Board of Directors Meeting (Public)
To be held on Wednesday 26th July 2023 12.45 – 3.45pm
Venue: Crowne Plaza Hotel, Harrogate

AGENDA

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

Item No.	Item	Lead	Action	Paper
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs	Discuss	Verbal
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chair	Note	Attached
1.4	**Minutes of the Previous Board of Directors meeting held on 31st May 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: Chief Executive Reports				
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, Midwifery and AHP Report**	Director of Nursing, Midwifery and AHPs	Note	Attached
3.4	**Medical Director Report**	Medical Director	Note	Attached

3.5	**Infection Prevention & Control Annual Report**	-	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
4.3	**Continuity of Carer**	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
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	**Risk Appetite**	Chief Executive	To approve	Attached
8.3	**Code of Conduct and Nolan Principles**	Chair	To approve	Attached
8.4	**WYAAT Programme Executive minutes**	-	Note	Supp. Pack
8.5	**Collaboration of Acute Providers minutes**	-	Note	Supp. Pack
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Public Board meeting:** Wednesday, 27th September 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 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 26th July 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. Member of Society of Local Authority Chief Executives 2. 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 (DRAFT)
Wednesday, 31 May 2023
Held at Crowne Plaza Hotel, Harrogate

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Jeremy Cross (JC)	Non-executive Director
Chiara DeBaise (CD)	Non-executive Director
Laura Robson (LR)	Non-executive Director
Wallace Sampson OBE (WS)	Non-executive Director
Richard Stiff (RS)	Non-executive Director
Julia Weldon (JW)	Non-executive Director
Kama Melly (KM)	Associate Non-executive Director
Jacqueline Andrews	Executive Medical Director
Matthew Graham	Director of Strategy & Transformation
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 People & Culture

In Attendance:	
Emma Edgar (EE)	Clinical Director for Long Term and Unscheduled Care Directorate (LTUC)
Kat Johnson (KJ)	Clinical Director for Planned and Surgical Care Directorate (PSC)
Natalie Lyth (NL)	Clinical Director for Community and Children's Directorate (CC)
Sue Grahamslaw	Assistant Company Secretary
Juliette Harris	Executive Assistant
"Nicola"	Patient *(for Patient Story – item 1.2)*
Jane Walton	Deputy Theatre Matron *(for Patient Story – Item 1.2)*

Observers:	
Lucy Doran	KPMG
Tony Doveston	Public Governor
Jackie Lincoln	Public Governor *(for Items 1 to 4.2b)*

Apologies:	
Andy Papworth	Non-executive Director
Azlina Bulmer	Associate Non-executive Director
Kate Southgate	Associate Director of Quality and Corporate Affairs

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BD/05/31/1 **1.1** **1.2**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting Apologies for absence were noted.
BD/05/31/2 **2.1**	**Patient Story** Nicola, who had a nursing background shared, her patient story with the Board, explaining her need for a knee replacement due to osteoarthritis. She outlined the treatment options she had been given up to the point of surgery, drawing attention to the positive experiences of the interactions with all staff, clinical and non-clinical,

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	during the course of her treatment. She commented on how her life, mobility and wellbeing had improved as a result of the surgery.
2.2	The only negative point she related was regarding her own recovery expectations. This was slower than anticipated as she had hoped for the fastest recovery time stated in her documentation when it had been closer to the longer time.
2.3	Non-executive Director (JW) shared that the Trust learns as much from good experiences as it does from bad and was grateful for the emphasis on the kindness shown by all those who came into contact with the patient.
2.4	Recognising the positive experiences, the Chief Executive also understood that there were always things that could have been done better. The patient surmised that it might have been better if more emphasis had been placed on the likelihood of the longer recovery time being experienced, although she was aware this was already clearly given on the documentation.
2.5	The Trust Chair thanked the patient for sharing her experiences and was grateful for the positive outlook. She also thanked the Deputy Matron for taking the time to help and arrange the patient's participation.
2.6	**Resolved:** The patient story was noted.
BD/05/31/3 **3.1**	**Declarations of Interest and Register of Interests** 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/05/31/4	**Minutes of the Previous Board of Directors meeting held on 29 March 2023**
4.1	**Resolved:** The minutes of the meeting on the 29 March 2023 were approved as a correct record, with minor punctuation errors to be amended but these did not affect the materiality of the minutes.
BD/5/31/5 **5.1**	**Matters Arising and Action Log** The actions were noted as follows: • BD/1/25/10.3: IBR – Ongoing – no further updates • BD/1/25/23.1: Rainbow Badge – Agreed action closed at March 2023 meeting. However, Non-executive Director (KM) noted that there had been questions on the policy about transgender issues which had been submitted for approval. • BD/3/29/30.5: Clinical Research – Action Closed • BD/3/29.30.7: and BD/3/29/36.2 – Not yet due
5.2	**Resolved:** All actions were agreed as above.
BD/5/31/6 **6.1**	**Overview by the Chair** The Trust Chair congratulated the Chief Executive on his appointment as permanent Chief Executive and thanked all those involved in the process, including the Interim Deputy Lead Governors feeding back to the Council of Governors.
6.2	The Trust Chair provided the meeting with a summary of the work she was involved in: • The recruitment for Hull and North Yorkshire Group Chief Executive Role was underway and the Chair noted the importance to the Trust of its involvement in the choice of System leadership.

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         6.3	• Listening to the voice of patients was paramount, so importance of the national initiative of having a Patient Safety Partner was highlighted. The key was think of a way people could have their voice heard. • Governor elections were underway and the vital nature of staff governor roles was emphasised in a teamTalk broadcast the previous day. • Feedback from a healthcare innovation summit had focussed on the electronic patient record (EPR). After attending the summit, the Chair felt confident that the Trust was on the right path. • The National Volunteer Network celebration would start on 1 June 2023 and the Chair thanked all those that volunteer in the Trust irrespective of their role. **Resolved:** The Chair's report was noted.
BD/5/31/7 **7.1** **7.2** **7.3**	**Chief Executive Report** The Chief Executive presented his report as read. The following points were highlighted: • There had been several national and system leadership changes – the turbulence in the system was noted. • At an external workshop for chairs and chief executives, there was thought to be a lack of clarity on the governance and management focus of provider collaboratives, ICB, etc. Whilst both system and organisational working were important, the Chief Executive noted that the focus should always be on benefits to patient. • The final System financial plan for 2023/24 had been submitted. • The boundary changes would result in some ambulances diverting from York. • Some theatre lists had commenced at Wharfedale hospital. • Collaborations with local authorities enabled additional funding into the system. • The final national plan to be published would be Workforce and was awaited by the Trust. HDFT strategy was on track with all other national plans. • The Trust was on track for its best urgent care and 0-19 services key performance indicators (KPIs). • The checklist for the planned care programme would be reviewed at the Resource Committee although it was noted that the Trust was already delivering this programme. • Improvement work around cancer services was ongoing. • Maternity CQC action plan – many actions already resolved or were on track. • Financial plan – it was acknowledged that the focus should be on issues that could be controlled, although there would be a cost from industrial action. • Agenda For Change – it was confirmed that all Harrogate Integrated Facilities staff would receive the pay awards. • All known industrial action had plans to enable delivery of safe services. • There would be a discussion in private board relating to the outline business case for the Electronic Patient Record (EPR OBC). The benefit to the Trust of having the Executive Medical Director as the System Senior Responsible Officer (SRO) was noted • Continuous Improvement Programme was launched in mid-April 2023 but staff's desire to undertake change was key. The Non-executive Director (LR) noted the discussion that had taken place at the Quality Committee earlier in the day relating to the positive outlook with a dedicated Health & Safety Manager was in situ. However, there was also concern about how the capital programme would be prioritised and the need for an audit trail, especially relating to risk mitigation. The Chief Executive outlined the way the spending of the health and safety financial envelope would be managed based on the Environment

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7.4	Board, HIF recommendations, asset register review, and consideration at Senior Management Team (SMT) meetings to mitigate risks.
7.7	In relation to further integration with the ICB raised by the Non-executive Director (WS), the Chief Executive confirmed that it was only the Group Chief Executive role that was currently planned, although it was noted that there had been ongoing discussions relating to the management of services around the Humber and the most effective way to manage collaboratives of different sizes of acute providers. It was recognised that HDFT was a medium-sized organisation and so would work with those nearby but would not necessarily have to form one group. However, to ensure staff retention, there needed to be clarity for the next five years. **Resolved:** The Chief Executive's Report was noted.
BD/5/31/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/5/31/9 **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	It was noted that there had been a discussion in the Quality Committee earlier in the day regarding the draft Quality Account, specifically relating to quality priorities, missed results and the reliance on EPR to progress further.
9.3	**Resolved:** The update on Best Quality, Safest Care was noted.
BD/5/31/10 **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 April 2023, the Committee received an informative presentation on the Theatres 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 May 2023 Committee assurance was received that significant progress had been made.
10.5	It was reported that a water safety group was now in place as a result of a discussion in the April Committee.
10.6	Metrics for the IBR were discussed.
10.7	In May 2023, the Committee had received an update on the Patient Experience Framework Priority, noting the need to record patient satisfaction differently.
10.8	The Committee had also discussed the draft Quality Accounts for 2022-2023, noting the year-on-year improvements and the affirmation that the Quality Committee were considering the appropriate topics.
10.9	There was a further discussion relating to violence and aggression with a request to understand if other committees had had similar discussions.
10.10	

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10.11 10.12	The Committee Chair advised that the draft Quality Account would be sent to all Non-executive Directors for their review, with any responses to be sent to the Associate Director of Quality and Corporate Affairs by 16 June 2023. The feedback from the Quality and Governance Management Group (QGMG) was noted. **Resolved:** The Board confirmed delegated authority for the Quality Committee to approve the Quality Account 2022-2023 on their behalf.
BD/5/31/11 **11.1** **11.2** **11.3**	**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. The Non-executive Director (CD) commented on the higher figures in the ratio of low harm incidents. The Executive Director of Nursing, Midwifery and AHPs advised that a greater figure was positive as it meant there was a willingness to report incidents, not that the incident rate had necessarily increased. **Resolved:** The Board noted the content of the report.
BD/5/31/12 **12.1** **12.2** **12.3** **12.4**	**Executive Director of Nursing, Midwifery and AHPs Report** The Executive Director of Nursing, Midwifery and AHPs' report was received and taken as read. It was highlighted that: • The Trust had hosted visits from outside organisations regarding their AHP leadership work and the support of personalised care. • The Trust had received the NHS Pastoral Care Award in relation to international recruitment. • The Patient Safety Incident Response Framework had been shared with the ICB with a proposal to launch in August 2023. • The business case for apprenticeships had been approved. The Committee requested that the Trust Board gave the Quality Committee delegated authority to sign of the Quality Account as it was not expected to hold another Board meeting before the end of June 2023 when the report was due for publication. **Resolved:** 1) The Board noted the content of the report. 2) the Board approved the delegated authority.
BD/5/31/13 **13.1** **13.3**	**Executive Medical Director** The Executive Medical Director took the report as read and highlighted: • E-rostering. • The innovation work that had been done in the Emergency Department. • Progress being made at WYAAT. • Benefits of partner working. • Outcomes from current HTA inspection would be reported. • Junior doctor rota gaps were arising due to emigration. **Resolved:** The Board noted the content of the report.
BD/5/31/14 **14.1** **14.2**	**Learning From Deaths Report 2022-2023 Quarter 4** The Executive Medical Director took the report as read, noting it had been discussed earlier at the Quality Committee and members had felt reassured. **Resolved:** The Board noted the content of the report.

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BD/5/31/15 **15.1**	**Annual Statement on Eliminating Mixed Sex Accommodation** The Director of Nursing, Midwifery and AHPs took the report as read.
15.2	The Associate Non-executive Director (KM) sought verbal confirmation that there had been no requirement to utilise mixed sex accommodation. The Executive Director of Nursing, Midwifery and AHPs advised the facility had been used once when a husband and wife had been brought in and wanted to remain together.
15.3	**Resolved:** The Annual Statement was approved.
BD/5/31/16 **16.1**	**Guardian of Safe Working Report** The Executive Medical Director took the report as read noting it had been reviewed at the earlier People & Culture Committee.
16.2	There was a discussion regarding the level of scrutiny applied when it had been categorised as a Blue Box item and the Guardian's annual report would be presented to Trust Board. Also, there was concern about compliance with reporting to Board if interim reports were only reviewed at sub-committee level. However, it was confirmed that the Trust's reporting arrangements were the same as similar Trusts.
16.3	The Chair was reassured that progression, not just reporting, would be shown in future and that any reported actions were being addressed.
16.4	**Resolved:** The Board noted the content of the report.
BD/5/31/17 **17.1**	**Board Assurance Framework – Great Start in Life** The Director of Strategy provided the Board with an update on this element of the BAF.
17.2	It was noted that after a meeting with HIF to review the community estate, the risk rating was anticipated to reduce to amber.
17.3	It was further explained how Hopes of Healthcare were progressing.
17.4	As the maternity objectives had been completed, with a three-year improvement plan in place, a new set of objectives would be provided at the next Board meeting.
17.5	**Resolved:** The update on Great Start in Life was noted.
BD/5/31/18 **18.1**	**Strengthening Maternity and Neonatal Safety** The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery took the report as read, highlighting the increased level of reporting to Board compared with other areas. However, reassurance was given that risks were being managed within the directorate, rather than on the Corporate Risk Register (CRR).
18.2	The Associate Director of Midwifery provided a summary of the report outlining the risks highlighted therein. Reassurance was provided that progress was being made with the maternity action plan.
18.3	Similarly, training, and specifically neonatal compliance, was improving although the recording of the training had not been fully updated.
18.4	It was noted that CQC actions were either complete or on track and the Non-executive Director (WS) requested a timeline be provided for managing risks in future reports. It was reported however that regulators such as CQC became more anxious with their reporting when media highlighted specific areas of concern.
18.5	

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18.6	The Non-executive Director and Quality Committee Chair (LR) agreed to receive the report at the Quality Committee in future. **Resolved:** The report was noted.
BD/5/31/19 **19.1** **19.2**	**Maternity CQC Action Plan** The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery took the report as read. **Resolved:** The report was noted.
BD/5/31/20 **20.1** **20.2**	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** The Chief Operating Officer provided the Board with an overall update on the ambition and goals for this area of the BAF. **Resolved:** The update on person centred, integrated care, strong partnerships was noted.
BD/5/31/21 **21.1** **21.2** **21.3** **21.4** **21.5**	**Resource Committee Chair Report** The Chair of the Committee noted the following items had been discussed at the Resource Committee earlier in the day: <u>Finance</u>: • Surge funding was not accounted for and that was the stretch. • Director of Finance was most concerned about reinvigorating CIP, and medicines. • SLT plan regarding operational costs and noted the ongoing work on recruitment in order to reduce agency costs, alt. This was being monitored on a monthly basis. • HIF - £20,000 surplus was noted, against the £200,000 in the year. <u>Other areas covered</u>: • Update provided on the issues with the CT scanner. • Dental waiting lists concerns, and the consequences in deprived areas. • Improvement in Referral to Treatment (RTT) pathways. • Low number of Emergency Department (ED) trolley waits and no ambulance issues. • Children and community performance indicators were all positive. • Nursing vacancy rates were discussed, including “growing our own”. • Reviewed the BAF. The Committee Chair highlighted that the input received from the Public Governor (KG) was stimulating, thought provoking and a welcome addition to the discussions. **Resolved:** The Board noted the content of the report.
BD/5/31/22 **22.1** **22.2**	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised. **Resolved:** The Board noted the content of the report.
BD/5/31/23 **23.1** **23.2**	**Chief Operating Officers Report** The Chief Operating Officer presented the report as read. Further information was given on the current Cancer position. Clarification was provided on the ambulance service boundary change and the reasons for the amendment. It was anticipated that the consequence would be two

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	additional ambulances to Harrogate District Hospital daily. However it was advised that the new boundary had been in place for 10 days and there had not been an influx of additional work.
23.3	The Non-executive Director (CD) noted the long-term challenges and short-term fixes that were being managed in the treatment of cancer and the improvement work that was ongoing such as more timely reporting of negative results back to patients.
23.4	**Resolved:** The Board noted the content of the report.
BD/5/31/24 **24.1**	**Director of Finance Report** The Director of Finance presented his report as read. The cash position was highlighted to the Board and it was noted that the Chief Executive had covered the key items in his report to the Board.
24.2	**Resolved:** The Board noted the content of the report.
BD/5/31/25 **25.1**	**Board Assurance Framework – At Our Best Place to Work** The Director of People and Culture updated the Board on this element of the BAF, noting that it had been reviewed in the People & Culture Committee earlier in the day.
25.2	It was advised that the Committee received an update on one corporate risk each month – this month the positive and negative impacts of staffing levels and engagement on service delivery were scrutinised.
25.3	**Resolved:** The update on the At Our Best, making HDFT the best place to work was noted.
BD/5/31/26 **26.1**	**People and Culture Committee Chair's Report** The Chair of the Committee noted a positive meeting had taken place. The Non-executive Director (JW) had chaired this month's meeting.
26.2	The following items had been considered: • The colleague story had been a specialist respiratory pharmacist who was also on the leadership programme. She had challenged the Committee diversity. • The Equality, Diversity and Inclusion Manager's presentation relating to staff leadership within the growing staff networks. • The Inpulse survey results. • Pathways to recruitment and retention. • The new-in-post Freedom to Speak Up Guardian. • Guardian of Safe Working Hours issues.
26.3	It had been agreed that there were no risks to escalate.
26.4	The Chair noted how positive and powerful the recent staff network day had been.
26.5	**Resolved:** The Chair's update was noted.
BD/5/31/27 **27.1**	**Integrated Board Report -** Indicators from Workforce Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
27.2	**Resolved:** The Board noted the content of the report.
BD/5/31/28 **28.1**	**People and Culture Director Report** The Director of People & Culture presented her report as read.
28.2	

Item No.	Item
	It was explained that the items in the report had previously been discussed at the People & Culture Committee and during the Board meeting.
28.3	The continued approach being taken on equality, diversion and inclusion was giving staff the power and ability to feel safe, especially with the staff networks in place.
28.4	**Resolved:** The Board noted the content of the report.
BD/5/31/29 **29.1**	**Public Sector Equality Duty (PSED) Report** The Director of People & Culture presented her report as read, noting the purpose of the paper was about "fostering good relations around those who have protected characteristics and those who do not."
29.2	It was noted that equality had been reported through all committees and this initial report provided the Trust's position to use as a benchmark going forwards.
29.3	It was noted that the background to the report advised the aims applied to eight of the 9 protected characteristics whereas it did cover all nine. It was also clarified that, in section 4.1 (Gender Pay Gap), the first set of figures referred to a mean average whereas the second set referred to the median.
29.4	The aims of the report were summarised and attention was drawn to the need to: • Focus on tackling perceived age discrimination within the Trust. • Encourage people to declare their sexual orientation, the importance of which may not have been emphasised when people first joined the Trust, especially if that was some time ago.
29.5	The Non-executive Director (CD) highlighted the proportion of staff survey responses relating to the fairness of the organisation. It was explained that the staff survey responses, which were all anonymous, were scrutinised in detail and that data was also collated from other sources to provide a more robust picture.
29.6	It was noted there was more work to do, including on the diversity of appointment panels which could be aided by consideration within the staff networks.
29.7	**Resolved:** The Board noted the content of the report and approved the publication on the external website, subject to the amends mentioned.
BD/5/31/30 **30.1**	**Modern Slavery Annual Declaration** The Director of People and Culture took the report as read and it was explained that due diligence had been applied to the statement before being written.
30.2	**Resolved:** The Annual Statement was approved.
BD/5/31/31 **31.1**	**National Staff Survey** The Director of People & Culture took the report as read. It was noted that a workshop on the National Staff Survey had already been held with Board members.
31.2	It was advised that the People & Culture Committee had reviewed the resultant actions, which had been shared at a Senior Management Team (SMT) workshop
31.3	**Resolved:** The report was approved.
BD/5/31/32 **32.1**	**Innovation Committee Chair's Report** The Chair of the Committee noted that the Committee was still in its infancy.
32.2	The following points had been discussed:

Item No.	Item
	• The Terms of Reference had been endorsed owing to the committee being non-quorate the previous meeting. • The Committee Workplan had been agreed. • Good progress was being made in the digital arena – noting the EPR OBC had been the main point of discussion. • Premises had been secured for the Innovation Hub. • Whilst research was becoming more ingrained in Trust activity, it was considered that further work was needed to embed it in financial planning as much of the work was around non-recurrent funding. • Continuous improvement work was focussing around readiness assessment and preparation for the EPR implementation.
32.3	The detailed discussions around the EPR OBC related to the recognition of regional and national relationships. The focus was on the benefits, noting they were not primarily financial. The risks were also scrutinised as were the capacity levels needed for it to be a success. It was advised that the Committee supported the approval of the EPR OBC which would be discussed further at Private Board.
32.4	**Resolved:** The Chair's update was noted.
BD/5/31/33 **33.1**	**Board Assurance Framework – Enabling Ambitions** The Executive Medical Director updated the Board on the Digital Transformation and Healthcare Innovation enabling ambitions noting that all current plans were completed or on track, with dedicated space now allocated and awaiting refurbishment to make it appropriate for clinical research.
33.2	A meeting had taken place with the Integrated Care Board (ICB) Senior Responsible Officer (SRO) to discuss digital transformation (non-EPR related) further. An additional meeting was being arranged.
33.3	However, it was reported that the full financial allocation of £8.2m had been spent with no waste. The Board previously noted that the funding allocation would be split evenly over a three year period. It was confirmed that this would now be allocated over an extended four year period.
33.4	**Resolved:** The update on the Enabling Ambitions was noted.
BD/5/31/34 **34.1**	**Board Assurance Framework – Enabling Ambitions** The Director of Strategy updated the Board on the environment enabling ambition.
34.2	The specific highlights were: • Risk relating to fire: there was a new staff within Harrogate Integrated Facilities (HIF) as well as internally at HDFT who had identified gaps in processes and governance which were being addressed. It was anticipated that the timeline for completion would be September 2023. • Investment would need to be made to mitigate current risks which would be reviewed by HIF and HDFT.
34.3	A summary of the status of key projects was provided: • Emergency Department – First phase was complete. • Radiology – department reconfiguration was on track. • Mobile CT scanner likely available first week in June 2023. • TIF – currently work in progress but both costs and timescales had increased.
34.4	**Resolved:** The update on the Enabling Ambitions was noted.

Item No.	Item
BD/5/31/35 **35.1** **35.2** **35.3**	**Director of Strategy Report** The Director of Strategy presented his report as read. The following areas were highlighted: • The charity accounts had not yet been submitted to the Charity Commission. This had been discussed at the Charitable Funds Committee the previous day. • Funding had been approved for the community diagnostics centre in Ripon. • Inpulse Survey responses indicated engagement with Continuous Improvement Programme. • Vaccination services were decommissioning with the new providers in situ. • Branding of new Continuous Improvement Programme confirmed as HDFT Impact. **Resolved:** The Director of Strategy Report was noted.
BD/5/31/36 **36.1** **36.2** **36.3**	**Audit Committee Chair's Report** The Chair of the Committee presented his report as read. The key points noted in the report were outlined for each Committee meeting. Additional information was provided regarding the external auditors' (Azets) timeline in that they were planning to complete all the required work to allow submission of final accounts by 31 August 2023 deadline. This would require Board approval at the August Board Workshop meeting. **Resolved:** The Board noted the content of the report.
BD/5/31/37 **37.1** **37.2**	**Going Concern** The Director of Finance explained the considerations around Going Concern, and the appropriateness of preparing the Trust annual accounts on that basis. **Resolved:** The Board approved the recommendation from the Audit Committee that the 2022/23 Accounts were prepared on a going concern basis.
BD/5/31/38 **38.1** **38.2** **38.3** **38.4**	**Annual Report and Accounts Timetable** The Director of Finance took the report as read. The Board were advised that work was ongoing with the charity and HIF accounts for 2021/2022. It was acknowledged that these were late and lessons would be learned in relation to audits being scheduled earlier in future in order that deadlines were met. A potential issue relating to the subsequent date for the Annual Members' Meeting was discussed outside the meeting. **Resolved:** The Board noted the annual report and accounts timetable.
BD/5/231/39 **39.1**	**WYAAT Programme Executive Minutes** **Resolved:** The WYAAT Programme Executive Minutes were noted.
BD/5/31/40 **40.1**	**Collaboration of Acute Providers Minutes** **Resolved:** The Collaboration of Acute Providers Minutes were noted.
BD/5/31/41 **41.1** **41.2**	**NHS Provider Licence Annual Self-Assessment** The Chief Executive took the self-assessment for the NHS Provider Licence annual statement as read. **Resolved:** The Board approved the annual NHS Provider Licence Self-Assessment.
BD/5/31/42 **42.1**	**Any Other Business** No further business was received.

Item No.	Item
BD/5/31/43 **43.1**	**Board Evaluation** The Trust chair requested for any comments about the meeting should be sent to her.
BD/5/31/44 **44.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 26 July 2023.
BD/5/31/45 **45.1**	**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 (updated after 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	27 September 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	Action closed at March 2023 Board meeting but questions were outstanding relating to the transgender policy.Update to be provided at the meeting	Open
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	Corporate framework on agenda to address issues.	Ongoing

BOARD OF DIRECTORS (PUBLIC)
26th July 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)
JULY 2023

CHIEF EXECUTIVE'S REPORT

National and system issues

1. The NHS celebrated its 75th birthday earlier this month. As part of the national celebrations, five colleagues (including a volunteer) attended a service for the NHS in Westminster Abbey, and locally we created a short video including a wide range of colleagues from across the Trust. As we said in our communications, the NHS is a fantastic organisation with the core principles from 1948 – a service available to all, free at the point of delivery, and where treatment is not dependent upon ability to pay – still applicable today. Despite challenges it is vital that we remain positive about the benefits of the NHS and collectively continue to be restless for improvement, ambitious for our services, and supportive of our colleagues, patients, and population.

