CQC SAFE DOMAIN

Safety is a priority for everyone. People should always be safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

- **Learning culture -** We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
- **Safe systems, pathways and transitions -** We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding -** We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
- **Involving people to manage risks -** We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
- **Safe environments -** We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
- **Safe and effective staffing -** We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development and work together effectively to provide safe care that meets people's individual needs.
- **Infection prevention and control -** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
- **Medicines optimisation -** We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	**Risk Appetite**	TBC at Trust Board July 23
Executive Committee	Quality Management Group (QGMG)	**Summary:** **The safe domain has the most risks escalated to the corporate register. 6 of the 7 risks are related to health and safety. This area remains a high priority for the trust and it is noted the KRI for CHS1, and CHS8 WILL be met over a longer term due to financial restraints and workforce development. CRR5 is also a key area of priority and has impacts on risks associated with resource use. CRR5 remains a 12 due to ongoing agency spend during recruitment of permanent staff.**				
Initial Date of Assessment	1st July 2022					
Last Reviewed	August 2023	**CRR79 is expected to reduce once assurance is in place for mitigations.**				

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**July Rating**	**August Rating**	**Target Rating**	**Target Date**
CRR5: Nursing Shortages	Best Quality, Safest Care	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage. The plans and actions are well defined. With the increase in student nurse placement and the Harrogate student Pathway in place the in addition to the current position improving the panel agreed to monitor the score for possible reduction. The actions and plans will continue and will be monitored.	12	12	12	8	TBC

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
1.Vacancy Rate improvement 2.Turnover stability 3.Increased recruitment and retention	Support worker vacancies have further decreased in July by 5.92wte. Staff in post has increased by 9.33wte this month, however this has been offset due to an increase in budgeted establishment of 3.41wte. Registered Nurse vacancies have decreased further in July by 5.75wte. This is due to an increase in staff in post as the budgeted establishment has remained static this month compared to May. Support worker vacancies have further decreased in June by 5.30wte and this is solely due to an increase in staff in post. Realignment of templates following SNCT have led to the ratios of HCSW on the wards changing in some areas, resulting in in an overall decrease of HCSW's . Increased Student nurse placements and 3rd year students have increase. Targeted recruitment events in place twice yearly. Legacy mentorship for all nurses available to improve recruitment and retention. Roster KPI meetings now embedded locally and now used as part of the resource meetings.	1.HCSW position to improve with international recruitment programme 2. Business case approved for 10 RNA to RN posts to commence programme in June '23 and 8 HCSW to RN apprenticeship programme to commence in January '24 3. Successful recruitment for 2 x 0.5 wte Legacy Mentors to support retention work. Commenced May '23 4. Roster KPI's now part of the resource review process – commenced 5/23 5. Increase in Student Nurse placements leading to recruitment (Harrogate Pathway students). Student Nurse recruitment Event on 5/6/23 Excellent turnout – job offers to be confirmed (approx. 10) Further event in October '23 6. Realignment of establishments and budgets following SNCT. Next review planned October '23 6. Realignment of establishments and budgets following SNCT. Next review planned October '23 7. Safe Care Implementation – early adopter wards due to go live early September '23

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR75: CHS1 Health and Safety	**An Environment that promotes wellbeing**	**CHS1 -** Identification and Management of risk Organisational risk to compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others.	16	12	12	8	Sept 23

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Sufficient compliance of contractors Environmental Audits Replacement of the existing SALUS risk management system, to ensure all have access to the relevant risk assessments.	The suitability of SALUS H&S folders results in the assessments not meeting legislative requirements and do not reflect current practices or relevant guidance. A new system (EVOTIX) is to be introduced. A draft Implementation pack and project timeline have been produced. All hazards not being identified and subsequently assessed, and therefore the Trust / HIF is failing to ensure suitable measure are being taken to protect the health and safety of its employees, patients and others who come in to contact with our activities New Risk Assessment templates created by H&S Team, now being used to create appropriate risk control and generate new content to be utilised on new system Current Position remains as at July with work ongoing on the creation of new RA's across HDFT	Temporary control measure are being introduced for current risk assessments. Business case being developed for the purchase of EVOTIX (approx. cost is 23k annually) and awaiting confirmation of cost based on 250 users – 250 users will be £28,957.75 (first year), initial 5 year term

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR75: CHS2 Health and Safety	**An Environment that promotes wellbeing**	**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, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	16	12	12	8	Dec 23

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Board level lead for Health and Safety Annual Audit programme for Health and Safety Health & Safety Committee	Risk assessment completed for the goods yard. Temporary measures have been implemented: Security guard (Mon-Fri 8am – 6pm) Temporary heras fenced walkway to access Pharmacy lift and stairwell. Instruction to all Trust staff made via email and Team talk. Use of his-vis clothing for those that need to routinely access the yard as part of their duties. Instruction to contractors that the yard area is not to be used as a car park, delivery drop off / collection only. Loading bay entrance remains unsecure 24/7 as doors do not close. Particular security issue on an evening / during the night when staff presence is limited and access remains open to patients and others. New pedestrian crossing markings provided July 2023 at entrance to goods yard / car park • Recent incident involving T3 security guard and member of HDFT staff, has led to urgent review of provision within the Goods Yard. • New communications to be shared with all HDFT staff re; use of the goods yard	Capital investment will be required to implement all control measures identified within the risk assessment. With plans to include this in backlog maintenance work. Discussions with Medical Gases Group / Pharmacy over non-conformity of physical barriers and controls in place for protection of the liquid oxygen store. Additional work will need to be included in costs for Goods Yard improvements

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR75: CHS3 Health and Safety	**An Environment that promotes wellbeing**	**CHS3**: Managing the risk of injury from fire Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	20	15	15	10	Dec 23

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Updated Fire Safety Policy and associated management protocols Completion of fire assessments Appointment of competent Fire Manager and Authorising Engineer Completion of assessments Implementation of fire procedures and policies	Fire risk assessments are not currently available for all areas of HDH Fire safety measures have been identified and are in the process of being implemented fully, of these fire compartmentation and fire door safety measures are inadequate. There is no clear picture of the Fire safety standards in properties leased by the Trust As part of Backlog Maintenance report – HDH site Fire Alarm system has been identified as being in need of urgent investment, Protec have provided a quotation in excess of £1.6m to replace the existing fire system Review of all compartmentation and fire doors at HDH. With an action plan in place to carry out identified remedial work. New Fire Policy and Fire Management Procedures in place. SLA with Leeds Teaching Hospitals NHS Trust (LTHT) is fully implemented. Mark Cox attending site weekly to carry out a range of activities (including review of all fire risk assessments, review of fire strategy in relation to current construction work, delivery of ad hoc training)	Review of all current fire safety provisions Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. Production of evacuation plans and training on evacuation. Mott MacDonald have produced a Fire and Life Safety Strategy Report – this details a number of urgent issues which require remedial action. To seperate fire risk in to individual risk entries – General Fire (RA's/Evac Plans/Training), Fire Alarm System, Fire strategy for HD site, including compartmentation/fire doors/remedial work to fire dampers. These will be added to the H&S Risk Register and escalated where appropriate. Work on this will be reported via the Fire Safety Group/H&S Committee/Environment Board. Costs for the remedial work for compartmentation, fire doors and fire dampers are being obtained Additional meeting to be held w/c 21st August to review and discuss current Fire support to community sites/teams

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR75: CHS8 Health and Safety	**An Environment that promotes wellbeing**	**CHS8**: 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.	16	12	12	8	Dec 23

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Structural inspection / surveying Health & Safety Committee surveying and ultimately to record plank condition Results from Regular progress reports to board and sub committees of the current position on RAAC Plans and the Risks	The HDH sit has been surveyed by WSP and an identification and deflection survey is on going. Some temporary safety measures have been implemented to support the roof. Areas of immediate action have been identified and at risk areas have also been identified. (ALL initial RAAC emergency work is complete) Funding of £490k secured from NHSE for 22/23, which will cover costs already incurred, surveying and remedial work being carried out. Additional bid made for 23/24 Responses from community landlords are being received (reminder email sent by Director of Strategy)- Data Collection Questionnaire for NHSE has been completed and sent The trust is expecting to hear about the funding arrangements imminently	To undertake and annual survey of every plank; or more frequently as advised by your structural engineer Be part of a communications approach led by NHS England, cognisant of: SCOSS Guidance; Duty of Candour; and duties under the Health and Safety at Work etc. Act 1974 Strategic plan in place to identify remedial action needed, with long term plan to eliminate RAAC from site by 2035. Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead – initial discussions with EPRR manager held Business Case being developed to implement RAAC eradication plan, including additional funding from NHSE – intention is to incorporate backlog maintenance work where possible

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR78	Best Quality, Safest Care	Failure of Nurse call bell system Nurse call systems are obsolete in most areas (33+ years old) and without a comprehensive maintenance contract in place. It will be "best endeavour's" to resolve any ongoing issues. Funding and replacement required site wide. NB. This is not an emergency call system	20	16	12	4	TBC

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Nurse call systems to be replaced in all areas	• A specialist maintenance provider has been procured, however, attendance is not 24h • Maintenance is on a best endeavours basis only given the availability of replacement equipment and that 99% of systems are in excess of 30 years old • Funding required which has not been included in 23/24. • Refurbished areas will be provided with a new Ascom system	1. The Trust is aware that significant capital funding is required 2. Capital investment to be established to allow a move to Ascom for all our clinical areas. This is estimated at £1.4m 3. Staff have been advised to use manual bells where systems fail as part of local contingency planning 4. Estates will endeavour to repair any failures within 48 hours

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR79	Best Quality, Safest Care	Hot Water circulation temperatures are below the minimum required in HTM 04 "Safe Water in Healthcare Premises"	20	15	15	5	April 24

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Temperatures are compliant with HTMs	• The Authorising Engineer has advised a twice weekly flush • Some areas are currently on a daily flush (Strayside) • The current position has been presented to IPCC and the WSVG • Woodlands is flushed 3 times daily The trust has implemented the recommendations from the authorising engineer of twice daily flushes and, the group is seeking assurance the steps are implemented and mitigations in place which will allow the score to be reduced.	1. The trust has been made aware that significant capital funding is required to resolve legacy infrastructure issues 2. Costs have been requested from Mott Macdonald and JCP to carry out a design check and design validation of the site domestic services infrastructure (Hot and Cold water services) 3. 100k has been allocated for design and feasibility works in 23/24 4. On receipt of the report from Mott Macdonald, further funding would be required to firm up the designs and replace legacy infrastructure issues

CQC CARING DOMAIN

People are always treated with kindness, empathy, and compassion. They are supported to live as independently as possible. Their privacy and dignity are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them.

- **Kindness, compassion and dignity -** We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
- **Treating people as individuals -** We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
- **Independence, choice and control -** We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
- **Responding to people's immediate needs -** We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
- **Workforce wellbeing and enablement -** We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Lead Committee	Quality Committee (Clinical Risk) People and Culture (Workforce Risk)	**Risk Type**	**Clinical**	**Workforce**		**Risk Appetite**	TBC at Trust Board July 23
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Caring Domain. Currently there is 1 Corporate Risk within this Domain. The impact of COVID and Operational Pressures on workforce wellbeing (previously wellbeing of staff) (CRR6) remains a High Level risk at 16, however data shows positive trajectory.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	July 2023						

Corporate Risk ID	**Strategic Ambition**	Principle Risk:	**Initial Rating**	**July Rating**	**August Rating**	**Target Rating**	**Target Date**
CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	**At Our Best – Making HDFT the Best Place to Work**	The impact of Covid and Operational Pressures on Workforce Wellbeing Risk to patient care and safety due to potential impact of staffing levels, including the impact of current/future strike action 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 The conditions that need to be in place • The right numbers of competent and qualified colleagues present and fit to work in the workplace. • Colleagues having the right environment/equipment/tools to enable them to fulfil their roles effectively. • Colleagues feeling valued and appreciated for the work they are doing.	12	16	16	12	July 2024

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
Staff Engagement – Survey Scores (Benchmark Group Acute & Community Trusts)	Staff Engagement – The scores for staff engagement over kindness, teamwork, integrity and kindness are higher than the benchmark for a second continuous month	Staff Engagement - All Directorates instructed to achieve 90% Appraisal compliance – completed appraisal numbers have increased significantly.
Turnover	Turnover - Target 12% Turnover Rate has had a further small decrease from from 14.73% to 14.69% as at 30 June 2023. The Trust has seen a general decreasing trend since October	Turnover - Work underway to develop career pathways, utilising the apprenticeship levy as a major lever for affecting improvements.
Sickness	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%.	Equality & Diversity and Inclusion work plan in place to reduce workplace inequalities and increase inclusion. Financial support on travel and lunch
Appraisals	Appraisals - Target 90% Appraisal Rates have seen a small decrease in June to 83.10% from 83.72% in May. Appraisal format to be reviewed to as part HDFT Impact programme	Sickness – Stress audit underway, fair and just culture project, health ad wellbeing activity
Vacancy rate	Vacancy rate - has decreased from 8.03% in May to 7.88% in June and equates to 354.38wte vacancies. The reason for the decrease in vacancies is solely due to an increase in the staff in post WTE.	Appraisals - Each Directorate working to achieve 90% compliance with staff appraisals Vacancy rate-Workforce planning, international recruitment, agile working policies, increase in apprenticeships

	CQC RESPONSIVE DOMAIN
	People and communities are at the centre of how care is planned and delivered at all times. Their health and care needs are understood and they are actively involved in planning care that meets these needs. Care, support, and treatment are easily accessible, including physical access. People can access care in ways that meet their circumstances and protected equality characteristics • **Person-centred care -** We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs. • **Care provision, integration, and continuity -** We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity. • **Providing information -** We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs. • **Listening to and involving people -** We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result. • **Equity in access -** We make sure that everyone can access the care, support and treatment they need when they need it. • **Equity in experiences and outcomes -** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this. • **Planning for the future -** We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Lead Committee	Resource Committee	**Risk Type**	**Clinical**	**Operational**	**Risk Appetite**	TBC at Trust Board July 23
Executive Committee	Operational Management Group (OMG)		**Summary in Month:** This area of the Corporate Risk Register is linked to the Responsive Domain. Currently there are 3 Corporate Risks within this Domain. Autism Assessment (CRR34) remains a High Level risk, this has reduced to 12 in August. RTT (CRR41) remains a High Level risk at 12 due to performance against the national standards. However, a wide range of mitigation in place and zero 104 and 78 week waits are noted. Finally ED 4 is at a 12 with data showing continuous improvement. A wide range of mitigation is in place including a pilot of new streaming pathways.			
Initial Date of Assessment	1st July 2022					
Last Reviewed	August 23					

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**July Rating**	**August Rating**	**Target Rating**	**Target Date**
CRR34: Autism Assessment	**Great Start in Life**	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. Need to reduce the backlog of referrals back to the NICE standard of 3 months (reduce the waiting list to approximately 120)	12	16	12	8	March 26

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate. Numbers on the waiting list Longest wait of CYP having commenced assessment Longest projected wait of CYP joining the waiting list	We have modelled the impact of the funded WLI's for 2023/24 and it will only slow the growth of the waiting list. The best case scenario for referral numbers into the service would see the waiting list continue to grow to 1253 by March 24. The projected wait for assessment by March 24 would be 31 months A regional meeting on 23rd June, chaired by HealthWatch, identified that our new process/pathway aligns with the new national guidance for commissioning of autism assessment services and all were happy for this to progress. Commissioners reiterated no additional funding was available for services in this financial year. There was agreement at this meeting that: 1) A task and finish group would be set up with consideration given to governance model for a North Yorkshire & York PLACE based approach (clinical network or HARA type model?). ICB to confirm how this will be project managed. 2) HDFT model will be reviewed once up and running with a view to rolling this model out across PLACE 3) To take a PLACE approach to risk assessing the waiting list and clinical prioritisation – TEWV to share their tool that is in place for Durham & Darlington service. •Numbers on the waiting list: 1178 (target 120) •Longest wait: 66 weeks (target 13) •Activity - 31 completed assessments in June against plan of 40, YTD 149 against plan of 160.	The projected waiting list and the lack of resources provided to the trust, with limited future planning is known and documented. The meeting with ICB commissioning experts will discuss and highlight next possible steps, the trust will also now need to consider the future of the service and sustainability of delivery. Progress with PLACE based work. Mobilisation of WLI and new pathways In order to stabilise the waiting list we would need to increase the service capacity to approx 90 assessments per month with the additional staffing costing £490k full year effect. The modelling has been shared at the CC Resources Review Meeting and has been escalated to the place ICB meeting with Execs as it was felt HDFT could no longer carry all the risk of these waits and there is currently no agreed plan to provide the resources required to address this longer term.

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR41: RTT	**Person Centred, Integrated Care, Strong Partnerships**	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)	12	12	12	6	March 24

Key Targets

RTT to meet constitutional standards, Reduction in waiting list size

92% 18 week incomplete performance standard
52+ Waits

78+ Waits (zero by March 23)

104+ Waits (zero by July 22)

Current Position

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Total incomplete RTT pathways	24,714	25,384	25,134	25,629	25,564	25,490	25,437	25,388	24,951
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350	1,285	1,201	1,228
> 65 weeks	499	461	463	471	500	519	477	401	477
> 78 weeks	205	184	169	155	144	133	112	100	118
> 104 weeks	11	3	1	0	0	0	0	0	0

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	*Jul-23 (Provisional)*	*Aug-23 (Provisional)*
Total incomplete RTT pathways	24,854	25,139	25,504	25,951	25,876	25,860	*25,832*	*26,760*
> 52 weeks	1,186	1,112	997	998	1,001	1,020	*1,062*	*1,139*
> 65 weeks	399	362	193	202	197	210	*218*	*250*
> 78 weeks	101	65	4	5	0	0	*1 (choice)*	*2 (1 choice, 1 complex)*
> 104 weeks	0	0	0	0	0	0	*0*	*0*

some impact April to August 2023 from industrial action causing cancellation of outpatients, theatres and endoscopy lists
*Zero reported >78 weeks as all breaches on choice pathway

Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels.

104+ week waiters
The target has been met, HDFT currently have no 104 week patient waits

78 week waiters (clearance target March 2023)
Zero position achieved by end of March 23 (excluding patient who have opted to remain on waiting list)

201 patients on waiting list between 65-77 weeks (T&O, Community Dental, Maxillofacial and Gynaecology account for 75%)

65 week waiters (clearance March 2024) Trajectory for specialties combined ahead of required. Gynae and H&N are specialties of concern and require further focus to ensure delivery.

Plans to Improve Control and Risks to Delivery

The following actions are underway/ completed to improve accuracy of waiting list, which will further reduce the numbers allowing closer scrutiny of genuine waiting patients.

• LUNA - supported validation tool has gone live although some further work is ongoing to enable the AI element.

Additional Theatre list at weekend- Clinicians continue to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery, Ophthalmology and Urology

• Pilot of text validation exercise has taken place with approximately a 1-3% closure of pathways similar to that seen elsewhere.

• The RTT team has been supported by x2 RTT agency validators, who have been in post since w/c 2nd January. They have reviewed just over 1,800 pathways with a removal rate of 13.9% so far. 2 substantive posts start in the next month.

• The RTT team continue to review all appointments without an RTT outcome and review our data quality reports, prior to their submission deadline of the 17th of each month to ensure the monthly RTT submission is as accurate as possible.

• Weekly elective recovery meetings are ongoing, with directorates implementing an equivalent at service level.

• 6:4:2 – booking levels and utilisation improving (continuing to be confounded by covid absence to some degree)

• RTT outcoming has now been ordered with implementation across Q1/2 of 2023- this project has no commenced

Harrogate and District NHS Foundation Trust Corporate Risk Register August 2023

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR61: ED 4-hour Standard	**Best Quality, Safest Care**	Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard	12	12	12	8	Nov 23

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches **4 hour performance** The national target for the 4 hour standard has been reduced from 95% to 76% until March 2024. HDFT hope to exceed this target and our local target for the 4 hour standard is 81%.	The national ED 4 hour performance target has been met for April and May 4 hour performance The national target for the 4 hour standard has been reduced from 95% to 76% until March 2024. HDFT hope to exceed this target and our local target for the 4 hour standard is 81%. 12 Hour DTA and 12 hour total waits have seen a gradual reduction since Dec 22 from 165 to 5 and 431 to 30. • May 2023 was a good month in terms of performance on all three of our key metrics. There was a significant reduction in handover delays and patients in the department for over 12 hours, however there is still work to do to eliminate these long waits completely. • The three bank holidays in May led to variation in performance and times of increased pressure, particularly when combined with other operational challenges including CT scanner downtime and breakdowns in the hospital lifts. • The ED Minors stream is currently operating within Fit2sit due to ongoing closures and disruption associated with the building works.	Support streaming with outreach work to improve streaming pathways to HDFT specialties, however getting buy in from other departments has been a challenge • Capital works ongoing to reconfigure ED to support new ways of working that will improve performance (ambulance RIAT bay) • The plans for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance The revised risk reduction target date reflects the timescale of implementing the new streaming model; the completion of phases 1 – 3 of the ED works (new workstation will open in March 2023, however disruption from building work expected until October 2023); and the impact of hospital occupancy and patient flow.

USE OF RESOURCES

Use of resources area Key lines of enquiry (KLOEs)

- **Clinical services -** How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
- **People**- How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
- **Clinical support services** - How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
- **Corporate services, procurement, estates and facilities** - How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
- **Finance** - How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

Lead Committee	Resource Committee	**Risk Type**	Financial	Workforce	Operational	**Risk Appetite**	TBC at Trust Board July 23
Executive Committee	Operational Management Committee (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Use of Resources Domain. Currently there are 3 Corporate Risks that are link to this domain. Agency Usage (CRR71) remains a High Level risk at 15, however it is noted that this risk is being used to off set CRR5 Nursing Shortages and CRR6 Staff Wellbeing. Underlying Financial risk (CRR76) is a High Level risk scoring 15. CRR86 has been amalgamated with CRR76 and has therefore been removed from the CRR.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	August 23						

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	June Rating	July Rating	Target Rating	Target Date
CRR 71: Agency Usage	**Overarching**	Agency Usage -The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this results in an adverse impact to quality and safety	15	15	15	9	March 24

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Monthly agency ceiling performance – expectation that agency spend will be below 3.7% of pay bill - £740k per month	The Trust is currently spending in excess of the agency ceiling – Month 3 £839k (4.2%). The Trust is currently spending in excess of the 2019/20 prorata agency spend – YTD £2,099k against 2019/20 £1.2m The Trust is now reporting performance to NHSE on a monthly basis.	1.Review at directorate resource review sessions 2.Substantive recruitment as per other risks

2. Performance against 2019/20 Agency expenditure (£4.9m FY). The Trust should target reducing to this level plus inflation. 3. Monthly price cap compliance	No datix reported as a result of agency staff not meeting substantive staff obligations.	3.Nursing oversight to be embedded 4.Medical e-rostering to be implemented during 2023/24 5.Target levels of agency compliance based on monthly return to be developed

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR 76: Underlying Financial Position	**Overarching**	There is a risk that the majority of clinical and corporate IT systems hosted by the Trust are unavailable due to overheating of the IT systems, severely impacting the Trusts ability to operate as normal across the Acute and Community.	20	15	15	5	March 24

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Monthly agency ceiling performance – expectation that agency spend will be below 3.7% of pay bill - £740k per month 2. Performance against 2019/20 Agency expenditure (£4.9m FY). The Trust should target reducing to this level plus inflation. 3. Monthly price cap compliance	The above assumes a funded pay award for all staff and a recurrent delivery of CIP – both are risks within directorate risk registers. It is also expected that ERF funding is achieved, again a risk to the Trust. The above pressures have been mitigated as part of the 2023/24 planning round, and the Trust is therefore receiving funding in the short/medium term for this. In year performance in 2023/24 is currently not at the levels anticipated, and therefore the risk scoring below remains at 15. Pressures in year related to – • Performance against the efficiency requirement for the Trust • Use of temporary, premium rate staffing • Inflation above the levels outlined above and within planning • Strike costs • Drug expenditure, again above the levels described above. • **NHSE productivity analysis outlines the Trust being below the median against 2019/20 productivity levels, as measured by NHSE. Month 12 2022/23 is 12.6% against ICB at 8.6% and region at 11.3%.**	1.Review at directorate resource review sessions 2.Substantive recruitment as per other risks 3.Nursing oversight to be embedded 4.Medical e-rostering to be implemented during 2023/24 5.Target levels of agency compliance based on monthly return to be developed

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR 85: Cooling of IT infrastructure	**Digital Transformation**	There is a risk that the majority of clinical and corporate IT systems hosted by the Trust are unavailable due to overheating of the IT systems, severely impacting the Trusts ability to operate as normal across the Acute and Community.	20	15	12	TBC	March 24

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Automated monitoring and alerting of the two server rooms temperature in case of air conditioning failure or temperatures rising above an acceptable level due to high external temperatures. 2. The legacy air conditioning units in both server rooms require replacing with new higher capacity units with a modern design intended for the demands of modern high capacity IT equipment.	The existing legacy air conditioning units in both server rooms cannot cope with the high summer temperatures and additional cooling demands as the levels of equipment have increased over the last few years. Earlier this year the existing AC unit in one server room experienced a failure causing critical overheating and impacting clinical systems availability. Portable units were deployed along with reducing the load in the affected server room to maintain operations but it took several weeks to repair the unit. We are also experiencing other issues reducing the reliability of the existing units. With the AC unit repaired and additional portable units available on standby, all IT systems are now operating from both server rooms as normal. A hold on additional IT equipment being implemented is in place so as not to increase the cooling requirements but this is having an impact on some project deliveries. The additional contingencies and also the unseasonably bad August weather had a positive impact on the server room temperatures.	**1**. The Business case was completed and approved by IT, the proposal for the new Server Room AC units and associated building works has been received from the consultants. **2**. The CP forms for capital approval and subsequent procurement activities have started on 4th July by the HIF and Trust procurement staff. Lead times on equipment are up to 16 weeks depending on stock availability. **3**. Additional power sockets have been implemented in each server room and higher-powered portable AC units are now available on a contract from a specialist supplier if needed.

CQC EFFECTIVE DOMAIN

People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Everyone is supported to see what works well and not so well based on indicators of quality. Continuous improvement is always guided by this insight

- **Assessing needs -** We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
- **Delivering evidence-based care and treatment -** We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
- **How staff, teams and services work together -** We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
- **Supporting people to live healthier lives -** We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
- **Monitoring and improving outcomes -** We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
- **Consent to care and treatment -** We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	Operational	**Risk Appetite**	TBC at Trust Board July 23
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Effective Domain. CRR87 has been raised to corporate level in August					
Initial Date of Assessment	1st July 2022						
Last Reviewed	August 23						

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR87	Best quality, Safest Care	Risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025. Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection which may impact on quality of life and treatment required.	**12**	**12**	**12**	6	**August 25**

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
•Numbers on the waiting list over 52weeks, 65weeks and 78weeks. **Current position – 2 patients over 78 weeks, 103 patients between 65-77 weeks, 339 patients between 52-64 weeks.** •No of overdue continuing care patients. **Current position – 2,722 patients overdue. Longest waiters 4 years overdue (due in 2019).**	Additional factors making performance against the 78wk target difficult are the continued impact of both industrial action on short-notice cancellations of GA theatre lists, York Hospital anaesthetic and theatre staffing issues leading to a higher cancellation rate. Staff morale is low due to the continued uncertainty around the contract and the feeling that we are not providing the service we would like to our vulnerable patient cohort. A business case identifying the additional resource required to deliver the 65 weeks target was developed and shared with our commissioners it is noted with commissioners the difficulty agree the direct award 18month extension of the contract because the funding envelope will not support the staffing required to deliver the 65wk national RTT target. The directorate has noted the options : 1) To continue with the current default which is not to agree the extension and cease being the provider of CDS in North Yorkshire local authority area and York (will also impact on WYAAT as we have clinics in Skipton & Settle). 2) To offer a transitional plan to commissioners with an interim option of continuing elements of the existing contract e.g. of GA and sedation services – this will take a lot of management time to model/work through but we have one of the best provider access to theatres across the regional providers (three ICBs which link into the managed clinical network). 3) To continue the entire scope of the service specification with the performance impact that this will have around the 65wk target.	Discussion at Trust Board of the three options and agreed next steps / approach. Notification from Service to ICB commissioners that we will not be able to sign the contract while we have this discussion at Trust Board. Follow up with ICB at Exec to Exec level to explain the current risk and to follow up previous place level agreement to meet to discuss a joint solution to the issue.

CQC WELL-LED DOMAIN

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities. There are effective governance and management systems in place. Leaders proactively support staff and collaborate with partners to deliver care. This care is safe, integrated, person-centred and sustainable care and helps reduce inequalities.

- **Shared direction and culture:** We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
- **Capable, compassionate and inclusive leaders:** We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
- **Freedom to speak up:** We foster a positive culture where people feel that they can speak up and that their voice will be heard.
- **Governance, management and sustainability:** We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
- **Partnerships and communities :**We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
- **Learning, improvement and innovation:** We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
- **Environmental sustainability – sustainable development:** We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.
- **Workforce equality, diversity and inclusion:** We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us."

Lead Committee	Trust Board	**Risk Type**	**Clinical**	**Workforce**	**Operational**	**Risk Type**	TBC at Trust Board July 23
Executive Committee	Senior Management Committee (SMT)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there is no Corporate Risk within this Domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	June 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**	**Target Date**

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**

Integrated Board Report - August 2023

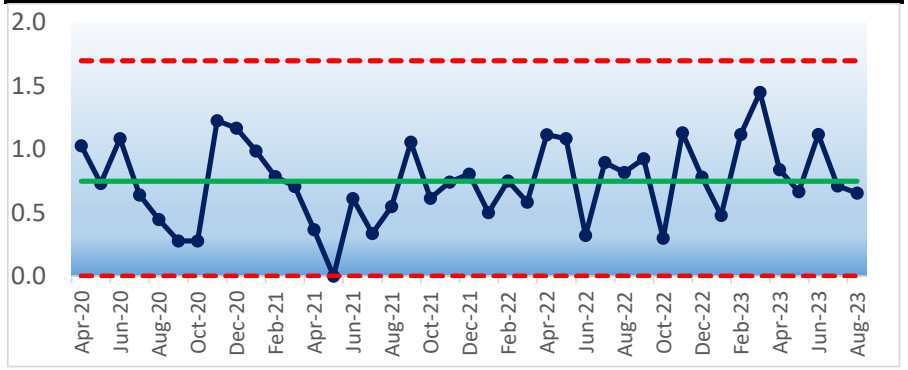
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	0.65

Indicator description

The number of hospital acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 bed days.

SPC chart



Narrative

There were 29 hospital acquired pressure ulcers (all categories) reported in August 2023, a slight increase from July 2023 (25). 6 pressure ulcers were verified as category 3 or above. Pressure ulcers assessed by TVN or podiatry as causing moderate harm or above will be investigated through the PULT process to identify any omissions in care. Device related pressure ulcers continue to be a focus for education for the TVN and fundamentals of care team, in particular increasing awareness of medical devices and the increased risk for pressure damage.

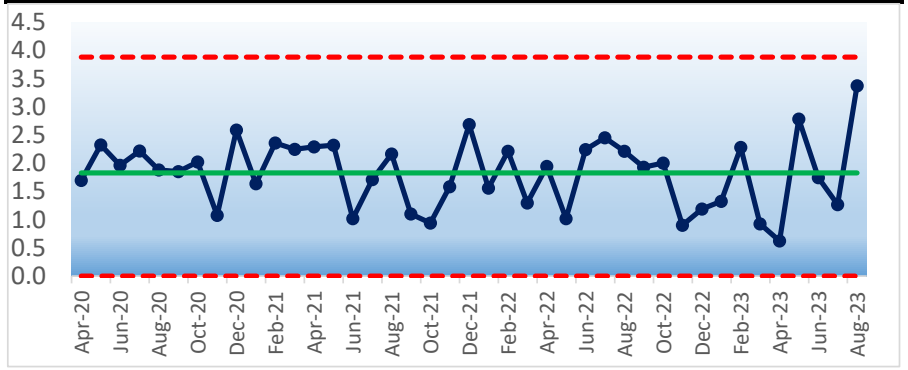
An audit of all reported hospital acquired category 2 pressure ulcers and moisture associated skin damage was undertaken in August. The final audit results will be shared following analysis. Preventing Pressure Ulcer training is delivered twice per month, face to face, for all clinical HDFT colleagues. Ad hoc training and education continues as clinical capacity allows.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	3.38

Indicator description

The number of community acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 community patient contacts.

