing substantive hours.

	Band	Funded WTE
Lead Professional Midwifery Advocate	7	0.6

2.1.16. Maternity Support workers – MSW's (hospital based)

This post supports all members of the MDT and works under the guidance of the midwifery staff. The role includes maternal observations, maintaining a clean and safe environment, assisting with infant care and feeding, always under the supervision of a midwife. They support and compliment the role of the midwife and undertake duties that cover 24 x 7 periods.

The contribution of maternity support workers is maximised when they are appropriately trained, managed and supervised by midwives.

	Band	Funded WTE
Maternity support workers	2	9.40

2.1.17. Admin and clerical including Ward clerks

It is essential that there are adequate support personnel to enhance the maternity team in any environment but particularly on Delivery Suite and Pannal Ward. Increasing activity requiring information input, admissions and discharges within delivery suite demonstrate the need for a ward clerk. An Administration Assistant also assists the Specialist Midwives, Team Leaders and Matron with administrative tasks.

	Band	Funded WTE
Ward clerk	2	1.50
Maternity Administration Assistant	2	0.6

2.1.18. Antenatal (AN) and Newborn Screening Coordinator

The Antenatal and Newborn Screening Co-ordinator ensures the provision and continuing effectiveness of a woman centred antenatal and newborn screening and diagnosis service for the Trust. The post holder acts as a co-ordinator between those involved in providing and those receiving the service, ensuring all midwives giving advice are trained to provide screening advice to all women who access the maternity service. The AN and Newborn Screening Coordinator has a deputy who is allocated to work 0.2 WTE to support this role.

	Band	Funded WTE
AN and Newborn Screening Coordinator	7	1.0
Deputy AN and Newborn Screening Coordinator	6	0.2 (no additional funding for this post)

2.1.19. Admin support for AN and Newborn Screening Coordinator

The admin support provides administrative and clerical support to the Antenatal and Newborn Screening Coordinator, based in the ANC and will report directly to this person. The clerk provides a point of contact for all matters relating to antenatal and newborn screening within the Trust. The post involves the collection and collation of data and to assist in the preparation and dissemination of reports.

The AN and Newborn Screening Coordinator is the only senior midwife in the department who has agreed clerical support within the establishment.

	Band	Funded WTE
Admin support for screening	3	0.60

2.1.20. ANC Midwives

These midwives work closely with the obstetric medical staff in the Consultant clinics; they provide time and information for the booking appointments that are predominantly “out of area” bookings.

	Band/role	Funded (WTE)
Midwives in ANC	6	2.80

2.1.21. Maternity Support workers in ANC

The post holders work within a multi-disciplinary team of both midwives and medical staff in the Antenatal Clinic (ANC) to support and advise women and their partners in the ANC setting. The post holder works under the direction of the midwives in ANC utilising their own skills and knowledge. The post holder has an understanding of the clinical requirements of the antenatal service including some antenatal screening and be responsible for running of the phlebotomy clinics.

	Band	Funded WTE
Maternity Support workers in ANC	3	1.60

2.2. Skill mix

Whilst the skill mix across shifts is at the discretion of the ward team leaders/off duty coordinators, it should reflect the need to balance care delivery, service needs and financial constraints.

Duty rotas must be prepared in line with the Trust annual/study leave and roster guidelines and enable an even distribution of staff throughout the week. The duty rotas are completed by Team Leaders or their deputy. Off duty is then reviewed for Delivery Suite and Pannal Ward

together (both midwifery and maternity support workers) to ensure adequate cover and appropriate skill mix in both areas. The rotas must be reviewed and approved by the Matron who will then know in advance where any shortfalls are (if any) and take appropriate action if required. Once approved, duty rotas must not be changed without the knowledge and authorisation of the line manager.

2.3. Agreed shifts for the unit

Early shift	07.30 – 15.30
Afternoon shift	12.00 – 20.00
Night shift	19.30 – 08.00
Long day	07.30 – 20.00

For midwives and maternity support workers in ANC and community the normal working day is 09.00 – 17.00.

Staff may choose to do the 7.5 hour shifts, all long shifts (paid for 11.25 hours) or a combination of both shifts. If a member of staff has requested a specific working pattern this must be agreed with the ward manager in the clinical area by completion of a flexible working request. All flexible working agreements are reviewed on an annual basis in line with the Trust flexible working policy.

2.4. Agreed minimum midwifery staffing levels within the Department

	Delivery Suite	Pannal ward	ANC	MAC	Community
09.00-17.00	N/A	N/A	2-3 (depending on day of week)		5
Bank holidays and weekends	4 4	3 3	N/A	1	3 - 4
E	4	3		1	
L	4	3		1	

LD	(4)	(3)		(1)	
N	4	3	N/A	N/A	17.00-08.00
On call 1st 2nd	1 (19.30-07.30)	N/A	N/A	N/A	1 1

If the level of staff drops below these numbers, the delivery suite co-ordinator and or the senior midwife on duty must assess the situation, assess the current workload on the maternity unit and if appropriate instigate the maternity escalation policy.

2.5. Bi - Annual review of Staffing Levels - Midwifery and Maternity Support Workers

Safety action 5 of the Maternity Incentive Scheme (NHS Resolution, 2021 – year 3) asks for demonstration of an effective system of midwifery workforce planning to the required standard and completion of a bi-annual report. The bi-annual staffing report includes evidence of a systematic process to calculate the midwifery establishment, the DS coordinator has supernumerary status and all women in active labour receive one to one care in labour. The bi-annual maternity staffing report is completed and is submitted to the Trust Board. A monthly maternity staffing report is completed and is included in the Strengthening Maternity and Neonatal Safety Report (required as part of the Perinatal Surveillance Model). The staffing summary is also reported at the bi monthly Maternity Risk Management Group. Should there be any shortcomings identified in staffing levels, this would be escalated to Planned and Surgical Care Directorate Board.as set out in the Maternity Risk Management Strategy. This information would be shared with the Excutive Director of Nursing, Midwifery and Allied Health Professionals who is the Trust Board Safety Lead for Maternity Services (NHS Resolution, 2020).

2.6. Process for the development of business plans

If midwifery staffing shortfalls have been identified on a continual basis (via MRMG), a business case would be developed by the ADOM, Matron, the Service Manager and finance manager in the Planned and Surgical Care Directorate. Consideration would be given to National recommendations and standards for staffing, Care Quality Commission (CQC), Royal College of Midwives (RCM). When there is an investment for additional staffing required, this would be requested and submitted to Trust Board via the Planned and Surgical Care Directorate Board.

2.7. Plans for 2023/24

- To provide monthly maternity staffing reports using the information in the Birthrate Plus acuity tool - to present and review bi-monthly at Maternity Risk Management Group, and Senior Management Team, and share information with staff.
- Completion of a bi-annual staffing report to Trust in line with safety action 5 of the maternity incentive scheme (NHS Resolution)
- Supporting the WY&H LMS in review of the role of the Maternity Support Worker to enable further development of this role and increase to banding accordingly
- Supporting band 5 midwives with experience of working within in all areas including community as part of the completion of their preceptorship
- Supporting student midwives within their clinical placements at Harrogate by including them within community teams to enabling case loading for 3rd year students
- Continue to be involved in the central recruitment of newly qualified midwives within the WY&H LMS
- Continued review of the flexible working requests – completed on an annual basis

3. Roles and responsibilities

Policy development is the responsibility of key stakeholders involved in the Paediatric and Maternity Services departments. The guideline is then ratified by a quorum of six members of Maternity Risk Management group (MRMG). Once the guideline has been ratified, it is the responsibility of all staff within the Maternity Service to ensure that the principles are adhered to in practice. In some circumstances it may be appropriate to deviate from the guidance but these decisions must be made at a senior level and the rationale documented in the notes.

4. Policy Development and Equality

4.1. Identification of Stakeholders

The departmental multidisciplinary team, services users, have been consulted in the writing and / or ratification of this guideline.

4.2. Equality Impact Assessment

This policy has undergone Stage 1 Equality Impact Assessment screening. Given the nature of maternity services provision, the guidance applies specifically to all women and their families, and does not discriminate on the basis of age, race, disability, sexual orientation, colour, ethnic origin, marital status, nationality, religion or social background. The guideline has been written with the aim of providing equal access, equal treatment, equal participation and equal outcomes and it does not require a full Stage 2 Equality Impact Assessment.

5. Consultation, Approval and Ratification process

5.1. Consultation Process

The consultation process is summarised in Section 10.1 (Appendix 1).

5.2. Approval Process

The guideline is approved by the Maternity Risk Management Group and the stakeholders identified above.

5.3. Ratification Process

The guideline will be ratified by the Maternity Risk Management Group.

6. Document control

6.1. Publication

The guideline will be published in the Trust electronic document library.

6.2. Archiving Arrangements

Any outdated paper copies of the guideline will be replaced by a new version. The document library administrator is responsible for archiving the old documents and uploading the new documents to the Trust intranet document library.

6.3. Access

Additional copies of policy documents will not be printed unless it is absolutely necessary, to reduce the risk that out of date copies may be in circulation. Requests for this policy in an alternative language or format (such as Braille, audiotape, large print etc) will be considered and obtained whenever possible.

7. Dissemination and implementation

Maternity Services staff will be notified of the publication of the guideline through communication via handover sheets and verbal notification.

7.1. Implementation

Changes in practice will be highlighted as per the *Dissemination* section above. Compliance with guideline practice will be monitored as per Section 8. Where there is a lack of compliance with the guideline an action plan, to include training where necessary, will be formulated as per the *Monitoring and Compliance* section.

7.2. Training and Support

Training in relation to the guideline will be provided where audit, monitoring or incident reporting identify that there are deficiencies in current practice.

8. Monitoring Compliance and Effectiveness

8.1. Standards / Key Performance Indicators

The standards that will be monitored via audit are detailed in Section 10.2 (Appendix 2).

8.2. Process for Monitoring Compliance

8.2.1. Monitoring

The Maternity Risk Management Group is responsible for monitoring compliance and effectiveness. Deviations from the guideline will be reported to PAP via a Datix form. The care in each case reported will be reviewed by PAP and where deficiencies have arisen this will be fed back to the appropriate staff.

8.2.2. Audit

Where incidents indicate any deficiencies in practice a more thorough one off audit may be instigated with assistance from the Clinical Effectiveness Department.

8.2.3. Feedback

Where audits are undertaken the results will be circulated and discussed at the Audit Group. Monitoring of any action plans as a result of audits will be carried out by the Maternity Risk Management Group and Audit Group.

9. References and Associated documentation

Ball, J. A, and Washbrook, M and the RCM; Birthrate Plus®: Using Ratios for Workforce Planning. British Journal of Midwifery, November 2010 Vol. 18, No. 11, pp 724-730

Birthrate Plus® Website 2007: Ratios for midwifery workforce planning at National, SHA and Local Level. www.birthrateplus.co.uk

Kings Fund, 2011: Improving Safety in Maternity Services. *How to ensure the right people, with the right skills, are in the right place at the right time.* A guide to nursing, midwifery and care staffing capacity and capability. Jane Cummings, Chief Nursing Officer for England, 2013. https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

NHS, 2010: National Patient Safety Agency, *National reporting and Learning Service.* Intrapartum Scorecard. Available at:

http://patientsafety.health.org.uk/resources/intrapartum-scorecard

NHS England (2016). National Maternity Review: Better Births, 2015. Improving outcomes of maternity services in England. *A 5 year Forward Review of Maternity Care.*

Royal College of Paediatricians and Child health. (2014): Safeguarding Children and Young People : *Roles and competencies for healthcare staff.* Intercollegiate Document. 3rd edition, March 2014. https://www.gov.uk/government/publications/safeguarding-children-and-young-people/safeguarding-children-and-young-people

NHS Resolution, 2020. Maternity incentive scheme (year 3), Maternity safety action 5. Available at; https://resolution.nhs.uk/wp-content/uploads/2021/02/Maternity-Incentive-Scheme-year-three-final-01022021.pdf

10. Appendices

10.1. Appendix 1: Consultation Summary

	List Groups and or Individuals Consulted
Those listed opposite have been consulted and comments/actions incorporated as required. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Clinical Lead for Delivery Suite
	Consultant Obstetricians
	Midwifery Team leaders and specialist midwives
	Anaesthetic Department
	Maternity Risk Management Group
	Planned and Surgical Care Directorate

10.2. Appendix 2: Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Appropriate numbers of staff are available to care for women in relation to activity levels on the maternity unit	The number of midwives and MSW's are monitored in relation to safer staffing levels, the midwife: birth ratio, 1:1 care in established labour – bi-annual midwifery staffing report	PAP	Ongoing monitoring via the BR+ acuity tool. Discussion of this will take place at PAP meetings.	PAP Maternity Risk Management Group (MRMG)	Planned and Surgical Care Quality and Governance Group
Process of escalation when staffing levels fall below the agreed minimum levels	Short term issues - maternity unit to follow the maternity escalation policy. Long term issues, departmental and Directorate risk registers are populated	PAP MRMG	Monthly Monthly	MRMG	Planned and Surgical Quality and Governance Group Trust Board
The maternity escalation procedure is implemented and followed as per the guideline (short term staffing issues)	The correct procedures are followed, appropriate documentation of the procedure and correct follow up of patients occurs in the event that the maternity unit needs to divert women to other hospitals as part of the escalation policy. An audit of the documentary evidence (RCA escalation template) to show compliance with this policy will be undertaken	PAP	Where the maternity unit has been required to divert women, CORM may request assurance that the correct procedures have been followed	CORM MRMG	Planned and Surgical Care Quality and Governance Group Trust Board

Appendix 2

ATAIN and Transitional Care provision report Quarter 4 (Jan- Mar 2023)

Report Overview

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, team work and improvement capability within maternity units.

Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Collaboration between neonatal and maternity staff at Harrogate District Hospital (HDFT) has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use our service. Along with this HDFT maternity and neonatal services completed the first year as a Wave 1 Trust, with the National Maternity and New born Safety Collaborative (NHSI). This national quality improvement programme enabled our maternity and neonatal service to further develop and focus on key areas for improvement using a consistent QI approach supported by the NHSI team and online resources. The improvement leads have focused on improving hypoglycaemia pathway of care and the jaundice pathway as well as communication with families and carers as part of the wider ATAIN programme of work. In addition to this we are trialling babies requiring readmission for jaundice to attend Pannal ward as first contact- we will be auditing this in due course as due to recent implementation.

The maternity and neonatal teams review the Term admissions at designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for HDFT is reviewed and tracked on the dashboard and shared with the local maternity and neonatal system. Actions are also generated in response to any themes or concerns.

ATAIN data: Quarter 4 2022/23:

During quarter four there were a total of 431 babies of all gestations born at HDFT, 410 of these were >37/40 weeks gestation and therefore applicable for the ATAIN audit. Of the 410 applicable babies, 16 babies were admitted to the neonatal unit (4%).

The most common condition for admission was Respiratory Distress Syndrome (RDS) with ten admissions in the quarter. This is a 50% increase from the previous quarter. One of the ten admissions with respiratory distress was deemed as avoidable. At the review panel it was concluded that there was an additional potentially avoidable admission of a baby that was admitted for a condition which would fall in the category of 'other'.

Condition	Number of Admissions	Number of Avoidable Admissions
Hypothermia	0	0
Jaundice	0	0
Respiratory Distress Syndrome	10	1
Hypoglycaemia	1	0
Other Clinical Conditions	5	1

Avoidable Admissions:

Case 1 – Respiratory Distress Syndrome

Reviewed at ATAIN meeting dated 20th March 2023 - born at 37 weeks gestation via planned caesarean section as a result of reduced fetal movements. Baby was born in good condition, but remained dusky (blueish hue to colour). At seven minutes of age it has been documented that baby was given oxygen to maintain saturations of >95%. However following the guidance of the Resuscitation Council algorithm, adopted in the trust guidance, saturations of 85-90% are acceptable at this time. Therefore, potentially less oxygen could have been administered. Baby remained on oxygen for 20 minutes in Delivery Suite and then was admitted to SCBU. The baby's condition improved on SCBU and oxygen was promptly weaned. It is felt that this care was a potentially avoidable admission. If observation of baby had continued for longer on delivery suite without starting oxygen it is likely that baby's condition would have normalised without requiring admission. The ATAIN panel would recommend that remaining with the baby for thirty minutes prior to admitting to SCBU is reasonable time to observe and reassess the condition of the infant. Action plan moving forward - further education on acceptable saturation limits after birth and the requirement for oxygen. Further education on giving expressed breast milk (when babies blood sugar is stable) instead of formula feeds for mothers who want to breast feed. Further team discussion into what is deemed as an acceptable blood sugar reading in term babies on SCBU. The postnatal ward guidance states 2.0mmols acceptable whereas SCBU guidance advises that 2.6mmols is acceptable. Parity across both services would mitigate cause for confusion. Furthermore reiteration of the importance accurate documentation of interventions, e.g. length of oxygen delivery.

Case 2 - Other

Reviewed at ATAIN meeting dated 2nd March 2023 - Baby born at 39+6 weeks gestation via emergency caesarean section under general anaesthetic due to pathological CTG and reduced fetal movements. Baby was born in poor condition and required resuscitation. Resuscitation was documented as two rounds of five inflation breaths and ten minutes of ventilation breaths before baby was breathing spontaneously. Baby remained floppy and the baby was subsequently admitted to SCBU for neurological assessment. It was determined after assessment that the baby did not meet both of Criteria A & B for active cooling (BAPM 2020) and was therefore warmed. IV fluids and IV antibiotics commenced as per protocol and these were stopped after 48hrs as blood cultures were negative. The ATAIN panel deemed that this was appropriate management and admission to SCBU, however this case was thought to be potentially avoidable. It was noted that there was a delay in an obstetric decision

to deliver this baby. The learning point that has arisen from this case is not to passively cool any baby on delivery suite. This decision needs to be made on SCBU, where a clinical assessment if baby meets both criteria A & B is necessary.

The ATAIN action log has been included in appendix 2 with the current and completed actions identified.

Transitional Care Provision and Standards:

Introducing Transitional Care (TC)

Through family integrated care, families have been encouraged to take an active role in caring for babies on the NNU. Introducing TC follows the same philosophy and thus services should be created with the needs of the family at the forefront.

One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Thus, reducing the risk of maternal and neonatal separation and increasing the chance that neonates remain well. This also ensures that care is cost effective. It is important that the staff working on the NNU and postnatal ward understand the difference between 'normal' post-natal care and TC. It is also vital that maternity and neonatal staff can evaluate and respond to the maternal and neonatal needs whilst being able to detect signs of deterioration as early as possible, therefore multidisciplinary collaboration is essential.

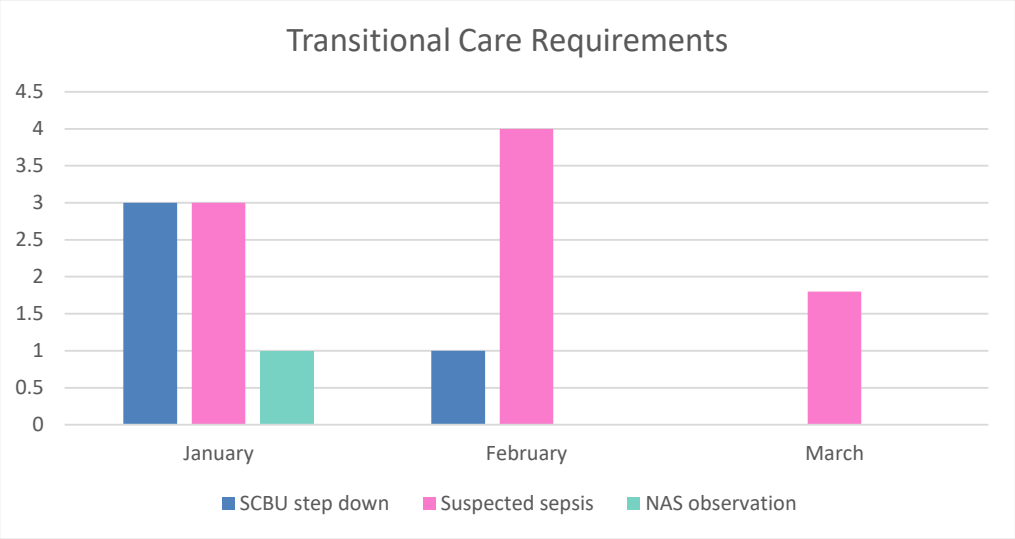
At HDFT, a review of TC babies occurs daily during dedicated rounds, where assessment takes place and plans of care are made. This review takes place using the jointly approved neonatal/maternity document. There is an escalation policy for any babies which are unwell which is well known by the team and followed should the need arise.

Transitional Care Provision 2022/2023:

The table below shows a breakdown of TC activity delivered within HDFT during 2022/2023.

Date	Number of admissions	Electronic method used to record data
April 2022	4	Badgernet
May 2022	5	Badgernet
June 2022	5	Badgernet
July 2022	4	Badgernet
August 2022	1	Badgernet
September 2022	4	Badgernet
October 2022	8	Badgernet
November 2022	3	Badgernet
December 2022	4	Badgernet
January 2023	8	Badgernet
February 2023	5	Badgernet
March 2023	6	Badgernet

Quarter 4 Transitional Care Data:



During quarter four there were a total of 19 babies requiring transitional care provision. 11 of these admissions were due to suspected sepsis and completed Intravenous Antibiotic treatment, five were stepped down from special care and reunited with parents on Pannal ward, one baby was treated for neonatal abstinence syndrome for five days and two babies have undocumented reasons for requiring transitional care.

12 of the 19 babies had transitional care booklets within their notes, 17 babies were noted to have daily ward rounds recorded and all 19 are noted to have badgernet documentation. There are two incidences where documentation could not be confirmed as notes had been archived. To improve the completion of booklets we have included discussion of this in the induction package for junior doctors rotating into paediatrics, furthermore if the document is incomplete they are returned to the doctor to complete and ensure data is captured.

Since 21st of March 2023 Badgernet for Maternity has been introduced which has capability to record Transitional Care episodes within it – the implementation of this is for further team discussion this month. It is hoped that use of Badgernet for Transitional Care will enable assessment of the requirement for transitional care booklets and if these can be replaced by Badgernet documentation.

In addition to the above there are noted incidences of babies remaining on SCBU that could be cared for under transitional care. There are two main factors for this occurring.

1. Babies with low flow oxygen requirement
2. Babies who require nasogastric feeding support

These babies would be fit for a transitional care ward and could be accommodated on the postnatal ward with adequate skill resources and training. This remains under discussion at present.

Next steps

It is recognised that an amount of special care activity, particularly babies born at term, could be delivered in a transitional care environment thus reducing the separation of mums and babies. To achieve this goal neonatal and maternity services at HDFT will continue to improve the scope for transitional care provision on the ward. In working towards this a trial is currently taking place which enables babies requiring readmission for treatment of jaundice to be directly admitted to Pannal ward.

Transitional Care Action Log:

Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date
Data Capture of babies on Pannal	Electronic handovers saved on Pannal Monthly data shared with SCBU staff to collate Badgernet information	Lesley Copeland	**Completed 6/1/23**
Increased documentation in TC booklets	Introduced at junior doctors induction, Badgernet training Datix completed if not completed correctly	Nina Kapur, Rachael Waddington	**31/05/23**
Transitional Care inclusion at Obstetric/ Neonatal Meeting	Transitional care added to agenda as a standing discussion item	Lesley Copeland	**31/05/23**
Requirement of TC booklets	Discussion to examine need of using booklets alongside Badgernet	Lesley Copeland Nina Kapur Rachel Robson	**31/5/23**

Appendix 1: Cumulative ATAIN Action Log

1. Quarter 3 & 4 – Added Actions

Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Hypothermia management - feedback from Neonatal-Obstetric meeting	For application of hats to babies born in main theatre. Discussion of more vigilance/action with babies having risk factors. Discussion about routine application of hats to all babies for first 24 hours (excluding skin-skin)	Jo Orgles/ Delivery Suite Managers	**Completed**	Message sent for application of hats to babies born in Main Theatre
Importance of nursing & medical documentation no matter how short the admission - nothing in baby notes or on Badger	Datix when no notes are documented	Lisa Nesbitt	**Completed**	
Baby should not come to SCBU for cannulation/IV drug administration, this can be done on Pannal with Mum	Communicate to medical & nursing staff	Lisa Nesbitt	**Completed**	Emailed Sobia 22/11
Vapotherm should not be commenced without Consultant approval	Check guidelines and ensure this is outlined within these. Communicate to medical & nursing staff	Lisa Nesbitt	**Declined**	Emailed Sobia 22/11- happy for clinical decision to remain with registrars

Hypothermia management improvement - hat applied instead of warmed by heater	Already actioned by Jo Orgles (see point 15 above)	Jo Orgles	**Completed**	
Try to monitor babies for longer on D/S with borderline sats/WOB before admitting (30 mins)	Continue to encourage staff to stay with baby for ~ 30 minutes if conditions allow	Lisa Nesbitt	**31/05/23**	Explore New ways to encourage this, as not really happening, 28/12 AS to laminate SOP and put on resuscitaires. Sobia will include borderline cases as a Simulation example.
Ensure parents are updated on baby's condition by medical team and this is documented on yellow notepaper - complaint received from parent	Discuss with neonatal lead	Sobia Bilal	**Completed**	
Baby should not be sent for active cooling without Consultant review	Discuss with neonatal lead	Sobia Bilal	**31/05/23**	

Appendix 2: Overview of Safety Action 3 Compliance

1.1 Safety Action 3 – Transitional Care Requirements

Required Standards following of MIS	Current status	Expected Evidence

a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	**Compliant**	Transitional care guideline jointly agreed with neonatal and maternity services in August 2020 reviewed and updated in 2022
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	**Compliant**	Transitional Care Guideline jointly agreed with neonatal and maternity services in 2017, reviewed and updated in 2022. Guideline implemented 2017 with review in 2022. Neonatal booklet agreed with neonatal and maternity services. Booklet completed for all transitional care admissions. Audit performed every 6 – 8 weeks by a band 7 and band 4 collaboratively with maternity and neonatal services.
c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	**Compliant**	Data recording on Badgernet for all TC admissions. Monthly audit of data recording compliance by band 4 from the neonatal unit and band 7 from maternity service. All TC admissions have an agreed neonatal/maternity booklet completed which aids in the capturing of TC data.

d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered	**Compliant**	
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	**Compliant**	These returns have not been requested by the ODN/Commissioner. If requested this data can be provided from the Badgernet system.
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred	**Compliant**	

or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.		
f) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.	**Compliant**	Action plan previously shared with Exec Safety Champion and Neonatal Safety Champion.
G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	**Compliant with action plan. See GAP analysis.**	See GAP analysis.

1.2 Gap analysis - Transitional Care (TC) requirements according to the MIS

Required Standard	Current status of TC at HDFT	Action Plan
G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	**Compliant of MIS with action plan.**	

Board of Directors
31st May 2023

4.2

Title:	**CQC Maternity Action Plan**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), Andy Brown (Lead Midwife for Safety, Quality & Clinical Governance), 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 an update on the CQC Maternity Action Plan.	
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	
	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	N/A	
Report History:	Maternity Risk Management Group, Maternity Services Forum, Senior Management Team	
Recommendation:	Board is asked to note the attached action plan and progress to date.	

TRUST BOARD (in Public)
CQC Maternity Action Plan

1.0 INTRODUCTION

In November 2023, the Care Quality Commission (CQC) inspected maternity service for HDFT. Following a factual accuracy process and final action plan was developed and submitted to the CQC.

2.0 ACTION PLAN

Attached at Appendix 1 is the CQC Maternity Action plan including actions completed to date. The action plan is monitored through the quality governance framework with the Trust.

3.0 RECOMMENDATIONS

The Board are requested to note the content of the action plan and progress to date.