2. As we marked the 75th birthday of the NHS, the long term workforce plan for the NHS was published, with proposals covering the next 15 years. The key watchwords are Train, Retain, and Reform, with a focus on creating a resilient and well-trained workforce to meet the future challenges of the NHS. Detail about how funding will flow to support training is yet to be seen, and we need to review the plans that we already have in place against the national plan aspirations. We will review this initially through our People and Culture programme and committee.

3. Absent from the national workforce plan was any discussion of pay, terms and conditions, and the current dispute with the medical workforce. We continue to manage periods of industrial action and we are becoming skilled at planning and delivering safe care in difficult circumstances. The strikes are costly in terms of additional cover costs, costly in terms of delayed treatments for patients, and costly in terms of the opportunity cost of focusing on strike management rather than other more positive improvement activity.

4. The consultant strike this week will be the first such action, and we are supporting all colleagues – those who strike and those who don't – and ensuring that safe services are provided whilst supporting people to make their voices heard. The dispute is with the government not HDFT, and it is important that at the end of this period of unrest, that there is no lasting legacy of internal difference.

5. Correspondence has been received from the HNY ICB in relation to financial controls. The communication builds on a similar letter from NHSE. The letter asks that certain actions are taken by organisations, including recruitment controls, executive approval of appointments, vacancy control measures, ICB approval of workforce plans, and ICB/Regional NHSE approval of non-clinical agency spend.

6. Whilst I do not object to the spirit of the communication – if we are not delivering our financial plan, then it is right to ask for an explanation – the suggested way of doing this is counter to the culture we are trying to develop in HDFT, and is not consistent with the improvement methodology that we are embracing and that NHSE have also committed to.

7. I have been in contact with the ICB, and we are working through the issue. It is important that we support the ICB in their work, but we have to do this proportionately and in line with our values.

8. As we discussed at our Board workshop last month, the HNY CAP organisations have collectively agreed the governance of the CAP and the creation of a Committee in Common. The first meeting is planned for next month.

9. The ICB has now set up a senior leadership forum as a regular way of bringing people together, with key discussions to cover the ICS operating model and how the ICB, organisations, Places, and Collaboratives work constructively and efficiently. There are similar discussions taking place in West Yorkshire that we are a part of. It is clear that we will continue to have to manage through the uncertainty and clunkiness of current arrangements for the moment, and we are ensuring that we continue to build relationships and be active participants in the various fora that exist.

10. There is continued significant scrutiny of the HNY position in relation to elective performance, urgent care performance, and cancer performance, where the system continues to struggle across many areas. We continue to lead a number of improvement workstreams and provide support where appropriate to do so. There are some specific challenges that directly impact ourselves in relation to the ENT service that we receive from York, and we are working through these at the moment.

11. We have contacted all of the Directors of Public Health from the local authorities where we provide services, to engage more proactively in the role that we can play as a willing and strong partner in different systems. We are also in dialogue with some areas about the option of developing longer term partnership relationships through Section 75 agreements.

12. We recently hosted a visit from Chris Witty, who spent some time with HARA colleagues and others as part of a day in North Yorkshire with North Yorkshire Council. He was interested in how we integrate services and provide support for older people across the rural area. This was a really positive session, and thanks to our colleagues who participated.

HDFT issues

Introduction

13. As I always state when introducing this part of the report, 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

14. I have already referenced the national workforce plan and also the periods of industrial action that we continue to have to manage.

15. The latest Inpulse survey closed this week and high-level results have now been received. We had the highest number of responses this quarter (over 1300 colleagues from across the Trust) and the general feedback continues to be positive, with many colleagues expressing positive comments. As we mentioned at the Board workshop, we compare very favourably with other NHS organisations, and the approach we continue to take – positive, open, kind, and challenging – is demonstrating consistent evidence of improvement. We absolutely recognise that there will be teams and individuals within HDFT that require further help and support, and we still have a number of colleagues who suffer stress and anxiety and are absent from work as a result. We are thinking through our approach to assess what further we can do in this area.

16. As a result of our national staff survey results we have been contacted by the national guardian's office, who would like to visit us and discuss our approach to improving speaking up arrangements and culture.

17. 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

18. We have undertaken an internal peer review of areas within the hospital, focusing on the CQC framework. There was positive feedback about our culture, values, infection control, pain management and patient feedback. Areas to improve included documentation, clutter, record storage, and in some areas ensuring appropriate access controls were in place. There were a couple of specific areas where further support is needed, and we are picking this up through our Clinical Directorates.

19. In relation to our maternity service, we continue to be well staffed, and we have had positive feedback from Healthwatch. As the Board will recall, we paused our work on implementing the Continuity of Carer model last year, and said that we would review the position when our staffing position was stronger, which it now is. We have undertaken this review and this will be part of the Quality Committee discussions this month that will be reported to the Board. We are recommending continuing to provide services as we currently provide them.

20. There have been a number of recent incidents of concern relating to patient care within the Emergency Department. This is being managed by the Directorate with support corporately, and improvement work is being taken forward in response.

21. Our first PSIRF thematic review has been launched that will look at results reporting within the Emergency Department.

22. Work in respect of Health and Safety continues to be a priority, with recent work focusing on violence and aggression and support for staff.

Our Services

23. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint. This is despite the operational and staffing challenges that we have been managing recently. Recent visits to 0-19 services (Gateshead and North Yorkshire) have been positive and demonstrated the commitment and quality of service within these areas.

24. As the Board is aware we are in the process of transferring our School Age Immunisations service (SAIS) to new providers. This transfer takes effect from September. We have raised some concerns with the Commissioner (NHSE) in relation to a few issues that we are concerned about, not to affect the commissioning decision in this case, but to ensure that we provide appropriate support to our existing colleagues and to potentially inform future procurement processes.

25. Our urgent care pathway performance continues to deliver well, with continued delivery of the ED 4 hour standard above 80%. We have also had no 60-minute ambulance handover breaches this financial year, which is impressive and is very different from other organisations in the region. We want to improve further but must also recognise the effort and work that has been undertaken to get to our current position.

26. In relation to cancer, we continue to have challenges in delivering the standard that we would want to, but overall the position is improving. There are capacity issues in relation to the breast 2ww in particular, but we are achieving a wait time of 19 days in this area.

27. 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

28. As you will read in the report from the Finance Director, our month 3 financial position is behind plan. The key drivers remain related to our pay expenditure, in particular the pressure on agency usage. We had a workshop session at our extended SMT this week, led by Russell, Jackie, and Emma, to discuss our approach, actions we can take, and fundamentally ensure ownership of the issue across our wider leadership community. This was a positive session.

29. Our approach will continue to be to empower people to take responsibility and solve problems locally with support, and we must ensure that use of resources is part of our improvement work and not seen as a separate issue. As I have referenced earlier, for us to have the freedom to take this approach – which is the right approach for sustainable quality and financial improvement – we need to acknowledge the political and system pressure to deliver quickly, and ensure that we are in a place where we all have confidence in our actions.

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

Other

31. We continue our initial work in relation to the continuous improvement programme. A number of workstreams are underway. We have a Leadership Team session this week to review the programme and inter-dependencies of the work to be done, before we launch the programme across the Trust properly in the autumn. We have discussed having a session with non-executive Directors sometime at the end of September, and we will also be planning to weave the programme into the October Board workshop, which is scheduled to discuss initial priorities and planning for 2024/25.

32. The Board will know that we undertook a recruitment process to recruit to the position of Director of Finance, and I'm delighted to formally report that Jordan McKie was successful and is now taking up the role permanently.

33. The Board will also be aware that last month we undertook a process to recruit to the Deputy Chief Executive role, and I'm delighted again to formally record that Emma Nunez has been appointed permanently into this role.

34. We received recent correspondence from NHSE in relation to the Domestic Abuse and Sexual Violence (DASV) programme that NHSE have established. This programme has been expanded to support the NHS's response to domestic abuse and sexual violence associated with NHS services and/or premises, whether experienced by patients, staff, or visitors. The initial ask is to appoint an Executive lead for this work within the Trust, and Emma Nunez will be our lead, linking this work to the work that we undertake in regard to safeguarding and health and safety.

35. Finally, I would like to reiterate comments that I have referred to through this report, namely our continued focus on improving services for patients and the population, and creating the positive environment for colleagues to do their best work. This will deliver the sustainable improvements that we want to achieve, help make progress against our ambitions, and ensure that we continue to meet the standards people should expect of the NHS as it moves into its 76th year.

Jonathan Coulter
Chief Executive
July 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=12	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 1.6) - decrease in reporting of low and no harm incidents for month of June which continues to be monitored via Quality and Learning Summit.
- Complaints (IBR 2.2.2 Response Time) – June performance was 59% against the 95% trajectory. Teams continue to plan delivery of 95% standard, escalating challenges in a timely way so support can be provided. Position improving throughout July.
- Work ongoing with Mental Health Teams following increase in admission of complex mental health patients to HDFT

Major actions commissioned & work underway

- CQC Well Led Self Assessment ongoing

Positive news & assurance

- HDFT awarded the National Interim Quality Award for the Preceptorship Programme
- Approval of Patient Experience Plan

Decisions made & decisions required of the Board

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

Matters of concern & risks to escalate

Best Quality, Safest Care

- Impact of medical industrial action- elective backlogs
- Scale of backlog maintenance for critical infrastructure remains a quality and IPC risk

Enabling Ambitions- Digital, Research, Innovation

- EPR contract award timescales remain very challenging due to requirements from ICB and NHSE regional teams

Major actions commissioned & work underway

Best Quality, Safest Care

- PolicyStat – the tool where all policies, procedures and guidelines will be held will go live in August 2023 as planned

Enabling Ambitions- Digital, Research, Innovation

- EPR readiness & enabling projects being planned/delivered, including – Single Sign On, Robot Process Automation, Paper Scanning, IT Infrastructure & CI, Datix, Cancer Tracking, eRostering, LIMS, YHCR, OP Flow & eOutcomes

Positive news & assurance

Best Quality, Safest Care

- Regional IPC team visit June 23 - excellent feedback for HDFT
- No detection Pseudomonas aeruginosa augmented care areas for 3 months.
- HTA inspection May 23- formal report received, no significant concerns
- Theatres Quality Priority presented to QGMG. Significant progress made, internal audit report has received significant assurance.
- Bereavement Officer post being created in Patient Experience Team following Mortality and End of Life Time Out

Enabling Ambitions- Digital, Research, Innovation

- HDFT now live on YHCR- sharing patient demographics plus ED, inpatient and outpatient encounters & appointments across Y&H
- Single Sign on now being rolled out at HDFT
- R&I team Time out held June 23- excellent feedback and output

Decisions made & decisions required of the Board

Best Quality, Safest Care

Proposed new medical additional rates supported by SMT

Enabling Ambitions- Digital, Research, Innovation

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.	12 (3x4)	6 (3x2) (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 **22/23 objective complete – to be closed**	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	• Complete • Complete • On Track	
Improving strategic relationship management with system partners	Improved outcomes for children Securing long-term partnerships		• Children's PH Strategy Workshop – Oct 22 • Review existing strategic relationships – Dec 22 • Stakeholder Management Plan supported by Children's PH Services Board WG – Jan 23 • Strategic meetings attendance plan – Jun 23 • Establish informal meetings with Lead Commissioners and DPHs – Sep 23	• Complete • Complete • Complete • On Track • On Track – written to lead commissioners and DPHs proposing meetings; positive responses from several local authorities and meetings being scheduled for Jul 23	
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 – Jun 23 (revised from Jan 23) • Review of community estate and processes – Jun 23 (revised from Mar 23) • Proposal for "Northern Hub" – Jul 23 (revised from Mar 23) • Draft Operating Model supported by Children's PH Services Board – Oct 23 (revised from Apr 23)	• Complete • On Track – workshop planned for 21 Jun 23 • At risk – baseline review complete; support options review complete • On Track – use of "Beehive" in Darlington being scoped • On Track – 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 • Delayed – further information to collect from directorates • At risk • 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

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 awaiting start date	
	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	• Released 31st May 23 – under review • In development	

Harrogate and District NHS Foundation Trust

4.2

Strengthening Maternity and Neonatal Safety Report

Trust Board (Public)

June 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 June 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	√
	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		
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting	
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 June 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 that 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 Possible delay in achieving compliance with audit for Three Year Delivery Plan/CQC Action Plan/Maternity Incentive Scheme due to awaiting start of Audit and Clinical Effectiveness Midwife.
5.3 On-going lack of compliance with Continuity of Carer.

6.0 Recommendation

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

Maternity – July 2023 (June's data)

Matters of concern & risks to escalate

- Ongoing issues with Antenatal Clinic ward clerks causing disruption to the service
- RIDDOR reportable fall for staff member who fell from chair
- There were five incidents of closure of the unit in June 2023.
- Three new risks added –
  - One risk added relating to insufficient list capacity for elective caesarean section (Score 12)
  - One new risk for possible delay in achieving compliance with audit for Three Year Delivery Plan/CQC Action plan/Maternity Incentive Scheme due to awaiting start of new Audit & Clinical Effectiveness midwife (Score 9).
  - One risk relating to ongoing lack of compliance with Continuity of Carer requirements (Score 8).

Major actions commissioned & work underway

- Work underway to meet requirements of Maternity Incentive Scheme (MIS), Three year Delivery Plan and Saving Babies Lives v3
- Task and Finish Group to review WHO checklist and implement NatSSIPs guidance
- Maternity Support Worker uplift project underway
- Service provision in EPAU - plan to review service and consider business case to move to a 7 day service
- The Trust has received the invite for the quadrumvirate (Obstetric Clinical Director, Operations Director, Neonatal Clinical Lead and Associate Director of Midwifery) to join the Perinatal Culture and Leadership Development Programme (PCLP).

Positive news & assurance

- Bereavement Midwife has secured funding from Petal's charity £10k for a 6 month trial offering specialist bereavement counselling to any family who experience the loss of their baby 14 weeks onward, neonatal deaths and support in subsequent pregnancy
- No new SI investigations
- No new HSIB incidents
- 100% complaint response rate
- Midwife led frenulotomy (tongue tie) clinics agreed with support from Peads
- 90% Appraisal rate for community midwifery

Decisions made & decisions required of the Board

- Plans for Continuity of carer

Narrative in support of the Provider Board Level Measures – June 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. The minimum measures to be included are:
    - Findings of review of all perinatal deaths
    - Findings of review of all cases eligible for referral to HSIB
    - The number of incidents logged as moderate or above and actions taken
    - Training compliance related to the Core Competency Framework and job essential training
    - Minimum safe staffing
    - Service User Voice feedback
    - Staff feedback from Safety champions and walk-abouts
    - HSIB/NHSR/CQC concerns
    - Coroner Reg 28
    - Progress in achievement of Maternity Incentive Scheme

2.0 Obstetric cover on the delivery suite, gaps in rota

Minimum safe staffing standards have been maintained at all times during June 2023. There remains one vacant slot on the middle grade night and weekend rota. In addition, there are vacant shifts on the first on call rota due to maternity leave and a doctor working less than full time. Recruitment has taken place to fill the maternity gap and the middle grade gap. These newly recruited staff will commence in September. The vacant shifts have all been covered in June 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.

3.1 Absence position

Unavailability of midwifery staff hours –
345.8 hours (2.13WTE) sickness absence
5.09 WTE maternity leave

Maternity support worker hours lost across maternity services –
267 hours (1.64WTE) sickness absence

3.2 Vacancy position

Currently there is zero midwifery vacancy. Two internationally recruited midwives coming from Ghana will commence their training at HDFT in July.
3.2WTE student midwives due to qualify in summer recruited.

There is 1.5WTE Band 3 Maternity Support Worker vacancy. 2.2 WTE Band 2 maternity Support Worker.

3.3 NHSP provision

Midwives -
1.52 WTE NHSP midwifery staffing used in June 2023. The percentage of shifts remaining unfilled has increased consistently over the last five months. This is related to the incentive rates being removed in March 2023.

Support workers –
3.42 WTE NHSP maternity support worker staffing has been used across maternity in June 2023. This has increased due to covering sickness and vacancy position.

5

3.4 Homebirth provision

Home birth provision is covered by community midwives working clinically in the day and a first and second on-call midwife every night between 17:00 – 08:00.

Three homebirths were booked for the month of June 2023. Two homebirths were attended at home, one of which transferred to hospital for pain relief at maternal choice. One woman is still pregnant. No homebirths were transferred to hospital due to a suspended service.

In the period 1/6/23 – 30/6/23, the home birth provision was suspended on three occasions. The service was suspended due to changes to staffing caused by sickness and occupational health adjustments.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Neonatal absence position

0.92WTE nurse currently on maternity leave.
0.9 WTE short-term absence
No long-term absence

4.2 Neonatal Vacancy

1.54 WTE remaining vacancy

4.3 Neonatal Recruitment

0.92 WTE B5 internal (non-QIS) to cover maternity leave
0.92 WTE B5 (QIS) recruited – start date 03/07/23

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.

Nurse 0.61 WTE completed QIS course – currently consolidating.

June 2023 – 71% QIS compliance

5.0 Birthrate Plus Acuity Staffing Data

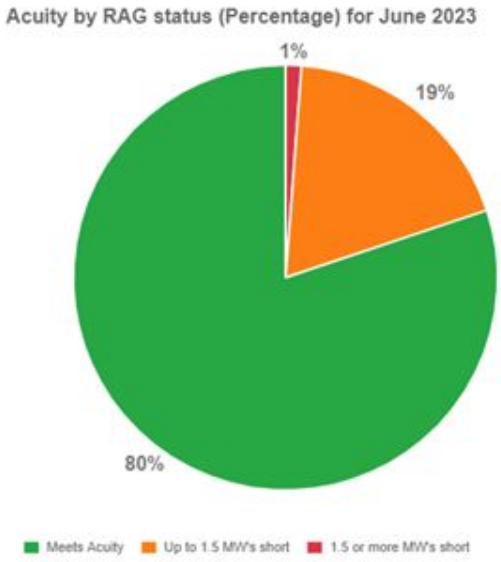
The Birthrate Plus score system is based upon indicators of normality in the progress and outcome of labour and the health of the baby at birth, together with other indicators which identify changes from normality. Using the Birthrate Plus classification system the tool provides an assessment of women's 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 180 scheduled assessment periods, of these 134 were completed, giving a confidence factor of 74.44%. Staffing met the acuity 80% of the time.



70% of the time, no clinical actions were required.
30% of the occasions clinical actions were required, these included:

- Delay in commencing induction of labour – twelve occasions (27%)
- Delay in continuing Induction of Labour – 24 occasions (55%)
- Coordinator not supernumerary – five occasions (11%)
- Delay in elective caesarean section – one occasion (2%)
- Postponed induction of labour at home – two occasions (5%)

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

To delay an induction of labour or elective caesarean section is usually the most clinically appropriate action to take in periods of high activity. The impact of a clinically appropriate delay is on patient experience. To mitigate the impact on patient experience staff ensure the women and families involved are fully informed of the delay, are regularly updated on the situation, and plan for their care provision.

99.2% of women received one to one care in labour within the unit. Two babies were born before the arrival of a midwife and one woman birthed on Pannal.

5.2 Pannal Ward Staffing

The Birthrate Plus Acuity App ward tool has been removed for development until August 2023. As a result, there is no obtainable data for Staffing Levels vs Workload.

During June 96% of day shifts and 97% of night shifts were covered with contracted midwifery hours. NHSP staff covered the remainder of shifts.

The maternity support worker (MSW) day shifts were covered 49% with contracted hours and 51% with NHSP. MSW night shifts were covered 96% with contracted hours and 4% with NHSP. Two MSWs have been off work due to long-term sickness reasons causing the increase in use of NHSP.

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.*

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 was one Red Flag identified from the Birth Rate Plus Data during June.

- Delayed or cancelled time critical activity – 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 01/06/2023 to 30/06/2023

MA1	Redeploy staff from Pannal	**10**	**29%**
MA2	Staff unable to take breaks	**3**	**9%**
MA3	Review of staff on management time	**1**	**3%**
MA4	Use of specialist midwife	**4**	**12%**

MA5	Use of staff on training days	2	6%
MA6	Use of ward/department managers	0	0%
MA7	Staff sourced from wider Trust (theatre & CSW's)	0	0%
MA8	Use of hospital MW on call	5	15%
MA9	Use of community MW	3	9%
MA10	Unit on Divert	6	18%
MA11	Patient diverted	0	0%
	Total	34	

6.3 Pannal Ward Red Flags

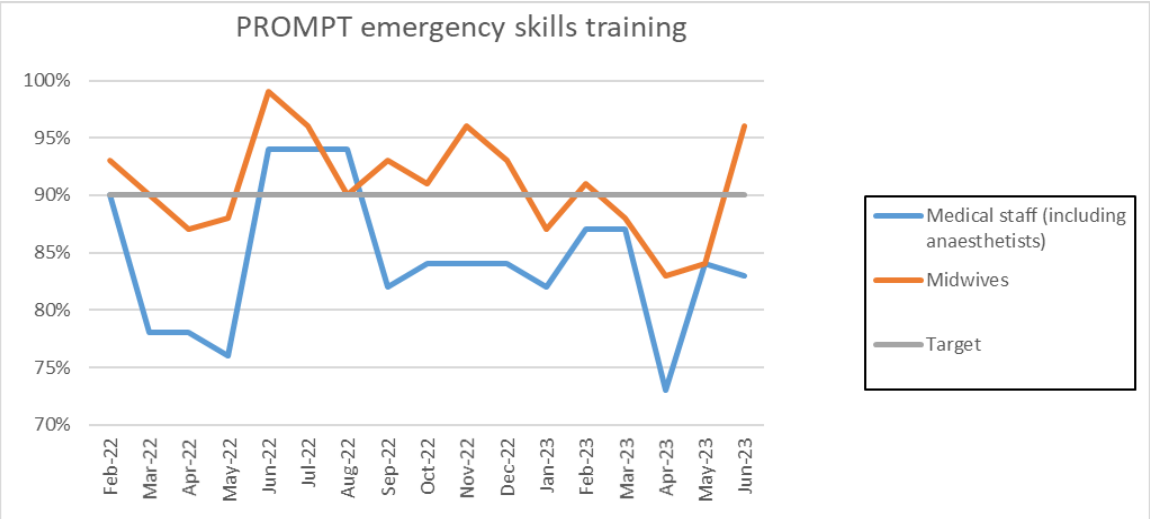
Red flag events were not captured during June on Birthrate Plus. Datix have been submitted for any incidents that occurred, as is normal practice.

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

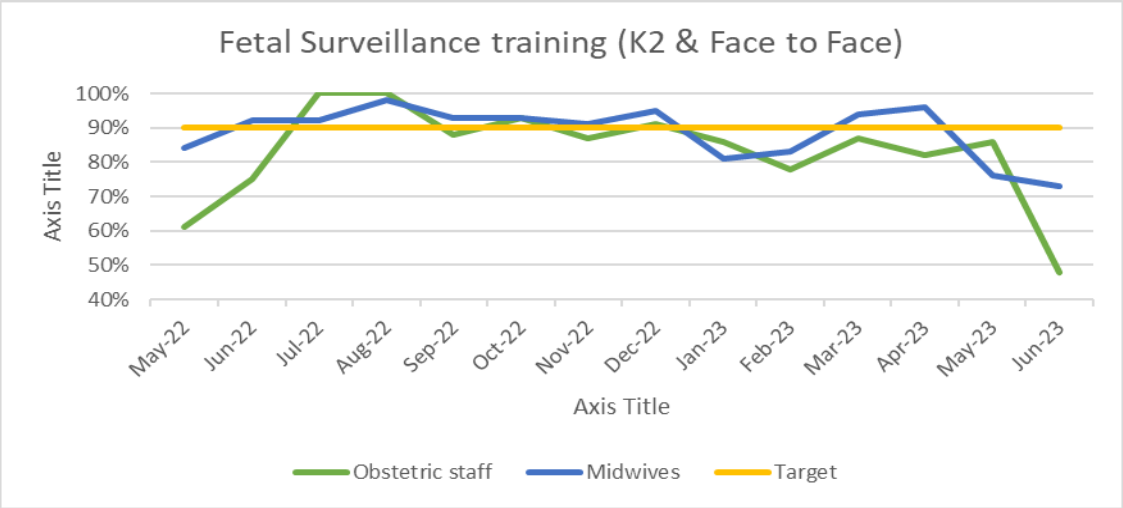
Maternity Area	***Headcount***	***Compliance***
Maternity staffing	54	88.4%
Community Midwifery	21	82.1%
Ante Natal Clinic	10	90.0%
Pannal Ward	21	87.6%
Obs and Gynae Medical	25	82.3%
EPAU	2	91.3%

7.2 Prompt emergency skills training



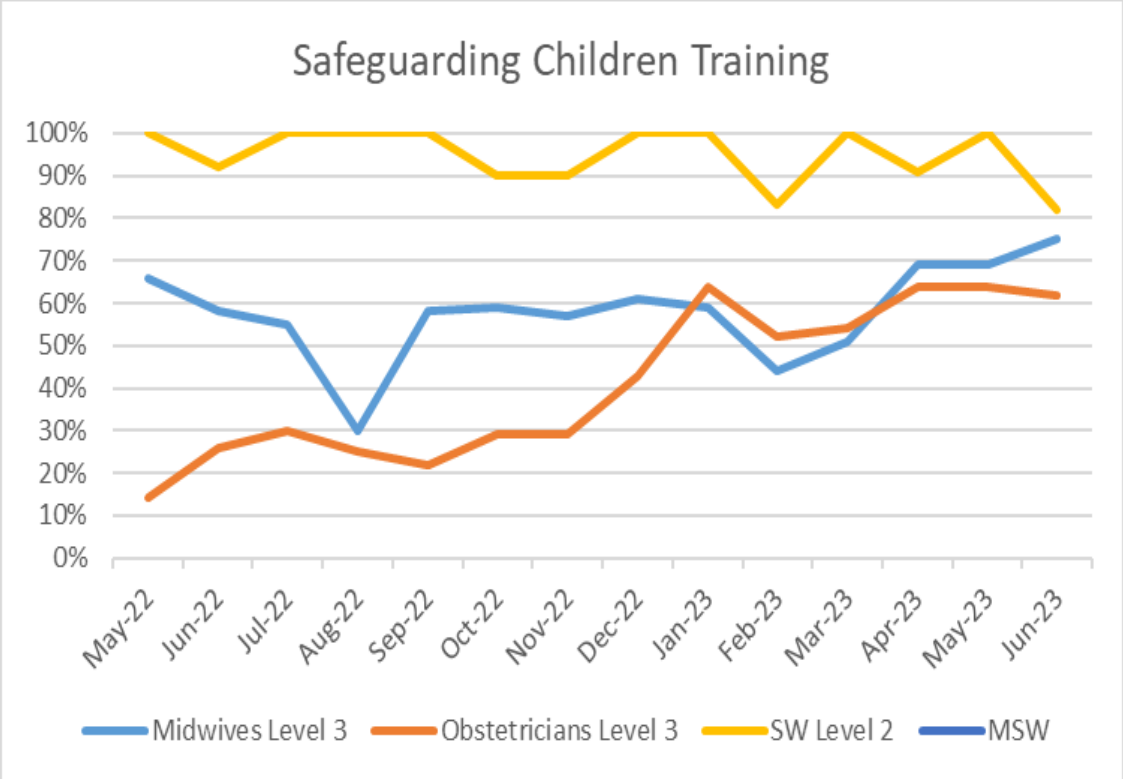
7.3 Fetal surveillance training

There has been a reduction in compliance of fetal surveillance training due to increased expectations of the training. Compliance with training now includes both K2 online package with a competency assessment test, and face-to-face training with local learning and case studies. The Maternity Incentive Scheme sets this requirement.