SPC chart



Narrative

There were 44 pressure ulcers (all categories) which developed or deteriorated in HDFT community care in August 2023 (up from 33 in July). Of these, 21 were verified as category 3 or above. Pressure ulcers assessed by TVN or podiatry as causing moderate harm or above will be investigated through the PULT process to identify any omissions in care.

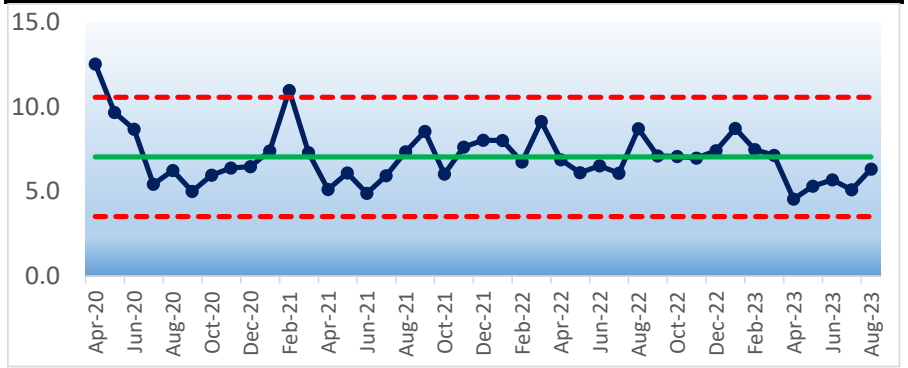
Capacity and skill mix continues to be a challenge across the CCTs, a rolling 4-week programme of education has commenced to support junior colleagues increase knowledge of wound healing and management. Feedback to date has been extremely positive.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	6.3

Indicator description

The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm.

SPC chart



Narrative

There has been an increase in the number of falls between July and August, this has gone from 45 to 68. However 80% of the Falls were no harm - there were 31 with no harm in July and 54 in August. Therefore, we can see that the number of falls causing harm has significantly decreased. It appears that most of these Falls were with people with capacity, choosing to stand and mobilise without support from staff and against advice, therefore the FoC team are trialling a 'Call, Don't Fall' campaign, to remind patients of the necessity of calling for assistance from staff before mobilising, if this is the recommendation for the patient.

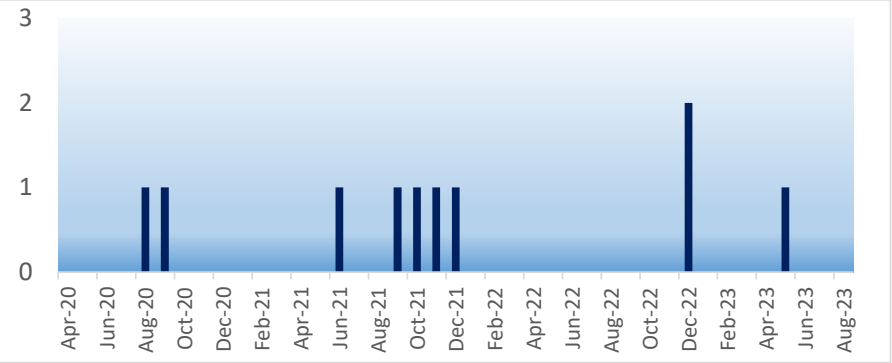
Notably, there was also reduced capacity in the FoC team of the month of August due to annual leave. Therefore this could also have been a contributing factor to the rise in Falls numbers. Training remains ongoing for each ward and the various staffing groups and there is a continued increase in compliance rates for lying and standing blood pressure monitoring and multifactorial risk assessment completion.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT's C. difficile trajectory for 2023/24 is a maximum of 26 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Trend chart



Narrative

There were 2 hospital acquired cases of C.difficile reported in August bringing the year to date total to 12. RCAs have been completed and agreed with the CCG for all 12 cases. 1 May case was deemed to be avoidable with a contributory lapse in care related to inappropriate antibiotic prescribing.

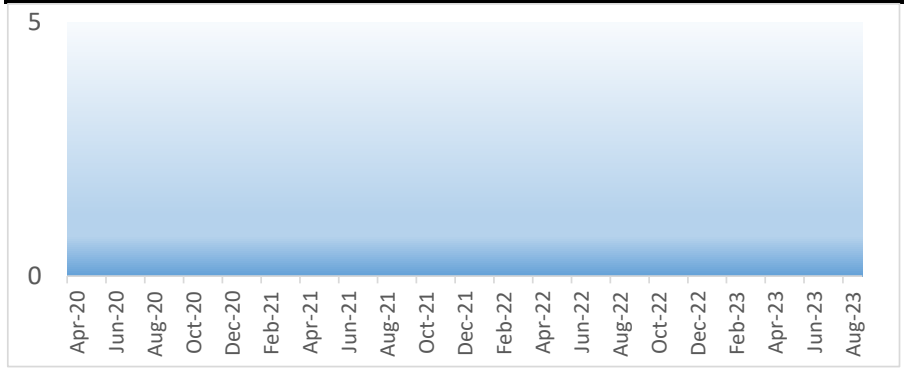
HDFT's C. difficile trajectory for 2023/24 has now been confirmed as a maximum of 26 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	0

Indicator description

The number of hospital acquired MRSA cases where root cause analysis has identified a lapse in care. HDFT's MRSA trajectory for 2021/22 is 0 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

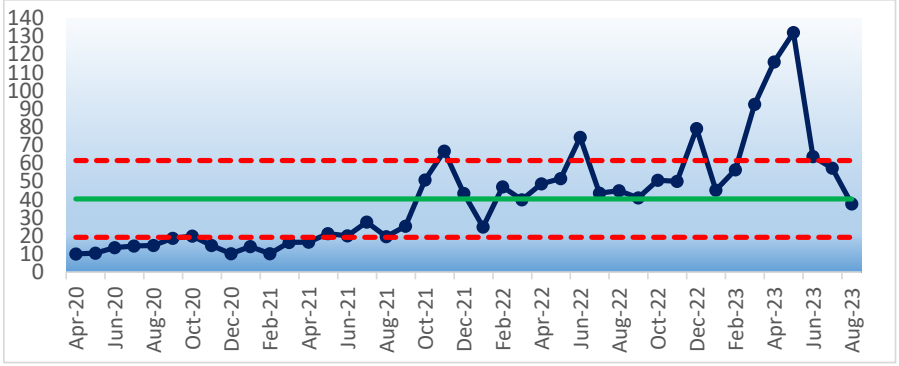
There were no hospital acquired MRSA cases reported in August.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	37.6

Indicator description

The number of incidents reported within the Trust each month. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture, i.e. a higher value for this metric is good.

SPC chart



Narrative

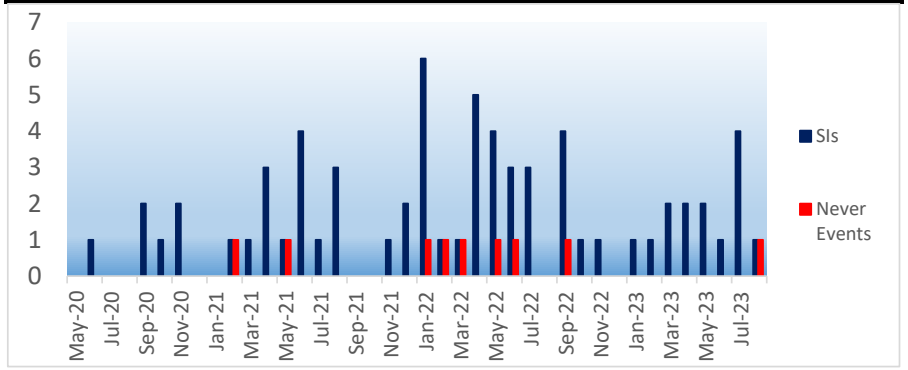
There has been a slight increase in reporting of no and low harm incidents throughout the month of August (1043 up to 1064). There has also been an increase in our moderate and above incidents (18 up to 24). This data continues to be reviewed at our Quality & Learning Summit.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	1 (SI), 1 (Never Event)

Indicator description

The number of Serious Incidents (SI) and Never Events reported. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.

Trend chart



Narrative

The Trust declared one Serious Incident (SI) and one Never Event in August. Both of these investigations have investigative teams appointed and are underway. They are both due to be reported to the PSEC in November.

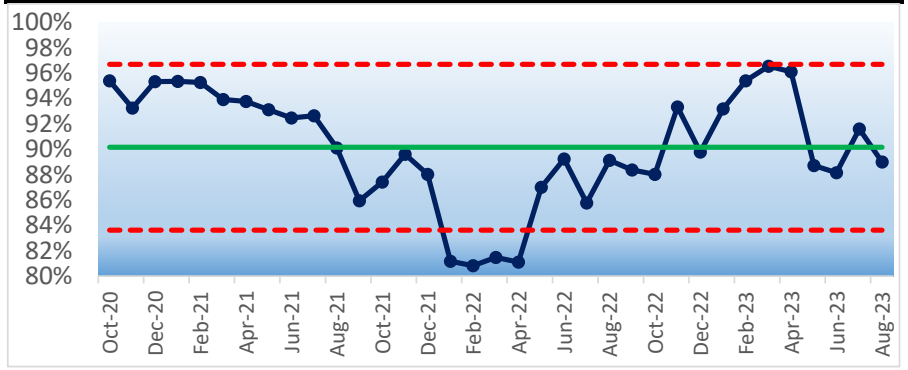
There were two patient safety events that will be investigated under the new PSIRF framework. One will be investigated using an Multidisciplinary Team Review (MDT) and the other will be a Patient Safety Incident Investigation (PSII).

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	89.0%

Indicator description

The chart shows the overall fill rate at HDFT for registered nurses/midwives (RN) and care support workers (CSW) for day and night shifts on inpatient wards. The fill rate is calculated by comparing planned staffing with actual levels achieved.

SPC chart



Narrative

Fill on our increased RN establishments, as a result of the SNCT establishment uplifts, has strengthened our vacancy position.

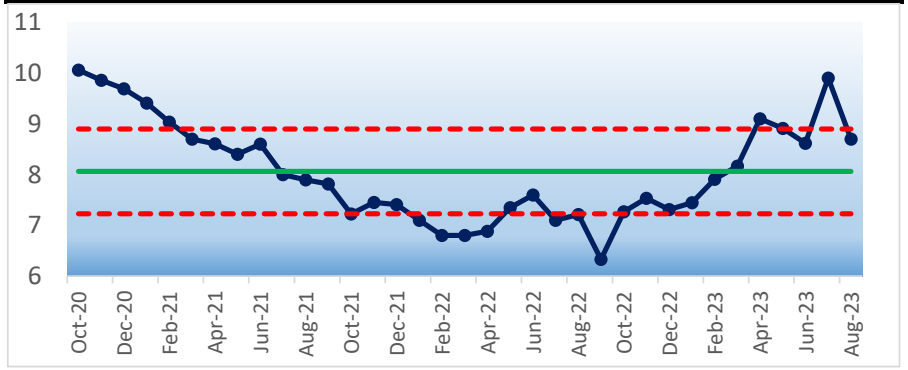
Vacant shifts are being sent to NHSP who are providing excellent fill rates for our current demand.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-22
Value / RAG rating	8.70

Indicator description

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

SPC chart



Narrative

CHPPPD data correlates with the fill data. Nutritional Assistants added to the CHPPPD data as per NHSE guidance.

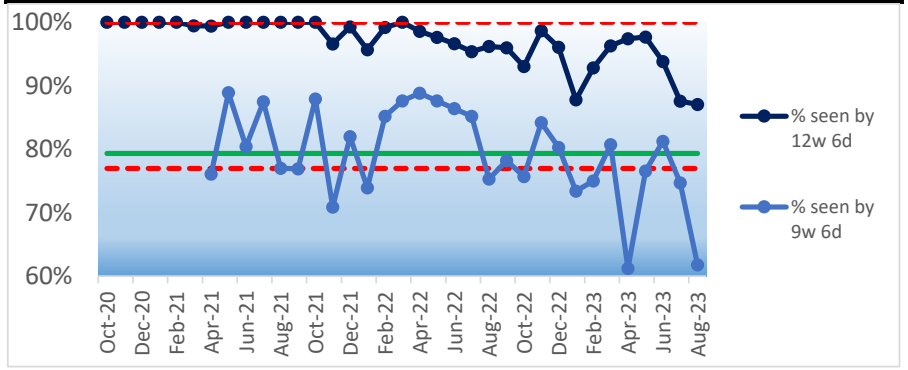
We continue to have excellent NHSP fill rates and improved recruitment of RN's to fill our new vacancies as a result of the SNCT uplift.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	87.1%

Indicator description

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

SPC chart



Narrative

The number of women booking within the required timescales has shown normal variation. 87% of women were seen by a midwife (or healthcare professional) by 12 weeks 6 days in August. For those women seen after 12 weeks 6 days, in all but 1 case, this was due to the women having previously booked elsewhere and then transferred to Harrogate part way through their pregnancy.

Indicator	**1.10 - Maternity - % women with Continuity of Care pathway**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

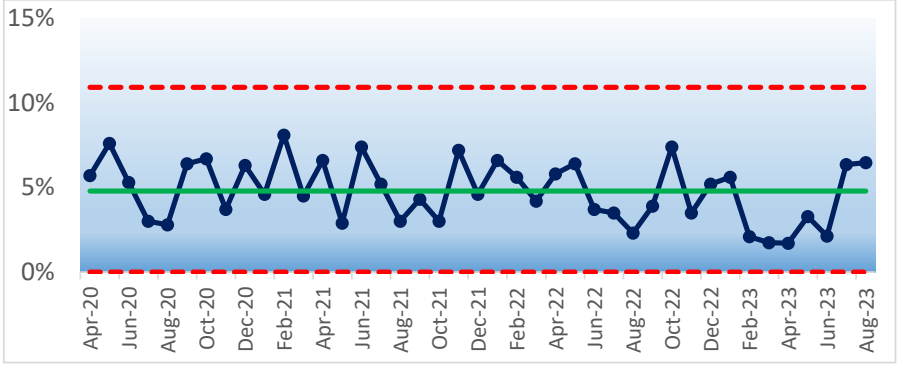
We continue to review the implementation of the Continuity of Care Team. The Trust provides continuity during the antenatal and postnatal periods but not intrapartum at the present time. On 01/08/2023, the Trust hosted a visit with the external Continuity of Care Team who were pleased with the progress of our building blocks and felt assured that we were progressing.

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	6.5%

Indicator description

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

SPC chart



Narrative

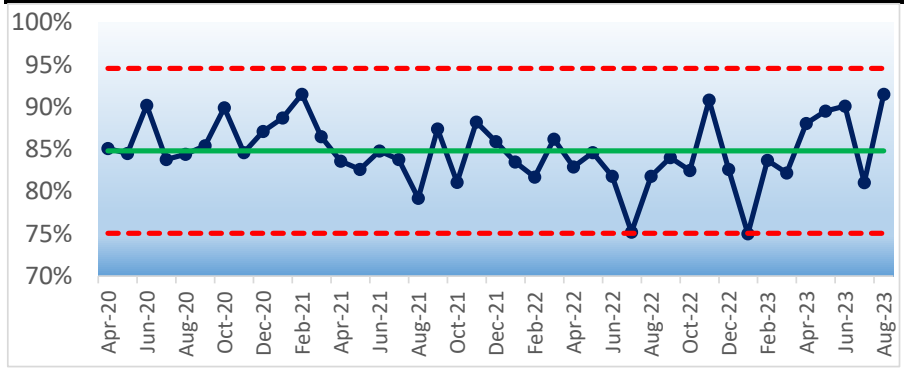
The number of people smoking at delivery has remained within normal variation. The service has moved to monitoring carbon monoxide levels at every appointment for all women to reinforce the importance of stopping smoking to all women and to ensure the non-smoking status is carbon monoxide verified.

Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	91.5%

Indicator description

The % of women initiating breastfeeding

SPC chart



Narrative

The rate of women choooosing to breastfeed their baby at birth has remained within normal variation. The Trust recently received confirmation of the re-accreditation of the GOLD Baby Friendly Initiative status following the submission of the staff and service user audits. A face to face training package is in place to maintain standards.

Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	94.6%

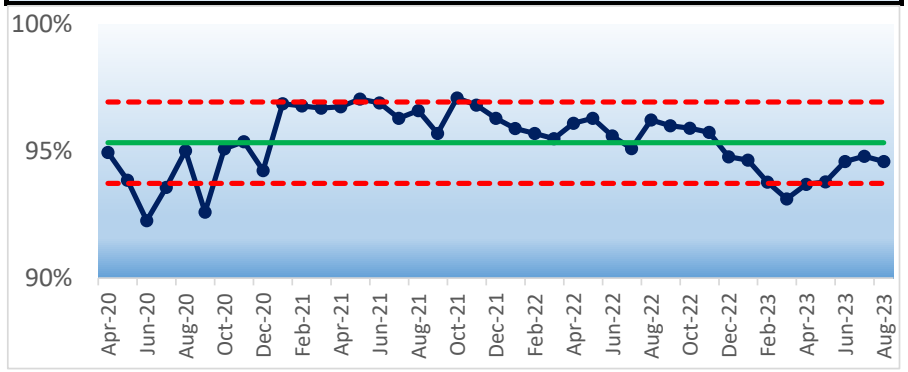
Indicator description

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

Narrative

Ongoing work to digitise the recording of VTE assessment - inpatient digital records due to be implemented from Sep-23.

SPC chart



Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	96.4%

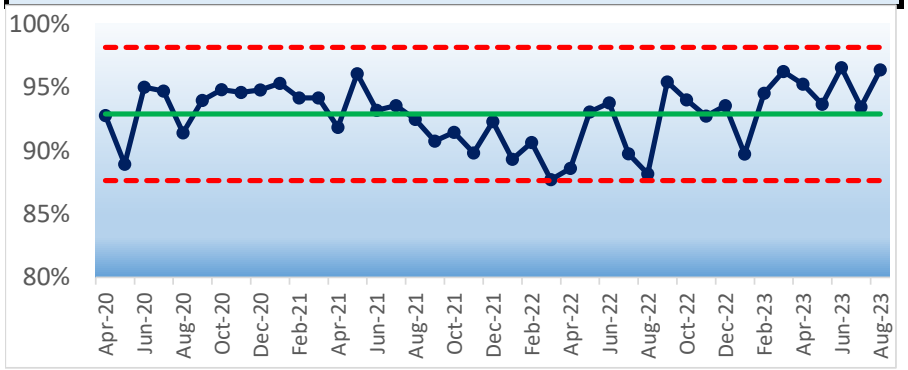
Indicator description

The percentage of eligible inpatients who were screened for sepsis.

Narrative

Remains consistently within control limits and performing above target.

SPC chart

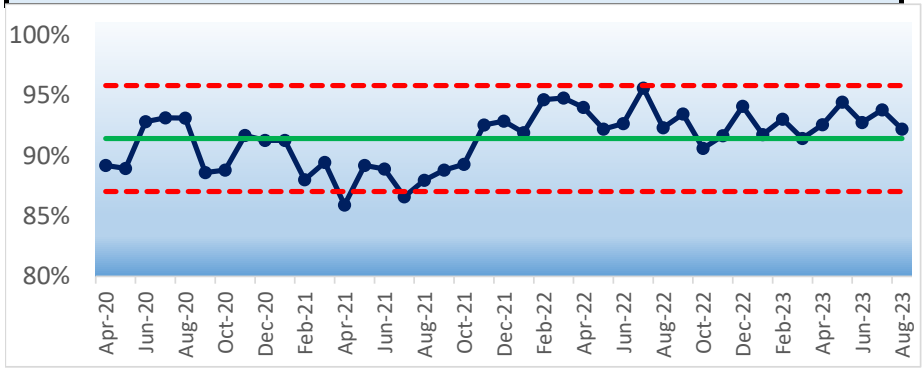


Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	92.2%

Indicator description

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

SPC chart



Narrative

Remains consistently within control limits and performing above target.

Integrated Board Report - August 2023

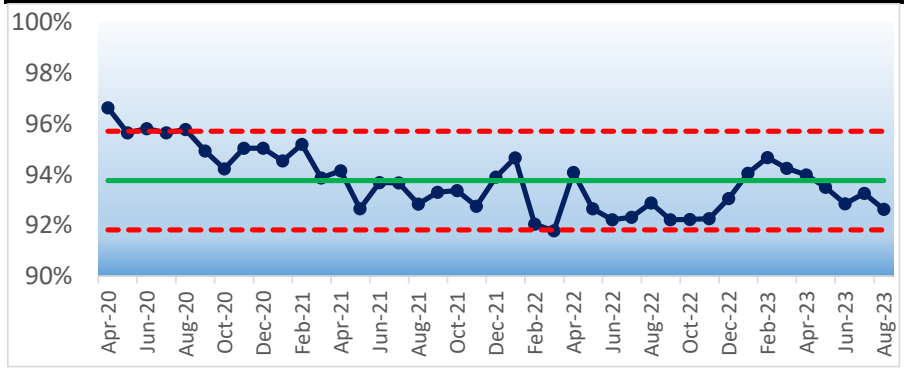
Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - All Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	92.6%

Indicator description

FFT gives patients and service users the opportunity to give feedback. They are asked about their overall experience of care, and can give a response ranging from Very Good to Very Poor. They are also asked to provide freetext comments to explain what went well and what could be done differently or better.

SPC chart



Narrative

Performance against this standard continues to remain steady, with only a slight decrease in positive responses in August.

Positive comments from the FFT in August describe staff as superb, attentive, professional, kind and people felt listened to. Patients described their care and treatment as 10 out of 10; reassuring and respectful. There was a particular comment relating to the care of a patient with a learning disability in SDEC; staff were "patient and brilliant" in supporting the patient.

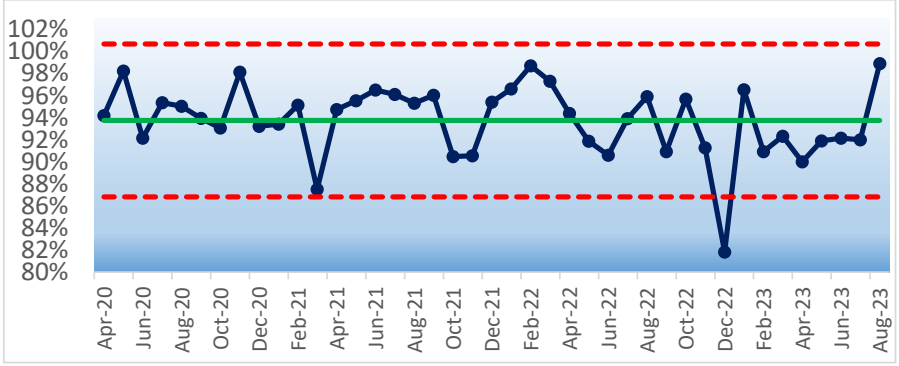
Less positive comments recieved via the FFT related to food on some wards lacking in variety and waiting times for discharge.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	98.9%

Indicator description

FFT gives patients and service users the opportunity to give feedback. They are asked about their overall experience of care, and can give a response ranging from Very Good to Very Poor. They are also asked to provide freetext comments to explain what went well and what could be done differently or better.

SPC chart



Narrative

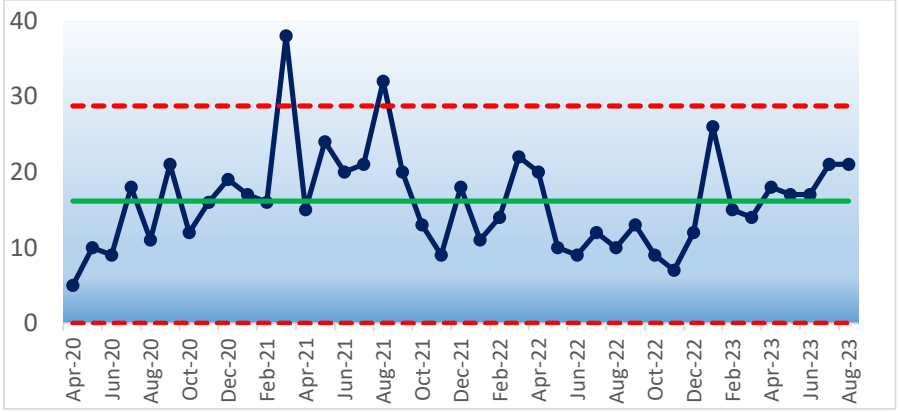
It is encouraging to see an increase in the number of good and very good responses to the Adult Community FFT.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	21

Indicator description

The number of complaints received by the Trust, shown by month of receipt of complaint. The data includes complaints relating to both hospital and community services.

SPC chart



Narrative

In total, there were 21 standard complaints received in August 23.

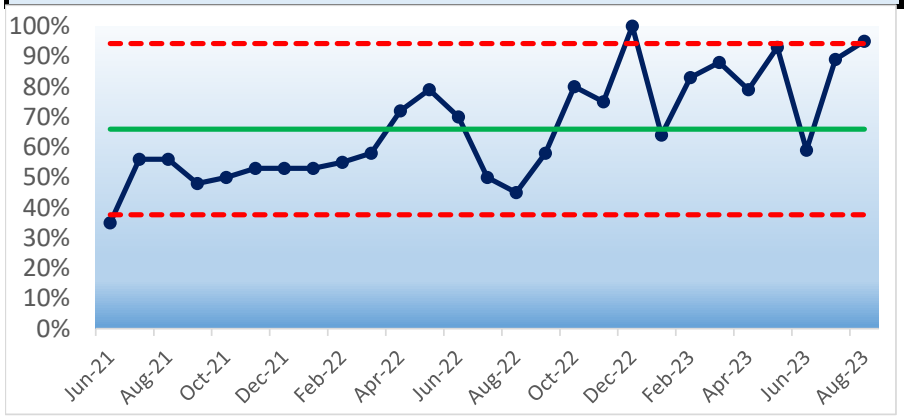
4 complaints came under Community and Children's Directorate, 7 under Planned and Surgical Care and 9 complaints came under Long Term and Unscheduled Care. There was also 1 complaint logged for Corporate Services.

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-23
Value / RAG rating	95%

Indicator description

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

Trend chart



Narrative

Following a drop in June's complaint response rate, it is encouraging to see an increase over July and August, with 95% of standard complaints responded to within the 25 day timeframe.

Integrated Board Report -August 2023

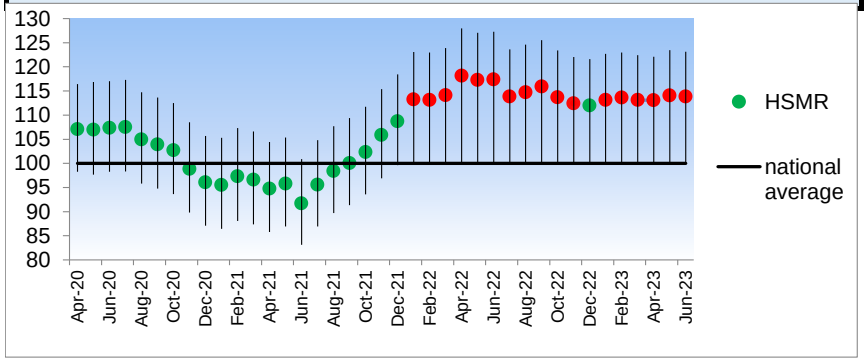
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jun-23
Value / RAG rating	113.82

Indicator description

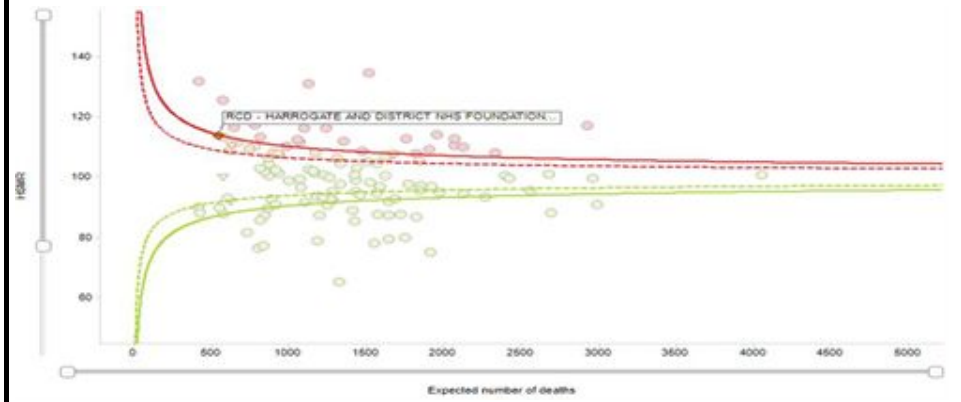
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains above the expected range - a deep dive with external scrutiny has been performed and no quality concerns identified. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a triangle) and all other Trusts. HDFT's mortality data will be discussed in more detail in the quarterly Learning from Deaths paper.

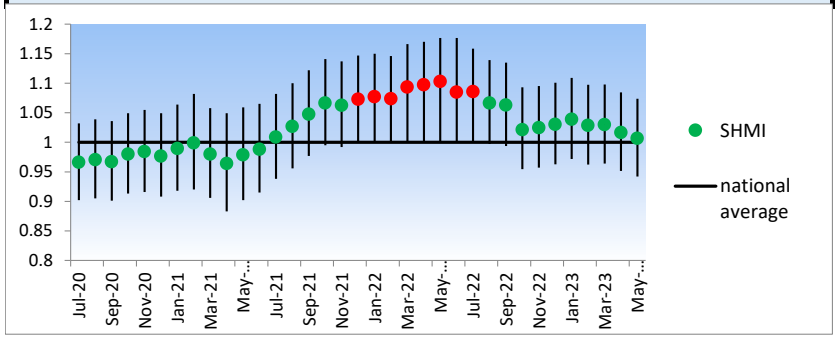


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	May-23
Value / RAG rating	1.007

Indicator description

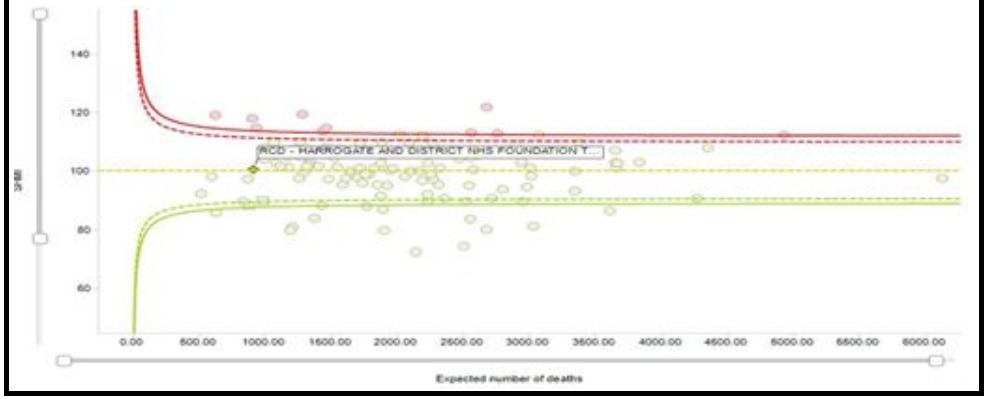
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

National average is 1 (100). HDFT's SHMI is within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a triangle) and all other Trusts. HDFT's mortality data will be discussed in more detail in the quarterly Learning from Deaths paper.

