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**	Minimal
Executive Committee	Quality Management Group (QGMG)	**Summary:** The safe domain has the most risks escalated to the corporate register. 5 of the 6 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 was reduced to 8 in October as the mitigations are in place and KRI being met, it has therefore be removed from the register.				
Initial Date of Assessment	1st July 2022					
Last Reviewed	October 2023	**CRR75; CHS5** Violence and aggression against staff was escalated and added to the Trust Corporate Risk register in September. Due to the consequences of this risk, it is a high priority for the trust.				

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**September Rating**	**October Rating**	**Target Rating**	**Target Date**
CRR75: CHS1 Health and Safety	**An Environment that promotes wellbeing**	**CHS1 -** Identification and Management of risk There is a risk of incidents arising and a risk of failure of 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 Risk Indicators	**Current Position**	**Controls and Plans to implemented**
1. Suitable and sufficient assessments of risk (Completed for all Trust / HIF activities) 2. Identification and assessment of Hazards (completed) 3. Replacement of the existing SALUS risk management system, to ensure all have access to the relevant risk assessments. 4. 5. Sufficient compliance of contractors 6. Completion of Environmental Audits	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 hs 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 activitiesNew 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 Extensive work now being carried out with multiple Departments / Wards / HIF teams to generate new risk assessments. 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 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**	**September Rating**	**October Rating**	**Target Rating**	**Target Date**
CRR75: CHS2 Health and Safety	**An Environment that promotes wellbeing**	**CHS2**: HDH Goods yard	16	12	12	8	Dec 23

	Organisational risk major injuries, fatality, or permanent disability to employees, patients and others, in addition to failure to comply with legislative requirements and and the unauthorised access of persons to restricted areas as a result of the improper use of the goods yard (including the unauthorised access of persons to restricted areas)	
Key Risk Indicators	**Current Position**	**Controls and Plans to implemented**
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 Risk assessment is to be reviewed every quarter reporting to H&S committee Review of access arrangements for catering entrance. Review of storage of bikes in hospital buildings Review of waste segregating and disposal Updates following meeting with waste AE, a new waste management group is tp be established to assist the process

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**September Rating**	**October 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 Risk Indicators	**Current Position**	**Controls and Plans to implemented**
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 Communication of fire procedures to all employee Audits and reviews of the above conditions at appropriate intervals.	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) Fire safety group established with monthly meetings, this provides actions from all risk assessments. The group will monitor the actions and escalate actions through the health and safety committee. Following two fire incidents fire reviews indicated all measures were in place	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 - Initial fire door remedial work to take place in medical records, due to high risk nature of the area, using existing 23/24 backlog funds – approx. £15k Recommendations of the Fire Authority being actioned Meeting

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	September Rating	October Rating	Target Rating	Target Date
CRR75: CHS5 Health and Safety	**An Environment that promotes wellbeing**	Violence and aggression against staff: Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	16	16	16	8	Jan 24

Key Targets	Current Position	Controls and Plans to implemented
Suitable and sufficient assessments of risk Trust / HIF activities. Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	• Current policies for Violence & Aggression, Security and Lone Working are out of date and do not reflect the current makeup of the Trust, the services it provides, locations and resources. • Risk assessments, where available, are generic and do not provide clear identification of hazard or control measures. • Security presence in the Acute setting is limited - Security guard in place on ED 6pm - 6am, currently single LSMS supporting entire Community footprint. • Training is limited and is not currently provided to staff on a risk based approach. • Conflict Resolution (Breakaway Skills) training provided to approximately 220 staff • Escalation procedures for staff in response to incidents and the procedures to follow when dealing with patients is limited and not consistently applied. • Reports on a daily basis of incidents of violence and aggression against staff across the Trust, both physical and verbal (20-30 Datix reports per month). • Trust supports and promotes a zero tolerance approach to V&A, however there is a culture of accepted levels. • Trust Security Forum in place – now reports directly to the Trust H&S Committee	• Task and Finish group established (led by Head of H&S and HON LTUC) – broad remit to review all existing policies, procedures and implement improvements where required. • Phase 1 work reviewing managing Patients who may self-harm / those suffering with mental health issues. New policy- in draft • New environmental assessments and creation of green spaces to allow safe areas for patients and staff (complete in Farndale and Oakdale) – to be contined across Acute setting • Provision of ligature training • Increase in provision of Breakaway Skills training to staff based on risk. • Mandatory elearning Conflict Resolution training for all HDFT staff • Visits to all Community teams/locations to identify current security, lone working procedures • Business case for resource to increase Conflict Resolution – Breakaway Skills training

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	September Rating	October 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	16	8	Dec 23

Key Targets	Current Position	Controls and Plans to implemented
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 Year 1 report indicates increased likelihood of a panel collapse – assessment of risk of collapse vs risk of harm cancelling clinical services in those areas required B3 Corridor (Farndale to ITU) has had significant water ingress – increasing likelihood of panel collapse Year 1 Report now received from WSP – analysis shows significant areas of remedial work required. Further meetings with WSP to identify course of action Relocation of teams and services are being implemented and monitored through fortnightly meetings.	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 1974Strategic 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. Work to carried out includes temporary stalls, netting and a scaffolded crash deck in addition to relocation of services Year 1 Report now received from WSP – analysis shows significant areas of remedial work required. Further meetings with WSP to identify course of action

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: People and Culture (Workforce Risk)	**Risk Type**	**Clinical**	**Workforce**		**Risk Appetite**	**Cautious**
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 was reduced to 12 in October, the risk is to remain on the corporate risk register and target score adjusted to 8. The reduced score is to reflect the positive performance against the KRI. The panel noted the possibility of winter pressured affecting the performace in the coming months.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	October 2023						

Corporate Risk ID	**Strategic Ambition**	Principle Risk:	**Initial Rating**	**September Rating**	**October 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	12	16	12	8	July 2024

Key Targets	**Current Position**	**Controls and Plans to implemented**
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. Metrics to be considered: Staff Engagement – Survey Scores (Benchmark Group Acute & Community Trusts) Turnover Sickness Appraisals Vacancy rate	Staff Engagement – The scores for staff engagement over kindness, teamwork, integrity and kindness are higher than the benchmark for a third continuous month Turnover - Turnover (Target 12%) Turnover Rate has reduced to 13.77% at the end of September. The Trust has seen a decreasing trend since October 2022. (This incorporates voluntary and involuntary turnover). Sickness - Target 3.9% - Sickness has fallen from 4.95% in August to 4.66% in September 2023. • (Sickness had been on the decrease to May) since it peaked in December 2022 at 5.32%) • We are starting to see a small increase in Staff Covid sickness • "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to just under a third of the overall sickness. Appraisals - Target 90%. Appraisal rate in September is 81.97%, which is a small decrease compared to the previous month. Vacancy Rate (Target 7%) Trust vacancy rate in August is 5.92%, which is a decrease compared to last month's vacancy rate of 7.71%.	Staff Engagement - All Directorates instructed to achieve 90% Appraisal compliance – completed appraisal numbers have increased significantly. Turnover - Work underway to develop career pathways, utilising the apprenticeship levy as a major lever for affecting improvements. Review of National Long Term Workforce Plan and implementation actions, in collaboration with HEIs Retention Group formed as a sub-group of Looking After Our People & Belonging – developing career conversation tool/process and new starter survey process. Equality & Diversity and Inclusion work plan in place to reduce workplace inequalities and increase inclusion. Financial support on travel and lunch Sickness – Stress audit underway, fair and just culture project, health ad wellbeing activity Sickness absence policy and procedures in place and line managers actively supported by the Operational HR Team in managing this. HR is also considering the policy and Staffside for further review and samples from other Trusts shared with Staffside. 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**	Minimal	
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), this has reduced to 12 in August. RTT (CRR41) remains a 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	October 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**September Rating**	**October 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	12	12	8	March 26

Key Targets	**Current Position**	**Controls and Plans to implemented**
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 end August 24 would be 47 months, this has increased due to the 6month average monthly referral rate of 84 and the higher current waiting list numbers. Mobilisation of WLI (additional 10 assessments per month for 12months) and newly agreed pathway changes (self-referral, MDT triage, pre-school pathway) continues well with service change communication for previous referrers shared with commissioners and positive feedback from GPs. It has been highlighted that non-recurrent 12month funding is very difficult for the service to manage, taking into account lead in times to secure additional capacity, train staff and national shortages in psychologists etc. This will not address the underlying mismatch between demand and capacity. The ICB task and finish group for North Yorkshire & York PLACE based approach has not progressed any capacity solutions and is focussing on standardising clinical prioritisation. An ICB wide group for autism and ADHD (for all ages) has now superseded the PLACE based group. •Numbers on the waiting list: **1423 (target 120)** •Longest wait: **: 68 weeks (target 13)** •Activity - - **53 completed assessments in Sept against ICB plan of 50, YTD 245 against plan of 250. (2 additional assessment for military completed YTD – funded separately).**	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	August Rating	September 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**	**Aug-23**	***Sep-23 (Provisional***
Total incomplete RTT pathways	24,854	25,139	25,504	25,951	25,876	25,860	25,831	25,802	*26,623*
> 52 weeks	1,186	1,112	997	998	1,001	1,020	1,033	1,124	*1,116*
> 65 weeks	399	362	193	202	197	210	208	259	*262*
> 78 weeks	101	65	4	5	0	0	1	4 (complex)	*0*
> 104 weeks	0	0	0	0	0	0	0	0	*0*

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. Performance will continue to be tracked. Work continues with commissioners to agree a sustainable funded model for community dental delivery.

None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, having patients waiting this long. Recovery plans in gastroenterology are currently in development.

Controls and Plans to implemented

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

Validation and real-time updating of RTT waiting lists

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

- LUNA - supported validation tool has gone live although some further work is ongoing to enable the AI element.
- LUNA is further supporting data quality at the front end of the RTT pathways.
- Pilot of text validation 86% of patients under 12 weeks are validated
- The RTT review and data quality review to ensure accurate monthly RTT submissions
- 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 Q3 of 2023- this project has now commenced

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	September Rating	October 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

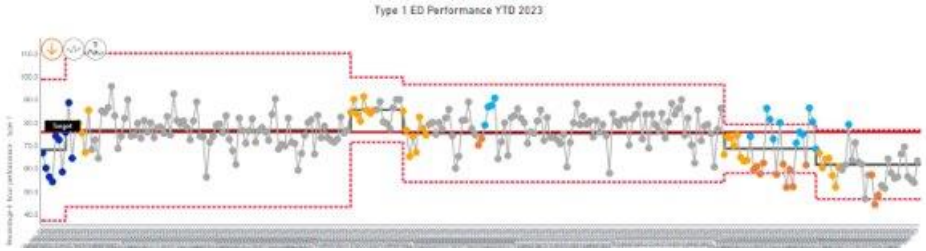
A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches

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%.

Current Position

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%. August and September have been challenging months in terms of 4 hour performance. Year to date performance is currently 77%

	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Type 1 & 3	72%	71%	67%	64%	68%	66%	63%	72%	81%	78%	83%	81%	80%	82%	73%	65%



12 hour waits

	12 Hour DTA	12 Hour total wait
July 23	0	33
August 23	0	65
September 23	1	119

Ambulance handover breaches
There has been a significant reduction in the time that patients are waiting to be handed over from ambulance crews to the ED team. The improvement correlates with the opening of the ambulance RIAT bay.

	30 Min HO (including 60+ mins)	60+ Min HO
July 23	12	0
August 23	22	3
September 23	15	1

Ongoing building works in the department mean ED2 is currently out of use, restricting space to see patients. Space will be limited until the end of the building works planned for December 2023

Controls and Plans to implemented

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**	Cautious
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	October 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**September Rating**	**October 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**	**Controls and Plans to implemented**
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 Trust is currently spending in excess of the agency ceiling – Month 6 £834k. The Trust is currently spending in excess of the 2019/20 pro-rata agency spend – YTD £3.7m against 2019/20 £1.6m The Trust is now reporting performance to NHSE on a monthly basis. No datix reported as a result of agency staff not meeting substantive staff obligations.	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**	**September Rating**	**October 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**	**Controls and Plans to implemented**
1. Monthly financial reporting – Break even operational plan 2. NHSE productivity analysis 3. Agency Expenditure	Currently reporting a deficit position of £5.5m. 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%. Whilst cash remains positive, the deficit position is having an impact. Cash has reduced by £15m since the end of 2022/23. 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	1. Continued discussions with ICB regarding underlying position – NHSE submission expected late summer 2. Recovery plans at directorate level – see appendix

4. Cash position		• Inflation above the levels outlined above and within planning • Strike costs • Drug expenditure, again above the levels described above. 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.

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**	Minimal
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	October 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**September Rating**	**October Rating**	**Target Rating**	**Target Date**
CRR87 **Community Dental**	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**	**Controls and Plans to implemented**
• Numbers on the waiting list over 52weeks, 65weeks and 78weeks. **Current position – 4 patients over 78 weeks, 106 patients between 65-77 weeks, 352 patients between 52-64 weeks.** • No of overdue continuing care patients. **Current position – 2702 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**	
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	October 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**

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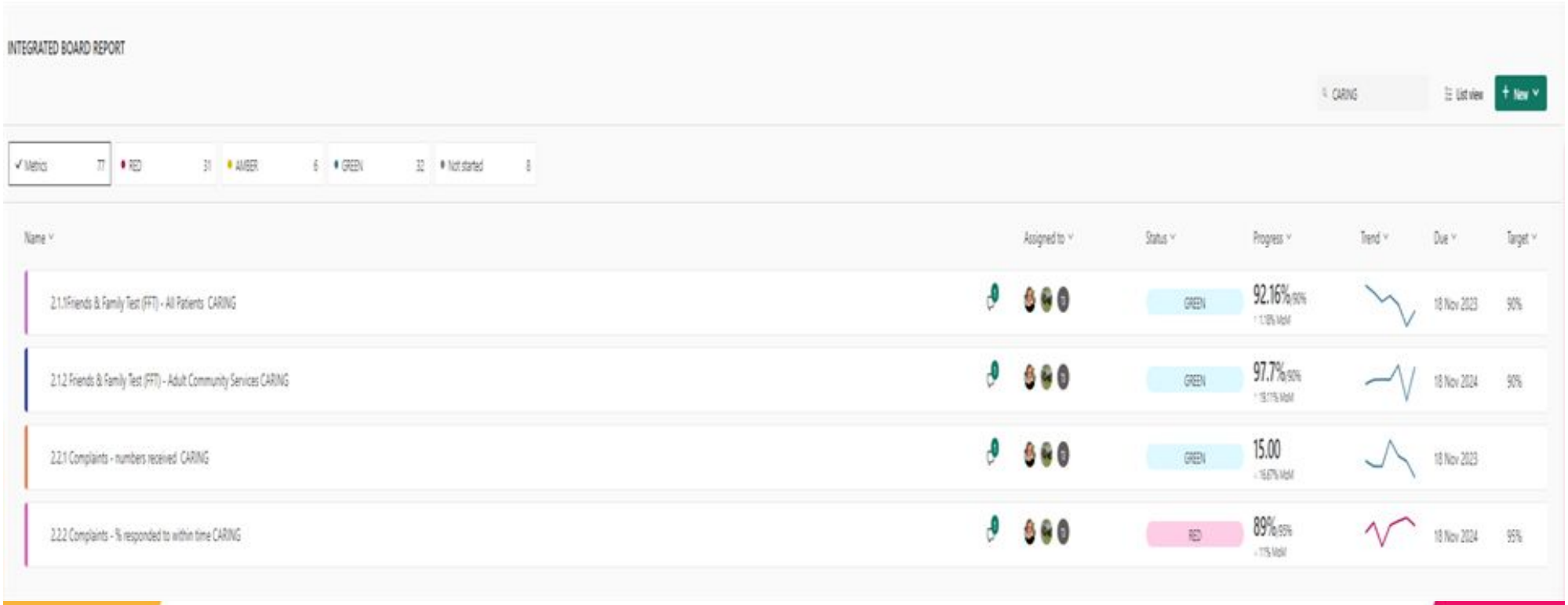
HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services