7.4 Safeguarding Children and Adults training

All midwives who are not meeting the requirements have been allocated time on their eroster to complete or attend training (as required). It is expected that midwifery compliance with Safeguarding children training will be above 90% by August 2023.



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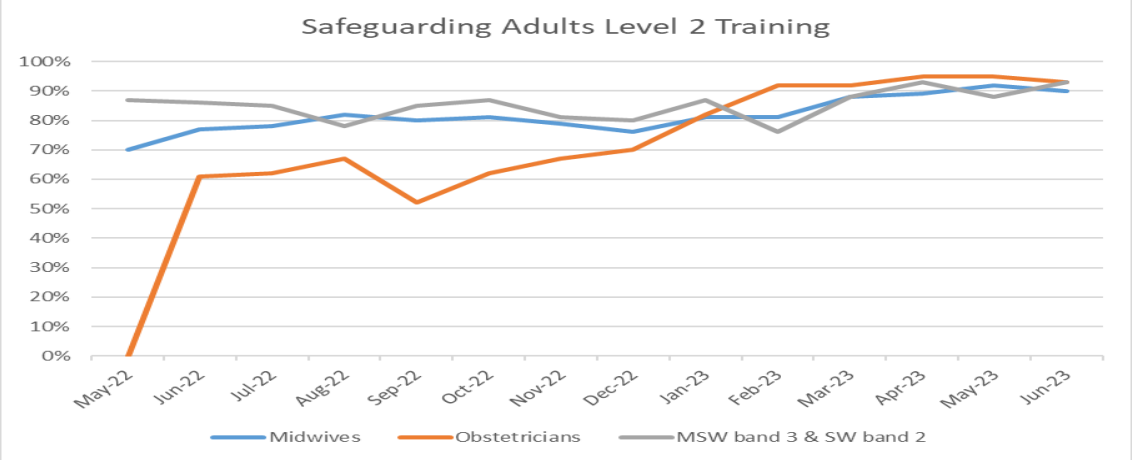
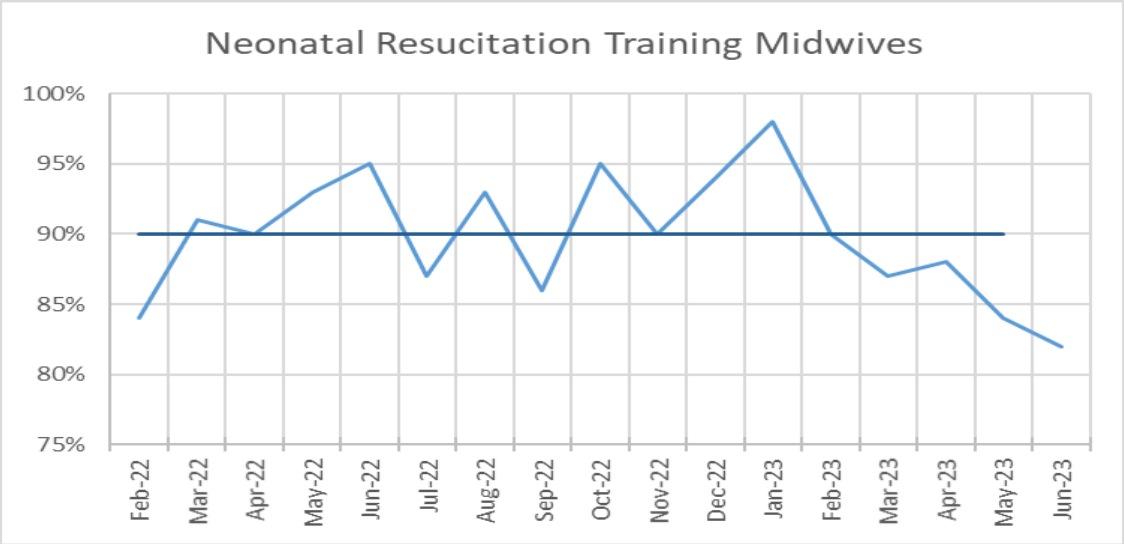
The level of training required for staff for Safeguarding Adults is under review.



7.5 Neonatal resuscitation – Midwives



The Clinical midwifery educator is attending RCUK Neonatal Life Support assessor training. Once certified this will improve the availability of an appropriately certified trainer within maternity services. Plans are in place to ensure 90% of midwives achieve NLS compliance by October 2023.

7.6 SCBU Training Compliance

Certification Name	Assignments	Not Achieved	Percentage Compliant
Harrogate Newborn Intermediate Life Support (HNILS)	1	0	100%
RCUK Newborn Life Support Face to Face	5	1	80%
Harrogate Newborn Advanced Life Support (HNALS)	14	8	43%
Adult Basic Life Support with paediatric modifications	15	1	93%

8.0 Risk and Safety

8.1 Maternity unit closures

There were five incidents of closure of the unit in June 2023. Six patients required diversion to other Trusts on dates of 12/13th June 2023, one of these women birthed and another was admitted and birthed several days later. The remaining four women were discharged home. An additional patient was diverted on night of 27th June. This woman was later discharged home.

8.2 Maternity Risk register summary

Three new risks added.

- One risk added relating to insufficient list capacity for elective caesarean section **(Score 12)**
- One new risk planned for possible delay in achieving compliance with audit for Three Year Delivery Plan/CQC Action plan/Maternity Incentive Scheme due to awaiting start of new Audit & Clinical Effectiveness midwife **(Score 9)**.
- One risk relating to ongoing lack of compliance with Continuity of Carer requirements **(Score 8)**.

Seven 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. Issues remain but some progress. Business Support Officer now working full time within clinic for interim period to assist and monitor issues. Support worker also undertaking additional work to clear pregnancy referral backlog. No change currently.
- **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).** Safeguarding communication capability improved within Badgernet, with ability to have improved sharing within the local team. Safeguarding Team are also Badgernet users and able to input information and have oversight. Plan for audit of safeguarding communication discussed with Named Midwife for Safeguarding. 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).** Agreement reached with paediatric staff about management of bleeding after treatment. No change at present.

One risk archived:

- **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 now rolled out. Breaches being tracked through Datix and red flags being monitored. Downgraded and archived.

8.3 Maternity Incidents

In June 2023 there were 68 total incidents reported through Datix (three were rejected due to being duplicates).

One incident recorded as Moderate Harm relating to a secondary postpartum haemorrhage (PPH) and transfer to High Dependency Unit. A 48-hour multidisciplinary team review and report has been completed and care was considered appropriate. Some learning was identified in relation to the antenatal management of anaemia. The anaemia management pathway has recently been updated and so learning from this incident will be shared with staff with the updated pathway.

One incident noted within Emergency Department relating to a patient death. As the patient had been pregnant within one year, it is reportable to MBRRACE as a late indirect maternal death. She had not received care under our Maternity Services.

One incident of a staff member suffering a head injury following a fall from a chair on the ward. This has been reported as a RIDDOR due to the length of time the staff member was absent from work following the incident.

Additional incidents of note include:

- Eight readmissions of mother/baby (six babies with feeding/weight loss/jaundice; two maternal issues; plus one duplicate)
- Seven incidents of incorrect treatment/test/procedure/pathway
- Five patients not triaged within timescale (new Datix category for monitoring)
- Five suspension of maternity services [plus 2 inadequate staff for workload]
- Four PPH≥1500ml
- Three low Apgar score
- One unexpected Term Admissions to SCBU (plus one duplicate)
- One undiagnosed vaginal breech birth.
- One incident relating to an unexpected placenta praevia requiring urgent delivery. However, some issues noted with CRIS system that incorrectly recorded her due date following transfer of care.
- One incident relating to aggressive partner and insufficient security staff
- One baby born <32 weeks at HDFT

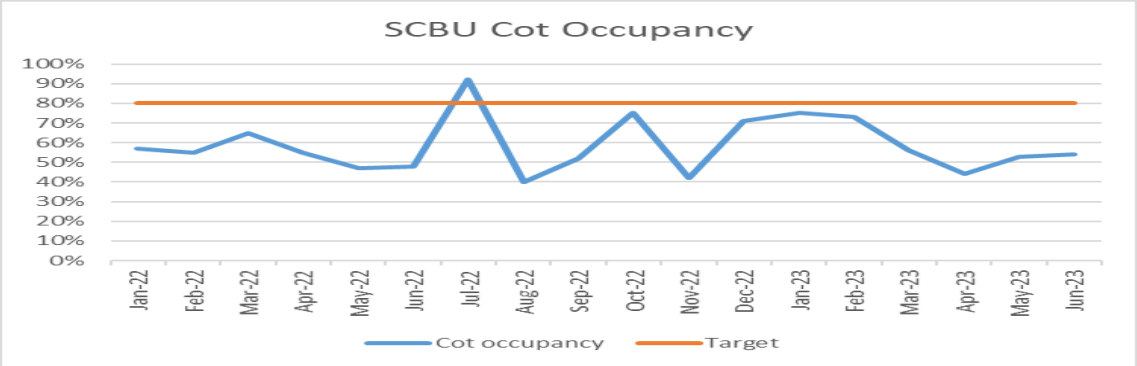
8.4 SCBU Incidents

No moderate harm incidents

8.5 SCBU Risk Register

No new risks.

8.6 Cot occupancy and babies transferred out



8.6.1 One baby was appropriately transferred out during June 2023 due to prematurity – 28 weeks.

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 that 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. Please see Appendix A for the quarterly report.

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 might 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

10.0 Service User feedback

“I cannot thank everyone enough, the care we have received as a family has been amazing from arrival to discharge. You’re all fabulous.”

“The midwives in the Pannal ward are fantastic and help you with all your post-natal care. I stayed in an extra night for extra support, which I got from everyone I asked. Couldn’t wish for a better service.”

"Midwife Laura and Student Midwife Amie were amazing throughout my birth experience. I gave birth under 6 hours of having my waters broken so it was very intense very quickly - also because of the drip. My baby girl Martha was Amie's first delivery, which was so special for us as first time parents to share this experience for the first time together. Laura helped me so much and made me feel proud of myself at the end.

I will never forget that day or all the special people who helped me."

"Dr Smith and Dr Johnson very friendly, good support from the community team, good early recognition of anxiety in pregnancy and support offered by the community team, very kind support from Abbie and Lizzie in MAC with reduced movements, the kids toys and water cooler at antenatal were enjoyed, love the cake at Pannal"

SCBU feedback - The team all have such a special bond and are a joy to listen to having fun and a joyful work environment. They are all very knowledgeable and their passion for nursing really shines though. I have been here for 10 days with my premature baby and they have been really reassuring, allowed me to sleep in a side room to care for my son and have helped me mentally though a really anxious time in my life. I will miss listening to the nursing team when I go and not to mention the cleaner too who was a very kind and friendly lady.

11.0 Complaints

One formal complaint received in June relating to care and follow up of pre-term twins (joint Obstetric/Paediatric complaint).

12.0 Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received.

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

No new concerns or request for action received in June 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 remaining actions relate to the on-going training of staff working in that area. The Manager of the Day provides oversight of the equipment checks on a daily basis and this is captured in the Tendable audit. Compliance with Safeguarding training is improving. An audit midwife has been recruited and will progress actions in relation to audit once in post.

14.0 Healthcare Safety Investigation Branch (HSIB)

In June 2023 there were no new HSIB incidents reported.

There is three active HSIB cases:

- October 2022 incident relating to Maternal Death/Stillbirth. Cause of death unascertained. Draft safety recommendation received. Draft report sent to family for factual accuracy checking. Awaiting final report.
- January 2023 incident relating to neonatal death. Neonatal panel planned for 13th July. Report panel planned for 31st July. Anticipate draft report after this.
- March 2023 incident relating to baby being cooled. Draft report in progress. Report panel planned for 20th July.

15.0 Maternity incentive scheme – year five (NHS Resolution)

The standards for year five have been published and can be viewed at Maternity Incentive Scheme. Compliance is due to be reported to NHS Resolution by 1st February 2024. A summary of the current compliance is as follows –

Safety Action	RAG rating and narrative (if not green)
SA1 - Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
SA2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
SA3 - Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
SA4 - Can you demonstrate an effective system of medical workforce planning to the required standard?	
SA5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6 - Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle version three?	Ongoing and on track - New elements added to Saving Babies Lives in version three released 1st June. Work is ongoing to implement the requirements.
SA7 - Listen to women, parents and families using maternity and neonatal services and coproduce services with users	
SA8 - Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Ongoing and on track – statement released by NHS Resolution to say this standard is to be updated to give further clarity of the requirements. Business Case in development to consider full implementation of Core Competency Framework Version Two.
SA9 - Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Ongoing and on track – PSIRF to be in place and maternity plans utilising PSIRF are to be reflected at Board.
SA10 - Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	

In support of Safety Action 9, there is a requirement to evidence in Board minutes that the work to better understand the culture within the maternity and neonatal services has been received. The Trust has received the invite for the quadrumvirate (Obstetric Clinical Director,

Operations Director, Neonatal Clinical Lead and Associate Director of Midwifery) to join the Perinatal Culture and Leadership Development Programme (PCLP).

The PCLP supports the:

• National ambition – To halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2025, by equipping senior perinatal leaders to create the conditions for a culture of openness, safety and continuous quality improvement through positive, inclusive and compassionate leadership.

• Three-year delivery plan for maternity and neonatal services – The plan sets out that by April 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership, including a diagnosis of local culture and practical support to nurture culture and leadership.

• Ockenden and Kirkup reports – The PCLP addresses themes of flawed team working; pulling in different directions, a lack of compassionate care and the importance of fostering a culture of learning and transparency. It emphasises the value of training together as a team, with a focus on relational aspects of the maternity and neonatal team dynamic, with compassion being at the centre.

This programme has three stages:

• Phase 1: Team 'Quad' leadership development – this stage focuses on the perinatal senior leadership team, responsible for supporting, role modelling and leading the cultural environment. It includes a leadership perspectives exercise for individual feedback.
• Phase 2: SCORE culture survey – an opportunity to gain insight into the team's safety culture, to help the team identify strengths and opportunities and to understand the role that relationships have in supporting improvement. Support will be provided by NHS England for the rollout of the survey.
• Phase 3: Cultural conversations and planning for improvement – support from an independent culture coach to have conversations about the SCORE survey findings with the teams. Support to co-develop an improvement plan based around a small number of identified key themes and linking with other work on going.

Phase 1 will commence in October 2023.

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.

Theme and Objective	RAG Status and narrative (if not green)
Theme 1: Listening to and working with women and families with compassion	Ongoing and on track – Audit of personalised care required.

Objective 1 - Care that is personalised	
Theme 1: Listening to and working with women and families with compassion **Objective 2 - Improve equity for mothers and babies**	Ongoing and on track – Audit of experience and outcome of women from different backgrounds required.
Theme 1: Listening to and working with women and families with compassion **Objective 3 - Work with service users to improve care**	
Theme 2: Growing, retaining and supporting our workforce **Objective 4 - Grow our workforce**	
Theme 2: Growing, retaining and supporting our workforce **Objective 5 - Value and retain our workforce**	Ongoing and on track – Develop a retention plan specifically considering high turnover of maternity support workers.
Theme 2: Growing, retaining and supporting our workforce **Objective 6 - Invest in skills**	Ongoing and on track – Business case in development to consider full implementation of Core Competency Framework Version Two.
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 7 - Develop a positive safety culture**	
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 8 - Learn and improve**	On-going and on track- PSIRF implementation required
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 9 - Support and Oversight**	Ongoing and on track – Neonatal Lead involvement in Board discussions required. MVP involvement in complaints process required.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 10 - Standards to ensure best practice**	Ongoing and on track – Work on going to implement Saving Babies Lives Version three.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 11 - Data to inform learning**	
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 12 - Make better use of digital technology in maternity and neonatal services**	

An action plan is in place that documents the steps required to meet the requirements of this document. This action plan is monitored via the Maternity Quality Assurance Meeting.

16.2 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.*

A review is being completed to consider next steps. This will be discuss at the SMT Workshop. Please see Appendix 2 for further information. A regional Continuity of Carer visit is planned for 1st August 2023.

17.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

Quarter One 2023/24 data is due in September 2023.

18.0 Local HDFT Maternity Services Dashboard June 2023

Performance Indicator	Apr-23	May-23	Jun-23
Registered Women gave Birth	117	152	141
Number of registered babies	117	153	143
Registered babies birth with CS_Elective	19	32	30
Registered babies birth with CS_Elective_rate	16.24	20.92	20.98
Registered babies birth with CS_Emergency	22	34	26
Registered babies birth with CS_Emergency_rate	18.80	22.22	18.18
Number of Normal deliveres (Vaginal)	76	87	89
Normal deliveres (Vaginal) rate	64.96	57.24	63.12
Registered women birth with CS_elective	19	31	30
Registered women birth with CS_elective(rate)	16.24	20.39	21.28
Registered women birth with CS_Emergency	22	34	22
Registered women birth with CS_Emergency (rate)	18.80	22.37	15.60
Women Registerged birth with induction	45	52	55
Women Registerged birth with induction_rate (National Average 34%)	38.46	34.21	39.01
Women Registerged birth with sucessful induction	43	51	49
Women Registerged birth with sucessful induction(Rate)	95.56	98.08	89.09
Women Registerged birth with instrumental	19	18	21
Women Registerged birth with instrumental (rate)	16.24	11.84	14.89
Number of Stillbirth	0	0	0
Number of Shoulder dystocia	0	3	1
Delivery number predictions			
VBAC (vaginal delivery of a baby after a previous pregnancy)	3	1	2
Number of women booked	138	144	146
Smoker at Booking	10	1	4
Percentage of smoking at booking (Target <6%)	7.25	0.69	2.74
Smoking at term	6	5	7
Percentage of smoking at term (Target <6%)	5.13	3.29	4.96
Women with PPH (1500-1999mls)	4	4	0
Women with PPH (2000+mls)	1	2	4
Women with 3rd or 4th degree tear at delivery	1	1	0
Women in RG*5 (having a CS with no previous births)	3	1	13
Women in RG* 2a (having a CS with no previous births)	5	7	6
Women in RG* 2b (having a CS with no previous births)	10	9	10
Women in RG* 1 (having a CS with no previous births)	2	3	2
Babies with APGAR score between 0 to 6	6	11	11
Babies Attempted to Breastfeed at First feed	98	122	109
Babies only Breastfeed	84	109	97
Number of Babies born preterm	3	13	7
Babies admitted to SCBU born 37 or above			

Work is ongoing with the Head of Performance and Analysis, and Data Analysts to present the dashboard in statistical process charts 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.

19.1 Term Admissions to SCBU

In June, there was one Term newborn admission to SCBU that is being reviewed at the ATAIN case review meeting).

19.2 ATAIN actions

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

Issue	Action	Status
ASCOM devices not being utilised routinely by maternity/paediatric staff	Work ongoing to increase use of ASCOM amongst ward staff and by paediatric doctors	In progress
Short admission to SCBU but no documentation by paediatric/SCBU staff in notes or Badgernet	Reminder to staff. Datix when no notes are documented	In progress
Try to monitor babies for longer on CLWS with borderline sats/work of breathing before admitting	Continue to encourage staff to stay with baby for ≈30 mins if conditions allow	In progress
No consultant involvement in decision to transfer baby for cooling (decision made by Embrace Team)	Discuss with neonatal lead	In progress
No formal observations with T21	Ensure formal observations completed in accordance with guideline and add to proforma	In progress
Follow 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' v3 (released 31 May 2023)

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025, and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there is more to do to achieve the Ambition in

2025. Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now six elements of care:

1. Reducing Smoking in Pregnancy
2. Fetal Growth: Risk Assessment, Surveillance and Management
3. Raising Awareness of Reduced Fetal Movement
4. Effective Fetal Monitoring During Labour
5. Reducing Preterm Birth
6. Management of Pre-existing Diabetes in Pregnancy

In addition to the provision of safe and personalised care, achieving equity and reducing health inequalities is a key aim for all Maternity and Neonatal services and is essential to achieving the National Safety Ambition. Each element in SBLCB v3 has been reviewed to include actions to improve equity, including for babies from Black, Asian and mixed ethnic groups and for those born to mothers living in the most deprived areas, in accordance with the NHS equity and equality guidance.

As part of the Three Year Delivery Plan for Maternity and Neonatal Services, NHS Trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards 4 (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. SBLCBv3 also sets out a number of important wider principles to consider during implementation. These are not mandated by the care bundle but reflect best practice care and are recommended to be followed in conjunction with the six elements.

The below table demonstrates the Trust's current position in relation to the previous guidance (v2). Work is underway to review the current compliance position with the new guidance (v3) and commence actions to enable compliance, and this will be reported next month.

	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)	May 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	3.0% (13/433)	0.65% (1/155) [<2nd, WHO centiles]
Percentage of babies <10th centile >39+6 weeks' gestation	4.6% (20/433)	1.3% (2/155)[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)	2 late miscarriage born 16-24 weeks (1.3%, 2/154)
• Preterm (24+0-36+6 weeks)	3.8% (live, 16/423) 0.2% (stillborn, 1/423)	8.4% (live, 13/154)

21.0 Conclusion and recommendation

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

Appendix 1

Compliance of completion of Perinatal Mortality Review Tool, Quarter 1, April-June 2023

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the first quarter, April to June 2023.

Safety action 1: *Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?*

Requirements of the Maternity Incentive Scheme Safety Action 1:

1. All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.
2. For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.
3. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.
4. Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.

Compliance of PMRT review process with MIS requirements

PMRT Case ID	Date of death	Reported to MBRRACE (within 7 working days)	Date Surveillance first closed (within 1 calendar month)	Review started (within 2 months)	Completed to draft report stage (within 4 months)	Report published (within 6 months)	Parent informed of review and questions/ concerns sought?
85403	6.1.23	9.1.23	9.1.23	9.1.23	18.4.23	18.4.23	Yes
85615	19.1.23	20.1.23	2.2.23	9.2.23	18.4.23	18.4.23	Yes
85647	20.1.23	23.1.23	2.2.23	2.2.23	11.5.23	11.5.23	Yes
86145	15.2.23	20.2.23	21.2.23	21.2.23	31.5.23	31.5.23	Yes
Overall Compliance against targets of Safety Action 1		100% - Compliant (Target 100%)	100% - Compliant (Target 100%)	100% - Compliant (Target ≥95%)	100% - Compliant (Target ≥60%)	100% - Compliant (Target ≥60%)	100% - Compliant (Target ≥95%)

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In view of this being the first quarterly report assessing the PMRT review process compliance with the updated MIS requirements, the historic action plans that are now complete are included below, as well as ongoing action plans that will be moving into the next quarter.