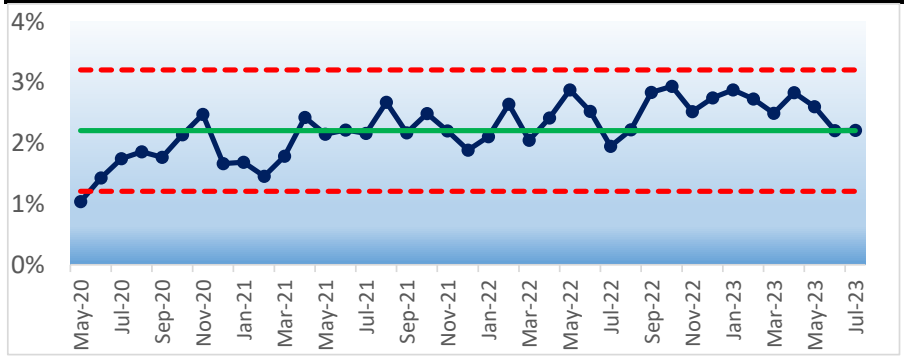


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	2.2%

Indicator description

The percentage of patients readmitted to the same specialty as an emergency within 30 days of discharge of an elective admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart



Narrative

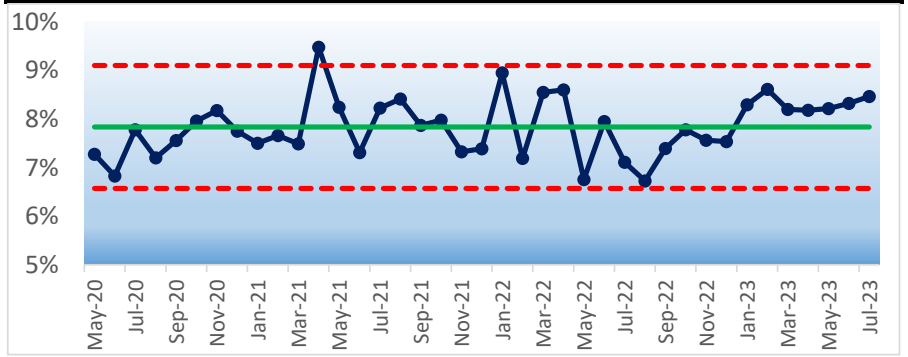
Readmissions following an elective admission remained at 2.2% in July and remain within control limits and less than national average.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	8.5%

Indicator description

The number patients readmitted to the same specialty as an emergency within 30 days of discharge of an emergency admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart



Narrative

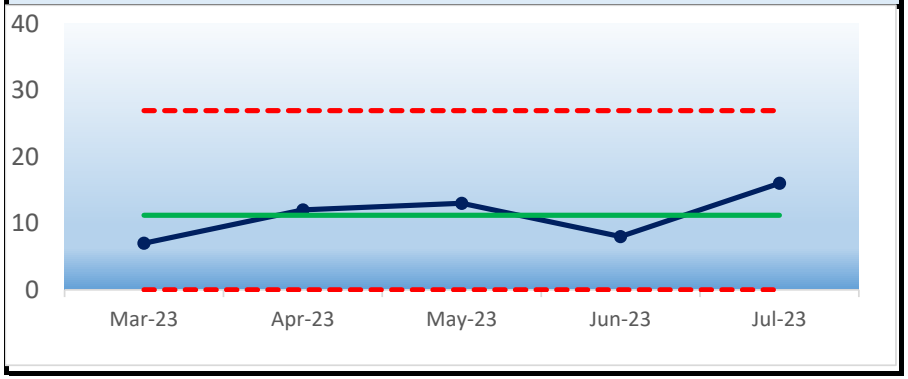
Readmissions following a non-elective admission increased to 8.5% in July, but remain within the control limits. The trend of increasing above the mean will need to be reviewed in more detail if further points show an increase.

Indicator	**3.4 - Returns to theatre**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	16

Indicator description

The number of patients who were unexpectedly returned to theatre within 30 days of their original surgery. This data is reported a month behind so that any recent returns to theatre are captured in the data.

SPC chart



Narrative

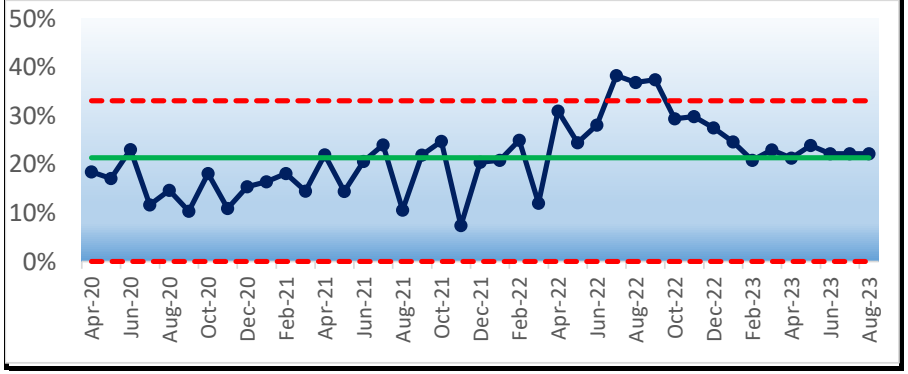
A process has been developed that will allow us to report on this metric going forward. July data has been reviewed and 16 cases of unexpected returns to theatre within 30 days were identified.

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	22.2%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep. This is a snapshot position as reported on the last Thursday of the month.

SPC chart



Narrative

22% of inpatients did not meet the criteria to reside which is a stable position. During July and August, there were some issues with collating this data . An interim data collection process is now in place from the beginning of September with 3 data points per week, moving to 5 shortly. A new system is in train (4-6 months implementation) to support collation and utilisation of this information which is in use across HNY(Optica).

66% of MFFD (medically fit for discharge) patients are waiting for PoC or Care home placements. The key issue is a lack of capacity in POC due to staffing issues in the care market. Staffing issues are also impacting on capacity in care homes both of which are leading to more patients meeting the critera to reside remaining in hospital. The Trust is now beginning to deliver packages of care for patients on discharge to support the care market.

HIF HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services

NHS
Harrogate and District
NHS Foundation Trust

Harrogate and District NHS Foundation Trust

Clinical Services Strategy

teamHDFT
At our best

WELCOME TO OUR

Clinical Services Strategy

Contents:

We are delighted to share with you our new Clinical Services Strategy.

Unlike other organisations, we have deliberately not put a "to and from" date on it, as we want our strategy to be a living document, acknowledging the frequently evolving world of healthcare delivery in the modern NHS.

Following the launch of our new overarching Trust strategy in 2022, we have embarked on a wide programme of engagement and consultation with both internal and external stakeholders, to agree what Harrogate and District NHS Foundation Trust's (HDFT's) clinical services could and should deliver in the coming years. What is clear is that there is deep commitment from our colleagues internally and our partners at a neighbourhood, place and wider system level to 1. support HDFT to continue to deliver the full complement of district general hospital clinical services including a type 1 Emergency Department and an obstetric and midwifery led Maternity Unit, to 2. support HDFT to deliver comprehensive community services at a district and wider county level, and also to 3. support HDFT in our nationally leading position as the largest provider of children's public health services in England. As a result, our new clinical services strategy will fully support our Trust purpose and ambitions to improve the health and wellbeing of our patients, children and communities.

Our new clinical services strategy will be ongoing evolution rather than revolution, as we are already delivering high quality district general hospital, community and children's public health services to over 500,000 citizens across the North of England and as a result, no significant changes are planned to our portfolio of acute and planned care services. However, we recognise that we have some unique challenges and therefore opportunities in Harrogate and District, particularly around the way we deliver clinical services to our frail elderly population, which per capita, is one of the largest populations in any district in England. Our new clinical services strategy will therefore deliver a bigger and more comprehensive model of care closer to home, ensuring better connectivity between acute (including virtual wards), intermediate and integrated services under the new overarching clinical model of HDFT@Home. Another large programme of work which will be undertaken as part of the new clinical services strategy will be further expanding our clinical networks and networked way of working, particularly with our colleagues across WYAAT (West Yorkshire Association of Acute Trusts) and at York and Scarborough NHS Foundation Trust to ensure we continue to deliver robust and resilient seven day acute services and high quality and timely planned care.

Underpinning our new clinical services strategy will be our investment and commitment to supporting and developing our clinical colleagues at HDFT. We know that working in the NHS is enormously rewarding, but can at times be challenging, and colleagues need to have opportunities for personal development, such as growing and diversifying our clinical leadership through portfolio working in areas such as quality and safety, education, research, innovation and digital. We will explore new ways of creating and supporting such opportunities to ensure we continue to recruit, retain and manage our talent pipeline, in particular embracing the diversity of clinical roles within HDFT to further enhance multidisciplinary ways of working.

It is a very exciting time for HDFT as we embark on a number of large scale transformation programmes. We are committed to becoming a continuously learning organisation and are working in partnership with a global leader in heathcare improvement to deliver HDFT Impact, our Trust wide improvement programme. A major workstream within HDFT Impact is the implementation of a new electronic patient record system following receipt of significant national funding to improve our digital maturity. Along with the refurbishment of a number of our inpatient areas and additional theatre capacity being planned, we are both looking forward to the next phase of HDFT's journey as a leading provider of healthcare in Yorkshire and the North of England. We hope you enjoy reading our new clinical services strategy and we would like to offer our grateful thanks to the many colleagues who have contributed to its development.

Dr Jacqueline Andrews
Executive Medical Director

Emma Nunez
Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)

Introduction

The aim of our clinical services strategy is to provide a framework to align our clinical services to our Trust wide purpose, ambitions, values and enabling ambitions, as the delivery of high quality and safe clinical services are key to the delivery of our overarching HDFT strategy.

The Trust exists to serve two groups: the patients who we care for in our hospitals and community services in Harrogate and District, and wider North Yorkshire; and the children and young people who we support through our Children's Public Health Services across large parts of the North East and Yorkshire. Our Strategy makes it clear that our patients and children always come first.

Our purpose is to improve the health and wellbeing of our patients, children and communities.

As one of the largest organisations and employers in North Yorkshire we are committed to playing a key role in our communities. We will promote health and well being and make every contact citizens have with us count.

Our Strategy guides our decision making about today's priorities, ensuring they support our purpose and long term ambitions. Annually, we will set clear, specific, priorities and objectives for each ambition and goal, and track their delivery.

About HDFT
Our Services

Hospital and Community Services for Harrogate and District, and wider North Yorkshire:

- Harrogate District Hospital
- Ripon Community Hospital
- HARA (Harrogate and Rural Alliance) - in partnership with North Yorkshire Council

Children's Public Health (0-19) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 500,000 children
- The largest provider of 0–19 services in England

The populations we serve:

HDFT delivers district general hospital and community services to the growing population of Harrogate and District, and wider North Yorkshire community services. This community has a higher than average population of older citizens, many who are already living well in older age and requiring specialist care to continue doing so, and many with complex health and social care needs which would benefit from better joined up healthcare, ideally taking place nearer to home.

New homes being built means the total district population is predicted to continue to grow, with the proportion of over 65s growing fastest.

HDFT also provides Children's Public Health Services across a wide geographic area in Yorkshire and the North East of England. This includes districts with significantly higher rates of household deprivation than average for the North of England. (ONS Census 2021).

Click here for further information on our Children's Services

Harrogate and District Population
Key Facts at a Glance

Harrogate and District Housing Growth

HARROGATE & DISTRICT LOCAL PLAN 2014-35 IS TO BUILD **13,000** HOMES

ASSUMPTION IS 2.7 PEOPLE PER HOME SO INCREASE IN POPULATION OF **35,000**

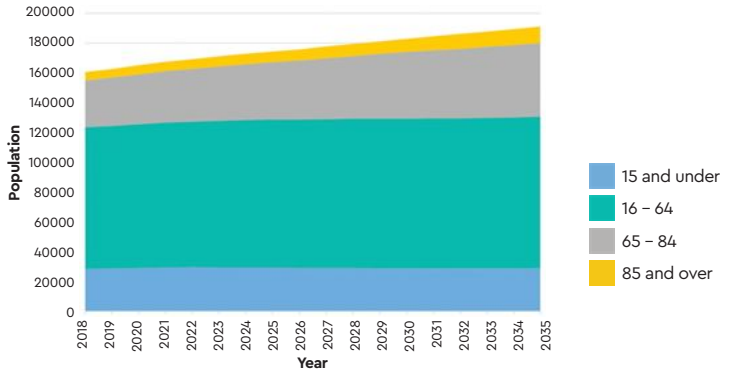
ANNUAL TARGET IS **637** 1700 PEOPLE

2014-2021 SAW **4249** HOMES BUILT AGAINST A TARGET OF 4459 BUT WITH MORE THAN THE ANNUAL TARGET BUILT FROM 2018

2021-26 HOUSING SUPPLY IS GREATER THAN THE TARGET, SO ASSUME WILL HIT TARGET EACH YEAR

FROM 2018-35 POPULATION EXPECTED TO GROW FROM **160k to 191k** (19%, ~1% PER YEAR)

Harrogate and District Age Distribution (Number)



Source: ONS 2018-based Ageing Statistics, Population Projections for Older People

How we Developed our Clinical Services Strategy

Working with HDFT colleagues, patients and families plus representatives from our partner organisations, we held a number of workshops and roundtables to gain valuable feedback which helped shape our new clinical services strategy.

To develop our Clinical Services Strategy we built on the

EXTENSIVE ENGAGEMENT TO DEVELOP OUR TRUST STRATEGY

LOCAL, REGIONAL AND NATIONAL HEALTH AND SOCIAL CARE GRAND CHALLENGES

also provided the framework for the new clinical services strategy:

- Reducing Health Inequalities
- Prevention of Ill Health 'Every Contact Counts'

SWOT ANALYSIS WAS UNDERTAKEN BY EACH CLINICAL SPECIALITY OR SERVICE

6 CLINICAL STRATEGY WORKSHOPS WITH CLINICAL TEAMS FROM ALL OUR SERVICES

took place to develop a future vision for their service in 5 years, considering:

What would **success look like** in 5 years time

How to **develop and enhance** our partnership working

Future clinical and operational models based on our populations health and care needs

Clinical Service interdependencies

Supporting **research, innovation** and **continuous improvement**

Training and developing the clinical workforce of the future

We analysed

THE SPECIALITY VISIONS FOR COMMON THEMES AND QUESTIONS

to develop an initial draft for the Clinical Services Strategy

The draft Clinical Services Strategy was reviewed, refined and developed through senior leadership workshops each involving over

50 CLINICIANS AND MANAGERS WHO LEAD OUR 12 CARE GROUPS

Our Core District General Hospital and Community Clinical Services are:

24/7 EMERGENCY DEPARTMENT
consultant led 24 hour service with full resuscitation facilities

OBSTETRIC AND MIDWIFERY-LED MATERNITY SERVICES

CORE DISTRICT GENERAL HOSPITAL SERVICES
to support our emergency and unplanned care teams plus delivery of outstanding planned care services

INTEGRATED SERVICES FOR OUR GROWING OLDER POPULATION

HDFT Clinical Services Strategy

In order to deliver our outstanding core District General Hospital and Community Services we will focus on the following priorities:

Best Quality, Safest Care with a Focus on Frailty

HDFT will:

- Provide high quality District General Hospital and community care for our Harrogate and District local population, prioritising and ensuring a proactive approach to people living with frailty in our community
- Create innovative ways of supporting domiciliary and residential care as an anchor organisation in our district

Integrated Care, Delivered as Close to Home as Possible

HDFT will:

- Transform our out of hospital pathways and services to create an overarching clinical programme, to be known as '**HDFT@Home**', a new integrated way of providing specialist care for patients and families in a community setting, supported by digital developments which reduces unnecessary admissions and enables earlier discharge
- Deliver hospital care via day case or short stay pathways, reducing length of stay wherever possible

Clinical Partnerships and Networks

HDFT will:

- Grow and develop regional specialist clinical networks within West Yorkshire Association of Acute Trusts and, for some specific services, with the Humber and North Yorkshire Integrated Care System (ICS)
- Grow and develop local, place-based networked relationships with Primary Care, Community Services, Social Care, Mental Health Services and Voluntary Sector Providers (through HARDLCP – Harrogate and Rural Local Care Partnership)
- Through these partnerships provide resilient and effective services to support our Clinical Service delivery ambitions, reduce health inequalities and make every contact count to prevent ill health

Children and Young People

HDFT will:

- Deliver quality Obstetric and Midwifery-led Maternity Services at Harrogate District Hospital

Click here for information on our Maternity Services

- Make Healthcare Accessible to children and young people driven by our seven '**Hopes for Healthcare**', designed by our Youth Forum
- Remain a national leading provider of Children's Public Health Services throughout the North East and Yorkshire

Click here for further information on our Children's Services

PRIORITY

Best Quality, Safest Care with a Focus on Frailty

HDFT will:

Provide high quality District General Hospital acute, planned and community care for our Harrogate and District local population, prioritising and ensuring a proactive approach to people living with frailty in our community

Provide a 24/7 Urgent and Emergency Care Pathway through our refurbished Emergency Department and Urgent Treatment Centres, as well as same day treatment through Same Day Emergency Care pathways for surgical and medical conditions.

Further develop our Bed to Board Governance Structures through the new Care Group Clinical Directorate Structures, ensure all services are delivered to best practice standards thorough networking and partnerships when necessary.

Deliver timely care for all urgent and planned care services. Drive improvements in planned care waiting times by transforming the ways we deliver outpatient services and by expanding our theatre capacity.

Continually develop our services through an embedded **HDFT IMPACT** continuous improvement model.

Enable and strengthen research, innovation and digital programmes and technologies.

Provide specialist frailty care through the Acute Frailty Unit to holistically assess and treat patients living with frailty and support same day discharge or shorter hospital stays where possible.

Identify frailty early and deliver Comprehensive Geriatric Assessment to inpatients who will benefit irrespective of their admitting speciality and throughout acute and planned care service provision.

Recognise that people living with frailty often have their needs met best in settings outside of acute hospital care and provide coordinated multidisciplinary crisis care and rehabilitation services in the most appropriate settings.

Work in partnership with patients and their relatives to deliver personalised care, supporting people to maintain active and healthy ageing through self-management where appropriate, and to engage effectively and compassionately with patients and carers to discuss end of life care when required.

PRIORITY

Integrated Care, Delivered as Close to Home as Possible

HDFT will:

Transform our out of hospital pathways and services to create an overarching clinical programme, to be known as 'HDFT@Home', a new integrated way of caring for patients and families in a community setting, supported by digital developments

Deliver hospital care via day case or short stay pathways and reduce length of stay wherever possible

The last few years have seen a significant growth in the number of services and pathways for patients which are being delivered outside of a traditional hospital footprint.

For some time there has been recognition of the benefits of delivering healthcare as close to home as possible, and the COVID pandemic has accelerated the necessary healthcare innovation and willingness to think and act differently when it comes to care delivery.

At HDFT we currently operate a number of acute and elective district general level services out in the community.

Although many of them are partially or fully integrated with other services, either provided by us or by a health or social care partner, there is work to do to create a truly seamless joined up approach to health care delivery, putting the patient and family firmly at the centre.

As part of our new clinical services strategy, we will transform our out of hospital pathways and services to create an overarching clinical programme, to be known as 'HDFT@Home'.

This will become the single point of contact for internal and external stakeholders, patient and families to ensure ease of navigation across complex acute, intermediate and integrated planned care pathways.

HDFT@Home will be a refreshed version of our current community and outpatient services model, ensuring that all current local and national drivers and enablers are included to deliver a state of the art offer to our 200,000+ citizens within the Harrogate District.

Our Current Provision of Health and Social Care in the Community:

Planned Outpatient Appointments for Diagnostic Procedures and Clinical Reviews

- Usually take place on a hospital site (Harrogate or Ripon). Regular follow ups for chronic conditions arranged irrespective of need at that point in time, rather than patient initiated

Community Care Teams

(Community nursing, therapies, social care, delivered in partnership with North Yorkshire Council 'HARA')

- Four Locality Community Care Teams: Harrogate South, Harrogate North, Knaresborough & Boroughbridge, Ripon and Rural
- Provide long and short term nursing interventions, rehabilitation and support the management of long term conditions such as diabetes, complex wounds and ulcers, falls and immobility and palliative and end of life care

Working in Partnership with Other Providers

- Primary Care – 17 local practices within the Yorkshire Health Network, comprising four Primary Care Networks
- Social Care – North Yorkshire Council
- Mental Health – Tees, Esk and Wear Valleys NHS Foundation Trust
- Voluntary Sector organisations

Intermediate Care

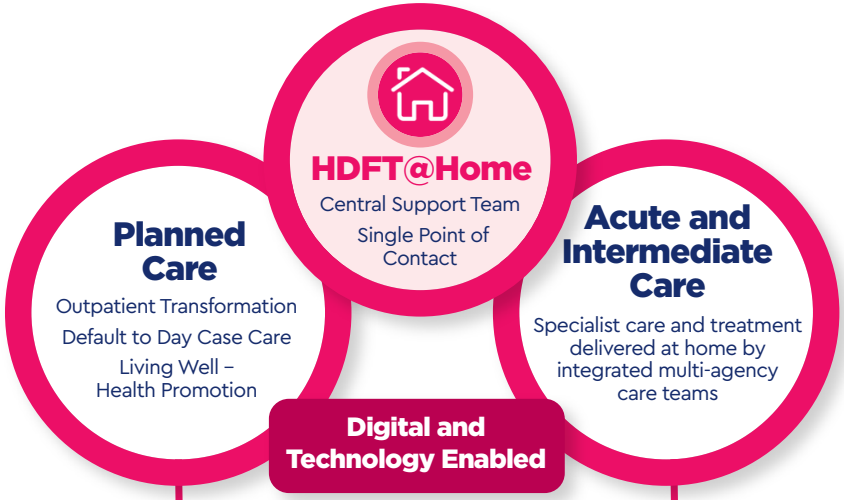
- Acute Response and Rehabilitation in the Community and Hospital (ARCH) Team
- Urgent Crisis Response Team

These HDFT Teams comprising specialist multidisciplinary health professionals provide care at short notice to prevent unnecessary hospital admissions and enable earlier discharge and rehabilitation outside the acute inpatient ward area

Acute Care

- Virtual Wards – Consultant-led multi-disciplinary teams delivering acute care for Frailty conditions or Acute Respiratory Infections in patient's own residence
- Advice and guidance virtual advice for GPs from specialists

Our New Integrated and Digitally Enabled Health and Social Care Model Delivered - HDFT@Home:



- Reduce unnecessary follow up appointments utilising patient initiated follow up and improving specialist advice provision
- Remote monitoring, patient portals, improved communication with primary care
- Fewer appointments and investigations in hospitals
- Maximise day case care opportunities
- Diagnostic services within or closer to home
- **Every Contact Counts** – health promotion

Integrated Acute and Intermediate Care teams with secondary care specialist leadership of criteria-led care pathways with a single point of access, enabling improved care coordination with community and primary care, mental health services, social care and voluntary services, improving admission avoidance and early supported discharge

PRIORITY

Clinical Partnerships and Networks

HDFT will:

Grow and develop our clinical networks within the three Integrated Care Systems (ICS) we partner with. We have many established clinical pathways within West Yorkshire ICS through our collaboration with WYAAT (West Yorkshire Association of Acute Trusts), and through this will further strengthen our clinical networks for urgent, emergency and planned care.

In our local neighbourhood - Harrogate and Rural Local Care Partnership (HARDLCP) - we have formed a collaboration between secondary care, community care, primary care, mental health, local authorities and the voluntary sector to provide outstanding integrated care across Harrogate and District. A key focus for HARDLCP is better integrated care for our frail and elderly patients across the district.

In addition, we will continue to grow our key partnership with local primary care colleagues through our four PCNs (primary care networks) and our Federation of Harrogate and District GP practices (the Yorkshire Health Network). We are committed to delivering the Academy of Medical Royal Colleges recommendations for exemplar interface working between primary and secondary care.

Click here for further information on Working Better Together

At HDFT we recognise that in order to provide excellent quality effective care, resilient and responsive patient-centred services we need to collaborate and work in partnership with other services across the regional health and care network, and with partner organisations in our local neighbourhoods.

By doing so we will design services which are fit for the whole patient care pathway – which are easier for patients to navigate and deliver the right care in the right place by the right professional. The majority of our hospital clinical services already have close networking partnerships with other secondary and tertiary care providers in either West Yorkshire or North Yorkshire and the Humber. We recognise some smaller services will benefit from growing these partnerships through effective collaboration to ensure resilient provision consistent with best practice care for the future.

Modern Integrated Care Systems deliver healthcare which promotes and encourages patient-centred system working. Through close and direct collaboration with our neighbourhood primary care alliance (The Yorkshire Health Network), we will improve patient care and experience through improving communication and reducing unnecessary and wasteful steps in pathways by utilising digital enablers such as integrating electronic records.

HDFT is part of three Integrated Care Systems (ICS):

West Yorkshire, Humber and North Yorkshire and North East & North Cumbria

West Yorkshire Health and Care Partnership

Humber and North Yorkshire Health and Care Partnership

ICS

HDFT is part of Harrogate and Rural Local Care Partnership (HARDLCP) - our local neighbourhood system for care delivery:

The Partnership includes – HDFT, four PCNs (Primary Care Networks), YHN (Yorkshire Health Network), TEWV (Tees, Esk and Wear Valleys NHS Foundation Trust), North Yorkshire Council and Local Voluntary Sector Organisations

PRIORITY

Care of Children and Young People

HDFT will:

Deliver Obstetric and Midwifery-Led Maternity Services at Harrogate District Hospital, meeting and exceeding all national quality standards

Remain a national leading provider of Children's Public Health Services

Make healthcare accessible to Children and Young People driven by national and local strategies for Children and Young People with a focus on our 'Hope for Healthcare', designed by our Youth Forum

The Seven 'Hopes for Healthcare' are:

1

Involve Children and Young People in Their Care:

Listen carefully, take time to explain, speak directly to the child or young person and actively involve them in decision making.

2

Encourage Confident Two Way Communication:

Encourage children and young people to ask questions, give clear explanations, ask rather than assume how someone is feeling.

3

Start Early with Health Information:

For example advise children and young people how and when to access the NHS and its services, promoting Healthy Child teams and on providing the right information at the right time.

4

Moving to Adult Healthcare Services

Start conversations early, explain options and enable smooth transitions.

5

Make Children and Young People Feel Welcome:

Providing easy to understand information, a warm welcome and suitable environments.

6

Healthcare Rights:

Treat children and young people as individuals and support them to understand their rights. Help to support the rights of young carers.

7

Having a Voice and Improving Healthcare Services:

Provide a range of feedback opportunities for CYP, independent of parents are carers, use the feedback to make a difference, involve young people in decision making through the Youth Forum and other groups.

Click here for information on our Maternity Services

Click here for further information on our Children's Services

Priority Programme Enablers

Clinical Workforce

- Deliver high professional standards which put our Trust values at the heart of clinical care
- Ensure multidisciplinary team provision meets service requirements
- Provide excellence in medical, dental, medical associated, nursing, midwifery and allied health professional training
- Develop Medical Associated and Advance Practice roles, with defined governance frameworks to ensure sustainable service delivery
- Develop staff clinically to enable career progression at HDFT, and provide and support clinical leadership development opportunities to ensure best experiences for staff at work

Click here for our People Plan

Digital Innovation

- Embrace new technology to support care closer to home
- Implement a new, integrated Electronic Patient Record System
- Digital processes to support workforce to provide excellent care

Click here for our Digital Strategy

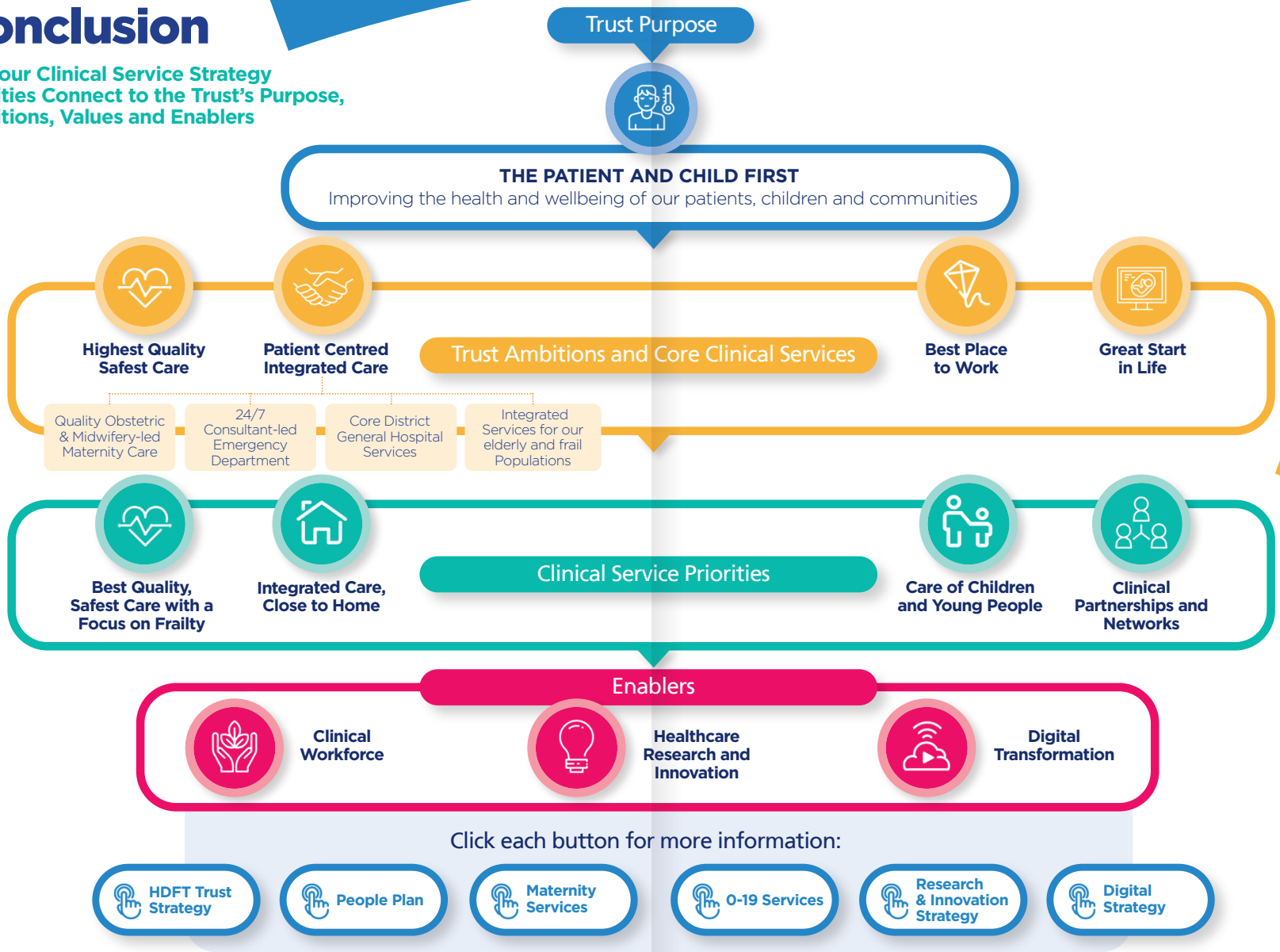
Research, Innovation and Improvement

- Embed continuous improvement methodology throughout all our services – HDFT IMPACT programme
- Embrace innovation in clinical services
- Increase opportunities for patients and workforce to benefit from research – Clinical Research Facility

Click here for our Research and Innovation Strategy

Conclusion

How our Clinical Service Strategy Priorities Connect to the Trust's Purpose, Ambitions, Values and Enablers



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At our best

HIF HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services

NHS
Harrogate and District
NHS Foundation Trust

Published September 2023

4

Board of Directors (Public)
27th September 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 August 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 August 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 Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 9).
5.2 Risk to compliance with CQC and Maternity Incentive scheme requirements for audit (Score 9).

6.0 Recommendation

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

Narrative in support of the Provider Board Level Measures – August 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 August 2023. The vacancies on the middle grade night and weekend rota has been filled. 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 75.76 WTE for midwifery staffing bands 5-7 and 13.3 WTE for Band 2 and 3 clinical support staff.

3.1 Absence position

Unavailability of midwifery staff hours –
410 hours (2.52WTE) sickness absence (97.5 hours due to COVID)
4.47 WTE maternity leave

Maternity support worker hours lost across maternity services –
224.5 hours (1.38WTE) sickness absence (no themes identified)

3.2 Vacancy position

Currently there is zero midwifery vacancy. One internationally recruited midwives started at HDFT in July. Another internationally recruited midwife is due to start in September.
3.2WTE student midwives due to qualify in summer and start work at HDFT in the autumn.
There is 1.5WTE Band 3 Maternity Support Worker vacancy. 0.5 WTE Band 2 maternity Support Worker.

3.3 NHSP provision

Midwives -

2.35 WTE NHSP midwifery staffing used in August 2023. This has remained consistent from July 2023.

Support workers –
4.34 WTE NHSP maternity support worker staffing has been used across maternity in August 2023.

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.

Four homebirths were booked for the month of August 2023. All four women attended the unit for birth by choice following medical reasons for attendance being recommended.

One woman was attended at home following plans to freebirth, Medical assistance requested was towards the end of labour. Baby was born before the arrival of the midwife.

In the period 1/8/23 – 31/8/23, the home birth provision was suspended on one occasion. The service was suspended due to notice of staff occupational health restriction.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Neonatal absence position

0.92 WTE nurse currently on maternity leave.
0.78 WTE sickness absence

4.2 Neonatal Vacancy

No neonatal vacancy at present.

4.3 Neonatal Recruitment

Fully recruited

4.4 Qualified in Speciality (QIS)

SCBU budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS = 8.274 WTE. The ODN have clarified that the QIS compliance is based on staff in post excluding any vacancy.

0.61WTE nurse completed consolidating their QIS skills and therefore included in the numbers from September.

August QIS compliance was 70%.