Maternity Services - CQC Action Plan

ID No	Must / Should Do	CQC Action Area	Action	Responsible Lead	Target Date	Current Status (Complete, Ongoing and on Track, Ongoing and off Track)
Mat1	Must	Regulation 12 (2) (a) The service must ensure they embed a system of oversight for women attending the MAC to prioritise their care appropriate and monitored	See Separate Action Plan	Associate Director of Midwifery	20-Apr-23	Ongoing on Track
Mat 2	Must	Regulation 12 (2) (a) The service must ensure all equipment is checked and escalated if needed in line with local policy and guidance and regulations.	Manager of the Day rota to commence which includes oversight and monitoring of equipment checks	Matron for Maternity Services	31st March 2023	Complete
Mat3			Ward Manager and Matron checks included on Tendable (auditing tool) for oversight and monitoring of equipment	Matron for Maternity Services	31st March 2023	Complete
Mat4			Auditing of safety checks scheduled for 3 months and 6 months	Matron for Maternity Services	31st March 2023	Complete
Mat5	Should	The service should complete all relevant documentation when incidents are reviewed	All 48 Hour Reviews taking place since 1st January 2022 to be audited to ensure that all relevant fields have been completed	Associate Director of Quality and Corporate Affairs	01-Feb-23	Complete
Mat6			All governance leads to be reminded on the importance of completing all sections of 48 Hour Review documentation including fields where Not Applicable should be indicated.	Associate Director of Quality and Corporate Affairs	01-Feb-23	Complete
Mat7	Should	The service should continue to ensure staff receive appropriate support, training, professional development supervision and appraisal	Team Leaders to present Mandatory Training Compliance at monthly Perfect Ward meetings for review and actions against exceptions	Associate Director of Midwifery	31st March 2023	Complete
Mat8			Named Midwife for Safeguarding to review Safeguarding Training Compliance and action against exceptions	Named Midwife for Safeguarding	31st March 2023	Complete
Mat 9			All relevant staff to be rostered to attend Safeguarding Training and Supervision	Named Midwife for Safeguarding	31st March 2023	Complete
Mat10			Monthly monitoring of compliance with Safeguarding training with a 90% target to be achieved by 30 September 2023	Associate Director of Midwifery	30th September 2023	Ongoing on Track
Mat11			Appraisals to be increased with 90% target to be achieved by 31st March 2023	Matron for Maternity Services	31st March 2023	Complete
Mat12			Pool evacuation training to be schedule for all staff annually	Professional Development Midwife	31st March 2023	Complete
Mat13	Should	The service should continue to embed systems to assess, monitor and improve the quality and safety of services	*In service auditing process to be commenced. Midwife to be recruited in to audit and quality role to enable appropriate clincal auditing. Results to be presented at MDT governance meeting and actions agreed as required.*	Matron for Maternity Services	30th June 2023	Ongoing on Track

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

May 2023

Russell Nightingale
Chief Operating Officer

Operational Update May 2023 (April Performance)

Matters of concern & risks to escalate

- Cancer 2WW performance was below the 93% target at 63.1% (5.10), increased from 60.5% in Mar.
- Cancer 62-day wait target not achieved at 77.2% (5.9.1)
- 2WW position driven by Skin (recovering), Colorectal (plan developed), Gynae (plan developed), Breast (additional capacity being implemented)
- >62 & >104 days cancer pathway high – focus on significant reduction following cancer away day.
- 4 x 12 hour trolley waits in April (42 in March) – no harms identified
- Non RTT waits - data collection being revised to create a sustainable and lean process with improved data quality.
- CT scanner resilience : loss of capacity in CT scanner due to several breakdowns of in building scanner impacting waiting times for patients.
- Community Dental long waiter recovery – significant risk of being unable to maintain <78 week wait without more sustainable funding from commissioners to increase capacity in the service

Major actions commissioned & work underway

- Turner & Townsend appointed to project manage TIF2 – scheme out on P23 for main contractor- closes end of May
- Focus on GIRFT productivity in surgical specialties to commence
- Agilisys project underway with phase 1 SoW agreed– working with Leeds Teaching Hospitals around shared data reporting model.
- Transformation role advertised to support step change in ward based patient flow (red to green methodology)
- Cancer performance moved to central team – focus on supporting cancer site teams in delivering improved performance/ experience for patients.
- CT resilience: rapid implementation of acute scanning capacity to provide resilience – onsite w/c 28th May
- RTT validation team enhanced alongside AI solution plus pilot of text message validation of patients of waiting list

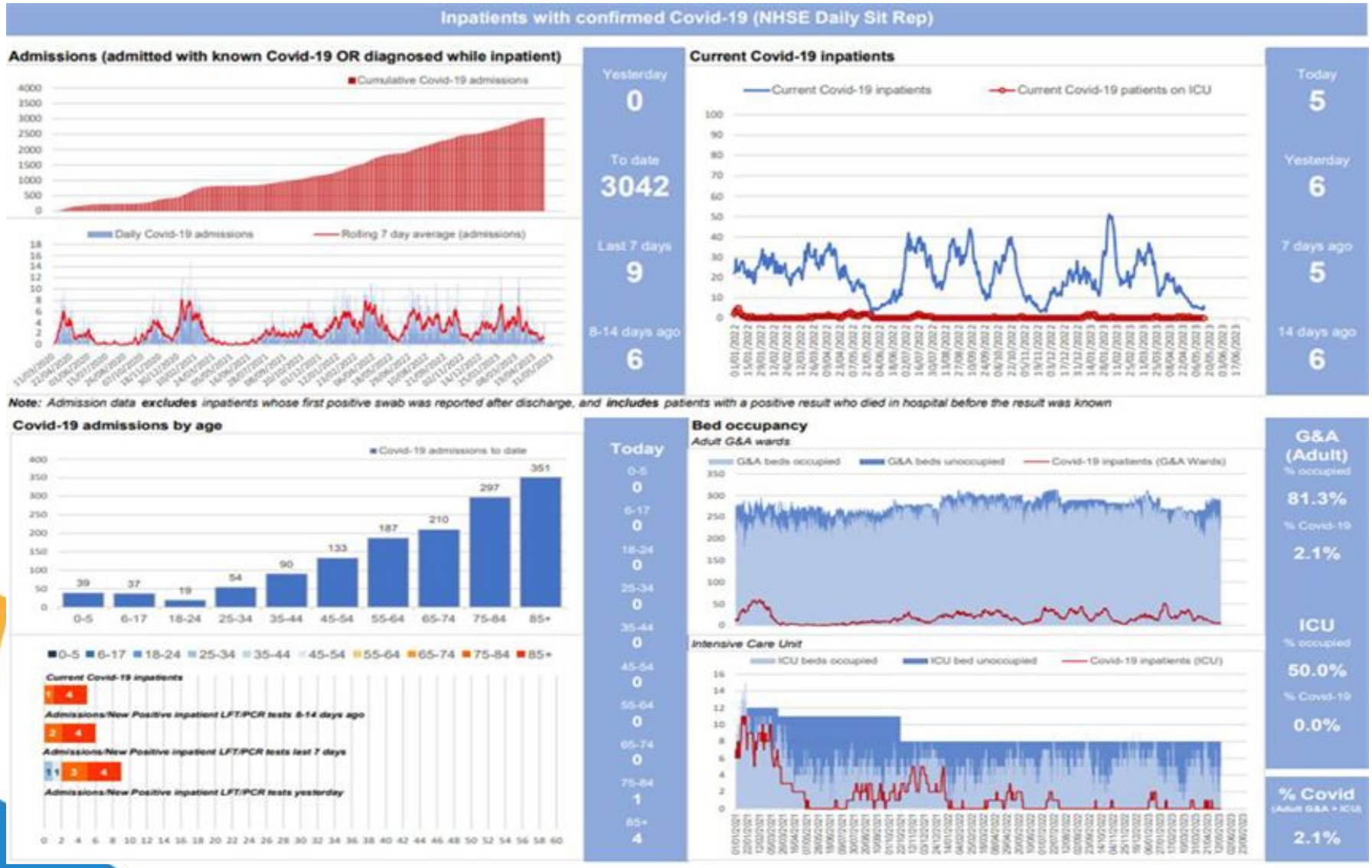
Positive news & assurance

- Cancer 31-day wait target achieved at 96.3% (5.1.2)
- Continued reduction in RTT waiters. 78 week target achieved end of March. Now working towards zero 65 week waits by 31.03.2024.
- The Trust had no over 60-minute ambulance handover breach in April (18 last month).
- Levels of COVID inpatients reducing to around 5 inpatients.
- ED Performance improvement sustained – above 80% (83.3%) for April, first time since Sept'21.
- Industrial action in April (Nursing, Junior Dr and Ambulance) – no safety incidents, some cancelled activity but no impact on long waiter recovery
- Cancer away day took place with 4 cancer site teams (Gynae, Urology, Colorectal and Skin) developing numerous actions to streamline and improve performance/ experience for patients
- Childrens & Community Performance 'green' across all measures YTD

Decisions made & decisions required of the Board

- Boundary divert for York patients to Harrogate agreed to reduce ad hoc diverts whilst continuing support to York District Hospital (c2.2 per day)

COVID-19 Management Report



Children's and Community

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North**	91.9%	94.3%	94.0%	96.4%	94.2%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	94.8%	96.0%	95.0%	97.4%	95.8%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	97.8%	99.2%	99.6%	97.8%	98.6%
Health Visiting – % of infants receiving a new born visit within 14 days of birth -	91.5%	96.9%	93.9%	96.5%	94.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	93.4%	96.4%	93.4%	95.7%	94.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	97.4%	97.6%	98.4%	99.0%	98.1%
Health Visiting - % of children receiving a 12 month review by 15 months - **North Yorkshire**	97.6%	98.1%	98.1%	97.1%	97.7%
Health Visiting – % of infants receiving a new born visit within 14 days of birth -	96.7%	95.6%	93.6%	92.5%	94.6%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	88.1%	93.5%	96.5%	96.5%	93.7%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	92.1%	91.5%	90.1%	89.1%	90.7%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	98.5%	96.9%	98.9%	97.0%	97.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	93.4%	96.0%	96.6%	95.7%	95.4%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	91.1%	96.9%	95.5%	95.7%	94.8%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	93.8%	96.4%	93.5%	95.9%	94.9%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	95.3%	95.7%	96.9%	98.0%	96.5%
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Northumberland**	93.9%	93.0%	90.8%	91.9%	92.4%

Adult Community
Service still running at OPEL 3 due to a continuing high vacancy rate in adult community nursing (currently 22.5%).
A number of initiatives continue to be undertaken including a District Nurse banding review and appoint to rotational nursing posts to support ARCHS and Community Care Teams.

0-19
SCPHN Health Visiting and School Nurse vacancies remain a key risk (currently 18.5%)
A revised recruitment and retention action plan has been pulled together by the Head of Nursing for Community and Children which is based on the outcome of inpulse / Staff Surveys, staff engagement sessions and shared learning from across the Directorate.
A newly configured Community and Children's Recruitment and Retention chaired by the Head of Nursing for CC is overseeing this action plan.

Safeguarding
Continued high levels of Safeguarding activity. There are particularly high levels of Safeguarding strategies in Middleborough. Two new Safeguarding roles to support 0-5 services in this area are now in place which are having a positive impact on health visitor workload.
Floating Safeguarding strategy Nurses continue to support most pressured 0-19 contact areas.
Statutory responsibilities still being delivered.

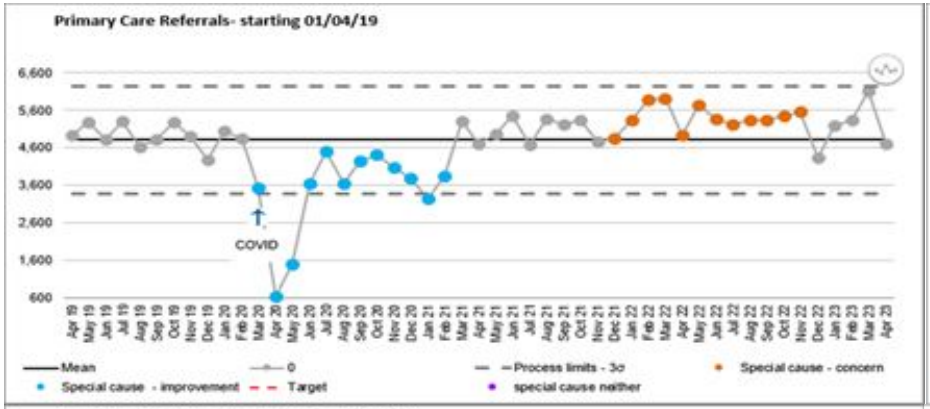
Community Dental
There were no patients who had waited longer than 78 weeks RTT at the end of March 23. Due to the volumes of patients waiting and capacity challenges maintaining 78weeks is a significant risk in the first quarter of 2023/24.
Paediatrics is the key pressure area and we have been unable to appoint to increase capacity due to a shortage of clinicians.
A Business Case has been pulled together to model waits and where investment will be required and a meeting set up to discuss. WLI's have continued to be scheduled at risk into 2023/24 while conversations with commissioners take place.