Completed Action Plan following PMRT review

Root cause/Contributory Factor	*Action*	*Risk at review*	*Evidence of Progress/Completion*
Parent's perspectives about care not sought.	MBEM (Maternity Bereavement Experience Measure) implemented on Harrogate internet page. PMRT questions regarding parent's perspectives sent to parents during PMRT process prior to review.	Complete	
Management of continuous fetal heart monitoring	Education and training for staff as part of yearly mandatory training. Monitoring May Education month to be shared with staff.	Complete	Monitoring May Education video presentations disseminated to maternity and obstetric staff for education.
Lack of documentation following telephone interaction regarding ongoing vaginal discharge.	Implementation of BadgerNet. Staff to ensure all contacts with clients are documented in full. Education and training at yearly bereavement mandatory training update.	Complete	
Parents were not offered the opportunity to take their baby home.	New bereavement checklist updated and reinforcement to staff, including yearly bereavement mandatory training update to staff.	Complete	
This mother had a history of a uterine abnormality and her antenatal care was not appropriate given her history.	Staff training and education about risk factors for Pre-Term Birth. Update to ICE requesting pathways for cervical length screening in pregnancy.	Complete	See action below regarding cervical length scans and pre-term birth pathway.
Mother's progress in labour not monitored with a partogram	BadgerNet implementation from March 2023, which will generate partogram and encourage users to complete for all women in labour.	Complete	
Not all HCP were informed about bereavement	Notification of pregnancy loss pathway. Implementation of BadgerNet, and to ensure discharge summaries are being sent to all appropriate members of staff who may be involved in pregnancy. Updated checklist to remind staff.	Complete	New pathway currently in development alongside BadgerNet to support antenatal ward clerks to ensure all HCP are notified following an earlier pregnancy loss.
Aspirin management in pregnancy	Implementation of BadgerNet, as well as haematology referral through BadgerNet. BadgerNet implementation in progress.	Complete	Pathway implemented within BadgerNet. Shared communication about aspirin dosage within BadgerNet

Ongoing Action Plan following PMRT review

Root cause/Contributory Factor	*Action*	*Risk at review*	*Evidence of Progress/Completion*
Domestic abuse routine questioning did not occur at booking	BadgerNet implementation from March 2023.	Low	Training in place for routine questioning. However, additional work required to reinforce and evidence DA questioning. Audit of compliance planned.
History of previous LLETZ and mother's care was not appropriate - not referred for cervical length scans	ICE pathway updated to allow booking midwife to request cervical length screening for intermediate risk factors of Pre-Term Birth (PTB). Education and information disseminated to staff regarding risk factors of PTB.	Low	Additional communication to staff. ICE updated for cervical length scanning profile. Booking midwife not currently requesting but remains responsibility of Obstetrician. Pre-term birth clinic in place with single consultant oversight. To remain open until assurance that all scans being requested as required. Plan for audit.
Communication barriers following maternal decision to decline IOL.	Implement standard operating procedure to support women who declined induction of labour. Education and training for staff.	Medium	Awaiting completion of SOP.
Patient not monitored when reported irregular tightenings	Fetal monitoring guideline to sit independently on trust intranet page alongside labour guideline.	Medium	Awaiting completion of guideline.

Appendix 2

SMT

19th July 2023

Title:	Maternity Continuity of Carer
Responsible Director:	Emma Nunez
Author:	Rachel Askey Continuity of Carer Lead Midwife Leanne Likaj Associate Director of Midwifery

Purpose of the report and summary of key issues:	The purpose of this report is to provide a position update on Midwifery Continuity of Carer against the national Maternity Transformation programme.	
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	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	Reputational risk of not currently offering continuity of carer. Submitting figures to LMS of 0% from May 2021. The PSC Care Group 1 Risk Register has been updated to reflect this.	
Report History:	Maternity Risk Management Group	
Recommendation:	SMT is asked to review the contents of the report and discuss next steps.	

Background

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff supported to deliver high quality care, which is continuously improving. At the heart of this vision was the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth (Better Births 2017). The national ambition was for Midwifery Continuity of Carer (MCoC) to be the default model of care with all eligible women offered the opportunity to receive continuity of carer through the antenatal, intrapartum and postnatal periods.

There is high quality evidence that Midwifery Continuity of Carer improves safety and outcomes, reduces interventions and improves women's experience (Sandall et all 2016) and that MCoC reduces pre-term birth (Medley et al 2018) and Stillbirth (Ota et al 2020). When correctly implemented this model of care provides a mechanism whereby midwives can gain a holistic understanding of women's needs and as such be the vehicle that drives improvements in many aspects of maternity care.

Maternity services in Harrogate have strived to achieve the national ambition since late 2018. There has been a number of achievements as well as challenges during this time. In early 2019, starting with willing volunteers, two consecutive continuity teams were launched; Ivy and Willow, this resulted in 24% of women booking onto a MCoC pathway. For a period, these teams worked well and evaluated positively by women and many of the midwives.

In light of COVID-19 and the impact on local midwifery staffing, the continuity of carer plan was reviewed and a new rollout plan was proposed, agreed and launched in January 2021. The revised plan has meant that the percentage of women in receipt of continuity of care has been 0% from May 2021. A further launch was planned for April 2022 utilising an integrated shift based model. A team of midwives was identified and was ready to roll out however community staffing was impacted by long term sickness and resignations and it was agreed it was not safe to proceed.

Due to national staffing pressures within maternity services, target dates for the implementation of MCoC were withdrawn in September 2022. This NHS England communication stated:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out. Continue to support at the current level of provision, or only provide services to existing women on MCoC pathways, and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

The Three-Year Delivery Plan for Maternity and Neonatal services, published in April 2023, reiterates the role MCoC has to play in ensuring the delivery of personalised care however states:

- 'Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022'.

- *The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.*

Delivering Midwifery Continuity of Carer at full scale: Guidance on planning, implementation and monitoring 2021/22 (NHS England, 2021) sets out ten 'Building blocks' to ensure services are in a position to deliver MCoC when safe staffing allows. This reports updates on our current position and progress with these building blocks.

The Current Position

Our MCoC provision remains at 0%. Consideration has been given to starting a continuity team given the current zero midwifery vacancy position. There remains anxiety amongst staff regarding this model of care, the safety of the unit as a whole and their working patterns. A recent expression of interest circulation only generated interest from two of the eight (headcount) midwives needed to staff a MCoC team.

Community midwives continue to work together in four geographical mixed risk teams across Harrogate and District. A number of midwives are continuing to work as integrated midwives, working across both community and delivery suite, in order to maintain their skills in both areas. Reorganisation of existing teams into hubs in Leon Smallwood in Ripon and Mowbray Square in Harrogate aims to improve antenatal and postnatal continuity, increasing opportunities for personalised care planning and improved patient experience and safety.

The attempts to implement MCoC over last few years has shown that as a small maternity unit any movement of staff can very quickly destabilise clinical areas, potentially affecting patient safety. The current strategy focuses on ensuring that Delivery Suite, Pannal ward and the Maternity Assessment Centre are appropriately staffed and that all women receive community care from a named midwife with an appropriate caseload size.

Due to the current position of women's care being captured on several systems and paper it is difficult to gain accurate data regarding continuity of carer of community. Badgernet will help with being able to pull data regarding continuity of carer to evidence this position once all women are on the system. Currently antenatal continuity with a community midwife is thought to be good. Midwives do their own clinics every week unless they are on annual leave or absent, or affected by a homebirth whilst on call. Women are always booked back into their usual clinic day to see the same midwife. Postnatal continuity is thought to be not as good, due to the part time work force, specific days postnatal women and babies need to be seen, and geographical area covered. For example, the named midwife may be working, but in her antenatal clinic all day so an alternative midwife from the team will visit her women. It is currently rare for a woman to be cared for in labour by a midwife who is known to her prior to the onset of labour.

Ten Building Blocks

1. Safe Staffing

The trust has made significant progress with recruitment and retention of Band 5 and 6 midwives. Harrogate maternity services are currently in a strong staffing position relative to other trusts within the HNY LMNS and WYH LMNS. Regionally and nationally there remains high midwifery and maternity support worker vacancy rates and due to this midwives able to secure alternative employment if a model of working is proposed that they do not find agreeable. There remains poor staff engagement with, and desire to, work in MCoC models both locally and regionally. Rolling out MCoC teams has the potential to destabilise the current staffing position both locally and regionally should midwives consider a move to a MCoC model be a reason to leave the profession.

Eight midwives (7.25 WTE) are currently working across both community and intrapartum areas. Our preceptorship programme will ensure that all band 5 midwives will have an opportunity to consolidate their skills in the intrapartum area and they will undertake a community rotation to ensure they have the broad range of skills to offer care across the whole maternity pathway. The Retention and Support Midwife will support midwives of all bands to develop their clinical skills to ensure they are supported in the transformation of the workforce.

2. Workforce planning

Configuring our Teams

For continuity teams to work effectively (provide relational care, avoid midwifery burnout etc.), the service needs to change its provision approach from one that has traditionally staffed a building (Delivery Suite, Antenatal Clinic and Pannal) to one that follows the women providing care where and when required.

In order to maintain safety, it is important that continuity teams only launch in the following conditions (in relation to staffing):

1. When there is appropriate staffing of in-patient services as per BR+ recommendations. This will give assurance that the launch of a continuity team will not have a negative impact on in-patient rosters. In order to consider reduction in core labour ward staffing, MCoC Intrapartum care needs robust rostering and contingency planning for episodes of staff absence.

2. Each team will need to demonstrate through mock rosters that they are able to cover their service 24/7. The provision of intrapartum care will not commence until a team has at least 7 WTE.

Best practice from the national guidance indicates that MCoC teams should be no larger than eight headcount midwives. This enables women to get to know a small number of midwives who will deliver her care. In order for the out of hours care to be provided staffing within teams needs to be at least 6.9 WTE. Due to a large proportion of the HDFT workforce working part time (many 0.6 WTE) it may be challenging to achieve this with eight midwives. Configuring teams with a larger headcount of midwives would affect women's experience of care and how much relational continuity is achieved.

Evidence suggests that mixed risk geographical teams are the most effective way of configuring teams, with each WTE midwife taking 3-4 bookings per month with a view to three women birthing each month (to allow for attrition). Birth Availability models place midwives within community settings where the majority of time is spent building relationships with women on their caseload, providing antenatal care, antenatal education and postnatal care. When a woman labours, the named midwife or member of the team if unavailable will attend Delivery Suite (or home) to provide intrapartum care. Out of hours intrapartum care is 'on call', shared by all team members. It is important that there are opportunities for women to meet all the midwives within the team during the antenatal period so the woman knows them. This model anticipates that with caseloads of 1:36 approximately 20% of time will be spent providing intrapartum care.

The National Continuity Lead completed the staff planning spreadsheet with the trust in 2022 (appendix 3) and suggested that safe staffing ratios can be maintained with five MCoC teams providing 24 hour on call cover for births. Through a phased roll out of MCoC core, inpatient staffing would be reduced from four midwives to two midwives on Delivery Suite. These core two members of staff would be able to provide care to out of area women or any women presenting on Delivery Suite requiring urgent care. Pannal Ward staffing would remain at three midwives during the day and two midwives at night. ANC and MAC staffing would remain at current levels. In addition to core staffing, there would be five midwives available to provide intrapartum care to women from their team. This would help alleviate the short-term pressures

The small number of women who receive AN and PN care but choose to birth elsewhere (approx. 40 per year) could be cared for within the MCoC caseloads. This would require an increase in establishment to 65.49WTE clinical staff (Band 7 LW coordinator and Band 6 and 5 midwives, excluding Management and Specialist midwives) which would need to be funded by a business case.

3. Communication and engagement

HDFT continuity journey commenced at the end of 2018 with willing volunteers, resulting in positive evaluations from women and midwives, however, for many staff working in traditional teams Continuity of Carer remained unpopular for a variety of reasons. In 2019, it was agreed that all staff should move to continuity teams and that those wishing to remain in an inpatient/outpatient area could apply for core positions. Following an internal application process, designed in conjunction with HR, midwives were identified to join continuity and other midwives were identified to form part of the in-patient and community core team. This process was poorly perceived by staff, and led to a significant period of instability, exacerbated by the pause in roll out due to the Covid 19 pandemic.

The national removal of targets for MCoC led most midwives to believe that continuity is no longer on the agenda and will not be implemented. This has disappointed and frustrated those who wish to work in this model but most midwives feel relieved that they will able to continue working in their preferred areas and shift models. This is evidenced by the lack of response to the most recent Expression of Interest.

The Project Lead has worked with early career midwives as part of their preceptorship programme to ensure they appreciate the rationale and evidence for MCoC, develop a realistic understanding of on call and Birth Availability working and recognise the need to develop their skills to provide care across the full range of maternity settings. This has also provided an opportunity to understand the challenges and concerns that midwives have about working in MCoC models and address them before these perceptions become embedded.

The maternity team are working with the local Maternity Voices Partnership (MVP) to seek engagement with service users. Initial meetings indicate a good awareness of the benefits of MCoC from women in our communities and a strong desire to receive continuity of carer. Some concerns have been raised from service users about how the model will be implemented to ensure those later in the phased roll out are not disadvantaged. The MCoC Project Lead has worked closely with the MVP Leads and MVP service representatives to ensure their voice is capture in the plans and communication. The MVP will also be invaluable partners in seeking feedback for evaluation through promotion and distribution of surveys, focus groups with service users as well as capturing ad hoc feedback.

4. Skill Mix

The LMS has developed a new structured preceptorship package for newly qualified Band 5 midwives (NQM). NQM have protected time twice monthly to meet, undertake clinical skills training, and achieve their required competencies. NQM will have opportunities to strengthen their learning and skills in all areas including appropriate supernumerary time and clinical support. MCoC teams should have a maximum of one NQM who should have a reduced caseload until they are confident in managing all aspects of their work. The deployment of Band 5 midwives to Continuity Teams is under review following Ockenden Report (2022) which stated that *all NQMs must remain within the hospital setting for a minimum period of one-year post qualification*.

An appropriately trained and skilled Maternity Support Worker (MSW) working at Band 3 will also support each team. Four community based MSW are already in post and will be support with both antenatal and postnatal care. In some trusts MSW also provide support at homebirths and this is something to consider moving forward.

It is also essential that Labour Ward Co-ordinators have confidence in the skill mix of the workforce providing intrapartum care. They also need to feel well prepared and confident in navigating this new way of working. One to one meetings have taken place with co-ordinator to improve engagement and understanding of the model.

5. Training

A training needs analysis has been written and will be used to prepare midwives prior to moving into a continuity team to identify any gaps in knowledge and skills. There will be supernumerary time provided to work in unfamiliar areas. For midwives who have worked in community settings for a long period, providing intrapartum care may feel extremely challenging. Steps will be taken to ensure the transition supports their individual needs with protected time, strong action plans and opportunities for review and feedback to ensure they feel empowered to provide safe and effective care. Midwives will be supported by the Professional Development Midwife, Fetal Wellbeing Lead, and Retention and Support Midwife to meet individual needs.

6. Team Building

Opportunities were provided in April 2022 for the staff to develop their own Team Charter and understand their own and their colleagues working style utilising Insight Discovery. This gave not only the team but also the leadership an opportunity to understand the team dynamics and work collaboratively to support the team to function well together. This model could be replicated for any future teams.

7. Link Obstetrician

A link obstetrician has been identified to work with the first team that rolls out. The link obstetrician will not necessarily be the named consultant for each woman needing obstetric led care within the team but will provide expert advice and support to the midwives. The named consultant will be invited to attend regular team meetings to ensure effective MDT working.

8. Standard operating procedure

A Standard Operating Procedure (SOP) for the birth availability model outlining roles and responsibilities within MCoC teams, and from the wider maternity team to support the delivery of MCoC, has been developed with all relevant stakeholders and will be passed through Governance prior to the roll out of teams. Ongoing evaluation will ensure that the SOP is fit for purpose.

9. Pay

No midwife should be financially disadvantaged for working in a MCoC Model. Various methods can be utilised to ensure pay adequately reflects workload. Prior to the roll out of the trusts second wave of continuity teams pay protection arrangements were put in place for those staff working in the proposed model. National recommendations for a 4% uplift for staff working in continuity teams are likely to be adopted to ensure consistency across the LMNS.

10. Estates and Equipment

The Better Births vision is that community hubs should be established, where maternity services, particularly antenatal and postnatal are provided alongside other family orientated health and social services provided by statutory and voluntary agencies (Better Births, 2017)

As continuity develops at HDFT, there will be an increasing numbers of continuity midwives spending a large proportion of their working week out in the community. This will be around 30+ WTE midwives, which is a significant increase from the original 16 headcount (approx. 12WTE) community midwife team. Historically midwives have been linked to a GP surgery;

however this posed significant problems with managing the flow of women through community services, ensuring adequate staffing to cover clinics in multiple locations and managing caseload sizes so midwives were working efficiently. Moving to Hubs would not only facilitate the implementation of MCoC it will significant improve the efficiency of the existing community teams and facilitate better antenatal continuity for their women.

Progress has been made with the planned opening of the Leon Smallwood centre at Ripon as a base providing clinical and office space for our community midwives working in our rural team community. Our two Harrogate based teams are now located in Mowbray Square Medical Centre for their community clinics. Whilst this does not provide any office space, opportunities for antenatal education, or any group activities this has significantly improved the ability of these teams to manage allocation of workload more effectively. An audit is planned to assess if there is also an improvement in antenatal continuity for women. Mowbray Square is located in Harrogate Centre and is easily access by our postcode area of highest deprivation and would therefore be the idea base for our first MCoC Team.

Black Asian and mixed race women are more likely to experience poor outcomes during pregnancy and birth, having four times higher rates of maternal mortality and two times higher rates of stillbirths. Plans should target those women as a priority to reduce this inequity. At HDFT 3.9% of women booking their pregnancies are from Black, Asian and Mixed Ethnicity backgrounds. These women do not live in a clearly defined geographical area; however it is of note that Mowbray Square PCN has the highest proportion of Black, Asian and Mixed Ethnicity women (6.7% compared to 2.3-4.3% in other PCNs).

Knaresborough based midwives continue to work form GP based clinics as currently no space has been identified to accommodate them. Work is ongoing to identify suitable space.

Evaluation

Monitoring and evaluating continuity of carer is essential so that we can measure consistently the level of continuity of carer provided over time. This monitors delivery and evaluates the extent to which particular models realise the benefits expected as set out in evidence. It will also help us to evaluate locally the impact that this model of care has on women and babies but also the impact that it has on the work/life balance of midwives.

Nationally defined measures to monitor continuity of carer (Sandall J, 2018):

A service reported measure of which person manages a specific care episode for the women concerned.

By recording which midwife provided the care for each woman at each contact and how many times lead midwife, ‘buddy’ or a team midwife provided care.

Barrier to achieving this: Changes made to the Maternity Services Data Set (MSDS) will eventually enable this. This is still some time away as nationwide maternity IT systems are struggling to meet the requirements**.**

Solution in WY&H LMS:

WY&H LMS have developed a data collection tool, requiring manual input for each maternity contact alongside key outcome measures. Data submitted quarterly to WY&H LMS.

Positives: The tool is a great way for midwives to see the data as it emerges. Midwives can take ownership and develop a sense of pride over their work. When teams engage with data collection, it can encourage a bit of healthy competition. It is also very useful to share the data amongst colleagues.

Negatives: It relies on midwives taking responsibility for recording each care episode. If this does not happen, it becomes a very time consuming task for one person to take responsibility for, particularly when staffing is tight and clinical care takes priority.

How is HDFT working towards meeting the requirement?

HDFT is now using Badgernet as the maternity EPR, and reporting will be significantly easier that the manual data collection that was used previously. There will need to be ongoing audit and compliance with completing the relevant fields and data quality to ensure that the data accurately reflects the current picture.

A woman-reported measure of whether women feel they have had continuity.

National survey

The CQC maternity survey includes a question on continuity. This is a nationally used indicator. By asking women their experiences, the survey tests whether the service-reported measure is having the expected impact. The woman is the ultimate arbiter of whether she felt she had sufficient continuity.

Conclusion

MCoC remains a challenging ask of maternity services. Work is ongoing to continue developing the team in preparation for rolling out continuity when the local and regional staffing position is acceptable.

References:

MBRRACE-UK (2020) *Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2019*

Medley et all (2018) *Interventions during pregnancy to prevent pre-term birth: an overview of Cochrane systematic reviews*

Ota, E et al (2020) *Antenatal Interventions for preventing stillbirth, fetal loss and perinatal death: an overview of Cochrane systematic reviews*

Sandall J, (2018). *RCM: Measuring Continuity of Carer: A monitoring and evaluation framework*. Kings College London

Sandall et al. (2016) Cochrane review. *Midwife-led continuity models versus other models of care for childbearing women*

NHS Long Term plan. See: https://www.longtermplan.nhs.uk/

NHS England. (2019) Saving Babies Lives Version 2: A care bundle for reducing perinatal mortality

NHS Resolution: Maternity Incentive Scheme, Year 2. See: (https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf)

Ockenden, D. (2020) *Independent report: Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust.* Department of Health and Social Care

NHS midwifery workforce modelling tool. See: (https://uat.continuityofcarer-tools.nhs.uk/tools/midwifery-workforce-modelling-tool)

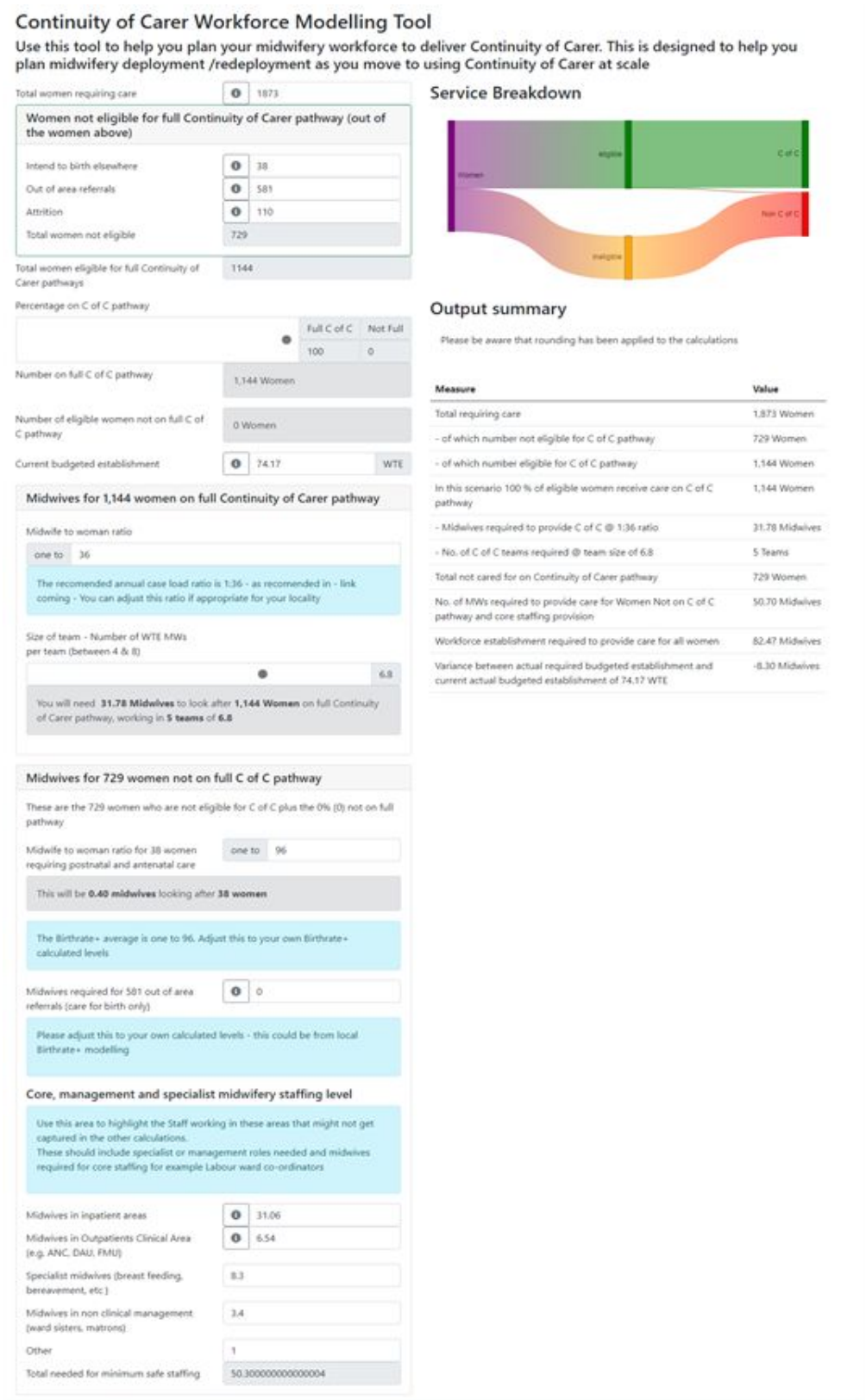
Department of Health and Social Care. (2021) Safer Maternity Care: Progress Report 2021. See: https://www.england.nhs.uk/wp-content/uploads/2021/03/agenda-item-9.4-safer-maternity-care-progress-report-2021-amended.pdf)

Cumberlege J. (2016) Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. See: england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Appendix 1: Breakdown of BR+ recommended staffing:

	WTE
Core Hospital Delivery Suite • Core Births (581) • Caseload births (230 - 20%) • A/N cases (310) • Escorted transfers out (13) • Non-viable pregnancies (27) Pannel Ward: • IoL (720 doses) • A/N Admissions (465) • AN Ward attendees (405) • P/N women (1610) • NIPE/Tongue Ties • Extra Care babies (205) Outpatients/MAU	11.97 19.09 6.54
Core Community	0.58
Caseload Teams	31.78
Total Clinical wte	**69.96**
Additional Specialist and Management (excluding B8 2 WTE)	7.55
Total Clinical, Specialist & Management wte	**77.51 WTE**

Appendix 2: NHSE workforce modelling tool



Continuity of Carer Workforce Modelling Tool

Use this tool to help you plan your midwifery workforce to deliver Continuity of Carer. This is designed to help you plan midwifery deployment /redeployment as you move to using Continuity of Carer at scale

Total women requiring care: 1873

Women not eligible for full Continuity of Carer pathway (out of the women above)

Intend to birth elsewhere	38
Out of area referrals	581
Attrition	110
Total women not eligible	729

Total women eligible for full Continuity of Carer pathways: 1144

Percentage on C of C pathway

Full C of C	Not Full
100	0

Number on full C of C pathway: 1,144 Women

Number of eligible women not on full C of C pathway: 0 Women

Current budgeted establishment: 74.17 WTE

Midwives for 1,144 women on full Continuity of Carer pathway

Midwife to woman ratio: one to 36

The recomended annual case load ratio is 1:36 - as recomended in - link coming - You can adjust this ratio if appropriate for your locality

Size of team - Number of WTE MWs per team (between 4 & 8): 6.8

You will need **31.78 Midwives** to look after **1,144 Women** on full Continuity of Carer pathway, working in **5 teams** of **6.8**

Midwives for 729 women not on full C of C pathway

These are the 729 women who are not eligible for C of C plus the 0% (0) not on full pathway