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 186 scheduled assessment periods, of these 176 were completed. Staffing met the acuity 88% of the time.

86% of the time no actions required. 14% of the occasions actions were required, these included:
· Delay in continuing induction of labour - nine occasions
· Delay in commencing induction of labour - twelve occasions (inpatient)
· Delay in elective caesarean section – one occasion
· Postponed induction of labour at home – three occasions

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.

100% of women received one to one care when labour within the unit.
Four women had a baby born before the arrival of a midwife.

5.2 Pannal Ward Staffing

The Birthrate Plus Acuity App ward tool has been removed for development. As a result, there is no obtainable data for Staffing Levels vs Workload. A meeting with the Birthrate Plus team is scheduled to train staff on the new tool on 20th September. There were no Datix reports relating to staffing and workload for August.

During August 91% of Midwifery day shifts and 97% of night shifts were covered with contracted hours. 7% of Midwifery day shifts and 12% night shifts were covered with NHSP.

MSW day shifts were covered 76% with contracted hours and 24% with NHSP. MSW night shifts were covered 74% with contracted hours and 26% with 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 were two Red Flags identified from the Birth Rate Plus Data during August.

· Delay between presentation and triage over 30 minutes – one occasion

· Midwife unable to provide 1:1 high dependency care for AN or PN patient – 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 01/08/2023 to 31/08/2023

MA1	Redeploy staff from Pannal	**11**	**61%**
MA2	Staff unable to take breaks	**0**	**0%**
MA3	Review of staff on management time	**0**	**0%**
MA4	Use of specialist midwife	**1**	**6%**
MA5	Use of staff on training days	**0**	**0%**
MA6	Use of ward/department managers	**0**	**0%**
MA7	Staff sourced from wider Trust (theatre & CSW's)	**0**	**0%**
MA8	Use of hospital MW on call	**3**	**17%**
MA9	Use of community MW	**3**	**17%**
MA10	Unit on Divert	**0**	**0%**
MA11	Patient diverted	**0**	**0%**
	Total	**18**	

6.3 Pannal Ward Red Flags

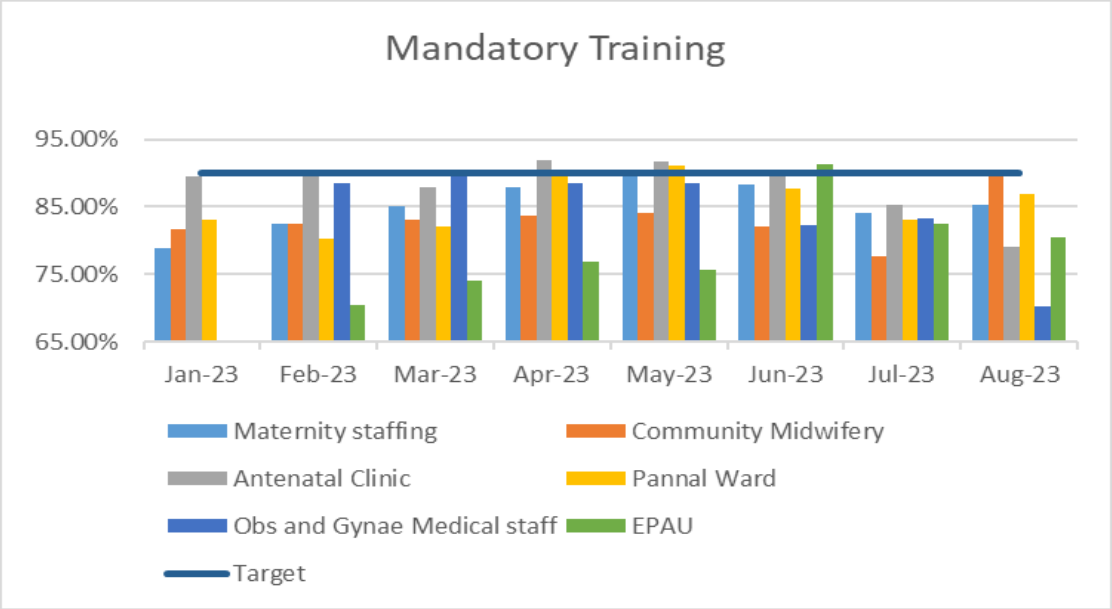
Red flag events were not captured during August on Birthrate Plus. A Datix would have been submitted for any incidents that occurred, as is normal practice.

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 (as at 12/09/23)

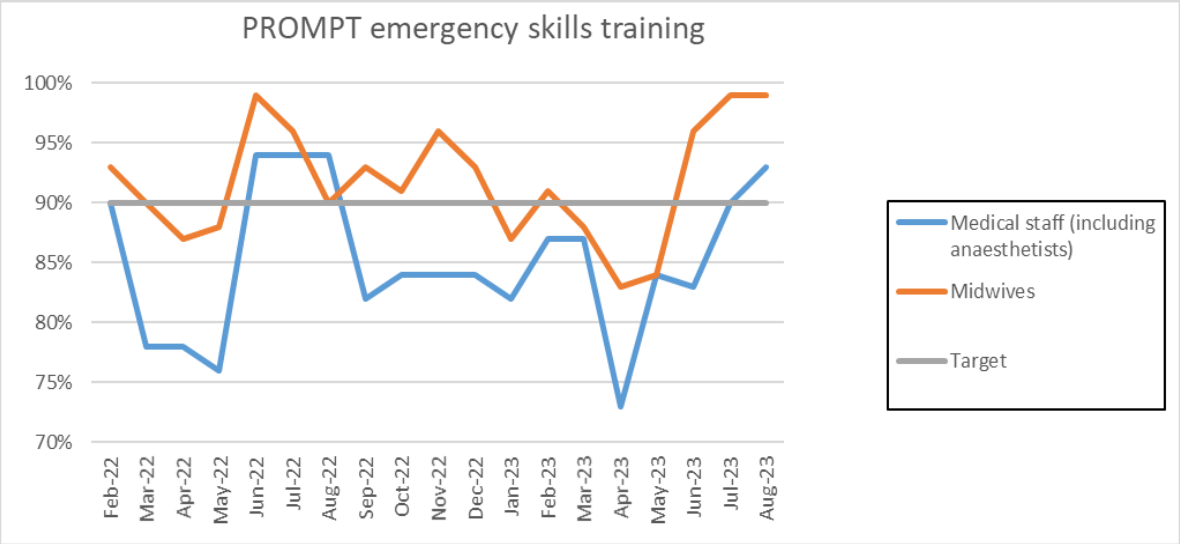
Maternity Area	***Headcount***	***Compliance***
Maternity staffing	54	85.3%
Community Midwifery	23	89.5%
Ante Natal Clinic	9	79.1%
Pannal Ward	21	86.8%

Obs and Gynae Medical	24	70.2%
EPAU	4	80.4%



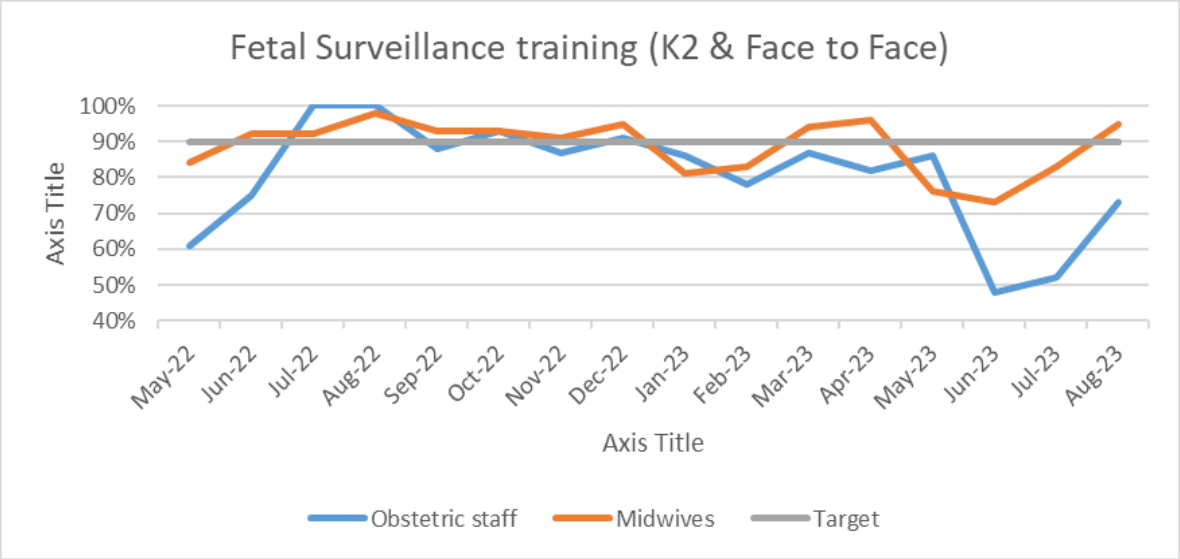
Any new doctors who join HDFT between August and December this year will have to have attended PROMPT at HDFT before 1st December, irrespective if they have already attended a full PROMPT day elsewhere within the past 12 months, in order to meet the requirements of Maternity Incentive Scheme. Obstetric trainees will also need to attend a full day of fetal monitoring training at HDFT. Three PROMPT training dates are scheduled between now and 1st December and two fetal monitoring training days. Managers have been contacted to ensure all relevant staff attend their allocated day, however the doctors strike will undoubtedly have an impact on attendance.

7.2 Prompt emergency skills training

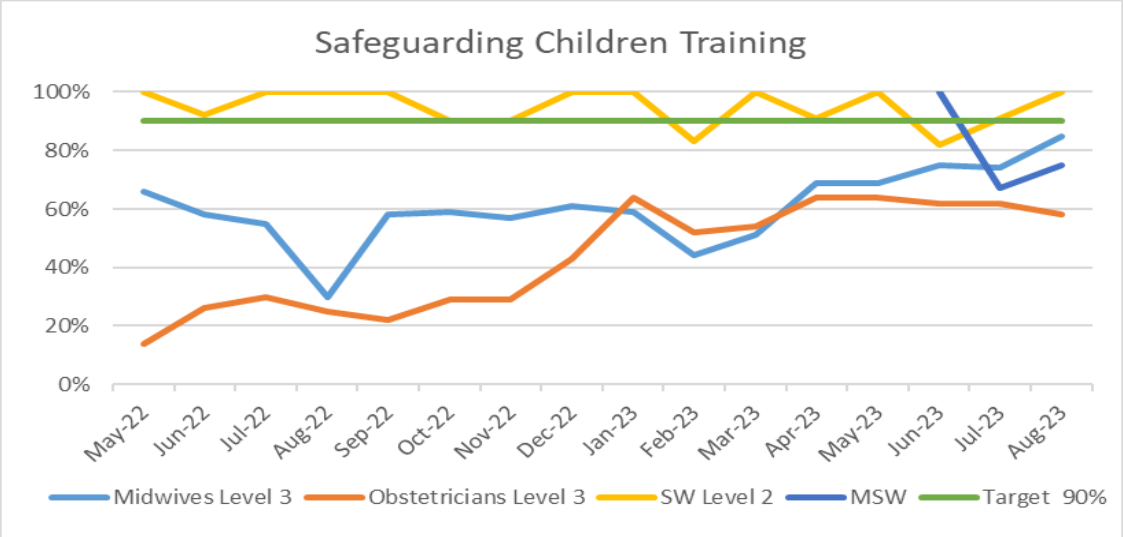


7.3 Fetal surveillance training

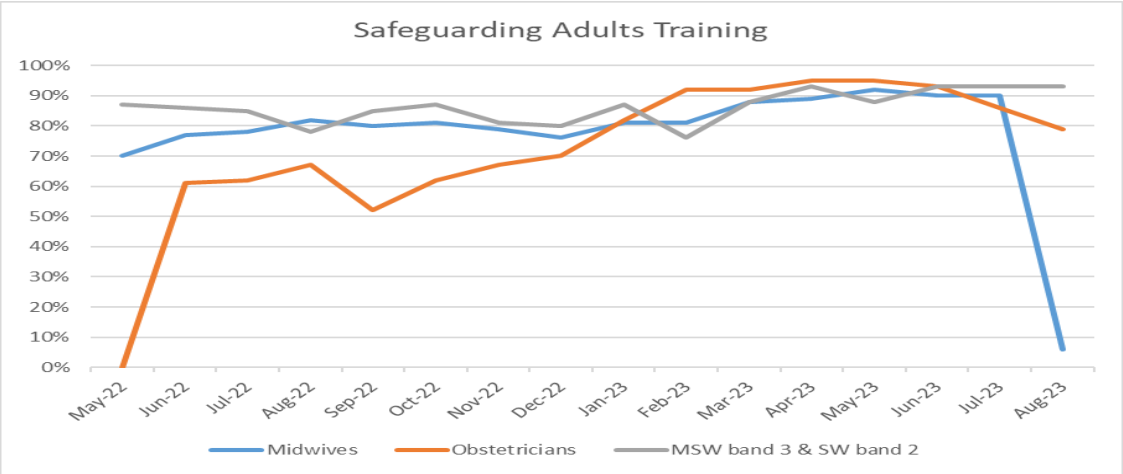
There was a reduction in compliance of fetal surveillance training due to increased expectations of the training in June 2023. Compliance with training now includes both K2 online package with a competency assessment test, and face-to-face training with local learning and case studies. The Maternity Incentive Scheme sets this requirement.



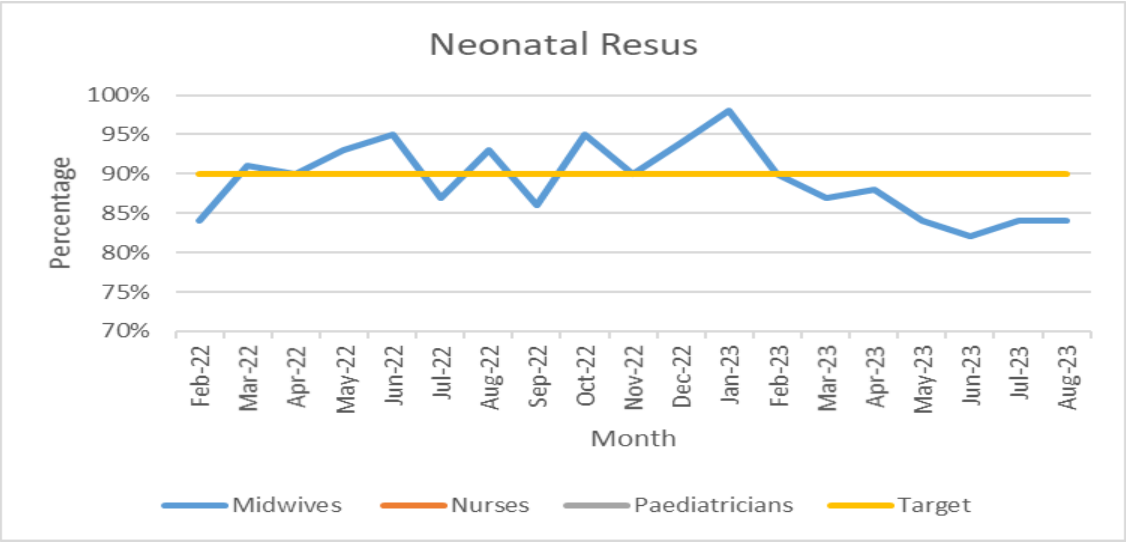
7.4 Safeguarding Children and Adults training



The level of training required for staff for Safeguarding Adults is under review. Midwives are required to undertake Safeguarding Adults training to Level 3. Currently only two out of 84 midwives are compliant with level 3 training. Plans are being developed to roll out Level 3 training.



7.5 Neonatal resuscitation – Midwives



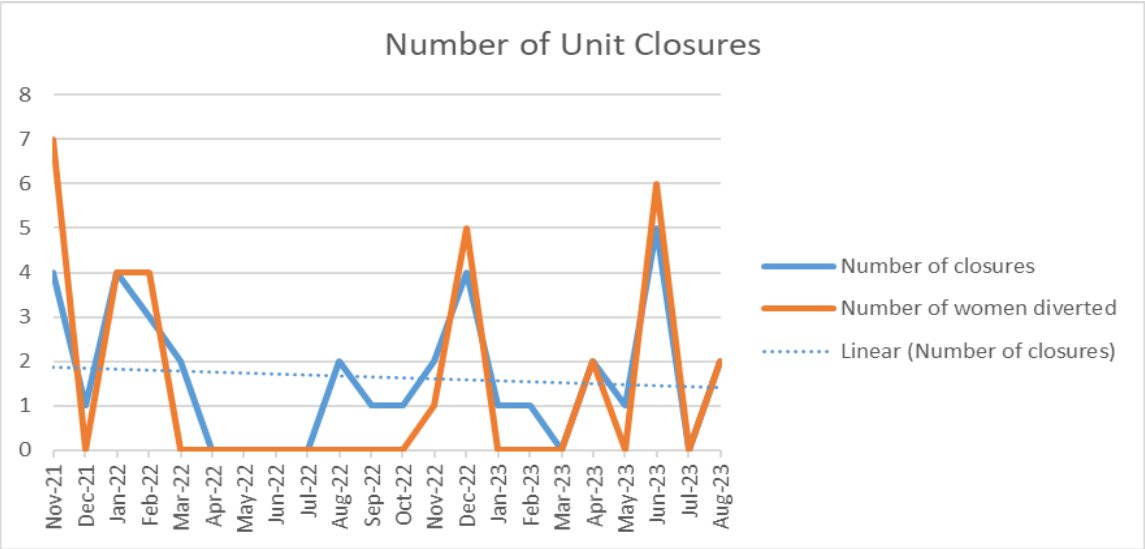
7.6 SCBU Training Compliance

Data unavailable at time of submission.

8.0 Risk and Safety

8.1 Maternity unit closures

There were two incidents of closure of the unit in August 2023.



8.2 Maternity Accepted Diverts

Work is on-going with the LMNS to gain oversight of the number of admissions to HDFT from other Trusts in periods of escalation at other Trusts and inductions of labour being moved across the region. Unfortunately this information is not easily gained from Bagdernet due to the number of women choosing to transfer care to Harrogate from out of area. Local paper records are being created to monitor this.

8.3 Maternity Risk register summary

No new risks added. Eleven pre-existing risks:

- **Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 9).** Plans ongoing for increased capacity
- **Risk to compliance with Ockenden and Maternity Incentive scheme requirements for audit (Score 9).** New Audit & Clinical Effectiveness midwife commenced in post and work progressing now
- **Risk to reputation and patient satisfaction for failing to meet national target and provide evidence based care in relation to Continuity of Carer (Score 8).** Building blocks being established and plans in place.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 8).** Issues with scheduling pregnancy appointments and missing time-critical appointment deadlines for screening. Issues remain but some progress. Business Support Officer has provided interim support. Support worker also undertaking additional work to clear pregnancy referral backlog. Change in management structure for clerical staff. Risk reduced.
- **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 ability to diagnose preterm labour due to national shortage of Hologic fetal fibronectin (FFN) cassettes (Score 6).** Diagnosis being undertaken by clinical assessment and use of alternative qualitative Actim Partus tests. Advised shortages likely to persist to 2024.
- **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).** New Middle Grade appointed. No change at present.
- **Lack of local freunlotomy service leading to delays in treatment of neonatal tongue-tie (Score 4).** Has been circulated to Paediatric Consultant team. Hopefully for implementation in the next couple of weeks. No change at present.

8.4 Maternity Incidents

In August 2023 there were 54 total incidents reported through Datix (one rejected as a duplicate).

One incident recorded as Severe Harm. This relates to a missed diagnosis of 4th degree perineal tear requiring return to theatre for repair on Day 6 with temporary colostomy (anticipated 6-12 months) with period of time on HDU. This incident is being investigated under PSIRF framework.

Additional incidents of note include:

- Brief (10-20 seconds) maternal cardiac asystole during elective caesarean section requiring initiation of CPR. Probable vagal response. 48h report completed.
- 8 Incorrect treatment/test/procedure/pathway
- 4 Born Before Arrival (including one patient that had intentionally free-birthed and one patient who was unaware that she was pregnant and gave birth in ED)
- 3 Readmissions of mother/baby (2 babies with feeding/weight loss/jaundice; 1 maternal readmission as above)
- 3 incidents of patients unable to be triaged within MAC timescales
- One further iron infusion reaction
- In utero transfer at 26+3 weeks
- One intra-uterine death identified at 20 weeks
- Known issue of epidural analgesia not being prescribed on EPMA
- Two incidents where safeguarding information had not been documented in Badgernet and other systems not checked by staff
- Incidents of elective caesarean section being undertaken in Delivery Suite theatre due to scheduling issues.

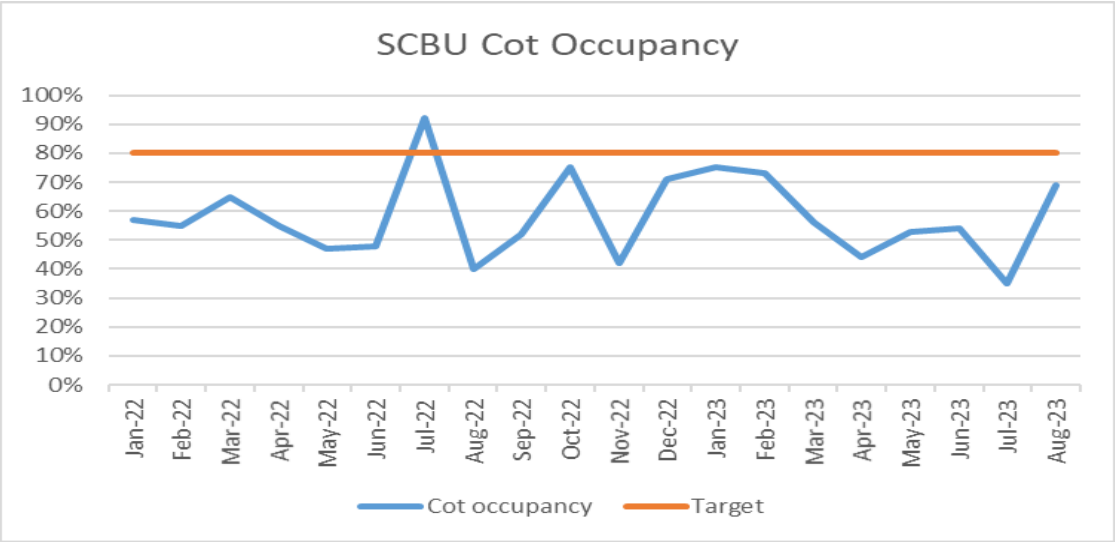
8.5 SCBU Incidents

No moderate harm incidents

8.6 SCBU Risk Register

No new risks. QIS risk to be closed due to being fully recruited.

8.7 Cot occupancy and babies transferred out



One baby was transferred out during August 2023.

8.8 Tendable

The below screenshots taken from Tendable show that both Delivery Suite and Pannal have good compliance with the inspections being completed however 100% compliance has not been achieved. Items of concern relate to the monitoring of fridge temperatures, pressure ulcer skin assessments, and the condition of the patient bathrooms. Action plans are in place and these items remain under review.

Delivery Suite –

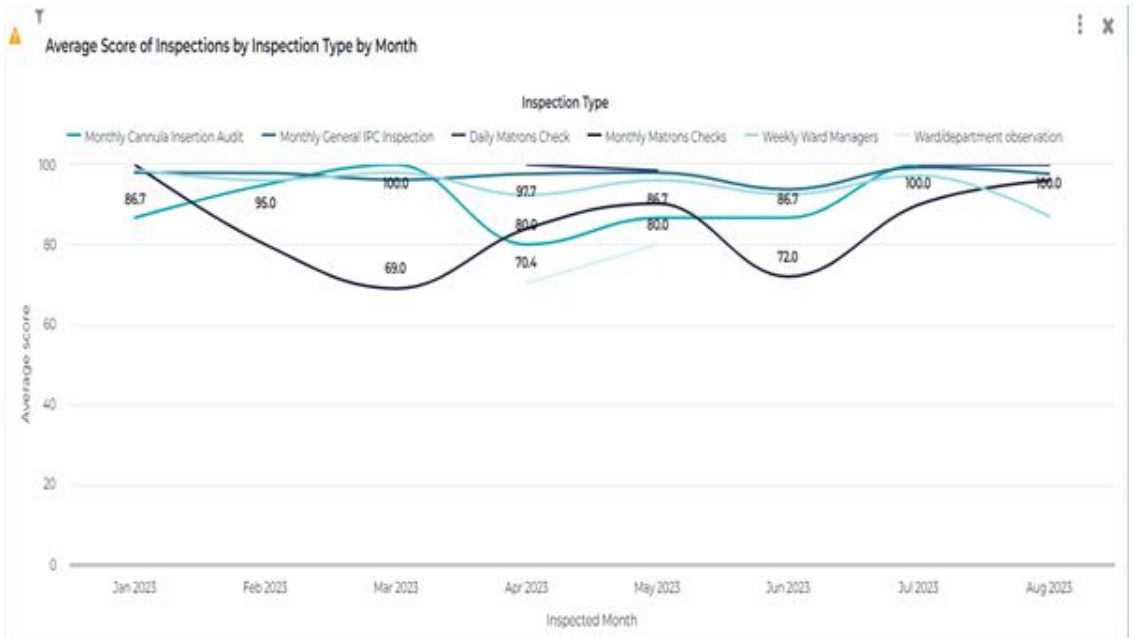
Average Score Across Areas and Inspection Types between 1 Jan 2023 and 31 Aug 2023

		Inspection Type				
	Area	Monthly General IPC Inspection	Daily Matrons Check	Monthly Matrons Checks	Weekly Ward Managers	Ward/department observation
1	Delivery	96.2	92.2	86.8	96.3	80.6

Pannal Ward -

Average Score Across Areas and Inspection Types between 1 Jan 2023 and 31 Aug 2023

	Area	Monthly Cannula Insertion Audit	Monthly General IPC Inspection	Daily Matrons Check	Monthly Matrons Checks	Weekly Ward Managers	Ward/department observation
		Inspection Type					
1	Pannal	91.9	97.3	99.5	85.2	94.6	75.2



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.

Ongoing actions are in relation to communication and counselling, cervical length scanning, lack of personalised care, cross-boundary working, continuity of carer and management of women who decline induction.

10.0 Service User feedback

We have recently received the CQC Picker Maternity Survey results. Of the sixty questions asked ten of the questions scored three percentage points or more better than the national average. Four questions scored three percentage points or more worse than the national average. Two of which had improved since the last survey however two were a deterioration. These four questions are as follows –

1. Felt they were given enough information before induction
2. Able to ask questions afterwards about labour and birth
3. Found partner was able to stay with them as long as they wanted (in hospital after birth)
4. Received support or advice about feeding their baby during evenings, nights or weekends

An action plan is being developed to improve the care provision in relation to this feedback.

SCBU feedback - We have received a Team of the Month award nomination for Special Care Baby Unit, they were nominated by a patient who said -

> *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 Staff feedback

Next quarterly Inpulse Survey due to report in November 2023.

12.0 Complaints

No formal complaints received in August. One concern addressed following Pregnancy and Birth Revisited appointment relating to delayed transfer to Delivery Suite during period of high activity. One delayed multiagency complaint ongoing relating to management of preterm twins.

13.0 Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received.

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

Progress continues against the CQC action plan. The Manager of the Day continues to provide oversight of the equipment checks on a daily basis and this is captured in the Tendable audit – see above point 8.8. Compliance with Safeguarding training and supervision is improving. An audit midwife has started in post in August and is making progress on the actions in relation to audit. No further requests for action have been received.

15.0 Healthcare Safety Investigation Branch (HSIB)

No new HSIB incidents have been reported in August.

There are three active HSIB cases:

- October 2022 Maternal Death/Stillbirth. Cause of death unascertained. Final report received. Arranging tripartite meeting with Yorkshire Ambulance Service, Clinical Director, Associate Director of Midwifery, HSIB and family.
- January 2023 Neonatal death. Post-mortem result received. Draft report received and factual accuracy submitted. Three draft safety recommendations received.
- March 2023 Neonatal cooling. Draft report received and factual accuracy submitted. One draft safety recommendation received.

16.0 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?	Delayed reporting of a fetal loss – one twin demised at 19 weeks but was delivered at 35 weeks with twin. Demise not reported until one month later when identified. Guidance states *'Where the death of a baby is*

	confirmed before 20+0 weeks gestation but the baby is delivered at 22+0 weeks gestation or later AND the birthweight is less than 200g, you will only be required to complete the initial notification.' This may affect compliance reporting.
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. Please see point 21.
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. Business Case in development to consider full implementation of Core Competency Framework Version Two. MDT attendance at training at risk due to strike action. Training Needs Analysis attached at Appendix A
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?	

17.0 National priorities

17.1 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 **Objective 1 - Care that is personalised**	Ongoing and on track – Audit of personalised care required.
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.
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.

17.2 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 regional Continuity of Carer visit took place on 1st August 2023. The regional team were assured regarding the progress on the delivery of the 'building blocks' for continuity. A further update on progress with the building blocks will be provided in October 2023.

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

Quarter One data –

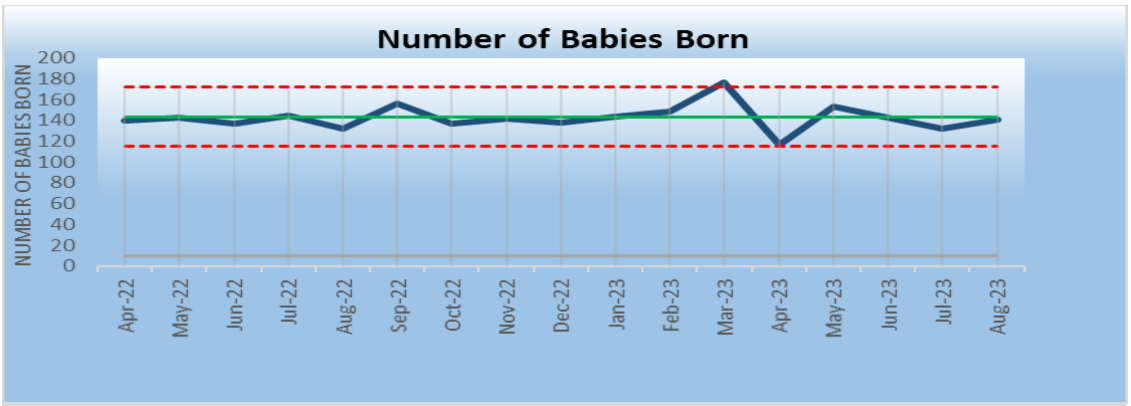
- Bookings less than 10 weeks are 67.4%. Y&H average is 70.2%. No Y&H Trust has yet met the 90% target.
- 1:1 care in labour was 61.5% a decline from 99.7% in Q4. However, there is noted to be a very wide discrepancy between data at other Trusts (61.5-120.5%) which may reflect data accuracy issues and changes in reporting criteria.
- BBA rate 1.5% is comparable to the Y&H average of 1.3%.
- Homebirth rate currently 0.2%, against Y&H average of 0.9%
- Normal delivery rate was 46.8% in this quarter, against a regional average of 52.9%.
- Total Caesarean section rate was 39.0% in this quarter (compared to the regional average of 37.4%). Of these, there were 25.1% elective Caesarean sections (significantly higher than the 15.6% regional average). This is the highest in the region.
- Induction rate in this quarter was 35.6%, and this is comparable to the Y&H average (35.4%), with the highest induction rate in the region being 45.2%.
- Significant PPH rate in this quarter 3.7% is in accordance with the regional average of 3.5%.
- Preterm birth rate <37 weeks in this quarter is 6.3%, this was lower than the regional average of 8.3%.