NHS Harrogate and District NHS Foundation Trust

SAFE DOMAIN - IBR

Name	Assigned to	Status	Progress	Trend	Due	Target
1.1 Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days SAFE		GREEN	0.61		18 Nov 2024	0.00
1.2 Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts SAFE		GREEN	1.37		18 Nov 2024	0.00
1.3 Inpatient falls per 1,000 bed days SAFE		GREEN	4.85		18 Nov 2024	5.00
1.4 Infection control - Hospital acquired C.difficile cases, lapse in care identified SAFE		GREEN	2.00		18 Nov 2024	0.00
1.5 Infection control - Hospital acquired MRSA cases, lapse in care identified SAFE		GREEN	0.00		18 Nov 2024	0.00
1.6 Incidents - ratio of low harm incidents SAFE		GREEN	73.20		18 Nov 2024	75.00
1.7.1 Incidents - comprehensive serious incidents (SI) SAFE		GREEN	0.00		18 Nov 2024	0.00
1.7.2 Incidents - Never events SAFE		GREEN	0.00		18 Nov 2024	0.00
1.8.1 Safer staffing levels - fill rate SAFE		AMBER	94.50 %		18 Nov 2023	96.00 %
1.8.2 Safer staffing levels - CHPPD SAFE		Not started	8.14		18 Nov 2024	
1.9 Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d SAFE		GREEN	91.9%		18 Nov 2024	95%
1.11 Infant health - % women smoking at time of delivery SAFE		GREEN	4.44%		18 Nov 2024	0%
1.12 Infant health - % women initiating breastfeeding SAFE		GREEN	92%		18 Nov 2024	95%
1.13 VTE risk assessment - inpatients SAFE		GREEN	95.1%		18 Nov 2024	100%
1.14.1 Sepsis screening - inpatient wards SAFE		GREEN	96.42%		18 Nov 2024	90%
1.14.2 Sepsis screening - Emergency department SAFE		GREEN	93.55%		18 Nov 2024	90%

CARING DOMAIN - IBR



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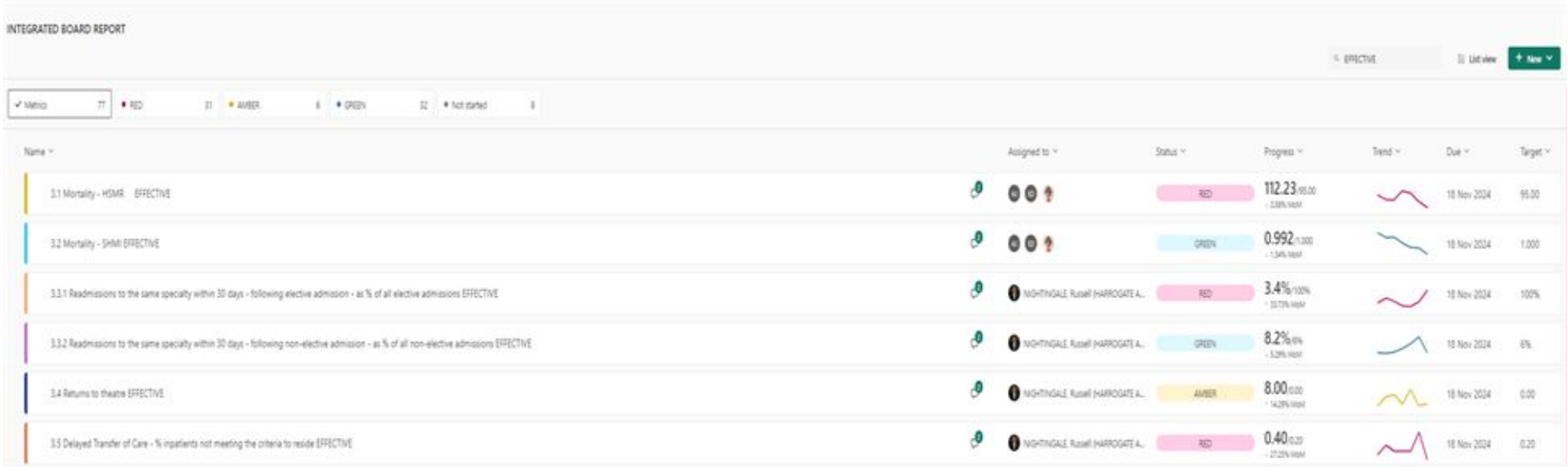
EFFECTIVE DOMAIN - IBR



Trust Board of Directors (Public)
29th November 2023

Title:	Learning from Deaths Quarterly Report 2: July-Sept 2023
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	X
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	N/A	
Report History:	Paper also submitted to Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Board Meeting Held in Public

29th November 2023 2023

Learning from Deaths Quarterly Report 2

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national trends.

SHMI has fallen over the last year to around the national normal value.

15 cases have undergone a structured judgement review since the last report. Median score for overall care was “good”. No cases delivering poor care were identified.

The HDFT Medical Examiner Office is now ready for the statutory introduction of the Medical Examiner function in April 2024.

A summary report of external reviews undertaken into deaths in patients with Learning Disabilities (LeDeR) has been received, with no lapses in care identified in the one case from HDFT.

2.0 Introduction

Although mortality data represents a very small percentage of all trust activity, it is important that it is monitored and examined appropriately. This report aims to triangulate mortality indices with other markers of quality of care, in particular that provided by structured judgemental reviews (SJRs) of medical notes.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 168 deaths were recorded in Q2, down from 172 in the preceding Q1 and also down from Q1 in 22/23 which had 179 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years.

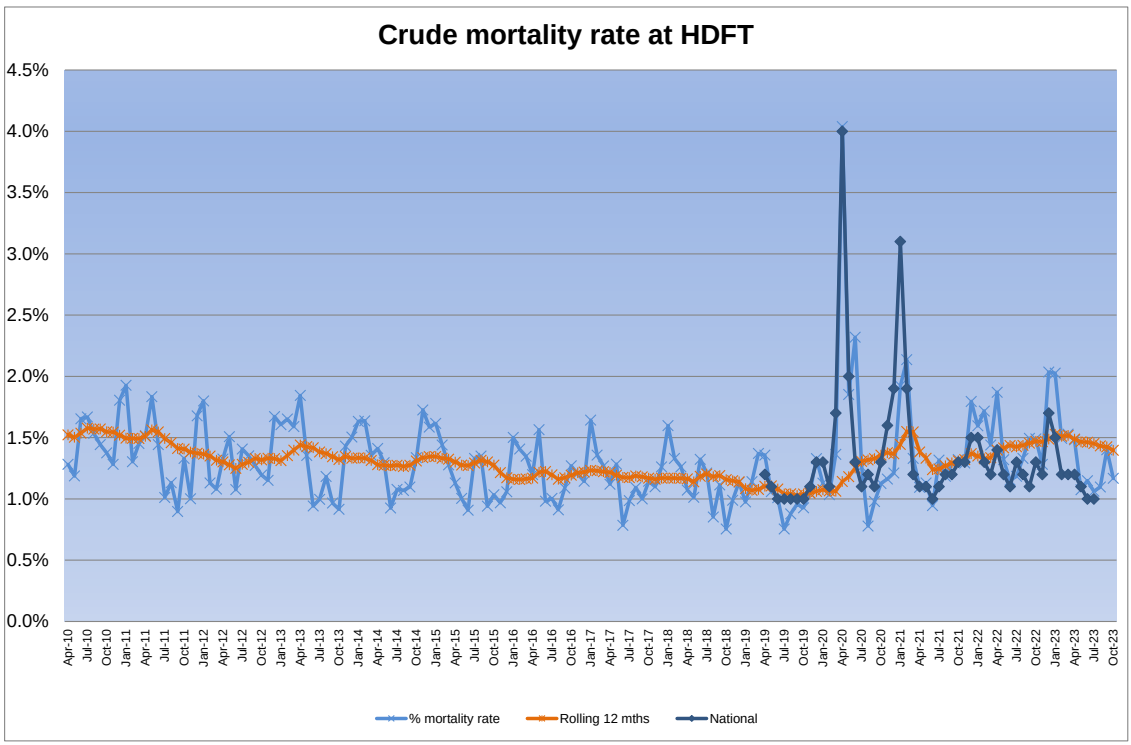


Figure 1: Crude mortality rates over the last 13 years (%deaths per qualifying episode)

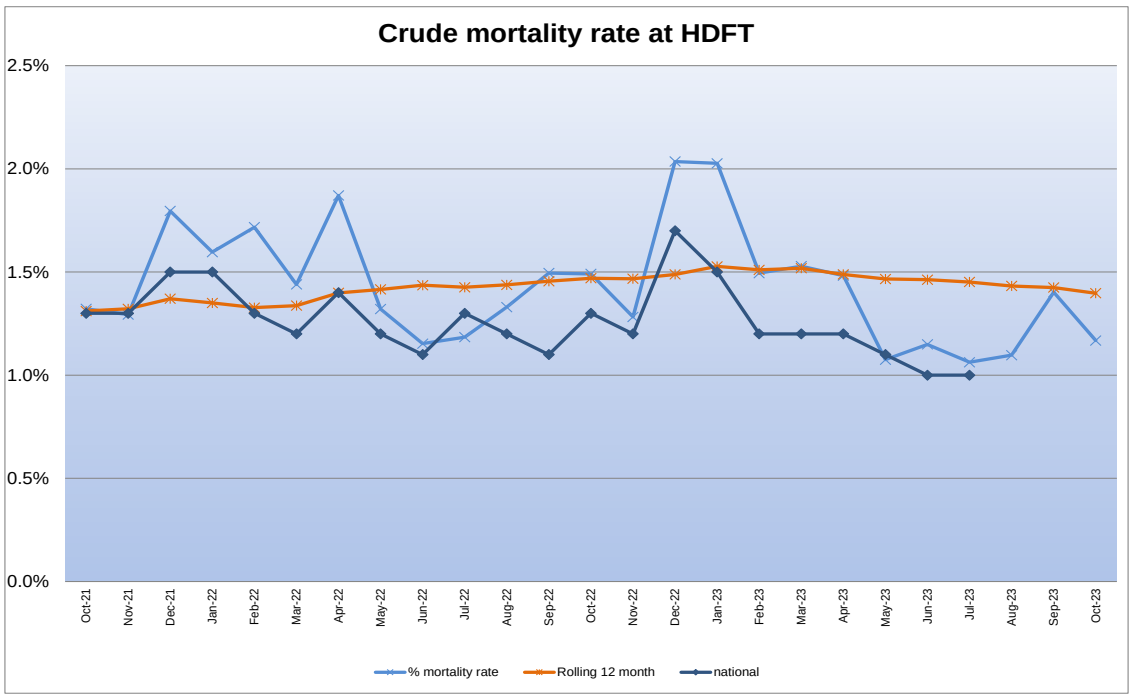


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

Figure 3 shows a decline in SHMI from a peak in April 2022. SHMI captures all diagnoses (excluding Covid-19), together with deaths occurring within 30 days of discharge.

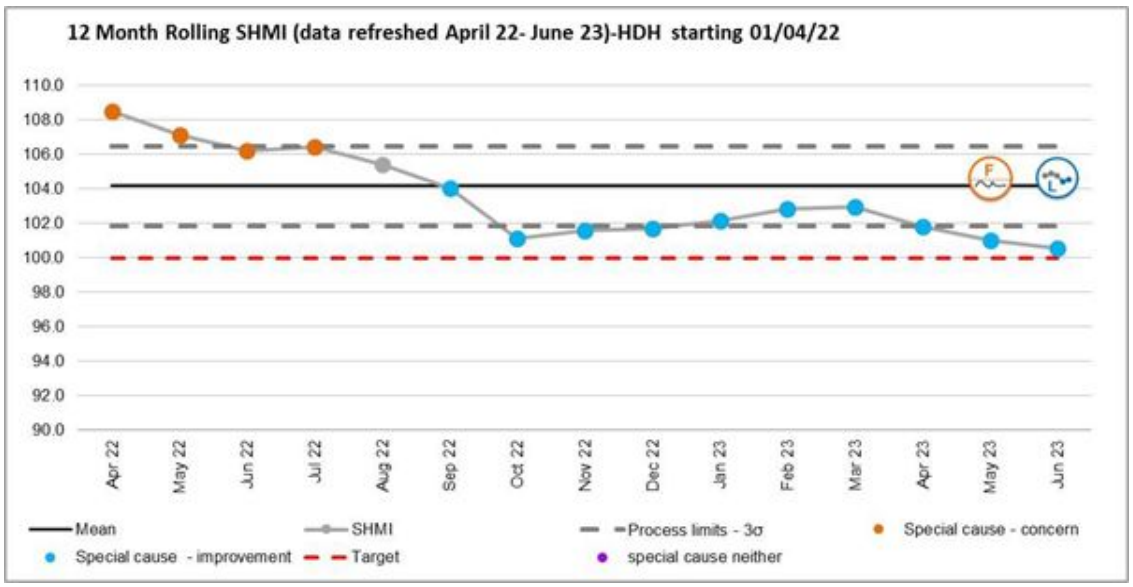


Figure 3: HDFT SHMI since April 2020

Figures 4 and 5 demonstrate the observed and expected death predicted by the SHMI model, with Figure 6 demonstrating the difference between these two values. The number

of expected deaths has risen throughout the last 12 months whereas the observed numbers have levelled off around March 2023.