Midwife to woman ratio for 38 women requiring postnatal and antenatal care: one to 96

This will be **0.40 midwives** looking after **38 women**

The Birthrate+ average is one to 96. Adjust this to your own Birthrate+ calculated levels

Midwives required for 581 out of area referrals (care for birth only): 0

Please adjust this to your own calculated levels - this could be from local Birthrate+ modelling

Core, management and specialist midwifery staffing level

Use this area to highlight the Staff working in these areas that might not get captured in the other calculations.
These should include specialist or management roles needed and midwives required for core staffing for example Labour ward co-ordinators

Midwives in inpatient areas	31.06
Midwives in Outpatients Clinical Area (e.g. ANC, DAU, FMU)	6.54
Specialist midwives (breast feeding, bereavement, etc.)	8.3
Midwives in non clinical management (ward sisters, matrons)	3.4
Other	1
Total needed for minimum safe staffing	50.300000000000004

Service Breakdown

Output summary

Please be aware that rounding has been applied to the calculations

Measure	Value
Total requiring care	1,873 Women
- of which number not eligible for C of C pathway	729 Women
- of which number eligible for C of C pathway	1,144 Women
In this scenario 100 % of eligible women receive care on C of C pathway	1,144 Women
- Midwives required to provide C of C @ 1:36 ratio	31.78 Midwives
- No. of C of C teams required @ team size of 6.8	5 Teams
Total not cared for on Continuity of Carer pathway	729 Women
No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision	50.70 Midwives
Workforce establishment required to provide care for all women	82.47 Midwives
Variance between actual required budgeted establishment and current actual budgeted establishment of 74.17 WTE	-8.30 Midwives

Appendix 3: Planning Spreadsheet

Uplift= 22%	**Birth rate plus**	**Actual**		**C of C**	**All women**		**Births**	Birth to MW ratio
							1725	
5.99			Head count per shift	MCoC	All care given: 1144 AN/PN only: 38	% of women birthing	in area: 1144 OOA:581	
Location					**1182**	**0.00%**	**1725**	
C of C team								71.99
DS	23.96	23.96	4				1725	
Pannal	19.09	19.09	3					
ANC	6.54	6.54	2					
MAC			1					
community	13.4	13.4						
TOTAL	**62.99**	**62.99**						
Wave 1		**1 team**		**20.71 %**		**14.19 %**		
C of C team		6.8	1	244.8		244.8		61.78
DS		23.96	4				1480.2	
Pannal		14.97	2.5					
ANC		6.54	2					
MAC			1					
Community		10.90	1 to 86		937.2			
TOTAL		**63.17**						
Wave 2		**2 teams**		**41%**		**28.38 %**		
C of C team		13.6	2	489.6		489.6		58.94
DS		20.96	3.5				1235.4	
Pannal		14.97	2.5					
ANC		6.54						
MAC								
Community		8.05			692.4			
Total		**64.12**						

36

Wave 3		**3 teams**		**62.13 %**		**42.57 %**		
C of C team		20.4	3	734.4		734.4		55.13
DS		17.97	2.5				990.6	
Pannal		14.97	2.5					
ANC		6.54						
MAC								
Community		5.20			447.6			
Total		**65.08**						
Wave 4		**5 teams**		**97.46 %**		**66.78 %**		
C of C		32	5	1152		1152		47.83
DS		11.98	2				573	
Pannal		14.97	2.5					
ANC		6.54						
MAC								
Community		0.00			0			
Total		**65.49**						

TRUST BOARD in Public

26th July 2023

4.3

Title:	Continuity of Carer
Responsible Director:	Emma Nunez, Director of Nursing, Midwifery and AHPs / Deputy Chief Executive
Author:	Leanne Likaj, Associate Director of Midwifery

Purpose of the report and summary of key issues:	The Quality Committee and Trust Board have previously been briefed on Continuity of Carer and it was agreed that periodic updates would be provided. This report details the current position statement, risks, benefits and recommendations	
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:	The report was discussed at the July 2023 Senior Management Team	
Recommendation:	The Quality Committee and the Trust Board are asked to review the content of the report. It is recommended that: 1. HDFT Maternity Services will continue to work towards provision of continuity of career (Midwifery and Obstetric) without including intrapartum care due to the issues/risks already highlighted. 2. To support HDFT Maternity Services to continue to work and progress the 10 Building Blocks By agreeing to these two key recommendations, enabling HDFT to work towards to the principles of MCoC with the exception of intrapartum care, HDFT will be able to continue to work with the	

	LMNS without further destabilising the local workforce, including mitigating against midwives from leaving the profession all together.

Freedom of Information:	Available under FOI

Continuity of Carer

July 2023

Situation

There is a current corporate risk relating to the fact that Harrogate and District NHS Foundation Trust (HDFT) are not currently offering Midwifery Continuity of Carer. The Trust has been submitting figures to the Local Maternity and Neonatal System (LMNS) of 0% since May 2021.

Background

Better Births, the report of the National Maternity Review, set out a vision for maternity services in England which are **safe and personalised**; that put the needs of the women, her baby and family at the heart of care; with staff supported to deliver **high quality care**, which is continuously improving.

At the heart of this vision is the idea that women should have **continuity of the person looking after them during their maternity journey, before, during and after the birth** (Better Births 2017).

Background 2

The national ambition was for Midwifery Continuity of Carer (MCoC) to be the default model of care with all eligible women offered the opportunity to receive continuity of carer through the antenatal, intrapartum and postnatal periods. Where safe staffing allows and key building blocks are in place, the target for achievement is March 2024.

However, in September 2022 due to national staffing pressures within maternity services, target dates for the implementation of MCoC were withdrawn in September 2022.

Background 3

NHS England communication stated:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out. Continue to support at the current level of provision, or only provide services to existing women on MCoC pathways, and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Background 4

Furthermore, the Three-Year Delivery Plan for Maternity and Neonatal services, published in April 2023, reiterates the role MCoC has to play in ensuring the delivery of personalised care however states:

- ‘Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022’.
- The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived areas.

Assessment

Since the MCoC target was sent by NHS E/I in 2020 concerns regarding the sustainability and implementation of MCoC have been raised by senior midwifery leaders.

Despite some areas of success, many providers have raised concerns about workforce and safe staffing, and unintended consequences to some areas of maternity services that made moving forward with further implementation of MCoC safely difficult.

Although the Three Year Delivery Plan (2023) continues to refer to Continuity of Carer the focus has now changed to consider this being most important for women from minority ethnic communities and the most deprived areas. This change in National focus undermines efforts to continue to progress the model.

Assessment 2

Anecdotally there continues to be anxiety locally among midwives in Harrogate regarding the change in working patterns and skills required to work in a continuity model.

There is a risk that pushing forward with continuity of carer model as advised in the guidance document released by NHSE in 2021 will force midwives to leave the Trust.

Listening to midwives working in the Trust there is anxiety from community midwives regarding childcare and mental wellbeing from working shifts/nights required for full continuity.

There is also anxiety regarding maintaining sufficient skills to manage high risk labours when an increased number of midwives are caring for a small number of women birthing per year.

Current Provision

The current strategy focuses on ensuring that Delivery Suite, Pannal Ward and the Maternity Assessment Centre are appropriately staffed and that all women receive community care from a named midwife with an appropriate caseload size.

Midwives continue to work together in four geographical mixed risk teams across Harrogate and the District.

A number of midwives are continuing to work as integrated midwives working across both community and delivery suite in order to maintain their skills in both areas. Reorganisation of existing teams into hubs in Leon Smallwood in Ripon and Mowbray Square in Harrogate aims to improve antenatal and postnatal continuity, increasing opportunities for personalised care planning and improved patient experience and safety.

Badgernet will assist with capturing the provision of continuity of carer once fully implemented.

Current Position

Currently antenatal continuity with a community midwife is working effectively. Midwives do their own clinics every week unless they are on annual leave or absent, or affected by a homebirth whilst on call. Women are always booked back into their usual clinic day to see the same midwife. In relation to MCoC benefits the 2018 and 2020 Cochrane reviews concluded that MCoC prevents stillbirth and preterm birth. This related to antenatal care rather than a known carer in labour. Antenatal continuity of carer should enable the same benefit especially when that continuity includes both midwives and obstetricians. Work is required to improve the antenatal continuity of carer that the women gain from Obstetric Medical staff currently at HDFT. This is work which is underway currently.

Postnatal continuity in HDFT is thought to be not as good currently due to the part-time workforce, specific days postnatal women and babies need to be seen, and size of the geographical area covered. For example, the named midwife may be working on the day a postnatal woman/baby needs to be seen however, the midwife is in antenatal clinic all day so an alternative midwife from the team will visit the women/baby.

Recommendation

The Senior Management Team (SMT) are asked to review the contents of this SBAR and support the recommendations that are proposed.

1. HDFT Maternity Services will continue to work towards provision of continuity of career (Midwifery and Obstetric) without including intrapartum care due to the issues/risks already highlighted.

2. To support HDFT Maternity Services to continue to work and progress the 10 Building Blocks

By agreeing to these two key recommendations, enabling HDFT to work towards to the principles of MCoC with the exception of intrapartum care, HDFT will be able to continue to work with the LMNS without further destabilising the local workforce, including mitigating against midwives from leaving the profession all together.

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

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

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 • Ongoing • 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 – February 23 • Train users – Feb 23 • WebV referral forms testing – March 23 • Phase 1 Go Live – March 23 • Phase 2 Comms – June 23 • Phase 2 Go live – June 23	• Complete • Complete • Complete • Complete • Complete • Ongoing • Ongoing	

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

July 2023

Russell Nightingale
Chief Operating Officer

Operational Update July 2023 (June Performance)

Matters of concern & risks to escalate

- Cancer 2WW performance was below the 93% target at 73.6% (5.10), up from 67.6% in May.
- Cancer 62-day wait target not achieved at 76.2% (5.9.1) 6th in Region but an improving position
- 1 x 12-hour trolley waits in June (1 in May) – no harm identified
- Community Dental long waiter recovery – significant risk of being unable to achieve further reduction beyond holding the <78-week position without sustainable funding from commissioners.
- Fragility of H&N services in York may impact on cancer / elective recovery due to mutual aid requests

Major actions commissioned & work underway

- TIF2 – scheme out on P23 for main contractor closed- interviews and selection w/c 12th June, concerns about funding
- Work on new future care group linked medical records model underway.
- Industrial Action Planning (junior doctors and consultants)
- Work to support unifying all paediatric outpatients to larger accommodation adjacent to CDC commenced.
- Roll out of video feedback/communication model (T&O Knee arthroscopy) within trust but also plan for regional and national roll out (£1m grant)
- Non RTT waits - data collection being revised to create a sustainable and lean process with improved data quality.
- R to G transformation work with wards has now started
- Power BI training and licences being deployed to analyst teams

Positive news & assurance

- Cancer 31-day wait target achieved at 96.4% (5.1.2)
- Size of cancer PTL reduced, reduced percentage of long waiters.
- Working towards zero 65 week waits by 31.03.2024. – ahead of achievement trajectory.
- The Trust had no over 60-minute ambulance handover breaches for the third consecutive month in June.
- ED Performance improvement sustained – remaining above 80% (80.3%) in June for the third month in the row.
- CT Scanner now in place and working- significant recovery already achieved

Decisions made & decisions required of the Board

Children's and Community

Metrics	Apr-23	May-23	Jun-23
% of antenatal contacts			
Darlington	95.3%	94.9%	96.4%
Durham	87.9%	87.7%	89.6%
Gateshead	92.1%	91.9%	96.5%
Middlesbrough	92.9%	84.7%	93.9%
North Yorkshire	90.1%	89.3%	87.8%
Northumberland	86.0%	82.1%	82.1%
Stockton	90.6%	94.8%	97.2%
Sunderland	93.8%	96.1%	94.7%
Wakefield	87.7%	90.4%	86.2%
% New Birth Visits completed by 14 days			
Darlington	98.7%	97.7%	100.0%
Durham	95.7%	96.1%	96.4%
Gateshead	90.9%	98.7%	98.4%
Middlesbrough	97.0%	97.8%	95.3%
North Yorkshire	95.4%	92.9%	91.6%
Northumberland	92.9%	91.0%	91.0%
Stockton	94.4%	96.0%	94.0%
Sunderland	99.0%	99.5%	100.0%
Wakefield	81.2%	74.2%	68.48%
% Infants Breastfeeding at 10-14 days			
Darlington	59.0%	43.7%	52.1%
Durham	44.5%	43.2%	43.4%
Gateshead	50.8%	62.5%	58.9%
Middlesbrough	56.3%	54.0%	62.2%
North Yorkshire	66.8%	66.8%	66.3%
Northumberland	60.1%	56.6%	56.6%
Stockton	45.0%	47.6%	52.7%
Sunderland	48.2%	43.3%	45.7%
Wakefield	57.3%	53.1%	55.7%
% infants breastfeeding at 6-8 weeks			
Darlington	44.1%	37.0%	34.1%
Durham	30.4%	34.5%	29.7%
Gateshead	50.8%	33.9%	49.3%
Middlesbrough	43.7%	47.5%	49.7%
North Yorkshire	57.7%	52.7%	52.7%
Northumberland	41.6%	42.5%	42.5%
Stockton	40.0%	31.9%	35.2%
Sunderland	25.5%	33.8%	29.4%
Wakefield	32.9%	36.1%	37.4%

	Apr-23	May-23	Jun-23
% of 6-8 week reviews completed by the time the infant is 8 weeks old			
Darlington	98.5%	94.0%	95.3%
Durham	95.2%	91.9%	92.1%
Gateshead	97.7%	98.4%	97.3%
Middlesbrough	90.1%	90.8%	97.9%
North Yorkshire	93.0%	88.1%	85.8%
Northumberland	87.1%	83.8%	83.8%
Stockton	93.4%	95.9%	98.6%
Sunderland	98.0%	98.1%	98.5%
Wakefield	76.9%	86.6%	85.6%
% of 12 month reviews completed by the time the child is 15 months old			
Darlington	100.0%	98.8%	98.9%
Durham	92.1%	94.8%	97.0%
Gateshead	99.3%	98.0%	98.7%
Middlesbrough	96.2%	98.3%	100.0%
North Yorkshire	97.3%	97.9%	95.2%
Northumberland	95.2%	91.9%	91.9%
Stockton	96.5%	97.2%	99.3%
Sunderland	97.2%	96.6%	96.4%
Wakefield	94.3%	94.6%	88.73%
% of 2-2.5 year reviews completed by the time the child is 2.5 years old			
Darlington	100.0%	97.7%	97.8%
Durham	90.9%	92.6%	95.1%
Gateshead	97.2%	97.4%	99.2%
Middlesbrough	98.6%	95.5%	95.7%
North Yorkshire	96.2%	98.0%	91.5%
Northumberland	89.2%	92.9%	92.9%
Stockton	92.8%	97.0%	97.1%
Sunderland	94.8%	93.8%	94.6%
Wakefield	90.9%	89.9%	93.91%
% of 2 to 2.5 year reviews completed in the month with a completed ASQ3			
Darlington	100.0%	100.0%	100.0%
Durham	90.9%	92.6%	95.1%
Gateshead	100.0%	97.7%	97.5%
Middlesbrough	100.0%	99.2%	99.3%
North Yorkshire	99.8%	100.0%	98.7%
Northumberland	97.3%	95.3%	95.3%
Stockton	96.1%	97.5%	98.5%
Sunderland	96.0%	93.3%	96.2%
Wakefield	98.1%	99.5%	100.00%

% Antenatal contacts

- Northumberland – Action plan in place. Strengethening maternity liaison and access to badgernet.

% new Birth Visits by 14 days

- Wakefield – Due to staffing and OPEL currently flexed to 10 to 19 days.

% Infants Breast Feeding at 10-14 days

- Durham – Increased focus on antenatal care including family hub developments and insights work commissioned by LA.

% Infants Breast Feeding at 6-8 weeks

- Sunderland – Due to reporting error as breast feeding status had not pull into the reports. Working with Information team to resolve.

% 6 to 8 week reviews completed by time child is 8 weeks

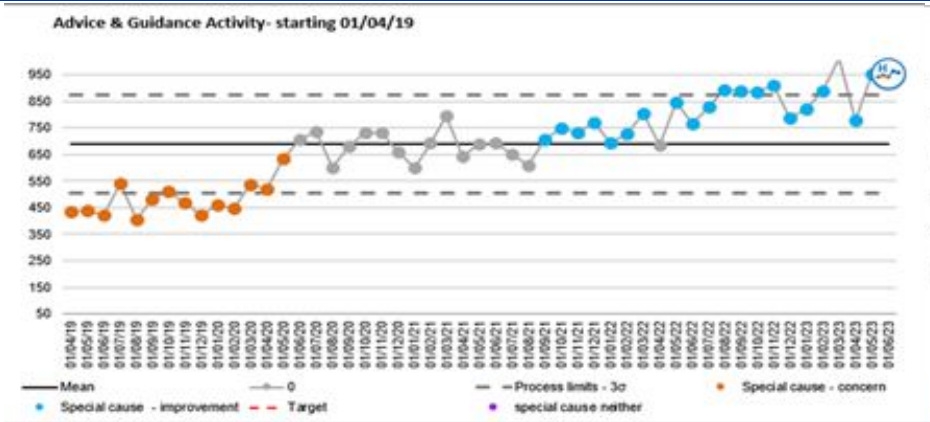
- Northumberland - Issue in central team where assessments being completed late as part of OPEL due to staff vacancies and sickness. Using NHSP and advert out for HV.
- North Yorkshire – Slip timescales due to OPEL. Using NHSP ot support delivey of core contact and working to implement service wide action plan to support vacancy level due to recent leavers.

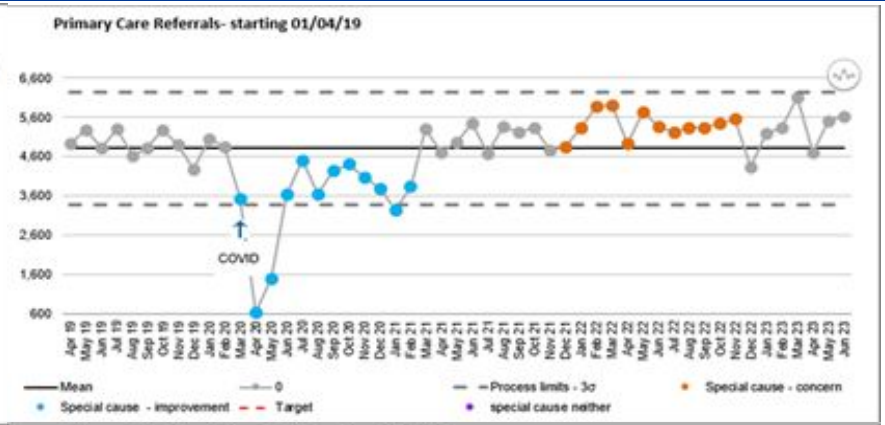
Planned Care Recovery

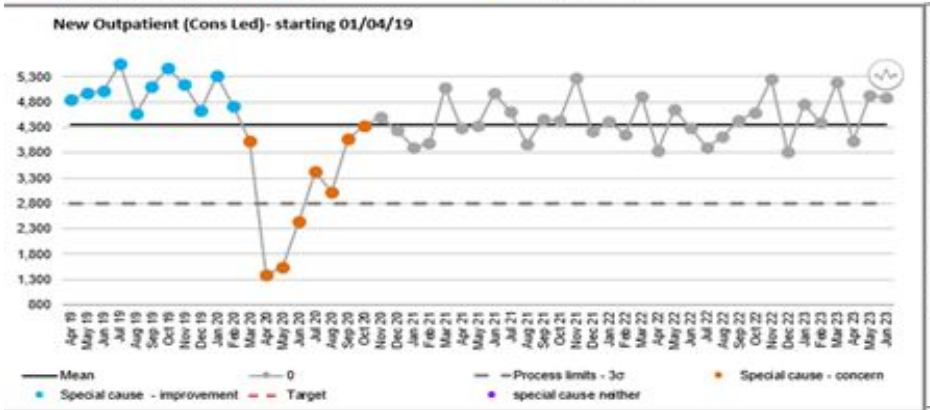
Outpatients	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	341	344	355	473	383	441	491	464	416	481	426	370
Actual	883	1,002	*984*									
Consultant-led first outpatient attendances (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	4,027	4,935	4,886									
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	8,973	10,598	10,448									
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	2,318	2,545	2,579									
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	2,161	2,321	2,350									
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	224	229									
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	1,063	1,144	*1,167*									
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	3,486	4,487	*4,333*									
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	5,756	6,788	*6,957*									
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	998	1,001	*1,079*									
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	202	197	*225*									
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	25,951	25,876	*26,098*									
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	64	56									

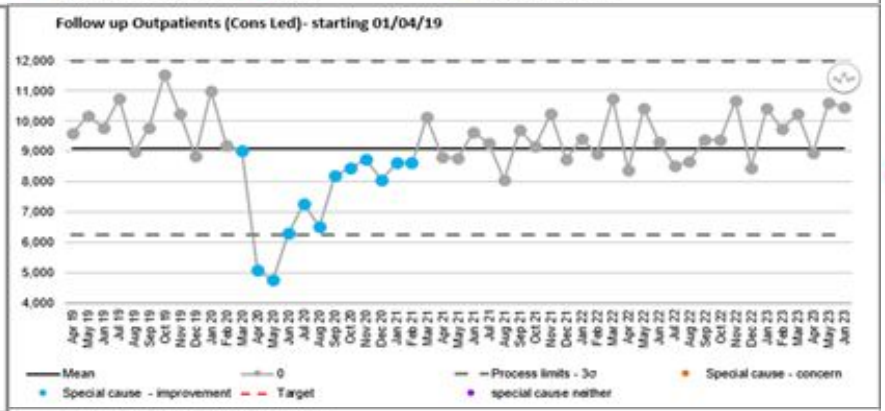
Increasing elective capacity to 2019/20 levels continues to be the key focus. 12% of 2019/20 was delivered through premium out of core sessions which may not be replicable.
New outpatient activity above plan for April to June.
Significant increases in advice and guidance activity from 2019/20 which do not get reflected in above figures (baseline of 450/month now up to 900/month) – agreed that this will now come into our activity. Junior doctor strikes impacted on delivery of planned activity affecting mainly outpatient and endoscopy.
End of June provisional RTT position – No reportable patients over 104. 1 patient over 78 weeks – now treated.

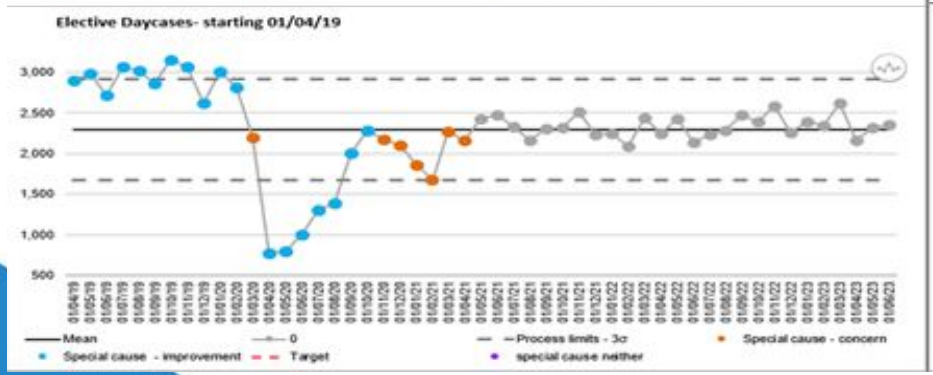
Elective Recovery

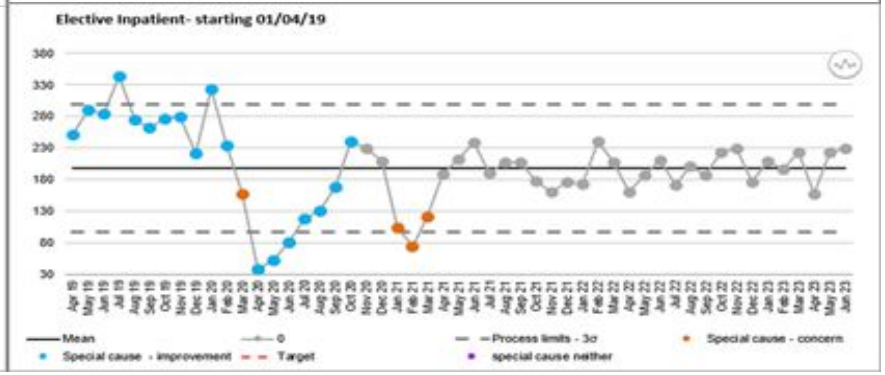












5.4

Referral to Treatment (RTT)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23 (Provisional)
Total incomplete RTT pathways	24,714	25,384	25,134	25,629	25,564	25,490	25,437	25,388	24,951	24,854	25,139	25,504	25,951	25,876	25,860	26,983
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350	1,285	1,201	1,228	1,186	1,112	997	998	1,001	1,020	1,048
> 65 weeks	499	461	463	471	500	519	477	401	477	399	362	193	202	197	210	211
> 78 weeks	205	184	169	155	144	133	112	100	118	101	65	4	5	0	0	0
> 104 weeks	11	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT new clock starts	6,403	7,219	6,382	6,817	6,917	6,669	6,727	6,869	5,226	6,397	6,409	7,296	5,756	6,788	6,955	2,873
RTT clock stops	4,290	5,136	5,119	5,244	5,515	5,291	5,655	5,998	4,563	5,262	5,194	5,935	4,552	5,367	5,565	1,257

RTT – the Trust had 25,860 patients waiting at the end of June, which reflects a small decrease in total RTT pathways.