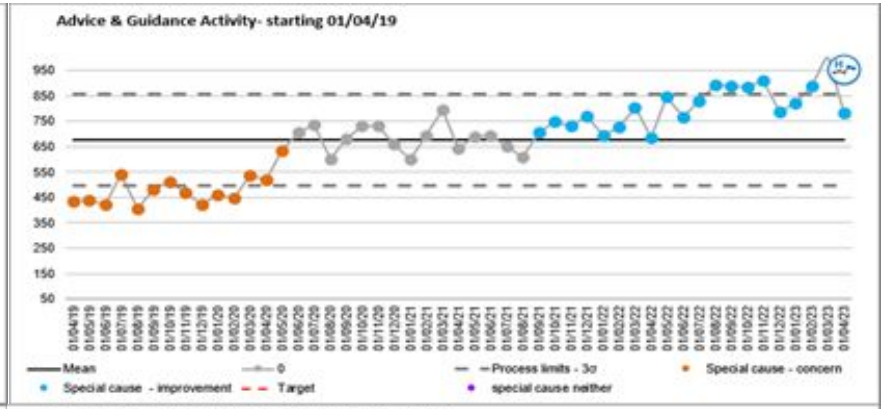
Planned Care Recovery

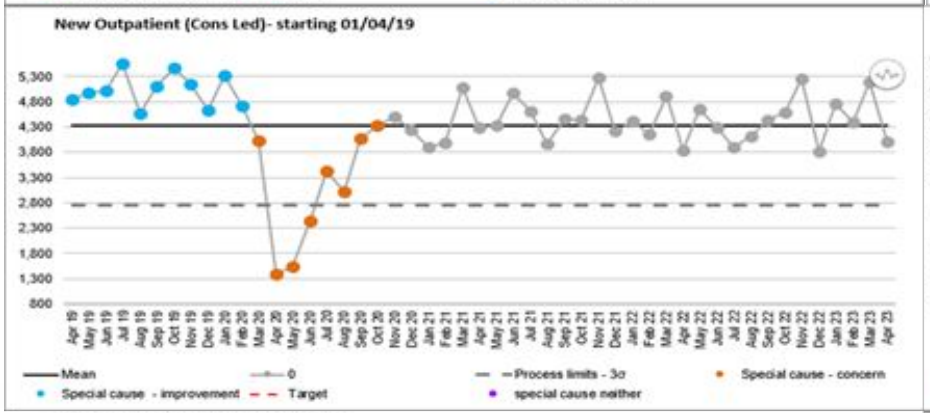
Outpatients	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	341	344	355	473	383	441	491	464	416	481	426	370
Actual	883											
Consultant-led first outpatient attendances (Spec acute) - Plan	3,623	3,658	3,778	5,032	4,075	4,691	5,223	4,931	4,419	5,112	4,528	3,929
Consultant-led first outpatient attendances (Spec acute) - Actual	4,012											
Consultant-led follow up outpatient attendances (Spec acute) - Plan	5,352	5,653	5,280	7,167	6,166	6,585	7,850	7,075	6,168	7,494	6,407	6,121
Consultant-led follow up outpatient attendances (Spec acute) - Actual	8,916											
Elective Admissions												
Total number of specific acute elective spells in period -Plan	2,103	2,480	2,270	2,977	2,878	2,711	3,035	2,957	2,499	2,944	2,691	2,057
Total number of specific acute elective spells in period -Actual	2,311											
Total number of specific acute elective day case spells in period -Plan	1,944	2,283	2,076	2,687	2,644	2,491	2,795	2,711	2,307	2,664	2,485	1,915
Total number of specific acute elective day case spells in period -Actual	2,154											
Total number of specific acute elective ordinary spells in period -Plan	159	197	194	290	234	220	240	246	192	280	206	142
Total number of specific acute elective ordinary spells in period -Actual	157											
RTT												
Number of completed admitted RTT pathways - Plan	840	986	897	1,161	1,142	1,076	1,208	1,171	996	1,151	1,074	828
Number of completed admitted RTT pathways - Actual	*1,064*											
Number of completed non-admitted RTT pathways - Plan	3,439	3,472	3,586	4,776	3,869	4,453	4,958	4,681	4,195	4,852	4,298	3,730
Number of completed non-admitted RTT pathways - Actual	*3,488*											
Number of New RTT pathways (clock starts) - Plan	5,339	5,534	5,622	7,688	6,738	7,136	8,152	7,576	6,756	7,824	6,949	5,688
Number of New RTT pathways (clock starts) - Actual	*5,757*											
Number of RTT incomplete pathways waiting +52 weeks - Plan	1,200	1,200	1,200	1,190	1,180	1,170	1,160	1,150	1,100	1,100	1,050	1,000
Number of RTT incomplete pathways waiting +52 weeks - Actual	*1,035*											
Number of RTT incomplete pathways waiting +65 weeks - Plan	470	470	470	450	440	430	390	370	350	300	200	0
Number of RTT incomplete pathways waiting +65 weeks - Actual	*211*											
Total number of RTT incomplete pathways - Plan	25,500	25,300	25,100	24,900	24,700	24,500	24,300	24,100	23,900	23,700	23,500	23,200
Total number of RTT incomplete pathways - Actual	*26,059*											
Cancer												
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Plan	65	65	60	60	55	55	50	50	50	50	50	50
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Actual	88											

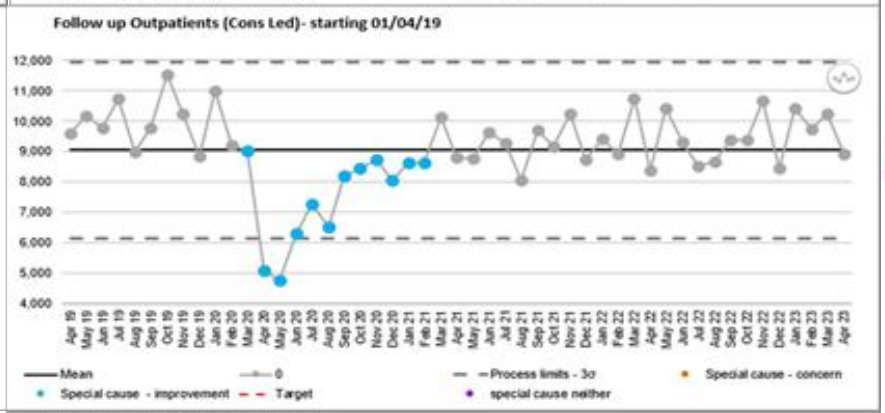
Increasing elective capacity to 2019/20 levels continues to be the key focus. 12% of 2019/20 was delivered through premium out of core sessions which may not be replicable.
New outpatient activity above plan for April. Follow ups significantly over delivered against a national ask of 25% reduction. Internal plan is 24% reduction – increased numbers of PIFU pathways are a step towards this. Plans for reducing follow up are being developed by services to create more capacity for new outpatients/ other activity. There remain some follow up backlogs which need to be cleared before a reduction can be actioned.
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) – we are working to include this activity (as itr directly avoids additional new outpatient appointments)
End of April – No reportable patients over 104 or 78 weeks. 5 patients over 78 weeks due to patient choice.
In addition supported York with 36 Max-Fax – 10 of which were >78 weeks at end March but these long waiters are reported by Y[illegible]nly RTT return.

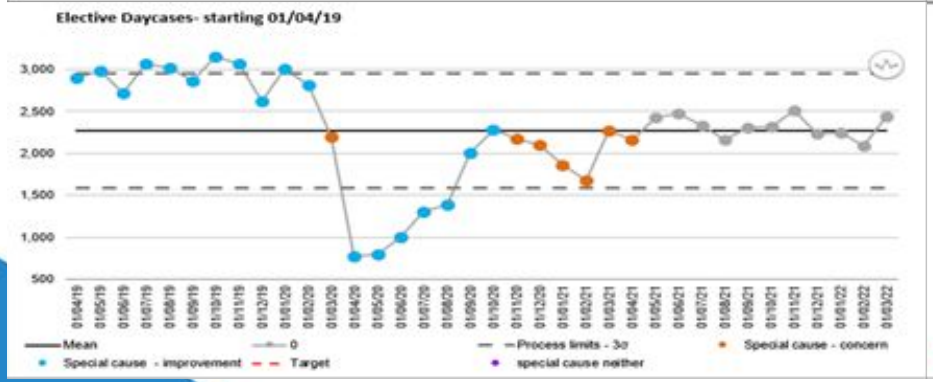
Elective Recovery

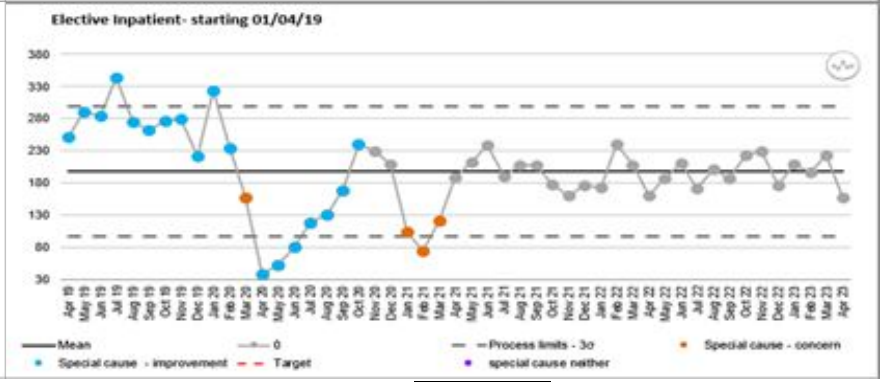










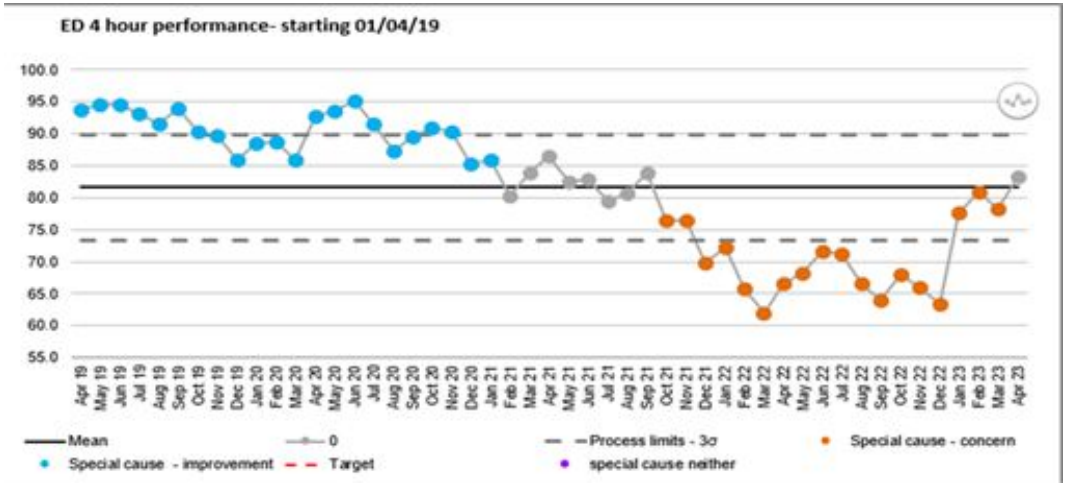


Referral to Treatment (RTT)

	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
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350
> 65 weeks	499	461	463	471	500	519
> 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	Mar-23
Total incomplete RTT pathways	25,437	25,388	24,951	24,854	25,139	25,504
> 52 weeks	1,285	1,201	1,228	1,186	1,112	997
> 65 weeks	477	401	477	399	362	193
> 78 weeks	112	100	118	101	65	4
> 104 weeks	0	0	0	0	0	0
	Apr-23					
Total incomplete RTT pathways	25,451					
> 52 weeks	992					
> 65 weeks	202					
> 78 weeks	0					
> 104 weeks	0					

RTT – provisional data indicates that the Trust had 26,059 patients waiting at the end of April, an increase in total RTT pathways. However 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 un-validated.
There are zero reportable patients waiting 78+ weeks
In addition, there were 10 York transfer patients waiting 78+ weeks – these patietns are reported by York Trust.
Of the 3,939 patients waiting for a procedure on our waiting list, 42% are Orthopaedics and 14% are Ophthalmology.

Urgent Care and Diagnostics



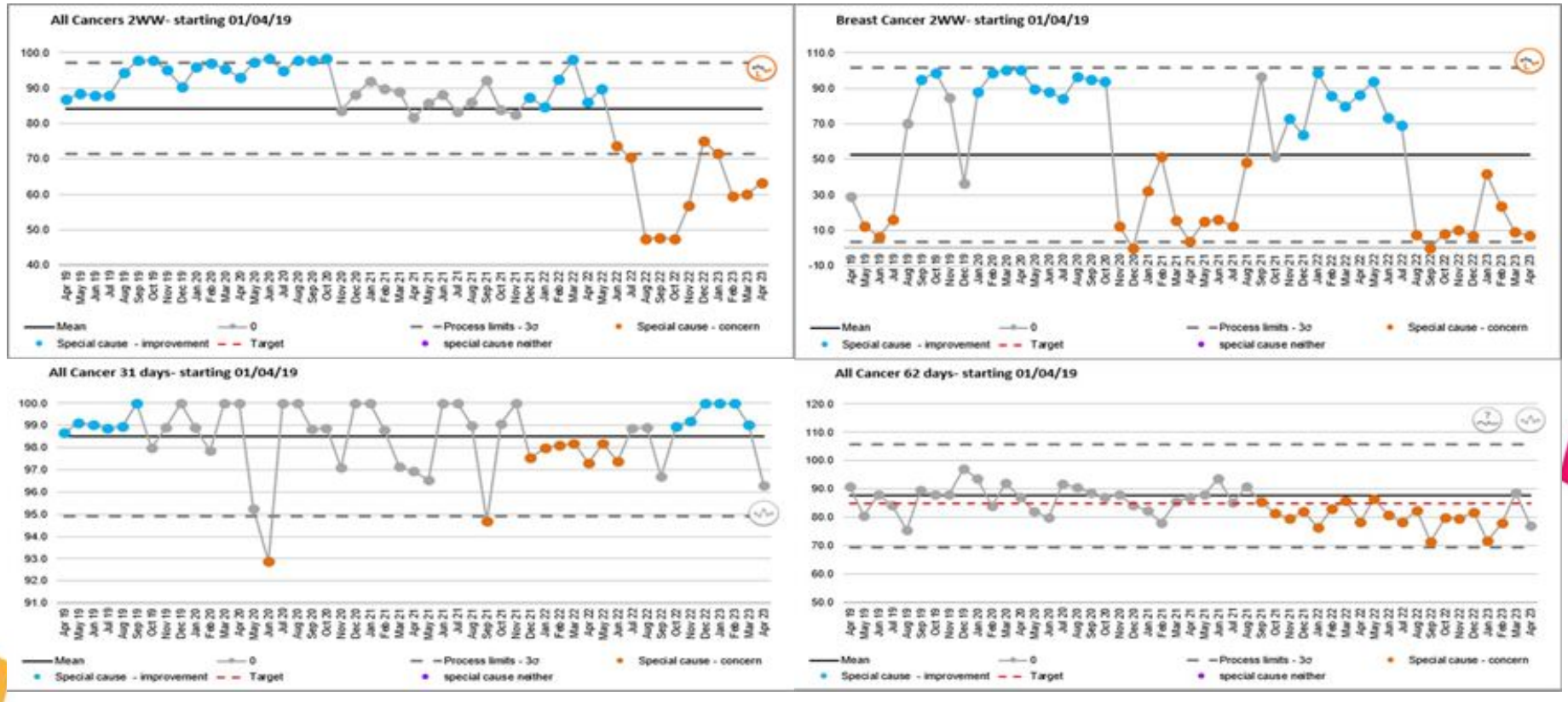
	12 Hour DTA
June 22	15
July 22	37
August 22	82
September 22	60
October 22	72
November 22	67
December 22	165
January 23	115
February 23	16
March 23	45
April 23	4