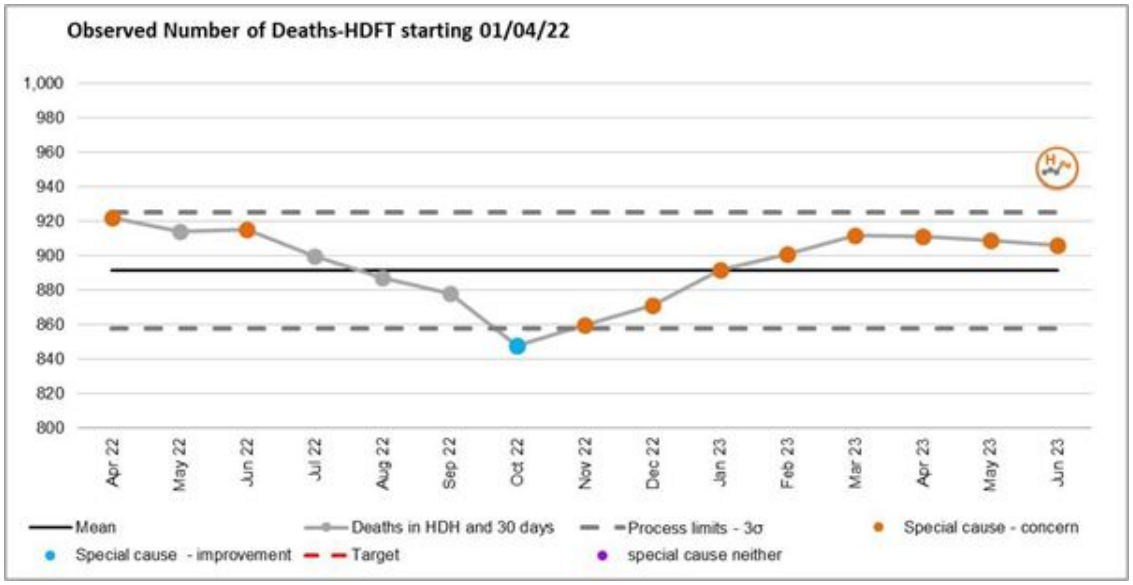


Figure 4: Observed deaths included into SHMI

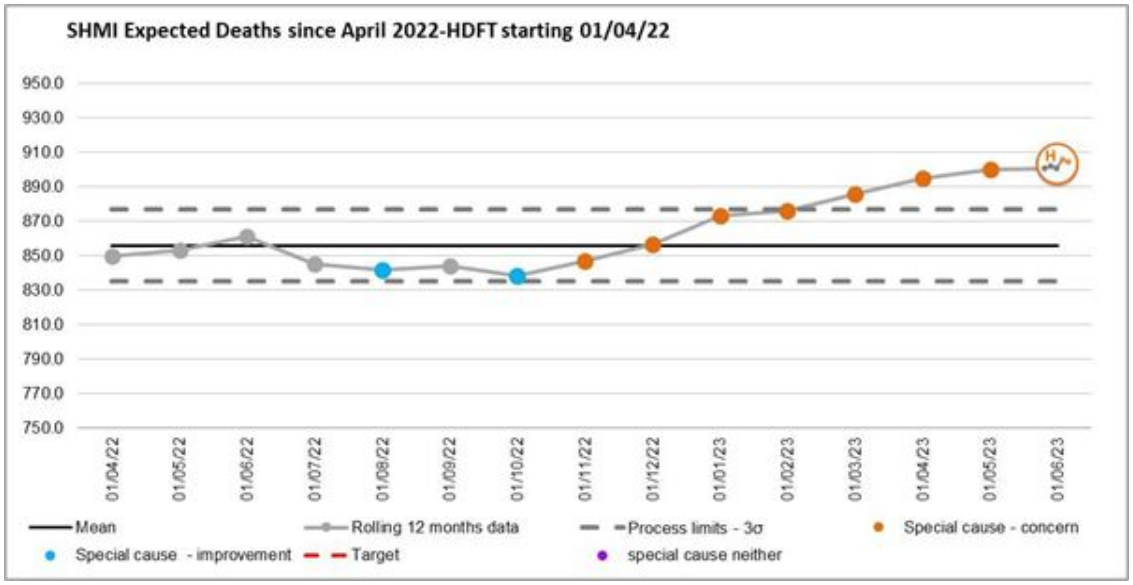


Figure 5: Expected deaths as predicted by SHMI. Note this has still not returned to pre-Covid levels

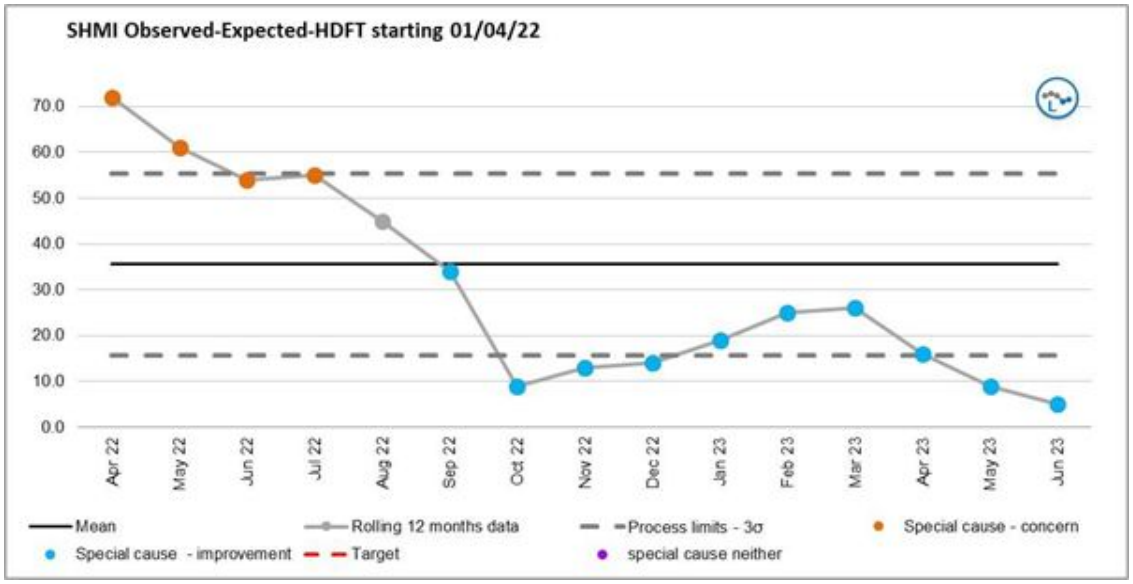


Figure 6: Observed-Expected Deaths, as predicted by SHMI

Figures 7 and 8 demonstrate our SHMI against that of national peer and regional trusts:

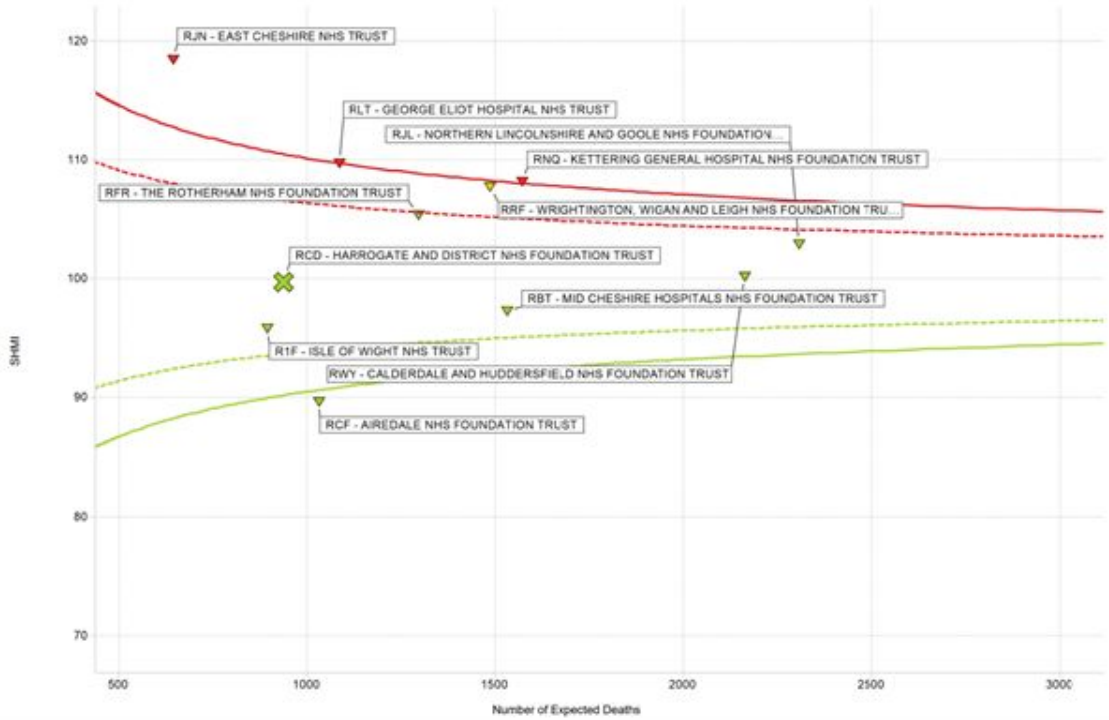


Figure 7: SHMI data for national peer organisations

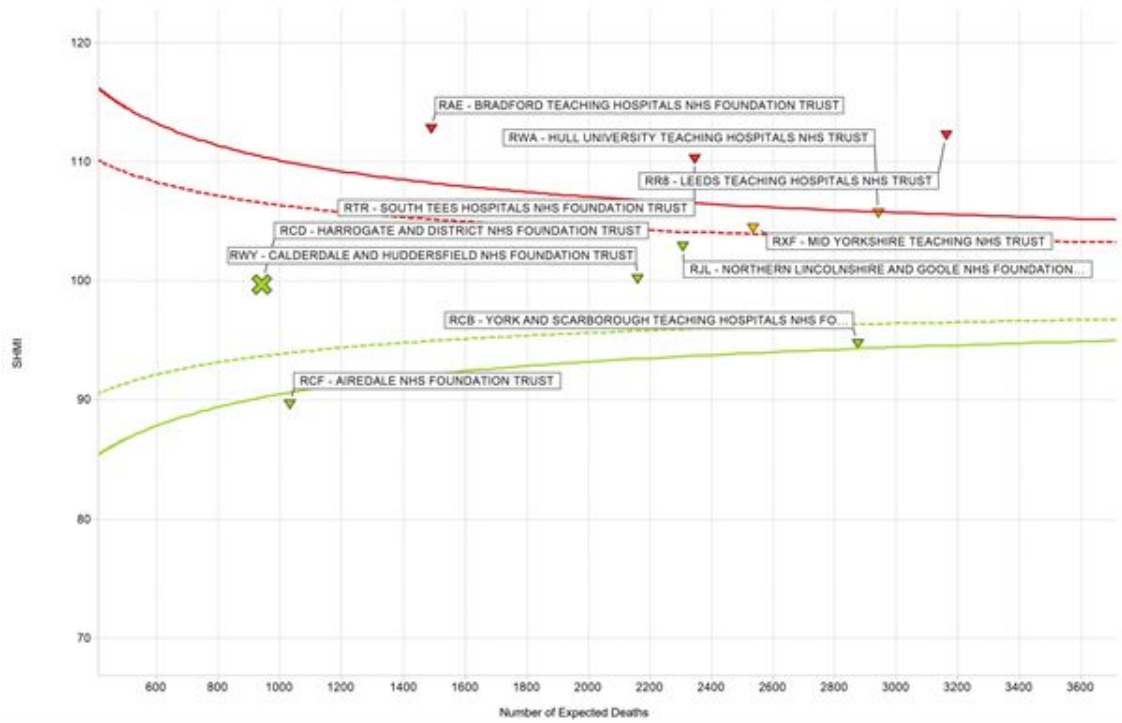


Figure 8: SHMI monthly data for regional peer organisations

3.3 Structured judgement reviews (SJR)

15 cases have been reviewed in this quarter with 2 relating to deaths in this quarter, 2 from Q1and the remainder preceding that. Cases are selected following recommendation from a Medical Examiner or randomly for assurance. We also review any case with a known learning disability or autism. Additional cases in this review are selected following mortality alerts in specific diagnostic categories. The overall assessment of standard of care of all cases is shown in Table 1:

Case ID	Admission Date	Learning Disability	Serious Mental Health Issue	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Dec 22	No	No	3	N/A	3	3	3
2	Oct 22	No	No	3	4	4	4	4
3	Jun 23	Yes	No	4	4	N/A	4	4
4	Mar 23	No	No	4	3	N/A	3	4
5	Jul 22	No	No	3	3	N/A	3	3
6	Feb 23	No	No	4	4	4	4	4
7	Feb 23	No	No	4	4	4	4	4
8	Dec 22	No	No	4	4	N/A	4	4
9	Jul 22	No	No	4	4	4	4	4
10	Sep 23	No	No	4	4	4	4	4
11	May 23	No	No	4	4	4	4	4
12	Nov 22	No	No	4	4	N/A	4	4
13	Sep 23	No	No	4	4	3	4	4
14	Mar 23	No	No	4	4	N/A	4	4
15	Jun 23	Yes	No	4	5	4	4	4

Median Score				**4**	**4**	**4**	**4**	**4**

Table 1: Structured Judgemental Reviews (SJR) conducted in Q2 2023-2024

No significant themes have been identified in these reviews.

2 cases were identified as having a Learning Disability. These will be subject to external review as part of the LeDeR process, and feedback from that will be provided when available in a future report. We have received a report from the ICB detailing the findings of their reviews across the region. This is attached for interest at the end of this report. Case number 11 is the only HDFT case reviewed, for which no lapses of care were identified.

A number of the cases reviewed this quarter were selected as they had been admitted during a weekend. No concerns were identified in this group, in particular there were no examples identified where access to treatment, investigation or senior review was not available.

Overall, the quality of care being delivered during this period remained of a good standard, although it should be noted that the deaths cover a broad timescale. The Medical Examiner team have confirmed that they are not seeing any recurrent themes in the recent cases scrutinised. SJRs are a more reliable method of detecting poor quality clinical care and provide assurance that mortality indices.

The trust is in the process of implementing new “Datix iCloud” software which has a module specifically for undertaking and interrogating SJRs. It is hoped to implement this in early 2024, and it should enable easier identification of any emerging themes.

A proportion of the cases selected for this review related to death from pneumonia or coronary disease, as these had been highlighted as possible outliers. No themes or concerns were identified in these categories.

The Mortality Review Group continues to meet on a monthly basis to review any cases of concern or of interest to a wider audience. Individual Care Groups now have allotted meetings to present their cases to ensure a broad spectrum of appropriate cases are discussed.

4.0 Medical Examiner Service

The Medical Examiner service has now completed its roll-out, providing scrutiny to all allocated healthcare organisations. From March, all paediatric (including neonatal deaths) will be scrutinised in addition to adult deaths. Discussions are underway with paediatric, obstetric and midwifery teams to ensure a smooth transition to the new process and minimising any additional stress for parents during a very traumatic time.

Secondary legislation is expected to pass Parliament in the autumn, and there is now a firm commitment for the Medical Examiner process to become statutory in April 2024. This will coincide with the introduction of an electronic medical certificate for the confirmation of death,

and possible changes in who can issue the certificate which reflect modern ways of delivering healthcare.

As part of the preparations for statutory function, discussions are underway to provide a seven-day service so that when an expedited release of a body for faith reasons is requested, the addition of Medical Examiner scrutiny does not cause avoidable delays. It has been confirmed that this will be fully funded from the centre, with a proposed service level of 2 hours on call for each weekend day and bank holiday.

5.0 Recommendation

The Board is asked to note the contents of this report and the processes for ensuring learning from deaths.