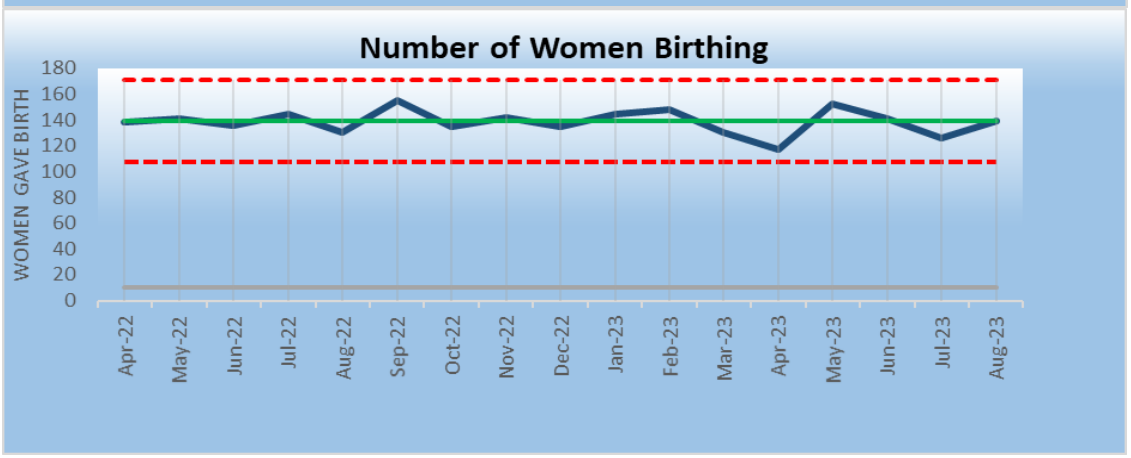
- There were no stillbirths at HDFT in Q1. Annual antenatal stillbirth rate is currently 2.4 per 1000 births compared with the Y&H average of 3.9 per 1000.
- Breastfeeding initiation rates remain high at 83.2% compared with the regional average of 71.0%.
- Smoking rates at booking and time of birth are 3.8% and 2.0% respectively, compared with Y&H average of 10.8% and 9.0%.

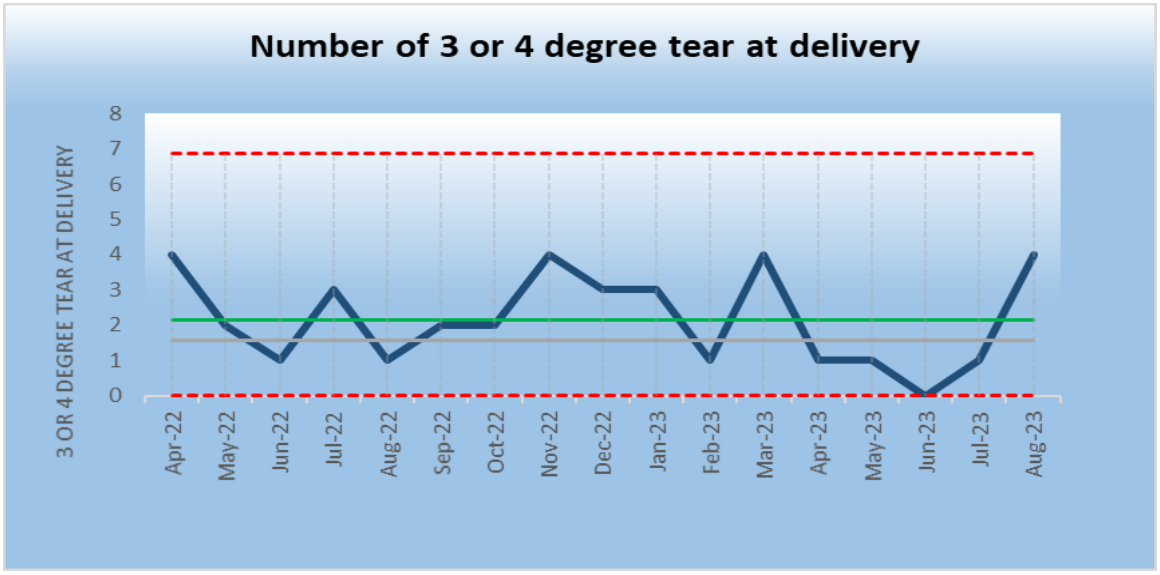
Further details shown in Appendix B.

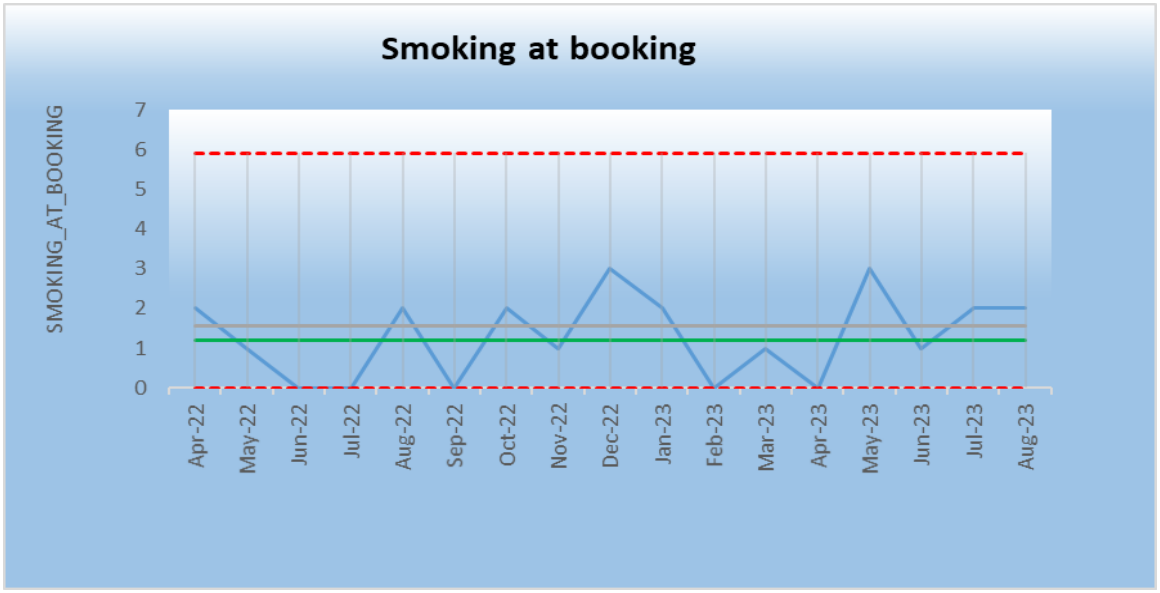
18.0 Local HDFT Maternity Services Dashboard

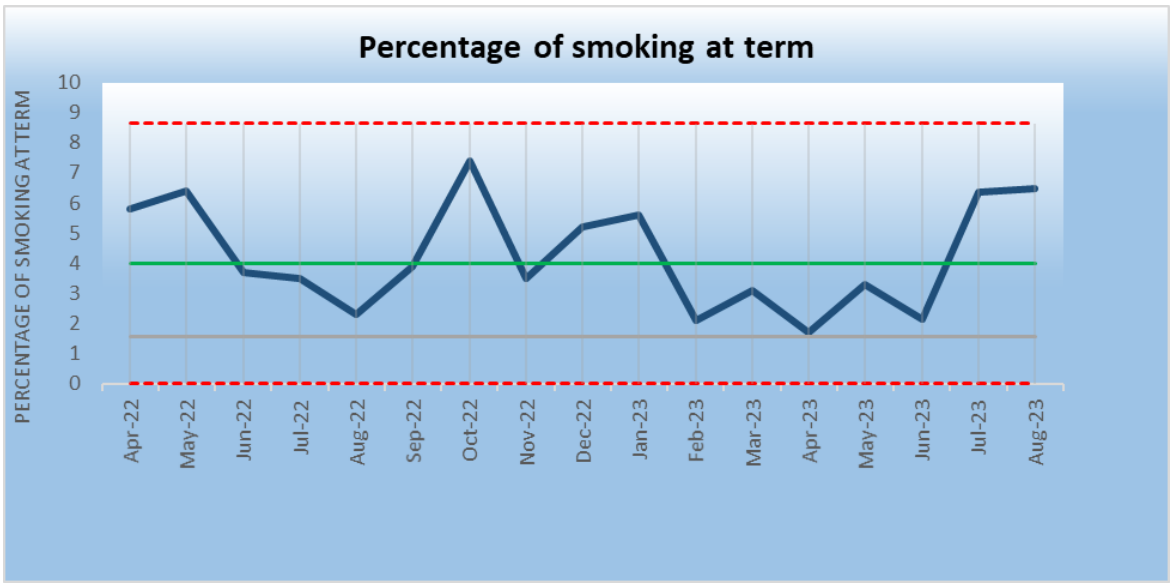
Work is ongoing with the Head of Performance and Analysis, and Data Analysts to present the dashboard in statistical process charts to enable better analysis. The metrics currently available demonstrate that there are no statistically significant outlying metrics this month however there has been an increase in women smoking at birth and women sustaining a 3rd or 4th degree tear. Given the small numbers these are variation of only one or two women.

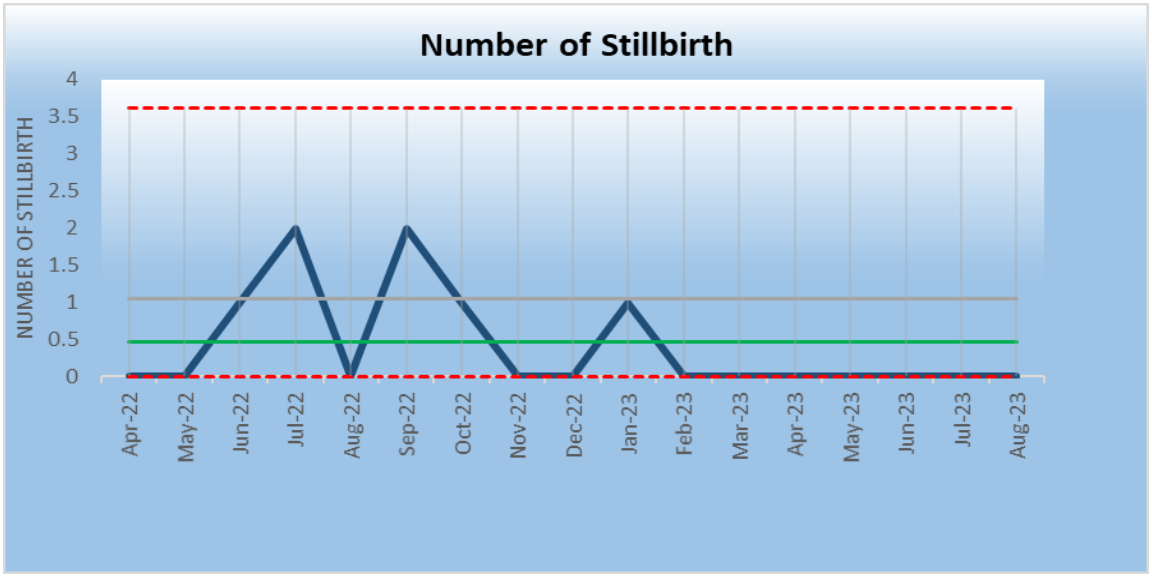





Number of 3 or 4 degree tear at delivery
3 OR 4 DEGREE TEAR AT DELIVERY
0
1
2
3
4
5
6
7
8
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23


Smoking at booking
SMOKING_AT_BOOKING
0
1
2
3
4
5
6
7
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
Aug-23


Percentage of smoking at term
PERCENTAGE OF SMOKING AT TERM
0
1
2
3
4
5
6
7
8
9
10
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
Aug-23


Number of Stillbirth
NUMBER OF STILLBIRTH
4
3.5
3
2.5
2
1.5
1
0.5
0
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
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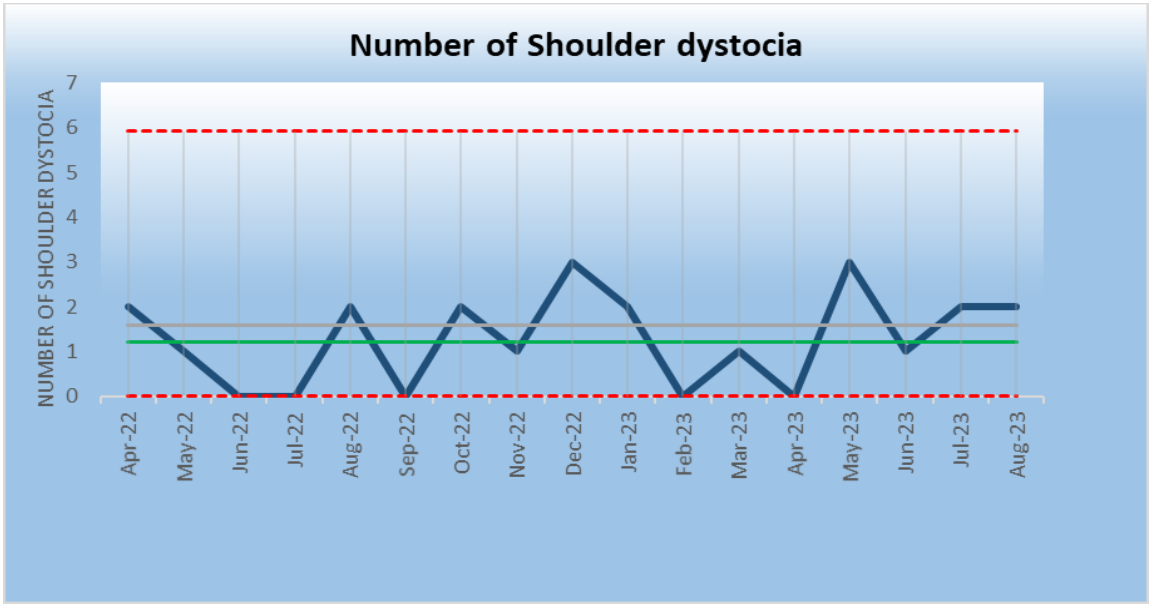
Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
7
6
5
4
3
2
1
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
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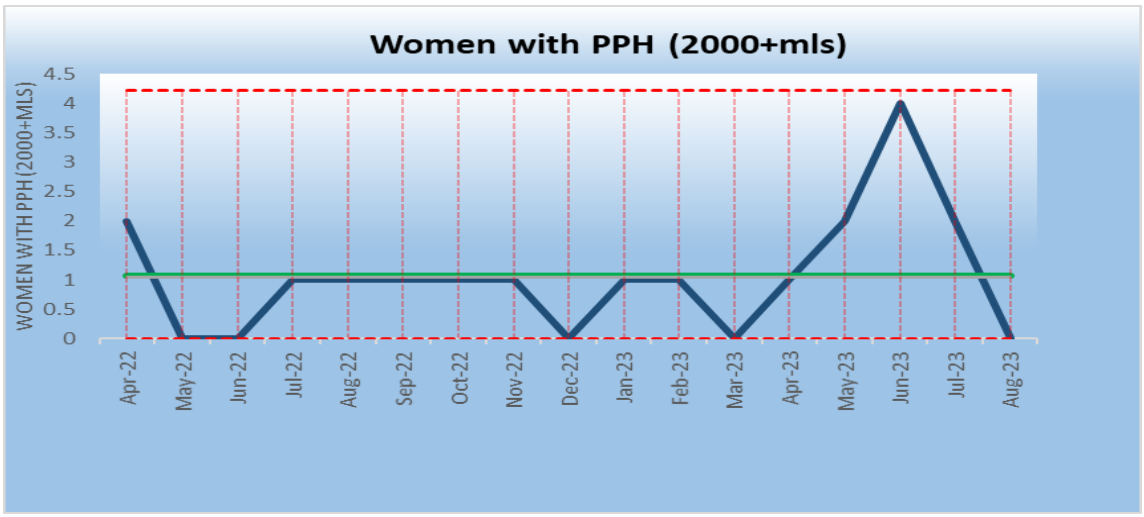
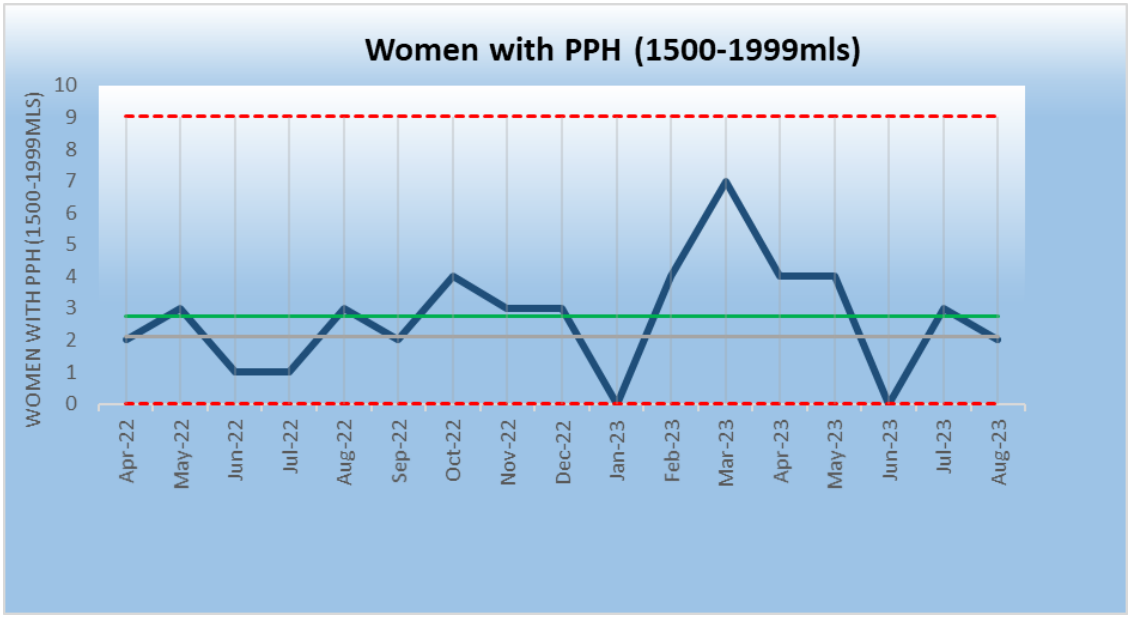
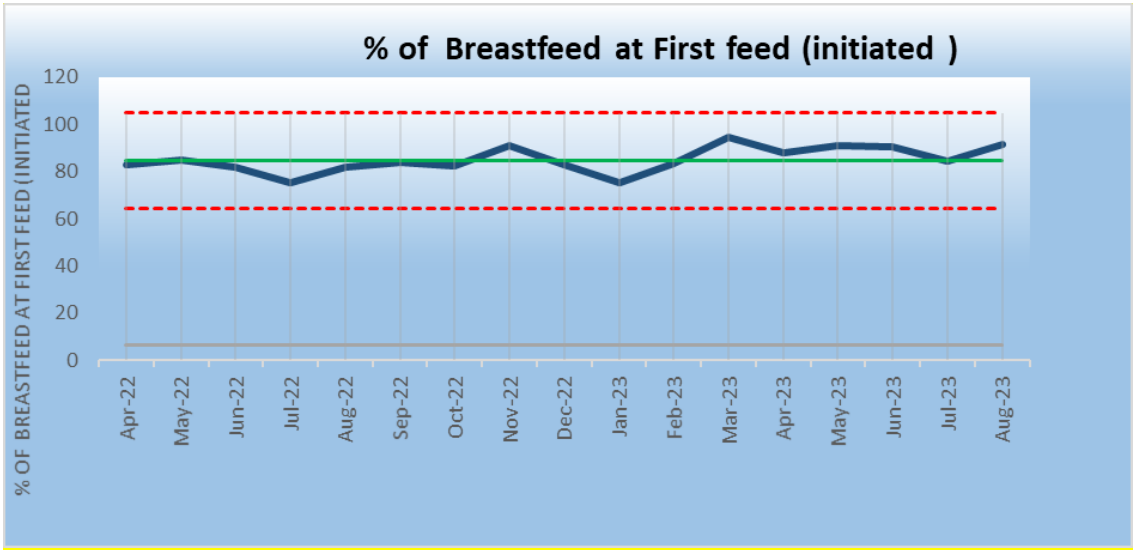
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23


Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
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
Aug-23

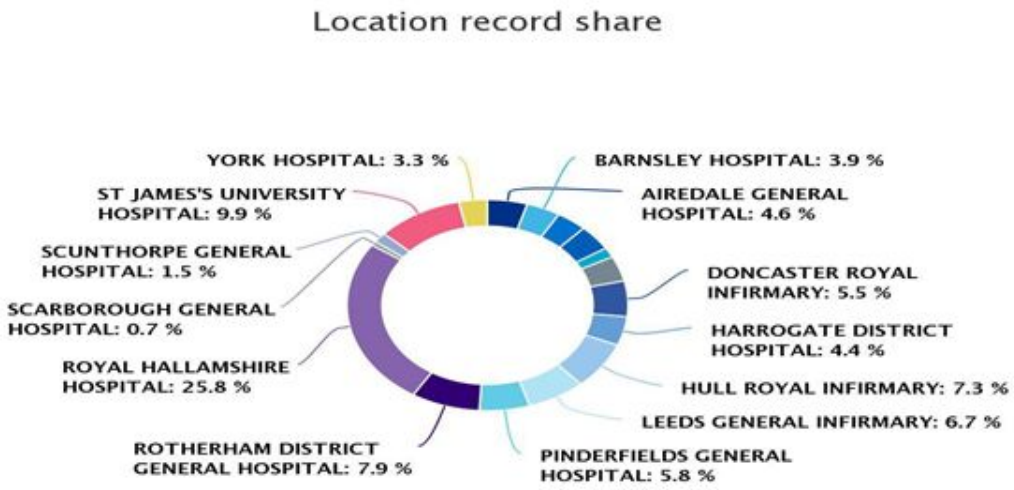




19.0 Maternal Enhanced and Critical Care MEaCC

Maternity services are increasingly tasked with caring for women with complex medical needs in maternity units. Yorkshire and Humber Maternal Enhanced and Critical Care (MEaCC) Task and Finish group was established to review priorities, national standards and recommendations to develop regional recommendations. The aim was to establish the skills and competencies a nurse or midwife should have when caring for a woman with enhanced or critical care needs, whether this care is delivered in a maternity or critical care unit. Enhanced Maternity Care (EMC) is a standard of care beyond normal maternity care for women with medical or surgical problems during pregnancy or the post-partum period, but without the severity of illness that requires full critical care support. Through EMC competencies we focus on early recognition and response to deterioration and closer working between maternity and critical care teams to optimise care. Audit data on women receiving maternal enhanced and critical care is submitted to the MEaCC portal from maternity units across the Yorkshire and Humber region to enable review of the care provision and identify actions that can be implemented to impact on morbidity.

Below data from the portal shows that 4.4% of information to the portal was submitted from Harrogate. This is reflective of our clinical complexity of women we care for.



The data shows us that up to eight women a month require enhanced maternity care each month. The main reason for this enhanced care is postpartum haemorrage however we can identify that 100% of women improved after enhanced maternal care. Actions in relation to this are ongoing and staff are being trained in enhanced maternity care with the support of critical care staff.

20.0 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. A quarterly ATAIN report is included in Appendix B.

20.1 Term Admissions to SCBU

In August, there was two Term newborn admission to SCBU. Both cases are being reviewed at the ATAIN case review meeting.

20.2 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	Current uncertainty about ongoing use of ASCOM devices within the Trust. Normal bleep system continues in use.	Close

Short admission to SCBU but no documentation by paediatric/SCBU staff in notes or Badgernet	Reminder to staff. Datix when no notes are documented. Paediatric staff still using paper notes on SCBU, but documenting Badgernet at delivery and transitional care	Close to continue monitoring
Try to monitor babies for longer on CLWS with borderline sats/work of breathing before admitting	Staff reminded to stay with baby for ≈30 mins if conditions allow. Flowchart distributed. Some improved practice evident	Close to continue monitoring
No formal observations with T21	Ensure formal observations completed in accordance with guideline and add to proforma. Awaiting implementation of NEWTTS2	In progress
Determine acceptable blood sugar level for term babies on neonatal units versus postnatal ward	Discussed with neonatal lead	Close

21.0 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.

Building on the achievements of previous iterations, Version 3 includes a refresh of all existing elements, drawing on national guidance such as from NICE and 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

	Quarter 2	
Small-for-gestational age/Fetal growth restriction detection rates	Q2: 45.5% detection (<10th centile; 20 cases) (National average 43.8%, Top 10 average 63.0%) Q2: 73.3% detection (<3rd centile; 11 cases) (National average 62.2%, Top 10 average 79.3%)	
	Quarter 1 (April-June 2023)	August 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	0.48% (2/418) [<2nd, WHO centiles]	0% (0/143) [<2nd, WHO centiles]
Percentage of babies <10th centile >39+6 weeks' gestation	1.9% (8/418)[WHO centiles]	0.7% (1/143)[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)	1 fetal loss born 16-24 weeks (0.7%, 3/410)	2 fetal loss born 16-24 weeks (1.4%, 2/139)
• Preterm (24+0-36+6 weeks)	5.6% (live, 23/410)	7.2% (live, 10/139)

The Local Maternity and Neonatal System plans to review HDFT evidence for Saving Babies Lives V3 at the end of September. They will validate compliance against each element and complete this in the implementation tool.

22.0 Maternity Safety Champions

Meetings of the maternity safety champions have occurred bi-monthly this year and have been allocated time to continue in to 2024. The executive director and non-executive director maternity safety champions complete a walk around of the unit prior to the meeting, and feedback any concerns raised by staff to the group during the meeting. During this months' walkaround the topics of conversation between staff and the maternity safety champions related to the changes in parking services.

23.0 Conclusion and recommendation

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

Appendix A – Maternity Training Plan

Harrogate and District NHS Foundation Trust

Introduction

Harrogate and District NHS Foundation Trust provides consultant and midwife-led maternity services for a wide geographical area including town and rural communities.

In 2020 we conducted a review of the training we delivered and made a plan to design and deliver a robust programme of multidisciplinary training, delivered in house by our own faculty, using externally validated programmes where required. Each element of the programme incorporated acquisition of knowledge and its application through team work.

This local training plan provides a description of each aspect of training, including what content is required to ensure it meets the standards for compliance.

The training plan will outline our anticipated vision for the provision of Multidisciplinary Training for Maternity at HDFT in the 3 year period from September 2023 – December 2026 and will provide us with clear information regarding the essential training requirements for midwives and other members of the wider multi-disciplinary team, to ensure compliance with National requirements. The plan has been updated to reflect our local capabilities, requirements and Vision at HDFT. It is hoped that a shared model across our LMS will increase the possibility of collaboration and sharing of training resources with our LMNS partners.

Please note – Progress with this training plan is subject to business case approval at Trust level.

Local and National Drivers.

The past few years has seen significant changes in the training required for those who care for women in a birth setting. The most noteworthy of these being:

- Saving Babies Lives Care Bundle v 3 (2023)
- Maternity Transformation Core Competency Framework v (2023)
- NHS Resolution (2023) Maternity Incentive Scheme - year 5
- The Final Ockenden Review (2022)
- The Single delivery plan (2023)

Key National Requirements / Evidence / Further reading

Link for NHS Resolution Maternity Incentive scheme (MIS) yr 5

https://resolution.nhs.uk/wp-content/uploads/2023/07/MISyear5-update-July-2023.pdf

Link for The 3 year single delivery Plan

https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/

Link for Final Ockenden review

https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions

Link for Each Baby Counts Learn and Support resources (inc AID and Treat or Treat)

https://www.rcog.org.uk/about-us/groups-and-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/escalation-toolkit/

Link for Core Competency Framework v2

https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/

Link for Saving Babies lives v3
https://www.england.nhs.uk/long-read/saving-babies-lives-version-3/

The Core Competencies Framework v1 (2020) was developed in partnership with national maternity partner organisations including the Royal Colleges, HSIB, NMC and NHS Resolution. This key document was published in 2020 detailing additional training requirements for maternity Trusts (NHS England 2020).

The Core Competency Framework v 2 aims to address the known variation in training and competency assessment across maternity services in England and ensure that Trusts meet the Ockenden immediate and essential actions in relation to workforce planning and, sustainability and multidisciplinary team training.

This local training plan is in place to ensure that all six core modules of the core competency framework version 2, will be included in our training programme, in order for HDFT to meet the standard required for the Maternity Incentive Scheme (MIS) Safety Action 8 of the Clinical Negligence Scheme for Trusts (CNST).

HDFT Maternity is part of West Yorkshire and Harrogate Local Maternity & Neonatal System (WY&H LMNS) which comprises 6 Acute Trusts. These trusts differ greatly both in size and patient demographic but have developed close links and a proven track record of partnership working particularly in relation to training.

Further detailed information to support this training plan can be found in HDFT CCFv2 TNA.

Information is also provided below on the provider of the training (or Subject matter expert – SME) and how to access any additional resources. Details include length, frequency and supportive evidence; including which national requirements underpin the need for each aspect of training. A summary table of requirements is provided below detailing frequency of attendance to each aspect of training. This will allow staff to plan their training needs in advance and allows workforce leads to plan staffing relating to hours allocated to training and how often.

Participation in training will be recorded in conjunction with the Learning and Development Team and will be visible to staff via their 'Learning Lab'. This will make it easier for staff to monitor their own compliance, reflect on their learning, record this for their revalidation and make it easier for compliance data to be collected by the Professional Development / Fetal wellbeing Midwives (Kathy McClune + Charlotte O'Donovan)) or Miss Siobhan Wilson (Training Lead / Fetal Wellbeing Lead Obstetrics.

All role specific training requirements for MIDWIVES that have been identified from the local and National Drivers are detailed in the 6 modules outlined below. Some are role specific and some will also apply to the Maternity MDT – namely Obstetricians, Maternity support workers, Anaesthetists, Neonatal nurses, Theatre staff and critical outreach staff. It comprises 3 CCFv2 modules and additional role specific training requirements. Additional training requirements are also described.

Module 1 – Saving babies Lives Care bundle

In 2023 all Midwives and Obstetric staff have been required to complete training on the saving babies Lives Care bundle via the online e-learning for health platform. This has been recorded on an individual's Learning lab.

Guidance in version 2 of the Core competency framework states that this mode of training is acceptable once every 3 years.

From January 2024, we will expect Midwives and Obstetricians to complete 5 elements of locally produced pre-recorded training via Learning lab.

Comprising the following -

- Fetal growth
- Reduced Fetal movements
- Smoking
- Diabetes
- Pre-term birth

Details of the content of each of these elements can be found in the HDFT CCFv2 TNA

Fetal Monitoring will be a stand-alone face to face day. A practical demonstration and assessment of SFH measurement will take place on this day.

Module 2 – Fetal Monitoring Training

Fetal Monitoring training at HDFT comprises 4 elements -

- Annual attendance on an MDT Face to face training in Fetal wellbeing and Fetal Monitoring for Midwives and Obstetricians.

The content of this full day has been set out and agreed by the West Yorkshire and Harrogate LMNS Fetal Wellbeing Leads forum which meets every month. Details of the content of this day can be found below.

- Competency assessment – Currently Midwives at HDFT are expected to complete a competency assessment in Antenatal CTG, Intrapartum CTG and Intermittent auscultation via the K2 online platform. The current pass mark is 80% but from January 2024 this will rise to 85% in line with National requirements.
  K2 can be accessed here –
  https://training.k2ms.com/Secure/Logon.aspx

- Annual update Training in the use of a Phillips CTG monitor, a Huntleigh CTG monitor, Dawes Redman analysis for AN CTG interpretation for Midwives.
  All Midwives who use CTG machines must complete a self-declaration of competency (annually) for each CTG device that they use.

- Participation in an MDT fetal monitoring case review in the clinical area led by one of the FM leads – when acuity allows.

As a Trust we must report as part of the Maternity Incentive scheme for CNST (Clinical Negligence Scheme for Trusts)

- Percentage of staff who have received training on CTG interpretation and auscultation, human factors and situational awareness
- Percentage of staff who have successfully completed mandatory annual competency assessment.

Saving Babies Lives v 2 sets out clear directives as to what Fetal Monitoring training staff should receive and what assurance Trusts require. Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret cardiotocographs (CTGs), always use the buddy system and escalate accordingly when concerns arise or risks develop. All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG)interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors

No member of staff should care for women in a birth setting without evidence of FM training and competence within the last year.

- Midwives this comprises of face to face training, competency assessments and equipment training.
- Obstetricians this comprises of face to face training and competency assessment.

Any staff member who does not have evidence will be contacted via email and their line manager informed.This will be escalated to the clinical lead for Obstetric or Matron for Maternity who will make a decision whether to remove the individual from clinical work in a birth setting.

The content of the Fetal wellbeing day will include –

- Effective fetal monitoring in low-risk pregnancies using IA, the role of IA in initial assessment, in established labour and indications for changing from IA to CTG.
- Impact of antenatal risk factors such as fetal growth restriction and intrapartum risk factors such as maternal pyrexia.
- Fetal responses to labour including changes in fetal heart rate (FHR).
- Interpretation of CTG including: normal FHR parameters, impact of intrapartum fetal hypoxia on the FH, classification of CTG, holistic interpretation of fetal monitoring in specific clinical circumstances (such as previous caesarean sections, breech and multiple pregnancy).
- Channels of communication to follow in response to a deteriorating CTG trace, and escalation.
- All staff to be competent in the use of fetal monitoring equipment.