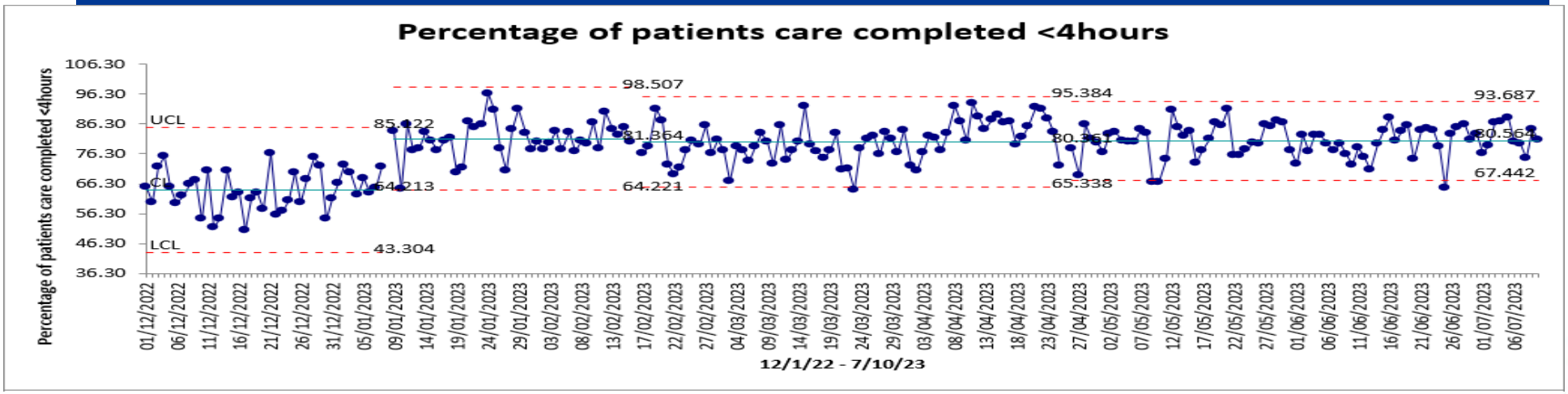
The AI solution for RTT validation is now in place, some final data imports issues are being resolved before the AI element can fully support validation. Only 150 pathways over 30 weeks are un-validated.

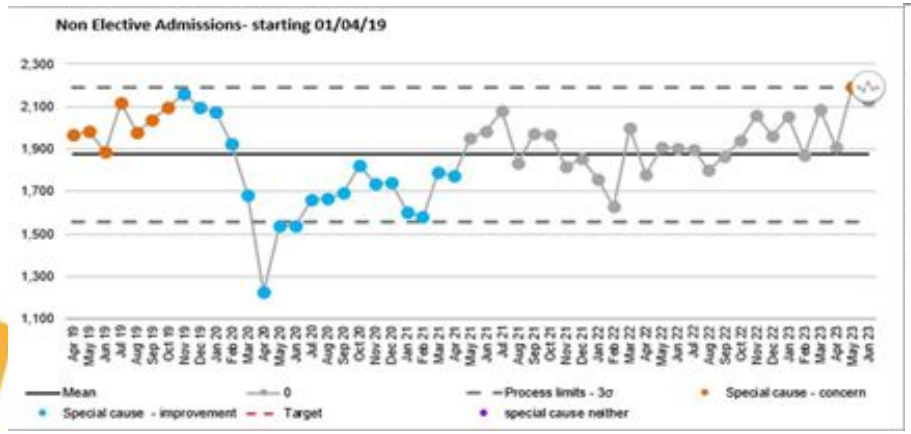
2 new substantive validator posts have recently joined the RTT team. Digital real-time outcoming project is now formally in flight with delivery Q3 which will again support more timely validation.

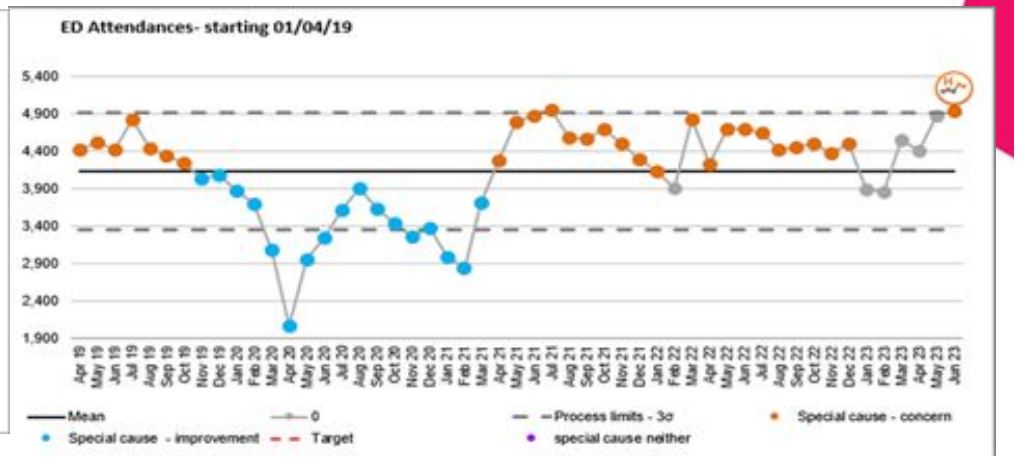
There were 0 HDFT reportable patients waiting 78+ weeks at end June. There was 1 York transfer patient waiting 78+ weeks – reported by York Trust.

Of the 3,939 patients waiting for a procedure on our waiting list, 40% are Orthopaedics and 14% are Ophthalmology.

Urgent Care and Diagnostics

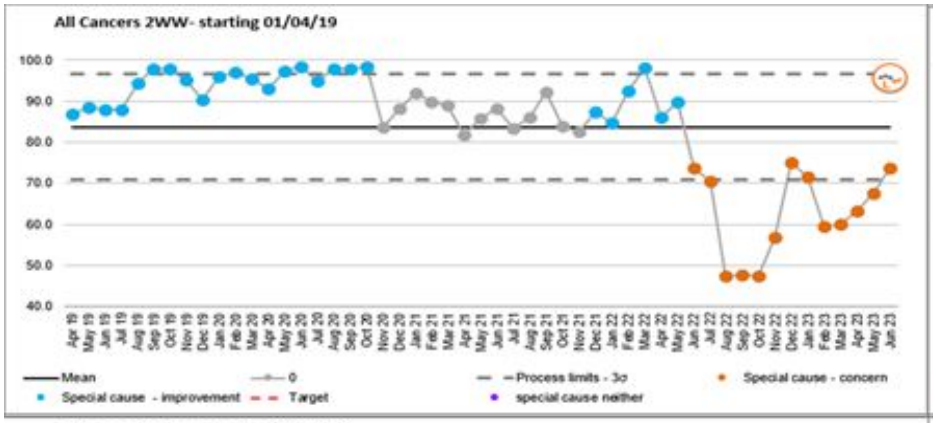


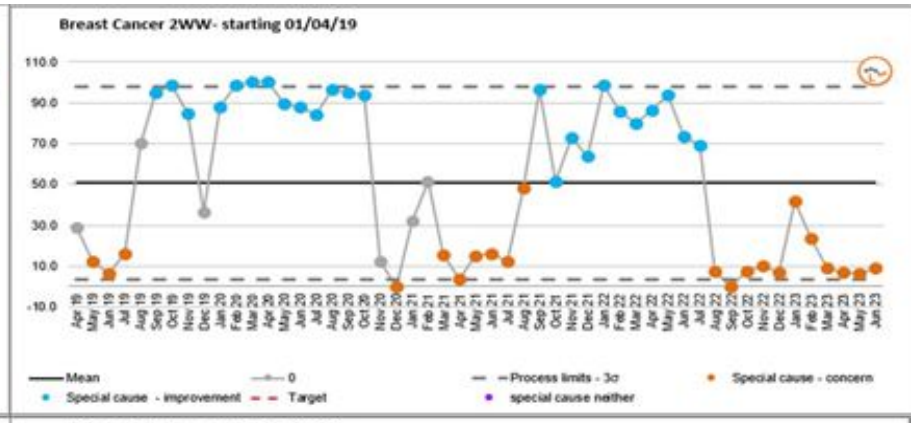


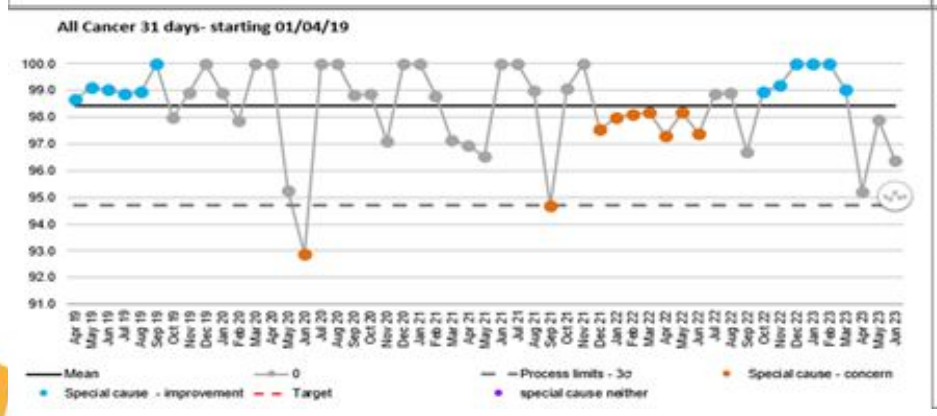


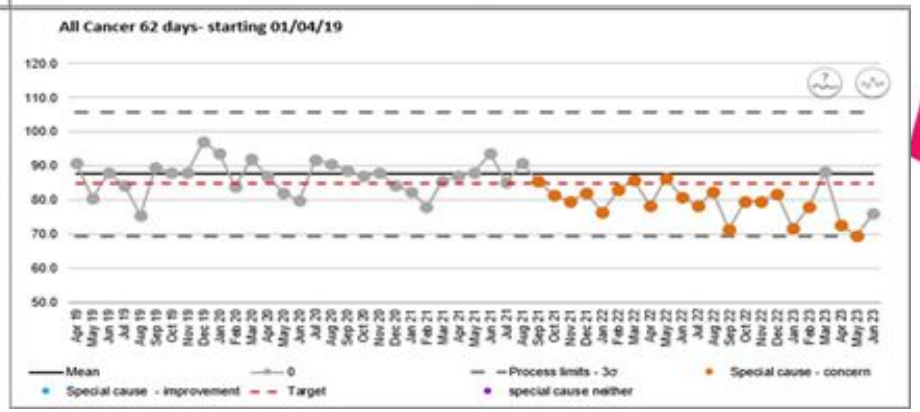
- Performance against the A&E 4-hour standard was at 80.3% in June, above the new performance standard of 76%. ED performance since streaming model commenced has shown a step change. This is also linked to an improved period of bed availability.
- There was 1 x 12-hour trolley wait breaches in June (1 in May).
- There was 9 over 30-minute ambulance handover breaches in May (8 in May) and none over 60 minutes.
- ED attendances are now back in line with 2019/20 levels.
- 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



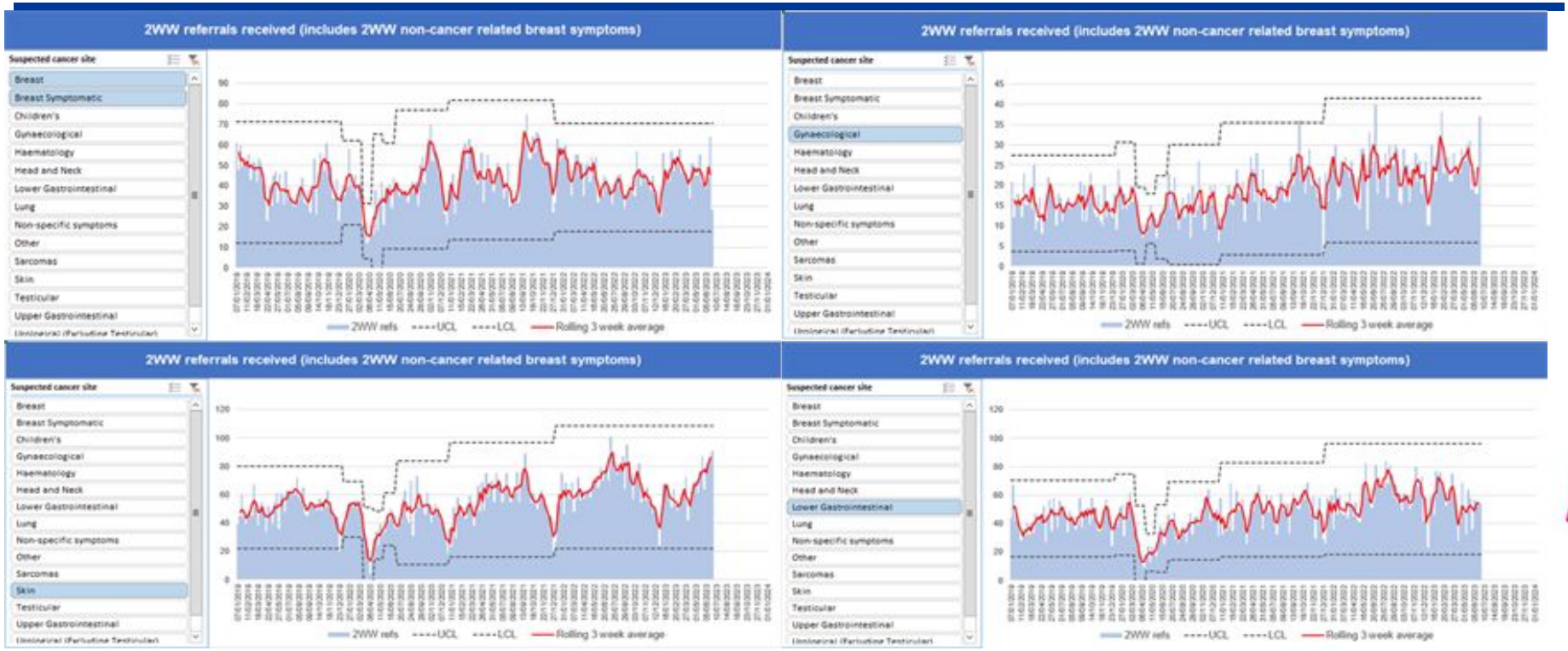






- The 62-day standard was not met in June with a performance of 76.2% against the 85% standard but is an improving position.
- The 31-day standard was met in June with a performance of 96.4% against the 96% standard.
- The 2-week wait standard was not met in June with a performance of 73.6%. A significant increase in 2WW referrals has been seen in several challenged services (Breast, Lower GI, Dermatology and Gynaecology). Again this is an improving position.
- The 2-week wait breast symptomatic standard was not met in June with just 9% of patients being seen within 2-weeks – patients are being seen at 18-19 days which has come down from 20 days last month.
- At the end of June, 56 (64 in May) patients remain on an open cancer pathway over 62-days with 9 (15 in May) 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, with support from some cancer alliance funding will benefit from enhanced FIT testing to address some of the demand issue.

Cancer Performance



- Performance against the 2WW Cancer standard continues to remain below the standard in June.
- 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 June 2023

Matters of concern & risks to escalate

- The Trust reported a deficit position in month 3 of £1.5m. This is £0.7m adverse to plan, however, this position assumes a positive impact against the stretch target set to support the system.
- Key drivers for the position include performance against saving requirements, premium expenditure, cover for the junior doctor strikes, and continued reliance on agency staff in some areas.
- Directorates have developed recovery plans. Positively this has a collective impact of £9.8m, however, risk adjusted the impact is nearer £5.9m.
- Whilst the Trust continues to report to plan in terms of forecast, the current operational forecast, including recovery, is £4.8m deficit, with a best case of break even and a worst case of £10m deficit.
- 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 charity accounts.

Major actions commissioned & work underway

- Working with Local Authority colleagues in relation to pay award funding and pressures this may create (financial or operational).
- 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.

Positive news & assurance

- HIF Accounts submitted to and accepted by Companies House.
- Audit process underway for 2022/23 audit process with Azets, as well as planning for 2022/23 subsidiary and charity audit.
- Pay award for A4C and HIF colleagues processed in June.

Decisions made & decisions required of the Board

The Senior Management Team is asked to discuss the forecast position, impact of the recovery plan and agree position moving forward.

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** **Sickness Absence** **Appraisal Compliance** **NHS Staff Survey** **Inpulse Survey** **Health and Wellbeing/OH Metrics** **Exit Interview/Leaver Data** **New Starter Data**	
Belonging	• **Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**	**NHS Staff Survey** **ER cases by protected characteristic** **WRES data** **WDES data** **Gender Pay Gap** **Ethnicity Pay Gap** **PSED**	
New ways of working	• **The right people, with the right skills, in the right roles**	**Vacancy Factor** **Agency/locum spend** **Time to Recruit** **Roster Compliance** **WTR Breaches**	
Growing for the future	• **Education, training and career development for everyone**	**Student Feedback (Medical and non-medical)** **Number of courses run** **Number of internal promotions** **Number of leaders trained** **Levy spend** **MEST Compliance**	

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: - 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.	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

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 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 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 Mandatory Training compliance of 90% across the Trust. • Review of reasons for people leaving, to ensure any recurrent themes are addressed. • Review on-boarding experience	• 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 84%. • All Directorates working to 90% Mandatory Training compliance • Retention Group established as sub group of Looking After Our People and Belonging. • Implementation of employee lifecycle surveys via Inpulse platform	
To continue to develop employment practices and policies, which support colleague work life balance.	• Improved attraction of staff. • 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. • Review flexible working offer • Implement reasonable adjustments passport • Implement carers passport	• Policy review partially completed. • Work to commence on Colleague Wellbeing Passports. • NHS Health & Wellbeing Diagnostic 100% completed. • Developing action plan from diagnostic	

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 • 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. • Ensure integration of HDFT impact programme with existing leadership/appraisal processes • Organisational Development programme to support Pathology Services Joint Venture	• Delivery plans in place for both programmes. • Leadership Journey is being re-mapped and communication plan for this under development, including how to build this into our recruitment processes. • Leading Transformational Triumvirates programme designed and commissioned with ILN, programme launched 23 November 22 and runs for 12 month period. • OD programme in Joint Venture under development.	

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. • Suite of EDI training to be launched.	• Programme to be developed and delivered by Senior OD Practitioner who joined on 09.01.23. • EDI training developed and delivery plan being developed.	
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. • 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.	• Additional training and development is being carried out for BAME leadership, cohort I and Reciprocal mentoring, cohort II. • World Staff Network day was well supported by the Trust with 200 information packs 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 - launched January 2023. • Training on Unconscious Bias being rolled out. • Neurodiversity being scoped. • 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. • Diversity Calendar activities on track • Achieved level II of Disability Confident • Updating policies, additional training developed and signposting materials. • Rainbow Badge Re accreditation achieved at bronze level	
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 include 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. • Over-recruitment to neutralise turnover rates		• 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 • Develop over-recruitment process • Implement Medical E-Rostering • Review Medical Additional Activity Pay rates • Review Bank Rates and Incentives	• Workforce round planning completed. • Over-recruitment process implemented from May 2023. • Medical Rostering Procurement completed, system implementation project being delivered. • Medical Additional Rates Group has reviewed pay rates, proposals going to SMT • Pay Incentives Group established and substantive bank rates being reviewed/developed to support agency migration	
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.		• 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, Armed forces Network • Review job descriptions, person specifications and job adverts to ensure modernized and appropriate	• 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. • Video to help Neurodiverse candidates prepare and navigate an interview process launched on Trust website	
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	• Medical Rostering Procurement completed, system implementation project being delivered. • WTR breaches reported in Subgroup, Directorate Reports and Performance Packs • Roster compliance reported in Subgroup, Directorate Reports and Performance Packs	

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. • Review Core and Role Specific Mandatory training requirements for each role • Support development of Domiciliary Care subsidiary • Support Medical Trainees to meet curriculum requirements • Support Clinical Education Fellow Posts across the Trust • Review impact of Long Term NHS Workforce Plan	• 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. • There are 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 • Long Term NHS Plan impact being reviewed	
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 undertaken. • Regular attendance at DEEF, Acute Trust Meeting, Regional MEM meetings etc. • Senior Leader date being finalised	
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.		• Target to recruit 31 international nurses • Support Ward Based Tutors to deliver curriculum requirements. • Review internal offering of training to meet Trust need. • Review of Commissioned Training.	• 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.	

	• Competent teams with diverse skill mix.		• Develop Learning Lab to its fullest potential.	• Learning Lab hosts all Mandatory Training, a robust leadership and wellbeing offering and is continuing to grow. • MPET Meeting held in July with positive feedback from Undergraduate Students	

People & Culture

Matters of concern and risks to escalate

Growing for the future

- Hotspot areas for escalation in relation to MEST ;
  - Foundation Training Overall Compliance is below the Trust target of 90% Mandatory: 75% ➔, Role Specific: 70% ↑13%,Overall: 69% ↑6% (Jun 2023)
  - Bank Training Compliance is below the Trust target of 90% Mandatory: 76% ↓5% , Role Specific: 74% ↑6% ,Overall: 75% ↑1% (Jun 2023)
  - Overall Medical Device Compliance for theory and devices 80% ➔ (Jun 2023) is below the Trust target of 90%

- Local Induction Checklist Compliance 80% ↑3% (June 2023) is below the Trust target of 90%
- Oliver McGowan Mandatory Training - a requirement of the health and Social care Act is service providers registered with the CQC must ensure their staff receive training on learning disability and autism appropriate to their role. It applies to all registered providers of all health and adult social care in England. Ongoing discussions are taking place to establish an SME to enable this to be incorporated proportionately into HDFTs mandatory training suite. This is funded for the first 3 years by Humber and North Yorkshire ICB

Major actions commissioned and work underway

Belonging

- BAME Staff network – arranging activities for South Asian Heritage Month to include dancing videos, authentic recipes and blogs
- LGBT+ staff network has been invited to attend Leeds Pride with LTHT (Aug Bank Holiday). Richard Dunston Brady to be part of an external discussion group who are considering activities for a Harrogate Pride event this year
- Reasonable Adjustments Passport has been developed for review and approval through the People and Culture Governance
- Face to Face training starting July for International Nursing cohorts regarding EDI to support cultural integration and advise on our Trust approach to inclusivity and diversity.

Growing for the future

- Mandatory training review – implementation of the changes continues; redefinition of mandatory training to align with the national core skills training framework and the CQC Minimum Data Set
- Deputy Directors of Medical Education appointed, Mr Biswajit Ray and Dr Thomasina Livingstone.

People & Culture

Matters of concern and risks to escalate

New ways of working

- Rosters are required to be published a minimum of 8 weeks prior to the commencement date .Compliance rate per directorate:- CCs – **40%** (6 rotas); LTUC **26.1%** (12 rotas); PSC **22.6%** (7 rotas); HIF **16.7%** (2 rotas)
- The Working Time Regulations 1998 (WTR) make provision for minimum standards in relation to working hours and rest periods. In the previous month of May, there was a total of **1,173 breaches within HDFT**
- Roster Compliance and WTR breaches to be reported at OMG, added to Directorate packs this month and Performance packs next month
- Trust vacancy rate – **8%**
- Number of staff in the recruitment pipeline – **296 which include HIF candidates**

Looking after our people

Turnover – Target 12%

- The Turnover Rate has decreased from 14.73% to 14.69% as at 30 June 2023. (This incorporates voluntary and involuntary turnover). LTUC Directorate and Corporate Services have both seen an increase in turnover this month. LTUC has increased from 12.52% to 12.96%. Corporate Services turnover has increased from 16.31% to 17.01%. Corporate Services has seen an increasing trend from 13.04% in October 2022 to the current rate of 17.01%.

Sickness – Target 3.9%

- Sickness has seen an increase from 4.22% in May to 4.36% in June. Sickness had previously seen a decreasing trend since peaking in December at 5.32%. The CC and PSC Directorates have both seen an increase in sickness this month, with CC Directorate increasing from 5.49% to 6.00% and PSC Directorate increasing from 3.59% to 4.01%

Appraisals – Target 90%

- Target 90% Appraisal Rates have seen a small decrease in June to 83.10% from 83.72% in May

Vacancy Rate

- Decreased from 8.03% in May to 7.88% in June and equates to 354.38wte vacancies.

Major actions commissioned and work underway

New ways of working

- The Pay Incentive Group is developing a critical shift payment rate and process for in hours, out of hours/on-call gaps and holiday periods
- Nursing overtime is being reviewed and no overtime will be allowed in the future from an agreed date
- NHSP Direct Bookings have been turned off to ensure Wards are not able to book directly with off-framework agencies.

Looking after our people

- Health & Safety Executive - Managing workplace stress audit. 2 teams in each of the 4 Directorates will pilot the implementation of the audit
- Retention Sub-Group established
- Plan agreed with CC to deliver a series of Health & Wellbeing roadshows across the footprint during September & October 2023, to be combined with the flu vaccination campaign
- Flu vaccination campaign underway, 4,000 vaccines ordered, 10 community sites/bases identified for delivery of vaccines in community in conjunction with the winter wellbeing programme. Flu CQUIN – 75% for staff vaccination (Trust aspiration 90%)
- Quarterly Inpulse Survey running 03-18 July- theme Teamwork.
- Care Group Triumvirate Team (LTUC & PSC) Leadership Development Programme mid-programme evaluation to be completed July / Aug 23.
- KITE colleague recognition Awards proposal is developed and under review by Leadership Team

People & Culture

Positive news and assurance

Belonging

- The Trust has received the Bronze Award for Rainbow Badge Accreditation.
- Digital informatics about the staff networks, blogs from the LGBT+ Network and Vlog from Wallace Sampson now on the recruitment page of HDFT.
- New Root Out Racism imagery going to print. “Ask me my preferred name” campaign.