Humber and North Yorkshire Health and Care Partnership

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Positive Practice and Identified Areas for Improvement from Learning Disability Mortality Review (LeDeR) Programme Reviews Completed across the Humber and North Yorkshire Health and Care Partnership

September 2023

Welcome to the newsletter which provides an overview of the positive practice and areas of improvement identified from LeDeR reviews completed across the Humber and North Yorkshire Health and Care Partnership during September 2023.

Review 1: (Focused Review)
Middle – aged gentleman who resided within the community in supported living accommodation. Following a deterioration in his health, he required admission to hospital where he sadly passed away.

Positive Practice Identified within the Review:
- Annual Health Check completed to a high standard.

Areas for Improvement Identified within the Review:
- Ensuring notification to the LeDeR programme by providers.
-

Review 2: (Focused Review)
Middle-aged lady residing at home with family. She required admission to hospital where her condition deteriorated, and she sadly passed away.

Positive Practice Identified within the Review:
- Provision of care by family.

Areas for Improvement Identified within the Review:
- Communication with family could be improved.
- Lack of hospital passport.

Review 3: (Initial Review)
Middle-aged gentleman who resided at home with family passed away suddenly at home.

Positive Practice Identified within the Review:
- Thorough Annual Health Check completed.
- Regular reviews and assessments within Primary Care.

Areas for Improvement Identified within the Review:
- The reviewer did not identify any learning within this review.

Review 4: (Initial Review)
Middle-aged lady residing within residential care supported by staff. She became unwell and sadly passed away within her home.

Positive Practice Identified within the Review:
- Thorough Annual Health Check completed.
- The care provided by the care staff.

Areas for Improvement Identified within the Review:
- Admission to hospital in the days preceding her death - the decision had previously been made that admissions to hospital were not in her Best Interests.

Review 5: (Initial Review)
Elderly gentleman residing within residential care. Following a gradual deterioration in his health, he unexpectedly and sadly passed away at home.

Positive Practice Identified within the Review:
- The multi-disciplinary care and support was provided to a high standard.

Areas for Improvement Identified within the Review:
- The reviewer did not identify any learning from within this review.

Review 6: (Initial Review)
Elderly gentleman who resided within his own home supported by care staff sadly passed away at home.

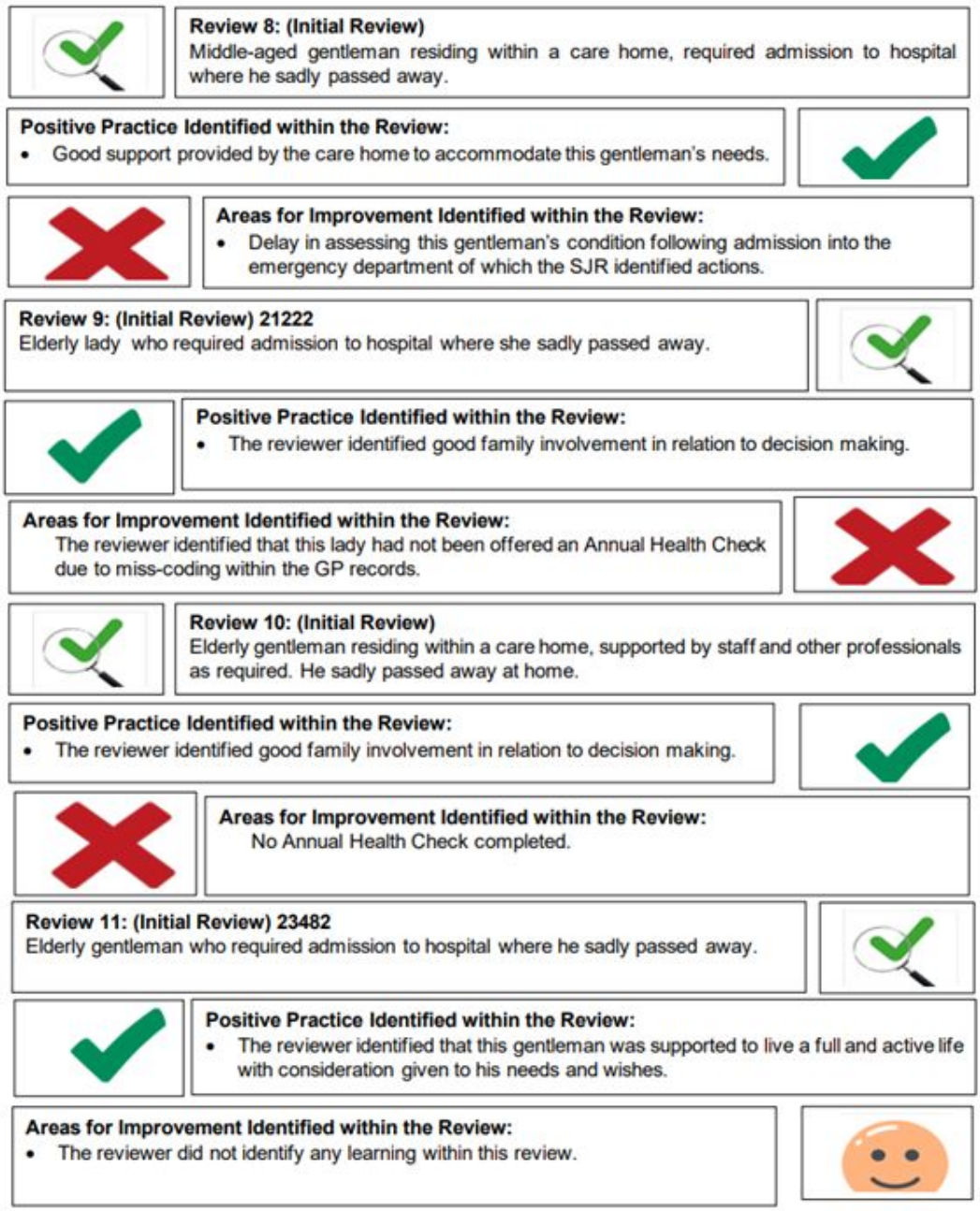
Positive Practice Identified within the Review:
- High level of multi-disciplinary team working.

Areas for Improvement Identified within the Review:
- The reviewer identified the requirement to raise the profile explaining the importance of the LeDeR programme within Primary Care.

Review 7: (Initial Review)
Young lady who resided within supported living and supported by staff to access the community. Following a deterioration in her condition, she sadly passed away within a hospice.

Positive Practice Identified within the Review:
- High level of multi-disciplinary team working identified.

Areas for Improvement Identified within the Review:
Raise the profile explaining the importance of the LeDeR process within Primary Care.



Review 8: (Initial Review)
Middle-aged gentleman residing within a care home, required admission to hospital where he sadly passed away.

Positive Practice Identified within the Review:
- Good support provided by the care home to accommodate this gentleman's needs.

Areas for Improvement Identified within the Review:
- Delay in assessing this gentleman's condition following admission into the emergency department of which the SJR identified actions.

Review 9: (Initial Review) 21222
Elderly lady who required admission to hospital where she sadly passed away.

Positive Practice Identified within the Review:
- The reviewer identified good family involvement in relation to decision making.

Areas for Improvement Identified within the Review:
The reviewer identified that this lady had not been offered an Annual Health Check due to miss-coding within the GP records.

Review 10: (Initial Review)
Elderly gentleman residing within a care home, supported by staff and other professionals as required. He sadly passed away at home.

Positive Practice Identified within the Review:
- The reviewer identified good family involvement in relation to decision making.

Areas for Improvement Identified within the Review:
No Annual Health Check completed.

Review 11: (Initial Review) 23482
Elderly gentleman who required admission to hospital where he sadly passed away.

Positive Practice Identified within the Review:
- The reviewer identified that this gentleman was supported to live a full and active life with consideration given to his needs and wishes.

Areas for Improvement Identified within the Review:
- The reviewer did not identify any learning within this review.

The good practice identified during the reviews of all LeDeR cases will be shared as widely as possible to enhance the care and service delivery provision to individuals with learning disabilities. Feedback is also provided to the services and/or individuals identified as providing the good practice.

The areas noted for improvement are discussed at both the LeDeR review panel meeting, where it is identified the action required to take forward and the lead person or organisation who will take the action forward.

The learning is also shared and discussed with the Humber LeDeR Steering Group. Where the action forms part of the wider areas of work already in progress, the workstreams are updated.

Progress and ensuring actions are taken forward and progressed are the responsibility of the Steering Group.

4

Strengthening Maternity and Neonatal Safety Report

SMT

October 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 October 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 October 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 The Board 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).

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 – October 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 Maternity and Newborn Safety Investigations (MNSI)),
- 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 MNSI
    - 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
    - MNSI/NHSR/CQC concerns
    - Coroner Reg 28
    - Progress in achievement of Maternity Incentive Scheme

2.0 Obstetric cover on Delivery Suite, gaps in rota

There is currently no obstetric rota gaps. There are nine obstetrics and gynaecology consultants, one of whom does not do obstetrics and one person is less than full time. Appropriate cover has been provided to Delivery Suite during the month of October 2023.

3.0 Midwifery safe staffing, vacancies and recruitment update

The Birthrate plus establishment setting report in 2021 recommended a total clinical, specialist & management maternity staffing of 76.21 whole time equivalent (WTE) for Harrogate and District NHS Foundation Trust (HDFT). The current budget is 75.76 WTE for midwifery staffing bands 5-7 and 13.3 WTE for Band 2 and 3 maternity support workers (MSW).

3.1 Absence position

Unavailability of midwifery staff hours –
2.24 WTE sickness absence (no theme identified)
2.44 WTE maternity leave

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

3.2 Vacancy position

Currently there is zero midwifery and maternity support work vacancy.
There is two newly qualified midwives and two maternity support workers all with start dates in the coming month.

Both internationally recruited midwives have started working with the Trust. One midwife has received her NMC PIN number and is working supernumerary. The other midwife has passed her OSCE and is awaiting her NMC PIN number.

3.3 Turnover rates

The turnover rates of Midwives is 8.9% and for maternity support workers is 45% which demonstrates a continued reduction.

3.4 NHSP provision

Midwives -
1.93 WTE NHSP midwifery staffing used in October 2023.

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

3.5 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 October 2023. One woman attended the unit for birth by choice at the onset of labour. Two homebirths were attended at home and one planned homebirth has not yet given birth.

In the period 1/10/23 – 31/10/23, the home birth provision was not suspended, on six occasions staff provided flexibility to cover for short notice sickness.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Neonatal absence position

0.92 WTE nurse currently on maternity leave.
2.3 WTE nurse 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.

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 180 scheduled assessment periods, of these 168 were completed. Staffing met the acuity 81% of the time.

88% (156) of the time no actions required. 12% (22) of the occasions actions were required, these included:
· Delay in continuing induction of labour 17 occasions
· Delay in commencing induction of labour 5 occasions (Inpatient)
· Delay in LSCS grade 3 (delivery suite) 1 occasions
· Postponed induction of labour (at home) 1 occasions
· Delivery Suite Coordinator not supernumerary 1

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. One woman had a baby born before the arrival of a midwife.

5.2 Pannal Ward Staffing

The Birthrate Plus Acuity App ward tool has remained unavailable during October due to review of the tool – as a result there is no consistent obtainable data for Staffing Levels vs Workload. There were no datix reports submitted regarding staffing for this period. The pilot period for the updated version of Birth Rate plus has commenced 30/10/23 - 6/11/23.

During October there were two additional LSCS lists created at short notice, creating an additional four midwifery shifts requiring staffing. Three of these shifts were uncovered resulting in the ward staffing being affected.

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**

One Red Flag was identified from the Birth Rate Plus Data during October.

- Delay between presentation and triage of over 30 minutes.

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 01/10/2023 to 31/10/2023

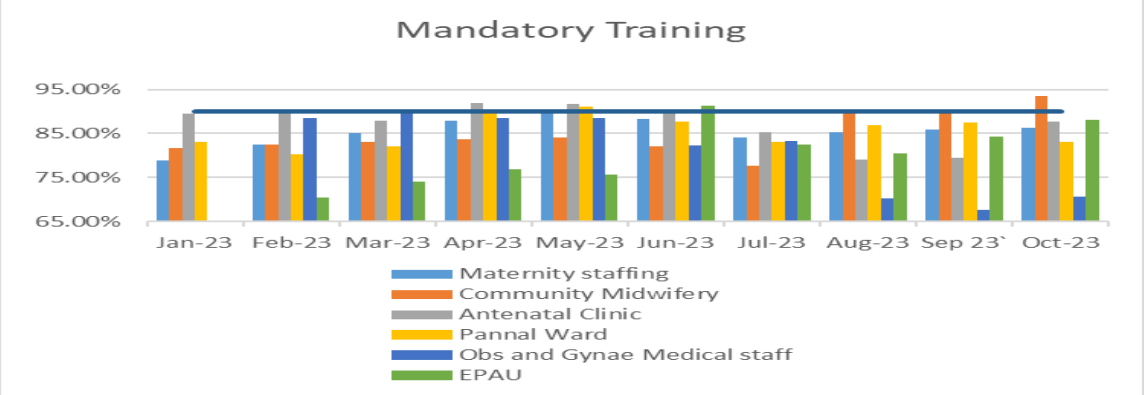
MA1	Redeploy staff from Pannal	11	35%
MA2	Staff unable to take breaks	7	23%
MA3	Review of staff on management time	2	6%
MA4	Use of specialist midwife	3	10%
MA5	Use of staff on training days	0	0%
MA6	Use of ward/department managers	0	0%
MA7	Staff sourced from wider Trust (theatre & CSW's)	0	0%
MA8	Use of hospital MW on call	5	16%
MA9	Use of community MW	0	0%
MA10	Unit on Divert	3	10%
MA11	Patient diverted	0	0%
	Total	31	

6.3 Pannal Ward Red Flags

Red flag events were not captured during September on Birthrate Plus. No Datix were submitted for a red flag event.