	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23
York ambulance diverts*	66	83	72	65	68	59	70	86	49	70	72	132

	30 Min HO (including 60+ mins)	60+ Min HO
June 22	30	1
July 22	14	2
August 22	16	2
September 22	77	25
October 22	42	41
November 22	79	28
December 22	183	97
January 23	80	39
February 23	26	9
March 23	39	18
April 23	2	0

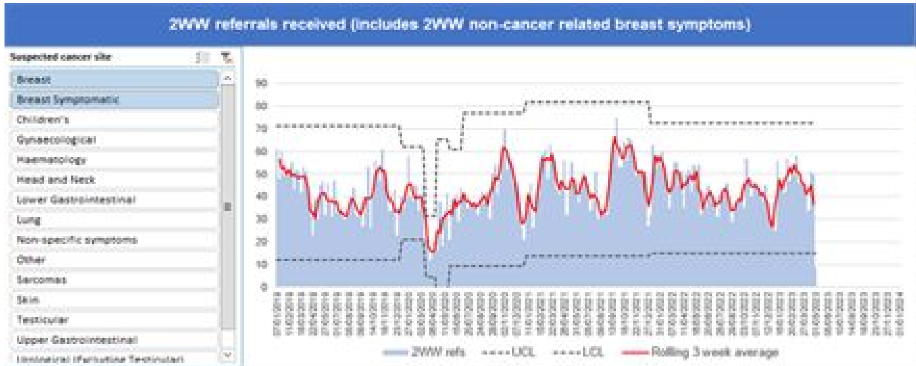
- Performance against the A&E 4-hour standard was at 83.3% in April, above the new performance standard of 76%. ED performance since streaming model commenced has shown a step change. This is also linked to an improved period of bed availability.
- There were 4 x 12-hour trolley wait breaches in April (45 in Mar).
- There were no over 30-minute ambulance handover breaches in April (42 in Mar).
- 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.

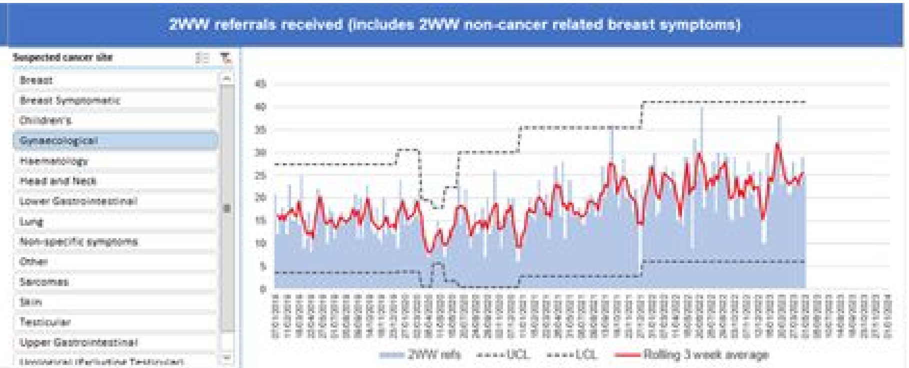
Cancer Performance

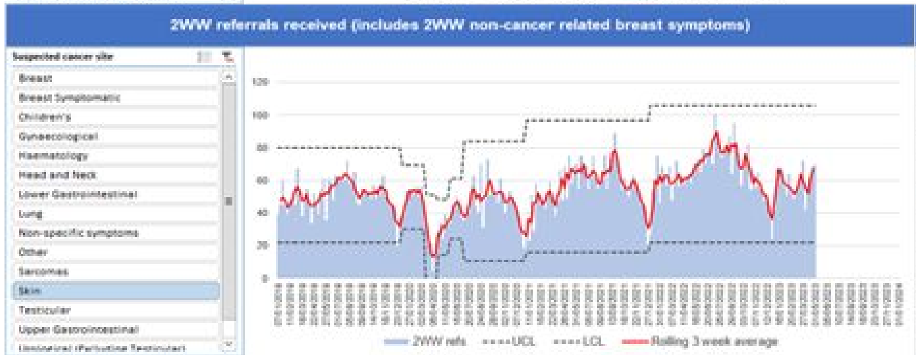


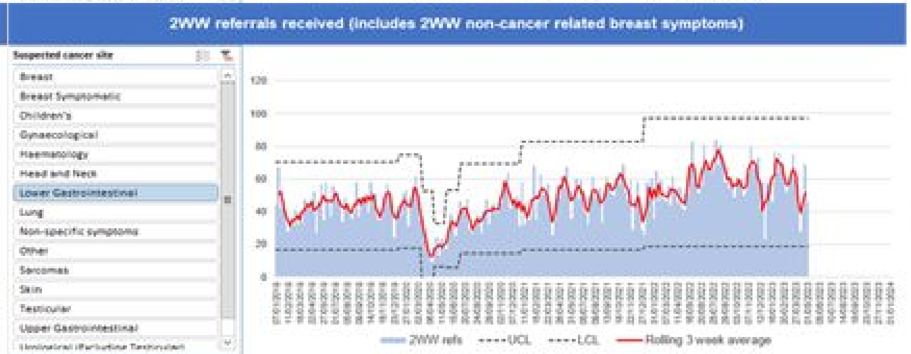
- The 62-day standard was not met in April with a performance of 77.2% against the 85% standard.
- The 31-day standard was met in April with a performance of 96.3% against the 96% standard.
- The 2-week wait standard was not met in April with a performance of 63.1%. A significant increase in 2WW referrals has been seen in several challenged services (Breast, Lower GI, Dermatology and Gynaecology).
- The 2-week wait breast symptomatic standard was not met in April with just 7% 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 April, 88 (80 in Mar) patients remain on an open cancer pathway over 62-days with 14 (17 in Mar) 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 April.
- 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. Nurse Hysteroscopist from Leeds is supporting improvement. Womens unit being overseen by newly recruited matron to support utilisatrion and efficiency
- Lower GI : Successful recruitment of a new General Surgeon will improve the Lower GI capacity from October. In the interim additional lists for independent middle grades and other utilisation of capacity on Mondays and Fridays (currently available consultant time but no theatre time) will support recovering position by July.
- The skin 2WW position which deteriorated following from the excellent recovery in November is now recovering again(May position) with new super clinic methodology being implemented to support a sustainable way of working.
- Breast – additional capacity clinics to run in June (48 slots) will deliver improvement.

Finance Position April 2023

Matters of concern & risks to escalate

- The Trust reported a deficit position in month 1 of £1.7m. This is £0.9m adverse to the Trust Operational Plan, and £2.2m adverse to the stretch plan set as part of the wider 2023/24 planning round.
- Key drivers for the position include performance against saving requirements, premium expenditure to cover the junior doctor strike, and continued reliance on agency staff in some areas.
- There is also adverse positions to address in the Emergency Medicine Care Group, Breast/General Surgery/Urology/Vascular Care Group, Maternity Care Group, and two of the Childrens Services contract areas.
- There are emerging impacts on the capital programme which will create a resource pressure such as the immediate needs to address CT capacity and resilience.
- There remain delays with the sign off of the audited subsidiary and charity accounts.

Major actions commissioned & work underway

- Implementation of the 2023/24 capital programme, reviewing the impact of reactive schemes such as CT, as well as emerging slippage.
- Development on Model Hospital reporting as well as wider benchmarking information to support directorates in opportunity identification of savings.
- Working with informatics and directorate colleagues to address counting and coding issues in relation to Elective Recovery Funding.
- Understanding the various impacts of the 2023/24 pay deal and funding, alongside the practical implementation from a payroll perspective.
- Supporting digital colleagues in finalising the EPR OBC.

Positive news & assurance

- Positive engagement from Care Groups in relation to financial accountability and autonomy.
- Cash position remains positive, with sustained Better Payment Practice Code performance. Focused work on procedures to drive further improvement.
- Audit process underway for 2022/23 audit process with Azets, as well as planning for 2022/23 subsidiary and charity audit.

Decisions made & decisions required of the Board

- Board of Directors are asked to approve the recommendation in relation to preparing the accounts on a Going Concern basis as per the attached document.

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. 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 OUR 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 completed and being reviewed at June People & Culture Programme Board and Health & Safety Committee. • 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 90%. • 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. • Retention Group established as sub group of Looking After Our People and Belonging, first meeting scheduled for 22 May.	
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. • Improved employee engagement via survey scores.		• Continue to deliver Pathway to Management and First Line Leader training. • Implement Pathway to Management as a mandatory requirement. • Develop and promote Leadership journey • 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.	• Delivery plans in place for both programmes. • Leadership Team discussion required around mandating Pathway to Management. • Leadership Journey is being re-mapped and communication plan for this under development, including how to build this into our recruitment processes. • 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 OUR 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.	
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 • World Staff Network day was well supported by the Trust with 200 information packes being handed out and this event has increased numbers in all staff networks. • 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 made by 28 Feb 23 following Equality Reference Group agreed on outcomes. Trust has scored as Developed across all 3 domains.	

				• Workshop being scheduled to support development of action plan. • Transgender training to be implemented prior to the introduction of the Transgender Policy.	
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 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 OUR 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 – achieved • 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 – completed. • . 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.	

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

GOAL: AT OUR 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

Belonging

- Suzanne Lamb will be standing down as executive sponsor of the LGBT+ staff network group. A replacement needs to be found, with agreed time to release.

Growing for the future

- Foundation Training Overall Compliance
  Core: 73% , Role Specific: 57% ,Overall: 62% (April 2023)
- Bank Training Compliance
  Core: 82% , Role Specific: 68% ,Overall: 75% (April 2023)
- Local Induction Checklist Compliance 76.3% up from 73.7% (April 2023)
- Overall Medical Device Low for theory and devices 78% (March 2023)
- Hot spot low compliance – see Mandatory Training Update Paper and Org RAG report
- Cedar room will no longer be available for Manual Handling, awaiting further information regarding room space to meet current training provision

Major actions commissioned and work underway

Belonging

- Transgender employee policy developed and to be implemented following a programme of education has taken place across the Trust to facilitate understanding of the policy and its' impact and implications.
- Discussions held regarding the implementation of Reciprocal Mentoring Cohort 2.
- Rainbow Badge Accreditation - final submission to Stonewall 19 April 23 – awaiting feedback
- EDS22 – Workshop to be held with relevant parties and Diverse McKenzie to scope and prioritise action plan.
  - Domain 1 to agree project lead (Jenny Nolan and Jo Twigger)
  - Domain 2 and 3 with Richard Dunston-Brady to progress and update – staff health conditions have been addressed by Wellbeing Manager but needs further publicity. Ward walks taking place with Richard Dunston-Brady and Mel Kavanagh from 2 May 2023
- National Day of Staff Networks taking place on 10 May 2023. All seven networks will be showcasing their work – including Wellbeing
- Wallace Sampson is attending each of the staff network groups.
- Pay gap reports for gender and ethnicity – action plan focus mostly on the CEA and will be addressed later in the year when the CEA panel is reconvened.

Growing for the future

- Induction action plan to phase improvements on induction and reporting in place.
- Medical Devices work continues to improve compliance.
- Mandatory training review continues
- Leadership Development Offering is being reviewed.
- Proposal for new governance structure for additions, changes and removal of mandatory training requirements paper developed for review by Leadership Team.

People & Culture

Matters of concern and risks to escalate

Looking after our people

- Staff Engagement – Survey Scores (Benchmark Group Acute & Community Trusts)
  - 7.20 – 31 Jan 2023 (Theme Kindness) – Benchmark Score 6.3
  - 6.84 - 30 Nov 2022 – National Staff Survey – Benchmark Score 6.76
  - 6.91 - 31 July 2022 (Theme Teamwork) – Benchmark Score – 6.37
  - 7.03 - 30 April 2022 (Theme Integrity) - Benchmark Score – 6.28
  - 6.96 - 31 Jan 2022 (Theme Kindness) - Benchmark Score – 6.36
- Turnover – Target 12% Turnover Rate has had a further small decrease from 15.44% to 15.12% as at 30 April 2023. The Trust has seen a general decreasing trend and was 15.5% in December. (This incorporates voluntary and involuntary turnover). Most Directorates have seen a decrease in turnover rates in March, with the exception of CCs Directorate which saw an increase from 15.46% to 15.67%.
- Sickness – Target 3.9% - Sickness remains at a similar level in April, seeing a minimal decrease from 4.57% in March to 4.55%.
- Appraisals – Target 90% Appraisal Rates have seen an increase in April to 84.76% from 82.11% in March.
- Vacancy Rate has increased from 8.01% in March to 8.75% in April, however this is due to an increase in budget going into the new financial year. This equates to 393.30wte vacancies. The difference between the March 2023 budget and the new budget for 2023/24 for April 2023 is 52.13wte and this is the reason for the vacancy position increasing. Our staff in post has grown from 4,088.45wte last month to 4,103.13wte (+14.68wte).
- Repurposing of Cedar Room to deliver clinical services displaces Moving & Handling Training, meaning some training dates cancelled whilst alternative provision made.