Growing for the future

- Core Mandatory Training for substantive colleagues
  Mandatory: 90% ↓4%, Role Specific: 91% ↑4%,Overall: 91% ↑1% (Jun 2023)

Looking after our people

- Work commenced to deliver Pertussis (Whooping cough) vaccine programme across Trust
- **Staff Engagement – Survey Scores (**Benchmark Group Acute & Community Trusts**)**
  - 7.15 – 30 April 2023 (Theme Integrity) – Benchmark Score 6.4
  - 7.20 – 31 Jan 2023 (Theme Kindness) – Benchmark Score 6.3
  - 6.84 - 30 Nov 2022 – NSS – 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

Decisions made and decisions required of Board

Decisions made at People & Culture Programme Board – 04/07/23

- Updated apprenticeship T&C salary ranges agreed.

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 (However, Re-Planning taking place) • On Track (However, Re-Planning taking place)	
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) • Complete • 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 • Complete • On Track • On Track (Now aiming for Mar 23) • On Track (Now aiming for Mar 23) • On Track (Now aiming for Apr 23) • 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 • Delayed – (Likely to be August)	

Yorkshire & Humber Care Record	To enable sharing of patient information across systems and organisations		• Regional Business Case approved – Jun 20 • Regional contract signed – Jun 20 • Initial Go Live – May 22	• Complete • Complete • Complete	

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Establish Harrogate Innovation Hub	Facilitate and accelerate the growth of innovative healthcare solutions by building partnerships with industry, academia, government and voluntary sector and offering a real world testbed for healthtech and digital innovations		• Harrogate Innovation Hub Launch event – Oct 22 • Identify Innovation Hub location – Oct 22 • Recruit Innovation Manager – Jan 23 • Appoint Clinical Lead for Innovation – Jan 23 • Further actions to be developed	• Complete • Complete • Complete • Complete	
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	• Complete – delayed start but now in use	
Building on our quality improvement approach, embed a philosophy and operating model for continuous improvement throughout the Trust	Improvement is embedded in daily work and linked to strategy enabling us to continuously improve quality across the Trust, including to realise the benefits of the new EPR.		• Issue tender for an external partner – Feb 23 • Appoint external partner – Mar 23 • Complete readiness assessment – Jun 23 • Operating model cohort 1 complete – Mar 24 • Operating model cohort 2 complete – Aug 24 (Milestones to be refined following second Readiness Assessment on 20 Jul 23)	• Complete • Complete • Complete (delayed to 20 Jul 23) • On Track • On Track	

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To understand Children's PH research and identify how we can contribute	Build the evidence base for Children's PH Services Improved outcomes for children		• Children's PH Services Strategy Workshop – Oct 22 • Paper on Children's PH research for Children's PH Services Board WG – Jan 23	• Complete • Complete (delayed to Jul 23)	
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 • Further actions to be developed and added	• Complete	

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

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

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
CHS2	HDH Goods Yard	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to unauthorised access to restricted areas of the hospital through the loading bay entrance.	12 (4x3)	4 (4x1) December 2023	Operational	TBC
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 (5x3)	10 (5x2) December 2023	Operational	TBC
CHS8	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 (4x3)	8 (4x2) December 2023	Operational	TBC
CRR78	Failures of Nurse Call system	Nurse call systems are obsolete in most areas (33+ years old) and without a comprehensive maintenance contract in place. It will be "best endeavours" to resolve any ongoing issues. Funding and replacement required site wide.	16 (4x4)	4 (4x1) Not yet known – dependent of funding	Operational	TBC
CRR79	Hot water temperatures at HDH	Hot Water circulation temperatures are below the minimum required in HTM 04 "Safe Water in Healthcare Premises"	12 (3x4)	4 (5x1) April 2024	Operational	TBC

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 • Schemes in 17, 19, 21 Wetherby Road, 50 Lancaster Park Road and surrounding buildings to be completed in Q1 23/24	• Complete • Complete • Complete • Complete • Complete • Delayed – now expected by Sep 23	

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
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Initial Design complete – Aug 22 • Tender & Contract award and Design – Mar 23 • Build complete – November 23 • Commissioning complete – Dec 23 • In service – Dec 23	• Complete • Complete • Delayed to Dec 23 (Drainage issues, AHU, Design sign off, scope gaps leading to delay and increased cost) • Delayed to Jan 24 • Delayed to Jan 24	
Imaging Reconfiguration	• To improve reliability and capacity of imaging services		• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Detailed Design Sep 23 • Tender & Contract award – Dec 23 • Phase 1 complete – May 24 • Phase 2 complete – Aug 24 • Phase 3 complete – Nov 24 • Phase 4 complete – Jan 25 • Fully in service – Feb 25 CT Business Continuity: • Canon Dismountable: 26 May 23 • Operational 10 Jun 23 • Portakabin on site 22 Jun 23 • Siemens CT in Portakabin operational 24 Jul 23	• Complete • Complete • Complete • On Track • On Track • On Track • On Track • On Track • On Track • On Track • Complete • Complete • Delayed to Aug 24 • Delayed to Sep 24	
ED2 (UTC) Reconfiguration	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build start – Mar 23 • Build complete – Aug 23 • Commissioning complete – Sep 23 • In service – Sep 23	• Complete • Complete • Complete • Complete (started May 23) • Delayed - Sep 23 • Delayed - Sep 23 • Delayed – 6 Oct 23	
Wensleydale Ward Refurbishment	• Dedicated cardiology and respiratory ward, including High Observation/Non-invasive Ventilation Beds		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build Start – Apr 23 • Build complete – Oct 23 • Commissioning complete – Nov 23 • In service – Dec 23	• Complete • Complete • Complete • Complete (started 24 Apr 23) • Delayed to Nov 23 • Delayed to early Dec 23 • On Track	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
HDH Additional Theatres (TIF2)	• Additional activity (General Surgery 750 day case/inpatient, Urology 1300 day case/inpatient, Gynaecology 60 day case/inpatient, Breast 250 day case/inpatient per annum) • Improved waiting time performance		• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Planning permission awarded – Jan 23 • Complete tender, appoint contractor – Jun 23 • Recruitment complete – May 24 • Construction complete – Jul 24 • Go Live – Aug 24	• Complete • Complete • Delayed due to revised timescales to appoint PSCP • Delayed – subject to further design • Delayed - Tender completed; PSCP appointment pending • On Track • Significant Risk – Current programme indicates completion in Mar 25, subject to detailed design and planning by PSCP. Indicative costs are now significantly above the original estimates. Increased and re-profiled funding being discussed with HNY ICB and NHSE. Recommend amending plan dates once funding addressed and PSCP updates programme. • Significant Risk – currently expected Apr 25	

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
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: • Completed • Installation complete; final connection to site services alongside other elements by Sep 23 • 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 • Complete • September 2023 part of the Car Parking Project – on Track	

Director of Strategy

Matters of concern & risks to escalate

PMO
- TIF2: funding shortfall vs current project cost estimate

Business Development
- Work experience placements being arranged by teams without appropriate safeguards and knowledge of Volunteer Team

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.
- Control of Contractors
- Water Temperatures

Continuous Improvement (HDFT Impact)
- Postponement of QI events due to doctors' strike and unplanned absence in team
- QI capacity to support the roll out of HDFT Impact and maintain QI training and RPIWs; QIA completed for LT consideration
- Interdependencies between agreement of breakthrough objectives (Strategy Deployment), QI capacity and start of Improvement Operating Model roll out

Major actions commissioned & work underway

PMO
- TIF2: discussions with NHSE to review timescale and funding; current timescale from PSCP is for completion is Mar 25; user engagement and detailed design to start following PSCP appointment
- Support: Med Errors, Missed Results, OP Transformation, Ripon CDC

Business Development
- Comms: plans for EPR, HDFT Impact; new intranet; NHS 75th birthday
- Decommissioning of Vaccination & Immunisation Services (1 Sep 23)
- Domicilliary Care: System1 module, NYC APL, further recruitment, HARA workshop, addendum to medicines management policy

Continuous Improvement (HDFT Impact)
- Development of implementation plans for 6 workstreams: Leadership, Strategy Deployment, Improvement Operating Model, Centre of Excellence, Communications, BI
- Second Leadership Team roadmap workshop on 20 July
- Planning for support to HARA, flu vaccination, wellbeing & recruitment

Capital Planning
- Estates Strategy for HDH in development; report due by end of August
- Wensleydale/ED2 works underway; commissioning team established
- Imaging Services: finalising BC for sign off by Trust & HIF in August
- CT: design of Portakabin and Rowan pad being finalised
- Feasibility: private outpatient; CRF
- Recruitment to Land & Property and Capital Programme Manager roles

Positive news & assurance

- 4 interns graduated from Project SEARCH: 2/3 have secured employment with the Trust; one working on bank until suitable role is available

PMO
- Prog Manager, 3x Project Managers in post
- Electronic IP referral for surgery successfully launched on 19 June
- Ripon CDC: room layouts agreed, formal appointment of designers

Business Development
- Stockton 0-19 s75 agreement
- Harrogate Proms held on 24 June

Continuous Improvement (HDFT Impact)
- Readiness Assessment completed: identifies strengths and areas of development in our improvement approach
- Strong demand for Silver QI training; additional course dates agreed
- Good progress with improvements in Antenatal and Elective C-Section

Capital Planning.
- Imaging Services phasing and layout drawings signed off by LTUC Board
- Preferred PSCP for TIF2 agreed
- Paediatric OPs successfully relocated next to Child Development Centre to provide temporary office space and, longer term, additional OP space

Decisions made & decisions required

Continuous Improvement (HDFT Impact)
- Agreement of implementation plans by Leadership Team on 20 July

Capital Planning
- Contract with preferred PSCP for TIF2 to be signed; clarity on whether HDFT or HIF to sign.

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:	29th June 2023
Date of Board meeting this report is to be presented	26th July 2023

Summary of key issues

Meetings continue to be held via Microsoft Teams and are well attended. Steve Treece observed and contributed the meeting on behalf of the Council of Governors.

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

- Governance Items – the Committee received and considered the draft Annual Governance Statement provided by the Chief Executive that will form part of the package of year end papers to be received by the Board in August.
- Internal Audit Programme Progress Report – a final report on Junior Doctors Rotas was received providing significant assurance. However, some of the information noted in the report appeared to be slightly at odds with reports received from the Guardian of Safe Working Hours and may require further discussion. It was noted that there were a further 11 reports currently at the draft report stage of the audit process.
- Audit Recommendations – a report was presented setting out the current position in respect of completed and overdue audit recommendations including some anonymised regional benchmarking data. The report showed some improvement on the position revealed in previous reports. The Committee decided to

request that benchmarking data continues to be presented until it is clear that a stable positive position has been achieved.

- Head of Internal Audit Opinion – the Committee received and considered the draft Head of Internal Audit Opinion for 2022/23. The final version of this document will form part of the year end papers to be considered by the Board in August. The draft opinion noted that 92% of the 2022/23 audit programme had been completed at the time of writing and that on the basis of work done a "significant assurance" opinion could be provided confirming that in the opinion of the Head of Internal Audit the Trust has in place a good system of governance, risk management and internal control and that controls are consistently applied. On a less positive note it was reported only 50% of Trust audit reports had benefitted from customer feedback.

- HIF Internal Audit Reporting – the Committee received a report on follow up of HIF audit reports noting that at the time of writing there were only four overdue recommendations.

- Counter Fraud Annual Report - this report provided the Committee with the opportunity to consider the work done by the Trust's Local Counter Fraud Specialist in 2022/23. Fraud and attempted fraud continues to be a significant threat to both the Trust and wider NHS and work done to prevent avoidable loss of funds is vital to ensure that resources made available for healthcare are used for the purpose intended. A formal mandated compliance assessment of HDFT's work in this area showed 12 green ratings and only one amber rating in a new area of assessment introduced in 2022 where it has been acknowledged at national level that the majority of Trusts will take between two and three years to achieve a green rating. This relates to the use of a new prescribed fraud assessment methodology. A small number of investigations had taken place during the year with the majority requiring no further action after proper investigation of concerns or allegations.

- External Audit – no Azets representative was required to attend this meeting. Azets colleagues had confirmed that they were planning to begin the work required to enable submission of final accounts by the 31st August deadline during the week following the meeting.

- The Committee received the minutes of two recent Post Project Evaluation Group meetings. No concerns were raised.

- A small number of single tender procurements were noted. No concerns were raised other than that the delay between the

procurements in question taking place and a report being submitted to the Committee was rather lengthy.

- Submission of HIF Accounts - the Interim Finance Director updated the Committee on progress being made towards the submission of HIF's annual accounts to Companies House. Although the initial deadline for submission had been missed Saffery-Champness (HIF's external auditors) were in the final stages of their work and submission by an agreed revised deadline date was anticipated. Any variations between the final audited accounts and previous drafts would not have a material impact on the Trust's group accounts.

The Committee is scheduled to meet in September with a special meeting on 24 August to consider the annual accounts prior to Board consideration the following week.

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 will need to convene a formal meeting within the planned August Board Workshop to consider the Trust's financial statements and related documents in order to meet the required 31st August submission deadline.

TRUST BOARD in Public

26th July 2023

Title:	Risk Appetite
Responsible Director:	Jonathan Coulter, Chief Executive Officer
Author:	Kate Southgate, Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	Following discussions with Board members at the December 2022 Board workshop, the risk appetite of the organisation was developed. This document brings together those discussions and relevant amendments. The risk appetite of the organisation will be managed through this document and reviewed on an annual 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	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:	This document has been developed following review at the Board workshop in December 2022	
Recommendation:	The Board is asked to review the content of the Risk Appetite document and approve the content.	

Freedom of Information:	Available under FOI

Risk Management and Risk Appetite 2022-23

8.2

Contents

Foreword

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects in order to improve the health and wellbeing of patients, service users and staff alike. Through the risk management process the Board of Directors is informed of the significant risks that face the organisation.

The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practised as a separate programme and that responsibility for its implementation is accepted at all levels of the organisation.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

Good risk management awareness and practice at all levels is a critical success factor for an organisation such as the Trust. Risk is inherent in everything that we do. HDFT will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

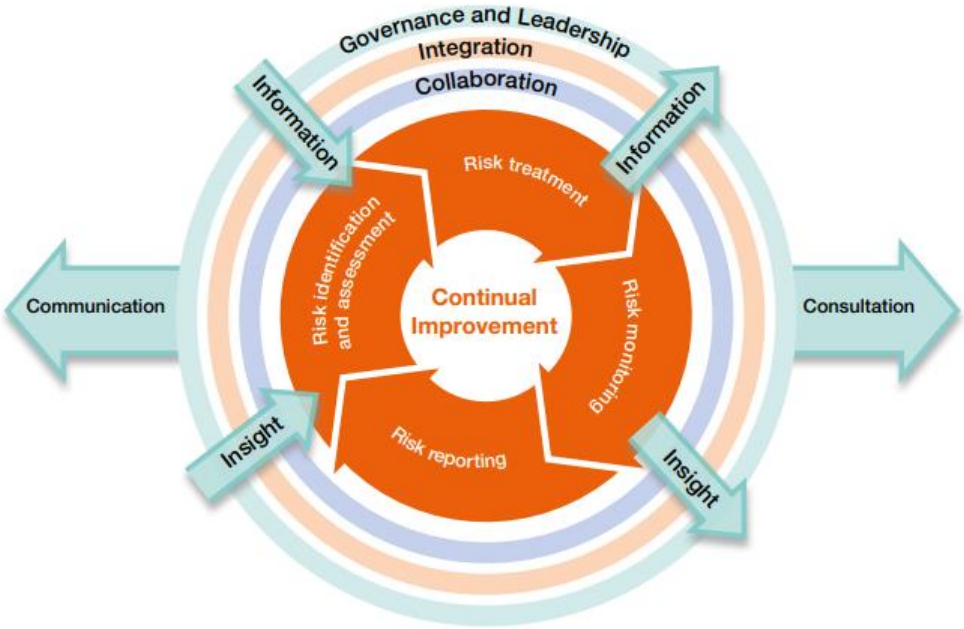
In December 2022 the Executive Team presented the draft Risk Appetite to the Board workshop. It was approved for 2023-2024 at the July 2023 formal Trust Board in Public.

Jonathan Coulter
Chief Executive Officer

Sarah Armstrong
Trust Chair

What is Risk?

Risk Management Framework



Source: *The Orange Book – Risk Appetite Guidance 2021*

The risk management framework supports the consistent and robust identification and management of opportunities and risks within desired levels across an organisation, supporting openness, challenge, innovation and excellence in the achievement of objectives.

For the risk management framework to be considered effective, the following principles shall be applied:

A. Risk management shall be an essential part of governance and leadership, and fundamental to how the organisation is directed, managed and controlled at all levels.

B. Risk management shall be an integral part of all organisational activities to support decision-making in achieving objectives.

C. Risk management shall be collaborative and informed by the best available information and expertise.

D. Risk management processes shall be structured to include: a. risk identification and assessment to determine and prioritise how the risks should be managed; b. the selection, design and implementation of risk treatment options that support achievement of intended outcomes and manage risks to an acceptable level; c. the design and operation of integrated, insightful and informative risk monitoring; and d. timely, accurate and useful risk reporting to enhance the quality of decision-making and to support management and oversight bodies in meeting their responsibilities.

E. Risk management shall be continually improved through learning and experience

HDFT's Risk Management Framework

A Risk Management Framework explains how a range of processes fit together to help ensure that risk is managed consistently at HDFT.

The key elements of this Framework are:

- **Our Trust Strategy** – this describes our ambitions and goals in HDFT
- **Risk Appetite** – how much risk we are willing to take in order to deliver the HDFT strategy, whilst ensuring we provide safe and effective outcomes for our patients and service users
- **Governance** – the structures we have in place to help ensure we make appropriate decisions and take approved risks
- **Risk Assessment** – how we review and understand our risks and consider the controls we put in place to limit the outcome we do not want
- **Incident Management** – the systems and processes we use when things go wrong, how we learn from them and how we prevent them occurring again
- **Monitoring and Assurance** – how we check that the controls we have put in place are working

Talking about Risk

Risk Language

At HDFT we use certain types of “risk language” on a regular basis. This includes the types of risk we have. These are broken down into two levels of risk. Level 1 is our 6 overarching types of risk: Clinical, Operational, Reputational, Financial, Workforce and External/Regulatory. Level 2 defines our risk categories that sit underneath each of these risk types.

Risk Types:

- **Clinical**: the risk of our patients and service users having a poor experience and / or outcomes resulting from inadequate systems and processes associated with the Trust’s capacity planning, infection prevention and control, patient experience, patient safety and outcomes from research and innovation
- **Operational:** the risk of direct or indirect loss resulting from inadequate or failed systems and process
- **Reputational:** the risk of direct or indirect damage to the organisations reputation due to a failure in systems and processes
- **Financial:** the risk of direct or indirect loss to HDFT’s management of finances, financial reporting, funding and liquidity
- **Workforce:** the risk of unsafe or ineffective patient care or outcomes for service users due to inadequate or failing systems and processes associated with HDFTs workforce supply, skills and capacity, retention and within an appropriate culture
- **External / Regulatory:** the risk of direct or indirect loss as a result of failure to comply with regulations, operate within the law and deliver our partnership and collaborative obligations.

Three Lines of Defence

Three Lines of Defence

At HDFT we have three key things that help us manage risk. The "three lines of defence" model provides a simple and effective way to help delegate and coordinate risk management roles and responsibilities within and across the organisation.

Board

Senior Management Team

First Line of Defence

Management Control

Internal Control

- Identify, assess, own and manage risks
- Design, implement and maintain effective internal control measures
- Supervise execution and monitor adherence
- Implement corrective actions to address deficiencies.

Second Line of Defence

Functions that oversee or specialise in risk management

- Set the boundaries for delivery through the definition of standards, policies, procedures and guidance
- Assist management in developing controls in line with good practice
- Monitor compliance and effectiveness
- Agree any derogation from defined requirements
- Identify and alert senior management, and where appropriate governing bodies, to emerging issues and changing risk scenarios.

Third Line of Defence

Internal Audit

- Provide an objective evaluation of the adequacy and effectiveness of the framework of governance, risk management and control
- Provide proactive evaluation of controls proposed by management
- Advise on potential control strategies and the design of controls.

Regulatory Bodies

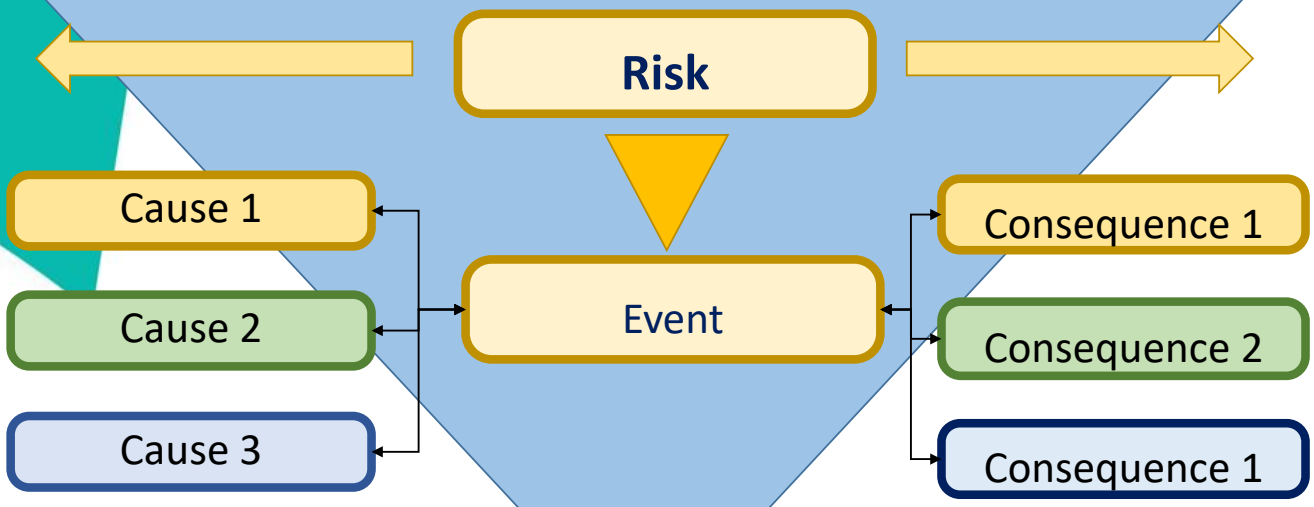
Responsibility for risk management

Independent

Adapted from: *The Orange Book – Risk Appetite Guidance 2021*

8.2

Stating Our Risks



When writing our risks we should describe them in three parts:

- **Event –** what is the event that will happen
- **Cause –** What is the trigger for the event occurring
- **Consequence –** What will happen if the risk materialises

"If <*event X*> happens then there is a risk <consequence> that the project could be impacted in <*Y way*>

In addition to this each risk should be:

- One single risk
- Understandable to the audience intended ie it should be jargon free or non-technical if targeted at executives
- The key point is that if people understand what the risk is they can then help to mitigate it.

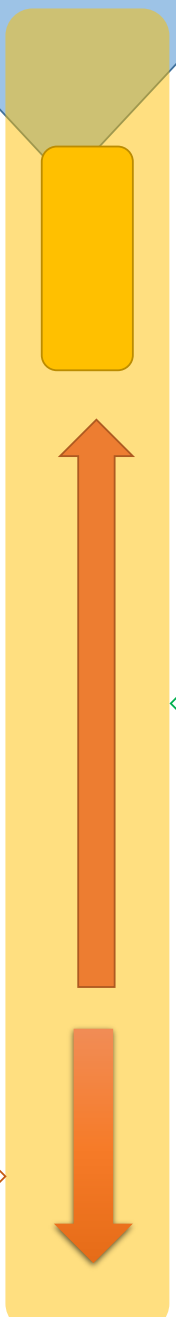
Talking about Risk Appetite

Risk Appetite – what is it?

Risk appetite as a concept is often referenced in organisations, without clearly defining what it is. Similarly, the terms risk appetite and risk tolerance are often used interchangeably. For our guide we will use the following definitions:

Risk Appetite: the level of risk with which **we aim** to operate.
Tolerable risk position: the level of risk with which **we are willing** to operate

Current Risk Position: The risk level at which we are **currently operating,** This level is tolerated by default, as cessation of activity is not an option. Risks are subject to management to drive activity into tolerance or appetite



Tolerable Risk Position: The level of risk with which we are **wiling** to operate, given current constraints. This is a balance between the funding position with the position outlined in our strategy. The tolerable position will shrink as we optimise the risk position.

Risk Appetite Position: The risk level at which we **aim** to operate. This is informed by our strategy, ambitions and vision. or appetite

8.2

Risk Appetite

At HDFT we have adopted an approach to risk appetite as described in *"The Orange Book". This means we have determined a 5 point scale of risk appetite:*

1. **Averse** – avoidance of risk and uncertainty is a key objective
2. **Minimal** – Preference for a safe option that has a low degree of inherent risk
3. **Cautious** – Preference for a safe option that has a low degree of residual risk
4. **Open** – Willing to consider all options and choose one that is most likely to result in successful delivery
5. **Eager** – Eager to be innovative and to chose options that suspend previous held assumptions and accept a greater uncertainty

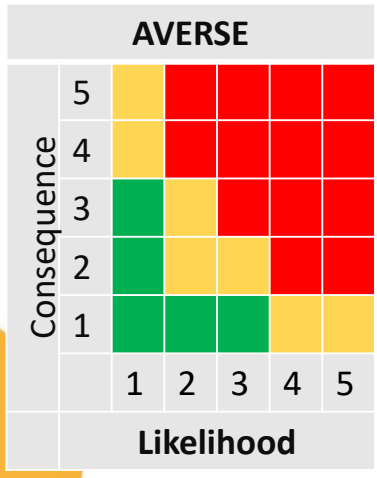
Risk Appetite - Scoring

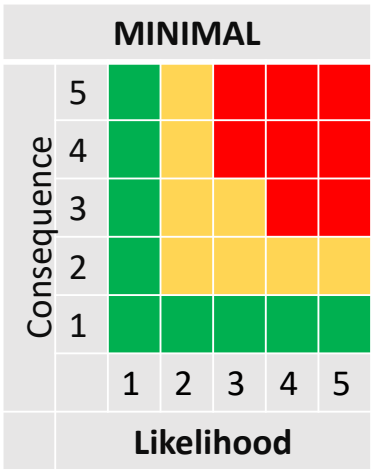
Moving forward how we score our risks and how we **escalate** them will be depended on our **risk appetite** as well as the overall score.