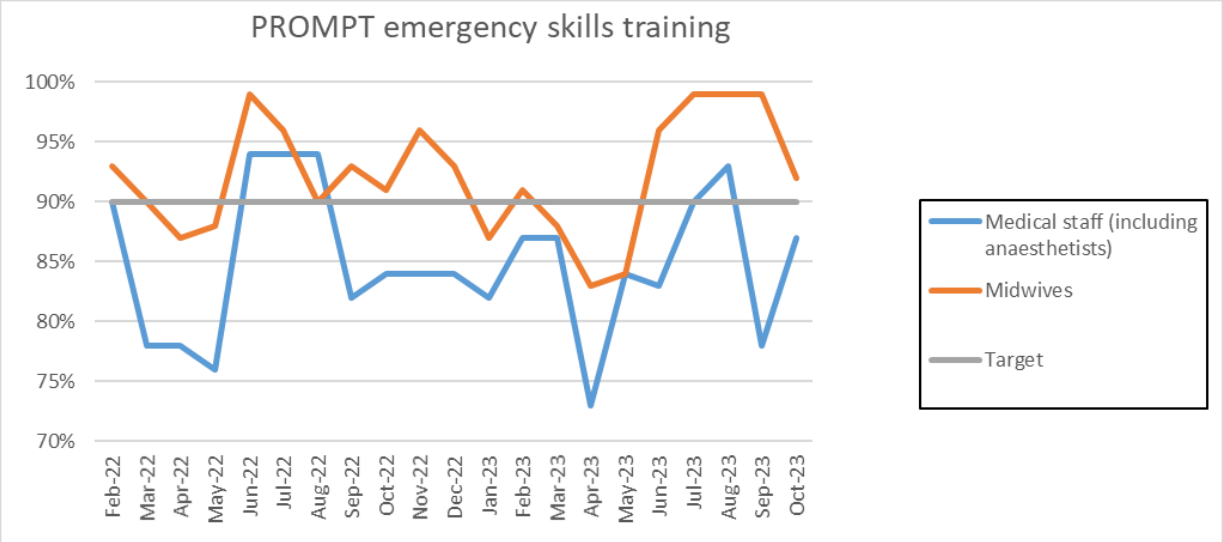
7.0 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

7.1 Mandatory training (as at 14/11/23)



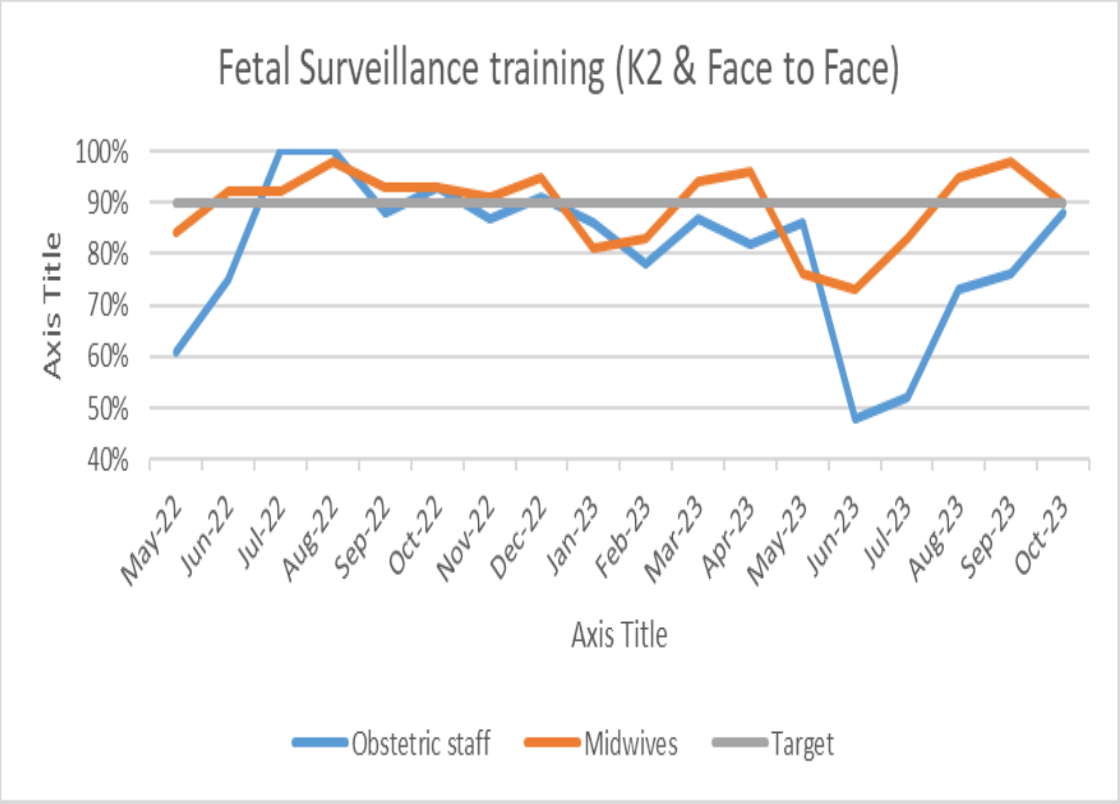
7.2 Prompt emergency skills training

All outstanding obstetric staff and two outstanding anaesthetists have been allocated a training date to attend before 1st December 2023.



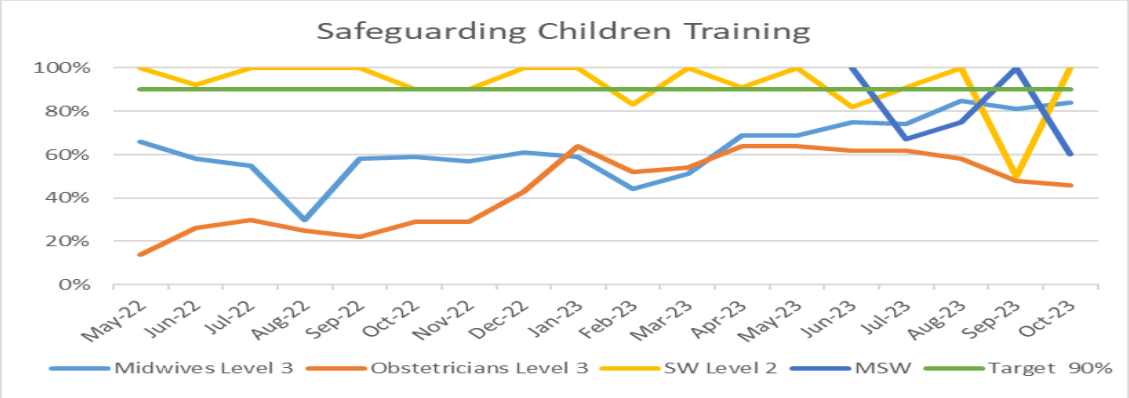
7.3 Fetal surveillance training

Compliance with training 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.



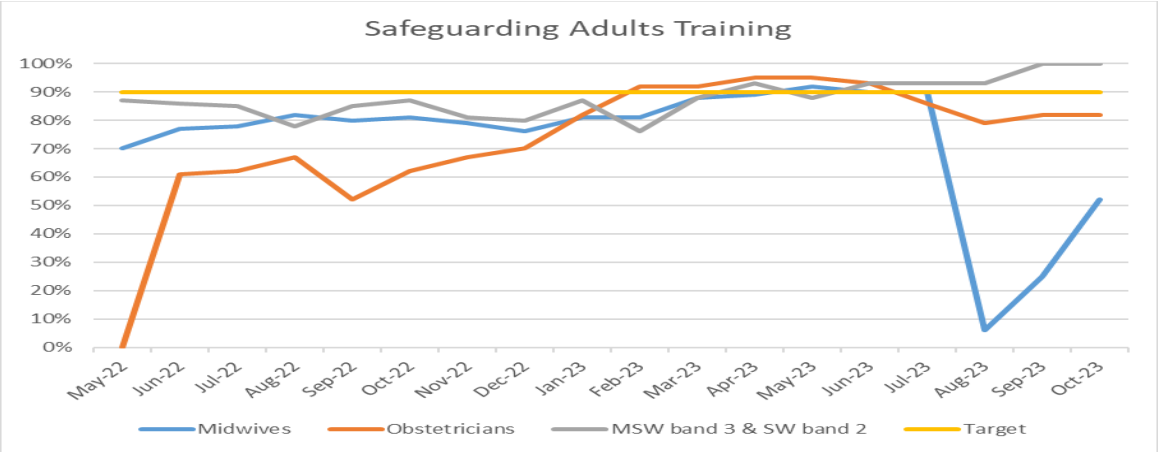
7.4 Safeguarding Children training

All obstetric staff have been contacted to complete their training and the clinical lead has been informed. Maternity support workers figures have dropped due to newly recruited staff joining the team and the small numbers.

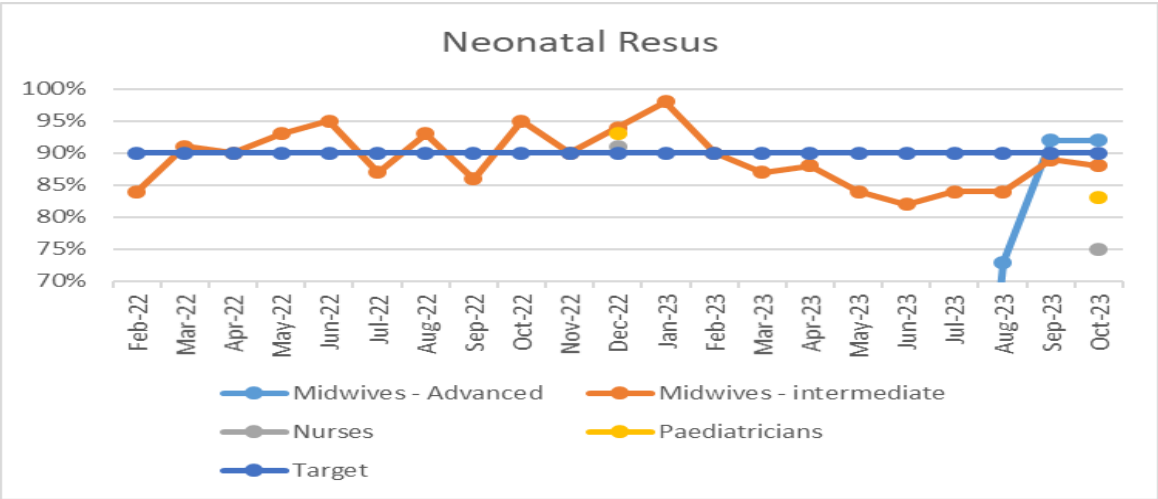


7.5 Safeguarding Adults training

Midwives are required to undertake Safeguarding Adults training to Level 3 and the below graph demonstrates that the monitored requirement changed in August 2023. The training compliance of midwives has shown an appropriate improvement over the last two months and this is planned to continue along this trajectory to meet 90% by the end of the financial year.



7.6 Neonatal resuscitation – Midwives



Plans are in place to meet 90% compliance for all professionals by December 2023. From January 2024 all midwives will be doing Harrogate Advanced Newborn Life Support. Advanced Newborn Life Support training was implemented for all Delivery Suite Co-ordinators in August 2023.

7.7 SCBU Training Compliance

Certification Name	Required	Not Achieved	Compliance %
Adult Basic Life Support with paediatric modifications	14	4	71%
RCUK Newborn Life Support Face to Face	5	3	40%
Harrogate Newborn Advanced Life Support (HNALS)	13	3	77%
Harrogate Newborn Intermediate Life Support (HNILS)	1	0	100%

8.0 Risk and Safety

8.1 Maternity unit closures

Three events of closure of the unit in October 2023. Two related to closures due to activity; one enforced closure due to security incident relating to bomb threat.

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 records have been created to monitor this although practice is still being embedded to ensure data is accurate. During October there were seven women transferred to Harrogate from across the region (Bradford, Hull and MidYorks) who laboured and birthed. Additional women were reviewed in MAC and discharged home.

8.3 Maternity Risk register summary

No new risks added. Two risks downgraded and archived. 9 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. Pressure on lists remain but being managed as required. Has been escalate to Directorate Board and plans being developed. No change at present.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 8).** Some improvements with new line management structure and new Clerical Team Leader in post. Additional long-term sickness with continued pressure from staffing levels. No change in risk level.
- **Risk to service provision for homebirths due to unreliable homebirth cover (Score 6).** Trial of additional CMW on-call on weekends completed, but some issues. Now improved homebirth cover with Team Leaver drive and improved staffing. Some issues of cover for short-notice sickness remains and further plans in consultation. Risk level downgraded.
- **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. No change.
- **Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 6).** Policies and procedures being completed by Named Midwife for Safeguarding. Three remaining

guidelines outstanding for completion and plan ratification by December. No current change in risk level but good progress.

- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 6).** Safeguarding communication capability improved within Badgernet, and good communication now between Community and inpatient teams. Plan for audit of safeguarding communication discussed with Named Midwife for Safeguarding. Processes between Social Care and hospital communication improving. New process for inpatient checking of WebV planned for implementation 1st December. No current change in risk level.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Compliance improving (currently 85% midwifery compliance but some issues remain with medical training). Action plan in place. Risk level currently remains unchanged.
- **Risk to compliance with Ockenden and Maternity Incentive scheme requirements for audit (Score 6).** New clinical Effectiveness & Audit Lead in post and good progress being made with required audits to support Saving Babies' Lives v3, 3 year delivery plan, Ockenden & MIS. Risk level reduced in view of progress.
- **Risk to reputation and patient satisfaction for failing to meet national target and provide evidence based care in relation to Continuity of Carer (Score 4).** Building blocks being established and plans in place. No change but no specific consequence at present. Risk reduced due to limited consequence.

Two risks downgraded and archived, relating to shortfall in Middle Grade staffing (staffing now improved) and lack of frenulotomy clinic (clinic now in place).

8.4 Maternity Incidents

In October 2023 there were 61 total incidents reported through Datix.

No incidents have been reported a Moderate Harm or above.

Two current Patient Safety Incident Investigations (PSII) are ongoing; one for neonatal death outside of MNSI criteria and one relating to missed diagnosis of a perineal tear.

Additional incidents of note include:

- Ten readmissions of mothers & babies (nine readmissions of babies for jaundice, weight loss and feeding issues; one maternal readmission for hypertension and chest pain)
- Six third degree tears (five at normal delivery, one at forceps delivery)
- Six incidents related to communication issues (e.g. relating to communication about LSCS, handover of care, missed cervical length scan)
- Five incidents for inadequate staffing for workload
- Three incidents of suspension of maternity services
- Three incidents of PPH≥1500ml

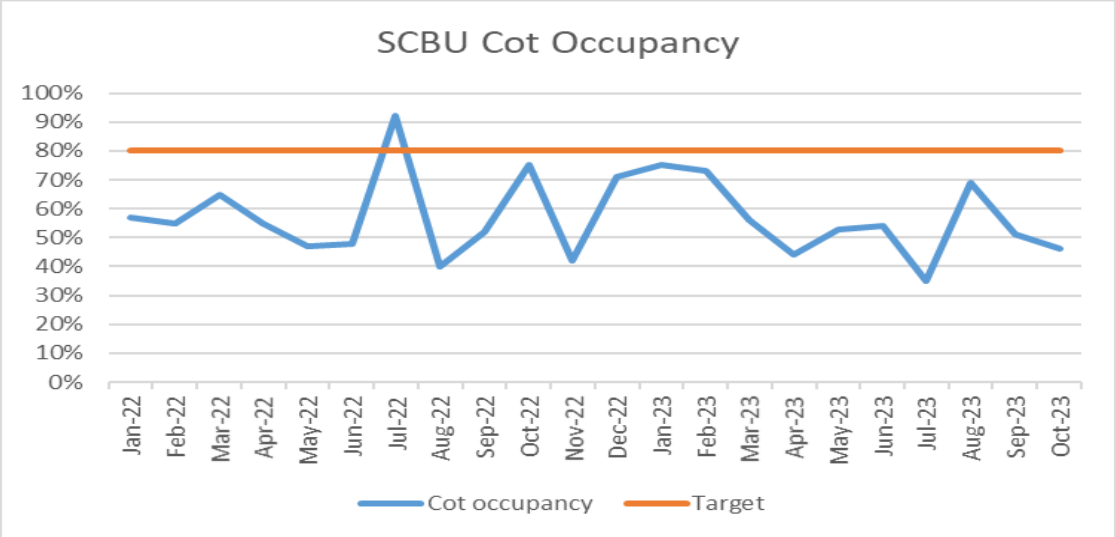
8.5 SCBU Incidents

No moderate harm incidents

8.6 SCBU Risk Register

No new risks.