At HDFT the Fetal Wellbeing Leads are –

Kathy McClune

Charlotte O'Donovan

Miss Siobhan Wilson

Module 3-Emergency skills Training

Feedback for both our PROMPT and Fetal Monitoring MDT courses has been consistently very positive from all staff groups and encouraged different staff groups to get to know each other in a 'Safe' learning environment

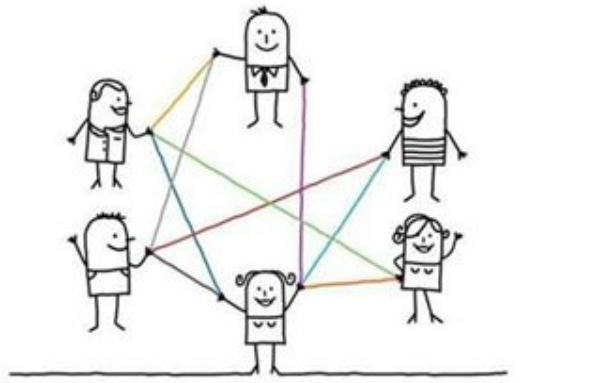
PROMPT- (**Pr**actical **O**bstetric **M**ulti-**P**rofessional **T**raining)

This is a full day Multidisciplinary course which is essential annual training for Midwives, Obstetricians, Obstetric anaesthetists and Doctors in training

This course is preferred for MSW, Obstetric ODP's, theatre staff and critical care outreach.

Our PROMPT (**Pr**actical **O**bstetric **M**ulti-**P**rofessional **T**raining) timetable is adapted annually to incorporate learning from incidents and all scenarios were underpinned by a focus on Human Factors (Situational Awareness, Teamwork, Communication and Timely Escalation)

We have learnt that human factors affect all aspects of clinical care, not just decision making in acute emergency situations. Patient safety in maternity is dependent upon excellent leadership, strong inter-disciplinary relationships, effective team work and evidence-based clinical care. We remain committed to building on our multi-disciplinary training in a way that fosters trust between individuals and staff groups, ensures our workforce maintains the knowledge underlying the provision of safe care and promotes excellent team working.



At least 11 sessions for hospital staff and 2 for Community Midwives and paramedic staff will be delivered each year. Midwives who work both in hospital and at home births will be expected to attend both days each year. Midwives who only work in a community setting will attend a community emergency skills course alongside Colleagues from Yorkshire Ambulance service.

The following will be covered by PROMPT at HDFT during the 3 year period running from September 2023– 2026. Our PROMPT timetable is updated every September.

- Shoulder Dystocia
- Breech
- APH
- PPH
- Cord prolapse
- Eclampsia
- Maternal collapse
- Maternal Critical care
- Sepsis
- VBAC and uterine rupture
- Impacted Fetal head
- Team culture / Civility
- Psychological Safety
- Adult basic life support
- Maternal mental health emergency
- Human factors – Communication, escalation, teamwork and Situational awareness.
- Learning from excellence scenario

We may also include additional topics in response to SI's, complaints or incidents, either locally at HDFT or in response to incidents of themes identified nationally or locally by HSIB, or West Yorkshire and Harrogate LMNS.

It is not always possible to run one of the simulations on PROMPT in the clinical area . We will therefore plan and facilitate a Monthly live drill of a simulated emergency. This may take place on either Delivery Suite, Pannal ward, ANC, Theatres or the Emergency department.

Module 4 – Equality, Equity and Personalised Care

From January all midwives will attend a half day of locally produced face to face facilitator led training. This will focus on Maternal metal health, personalised care and support planning and communication.

This training will be delivered by our perinatal mental health Midwife,will include local guidance, referral procedures and 'red flags and include local case histories.

We will use training resources during this day that have been co-produced locally with our MVP to learn directly from service user voices and include training on advanced communication skills for personalised care.

Safeguarding childrens level 3 specialist training –

In the period Jan 2023 – 24 all Midwives and Obstetricians at HDFT will have completed training in child sexual exploitation (CSE) and female genital mutilation (FGM) plus an update on routine enquiry about domestic abuse and DASH risk assessment

From January 2024 onwards will be a half day face to face and include learning that fulfils the requirements of Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff at level 3 including maternity role specific additional knowledge skills and competences. This will ensure that as a trust we are compliant with the intercollegiate document.

Training will include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, and lessons from research and audit.

Learning outcomes will include:

- To know how to undertake, where appropriate, a risk and harm assessment.
- To know how to contribute to, and make considered judgements about how to act to safeguard/protect a child or young person, including escalation as part of this process.
- To know how to appropriately contribute to inter-agency assessments by gathering and sharing information, documenting concerns appropriately for safeguarding/ child protection and legal purposes, seeking professional guidance in report writing where required
- Able to assess the impact of parental issues on the unborn child, children, young people, and the family, including mental health, learning difficulties, substance misuse, and domestic abuse and violence
- To know how to work effectively on an inter-professional and interagency basis when there are safeguarding concerns about children, young people and their families.

- To know how to effectively manage diagnostic uncertainty and risk.
- To know how to advise other agencies about the health management of individual children in child protection cases.

Module 5 – Care during Labour and immediate PN period

In 2023 we have been delivering a locally produced training update on GBS, OASI, Infant feeding and Operative vaginal birth (failed forceps scenario)
Moving into 2024 we will improve the quality of this training by delivering additional face to face training for Midwives. It will be preferred that this session will be also attended or facilitated by at least 1 Obstetrician to ensure that this training is meaningful and fosters a culture of mutual respect, psychological safety and excellent team-working.

Training will Include –

- learning from incidents, audit reviews and investigations, service user feedback and local learning
- Learning from themes identified in national investigations e.g. HSIB
- Have a focus on deviation from the norm and escalating concerns
- Include national training resources within local training e.g., OASI Care Bundle (obstetric anal sphincter injuries), RoBUST Operative Simulation Birth Course, prevention and optimisation of premature birth. .
- Be tailored for specific staff groups depending on their work location and role e.g. Homebirth or birth centre teams/ MSW

The following subjects will be covered over the next 3 year period.

Management of labour including latent phase

VBAC (vaginal birth after caesarean) and uterine rupture

GBS (Group B Streptococcis) in labour

Management of epidural analgesia and recovery care after general anaesthetic

Operative vaginal birth

Pelvic Health & Perineal Trauma – prevention of & OASI pathway and PFMT

Multiple Pregnancy

Infant Feeding

ATAIN (Avoiding Term Admissions into Neonatal Units).

See HDFT CCFv2 TNA for annual content

Module 6 – Neonatal Basic Life support

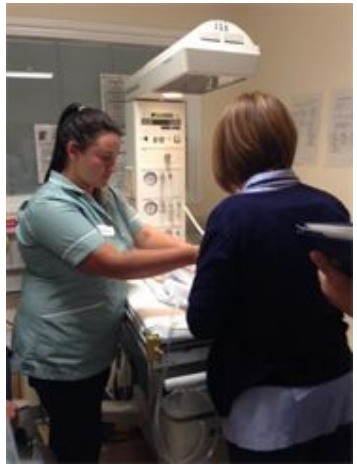
From January 2023 we have made improvements, in line with National recommendations, to our in- house Newborn life support training.

This training will be further improved from January 2024 to include an MDT scenario and cover scenarios in different environments.

A focus on the importance of communication, escalation, psychological safety and teamwork will be emphasised.

We are committed to ensuring that we have sufficient RCUK accredited trainers to deliver the highest quality training and that all band 7 delivery suite co-ordinators and community midwives, who attend home birth, attend a national RCUK NLS course every 4 years.

We hope to be accredited as an RCUK NLS training centre in 2024.



Additional Training requirements

Skills & Drills (Clinical and community areas)

This is Unit level multi-professional training for all staff caring for pregnant & postpartum women.

Skills & Drills relate to practical ad hoc sessions, to test systems, held within clinical areas and are led by the shift leaders or education teams within the trust.

They may be based on hospital or community based scenarios. They may also take place in the Emergency Department to improve Multi-professional team working. When taking place in a hospital environment the whole team

Including Theatre staff, Maternity support workers and Theatre staff / ODP's will be involved.

Skills & Drills may cover the following topics in line with core competencies framework:

- Antepartum Haemorrhage and Postpartum Haemorrhage
- Impacted Fetal head
- Pre-eclampsia/eclampsia severe hypertension
- Uterine Rupture
- Sepsis
- Maternal resuscitation
- Vaginal breech birth
- Shoulder dystocia
- Cord prolapse
- Team culture / escalation

It is hoped that the Skills & Drills approach will be agreed across the LMS with standardised scenarios being delivered in line with risks identified and reviewed regularly. It is also hoped that Trusts within the LMS can work together collaboratively to deliver Skills and Drills.

Human Factors Training

Teamwork, Communication and Situational awareness are key elements of Human Factors training that we have incorporated into all our training at HDFT Maternity.

This has been in response to key recommendations.

- NHS England (2020) Core Competencies framework v 1: Delivery of training requirements must include consideration of human factors.
- CNST Safety Action 6, element 4: Percentage of staff who have received training on fetal monitoring in labour in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.

We have utilised locally trained Human Factors trainers to embed learning about Human factors in order to improve MDT team working in safety critical situations. We focus on maintaining situational awareness and the importance of escalation.

We have developed specific training and a Simulation in response to a serious incident of failed forceps and impacted fetal head. This has been shared with our LMS partners.

The following resources have also been utilised –

RCOG Human Factors & Situational Awareness Video - https://vimeo.com/237708522

Little Voice Inside video - http://voiceinside.co.uk/

Each Baby Counts learn and support - https://www.rcog.org.uk/about-us/groups-and-societies/the-rcog-centre-for-quality-improvement-and-clinical-audit/each-baby-counts-learn-support/

Human Factors training will be incorporated into all Fetal Monitoring and MDT emergency skills training.

In 2024 this training will focus on Civility and its effect on patient safety and the importance of a culture of Psychological safety within teams to ensure effective team work and clinical escalation.

Infant feeding and relationship building

All Midwives will be required to attend full day of face to face, Once only - within 6 months of employment, complete a course workbook and have a skills review. All Midwives will then be required to have an update session every 3 years delivered by the Infant feeding Lead Midwife.

Jo Orgles – joanne.orgles@nhs.net

The update will cover any areas of weakness in implementing the standards and / or updates to consolidate training.

The training will enable midwives and maternity support workers to implement the infant feeding policy and provide effective information and care according to their role. The training will cover:

- Why breastfeeding is important
- Early relationships
- How breastfeeding works
- Skin to skin contact and immediate care after birth
- Supporting effective breastfeeding
- Supporting responsive formula feeding
- Person centred communication
- Implementation of the International Code of Marketing of Breastmilk Substitutes

In addition the midwives will also cover:

- Recognition and management of the at risk baby and implementing the hypoglycaemia policy
- Jaundice in the newborn
- Breastfeeding support for pre-terms
- Recognition and management of breastfeeding complications

National Requirements / Evidence / Further reading related to infant feeding

Health Matters: giving every child the best start in life (2016) https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life

Healthy Child Programme (hcp) https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life

Nursing and midwifery actions at the three levels of public health practice (2014) https://www.gov.uk/government/publications/nursing-and-midwifery-actions-at-the-three-levels-of-public-health-practice

1001 Critical Days Manifesto (2015) https://parentinfantfoundation.org.uk/1001-days/

A framework for Personalised Care and Population Health (2014)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/377450/Framework_for_personalised_care_and_population_health_for_nurses.pdf

Screening

As a provider of maternity care and screening services, HDFT is responsible for:

- ensuring that there is an ongoing educational programme for staff/health professionals involved in screening
- funding training requirements to maintain an effective screening workforce, including continuous professional development
- maintaining a record of training

The following specifications are a requirement from the Service specifications for all ANNB screening programmes in the contract with our Commissioners -

- Yearly update on new or extended services in the Antenatal and Newborn Screening Programmes
- Review of existing services that are less known or used
- Updates on incident outcomes
- Updates on screening programmes outcomes

All new starters at HDFT Maternity are required to complete the NBBS e-learning on e-lFH – unless they have evidence of prior completion.

All Midwives will be required to complete the AN and PN screening training package on E-lfh ONCE.

Updates will be delivered either via the e-LFH portal or in house by screening team – Odile Poole odile.poole@nhs.

Enhanced Maternity Care training:

CNST Safety action 8 requires that the multi-professional labour ward team (midwifery, obstetrics, anaesthetics as well as representatives from medical & critical care specialists) should have training in maternal critical care, including: the use of maternal critical care observation charts, structured review pro formas, deterioration & escalation thresholds, timing of birth and postnatal care.

These training sessions should also cover the importance of twice-daily multidisciplinary structured reviews to ensure comprehensive, multi-disciplinary and coordinated care across different care settings.

MIS Safety Action 8 requires that the multi-professional labour ward team should have training in enhanced maternity care (EMC). A bespoke course has been developed under the leadership of Dr Hayley Kemp (Consultant Anaesthetist) in collaboration with the Critical Care Outreach Team, and with support from staff from the Intensive Care Unit (ICU). The training is designed to equip midwives with the skills required to provide care to those women who become acutely unwell during pregnancy and birth, are at risk of deterioration, or who might recently have been "stepped down" from the intensive units.

Course attendees in the first instance have included Labour Ward Coordinators, core Labour Ward midwives, and those midwives who have expressed an interest in providing care to "high-risk" women. The training will then be rolled out through the workforce, with the minimum requirement that there is at least one member of staff on each shift who is EMC trained.

Training comprises attendance at the Maternal Acute Illness Management (AIMS) and modified PROMPT-CIPP (Care of the Critically Ill Pregnant Patient) one-day courses, held in-house, and then an observation placement on ICU. The AIMS course includes teaching on recognition of the deteriorating patient and A-E assessment, sepsis, shock, neurological conditions, fluid balance management, situational awareness, human factors and escalation tools, and COVID-19. To complete the course, attendees are required to pass an OSCE-style assessment and MCQ test. The PROMPT-CIPP course comprises further teaching and skills stations covering specialised critical care observation charts and fluid balance calculation, ECG interpretation, airway management and the administration of oxygen therapies, and the management of central and peripheral lines. Once these courses are completed, staff are rostered to complete a 6 hour observation placement in the ICU (ideally within six weeks), where they will be able to consolidate this teaching and hopefully get some hands-on experience. EMC midwives are also provided with a competency passport (approved by the Yorkshire the Humber Clinical Network's MEaCC steering group), as evidence of their training, to record any skills demonstrated, and to ensure these skills are transferrable when staff move around the region.

Bereavement care:

Yorkshire & Humber Stillbirth & Bereavement Care Recommends training for Maternity Services. Many Midwives report low levels of confidence in dealing with bereavement cases.

The NHS Core competency framework Priority area 4 – personalised care stipulates that staff must receive Bereavement care training.

At HDFT all staff who care for women have received a face to face update delivered in house by our specialist bereavement Midwife

during the period 2021-2024 on the following-

- An update on the unit's policies & procedures
- Causes of Stillbirth
- Effective & sensitive communication with bereaved parents including self-awareness
- Cultural or religious aspects
- Post Mortem
- Funeral arrangements

Blood Transfusion / anti D training :

The taking of blood samples and safe administration of blood products is not Maternity specific training but all Midwives must receive this training once on commencement of employment at HDFT.

New starters are notified to the transfusion dept and one of the team will provide 1:1 training and assurance of competency within the clinical area. Generic training regarding blood components does not cover the administration of Anti D in midwifery practice. To comply with the safe administration of blood components national requirements this element is a new additional requirement for maternity staff.

Staff are required to access the Anti – D clinical module via eLFH every 3 years. Topics covered include:

- Understanding Maternal Sensitisation
- Anti-D Prophylaxis
- Management of Pregnancies at Increased Risk
- Anti-D - Routine Use
- Anti-D - Informed Decision Making
- Anti-D - Safe Storage and Administration

A face to face update on Safe transfusion practice and the Major Obstetric haemorrhage protocol will be delivered in 2022-23 to Midwives by the Transfusion department as part of the Mat 1 training day.

Additional Supporting Information

- NHS England (2020) Maternity Transformation Core Competencies framework https://www.england.nhs.uk/wp-content/uploads/2020/12/core-competency-framework.pdf
- NHS England (2023) Maternity Transformation Core Competencies version 2 https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/
- NHS Resolution (2021) Maternity Incentive Scheme – year five
- NHS Resolution (2020) Maternity Incentive Scheme. An interim evaluation. NHS Resolution. https://resolution.nhs.uk/wp-content/uploads/2020/04/Maternity-Incentive-Scheme-evaluation-report.pdf
- NHS England (2020) Better Births,Four Years On; A review on progress. https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf
- Saving Babies Lives Care Bundle Version 2 (2019) https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf
- NHS Resolution Maternity Incentive Scheme (2019) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
- The NHS Long Term plan (2019) Maternity and Neonatal Services https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
- The Okenden Report (2020) The Department of Health, London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943011/Independent_review_of_maternity_services_at_Shrewsbury_and_Telford_Hospital_NHS_Trust.pdf
- Health Education England (2018) HEE Maternity Programme e-LfH Guide. HEE. London https://www.hee.nhs.uk/sites/default/files/documents/Maternity%20Programme%20e-LfH%20Guide%20v3%20June%202018.pdf
- Health and Social Care Evaluations (2018) The Maternity Safety Training Fund: An Evaluation. Health Education England. https://www.hee.nhs.uk/sites/default/files/documents/Maternity%20safety%20transformation%20fund%20evaluation%20Feb%202019.pdf
- NHS England (2020) Core Competencies Framework https://www.england.nhs.uk/wp-content/uploads/2020/12/A-Core-Competency-Framework-FINAL-REVISED-21.12.-2020-002.pdf
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- NHS England (2016) The National Maternity Review. Better Births, Improving Outcomes of Maternity Services in England.

- Dixon-Woods, M., Liberati, E., Tarrant, C., Willars, J., Draycott, T., Winter, C., ... & Hocking, L. (2020). Seven features of safety in maternity units: A framework based on multi-site ethnography and stakeholder consultation.
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- Kirkup, B. (2015). The Report of the Morecambe Bay Investigation: An independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013. Stationery Office.
- Royal College of Obstetricians and Gynaecologists. (2017). Each Baby Counts: 2015 Full Report.
- Gale, A., Hanson, J., Schram, C., & Davis, M. (2019). Better training, better births project: a preliminary evaluation. Med Ed Publish, 8.
- Healthcare Safety Investigation Branch (2021) National Learning Report. Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic. https://www.hsib.org.uk/documents/285/HSIB_Maternal_Death_Report_V13.pdf
- Care Quality Commission (2020) Getting Safer Faster: key areas for improvement in Maternity Services. https://www.cqc.org.uk/publications/themed-work/getting-safer-faster-key-areas-improvement-maternity-services

Essential Maternity Requirements summary

Training	Frequency	Access	Time allocated
BFI 1 Day	Once only	Via infant feeding lead Jo Orgles either face to face or via e- learning workbook	7.5 hours
Transfusion training	Once only	Linda Lowry / Transfusion	One hour
Newborn blood spot training	Once only	E learning for health	30 mins
Antenatal / Postnatal screening	Once only	E learning for health	4 hours
Very Brief advise	Once only	E learning for health	One hour
Female genital mutilation	Once only	E learning for health	2 hours
TOTAL HOURS FOR (Maternity specific) ONCE ONLY TRAINING REQUIRMENTS			15 hours
PROMPT (PRactical Obstetric Multi-Professional Training) Face to Face	Yearly	PROMPT faculty	7.5hours
Face to face Fetal Wellbeing Training (Mat 2)	Yearly	Fetal Wellbeing Lead Midwife and Obstetrician	7.5 hours

Care in labour and PN / personalised care	Yearly	PDM's	7.5 hours
Saving Babies Lives Care bundle	Yearly Modular training delivered by Learning Lab or e-lfh	https://www.e-lfh.org.uk/	7.5 hours
Harrogate Newborn life support	Yearly	Half day face to face	3.45hours
Safeguarding level 3	Yearly	Half day	3.45 hours
Skills & Drills (clinical and community areas)	Yearly	In Trusts	Variable – not associated with time allocation as delivered with teams on shift
TOTAL HOURS REQUIRED FOR (Maternity specific) YEARLY TRAINING REQUIRMENTS			37.5
Anti D training	Three yearly	https://www.e-lfh.org.uk/	30 mins
Safeguarding children Level 3 specialist	Three yearly	https://www.e-lfh.org.uk/	4 hours (per year)
TOTAL HOURS REQUIRED FOR THREE YEARLY TRAINING REQUIRMENTS			12.5 hours

Personal Training Passport

NHS
Harrogate and District
NHS Foundation Trust

Training Requirement	Year One - date	Year Two - date	Year Three - date	learning points / hours
Prompt / Emergency skills				
K2 Fetal Monitoring competency assessments				
Child sexual exploitation				
Safeguarding Level 3 specialist update				
Face to face fetal monitoring training				
FM equipment training Phillips & Huntleigh				
FGM				
Epidural Training (e learning) Human Factors training				

Maternal critical care + theatre recovery				
Smoking VBA				
Smoking update				
Raising awareness of reduced fetal movements				
Immediate PN care				
Care in labour				
Breastfeeding Update				
Maternal Mental health				
Gap/ELFH				
Cultural competency				
Saving Babies lives e-learning				
Bereavement care Update				
Learning from incidents / Andy's update newsletter				

Draft timetable – PROMPT MDT training day

	Sessions	Timing	Facilitator
08:30	Housekeeping and Ice breaker	10 mins	WE
08:40	Introduction – local learning, HSIB, MBRRACE	40 mins	SW
09:20	Service user story and race inequality	20 mins	KMcC
09:40	APH teaching	30 mins	SW
10:0:0	Coffee		
10:15	APH scenario and feedback	30 mins	
10:45	LAST teaching	20 mins	WE
11:05	Cord prolapse scenario and debrief	55 mins	
12:00	Clinical escalation / Human factors	15 mins	KMcC
12:15	Lunch		
13:00	Uterine rupture CBD	45 mins	KMcC/COD/ECJ

13:45	Anaphylaxis scenario and debrief (in clinical area)	45 mins	
14:30	Civility, psychological safety	30 mins	KMcC
15:00	Tea		
15:15	AFE and Maternal collapse, including ABLS	1 hour	SW/WE/KMcC/COD
16:15	Feedback and key learning points	15 mins	
16:30	Close		

Draft timetable Mat 1 – NLS and Safeguarding Training

Time08.00-16.00	**Session –**	**Location**	**Facilitator**
08.30-10.00	Newborn Life Support – updated 2021 RCUK guidance part 1		Kathy McClune Paula de Souza
10.00-10.15	COFFEE		
10.15-11.30	NLS part 2		Kathy McClune Paula de Souza
11.30– 12.30	Domestic abuse?? IDAS / police speaker		TBC
12.30 – 13.15	LUNCH		
13.15 – 16.30	Safeguarding children level 3 training To include 15 min tea break		Vanessa Corrigan Safeguarding team
16.30	Evaluation and close		

Draft timetable Mat 2 – Fetal Wellbeing MDT training		
Mat 2 Time: 08.30 – 16.30	**Session**	**Person Facilitating Session**
08.30 – 09.30	Intermittent auscultation – role in initial assessment and established labour.	TBC
09.30– 10.00	Human factors – psychological safety and clinical escalation	KMcc
10.00-10.30	Update on NICE guidance and Service user involvement	TBC
10.30-10.45	Coffee	
10.45 – 11.30	Impact of Risk factors – Antenatal and Intrapartum	
11.30 – 12.15	AN CTG case discussions / Dawes Redman update	
12.15– 12.45	Competency assessment CTG equipment / Fundal height measurement	Kathy McClune / Charlotte O'Donovan
12.45 – 13.30	Lunch	
13.30 – 14.00	Fetal responses to labour including changes in fetal heart rate (FHR).	Kathy McClune
14.00 – 14.30	Local case discussions	

14.30 – 14.45	Break	
14.45 – 15.30	Twins – regional learning	Kathy McClune / Siobhan Wilson
15.30 – 16.30	CTG Interpretation – group work	Charlotte O'Donovan
16.30 – 18.30	K2 competency assessments	

Maternity Support Worker Band 3 Skills Day – Proposed timetable

Time	Session	Facilitator	Location
08.30 – 10.30	Deterioration of the newborn & Neonatal observations & Blood glucose monitoring	Wendy Bacaksiz	TBC Planned 27/11/23 and 18/12/23 Days – Woodlands seminar room
10.30 – 10.45	Coffee Break		
10.45 – 11.15	Weighing a newborn	Wendy Bacaksiz	
11.15 – 11.45	Biliflash monitoring	Wendy Bacaksiz	
11.45 – 12.15	Newborn bloodspot	Wendy Bacaksiz	
12.15 – 13.00	Lunch		
13.00 – 13.30	Bladder care and removal of catheters and fluid balance	Wendy Bacaksiz	
13.30 - 14.00	Emergency documentation		
14.30 – 16.00	Maternal observations & Deterioration of antenatal and postnatal women.	Wendy Bacaksiz	
16.00 – 16.30	Close & feedback	Wendy Bacaksiz	

Draft timetable for MSW day

Draft timetable Mat 3 – Care in labour & personalised care

08.30-16.30

Time	Session	facilitator	location
08:30 – 11.00	Maternal mental health including local guidance, referral procedures and 'red flags	Anna Sebine	TBC
11.00 – 12.30	Personalised care inc birth outside guidance and communication skills	TBC MVP?	TBC
12:30 – 13:15	Lunch		
13:15 – 14.30	Management of labour including latent phase of labour		
14.30-14.45	Coffee		
14:45 – 16.00	Twins – Local guidance for pregnancy and labour care		
16:00 – 16:30	Service user stories		
16:30	Feedback		

Appendix B – Yorkshire and the Humber Dashboard

YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - CORE INDICATORS	Trust	Harrogate District Hosp… Hospital Maternity Unit	…ter/Year	Q1_2023 _2024

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

Indicator	Measure	Trust/Site Quarterly Data		Y&H Average (Sites)	Y&H Range (Sites)	Y&H Interquartile Range (Sites)	Previous Q	Y&H Avg
		Previous	Latest					
ACTIVITY INDICATORS								
Number of Bookings	Number of women booked	455	393	797.1	305 to 1683	478.25 to 1086.75	##	##
Bookings <10 weeks	Number of women booked <10 weeks	350	265	559.7	204 to 1175	306.5 to 743	##	##
% Bookings <10 weeks	% of women booked <10 weeks	76.9%	67.4%	70.2%	59.6% to 87.8%	64.3% to 74.7%	-0	-0
Women birthed	Number of all women birthed	426	410	685.2	2 to 1348	398 to 1058	##	##
Women who birthed a live baby	Number of women who birthed with a live baby	425	410	680.6	2 to 1340	395.75 to 1044	##	##
Total births	Number of all babies born	431	413	691.4	2 to 1369	402.5 to 1063.25	##	##
Live births	Number of live babies born	430	413	688.8	2 to 1363	401.75 to 1057.75	##	##
Live births at term	Rolling annual number of live babies born at term	1602	1587	2580.2	8 to 5081	1467 to 3995	##	##
Total births	Rolling annual number of all babies born	1690	1694	2800.1	9 to 5429	1598 to 4325.75	4	##
Planned homebirths	Number of women who planned and birthed a term baby at home	4	1	6.2	0 to 17	1.25 to 9	-3	-5

Planned homebirths	% of planned homebirths	0.9%	0.2%	0.9%	0.0%	to	100.0%	0.4%	to	1.5%	-0	-0
1:1 Care in labour	Number of women who have received 1:1 care in labour	337	252	606.5	2	to	1269	300	to	1022	##	##
1:1 Care in labour	% women who have received 1:1 care in labour	99.7%	61.5%	100.6%	61.5%	to	120.5%	97.6%	to	111.9%	-0	-0
BBAs (Born Before Arrival)	Number of women who have a BBA.	4	6	9	0	to	52	4	to	11	2	-3
BBAs (Born Before Arrival)	% of women who have a BBA.	0.9%	1.5%	1.3%	0	to	1	0	to	0	0	0
MATERNAL CLINICAL INDICATORS												
Normal births	Number of women with a vaginal birth	213	192	362.5	2	to	801	199.75	to	578.5	##	##
Normal births	% of women - normal births	50.0%	46.8%	52.9%	40.2%	to	100.0%	51.1%	to	56.6%	-0	-0
Assisted vaginal births	Number of women with an instrumental birth	58	58	65.9	0	to	165	35	to	94.75	0	-8
Assisted vaginal births	% of women - assisted vaginal births	13.6%	14.1%	9.6%	0.0%	to	14.1%	7.3%	to	11.3%	0	0
Elective C/S births	Number of women - El C/S	84	103	106.8	0	to	245	75	to	144.75	19	-4
Elective C/S births	% of women - El C/S	19.7%	25.1%	15.6%	0.0%	to	25.1%	13.2%	to	17.8%	0	0
Emergency C/S births	Number of women - Em C/S	71	57	149.6	0	to	298	69.5	to	223.75	##	##
Emergency C/S births	% of women - Em C/S	16.7%	13.9%	21.8%	0.0%	to	36.0%	17.4%	to	22.2%	-0	-0
Number of C/S births	No. of women - Total all C/S	155	160	256.4	0	to	543	151.75	to	362.25	5	##
C/S deliveries	% of women - Total all C/S	36.4%	39.0%	37.4%	0.0%	to	48.4%	33.5%	to	40.0%	0	0
3rd/4th degree tear - normal birth	Number of women with 3rd and 4th degree tear following a normal birth	3	2	6.7	0	to	19	3	to	10	-1	-5
3rd/4th degree tear - normal birth	% women with 3rd and 4th degree tear following a normal birth	1.4%	1.0%	1.8%	0.0%	to	3.3%	0.9%	to	2.2%	-0	-0
3rd/4th degree tear - assisted birth	Number of women with 3rd and 4th degree tear following an assisted birth	4	0	2.9	0	to	9	1.25	to	4	-4	-3

3rd/4th degree tear - assisted birth	% women with 3rd and 4th degree tear following an assisted birth	6.9%	0.0%	4.5%	0.0%	to	8.6%	3.5%	to	5.5%	-0	-0
Induction of Labour	Number of women commenced induction of labour	146	146	242.4	0	to	480	151	to	357.5	0	##
Induction of Labour	% women commenced induction of labour	34.3%	35.6%	35.4%	0.0%	to	45.2%	29.9%	to	41.2%	0	0
PPH ≥ 1500ml	Number of women who have birthed with PPH ≥ 1500ml	14	15	24.2	0	to	58	10.5	to	35.5	1	-9
PPH ≥ 1500ml	% women who have birthed with PPH ≥ 1500ml	3.3%	3.7%	3.5%	0.0%	to	5.1%	2.5%	to	4.1%	0	0
NEONATAL CLINICAL INDICATORS												
Preterm births <37 weeks	Number of preterm births <37 weeks	22	26	57.1	0	to	137	36.25	to	70.75	4	##
Preterm birth rate < 37 weeks	% preterm births <37 weeks	5.1%	6.3%	8.3%	0.0%	to	10.6%	6.4%	to	9.3%	0	-0
Preterm births 32 weeks to 36+6 weeks	Number of preterm births 32 weeks to 36+6 weeks	19	23	45.9	0	to	102	31.5	to	58.75	4	##
Preterm birth rate 32 weeks to 36+6 weeks	% preterm births 32 weeks to 36+6 weeks	4.4%	5.6%	6.7%	0.0%	to	9.7%	5.5%	to	7.5%	0	-0
Number of preterm births 27 weeks to 31+6 weeks	Number of preterm births 27 weeks to 31+6 weeks	2	3	7.3	0	to	18	1.5	to	10	1	-4
Preterm birth rate 27 weeks to 31+6 weeks	% preterm births 27 weeks to 31+6 weeks	0.5%	0.7%	1.1%	0.0%	to	2.0%	0.4%	to	1.3%	0	-0
Preterm birth <27 weeks	Number of preterm births <27 weeks	1	0	3.8	0	to	17	1.0	to	4.3	-1	-4
Preterm birth rate < 27 weeks	% preterm births <27 weeks	0.2%	0.0%	0.6%	0.0%	to	1.3%	0.2%	to	0.5%	-0	-0
Rolling annual number of low birth weight at term - live births	Rolling annual number of live babies at term < 2200g	2	1	18.3	0	to	50	8	to	31.5	-1	##
Low birth weight at term - live births	Rolling annual % live babies at term < 2200g	0.1%	0.1%	0.7%	0.0%	to	1.1%	0.4%	to	0.8%	-0	-0
STILLBIRTHS												
Stillbirths - Rolling annual total	Annual number of ALL stillborn babies	7	4	10.9	0	to	33	4.25	to	13.25	-3	-7
Stillbirth rate - Total	Annual rate for ALL stillborn babies / 1000 births	4.1	2.4	3.9	0.0	to	6.3	2.4	to	3.9	-2	-2