Major actions commissioned and work underway

Looking after our people

- Occupational Health & Wellbeing system change – Cority (COHORT) project established and work to commence in June.
- National Health & Wellbeing Diagnostic Tool – diagnostic completed and action plan under development
- Health & Safety Executive - Managing workplace stress audit – desk based Trust-wide audit undertaken and proposal for programme of work to be considered at June People & Culture Programme Board and Health & Safety Committee meetings.
- CQUIN – 85% for staff vaccination has been signed up to. Vaccination Steering Group to re-commence meeting in June 2023
- Cost of living question analysis from Inpulse Kindness Survey to enable identification of most beneficial support. Identified that some colleagues unaware of the support available.

New ways of working

- Clear grasp and understanding on temporary staffing across the Trust in all staff groups has begun and a project team has been identified to take this work forward
- Over Recruitment guidance has been signed off and the first selection of staff groups for over recruitment selection has been agreed at NWOW.
- Medical e-rostering business case has been submitted to Director team for final sign off.
- Re-introduction of the Pay Incentive Group
- Medical Additional Rates Group in place.

People & Culture

Positive news and assurance

Belonging

- All staff network chairs have two hours of protected time per week to carry out their duties should it be required
- BAME leadership programme – receiving very positive remarks from cohort 1. Two of six sessions have been completed

Growing for the future

- Core Mandatory Training for substantive colleagues, compliance is 87% overall. Permanent staff – Core: 94% , Role Specific: 87% ,Overall: 90%
- Received Virtual Reality Pilot commenced this week with Gui Tran teaching Knee Injection
- Confirmed funding from Medical Education to support the next Dr in Training Improvement event.

New ways of working

- A large number of consultant recruitment campaigns are taking place in the month of April/May with applicants received in all vacancies. Already appointed so far in April was Obstetrics & Gynaecology as well as General Surgery. Trauma and Orthopaedics, Acute Medicine, Community Paediatrics and Oncology is still to be interviewed.

Decisions made and decisions required of Board

Belonging

- Implementation of cohort 2 of the Reciprocal Mentoring programme

Growing for the future

- Continue to release colleagues to attend mandatory training
- Continue Mandatory training follow up procedures
- Ensure Bank colleagues to complete training
- Encourage Drs in Training to complete mandatory Training
- Support room allocation for Manual Handling
- Approve changes to mandatory training governance structure

Looking after our people

- Vaccinations – named person required for patient vaccinations.

Board of Directors (Public)
31 May 2023

Title:	Public Sector Equality Duty Report 2022/2023
Responsible Director:	Director of People and Culture
Author:	Deputy Director of People and Culture Equality, Diversity and Inclusion Manager

Purpose of the report and summary of key issues:	The report has been written to appraise the board on the Trust's progress made against the Public Sector Equality Duty. The report is for noting, approval and assurance. The Trust demonstrates compliance with the Duty through our overall reporting and monitoring and the Workforce Race Equality and Workforce Disability Equality Standard and the Gender Pay Gap Reports.	
BAF Risk:	**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	
	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 report has not been discussed or presented elsewhere.	
Recommendation:	It is recommended that the Board approves this report for publishing on our Trust external website.	

Purpose

The Equality Act 2010, sets out the Public Sector Equality Duty (PSED) three key areas of compliance:

- To advance equality of opportunity
- To foster good relations between those who share a protected characteristic and those who do not, and
- To eliminate unlawful discrimination, harassment and victimisation

Under the act, there are specific duties too:

- Publish information to demonstrate compliance with the general duty
- Publish data on the make-up of the workplace
- Publish data on those affected by the Trust policies and procedures
- Publish one or more equality objectives.

1. Background

The first two aims of the PSED (advancing equality and fostering good relations) apply to the first 8 of the 9 protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage or civil partnership status). The last aim, eliminating unlawful behaviour, applies to all 9 protected characteristics.

We aim to promote a culture of equality and inclusion with our colleagues so that, working in partnership with our local communities, we can deliver compassionate care, equitable outcomes and experiences for all our patients.

This report will now set out the Trust data under the three key areas of the PSED.

2. To advance equality of opportunity

Staff Survey Results

The national staff survey results for 2022 provided an opportunity to test engagement and for the Trust to receive valuable feedback from staff. The survey evidenced that 1915 (43%) people had taken part in it.

Through the survey colleagues have feedback on how well they feel that the Trust respects differences.

The question and results are as follows:

- I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc). 71.3% responded positively.
- Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? 53% said yes.

3.0 Ethnicity

The proportions of Black and Minority Ethnic Staff (BAME) have remained relatively similar over the last two years (with a small increase from 11% to 12%) and are at much higher levels than the local population (around 1.1% ONS.GOV.UK).

	31st Mar 21	31st Mar 22	31st Mar 23	Change Mar 2022 to Mar 2023
BAME	11%	11%	12%	+1%
White	83%	84%	82%	-1%
Not known	6%	6%	6%	0%

Of the 572 BAME staff as at 31st March 2023, including the following ethnic identities:

- Asian or Asian British – Indian 209
- Black or Black British – African 78
- Asian or Asian British – Pakistani 55
- Asian or Asian British – Any other Asian background 35
- Any Other Ethnic Group 34
- Filipino 26

3.3 Seniority and Ethnicity

Using the three broad pay bandings of (BAME) colleagues, the 'Bands 2-8' and 'Band 9 and VSM' groupings have increased between 2021 and 2022 (see yellow and green highlights).

31st Mar 2023				
	BAME	Not Stated	White	Total
Bands 2-8	428	253	3,675	**4356**
	10%	6%	84%	
Band 9 and VSM	4	1	13	**18**
	22%	6%	72%	
Medical and Dental	140	30	280	**450**
	31%	7%	62%	
31st Mar 2022				
	BAME	Not Stated	White	Total
Bands 2-8	327	235	3,544	**4,106**
	8%	6%	86%	
Band 9 and VSM	2	0	13	**15**
	13%	0%	87%	
Medical and Dental	156	25	275	**456**
	34%	5%	60%	

The diversity of the highest paid staff (bands 9+) has increased the most and is mainly due to Consultants and 'Other Medics', who comprise the majority of this group.

The difference in other bands between BAME and White staff could be due to the demographics of the area. However, the Trust remains committed to recruiting and developing staff from all groups and through positive action has introduced a BAME leadership programme for those staff looking to progress within the organisation.

(NB. Band 9 and VSM went up from March 2022 to March 2023, however, this was due to the appointment of BME NEDs. As the numbers were very small it would highlight a significant increase, potentially skewing the data set.)

3.4 Workforce Race Equality Standard (WRES) Data

The WRES data, see Appendix 1, shows that the majority of indicators have improved in the last 12 months. This helps to confirm there is an advancement of equality of opportunity at the Trust.

We have our BAME and "Ally's" staff network group which is well-established with around 111 members. Typical activities include:

- Workforce celebrations and awareness raising, i.e. ethnicity, gender, sexuality, disability, job roles etc
- Information through twitter, Facebook pages and TeamTalk – our weekly Chief Executive led live MS Teams Trust-wide communication session.
- Wallace Sampson – NED and EDI Champion attends staff network meetings.
- Exec Sponsor, Russel Nightingale, and NED Wallace Sampson have both attended the meetings recently.

4.0 Gender

The workforce remains predominantly female (86% in March 2022 and 85% in March 2023). Although there is good representation this reduces in the higher pay bands.

	31st Mar 2022			31st Mar 2023		
	Employees	Female	Male	Employees	Female	Male
Bands 2-8	4,106	90%	10%	4,356	89%	11%
Band 9 and VSM	15	40%	60%	18	50%	50%
Medical and Dental	456	55%	45%	450	52%	48%

The data tells us:

- There are far more women in the lower/middle paid roles (89%)
- The higher paid roles are relatively even between Males and Females.

4.1 Gender Pay Gap

As part of legislation, employers with over 250 staff are required to report their gender pay gap, bonus pay and pay data by quartile.

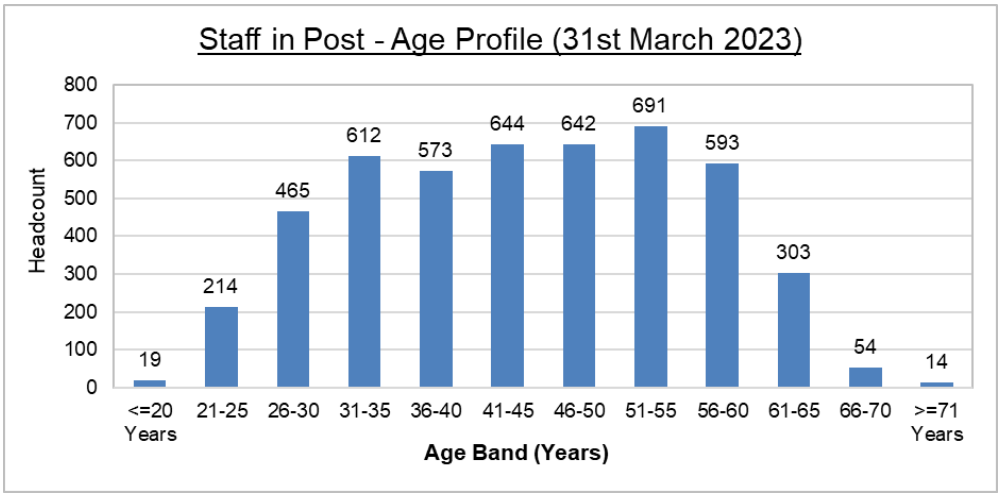
Females earn on average £18.00 per hour compared to £24.88 for males. This means that females earn £6.88 less per hour which equates to a 27.66% gender pay difference or 'gap'. Last year this was 27.61%, which means that our gap marginally widens (by 0.05%) on a year on year basis.

Females earn £16.52 per hour compared to £19.33 per hour for males. This equates to females earning £2.81 less per hour and a median percentage difference of 14.53%. Last year this was 14.51%, which means that our gap widens by 0.02% on a year on year basis.

We have developed an action plan to reduce the Gender Pay Gap and progress against this will be monitored by the EDI Delivery Group.

5.0 Age

The majority of staff are in the age brackets of 41-45, 46-50 and 51-55.



Our age profile shows that our age categories of 61 and over are smaller in comparison to the other age categories, a factor of this is due to colleagues choosing to retire. If we can retain staff to the current national retirement age of 67 then we would have more very experienced people for approximately an extra 7 years.

6.0 Disability

The number of staff who have disclosed on ESR who identify themselves as having a disability has risen this year. The percentage of staff who had chosen not to disclose their disability status was at 14% (625 employees) in March 2022; however, this decreased to 12% (584 employees) in March 2023.

The ESR self-service platform had a system development in September 2022 in which employees are asked to verify their personal information, including protected characteristics. The ability to report on who has or has not verified their information is now reportable from March 2023. This development may improve our data quality as employees logging into the system to view their payslips or book annual leave will see this new portlet and be prompted to view and update information where necessary.

Most ESR data is provided at the start of employment; however, it should be considered that the majority of disabilities are acquired during employment, which means the ESR figures are potentially low. The annual staff survey shows around 26% of staff identify as having physical or mental health conditions or illnesses (compared to a national average of 23%). Equalities data on ESR has been increased in a number of ways, including regular communications in our all staff weekly bulletin, promoting a step-by-step guide to complete ESR, highlighting what the data is used for on the Intranet.

6.1 Reasonable Adjustments

The national staff survey asks the question, “Has your employer made adequate adjustment(s) to enable you to carry out your work?” At HDFT, 68% of staff said, yes, they had received adequate adjustments.

6.2 Workforce Disability Equality Standard (WDES) Data

Please see Appendix 2 for WDES data where the majority of the indicators have improved.

A significant amount of work has taken place in the organisation regarding disability and long-term conditions, including:

- Encouraging membership of the disability and long term conditions network. Since January 2023 the network membership has more than doubled to around 54 people with almost half now attending the live network meetings online.
- Examples of regular discussion topics at the network include WDES data, and parking facilities with each meeting holding a safe space for people to raise issues.
- Communication includes E-updates, intranet articles, in addition to the meeting being recorded during the first 30 minutes before personal and private information is discussed.
- Exec Sponsor, Matt Graham, and NED Wallace Sampson have both attended recent meetings to offer their support.
- Equality, Diversity and Inclusion training is delivered during the staff induction and a more detailed programme is delivered online.
- A hub of useful information is being collated and is expanding across all of the protected characteristics and can be found on the Intranet.
- 'Understanding Bias' training is being delivered across teams on an ad hoc basis. To date, approximately 80 staff have been trained.

The Neurodiversity Staff group have run three sessions since March 2023. As it is a new staff group, the numbers attending the meeting fluctuate between four and seven with a membership of ten, to date. Topics of discussion are usually based on people's lived experiences, and their personal strategies to 'get by'. People attending the group also gain understanding and learn from others as to how they might do things differently. Reasonable adjustments are also discussed and learning is shared.

The Trust is recognised under the Disability Confident scheme. The scheme is a best practice standard to ensure that those people who identify as being disabled can reach interview stage if they can demonstrate they meet the minimum requirements of the role. The Level 2 (Disability Confident Employer) assessment was awarded in February 2023. Further work is being carried out to embed the scheme into the recruitment and selection process ensuring that people who identify as having a disability are not disadvantaged. Other work to support the scheme is included in the updating of HR procedures to support people's health, including OH reports, return-to-work meetings and phased returns. The Menopause policy (to be ratified) will support equity in gender, age and potentially disability.

The Trust has several initiatives or points of contact in place to prevent the development of long-term mental health conditions, including burnout:

- Mental Health First Aiders
- Workforce Psychologist
- Awareness of our wellbeing manager
- Referral links between Vivup, the Employee Assistance Programme and occupational health.
- Annual health and wellbeing events
- Health promotions using the Blue Light Card
- Where possible, staff rest areas are being introduced within the hospital

7.0 Sexual orientation

The number of staff who have declared their sexual orientation has remained at the same rate of 78% (including LGB+ and heterosexual) across the last 2 years. The number of people on ESR who are LGB+ has increased by 38% from 37 employees to 51 employees.