8.7 Cot occupancy and babies transferred out



One baby was appropriately transferred out during October 2023.

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

A detailed report of Quarter 2 can be found in Appendix A. In summary, during Quarter 2, one perinatal death was eligible for reporting to MBRRACE-UK within 7 working days, and surveillance form to be completed within 1 calendar month of the death. This timescale was missed following a misinterpretation of the eligibility criteria for reporting to MBRRACE-UK. Moving forward, a flowchart has been developed to support the clinician in assessing the eligibility of perinatal death for reporting to MBRRACE-UK.

It can be noted there has been good progress made with regards to the ongoing PMRT action plan, with two further actions completed within Quarter 2. Moving into Quarter 3, there will be a focus on auditing compliance with routine questioning at booking and cervical length scan requests for women with intermediate risk factors for pre-term birth.

10.0 Service User feedback

Maternity service user feedback -

- *Very friendly staff, always willing to check things out, always welcoming. Would like more availability for midwife appointments.*
- *The midwives are always supportive and reassuring. I would have liked to have the same midwife throughout pregnancy. Maybe more information given to second time mums about labour as I felt like I was meant to know it as I already had a child.*
- *Friendly service. Would have liked more antenatal classes*.
- *Well informed during hospital stay, no pressure to leave following birth*. Helpful staff with patience to ensure any questions were answered. Would have liked less visits postnatal and to be better informed regarding appointment times with greater notice and accuracy (text message with single hour appointment and at least three days in advance).

SCBU service user feedback –

SCBU have received amazing feedback from the entire Woodlands team for their support over the month of October during the winter pressure in acute paediatrics. While cot occupancy was low SCBU ensured they were over to support as much as possible and it has not gone unnoticed.

11.0 Staff feedback

NHS Staff Survey currently open for feedback.

12.0 Complaints

Three formal complaints have been received in October, one related to Safeguarding issues management, one related to attitude of sonographers and care following scans and one related to care before and after sustaining a perineal tear. All complaints are being reviewed and actions being taken to improve care provision where required.

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, MNSI, CQC

Query received from NHS Resolution relating to declaration of compliance with Maternity Incentive Scheme year four, in light of CQC report. Response being finalised.

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. The Safeguarding action plan has three outstanding actions all of which are due to be complete in December 2023. Progress is being made on the actions in relation to audit.
No further requests for action have been received.

15.0 Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported in October 2023.

All previous HSIB cases now closed:

- March 2023 case relating to HIE/cooling – closed with no safety recommendations

Two tripartite meetings completed in October with the families of the two most recently received final reports.

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?	Quarterly report included at Appendix B.
SA4 - Can you demonstrate an effective system of medical workforce planning to the required standard?	Action plan required regarding Consultant and SAS doctors compensatory rest. Neonatal Dining tool assessment is included at Appendix C and the BAPM action plan included at Appendix D
SA5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Bi-annual midwifery staffing report included at Appendix E
SA6 - Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle version three?	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 going through governance process to consider full implementation of Core Competency Framework Version Two. Plans are in place to meet compliance requirements by December 2023.
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?	
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
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**	

Theme 2: Growing, retaining and supporting our workforce **Objective 6 - Invest in skills**	Ongoing and on track – Business case going through governance process 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**	PSIRF implementation has commenced
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 fully implement Saving Babies Lives Version three and ensure NICE compliance.
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 NHS England Perinatal Culture And Leadership Programme

This programme is built around the perinatal quadrumvirate, or 'quad', group of senior leaders (The Associate Director of Midwifery, Operations Director, Clinical Director and Neonatal Clinical Lead) with the aim of nurturing a positive safety culture, enabling psychologically safe working environments and building compassionate leadership to make work a better place to be and is included in the requirements for Maternity Incentive Scheme Year 5. The programme includes a series of workshops and action learning sets which commenced in October 2023 and provides dedicated time to the quadrumvirate to work and learn together, accompanied by individual time to focus on personal development. The final component of this is the SCORE Culture Survey, an independently facilitated programme with team and quad debriefing sessions to co-design the cultural improvement actions identified. The data collection phase of the SCORE culture survey will take place in Quarter 4.

17.3 Continuity of Carer

NHS England have stated **-** *While we have announced that there is no target date for services to deliver MCoC as the default model of care to all women, NHS England will continue to*

support maternity services to pilot enhanced MCoC teams where safe staffing is in place to continue. This decision should be made by trusts, with ongoing consideration given to the local workforce situation.

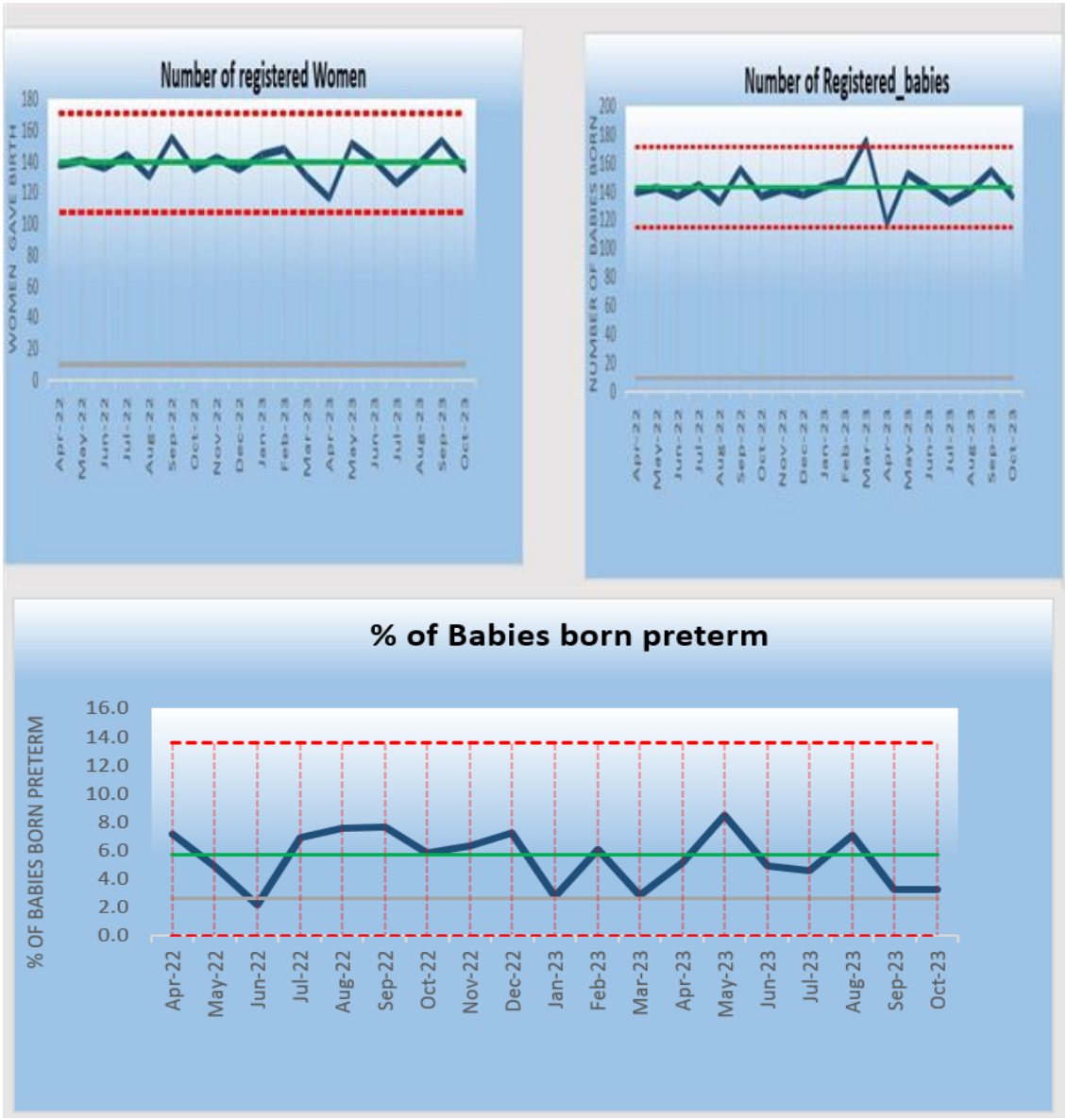
A regional Continuity of Carer visit took place on 1st August 2023. The regional team were assured regarding the progress on the delivery of the 'building blocks' for continuity. A more detailed report is provided at Appendix F

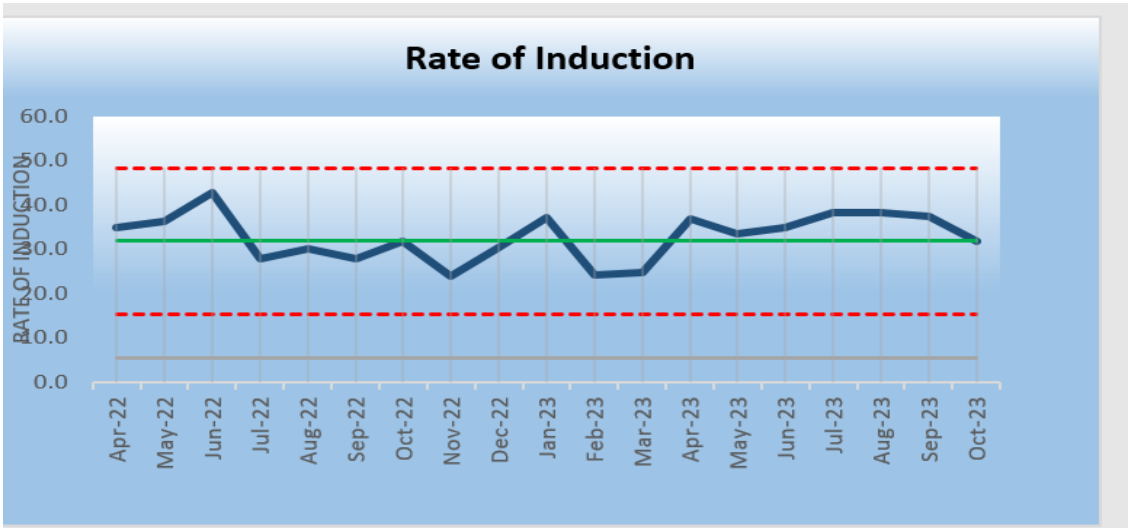
18.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

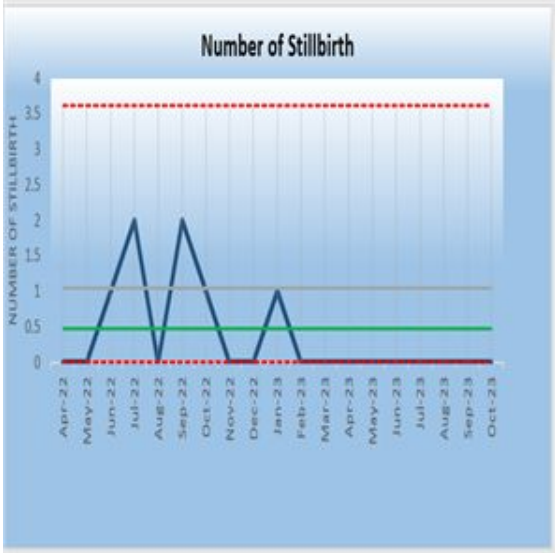
Quarter two data is due in December 2023.

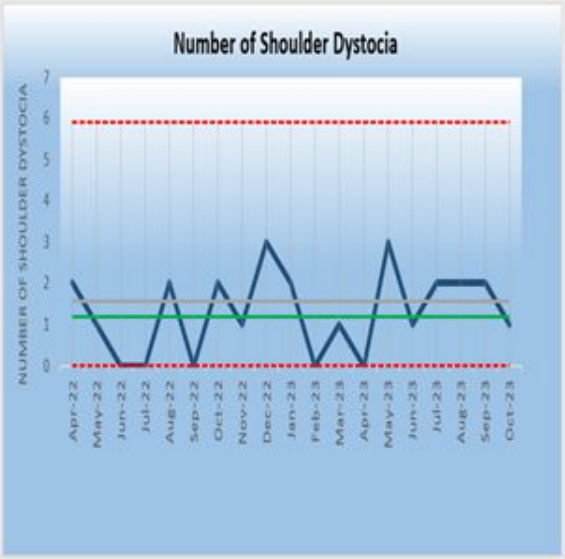
19.0 Local HDFT Maternity Services Dashboard

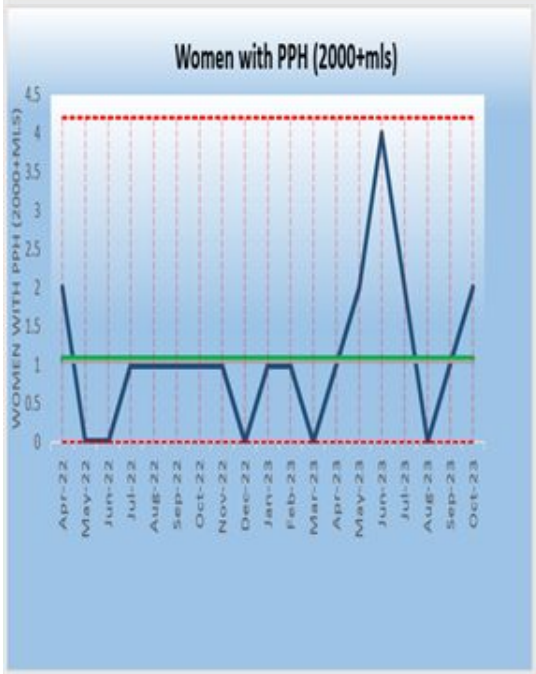
The metrics currently available demonstrate that there are no statistically significant outlying metrics this month.