Stillbirths	Number of all babies stillborn	1	0	2.6	0	to	9	1	to	3.75	-1	-3
Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	7	4	10.0	0	to	27	4	to	13	-3	-6
Stillbirth rate - Antenatal	Annual rate for antenatal stillborn babies / 1000 births	4.1	2.4	3.6	0.0	to	5.2	2.3	to	3.6	-2	-1
Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	0	0	0.9	0	to	6	0	to	1	0	-1
Stillbirth rate - Intrapartum	Annual rate for intrapartum stillborn babies / 1000 births	0.0	0.0	0.3	0.0	to	1.2	0.0	to	0.4	0	-0
HSIB reportable births	Rolling annual number of reportable births	5	3	2.7	0	to	12	1	to	3.75	-2	0
HSIB reportable births	Rolling annual % reportable births	0.3%	0.2%	0.1%	0.0%	to	0.3%	0.0%	to	0.1%	-0	0
Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	7	4	9.0	0	to	27	3.25	to	10.75	-3	-5
Stillbirth rate - adjusted to exclude lethal abnormalities	Annual stillborn babies / 1000 births excluding babies with lethal abnormality	4.1	2.4	3.2	0.0	to	5.2	1.5	to	3.9	-2	-1
Stillbirths at term	Rolling annual number of babies stillborn at term	2	1	2.4	0	to	8	1	to	4	-1	-1
Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	0	0.3	0	to	2	0	to	0	0	-0
Stillbirths at term with low birth weight	Annual % of stillborn babies < 2200g	0.0%	0.0%	11.4%	0.0%	to	200.0%	0.0%	to	6.3%	0	-0
All losses under 24+0 weeks gestation	Number of all losses under 24+0 weeks gestation	2	5	26	0	to	229	1	to	12	3	##
Hold for %		0.0%	0.0%	0	0	to	0	0	to	0	0	0
PUBLIC HEALTH INDICATORS												
Breastfeeding Initiation	Number of women who breastfed their baby/ies for their first feed	356	341	483.2	1	to	1090	275.25	to	763	##	##
Breastfeeding Initiation	% of women commenced breastfeeding	83.8%	83.2%	71.0%	50.0%	to	100.0%	63.6%	to	77.1%	-0	0
Smoking at time of booking - self reported	Number of women who were smokers at time of booking	20	15	86.4	15	to	168	58.25	to	106.75	-5	##
Smoking at time of booking	% of women who smoke at booking	4.4%	3.8%	10.8%	3.8%	to	18.4%	8.3%	to	13.4%	-0	-0

Smoking at time of birth - self reported	Number of women who were smokers at time of birth	19	8	61.8	0	to	136	37.25	to	80.75	##	##
Smoking at time of birth - self reported	% of women who smoke at time of birth	4.5%	2.0%	9.0%	0.0%	to	50.0%	7.6%	to	11.1%	-0	-0
Carbon Monoxide monitoring at time of booking	Number of women who received CO testing with a measurement ≥ 4ppm at booking	76	57	83.3	0	to	173	51	to	112.5	##	##
Women received CO testing at booking	Number of women who received CO testing at booking	435	399	637.4	0	to	1339	397.5	to	856.25	##	##
Carbon Monoxide monitoring at time of booking	% women who received CO testing with a measurement ≥ 4ppm at booking	17.5%	14.3%	13.1%	6.7%	to	23.2%	11.5%	to	15.1%	-0	0

Integrated Board Report - August 2023

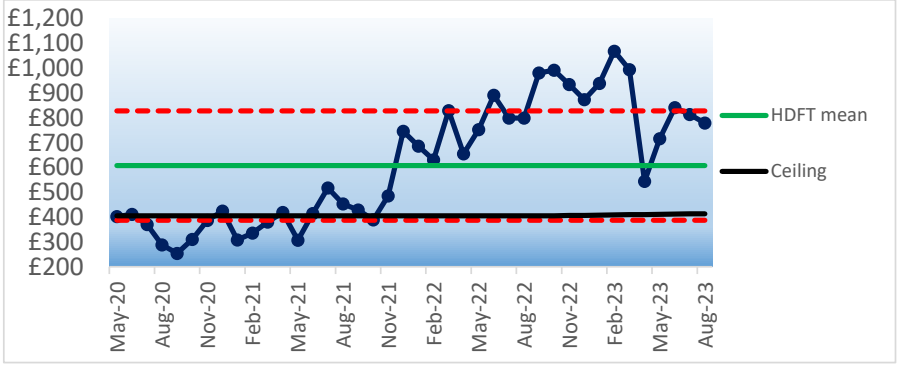
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	£778

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

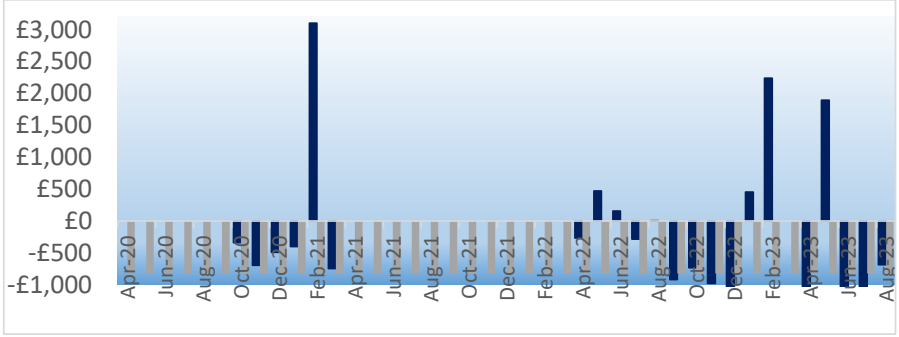
Significant agency costs remain across the Organisation, but there has been a reduction again to the prior month. All Directorates are reviewing their agency spend and considering options to reduce current usage. In month Medical and Dental spend does fluctuate but Radiology and Pathology have contributed to the month on month spend, however costs are associated with July and August.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	-£686

Indicator description

Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.

Trend chart



Narrative

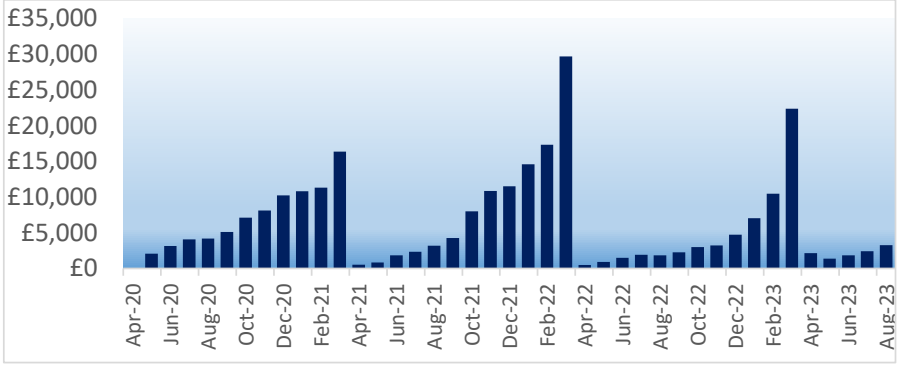
Pressures around Wards, Drugs, Elective Recovery, delivery of CIP, Strikes and Agency spend continues. Recovery plans have been developed by Directorates but currently these are not being delivered due to a number of schemes being high risk. There could also be a further risk in terms of ERF income as we are not delivering plan.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	£3,266

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

As at August, £3.2m has been spent on Capital, CT pressures have emerged which wasn't part of the original plan.

CDEL Schemes are currently forecast to at £12.6m, £3m more than plan and PDC schemes (TIF2 and EPR) are still being finalised. The Board is reminded that the Trust is also part of the Wharfedale development, with £1m of funds being allocated to Leeds Teaching Hospital Trust, previously "allocated" to Harrogate.

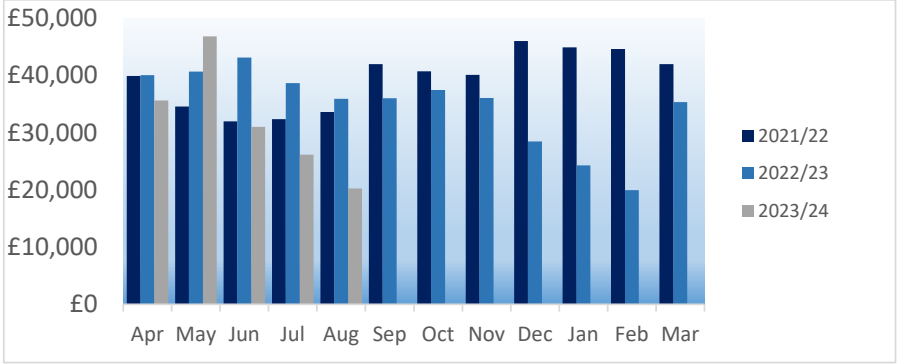
Emerging pressures with RAAC (£30m) and Backlog maintenance (£24m) have been identified that need to be worked through.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	£20,252

Indicator description

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

Trend chart



Narrative

The Trust cash balance continues to remain positive as at the end of August however we have seen a significant reduction. There are a number of outstanding significant payments, £2.4m Depreciation Funding, 1.2m Council Contract, 1m Pay Award and a collection of smaller items.

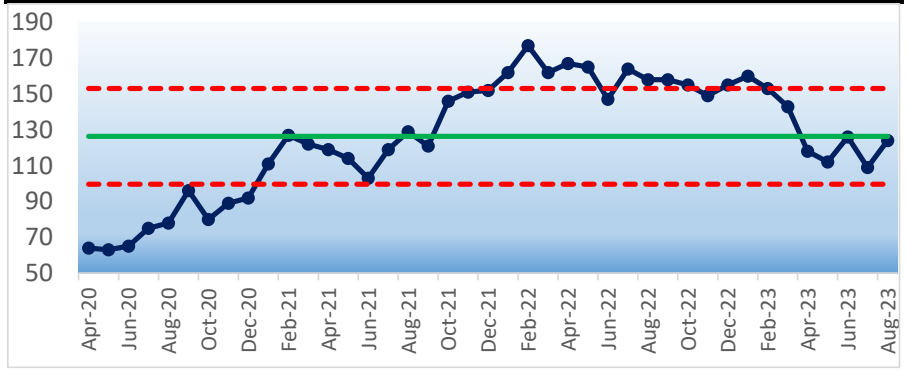
A forecast is being prepared to understand any upcoming issues.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	124

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

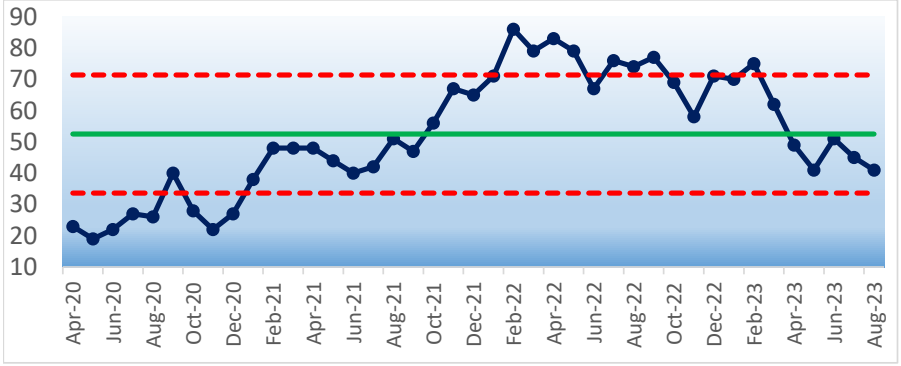
The number of long stay patients (> 7 days) was 124 in August, an increase on last month but within confidence intervals i.e. normal variation.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	41

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

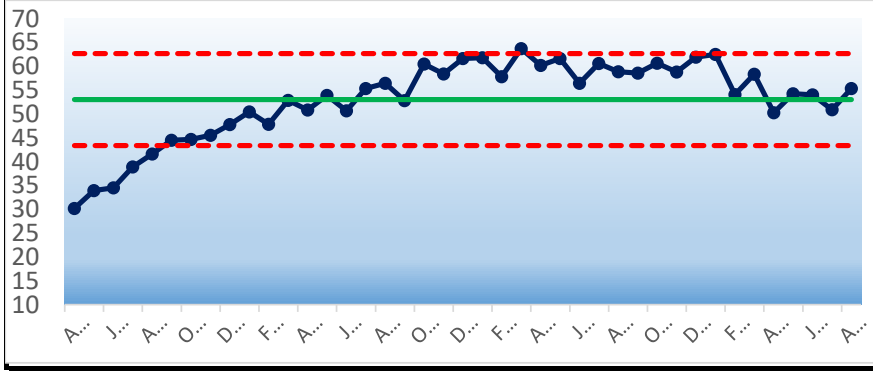
The number of long stay patients (> 21 days) was 41 in August, a decrease on last month.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	55.3

Indicator description

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

SPC chart



Narrative

Occupied bed days per 1,000 population were at 55.3 in July, an increase on last month. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, above the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	2.01

Indicator description

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

Narrative

Elective length of stay decreased in August and is now below our local stretch target of 2.5 days and within confidence limits .

SPC chart

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	4.27

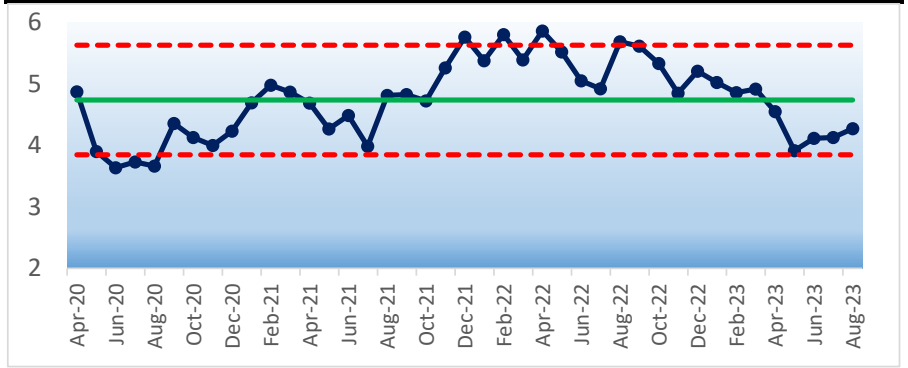
Indicator description

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

Narrative

Non-Elective length of stay increased to 4.3 days in August, remaining above our local stretch target but within the range of normal variation.

SPC chart

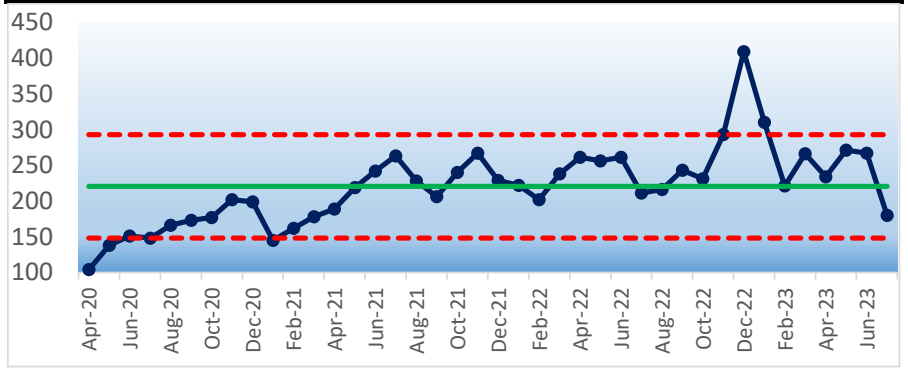


Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	180

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart



Narrative

Provisional data indicates that there were 180 avoidable admissions in July, within expected levels. The most common diagnoses remain as pneumonia and urinary tract infections. Excluding children and admissions to SDEC, the figure was 105.

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

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	80.6%

Indicator description

The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions.

SPC chart

Narrative

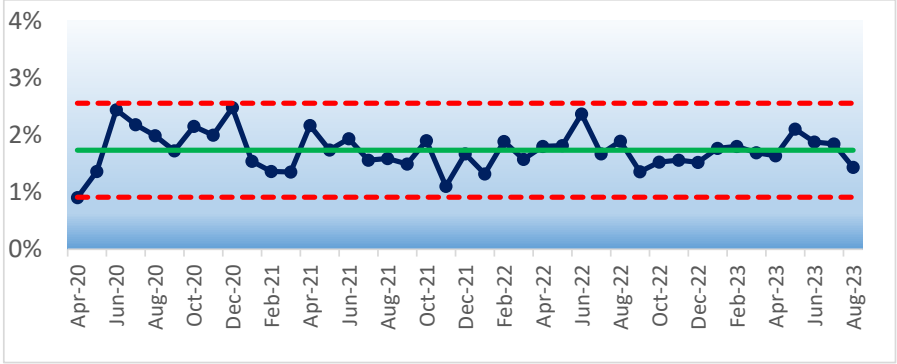
Theatre utilisation was at 80.6% in August, an increase on last month but remaining below the local intermediate target of 90%. There is ongoing work across the board but focussed initial work with ophthalmology colleagues to understand how we achieve GIRFT productivity within HDFT. There remains an impact from Covid-19 causing late cancellations, as well as industrial action which both impact upon utilisation.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	1.4%

Indicator description

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

SPC chart



Narrative

1.4% (32 patients) of intended day cases stayed overnight or longer in August, a decrease on last month and remaining within the control limits.

Integrated Board Report - August 2023

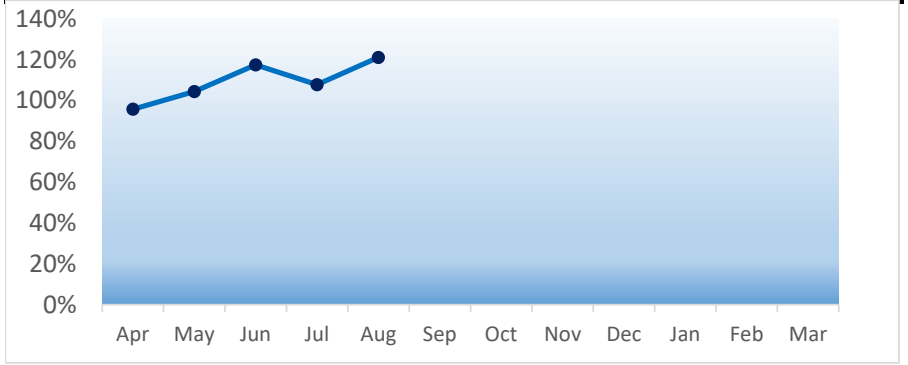
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	121.1%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

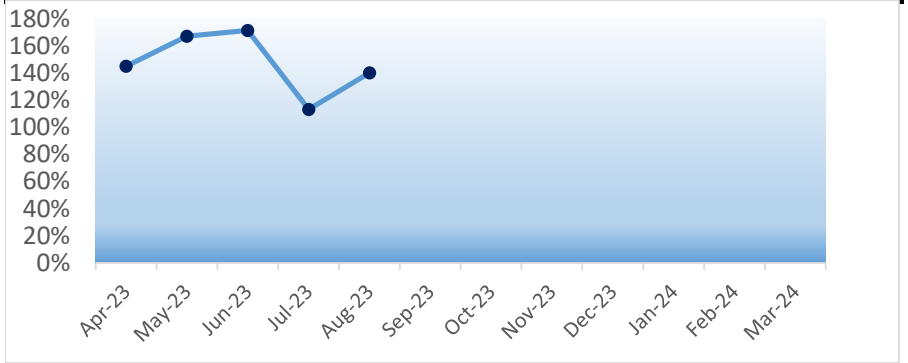
In August, GP referrals were 21% above the equivalent month in 2019/20. On a year to date basis, GP referrals are 9% above 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	140.2%

Indicator description

Outpatient activity (consultant led) against plan. The data includes new and follow up attendances.

Trend chart



Narrative

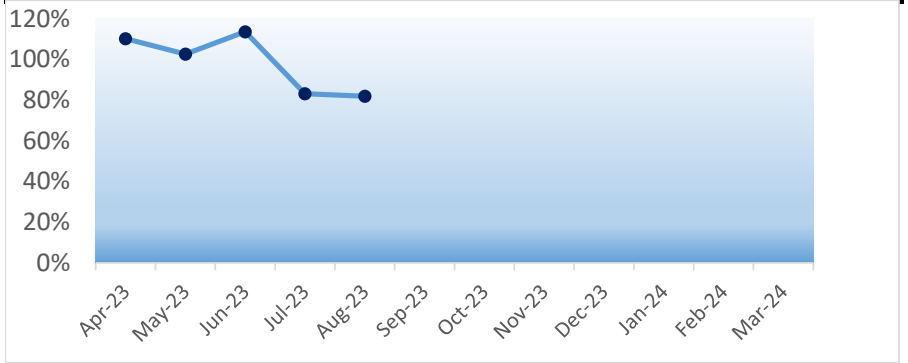
Outpatient activity was 13% above plan in July. New outpatient attendances were 11% below plan and follow up attendances were 29% above plan. Work is underway on how to reduce follow up activity - however HDFT are already achieving significant follow up avoidance through Patient Initiated Follow up (PIFU). Further analysis to understand the breakdown of the additional follow up activity is underway.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-23
Value / RAG rating	81.9%

Indicator description

Elective activity against plan. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

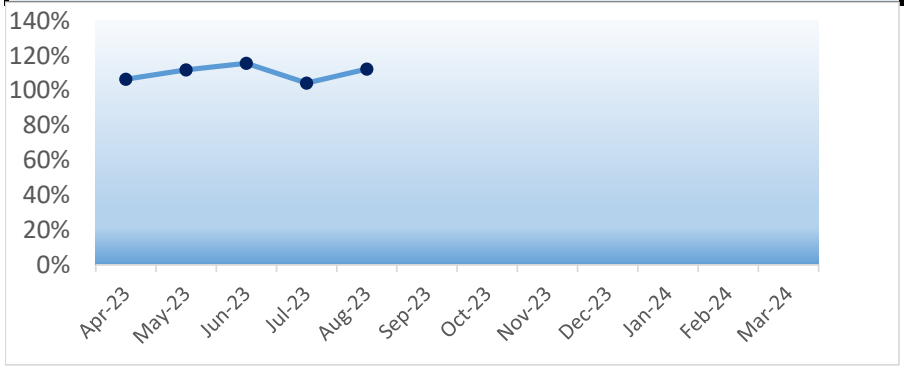
Elective admissions were 18% below plan in August. Elective day cases were 17% below plan and elective inpatients were 32% below plan. Industrial action as well as theatre downtime (for new ventilation system) continue to impact.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	112.2%

Indicator description

Non-elective activity against plan.

Trend chart



Narrative

Non-elective activity was 12% above plan in August.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-23
Value / RAG rating	105.2%

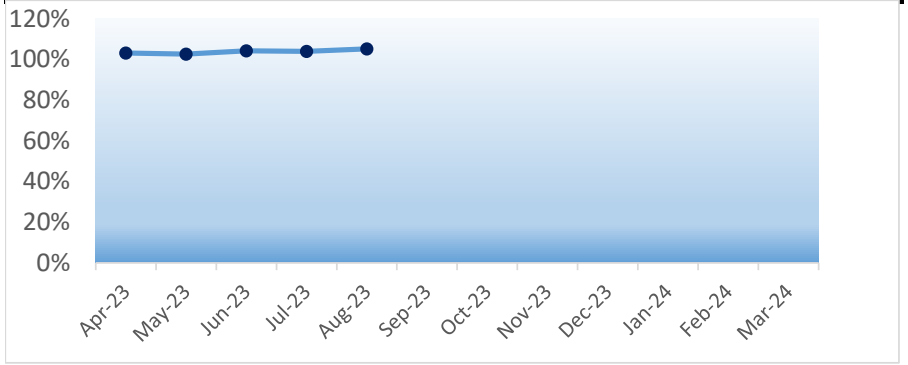
Indicator description

Emergency Department attendances against plan.

Narrative

Emergency Department attendances were 5% above plan in August.

Trend chart



Integrated Board Report - August 2023

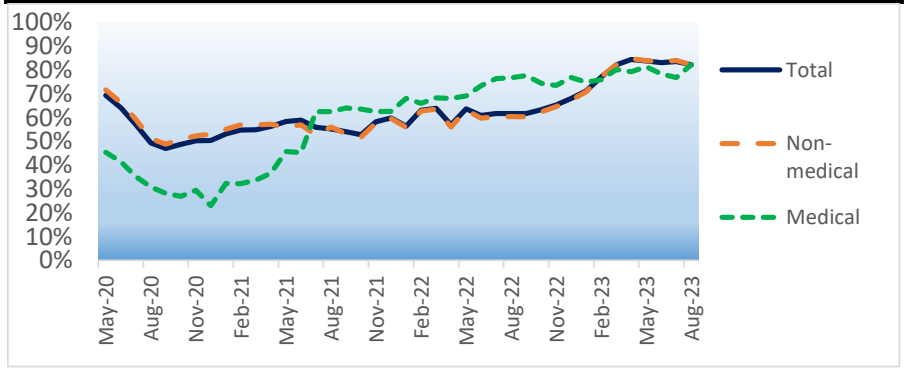
Domain 4 - Workforce

Indicator	**4.1 - Appraisal Rate - Non Medical and Medical Staff**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-23
Value / RAG rating	82.2%

Indicator description

The number of Non medical staff who have had a 4S appraisal and Medical staff who have had a Medical Staff appraisal. The Trust aims to have 90% of staff overall appraised.

SPC chart



Narrative

The appraisal rate in August is 82.2%, which is a small decrease in comparison to July(83.5%). All Directorates, with the exception of PSC, saw a decrease in appraisal compliance in August. Corporate Services saw the greatest decrease of 4.9%. 667 appraisals are outstanding as at 31st August 2023.

- Non-Medical appraisal = 82.2% (previous month 84.0%)
- Medical appraisal = 82.2% (previous month 76.8%)

Indicator	**4.2 - Mandatory and Essential Skills Training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-23
Value / RAG rating	90.0%

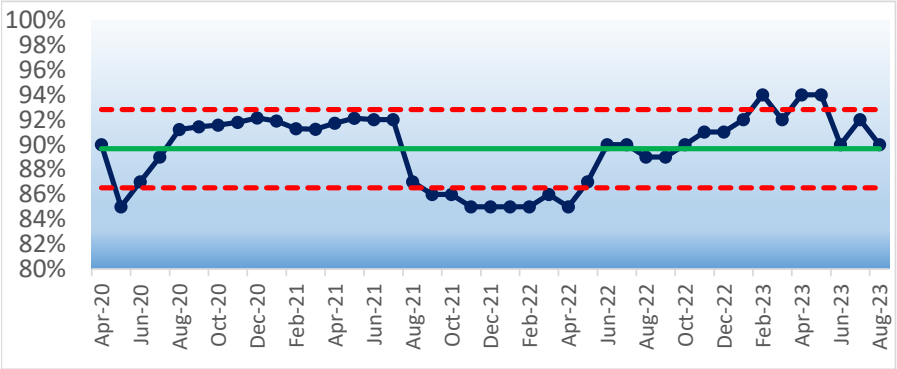
Indicator description

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

Narrative

Trust rates have reduced since last month but are still withing target.

SPC chart



Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-23
Value / RAG rating	4.9%

Indicator description

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

SPC chart

Narrative

Sickness has increased further in August from 4.4% to 4.9%. The Trust has seen an increasing trend from 4.2% in May 2023. "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and 128 employees were recorded as sick in August due to this reason. Sickness due to this reason contributed to 33% of the overall sickness this month and the number of whole time equivalent days lost increased from 1,970.9wte in July to 2,074.3wte. The Trust Team stress risk programme starts in October. All Directorates, with the exception of PSC, have seen an increase in sickness in August. CC Directorate continues to see high sickness rates and is at 6.5% in August, which is an increase from 6.0% in the previous month. The top 5 areas of highest sickness are all within the CC Directorate and the top 4 are within Children's Services. Stockton 0-19 Children's Services and Children's Safeguarding have the highest sickness rates this month of 12.3% and 9.2% respectively and both have increased from July.

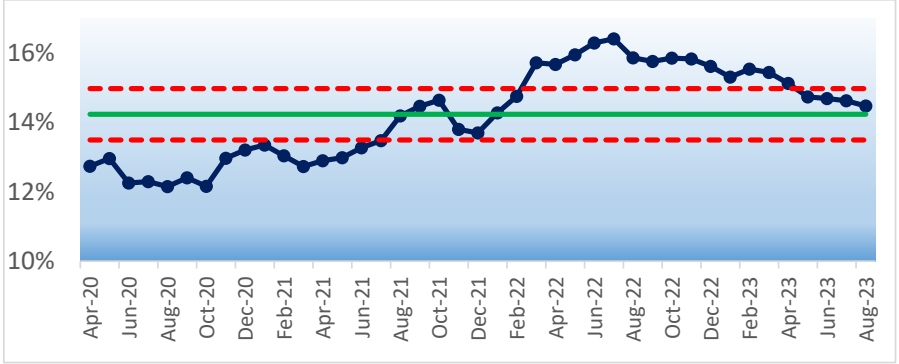
Short term sickness has increased from 1.6% to 1.8% and long term sickness has increased from 2.8% to 3.2%.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-23
Value / RAG rating	14.5%

Indicator description

The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

SPC chart



Narrative

Turnover has seen a decreasing trend since February 2023 and August has seen a decrease of 0.1% compared to the previous month, however it remains above the Trust target of 12%. (This incorporates voluntary and involuntary turnover). Voluntary turnover has decreased from 11.1% in July to 11.0% this month.

20% of leavers over the last 12 months are due to retirements, which includes those who intend on flexi-retiring and returning to the Trust. CC and PSC Directorates continue to see a decreasing trend in turnover rates, however LTUC and Corporate Services have further increased this month.

With the exception of the upper age bands, the age band with the highest turnover is 21-25 years, with a rate of 30.1%. The turnover rate of those with less than 1 years' service has seen a further decrease this month to 21.0%, but this remains above the average of 20.2% for the Trust.

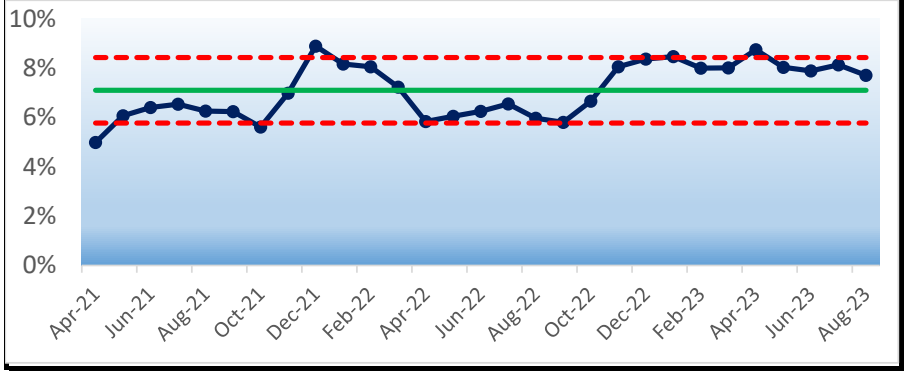
The stability index is 84.7% in the rolling 12 months to August 2023. This is a small increase from 84.5% last month. A career conversation tool is being developed and we are setting up Inpulse to undetake new starter surveys.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-23
Value / RAG rating	7.7%

Indicator description

The chart shows the total number of vacancies across the Trust. This data is provided a month in arrears.

SPC chart



Narrative

The Trust's vacancy rate in August is 7.7%, which is a decrease from 8.1% in the previous month. This equates to 348.96wte vacancies. The vacancy rate has decreased due to an increase in the number of substantive staff in post of 17.26wte.

All Directorates, with the exception of LTUC, have seen an increase in vacancies in August and this is due to an increase in budgeted establishment in these Directorates. LTUC continues to have the greatest vacancy rate, with a rate of 12.7% (168.90wte vacancies), however this is a decrease from 13.1% last month.

Board of Directors (Public)
27th September 2023

Title:	Freedom to Speak Up Guardian Bi-annual Report
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHPs
Author:	Freedom to Speak Up Guardian

Purpose of the report and summary of key issues:	To provide The Trust Board with a bi-annual update on Freedom to Speak Up 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	✓
	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:	Update provided to People & Culture Committee 27/09/23	
Recommendation:	Trust Board members are asked to receive this report for information.	

7

Board of Directors Meeting

Freedom to Speak Up Guardian update

1.0 Executive Summary

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

2.0 Background

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

3.0 Introduction

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

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

4.0 Quality Implications and Clinical Input

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

5.0 Equality Analysis

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

6.0 Risks and Mitigating Actions

6.1 Delay in substantive FTSUG getting into post on return from maternity leave, and subsequent protracted training and registration period.