Although this is positive, the number of people who have 'not stated' their sexual orientation remains high at 21.6%. This may be for a number of reasons that some people are fearful of bullying, harassment, or limited career opportunities or that they disclose elsewhere but do not feel it is relevant to their employer and further work is being done in this area.

The table below shows the number of LGBT+ people who have declared their sexuality on ESR.

	Bisexual	Gay or Lesbian	Undecided	Other sexual orientation not listed	Heterosexual or Straight	Not stated *	Unspecified **
31st March 2023	0.7 %	1.1%	0.1%	0.1%	76.2%	21.6%	0.4%
31st March 2022	0.7 %	0.8%	**0.1%**	0.1%	76.0%	22.2%	0.2%

* Person asked but declined to provide a response
** Not recorded

The Trust has an LGBT+ staff network which includes a safe space to talk about workplace issues, raise awareness and create a community. However, to date, while there are around 50 people on the membership list, only three or four people attend the meetings.

June 2023 is Pride month and network members are trying to encourage more staff to join the network and to highlight that it is safe to disclose your sexual orientation at work by having their photograph and a short blog displayed. Equally, it is anticipated this activity will also have a positive impact on the declaration rates on ESR.

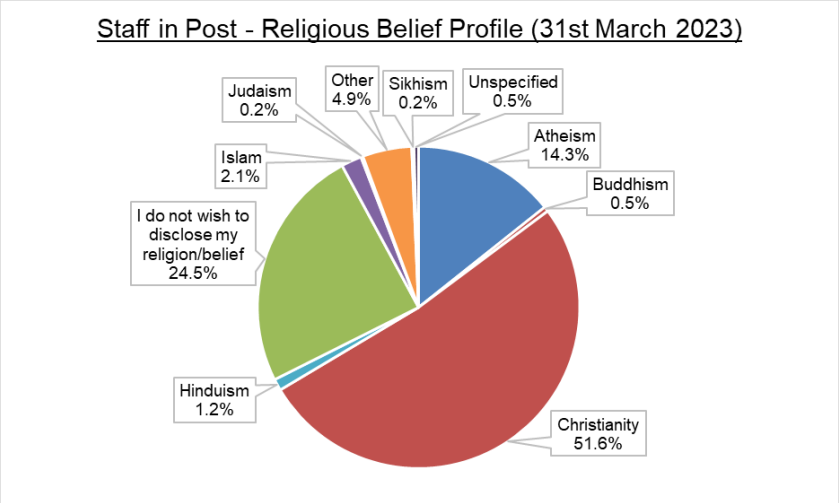
8.0 Gender Reassignment and Transgender

Records of non-binary colleagues are limited as currently the ESR system is programmed to only record male or female. The way for colleagues to declare non-binary is to identify as "Mx" (gender-neutral title) in the title category. We currently do not have any employees at the Trust recorded with an "Mx" title.

The LGBT+ staff network reaches out to and supports transgender people, as above. They request all staff to demonstrate care and respect for the transgender community by including preferred gender pronouns in the email signature, alongside your name. (Examples include: "he, him, his", "she, her, hers" or "they, them, theirs"). Since March 2023, pronouns can be added to your employee ID badge by requesting a new one to be made.

9.0 Religion

Compared to the previous year, the proportional split of religious groups have stayed approximately the same (i.e. most declared they were Christian and this remains the majority group by far). A quarter of the workforce have not disclosed their religion in ESR.



The Trust's Chaplaincy offers emotional, spiritual and religious support to people of all faiths and beliefs. Chaplains provide a confidential 'listening ear' with visibility for staff and patients at the ward level. The Chaplains are also available for prayers, communion and confession should our employees seek this. The Chaplain Service has recently joined up with Wellbeing, Freedom to Speak Up and the EDI lead to share strategies and report on 'gaps' where the workforce needs greater visibility of their combined pastoral work.

10.0 Pregnancy & Maternity and Part-time working

222 employees had maternity leave in 2022/23, of which 129 had a return date within the period. 23 of the 129 employees left employment after their maternity leave came to an end in 2022/23, which is 17.8%. This is just above the Trust turnover rate of 15.4% for the same period.

Of the remaining 107 people who had been on maternity leave in 2022/23 and stayed with us, 71% returned part-time and 21% full-time. In the previous year there were more people who returned full-time (41%).

All pregnant staff have a risk assessment, which may involve an Occupational Health referral if required. This considers the pregnant worker's physical and mental health.

Policies regarding pregnancy are currently under review to ensure they are inclusive to all people who may be pregnant. This would include women, men, birthing people and birthing parents.

11.0 Fostering good relations between those who share a protected characteristic and those who do not

There are regular events run by all of the networks to improve people's understanding of the different marginalised groups; all staff are invited to participate. The recent National Day of Staff Networks held on 10 May 2023 was successful with over 200 visitors who came to see the displays. Previously, the LGBT+ staff network has promoted LGBT History Month, World Aids

Day, IDAHO-bit, and Lesbian Awareness Week. There are Disability Network members who often share their lived experiences in the network meetings, and also promote awareness days via Team talk and our social media platforms. Similarly, the BAME and Allies network have celebrated Black History Month.

There are other initiatives planned, such as reciprocal mentoring for BAME colleagues, which will improve employees' opportunities for career progression and further inclusion and increased understanding by non-BAME colleagues of the daily 'lived experience' of being a BAME colleague.

12.0 To eliminate unlawful discrimination, harassment and victimisation

The national staff survey asks the following questions regarding discrimination at work:
The results from the staff survey are shown below.

DISCRIMINATION: % OF STAFF EXPERIENCING DISCRIMINATION BY:-

- Gender: Static trend slightly worse than average.

	2018	2019	2020	2021	2022
Your org	16.0%	22.2%	21.5%	22.7%	21.8%
Best	5.2%	10.0%	9.6%	6.0%	11.0%
Average	19.9%	20.1%	20.0%	20.6%	20.3%
Worst	31.6%	29.4%	28.7%	30.8%	30.1%
Responses	139	169	140	188	186

- Religion: Declining trend since 2021, worsening beyond the average.

	2018	2019	2020	2021	2022
Your org	1.5%	2.0%	2.0%	2.2%	5.4%
Best	0.0%	0.0%	0.0%	0.4%	0.8%
Average	3.6%	4.0%	3.7%	4.3%	4.3%
Worst	12.0%	15.4%	17.1%	14.6%	16.6%
Responses	139	169	140	188	186

- Sexual orientation: Improving trend closing the gap with best in the group.

	2018	2019	2020	2021	2022
Your org	2.8%	5.2%	3.8%	4.4%	2.2%
Best	0.0%	0.0%	0.0%	1.2%	1.4%
Average	3.3%	3.7%	3.6%	4.1%	3.9%
Worst	9.8%	9.2%	10.1%	23.4%	8.3%
Responses	139	169	140	188	186

- Disability: Improving trend over the last two years but still working towards the average.

	2018	2019	2020	2021	2022
Your org	7.4%	5.6%	12.5%	13.4%	11.2%
Best	1.2%	2.9%	2.8%	3.2%	3.8%
Average	7.0%	7.3%	8.1%	8.3%	8.7%
Worst	16.7%	13.8%	15.6%	19.3%	20.4%
Responses	139	169	140	188	186

- Age: Improving trend over the last two years, moving towards the average.

	2018	2019	2020	2021	2022
Your org	22.6%	21.4%	27.4%	22.2%	19.7%
Best	9.0%	4.5%	10.5%	11.7%	13.0%
Average	18.2%	19.0%	19.0%	18.9%	18.8%
Worst	29.8%	33.9%	27.4%	31.8%	28.1%
Responses	139	169	140	188	186

- Other: worsening trend over the last two years, drifting closer to the worst in the group.

	2018	2019	2020	2021	2022
Your org	40.2%	37.5%	31.5%	34.4%	34.2%
Best	19.1%	14.5%	15.5%	14.7%	15.2%
Average	31.9%	29.1%	27.6%	26.6%	24.4%
Worst	62.7%	43.6%	45.1%	45.4%	37.5%
Responses	139	169	140	188	186

6.5

The Trust has the appropriate policies, processes and networks to support staff where this is raised:

- Campaigns are being run this year to demonstrate our response to racism and abuse. Closer working relationships are being forged with Chaplains, EDI, Wellbeing and Freedom to Speak Up.
- More positive imagery to be used to advertise the diversity of staff – members of the LGBT+, BAME, and disabilities networks are using headshots and blogs to highlight the diversity and inclusion in the organisation.
- The Trust was awarded Disability Confident Employer level II in February 2023
- We are awaiting the outcome of our submission of the Rainbow Badge Accreditation Scheme.
- Our EDS22 assessment has scored the Trust as 'Developing' across all 3 domains and an action plan is being developed to support improvement to 'Achieving'.

13.0 Conclusion and proposed equality objective

The results shown in this report demonstrate some improvements in the indicators detailed. (Workforce Race Equality Scheme and Workforce Disability Equality Scheme).

It is therefore proposed that the Trust fully implements the EDS22 action plan (currently under development, following assessment) and uses the EDS22, alongside the WRES and WDES standards to inform the future Trust's equality, diversity and inclusion agenda. This will help us in benchmarking, measuring, monitoring and developing future activity and plans.

14.0 Recommendations

The Board of Directors are asked to:

- Review the enclosed paper and note how the Trust is meeting the Public Sector Equality Duty requirements.
- Approve the report for publication on the Trust website.

Appendix 1

WRES Data 2022/2023
(Workforce Race Equality Standard)

Point of note
Point 2 - A figure below 1.00 indicates that BME staff are more likely than White staff to be appointed from shortlisting.

Point 3 - It is 0.00 for 2023 as no BME colleagues entered the formal disciplinary process in 2022/23, whereas white colleagues did.

Point 4 - A figure below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

			March 2022	March 2023		Comment
1	Percentage of BME staff	Overall	10.6%	11.8%	↑	
		VSM	14.3%	14.3%	↔	Does not include NED's/Chairman
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.29	2.19	↑	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.49	0.00	↓	
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		6.42	0.63	↓	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	BME	30.4%	29.4%	↓	Close to equal (BAME + White)
		White	26.3%	28.1%	↑	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	27.7%	23.6%	↓	Close to equal (BAME + White)
		White	23.2%	23.4%	↔	
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	BME	43.9%	50.3%	↑	Much improved but still room for improvement
		White	60.1%	58.0%	↓	
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.2%	14.2%	↔	
		White	5.3%	6.9%	↑	
9	BME board membership	BME	12.5%	22.2%	↑	
		White	87.5%	77.8%	↓	

Appendix 2

WDES Data 2021/22
(Workforce Disability Equality Standard)

*The March 2022 WDES submission included bank staff and therefore data is not entirely comparable

		March 2022			March 2023		
1	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members, but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce.	Disabled (number)	Disabled (%)		Disabled (number)	Disabled (%)	
	Cluster 1 (up to Band 4)	77	4.90%		89	5.65%	↑
	Cluster 2 (Bands 5-7)	114	4.62%		142	5.58%	↑
	Cluster 3 (Bands 8a-8b)	14	6.97%		15	6.88%	↓
	Cluster 4 (Bands 8c-9 and VSM)	1	4.00%		1	3.70%	↓
	Cluster 5 (Medical/dental consultants)	2	1.28%		4	2.47%	↑
	Cluster 6 (Medical/dental, non-consultants)	0	0.00%		0	0.00%	↔
	Cluster 7 (Medical/dental, trainees)	10	5.75%		6	4.03%	↓
		218	**4.56%**		**257**	**5.34%**	↑
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	1.04			1.09		↑
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.00			0.00		↔
		Disabled	Non-Disabled		Disabled	Non-Disabled	
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients or other members of the public	33.1%	26.9%		32.3%	27.8%	↓
4b	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	24.3%	11.7%		18.5%	9.6%	↓

		March 2022			March 2023		
4c	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues	24.9%	17.4%		26.0%	18.4%	↑
4d	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	45.8%	43.9%		50.0%	46.1%	↑
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	47.4%	54.4%		48.2%	55.8%	↑
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	31.8%	21.5%		29.6%	22.7%	↓
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	34.7%	50.8%		35.0%	45.5%	↑
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	67.5%	69.6%		n/a	n/a	↑
9a	The staff engagement score for Disabled staff, compared to non-disabled staff.	6.4	7.0		6.3	6.9	↓
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes			Yes		↔
10a	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (voting membership of the Board)	-5%			-5%		↔
10b	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (Executive membership of the Board)	-5%			-5%		↔

Code:

	The score has worsened
	The score has remained at the same or similar level as the previous year
	The score has improved

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 • Complete	
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 – Jun 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 • Complete	
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 • Complete • 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 – Nov 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 • Complete	
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 • Complete • 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	• Complete • Complete • 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 June/July 23 • Complete • Delays with HR, appointed May 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 - delays due to start date of Innovation facilitator – scoping and discussions ongoing with QI and clinical effectiveness, due Jun 23 • 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 20/03 /23 update 4 studies open (Ostrich Baby breath , Dentistry study and Elim) 3 in set up Elsa , Henry and Babi.	