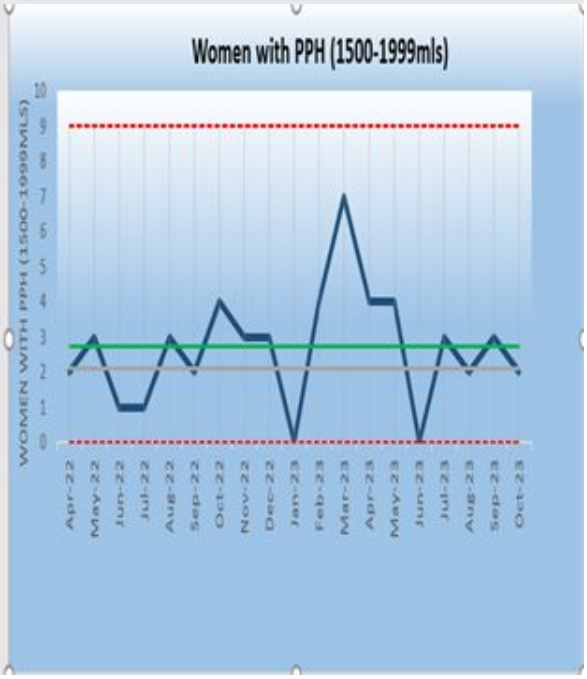


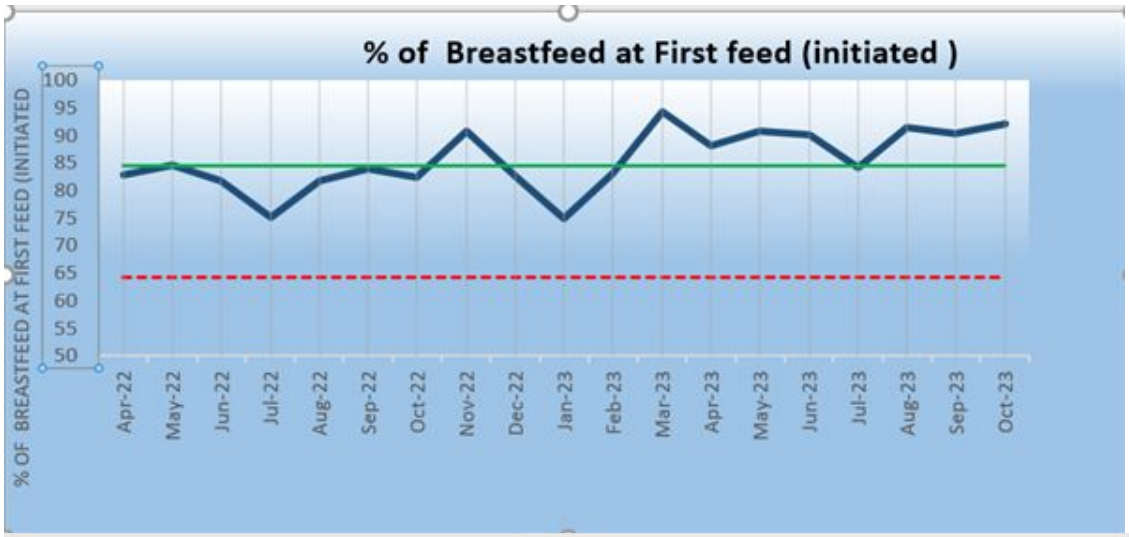

Rate of Induction
RATE OF INDUCTION
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23

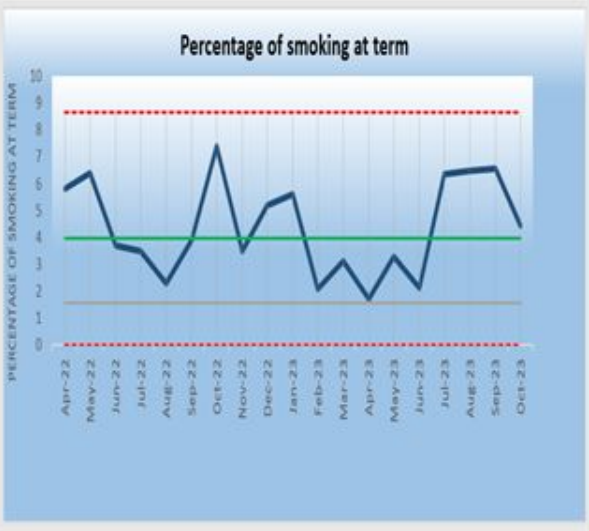

Number of Stillbirth
NUMBER OF STILLBIRTH


Number of Shoulder Dystocia
NUMBER OF SHOULDER DYSTOCIA


Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)


Women with PPH (1500-1999mls)
WOMEN WITH PPH (1500-1999MLS)





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. Please see Appendix B for the quarterly report.

20.1 Term Admissions to SCBU

There were two incidents of Term babies being admitted to SCBU in October (including one admission following emergency caesarean section (LSCS) requiring resuscitation and one with oxygen requirement following elective LSCS).

20.2 ATAIN actions

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

Issue	Action	Status
No formal observations with T21	Ensure formal observations completed in accordance with guideline and add to proforma. Awaiting implementation of NEWTTS2	In progress
Lack of adherence to hypoglycaemia policy	Reinforcement of policy to midwifery and SCBU staff	In progress
HGP commenced incorrectly (significant resuscitation risk factor no longer specified)		
Blood glucose checked unnecessarily in response to jitteriness alone		
Formula via NGT should be 1st line treatment for hypoglycemia (unless <1.0) on SCBU, instead of IV fluids		

21.0 Saving Babies Lives' v3 (released 31 May 2023)

The Saving Babies' Lives Care Bundle (SBLCBv3) 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

Some of the key metrics being monitored for SBLCBv3 are detailed below.

	Quarter 2	
Small-for-gestational age/Fetal growth restriction detection rates	Q3 (calendar): 35.4% detection (<10th centile; 17 cases) (National average 42.6%, Top 10 average 59.3%) Q3 (calendar): 69.2% detection (<3rd centile; 9 cases) (National average 60.8%, Top 10 average 75.9%)	
	Quarter 2 (July-Sept 2023)	October 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	0% (0/433) [<2nd, WHO centiles]	0% (0/138) [<2nd, WHO centiles]
Percentage of babies <10th centile >39+6 weeks' gestation	1.6% (7/433)[WHO centiles]	0.7% (1/138)[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)	4 fetal loss born 16-24 weeks (0.96%, 4/413)	1 fetal loss born 16-23+6 weeks (0.7%, 1/134)
• Preterm (24+0-36+6 weeks)	5.1% (live, 21/413)	4.5% (live, 6/134)

A current position of compliance with the requirements of SBLCBv3, verified by the Local Maternity and Neonatal System (LMNS), is detailed below. An action plan is in place and compliance will be reassessed by the LMNS. Maternity Incentive Scheme requires each

element to be 50% implemented and 70% implemented across all elements. The ask of Saving Babies Lives Care Bundle is for full implementation by March 2024.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	50%	Partially implemented	50%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	75%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	60%
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	81%
Element 6	Diabetes	Partially implemented	33%	Partially implemented	50%
All Elements	TOTAL	Partially implemented	76%	Partially implemented	71%

22.0 Maternity Safety Champions

Bi-monthly walk around and meetings continue. Maternity Voices Partnership Chair requested and welcomed to join the meetings. Next walk around and meeting scheduled to occur on 20th November 2023. Concerns raised by staff at the previous walkaround regarding parking following the change to ParkingEye. These concerns have been addressed and on call staff are now able to park in the car park and safely enter the unit overnight.

23.0 Conclusion and recommendation

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

Appendix A

Compliance of completion of Perinatal Mortality Review Tool, Quarter 2, July-September 2023

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the second quarter, July-September 2023.

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

Requirements of the Maternity Incentive Scheme Safety Action 1:

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

Compliance of eligible perinatal deaths with MIS requirements

Quarter 2 saw only one eligible perinatal death for reporting to MBRRACE-UK (please refer to Table 1 below). It should be noted that although Case 88825 met the criteria for reporting to MBRRACE-UK and completion of surveillance form, due to the gestation at the time the pregnancy loss was confirmed, the case was not eligible for a PMRT.

Table 1: Eligible perinatal death against MIS requirements

MBRRACE-UK Case ID	Date of death	Date of birth	Reported to MBRRACE (within 7 working days)	Date Surveillance first closed (within 1 calendar month)
88825	24.2.23	10.6.23	9.8.23	11.8.23
Overall Compliance against targets of Safety Action 1			0% - Compliant (target 100%)	0% - Compliant (target 100%)

During Quarter 2, it was identified that MBRRACE-UK was not notified of the eligible reportable perinatal death (Case 88825) within the expected time-frame of 7 working days. This was due to confusion during the interpretation of the eligibility criteria for reportable perinatal deaths to MBRRACE-UK. Advice and clarification was sought from MBRRACE-UK, who advised that although the perinatal death was not eligible for a PMRT, the death was to be reported and surveillance form completed. We are therefore not compliant with Standard 1 of the Safety Action 1 for this Quarter. To this date, we have not received confirmation from MBRRACE-UK regarding this missed notification, however this may occur in due course.

To reduce the risk of reoccurrence of missed notifications to MBRRACE-UK, a flowchart has been developed to support the clinician to assess the eligibility of a perinatal death for MBRRACE-UK notification and requirement of a PMRT.

During Quarter 1, 4 cases were eligible for reporting to MBRRACE-UK, as well as for a PMRT review. All 4 of these cases are now closed, and did not require any further action during Quarter 2.

There have been no PMRT reviews during the months of July to September 2023, as there have been no eligible perinatal deaths for PMRT during Quarter 2.

Ongoing Action Plan following PMRT review

Root cause/Contributory Factor	*Action*	*Risk at review*	*Evidence of Progress/Completion*	*Target completion date*
Communication barriers following maternal decision to decline IOL.	Implement standard operating procedure to support women who declined induction of labour. Education and training for staff.	Complete	SOP written, awaiting approval from next MQAM meeting on 4.12.23.	N/A
Abnormal CTG with concerning features discontinued to allow patient to go to the toilet.	Education and training for staff.	Complete	Case study shared on risk management newsletter and on the online maternity Padlet.	N/A
Domestic abuse routine questioning did not occur at booking.	BadgerNet implementation from March 2023.	Low	Training in place for routine questioning. However, additional work required to reinforce and evidence DA questioning. Audit of compliance planned. Audit and Clinical Effectiveness Lead Midwife now in post.	1st December 2023
History of previous LLETZ and mother's care was not appropriate - not referred for cervical length scans.	ICE pathway updated to allow booking midwife to request cervical length screening for intermediate risk factors of Pre-Term Birth (PTB). Education and information disseminated to staff regarding risk factors of PTB.	Low	Additional communication to staff. ICE updated for cervical length scanning profile. Booking midwife not currently requesting but remains responsibility of Obstetrician. Pre-term birth clinic in place with single consultant oversight. To remain open until assurance that all scans being requested as required. Plan for audit. Audit and Clinical Effectiveness Lead Midwife now in post.	1st December 2023

Patient not monitored when reported irregular tightenings.	Fetal monitoring guideline to sit independently on trust intranet page alongside labour guideline.	Medium	To be discussed further with the multidisciplinary team at delivery suite forum planned for the 24.11.23.	4th December 2023
Concerns regarding abnormal features on CTG escalated to obstetric staff, although difference in opinion experienced regarding classification of CTG, and ongoing care recommendations.	Development and maintenance of a conflict of clinical opinion policy to support staff members being able to escalate their clinical concerns when a disagreement occurs between health care professionals.	Medium	Guideline currently in development, and for wider discussion with the multidisciplinary team at MQAM on the 4.12.23.	4th December 2023

In summary, during Quarter 2, one perinatal death was eligible for reporting to MBRRACE-UK within 7 working days, and surveillance form to be completed within 1 calendar month of the death. This timescale was missed following a misinterpretation of the eligibility criteria for reporting to MBRRACE-UK. Moving forward, a flowchart has been developed to support the clinician in assessing the eligibility of perinatal death for reporting to MBRRACE-UK.

It can be noted there has been good progress made with regards to the ongoing PMRT action plan, with two further actions completed within Quarter 2. Moving into Quarter 3, there will be a focus on auditing compliance with routine questioning at booking and cervical length scan requests for women with intermediate risk factors for pre-term birth.

During Quarter 2, the Trust was expected to evidence compliance with the Saving Babies Lives care bundle Version three (SBLCBV3). This included identifying the eligible perinatal deaths for PMRT, and assessing the relevant elements from the Saving Babies Lives Care Bundle Version three report. Please refer to Appendix 1 for further details on each element from the SBLCBV3.

<u>The elements of the Saving Babies Lives Care Bundle Version three are the following:</u>

Element 1: Reducing smoking in pregnancy. Smoking increases the risk of pregnancy complications, such as stillbirth, preterm birth, miscarriage, low birthweight and sudden infant death syndrome (SIDS).

Element 2: Fetal Growth: Risk assessment, surveillance, and management. There is strong evidence linking undiagnosed FGR to stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the baby.

Element 3: Raising awareness of reduced fetal movement. Enquiries into stillbirth have consistently described a relationship between episodes of RFM and stillbirth, ranging from the 8th CESDI report published in 2001 to the MBRRACE-UK reports into antepartum and intrapartum stillbirths respectively. In all these case reviews unrecognised or poorly managed episodes of RFM have been highlighted as contributory factors to avoidable stillbirths.

Element 4: Effective fetal monitoring during labour. As well as reducing stillbirth rates, there is a need to reduce avoidable fetal morbidity related to brain injury causing conditions such as hypoxic-ischemic encephalopathy (HIE) and cerebral palsy.

Element 5: Reducing preterm births and optimising perinatal care. Preterm birth (PTB), defined as birth at less than 37+0 week's gestation, is a common complication of pregnancy, comprising around 8% of births in England and Wales. Prematurity is the most significant

cause of mortality in children under five and is associated with significant morbidity in surviving infants.

Element 6: Management of Pre-existing Diabetes in Pregnancy. The new Element 6 covers the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes.

Below, is a table outlining the 6 PMRT cases that were identified within the last year that were reviewed as a part of the LMNS report and their relevance to the SBLCBV3 elements.

Case ID	Element 1	Element 2	Element 3	Element 4	Element 5	Element 6
83354	Yes	Yes	Yes	No	No	No
83965	No	Yes	No	No	No	No
85403	No	Yes	No	No	No	No
85615	No	Yes	Yes	No	Yes	No
86145	No	No	No	No	No	No
85647	No	No	Yes	Yes	No	No

Table 2: Elements of Saving Babies Lives Care Bundle and their individual relevance to PMRT cases in 2022-2023

No

Yes

The findings of the report highlighted the relevance of the Saving Babies Lives Version three elements in relation to perinatal morbidity and mortality, and this is also highlighted within the current ongoing action plan following PMRT reviews for Quarter 2.

Table 2 identifies the significance of Element 2: Fetal growth: Risk assessment, surveillance and management and Element 3: Raising awareness of reduced fetal movement; and their relevance to the perinatal deaths seen within the Trust over the last year.

The current ongoing action plan following PMRT review, as part of this Quarter 2 review also highlights Element 3 as requiring further action and development of services.

By undertaking the requirements and recommendations of the Saving Babies Lives Care Bundle Version three, it is expected there will be a reduction in perinatal morbidity and mortality across the Trust.

Appendix 1: Saving Babies Lives Care Bundle Version three (SBLCBV3)

Element 1 focuses on Reducing smoking in pregnancy by implementing NHS-funded tobacco dependence treatment services within maternity settings, in line with the NHS Long Term Plan and NICE guidance. This includes carbon monoxide testing and asking women about their smoking status at the antenatal booking appointment, as appropriate, throughout pregnancy. Women who smoke should receive an opt-out referral for inhouse support from a trained Tobacco Dependence Adviser who will offer a personalised care plan and support throughout pregnancy.

Element 2 covers Fetal Growth: Risk assessment, surveillance, and management. Building on the widespread adoption of mid-trimester uterine artery Doppler screening for early onset fetal growth restriction (FGR) and placental dysfunction, Element 2 seeks to further improve FGR risk assessment by mandating the use of digital blood pressure measurement. It recommends a more nuanced approach to late FGR management to improve the assessment and care of mothers at risk of FGR, and lower rates of iatrogenic late preterm birth. 4

Element 3 is focused on raising awareness of reduced fetal movement (RFM). This updated element encourages awareness amongst pregnant women of the importance of detecting and reporting RFM, and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. Induction of labour prior to 39 weeks gestation is only recommended where there is evidence of fetal compromise or other concerns in addition to the history of RFM.