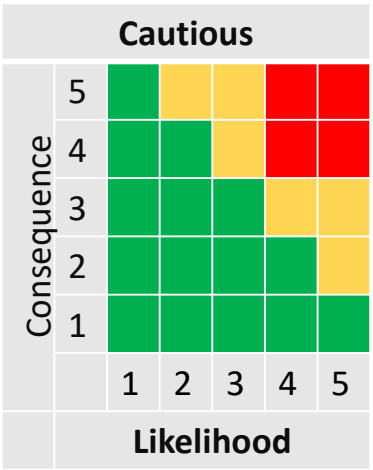
Key Risks:

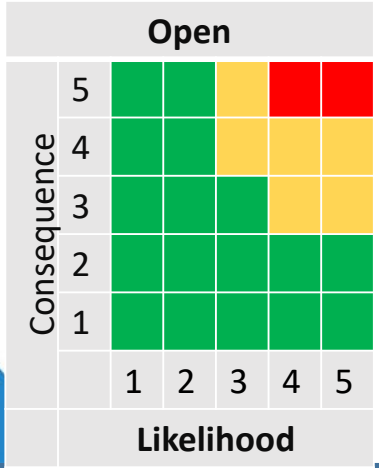
- Risks **above 15** – will be noted at Board via the Corporate Risk Register
- Risk between **9 and 12** – will be noted at Executive Risk Management Committee and SMT
- Risk **below 8** – will be noted at Directorate and Speciality Review Meetings

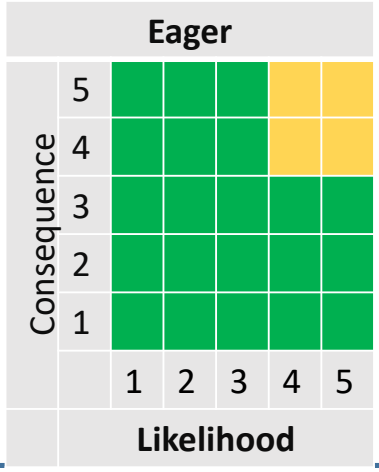
In addition, where we have a risk in breach of our risk appetite these will be reviewed at Resource Review meetings and escalated to Executive Risk Management if assurance on mitigating actions is not evident











Risk Appetite - Clinical

Clinical risks is the risk of poor patient experience and outcomes resulting from inadequate systems and processes associated with our capacity planning, infection prevention and control, patient experience, patient safety and outcomes and research and development.

HDFTs appetite overall for **clinical risk** is **minimal.** Meaning that we will only accept very limited clinical risks if essential to patient care and outcomes, aiming to optimise patient experience.

Clinical Risk	Statement	Appetite
Capacity Planning	We will ensure that capacity is planned at a level to meet demand both within our acute setting and our community framework.	Cautious
Infection, Prevention, Control	We will manage our risks to reduce the transmission of infection in our acute setting	Minimal
Patient Experience	We will comply with all minimum patient experience targets	Minimal
Patient Safety	We will provide high quality care to our patients and service users and manage the risks that could limit our ability to provide safety and effective outcomes	Minimal
Research & Innovation	We will deliver minimum research and innovation priorities with health, social care, voluntary, education and private sectors	Open

8.2

Risk Appetite - Operational

Operational risk is the risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external events

HDFTs appetite overall for **operational risk** is **cautious.** Meaning that we have an ongoing commitment to meeting minimum good practice standards. We will seek to priorities upgrades and business cases based on our desire to meet these standards. We will not accept operational risks that could directly impact upon the safe delivery of care.

Operational Risk	Statement	Appetite
Business Continuity	We will develop and maintain stable and resilient services, operating to consistently high levels of performance	Cautious
Change	We will deliver change aligned to our strategy on time and to budget	Cautious
Health and Safety	We will protect the health and wellbeing of our patients and colleagues by delivering services and environments in line with health and safety laws and guidelines	Minimal
Information Governance	We will manage information through appropriate storage, management and maintenance of information. We will meet data protection and healthcare information governance requirements	Cautious
Information Technology	We will develop and maintain stable and resilient services operating to high level standards	Cautious
Assets	We wil optimise our building and estates to provide a good environment for patients and colleagues	Cautious

Risk Appetite - Reputational

Reputational risk is the risk of patient and public loss of confidence in us resulting from inadequate or failed internal processes and systems or from external events

HDFTs appetite overall for **reputational risk** is **minimal .** Meaning that we endeavour to have systems and processes in place that inspire confidence in our patients and the public.

Reputational Risk	Statement	Appetite
Reputational	We will operate services and systems that provide the public and our patients with confidence in our ability to deliver and operate as a trusted organisation.	Minimal

Risk Appetite - Financial

Financial risk is the risk of direct or indirect loss resulting from inadequate systems and processes to the our management of finances, financial reporting, funding and liquidity.

HDFTs appetite overall for **financial risk** is **cautious.** Meaning that value for money and patient care and outcomes being a key factor in our decision making. We will accept risks that have limited financial impact or losses on the basis that there may be upside opportunities with the safe and effective delivery of patient care, but we will not accept risks that may lead to material variances to forecast, reporting misstatements or unplanned overspend against our agreed revenue control target. We have a zero-tolerance approach to fraud.

Operational Risk	Statement	Appetite
Counter Fraud	We will adopt a zero tolerance approach to workforce fraud through the maintenance of an anti-fraud culture, investigating all reported instances of fraud and following disciplinary and criminal proceedings	Averse
Financial Management	We will deliver sound financial management and reporting with no material misstatements or variances to forecast	Cautious
Revenue, Funding and Liquidity	We will retain a minimum balance in line with requirements of a trust of our size	Cautious
Supply Chain	We will manage suppliers in a manner that protects our interests and service to our patients and service users	Open

Risk Appetite - Workforce

Workforce risk is the risk of unsafe or ineffective patient care and service user experience resulting from inadequate systems and processes associated with our workforce supply, skills & capacity, performance and retention within an appropriate culture.

HDFTs appetite overall for **workforce risk** is **cautious.** Meaning that we will only accept limited risks if by taking them we could yield improvements to our patient and service user outcomes and experience. We will not accept risks if this is not the case.

Operational Risk	Statement	Appetite
Workforce Supply	We will deliver safe and effective patient and service user care and experience through having adequate systems and processes in place to ensure appropriate levels of workforce supply	Cautious
Workforce Deployment	We will deliver safe and effective patient and service user care and experience through the deployment of resources with the right skills and capacity to do what is needed	Cautious
Workforce Retention	We will deliver safe and effective patient and service user care and experience through supporting training, development and health and wellbeing of our colleagues to retain the appropriate levels of resource to continue meet our clinical demands	Cautious
Workforce Performance	We will deliver safe and effective patient and service user care and experience through having the right systems and processes in place to manage the performance of our colleagues	Cautious

Risk Appetite - Regulatory

Regulatory risk is the risk of direct or indirect loss as a result of a failure to comply with regulation, operate within the Law and deliver our partnership obligations.

HDFTs appetite overall for **regulatory risk** is **averse.** Meaning that we have zero appetite for any management decisions that present risks to HDFT maintain its CQC registration or compliance with the law.

Operational Risk	Statement	Appetite
Legal and Governance	We will operate HDFT in compliance with the Law and UK Corporate Governance Code, where applicable	Averse
Partnership working	We will maintain well-established stakeholder partnerships which will mitigate the threats to the achievement of our strategic ambitions	Open
Regulatory	We will comply with or exceed all regulations, retain our CQC registration and always operate within the law	Averse
Strategic Planning	We will deliver our strategic ambitions as outlined in our Trust Strategy	Cautious

Risk Appetite in Practice

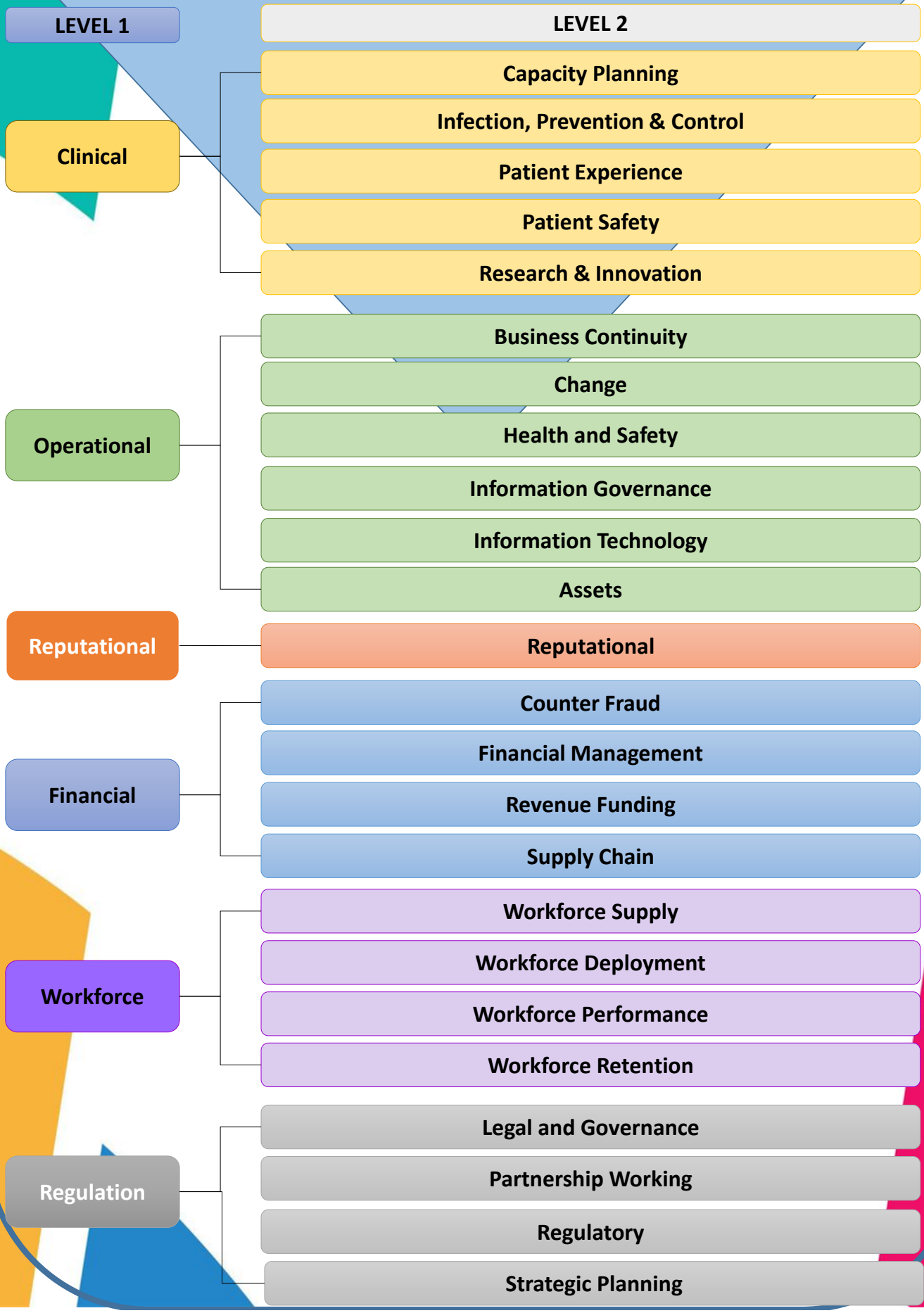
How we use **risk appetite** will be based on four key elements: Our Trust Strategy, strategic planning, decision making and risk escalation.

- **Trust Strategy –** sets out our ambitions. Our risk decisions should be shaped by this.

- **Strategic planning –** risk appetite must be considered as part of the strategic planning process
- **Decision making –**staff decision making as well as Committee proposals should consider their impact on the our risk profile and risk appetite adherence
- **Risk escalation –** where risks are identified and do not adhere to our risk appetite, then these instances must be escalated through the appropriate channels

8.2

Risk Types and Categories - Summary



8.2

Risk Categories by Risk Appetite

	Averse	Minimal	Cautious	Open	Eager
Clinical	**Zero appetite** for any decisions with high chance of adverse impacts upon patient care and outcomes and / or HDFT's clinical reputation	Appetite for takin **very limited clinical risks** if essential to patient care and outcomes. Such risks are properly assessed with mitigating controls in place	Appetite for taking **moderate clinical risks** if essential to patient care and outcomes. Such risks are properly assed with mitigating controls in place	Appetite for taking **significant clinical risks if essential** to patient care and outcomes. Mitigating controls are not fully implemented	Appetite for taking **significant clinical risks** that may result in **serious events, never events or formal regulatory actions.** Mitigating controls are not fully implemented
Operational	**Defensive approach to operational service** delivery – aim to invest in current risk management capacities to protect services. Priority for close management and controls	Legacy technologies and sub-optimal risk management capabilities **largely avoided or prioritised as part of HDFT's change programme.** Decision making authority held by senior management	Risk Management capabilities in place to **meet regulatory standards** to deliver safe and effective patient services. Robust oversight processes in place	Appetite to investment decisions in areas which are likely to expose HDFT to **periodic operational service failure** to elective patient services	Appetite to take investment decisions in areas which are likely to expose the Trust to **regular operational service failures** to non-elective and community services
Reputational	**Zero appetite** for any decisions that could impact on patient safety and therefore public confidence in HDFT	Only prepared to accept the possibility of **minor adverse publicity** if related to actions that are essential to the safe and effect patient care and outcomes	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**Prolonged** adverse social / local / national media coverage with **serious impact** on patient trust and public confidence	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability
Financial	**Avoidance of any financial impacts or losses, variances in forecast, reporting misstatements or workforce fraud** are key objectives	Only prepared to **accept the very limited possibility of material financial impacts or losses or reporting misstatements** if essential to safe and effective patient acre and outcomes	**Limited financial impacts or losses** are accepted if they yield upside opportunities elsewhere in HDFT. **Minimum cash balance retained for a trust our size**	**Prepared to invest** and / or accept **financial impacts and losses** for the benefit of patient care and outcomes. At points in the year minimum cash balance **less that XXXX**	Prepared to invest and / or accept **financial impacts and losses** for the benefit of patient care and outcomes. At points during the year, HDFT has a **negative cash balance**
Workforce	**Avoidance of any workforce risk** that threaten the safe and effective patient care and outcomes, is a key objective	Only prepared to **accept the possibility of very limited workforce risk** impacts if essential to safe and effective patient care and outcomes	Seek options to deliver safe and effective patient care and outcomes **with limited workforce risks** only if it could yield patient care opportunities elsewhere in the Trust	Appetite to take workforce management decisions that may give rise to opportunities, but with the **potential to expose HDFT to sub-optimal patient care and outcomes**	Appetite to take workforce management decisions that may give risk to opportunities, but which are **likely to expose HDFT to sub-optimal patient care and outcomes**
Regulation	**Zero appetite** for any decisions that present risks to the Trust maintaining its CQC registration and complying with the law	Only prepared to accept the possibility of **minor regulatory observations** if related to actions that are essential to the safe and effect patient care and outcomes	**Moderate regulatory observations and judgements** are reported within the periodic CQC inspection report	**Significant regulatory observations /judgements** are reported within periodic CQC inspections but any **impact on patient care and outcomes are likely to be limited**	**Significant regulatory observations / judgements** are reported within the periodic CQC inspection report or **other regulatory notification**

8.2

TRUST BOARD (in Public)
PLEDGE TO CODE OF CONDUCT, NOLAN PRINCIPLES AND HDFT KITE VALUES
26th July 2023

Title:	PLEDGE TO CODE OF CONDUCT, NOLAN PRINCIPLES AND HDFT KITE VALUES
Responsible Director:	Chair
Author:	Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	Governance principles are set out in the Nolan Principles: The Seven Principles of Public Life, which sets out the behaviours of senior leaders and Boards of Directors. This is supported by the Health and Social Care Act Regulation 2015 which sets out the requirements for NHS bodies to meet the Fit and Proper Person Test as well as supporting the principles of Duty of Candour which should ensure that the Trust is open, honest and transparent. All NHS Boards and Council of Governors are required to have a Code of Conduct that underpins the behaviours of members. The Trust Board are annually invited to endorse their support to the Code of Conduct for Directors at HDFT.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	X
	Great Start in Life	X
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	X
	Digital transformation to integrate care and improve patient, child and staff experience	X
	Healthcare innovation to improve quality	X
Corporate Risks	None	
Report History:	Annually	
Recommendation:	The Board are recommended to endorse the Board of Directors Code of Conduct and ensure all Director of HDFT sign the declaration.	

Freedom of Information	Available via FOI: Publicly Available.

TRUST BOARD (in Public)

PLEDGE TO CODE OF CONDUCT, NOLAN PRINCIPLES AND HDFT KITE VALUES
26th July 2023

1.0 INTRODUCTION

Governance principles are set out in the Nolan Principles: The Seven Principles of Public Life, which sets out the behaviours of senior leaders and Boards of Directors. This is supported by the Health and Social Care Act Regulation 2015 which sets out the requirements for NHS bodies to meet the Fit and Proper Person Test as well as supporting the principles of Duty of Candour which should ensure that the Trust is open, honest and transparent.

All NHS Boards and Council of Governors are required to have a Code of Conduct that underpins the behaviours of members.

The Trust Board are annually invited to endorse their support to the Code of Conduct for Directors at HDFT.

The Council of Governors are bi-annually invited to endorse their support to the Code of Conduct for Governors and the wider Council at HDFT.

2.0 BOARD OF DIRECTORS - CODE OF CONDUCT

The Board of Directors – Code of Conduct is detailed in full at Appendix 1.

3.0 RECOMMENDATIONS

The Board are recommended to endorse the Board of Directors Code of Conduct and ensure all Director of HDFT sign the declaration.

Kate Southgate, Associate Director of Quality and Corporate Affairs

20th July 2023

Harrogate and District NHS Foundation Trust
Board of Directors – Code of Conduct

1. Introduction

High standards of corporate and personal conduct are an essential component of public service enabling public confidence and assurance. The purpose of this Code of Conduct ('the Code') is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

As an NHS Foundation Trust, Harrogate and District NHS Foundation Trust (HDFT) complies with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The HDFT Board of Directors is a unitary Board, meaning that Directors have equal and shared accountability. This code also applies to non-voting Associate and Clinical Directors who attend Board of Director meetings.

The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors. It seeks to outline the appropriate conduct for Directors of Harrogate and District NHS Foundation Trust ('the Trust'). It addresses both the requirements of office and of personal behaviour.

This Code, with the Board Code of Conduct and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code is intended to operate in conjunction with the Trust's Constitution, Standing Orders and the Code of Governance for NHS Foundation Trusts. The Code applies at all times when Directors are carrying out the business of the Trust or representing the Trust.

2. Compliance, interpretation & concerns

All Directors are required to give an undertaking that they will comply with the provisions of this Code. Questions and concerns about the application of the Code should be raised with the Company Secretary. The Chair will be the final arbiter of interpretation of the Code.

3. Principles of public life

The principles underpinning this Code of Conduct are drawn from the 'Seven Principles of Public Life'[1.] as follows:

- ***Selflessness*:** Holders of public office should act solely in terms of the public interest.
- ***Integrity*:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- ***Objectivity*:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- ***Accountability*:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

- ***Openness*:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- ***Honesty*:** Holders of public office should be truthful.
- ***Leadership*:** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

4. The Trust's vision & values

The Trust's purpose is "the patient and child first", meaning improving the health and wellbeing of our patients, children and communities. To do this the Trust's ambitions are to provide:

- Best quality, safest care;
- Person-centred, integrated care; strong partnerships;
- A great start in Life.

The Trust's values lie at the heart of who we are, what we do, and the culture we want to establish, having a direct impact upon both colleagues and the public we service.

Our KITE values are:

- ***Kindness*** - We show compassion, and are understanding and appreciative of other people.
- ***Integrity*** - We display personal and professional integrity, are honest and bring a positive attitude.
- ***Teamwork*** - We are helpful to each other, listen intently and communicate clearly.
- ***Equality*** - We show respect, we are inclusive and we act fairly

5. General principles, directors' duties and liabilities

Foundation Trust Boards' of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board of Directors, and of each director individually, is to:

- Promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole and for the public.
- Work with the Trust's Council of Governors in an open and transparent way and observe and embed of a duty of candour throughout the organisation.
- Set an example in the conduct of its business and to promote the highest corporate standards of conduct.
- Ensure that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying scheme of delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this code will inform and govern the decisions and conduct of all Directors.

6. Confidentiality and access to information

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances, and advisably, only in consultation with the Company Secretary.

Information on decisions made by the Board of Directors and information supporting those decisions should be made easily available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Board of Directors has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors.

Nothing said in this code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998.

Nothing said in this Code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The Company Secretary or the Freedom to Speak Up Guardian should be consulted for guidance.

7. Fit and proper person

It is a condition of the Trust's licence that each Director serving on the Board of Directors is a 'fit and proper person'. A person may not continue as a member of the Board of Directors if they are:

(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,
(b) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,
(c) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her,
(d) subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person, or if it comes to light that a Director is not a fit and proper person, they are suspended from being a Director with immediate effect pending confirmation and any appeal. Where it is confirmed that a Director is no longer a fit and proper person, their membership of the Board of Directors is terminated in accordance with the Constitution.

8. Register of interests

Directors are required to register all relevant interests in the Trust's register of interests in accordance with the provisions of the Constitution and the Trust's Conflicts of Interest Policy. It is the responsibility of each Director to provide an update to their register entry (within 7 days) if their interests change. A pro forma is available from the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

9. Conflicts of interest

Directors are required to comply with the Trust's Conflicts of Interest Policy. In particular, Directors must avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Directors must not accept a benefit from a third party by reason of being a Director for doing (or not doing) anything in that capacity. Directors must not offer a benefit to a third party by reason of being a Director for doing (or not doing) anything in that capacity.

Directors are required to declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair to advise whether it is necessary for the Director to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this Code.

10. Gifts & hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust budget for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

The Board of Directors has adopted a policy on gifts and hospitality (The Conflicts of Interest Policy) which will be followed at all times by Directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

11. Whistle-blowing / Speaking Up

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature and positively establishes a culture for sharing concerns. The Board of Directors has adopted a Speaking Up (whistle-blowing) policy on raising matters of concern which will be followed at all times by Directors and all staff.

12. The Bribery Act 2010

The Board of Directors will ensure that it acts at all times in compliance with the Bribery Act 2010, acknowledging that it is a criminal offence to give, promise, or offer a bribe and to request, agree or receive a bribe.

13. Meetings

Directors have a responsibility to attend meetings of the Board of Directors and of any committees or working groups to which they are appointed. When this is not possible, apologies should be submitted to the Company Secretary in advance of the meeting. Persistent absence from Board of Directors' meetings without good reason is likely to constitute a breach of this Code.

14. Personal conduct

Directors are expected to adopt and promote the values of the Trust and the NHS. Moreover, Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, irecors must:

- Treat each other, Directors and Trust staff with respect; not breach the equality rights and not bully any person.
- Not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the Trust's rules on the use of its resources.
- Uphold the seven principles of public life (see above).
- Be honest and act with integrity and probity at all times;
- Respect and treat with dignity and fairness, the public, service users, relatives, carers, NHS staff and partners in other agencies.
- Seek to ensure that fellow Directors are valued as colleagues and that judgements about colleagues are consistent, fair and unbiased and are properly founded;
- Accept responsibility for their actions.
- Show their commitment to working as a team member by working with colleagues in the NHS and wider community.
- Seek to ensure that the membership of the constituency they represent is properly informed and able to influence services.
- Seek to ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.
- Comply with the Standing Orders and Standing Financial Instructions of Harrogate and District NHS Foundation Trust.
- Respect the confidentiality of individual patients and comply with the confidentiality policies of the Trust.
- Not make, permit, or knowingly allow to be made, any untrue or misleading statement relating to their duties or the functions of the Trust.
- Seek to ensure that the best interests of the membership, general public, service users, stakeholders and staff are upheld in decision making and the decisions are not improperly influenced by gifts or inducements.
- Acknowledge that Harrogate and District NHS Foundation Trust is an apolitical organisation.
- Support and assist the Accountable Officer of the Trust in their responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully faithfully declaring and explaining the use of resources and the performance of the total NHS in putting national policy into practice and delivering targets.
- Must have regard to advice provided by the Chair, Chief Executive and Company Secretary pursuant to their duties.

It is essential that the conduct and behaviour of Directors at all times support the ethos and values of the Trust. Should there be any concern about the activities of a Director the nature of which might undermine public confidence then the Chair's decision on that person's role will be final.

15. Training & development

The Trust is committed to providing appropriate training and development opportunities for Directors to enable them to carry out their role effectively. Directors are expected to undertake to participate in training and development opportunities that have been

identified as appropriate for them. To that end, Directors will participate in the appraisal process and any skills audit carried out by the Trust.

16. Visits to Harrogate and District NHS Foundation Trust Premises or other services provided by the Trust

Where Directors wish to visit the premises or services of Harrogate and District NHS Foundation Trust in a formal capacity, as opposed to individuals in a personal capacity, the Director should make arrangements in advance.

17. Review and revision of the Code

This Code has been agreed by the Board of Directors on *26 July 2023.* The Company Secretary will lead an annual review of the Code. It is for the Board of Directors to agree to any amendments or revisions to the Code.

18. Declaration

I hereby confirm that I will adopt and comply with this Code of Conduct for the Board of Directors.

Signed: Name:

…… ……

Date: ……..…

1. https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--