7.0 Consultation with Partner Organisations

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

8.0 Monitoring Performance

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

9.0 Recommendation

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

10.0 Supporting Information

10.1 The following paper appended makes up this report:

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

Date: September 2023

Introduction

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

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

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

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

(The King's Fund: Improving NHS culture)

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

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

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

This training has now been rolled out across the trust and engagement at this stage continues to be promising.

The overall compliance for Trust staff to date:

Workforce	Required	Not Achieved	Compliance %
HDFT Substantive	4549	1329	71%
HDFT Bank	169	97	43%

Workforce	Required	Not Achieved	Compliance %
HIF Substantive	314	200	36%
HIF Bank	72	50	31%

Workforce	Required	Not Achieved	Compliance %
Overall HDFT & HIF Substantive	4863	1529	69%
Overall HDFT & HIF Bank	241	147	39%

Local work

Freedom to speak up current data

The following table captures the numbers of cases received by the Freedom to Speak Up guardians between July – September 2023, common themes identified and a summary of learning points. Data is submitted to the National Guardian Office on a quarterly basis, this is the same quarterly basis for the below data.

Numbers of referrals to Freedom to Speak Up has seen an increase in this quarter. Added to this it remains evident that FTSU cases are brought to other members of the team, including the Executive Directors and therefore this data is not always captured and reported directly to the NGO. The following data is captured from concerns raised directly to the FTSU Guardian.

Numbers of cases brought by professional level	Student Worker Manager Senior leader Not disclosed	1 7 4 2
Numbers of cases brought by professional group	Medical Registered Nurses, Midwives & AHPS Administration, Clerical & Maintenance/Ancillary Non-registered clinical support staff Undisclosed	1 8 2 1 2
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		4
Response to the feedback question; 'Given your experience, would you speak up again?	Total number of responses The number of these that responded 'Yes'	All cases remain open / await feedback.
Common themes identified	Concerns with new leadership approach Bullying/Harassment from colleagues Staff retention – team culture; changes in management structure Poor communication from management Appropriate staff skill set for post	
Summary of learning points	Communication and consideration for current teams well-being and feeling of being valued.	

	More time is needed for the guardian role	

NHS Staff Survey 2022 Fear & Futility findings

The National Guardian's Office has recently published analysis of the Freedom to Speak Up questions as outlined in the NHS Staff Survey 2022 Fear and Futility: what does the staff survey tell us about speaking up in the NHS? - National Guardian's Office . HDFT has been identified as being in the top ten most improved in terms of the Freedom to Speak Up sub-score (called the Raising Concerns sub-score in NHS Staff Survey reports). The sub-score is made up of the four questions relating to speaking up.

The Freedom to Speak Up Guardian role update

The allocation for the Guardian role is currently 7.5 hours per week. A scoping exercise is underway across the regional guardian network to establish comparative Freedom to Speak Up models and time allocation. This will be used to review the current model at HDFT, taking into consideration all proactive and reactive aspects of role. We await the findings being shared with the network.

The Guardian is now established within the Regional Guardian Network and attending regular network meetings and sharing best practice.

Next steps / Action Plan:

- Continue regular meetings with Executive Director of Nursing to capture anonymised data from the concerns raised directly to the Director team

- October is Speaking up Month and this year's theme is Barriers to Speaking Up. Staff engagement opportunities are scheduled during the month, to raise awareness of FTSU and also explore the barriers colleagues feel prevent them from speaking up. The findings from this will be used to inform FTSU moving forward.

- To continue to include the FTSU Guardian and Associate role in the current work on the organisational culture, values and behaviours –
    - Presented on Team Talk
    - Attended multiple staff engagement meetings and more planned.
        - Just and learning culture
        - Speak Up, Listen Up, Follow Up training modules.
        - Linking FTSU Champions monitoring and reporting with Well Being champions
        - Facilitating induction training
        - Facilitating Pathway to Management training

- To continue the rebrand of FTSU at HDFT 'Listening at Our Best' to embed FTSU into the #teamHDFT values and 'At our Best' programme, current project plan.

- One Associate Guardian is in situ and there is currently a vacancy for a second Associate Guardian. The Associate role is currently being defined, with a focus on Fairness Champions: recruitment, training and network events.

- The Fairness Champion directory is currently being updated: contact made with each Champion to ensure details are correct and up to date and that they want to remain a Champion. Applications are being accepted to become a champion and new recruits are being trained on a rolling basis. The recruitment process is being reviewed and updated with HR.

Action Required	Lead	Date for completion
To formalise and agree a job description for the associate role	FTSU Lead	Ongoing
Continue with the launch of the visible "Pledge Wall" and other FTSU material	Communication & Marketing Team	Ongoing
Review the NGO Gap Analysis and Just Culture Gap Analysis	FTSU Lead & HR / OD	Ongoing
Launch the e - learning package as mandatory training	Learning & Development	Completed
Update of Fairness Champions directory	FTSU Lead and Associate	Ongoing
Regional scoping of comparative FTSU models	FTSU Lead via Regional Network	Ongoing
To gain feedback from completed cases and use this to inform FTSU process moving forward.	FTSU Lead	Ongoing

The following table captures the numbers of cases received by the current Freedom to Speak Up Guardian, since starting in post in October 2022 – September 2023.

Numbers of cases brought by professional level	Student Worker Manager Senior leader Not disclosed **TOTAL**	2 30 5 5 **42**
Numbers of cases brought by professional group	Medical Registered Nurses, Midwives & AHPS Administration, Clerical & Maintenance/Ancillary Non-registered clinical support staff Undisclosed **TOTAL**	4 23 10 3 2 **42**
Number of cases raised anonymously		2
Number of cases with an element of bullying or harassment		14

In Summary:-

What were we aiming to achieve?

At HDFT we aim to make it as easy as possible for every colleague to speak up safely when they want to raise a concern that they do not feel they can do through the usual methods of speaking to their line manager. We aim for speaking up to be business as usual at HDFT and to have Fairness Champions in each clinical and non-clinical area to support with signposting and championing speaking up. We aim for colleagues and ex-colleagues, whether employed directly or as contractors,

students or volunteers to be able to speak up about anything that gets in the way of doing a good job.

What have we done?

We have continued to embed the Freedom to Speak Up values of courage, impartiality, empathy and learning into our shared understanding of the key elements of a fair, just and safe culture, which are:

1. Fairness, compassion and psychological safety: ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring.
2. Diversity, inclusivity, trust and respect: ensuring people are treated fairly regardless of ethnicity, gender, disability or other characteristics;
3. Speaking up and listening: ensuring speaking up about concerns, events, errors or poor behaviour is welcomed, and seen not just as safe, but the right thing to do;
4. Leadership and teamwork: ensuring supportive, effective and ideally multidisciplinary teamwork alongside compassionate and collective leadership to reinforce a sense of care and belonging, a culture of honesty, authenticity and safe conflict;
5. Trust Values and behaviours: ensuring we promote and expect positive behaviours that improve patient safety and colleague experience, and that behaviour which is at odds with our values is called out and challenged;
6. Open to learning and improvement: ensuring that when things go wrong there is focus on no blame, a just culture, an understanding of human factors, supporting staff, and learning.

What are the results?

Currently, the Freedom to Speak Up Team includes:

1 x Freedom to Speak Up Guardian
1 x Freedom to Speak Up Associate Guardian
42 x Fairness Champions across the organization

Training of 5 new champions is being carried out in October 2023 and confirmed ongoing commitment from the existing champions has been obtained.

Looking at the recent data awareness and engagement with FTSU appears to be increasing with an increase of contacts from 7 during the previous quarter to 12 during the last quarter.

Mobile App developments are under consideration to improve access remotely for colleagues to Speak Up as well as to support with data collection which is reported quarterly to the NGO.

Summary

A culture that inhibits speaking up because of recrimination and blame acts as a significant barrier to staff wellbeing and patient safety. The work to promote a fair, just and safe culture is focused on ensuring our leaders and managers create positive, supportive environments for all colleagues, knowing that they will then create caring, supportive environments and deliver high quality care for patients. We must promote and expect positive behaviours that improve patient safety and staff

experience, constructively challenging behaviour that is at odds with our values to enable people to learn about the impact of their words or actions. All colleagues need to be confident that they will be treated fairly and compassionately, and that speaking up about concerns, events, errors or poor behaviour is welcomed, the right thing to do and an opportunity to learn. We must continue to train colleagues to be positive and compassionate leaders and effective members of teams, where they can reinforce a culture of honesty, authenticity and safe conflict. We continue on a journey towards ensuring all of our staff work in positive and supportive environments that enable them to deliver the highest quality of care for our patients.

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting Notes and Actions

Date	**4 July 2023**	**Location**	MS Teams
Chair	**Brendan Brown**	**Minutes prepared by**	Geraldine Morris
Attendees	Brendan Brown, Jonathan Coulter, Mel Pickup, Phil Wood, Len Richards, Lucy Cole, Ben Roberts, Rob Aitchison, Sal Uka, Asifa Ali		
Apologies	Foluke Ajayi		

Agenda

ITEM		WHO
1	Welcome and apologies	Chair
2	Minutes and Actions	All
3	Trust updates / key issues	All
4	Collaborative Report and WY HCP Report	LC
5	Endoscopy Update • RTC Host – for approval	Rob Aitchison
6	ERF proposal	Ben Roberts
7	WYAAT Strategy • Update for CiC • WY ICB Operating model	LC/BB
8	Neurology Update	Sal Uka and Asifa Ali
9	Specialised commissioning risks • Paper included from Shelford Group for information	LC
10	CiC Agenda	LC
11	AOB	All
12	Close	Chair

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
Attendance & Apologies	Apologies noted and accepted for Foluke Ajayi.	

Review previous meeting minutes and action points	The minutes from the previous meeting were approved as an accurate record. **The action log was reviewed, and the following updates were given:** • *Action 99: WYAAT Strategy draft – LC to invite national colleagues to future meetings* – on track • *Action 101: Collaborative Report & WY HCP Report – SU to bring progress on neurology to next meeting* – on track • *Action 111: WYVaS options – WYVaS team to bring overview of outcomes to meeting in October 2023* – to be discussed in autumn • *Action 112: Haematology - SU to bring progress update on haematology to meeting in August 2023* – on track • *Action 113: AOB - LC to confirm times of event and agree programme exec session around this* – on track • *Action 114: Strategy workshop – Review Strategy next steps at July meeting* – on track Lucy Cole (LC) updated that Steve Russell would attend when he can confirm a date.	
Trust updates / key issues	Trusts gave the following updates: • CHFT – proposed a single response to Sarah Dodd's letter on bank pay and that the response should come from Bev Geary. Members agreed. • LTHT – updated on industrial action (IA): LTHT radiographers didn't get a mandate, but ANHSFT radiographers did. Members were advised to be aware if there's a mutual aid issue arising from this action. It's expected more will be known tomorrow on proposed IA by consultants on 20-21 July. • BTHFT – shared with members that HRH Princess Anne would be visiting the Trust on Thursday to open the new Maternity Theatres and Maternity High Dependency Unit complex. Members had a wider discussion around rate cards and time off in lieu (TOIL) during IA. The possibility of consultants taking part in IA and the resultant disruption it would cause in A&E was also discussed. Members agreed to keep each other apprised of any IA issues.	
Collaborative Report and WY HCP Report	LC presented on Collaborative Report and WY HCP Report. • **Community Diagnostic Centres (CDC)** There are approved sites in Wakefield, Huddersfield, Halifax, Seacroft, Armley and Beeston in Leeds. Phase 2 Seacroft was rejected, the implications of which are being reviewed. A summary that cross-references with regional/national teams will be produced. The proposal is to make the West Yorkshire (WY) element about place-based implementation. LC to provide update.	**ACTION: LC to update on CDC proposal.**

	• **Non-Surgical Oncology (NSO)** Good progress being made on North and South sectors. Engagement work commenced with patients and public. On-point communication will be issued around what's happening in local places and how output will be utilised. • **Chemotherapy Prescribing Systems** Issues noted around the sign-off process on the specification and understanding of clinical and operational colleagues of the need to go out to procurement regardless of the strategic direction to move to a single system. Ben Roberts (BR) ensuring all understand the process and satisfied with specification. BR to take it through steering group and report back here. CEOs reiterated support for a single system and that there would need to be a strong clinical case presented to the group to move in another direction. • **Pathology** LC updated that the legal challenge to the equipment MSC had been dropped by the unsuccessful bidder, and extended her thanks to BR, procurement, clinical and operational colleagues for their great work on this. LC will share lessons learned with WY and more widely for the benefit of others. On the LIMS, LC updated that additional external resource had been approved through the Board, using available capital in order to accelerate testing and mitigate the risk of further delays. This is biomedical scientist resource, experienced with WinPath, which other networks have utilised. Go live dates will be announced after upcoming replan. • **Pharmacy** Progress is being made on implementation, but the business case is still awaiting sign-off by NHSE. This is not impeding progress in the short-term but will if this continues and hinders our ability to sign a lease for the facility later in the year. It's hoped in the next week or two there will be some movement on this. • P**rocurement** Directors of Finance (DOFs) are taking a fresh look at the model for collaborative procurement. The current model was agreed as an interim stage in 2019 and there is appetite from procurement leads to revisit this. Chris Slater is leading the work to support an appraisal of the options. • **Planned Care** LC reported good local and regional engagement. Issues continue around glaucoma provision and glaucoma surgery. Challenges in the long-term versus current solutions are being reviewed and more sustainable solutions being sought. LC stated that areas of focus such as setting up urgent care, same-day emergency care (SDEC), Yorkshire Ambulance Service (YAS) handovers, as well as work around cancer to ensure operational rigour, faster diagnosis etc, were reviewed at the recent Chief Operating Officers (COOs) time out.	

	Brendan Brown (BB) shared that he had discussed workforce (WF) with Asifa Ali (AA) yesterday, who will report back to this meeting soon. LC confirmed there was nothing major identified in the West Yorkshire Health and Care Partnership (WY HCP) report. *The report was taken as read.* Members discussed the operating model. Mel Pickup (MP) raised that place leaders have a different view to directors on how to execute responsibilities. BB commented that direction on responsibilities had come from Richard Barker. Len Richards (LR) supported MP's comments. He felt, and BB agreed, it was important to keep a watching brief on this work.	**ACTION: AA to update on workforce at a future meeting**
Endoscopy Update - RTC Host – for approval	*Rob Aitchison (RA) and Jane Lang (JL) joined the meeting* • RA presented on Endoscopy Training Academy. He reported that the process has been through working groups and there is a new, more coordinated national approach, with more trainees ready to deliver sooner. Sheffield will lead as a virtual endoscopy academy, supported by a regional training centre in West Yorkshire. The proposal is for this to be hosted at Mid Yorkshire Teaching Trust (MYTT) with all other sites delivering immersion training in a dispersed model. The funding is somewhat uncertain beyond April 20245 but there is lobbying nationally to support the continuation of this. Alternatively, collective funding will need to be found in West Yorkshire to support the continuation of this provision. There are some ST4s coming through in September. If approved today, work will commence to establish it and commence immersion training in the Autumn. MP noted that the pragmatic way forward is to support this and MYTT. All members endorsed this. BB commended this as a good piece of work. *RA and JL left the meeting*	
ERF proposal	Ben Roberts (BR) – presented an update on ERP proposal. • BR stated there had been confirmation from NHSE that our proposal to use an alternative ERF mechanism to PbR has been accepted. In order to ensure success, a system oversight group has been put in place, headed by Simon Worthington with a Clinical Reference Group (CRG) below it, chaired by Dr Mark Liddington. Ben confirmed he will chair the technical group with finance colleagues to work through transactional issues. Simon Worthington and Jonathan Webb will continue to meet with DHSC and NHSE to update them. Most things are in place - now need to capture the benefits and good work coming out of this.	**ACTION: BR to update on feedback from national meetings.**

	BB asked BR to report back to members on dates of national meetings, on whether COOs and DOFs could take part in the conversation, and if they could meet. The group discussed the challenges of elective delivery, particularly improvements in productivity and reducing outpatient follow-ups. LC suggested that we could invite clinical network chairs to the all exec meeting in the Autumn to support understanding some of the challenges.	**ACTION: LC to invite clinical networks to September meeting.**
WYAAT Strategy - Update for CiC - WY ICB Operating model	LC presented an update on WYAAT Strategy. • LC updated on WYAAT Strategy, as well as what to take back to the Committee in Common (CIC) meeting at the end of July. LC highlighted that she is looking at October being a culmination of all the work, taking the Strategy document to CiC for approval in October. PW proposed using the overarching principles of WYAAT to progress this, rather than setting up a structure. He drew attention to not convening too many WYAAT groups, avoid duplication and using people's time. LR suggested being clear about short, medium, and long-term objectives would be of benefit, and highlighted the real power of six organisations committing to something. He added that with landscapes changing, being in something at the start was a good thing. BB summarised there was a lot of support and cautioned to not lose sight of sharing best practice. Members agreed for LC the continue the work on finalising the Strategy. Members agreed to meet in September and invite all executive colleagues. *PW left the meeting.*	**ACTION: PMO to circulate paper 7 after the meeting** **ACTION: LC to bring final draft strategy to October programme executive meeting.**
Neurology Update	*Sal Uka (SU) and AA joined the meeting* • AA gave a presentation on the neurology programme. SU confirmed there was a clinically led agreed model of what this will look like and Trust-wide visits with clinical operational teams were being conducted. After discussing with all WYAAT groups, it was felt this is the right direction. BB emphasised that the amount of work to get to here should not be underestimated and commended it. LR pointed out there is a good model in BTHFT but little elsewhere, adding it would be good to understand the demand at BTHFT compared to other areas without a comparable GPSI service. A good structure would help with dealing with this. AA agreed this was a good point. She confirmed she met with GPSIs at BTHT and will unpick the data to do a comparison.	

	SU highlighted that headache is a huge referral source and should be very community-based. He suggested focussing on headache first, adding that sorting this model would provide access to primary services. LR agreed. JC raised being mindful of workforce challenges and GPSI capacity, as clinical colleagues are limited and need support. LR queried if all neurologists would be based out of Leeds, with visiting sessions to outpatients. SU confirmed this could be an option but reflected that a more explicit description may be required. SU clarified that two thirds would be working together in Trusts, with remainder working as WY service. LR discussed the impact of some of these services on acute physicians, urging they're made aware that CEOs are aware. LC completely agreed with LR's comments BB suggested a further update on this at a future meeting and asked AA how members could support this work. AA highlighted members had previously considered mapping out WYAAT's response. SU proposed this might need a separate conversation and offered to organise this. BB agreed and suggested tying it in with workforce plan. BB asked LC to provide update later, but September meeting looking busy. *Sal Uka and Asifa Ali left the meeting*	**ACTION: SU to pick up considerations in relation to acute physicians.** **ACTION: Further neurology update to be added to the agenda in October.**
CiC Agenda	LC informed members that YAS would attend second half of CiC and summarised that the first half of the agenda would be to discuss business and the second half would be for people joining the meeting. Members were happy with the CiC agenda plan. LC to add letter to the ICB as an attachment to BB's update in the papers. JC queried if YAS were attending at their request. LC confirmed the request had come from Martin Havenhand, new chair at YAS. *MP left the meeting*	**ACTION: LC to include WYAAT letter to the ICB in CiC papers.**
Specialised commissioning risks	LC discussed if there was a need to articulate the risk that sits around the transfer of specialised commissioning responsibilities, as she had not seen any evidence of any concern / risk at an ICB level. BB suggested this could be a conversation with Ian Holmes at ICB level. LC explained the process is so focused, the implication for providers seems to be lost with delivery, financial risk and transformation requirements being missed. LC to meet with Ian Holmes.	**ACTION: LC to meet with Ian Holmes.**

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting Notes and Actions

AOB	BR reported that the national lead for artificial intelligence (AI) has reached out wanting to talk discuss AI opportunities with trusts. BR advised members that if they have anything going on with AI, he could put them in touch with the national lead for AI re bidding. BR confirmed he will also ask Trust DOFs. LR asked if WYAAT programmes such as imaging, pathology and digital pathology would also be included. BR confirmed yes. BB informed members that PW to cover for him at the CIC meeting due to annual leave.	

OTHER ISSUES TO NOTE

N/A

NEW RISKS/ISSUES RAISED

N/A

Next Meeting	**WYAAT Programme Executive**		
Date	1 August 2023, 09:30-12:30	**Location**	MS Teams

Humber and North Yorkshire Health and Care Partnership

Humber and North Yorkshire Collaboration of Acute Providers (CAP) Board Meeting
Tuesday 4 July 2023, 1.00pm – 2.30pm
via Microsoft Teams

Those Present: Chris Long (CL), Chief Executive Officer, HUTH (Chair)
Ivan McConnell (IMc), Director of Strategic Development, NLaG
Jonathan Coulter (JC), Chief Executive Officer, HDFT
Matt Graham (MG), Director of Strategy, HDFT
Shaun Stacey (SS), Acting Chief Executive Officer, NLaG
Shauna McMahon (SM), Joint Chief Information Officer, HUTH / NLaG
Simon Morritt (SM), Chief Executive Officer, YSTFT
Wendy Scott (WS), Managing Director, HNY CAP

In Attendance: Carla Mitchell (CM) Executive Assistant, HUTH
Lucy Turner (LT), Managing Director, HNY Cancer Alliance
Lynette Smith (LS), Deputy Managing Director, HNY CAP
Rebecca Elsom (RE), UEC Programme Director, HNY CAP

1 Apologies:
Kate Wood (KW), Medical Director, NLaG
Andy Bertram (AB), Finance Director, YSTFT

2 Minutes from the Last Meeting
The minutes from the meeting held on 24 April 2023 were taken as a true and accurate record.

CL asked if the clear prioritisation framework had been created. LS confirmed it had not been created yet, and a piece of work had been sent to the Humber and North Yorkshire Integrated Care Board (HNY ICB) as part of the ICB's work on the responsibility agreement and operating framework. This was an outstanding action for LS and Penny Gray who had been appointed as the Director of Commissioning. A flow chart approach was being worked through identifying what was Trust specific, Place specific or where value was added by being part of the Collaboration of Acute Providers (CAP). Following the work undertaken on the Organisational Development (OD) piece, further work was required on identifying other areas that were being missed and there was an opportunity to reframe to not only look at the Integrated Care System's (ICS) work, but also the areas the Trusts would like the Collaborative to work on.

A discussion ensued on the formal establishment of subgroups including with Chief Medical Officers (CMOs) and Chief Operating Officers (COOs). WS noted the CAP Programme Executive Group (PEG) had been stepped up to escalate and lead on work from the newly formed Committee in Common (CiC) and Chief Executive Officer (CEO) Group. W Scott was meeting with Dawn Parkes who had been appointed as the Chief Nurse at York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTFT) to discuss how the CAP supported work with Chief Nurses across the ICS. The CMO / Medical Director (MD) subgroup had not been established, however a meeting had taken place with Dr Nigel Wells (Executive Director of Clinical and Professional, HNY ICB) who was actively encouraging CMOs to meet regularly.

Humber and North Yorkshire Health and Care Partnership

It was confirmed the ICB had allocated communications and engagement resource for the CAP and work would be undertaken on communicating the CAP's work across Trusts and stakeholders.

3 Action Log

The action log was discussed and would be updated accordingly prior to the next meeting.

JC noted Action 4b referred to creating a dashboard to be informed of the demand and capacity requirements within social care to gain an understanding of the gaps and workforce requirements. IMc and JC agreed to discuss outside the meeting to ensure work was aligned.

Action: IMc and JC to further discuss the dashboard (regarding demand and capacity requirements in social care) to ensure work was aligned.

4 CAP Governance

WS provided an update on the CAP governance arrangements. A monthly CAP CEO Group would be established, chaired by SM, and a quarterly CAP Board (acting under the HNY CAP CiC) with nominated non-executive directors (NEDs) from each Trust. The Terms of Reference (ToR) and membership had been agreed for the PEG and the meetings were scheduled for the rest of the year.

In regards to the CAP information sharing agreement, Becky Bradley from YSTFT was leading on this and would be liaising across Trusts. The agreement would be added to the Joint Working Agreement (JWA).

The responsibility agreement from the ICB would form part of the JWA as an appendix once agreed and signed off.

WS thanked CAP Board Members for their work on the CAP governance arrangements.

5 CAP Resources

LS conveyed the Finance Directors had been working on the staff liabilities and employment piece which would be added to the JWA.

An overview was provided on CAP recruitment. A Programme Director had been appointed for the diagnostic programme and two Project Managers had been appointed to support the development of the networks around imaging, endoscopy and physiological measurement. Project Support would also be recruited to as there had not been significant admin support for the diagnostic programme. A Programme Manager had been appointed for the elective programme to support the clinical networks and the second Programme Manager role may be re-advertised. Two Programme Leads working to the Programme Director had been appointed for the Urgent and Emergency Care (UEC) Programme. All roles were expected to commence by September 2023. Work would be undertaken with COOs on how the roles embedded with existing PMO teams and how they supported delivery within Trusts, including the clinical leadership element. The Personal Assistant for the CAP would commence in post on 10 July 2023.

A number of clinical network lead posts, which respective MDs had been involved in, would hopefully be appointed in the next couple of weeks to progress the clinical network development.

Humber and North Yorkshire Health and Care Partnership

A review would be undertaken in quarter three to understand the resources required going into next year to ensure a smoother recruitment process.

C Long thanked WS and LS for their work on CAP resources, and thanked CM for providing admin support.

6 Programme Executive Group Escalations

6.1 Cancer Alliance – Performance and Risk Escalations

LT presented slides on the Cancer Alliance performance and programme risks for 2023/34.

The biggest performance risk was the position against the planned backlog trajectory reduction where 195 patients were over trajectory. The target was 552 patients for over 62 days, however by the end of May 2023 it was 747 patients. The biggest contributor was Hull University Teaching Hospitals NHS Trust (HUTH) in terms of their position within the first two months of the 2023/24 financial year and due to a number of factors since Easter the Trust had been impacted more than other Providers. Rigorous challenge had taken place to identify ways to ensure investment was in the correct places of the transformation programme and if there was anything more that could be done to help. Further consideration was required on how long the recovery process would take.

HUTH met the Faster Diagnosis Standard (FDS) for May 2023, and it was expected for HUTH to continue to meet the FDS going forward. Even though HUTH met the target, it had no impact on reducing the backlog or getting near to the 62 day performance. Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) remained just on trajectory and YSTFT were struggling with meeting the FDS. An overview was also provided on the Cancer Outcomes and Services Dataset (COSD) and the Rapid Cancer Registration Data (RCRD).

The programme risks were presented to the monthly Cancer Alliance Oversight and Assurance Meeting and also the System Board. The Cancer Alliance was rated quarterly for delivery and risk by Regional and National Cancer Teams. The HNY Cancer Alliance was rated amber 'partial assurance' for quarter four 2022/23. LT proceeded to provide an overview of the red risks.

C Long noted it would be beneficial to discuss the lung health check and bowel screening programme risks at a future meeting. CAP Board members agreed.

A discussion ensued on the Society of Radiographers (SoR) strike action and the impact this would have on diagnostics. SS proposed to discuss further at the COO Group, including options for delivery, and LT agreed noting she had been invited to the August 2023 meeting and would discuss this further with the Chair of the COO Group.

Action: To discuss the lung health check and bowel screening programme risks at a future CAP Board.

6.2 HNY UEC System Plan – Phase 1 (Tier 1 Plan)

RE presented slides on the HNY UEC Programme Priorities 2023/24 which included HNY Place UEC Improvement Plans. The HNY UEC Recovery Plan selected key priorities from these Plans to deliver across the system, and RE proceeded to explain the priorities for HNY as well as priorities and risks for each Place.

Humber and North Yorkshire Health and Care Partnership

A discussion took place on performance and outcomes, and the lack of changes compared to the amount of investment. RE noted there were contributing factors such as the demographic of the population, the geographical area which was more dispersed and rural, and recruiting and retaining workforce. It was noted in order to improve, specific areas should be focussed on one at a time. It was also important to celebrate successes.

LS noted it would be useful to use the support of the Emergency Care Intensive Support Teams (ECIST) to understand, when compared to other ICSs, what was similar to HNY and what had made a difference in more rural areas.

6.3 Diagnostics Update (Including CDC)
LS provided an update on the diagnostic programme and highlighted pertinent points from the paper circulated prior to the meeting.

From a Community Diagnostic Centre (CDC) perspective, the team had been very successful in terms of capital. The IS partnership approach to the Hull Hub had been moved to an NHS based Hub, but not at full level. A £16 million capital allocation would be allocated to Hull to progress, subject to reworking the plan which IMc was leading on with Place colleagues. Grimsby CDC Spoke had been approved for £9.96 million, but excluded audiology and ophthalmology. LS provided an overview of each site.

It had been proposed that the Trusts lead on the capital build to ensure oversight which included oversight on any major risks. The clinical pathway work would be led at Place alongside Trust colleagues. A new governance structure would be established to include three CDC HNY-wide groups on workforce, digital and finance and activity.

The key risk for the CDCs was the delays to builds due to capital processes and lack of equipment, staff and space. The CDCs received funding through a weekly portal submission, and any activity that was undertaken through a Hub or Spoke was reported through the submission and then payment was received through that route. The delays would have a significant revenue impact. An assessment would be taking place in September 2023 and, if below the activity plan, then a lower amount of money would be received in the second half of the year. The CDC Finance and Activity Group were working on three different scenarios on what the level of risk would look like.

There would be a surplus of £3 million if all activity was undertaken in the Plan. However, based on the current position, a deficit of £80,000 was forecasted. A group of principles had been agreed to include a risk share approach so all costs were covered and this would be managed across the CAP and ICS. This was particularly important as HUTH had already purchased the mobiles on behalf of the entire system and running the mobiles would need to be cost covered.

If enough activity was undertaken based on the ability to deliver to cover costs, the surplus would be shared across the Providers. The Finance Directors were leading on the risk share element and the operational team leaders were involved in terms of how activity was maximised. There was the remainder of the year to scope out what next year's activity looked like and it was important that Place Leads directed this piece of work.

It was noted a meeting had taken place between WS, LS and Stephen Eames (Chief Executive, HNY ICB) to discuss due diligence and the risks with the CDCs being delegated to the CAP. A discussion followed on if the £3 million had been factored into

the ICS financial plan and improving performance. It needed to be clear what a reduction in revenue meant for Providers and to ensure oversight on risks and cost pressures.

CL thanked the CAP team and IMc for their work on the CDCs.

It was agreed for a further update on CDCs to be brought to the next CAP Board.

A brief overview was provided on the performance element of diagnostics. Diagnostics was one of the two areas where a failed plan had been submitted for the year which had attracted interest from national and regional teams from an assurance perspective. Support would be provided from the Intensive Support Team and it had been discussed and agreed at the Diagnostics Board that the CAP would work with Trust colleagues and the network to gain an overview of HNY, particularly the demand profile from some of the most challenged specialties.

Action: LS to provide an update on the CDCs at the next CAP Board.

6.4 Learning Disabilities
LS asked for CAP Board members approval to progress with the Learning Disabilities (LD) work, as outlined in the paper circulated prior to the Board Meeting. CAP Board members supported this.

7 Finance and Procurement Update
LS provided an update on finance and procurement. It was noted WS, LS and Sue Woodfine (Section Head of Management Accounts, YSTFT) were meeting with colleagues from the ICB to undertake a final reconciliation. There was still a lack of clarity on how much money would be allocated to the CAP. A detailed report would be circulated prior to the next Board meeting.

Action: To draft a detailed finance and procurement report prior to the next CAP Board meeting.

8 AI Funding Bid
WS reported there was national funding available to support diagnostic artificial intelligence (AI). This was discussed at the Digital Committee with a suggestion that the CAP may want to lead on the bid working with digital colleagues. Work was being undertaken to identify what an AI bid may look like, in particular in radiology. The submission date was in August 2023. An update on the bid would be provided at the next meeting.

Action: An update to be provided on the AI Bid at the next CAP Board.

It was noted funding applications often had short turnaround times and there was limited capacity within teams to support. Further thought was required on sharing information on funding applications through a central point instead of directly to programme leads. CL noted he would write to Richard Barker (Regional Director for the North East and Yorkshire and North West Regions, NHSE) regarding this.

Action: CL to write to Richard Barker regarding funding applications and sharing information through a central point.

Humber and North Yorkshire
Health and Care Partnership

9 Any Other Business

CL confirmed it was his last meeting as Chair of the CAP Board and CL thanked CAP Board members for their support.