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 - accommodation acquired in Hawthorn Ward (Apr 23), plans being formulated to develop space	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 ? Dr Layton to update on this • Ongoing Update 20/03/23 – Preceptorship research training starts June 23. Opportunity to get involved in NIHR / CRN pilot of embedding research into trust.	
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 – 20/3/023 Delayed due to lack of resources and extra demands on service. Now due end of May 23 • Complete	Amber

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.	15 (3x5)	10(2x5)		Averse
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.	12 (3x4)	8(2x4)		Averse
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)		Averse

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 • Complete • Complete • Complete	

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 • Complete • Delayed – completion 8 May 2023	
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 • Complete • Delayed to Sep 23 • Delayed to Nov 23 • Delayed to Nov 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 • Detailed Design September 2023 • Tender & Contract award – December 2023 • Build complete – January 2025 • Commissioning complete – February 2025 • In service – February 2025	• Complete • Complete • Complete • May – September 2023 • October –December 2023 • Phase 1 January 2024- May 2024 • Phase 2 May – August 2024 • Phase 3: September to November 2024 • Phase 4 November 2024 to January 2025 CT Business Continuity • Canon Dismountable: 26 May 2023 • Operational 10 June 2023 • Installation of Portakabin on site 22 June 2023 • Siemens CT in Portakabin operational: 24 July 2023	
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 • Complete • Delayed – start May 23 • Delayed - Sep 23 • Delayed - Oct 23 • Delayed - Oct 23	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
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 • Complete • On Track – start 24 Apr 23 • Delayed to Nov 23 • Delayed to early Dec 23 • 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 • Complete • Delayed • Delayed • On Track – PSCP appointment planned June 23 • On Track • Significant Risk - Turner & Townsend initial programme suggests 12 month design period, 18 months construction, with Go Live in Dec 25. This has significant implications for cost and funding profile which are being investigated. The programme is being reviewed with an intention to bring the completion closer to March 2025, the project costs will be reviewed as soon as a PSCP is appointed. • Significant 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 long term plan and governance structure for the reduction of the Trust's carbon emissions		• Green working group to deliver the programme of work Governance structure, Sustainability Board, in place reporting to HIF Board • Each work group is currently developing this year's quantifiable objectives which to be agreed at the Sustainability Board • Develop a communications strategy and work with partners to develop a strong and cohesive plan	• Sustainability Board now to meet bi-monthly with emphasis on the sub groups meeting monthly and completing their actions-on Track • Complete 2023-2024 now agreed. • May 2023 – on Track	
SALIX Carbon Reduction Programme	To improve the estates infrastructure at Harrogate District Hospital in order to reduce carbon emissions		Revised programme (second extension): • Window replacement (except Wensleydale) – Apr 23 • Air and ground source heat pumps – Jun 23 • Solar panels – Aug 23 • Roof Top Plant Rooms – Aug 23 • Air Handling Units – Sep 23	• Significantly behind original programme which was due to complete in Apr 22, but on track to meet current timescales: • On Track • On Track • On Track • On Track • On Track	
Travel Plan	To develop sustainable models of transport for patients, staff and visitors		• Work with local and national cycle retailers to obtain a discount code for staff – promote this through newsletters and a Travel Information Leaflet. • Investigate the possibility of holding cycle maintenance training at Harrogate and Ripon hospitals. This should include the provision of a permanent cycle maintenance kit to be placed at both sites. • Deliver cycle training to staff who are interested in cycling commuting. • Investigate a renewed partnership with Liftshare or internal equivalent to encourage car sharing both for commuting and business trips. • Sign up to Modeshift STARS. • Reintroduction of parking permits. Revenue raised to be used to support active and sustainable transport initiatives.	• Summer 2023 – on Track • Summer 2023 - on Track • Free of charge provider now found, action to promote to all staff Summer 2023 - on Track • Summer 2023 - on Track • September 2023 part of the Car Parking Project – on Track	

Director of Strategy

Matters of concern & risks to escalate

Capital Planning
- RAAC. Ongoing survey and monitoring; BC submitted by HIF for NHSE funding for multi-year eradication programme
- Fire. Significant work required to improve fire compliance across Trust.
- Water Safety. Risk in Strayside Wing due to low hot water temperatures; measures in place to mitigate and Water Safety Plan developed.
- TIF2. Realistic timescale now end Q4 2024/25 and increased cost; discussion with NHSE about timescale and additional funding
- CT Business Continuity. Provision of Canon Dismountable CT Scanner by early June to increase resilience of CT service
- ED2: concerns about impact on patients of relocation of phlebotomy to Cedar ward; improved wayfinding, additional volunteers
- 23/24 Capital Programme. Since setting the programme, a number of additional project costs have become apparent increasing the level of over-commitment.

Continuous Improvement
- Risk that colleagues dis-engage from existing improvement training and events because they are waiting for a new approach. Clear comms provided that the Continuous Improvement programme will build on our existing approach so training and events remain relevant.

Charity
- Charity accounts overdue submission to Charities Commission due to delays completing their audit

Major actions commissioned & work underway

PMO
- Projects supported: OP Transformation (waiting list validation, digital patient letters); TIF1, TIF2, Data Platform, CDC, UEC (inpatient referrals phase 2); Quality (Insulin & Opiates Medicines Errors, Missed Results); Hopes for Healthcare

Continuous Improvement
- Support to Readiness Assessment
- Support to EPR OBC, in particular on benefits realisation
- Improvement Workshops: Deep Vein Thrombois and Pulmonary Embolism Pathways, Delirium Care Pathways, Enhanced Recovery for Colorectal Care, Orthopaedic Infection Rates
- Ongoing planning of an Improvement Campaign linked to Quality Priorities

Capital Planning
- TIF2: Principal Supply Chain Partner (PSCP) tender responses by 26 May
- Imaging: detailed design underway
- Aseptics: revised air handling design produced for approval
- Feasibility: private outpatient site; hydrotherapy pool; fracture clinic
- Development of HDH site strategy
- Staff consultation on transfer of capital design function to HIF underway

Business Development
- Comms: development of new Intranet and Sharepoint; wayfinding video
- Decommissioning of Vaccination & Immunisation Services

Positive news & assurance

PMO
- Programme Manager, 3x Project Managers now appointed to PMO
- Ripon CH CDC approved by NHSE: £1m capital, £363k revenue for 23/24
- Outpatients: 72% response rate to waiting list validation messages

Continuous Improvement
- Very positive engagement at launch event for Extended SMT on 19 April
- Good progress on Readiness Assessment; first workshop on 1 June
- Bronze QI virtual learning now available through Learning Lab
- 42 colleagues completed Bronze and Silver QI training
- 29 Making A Difference awards in March – busiest month ever!

Capital Planning.
- ED Phase 2B completed on 12 May
- Wensleydale/ED2: work underway

Business Development
- Volunteer week 1-7 June; nominations for Helpforce Awards
- Dom Care: CQC registration submitted, staff recruitment increasing

Decisions made & decisions required

- Continuous Improvement programme brand agreed as “HDFT Impact”

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:	25th April and 3rd May 2023
Date of Board meeting this report is to be presented	31st May 2023

Summary of key issues

Meetings continue to be held via Microsoft Teams and are well attended. Kathy Gargan and Steve Treece observe and contribute to Audit Committee meetings on behalf of the Council of Governors.

25th April 2023

This meeting was focussed on the 2022-23 accounts. The Committee agreed the preparation of the Trust's accounts on a "going concern basis", received a verbal report on the valuation of assets emerging from the audit of HIF accounts for 2022-23 and noted the external audit plan for 2022-23 which would require additional work to be done as the result of the introduction of new audit standards applicable across the public sector with a commensurate increase in the external audit fee. A private session for Committee members and Governors provided an opportunity to consider the current draft statements page by page.

3rd May 2023

This was a standard meeting within the Committee's annual cycle. Key items on the agenda included -

- Corporate Risk Register – the corporate risk register overview report was received, considered and noted. The need to include risks arising from current NHS staff strikes was discussed. It was noted

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that these risks had not achieved the “12” rating which would require their inclusion due to effective mitigations being in place.

- Quality Committee – the Committee received and considered minutes from recent Quality Committee meetings (February and March 2023) and also received a verbal update from the Quality Committee Chair. Concerns relating to stroke services were noted.
- The Committee received the CQC maternity services inspection report, noting that primary scrutiny of the action plan arising from the report would be delivered by the QCMG and the Quality Committee.
- 2023/24 Internal Audit Programme – the Committee considered the proposed 2023-24 internal audit programme. Links between planned and previous audits were discussed particularly in relation to nutrition and food. The plan was agreed in principle.
- Internal Audit Programme Progress Report – three reports had been finalised since the last meeting; “Caring at Our Best” (Significant Assurance), “Service Improvement - Hopes for Healthcare” (Significant Assurance) and a follow up report “Infection Control – Urinary Catheter Care” (Significant Assurance).
- Audit Recommendations – a report was presented setting out the current position in respect of completed and overdue audit recommendations including benchmarking data comparing the Trust’s performance against others in the Audit Yorkshire client portfolio.
- HIF Internal Audit Reporting – the Committee received a report on the delivery of the 2022/23 HIF internal audit programme. A limited Assurance report was received relating to arrangements for the management of the medical device maintenance and repair contract. Good progress is being made by HIF with actions to improve the position either in place or in development. HIF’s very positive progress in actioning internal audit report recommendations was noted.
- Improving Financial Sustainability – the Committee received Audit Yorkshire’s report. It was noted that there were no specific matters for HDFT to address arising from this nationally mandated audit.

- NHS Counter Fraud Authority Post Event Report - a report from the national NHS Counter Fraud Authority relating to a post event assurance audit carried out to evaluate actions taken during the Covid-19 pandemic was received. Key issues identified at a national level included matters related to inadequate due diligence checks on suppliers and fraud risk management. There were no matters relevant to HDFT as the Trust had not utilised the approaches reviewed in the audit (cancellation of contracts due to identified risks, direct award of contracts and supplier relief payments).

- External Audit – Chris Brown from Azets attended the meeting and confirmed that the draft 2022/23 financial statements had now been submitted to NHSE. Azets were planning to complete all the required work to allow submission of final accounts by the 31st August deadline.

The Committee is scheduled to meet in September, additional meetings will be required in June 2023 to consider the annual accounts, the Head of Internal Audit Opinion etc and a final accounts related meeting prior to Board consideration of the final draft accounts and related documents in August.

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.

Board of Directors
31st May 2023

Title:	Consideration of Going Concern
Responsible Director:	Jordan McKie, Acting Director of Finance
Author:	Jordan McKie, Acting Director of Finance

Purpose of the report and summary of key issues:	This paper outlines the considerations around Going Concern, and the appropriateness of preparing the Trust annual accounts on this basis.	
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	
	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	N/A	
Report History:	The approach has been discussed by the Senior Finance Team, and considered by Audit Committee.	
Recommendation:	The Board is asked to approve the recommendation from Audit Committee that the 2022/23 Accounts are prepared on a going concern basis	

Consideration of Going Concern
Board of Directors
May 2023

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern.

The 2022/23 Department of Health and Social Care Group Accounting Manual (DHSC GAM) states the following:

*"**Going concern***

4.18 The FReM notes that in applying paragraphs 25 to 26 of IAS 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context.

4.19 For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

4.20 A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

4.21 Sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate.

4.22 Where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

4.23 While an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity.

4.24 DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

4.25 Where a DHSC group body is aware of material uncertainties in respect of events or conditions that may bring into question the going concern ability of the entity, these uncertainties must be disclosed.

4.26 As the continued provision of service approach, per paragraph 4.22, applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

4.27 Should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances), it must raise the issue with its sponsor division or relevant national body as soon as possible.

4.28 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment."

Conclusion

The Senior Finance Team have considered the paragraphs above with their collective knowledge of the organisation and have reached the conclusion that the Trust should prepare the 2022/23 Accounts on a going concern basis.

This consideration was discussed by the Audit Committee, who support the proposal to prepare the accounts on a Going Concern basis, recommending this approach to the Board of Directors.

Recommendation

The Board of Directors is asked to:

- Approve the recommendation from Audit Committee that the 2022/23 Accounts are prepared on a going concern basis

The Board will receive the audited accounts for approval on 30th August 2024.

Jordan McKie, Acting Director of Finance

Board of Directors
31st May 2023

Title:	Annual Report and Accounts - Timeline
Responsible Director:	Jordan McKie, Acting Director of Finance
Author:	Jordan McKie, Acting Director of Finance Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	This paper has been developed to update the Board on the timeline for sign off and submission of the 2022/23 Annual Report and Accounts.	
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	N/A	
Report History:	The Board have been previously updated on the changes in the HDFT timeline, as well as more detailed information shared with the Audit Committee.	
Recommendation:	The Board is asked to note the contents of the report	

8.3

Annual Report and Accounts - Timeline
Board of Directors
May 2023

Background

As the Board is aware, 2020/21 was the final year where audit was undertaken by the previous External Audit partner, KPMG. Following a number of unsuccessful attempts to secure an External Audit partner, the Trust negotiated extended terms for submission of the Annual Report and Accounts with NHS England, agreeing a multiyear approach that would afford a new provider greater flexibility.

As a result of this and further work, the Trust engaged Azets Audit Services and successfully closed the 2021/22 audit cycle in October 2022 for the Trust and Group.

Timeline for 2022/23

2022/23 is the second year of the extended arrangement agreed with NHS England. As a result, whilst other organisations are currently aimed to submit audited accounts by 30th June, the HDFT deadline is 31st August 2023. The following table is an extract from the external audit plan presented at Audit Committee –

Event	Date
Audit planning meeting	9 January 2023
Planning	6 March 2023
National submission deadline of draft accounts to NHSI	27 April 2023
Commencement of audit fieldwork	17 July 2023
Manager review	w/c 31 July 2023
Partner review	w/c 7 August 2023
Clearance meeting to discuss our findings	w/c 14 August 2023
Audit Committee	w/c 21 August 2023
Target date of approval of accounts	30 August 2023
NHSE/I agreed deadline	31 August 2023

This is supported from a management perspective and has been agreed at Audit Committee. As a result, part of the Board of Directors workshop session on 31st August will be dedicated to the formal sign off of the Annual report and Accounts.

Added to the above, an additional Audit Committee has been scheduled for 29th June 2023 in order to ensure the Committee received the final summary of internal audit work undertaken during 2022/23, as well as the Head of Internal Audit Opinion.

Other Key Points

It should be noted that at the time of writing the accounts for the Trust subsidiary, HIF, and Charity, HHCC, are being finalised for 2021/22. As a result of the delays in finding an audit partner outlined above, the decision was made following the unsuccessful tenders to partner with another firm for these accounts – Saffery Champness.

There have been multiple issues which have contributed to this delay, and as a result the learning from the audit cycle will be input into the 2022/23 timeline. This will be finalised with HIF and HHCC as appropriate.

Summary

The Board of Directors is asked to note the contents of this report.