Element 4 promotes Effective fetal monitoring during labour through ensuring all staff responsible for monitoring the fetus are competent in the techniques they use (IA and/or CTG) in relation to the clinical situation, use the buddy system, and escalate accordingly when concerns arise, or risks develop. This includes staff that are brought in to support a busy service from other clinical areas, as well as locum, agency of bank staff.

Element 5 on reducing preterm birth recommends three intervention areas to reduce adverse fetal and neonatal outcomes: improving the prediction and prevention of preterm birth and optimising perinatal care when preterm birth cannot be prevented. All providers are encouraged to draw upon the learning from the existing BAPM toolkits and the wide range of resources from other successful regional programmes (e.g. PERIPrem resources, MCQIC).

Element 6 covers the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes. It recommends multidisciplinary team pathways and an intensified focus on glucose management within maternity settings, in line with the NHS Long Term Plan and NICE guidance. It includes clear documentation of assessing glucose control digitally; using HbA1c to risk stratify and provide additional support/surveillance (National Diabetes Audit data); and offering consistent access to evidence based Continuous Glucose Monitoring (CGM) technology to improve glucose control (NICE and NHS plan).

Appendix B (ATAIN)

ATAIN and Transitional Care provision report

Quarter 2 (July-Sept 2023)

Report Overview

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

The National Ambition

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

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

Why is it important?

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

Collaboration between neonatal and maternity staff at HDFT has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use our service. Along with this HDFT maternity and neonatal services completed the first year as a Wave 1 Trust, with the National Maternity and New born Safety Collaborative (NHSI). This national quality improvement programme enabled our maternity and neonatal service to further develop and focus on key areas for improvement using a consistent QI approach supported by the NHSI team and online resources. The improvement leads have focused on improving hypoglycaemia pathway of care and the jaundice pathway as well as communication with families and carers as part of the wider ATAIN programme of work. In addition to this we are trialling babies requiring readmission for jaundice to attend Pannal ward as first contact. Following implementation 16 midwives have achieved competence in obtaining Serum bilirubin tests from babies- this has streamlined treatment and reduced delays between admission and commencing treatment. The maternity and neonatal teams review the Term admissions at designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for HDFT is reviewed and tracked on the dashboard and shared with the local maternity and neonatal system. Actions are also generated in response to any themes or concerns.

ATAIN data: Quarter 2 2023/24:

During quarter 2 there were a total of 413 babies of all gestations born at HDFT, 387 of these were 37 weeks gestation and over and therefore admissible for ATAIN audit. Of the 387, nine babies of 37 weeks gestation and over were admitted to the neonatal unit. Two of these admissions were deemed potentially avoidable and detailed below.

On review of the ATAIN admissions and the increase in respiratory distress cases over the previous quarters we have added the 'Management of Term Babies with Respiratory Distress in the First Hour of Life' flow chart to all resuscitaires. This flow chart allows for safe assessment and placement of the term infant showing symptoms of respiratory distress, whilst aiming to reduce inappropriate separation of mother and baby. This information has been disseminated to both midwifery and medical staff for immediate implementation.

Condition	Number of Admissions	Number of Avoidable Admissions
Hypothermia	0	0
Jaundice	0	0
Respiratory Distress Syndrome	4	2
Hypoglycaemia	2	0
Other Clinical Conditions	3	0

Potentially Avoidable Admissions:

Case 1

Discussed at ATAIN meeting. Baby admitted to SCBU at 12:30 and returned to parents at 15:30. Following birth, equal air entry and normal gases and Apgars but poor tone and low heart rate. Baby had three rounds of inflation breaths and then ventilation breaths by consultant. Commenced PEEP and on SCBU for reassessment, subsequently recovered quickly, weaned off oxygen and returned to parents. In view of only three hour admission, appears potentially avoidable admission and perhaps could have remained on Delivery Suite longer for assessment.

Case 2

Discussed at ATAIN meeting. Forceps delivery and cord snapped. Transferred to SCBU for suspected anaemia due to pale appearance following cord snapping. Baby's heart rate 188bpm and raised temp 38.2 degrees Celsius. Baby had been in skin to skin with mother and temperature resolved quickly. Cord gas haemoglobin indicated baby was not anaemic and baby had no other clinical concerns. Returned promptly to parents. Considered an avoidable admission.

Transitional Care Provision and Standards:

Introducing Transitional Care (TC)

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

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

At HDFT, a review of TC babies occurs daily during dedicated rounds, where assessment takes place and plans of care are made. This review takes place using the jointly approved

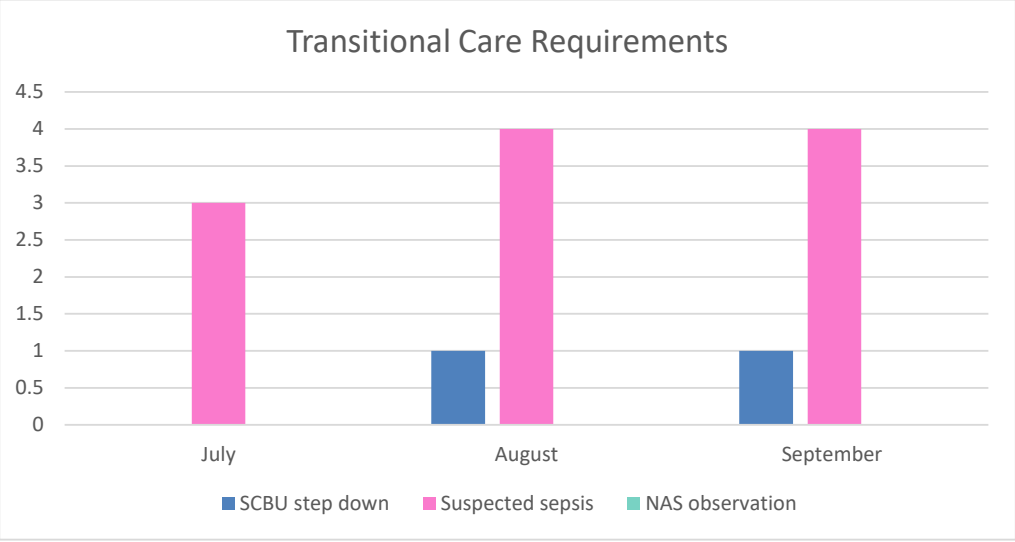
neonatal/maternity document. There is an escalation policy for any babies which are unwell which is well known by the team and followed should the need arise.

Transitional Care Provision 2022/2023:

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

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

Quarter 2 Transitional Care Data:



During quarter 2 there were a total of 13 babies requiring transitional care provision. 11 of these admissions were due to suspected sepsis and completed Intravenous Antibiotic treatment, two were stepped down from special care and reunited with parents on Pannal ward, and all babies have documented reasons for requiring transitional care.

One of the 11 babies had a transitional care booklet within their notes, all 11 were noted to have daily ward rounds recorded and all 11 are noted to have Badgernet documentation. Since the previous quarter, transitional care documentation has commenced under the dedicated

tab in Badgernet. The need for transitional care booklets is to be revisited at the next multidisciplinary meeting.

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

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

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

Recommendations:

It is recognised that a significant amount of special care activity, particularly babies born at term (NHS Improvement (2017) and within safety action 3 of the Maternity Incentive Scheme (Appendix 2), could be delivered in a transitional care environment. To achieve this goal neonatal and maternity service at HDFT will continue to improve the scope for transitional care provision on the ward. In working towards this babies requiring readmission for treatment of jaundice have been directly admitted to Pannal ward and this is being audited.

Transitional Care Action Log:

Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date
Data Capture of babies on Pannal	Electronic handovers saved on Pannal Monthly data shared with SCBU staff to collate Badgernet information	Lesley Copeland	**Completed 6/1/23**
Increased documentation in TC booklets/ Badgernet	Introduced at junior doctors induction, Badgernet training Continued meetings with digital midwife to assess possibility for inputting on Badgernet. Will be included in induction.	Nina Kapur, Rachael Waddington	**Completed 30/09/23**
Transitional Care inclusion at Obstetric/ Neonatal Meeting	Transitional care added to agenda as a standing discussion item	Lesley Copeland	**Completed 30/11/23**
Requirement of TC booklets	Discussion to examine need of using booklets alongside Badgernet	Lesley Copeland Nina Kapur Rachel Robson	**Completed 01/09/23**

Appendix 1: Cumulative ATAIN Action Log

Quarter 3 & 4 – Added Actions

Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Hypothermia management - feedback from Neonatal-Obstetric meeting	For application of hats to babies born in main theatre. Discussion of more vigilance/action with babies having risk factors. Discussion about routine application of hats to all babies for first 24 hours (excluding skin-skin)	Jo Orgles/Delivery Suite Managers	**Completed**	Message sent for application of hats to babies born in Main Theatre
Importance of nursing & medical documentation no matter how short the admission - nothing in baby notes or on Badger	Datix when no notes are documented	Lisa Nesbitt	**Completed and Ongoing**	
Baby should not come to SCBU for cannulation/IV drug administration, this can be done on PNW with Mum	Communicate to medical & nursing staff	Lisa Nesbitt	**Completed**	Emailed Sobia 22/11
Vapotherm should not be commenced without Consultant approval	Check guidelines and ensure this is outlined within these. Communicate to medical & nursing staff	Lisa Nesbitt	**Declined**	Emailed Sobia 22/11- happy for clinical decision to remain with registrars
Hypothermia management improvement - hat applied instead of warmed by heater	Already actioned by Jo Orgles (see point 15 above)	Jo Orgles	**Completed**	

Try to monitor babies for longer on D/S with borderline sats/WOB before admitting (30 mins)	Continue to encourage staff to stay with baby for ~ 30 minutes if conditions allow	Lisa Nesbitt	**Completed and Ongoing**	To remain as ongoing as some improvement noted at last ATAIN forum
Ensure parents are updated on baby's condition by medical team and this is documented on yellow notepaper - complaint received from parent	Discuss with neonatal lead	Sobia Bilal	**Completed**	
Baby should not be sent for active cooling without Consultant review	Discuss with neonatal lead	Sobia Bilal		

Appendix 2: Overview of Safety Action 3 Compliance

1.1 Safety Action 3 – Transitional Care Requirements

Required Standards following of MIS	Current status	Expected Evidence
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	**Compliant**	Transitional care guideline jointly agreed with neonatal and maternity services in August 2020 reviewed and updated in 2022
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	**Compliant**	Transitional Care Guideline jointly agreed with neonatal and maternity services in 2017, reviewed and updated in 2022. Guideline implemented 2017 with review in 2022. Neonatal booklet agreed with neonatal and maternity services. Booklet completed for all transitional care admissions. Audit performed every 6 – 8 weeks by a band 7 and band 4 collaboratively with maternity and neonatal services.
c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	**Compliant**	Data recording on Badgernet for all TC admissions. Monthly audit of data recording compliance by band 4 from the neonatal unit and band 7 from maternity service. All TC admissions have an agreed neonatal/maternity booklet completed which aids in the capturing of TC data.
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had	**Compliant**	

surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered		
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	**Compliant**	These returns have not been requested by the ODN/Commissioner. If requested this data can be provided from the Badgernet system.
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.	**Compliant**	
f) An action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, including those identified through the Covid-19 period as in point e) above has been agreed with the maternity and neonatal safety champions and Board level champion.	**Compliant**	Action plan previously shared with Director of Nursing, Midwifery and Allied Health Professionals and Neonatal Safety Champion.
G) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions.	**Compliant with action plan.**	See GAP analysis.

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

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

Appendix C – Neonatal Staffing report

Neonatal Staffing report

Harrogate Special Care Baby Unit (SCBU)

The Neonatal Unit (NNU) staffing is captured on a Badgernet database twice a day, the staffing levels and acuity are defined by the BAPM (British Association of Perinatal Medicine) staffing toolkit. The data is analysed using the Dinning neonatal staffing tool which provides a quick analysis of cot-side nurse staffing based on a unit's care activity and nursing budget, identifying any shortfall against the national neonatal service specification. As well as nurse staffing requirements, the tool calculates unit occupancy and provides a suggested cot configuration based on one year's activity entered either retrospectively or prospectively. The tool was shared across all neonatal operational delivery networks (ODNs) in England in 2013 and has been in regular use by neonatal ODNs since then. The tool was reviewed by the Clinical Reference Group (CRG) and adopted as part of the National Neonatal Review to provide a national audit of nurse staffing.

The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. Specialised neonatal nursing requires specific knowledge and skills. All nurses attending deliveries and/or involved in direct clinical care of the neonate are required to undertake a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK and receive regular training updates.

BAPM (2002) state that because of the acute nature of neonatal practice and the difficulty of predicting patient activity, there will be times when recommended nurse staffing levels are not able to be met, and conversely time when the nursing staff provision is more generous. It is essential that the average nurse:patient ratio meets recommended standards. Periods of relatively less intense NNU activity should be seen as an opportunity for neonatal nursing staff to undertake self-directed learning or participate in unit-based teaching, e.g., simulation sessions.

Day to day management of nursing care provision on Neonatal Units should be undertaken by a senior nurse (generally Band 7 level) who has no clinical commitment during the shift (often referred to as the shift coordinator). This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time, e.g., during the acute period of admissions or the internal and external transfer of babies BAPM 2022). Harrogate SCBU do not have a supernumerary shift co-ordinator on every shift however there is a Band 7 Unit Manager on site Monday - Friday 08:00-16:00 to support shift responsibilities. Cross cover is also provided from co-located Paediatric ward in event of unwell baby being born.

Harrogate SCBU has seven special care cots which are commissioned. The below tables demonstrate that care is provided by a mix of Band 5 and Band 6 nurses, some of whom are Qualified in Speciality (QIS). During quarter 2 there has been a 24% vacancy rate, 9.68% sickness rate and 7.78% maternity leave. These absences have been covered by 4.44 WTE bank usage.

Definitions -

Declared Cots:	The number of cots, by care level, which a unit are operating.
Required Cots:	The number of cots, by HRG, required to deliver the activity undertaken in the reporting period at an average occupancy of 80%.
HRG 1:	Intensive Care as per HRG 2016
HRG 2:	High Dependency as per HRG 2016
HRG 3-5:	Special Care, and any other care HRG 3-5 that takes place on NNU, as per HRG 2016
WTE:	Whole time equivalent

Neonatal Nursing Workforce Summary: Harrogate

INPUT UNIT DETAILS			
Trust	Harrogate & District NHS Foundation Trust		
Unit	Harrogate		
Designation	SCU		
Completed by	Victoria Lister/Amy Howard		
Date completed	27/09/23		
Activity period Start Date:	01/04/22	End Date:	31/03/23
	HRG 1 (IC)	HRG 2 (HD)	HRG 3-5 (SC)
Activity by care level	31	49	1294
Comissioned cots by care level	0	0	7

DIRECT PATIENT CARE				
Role Title	Band	WTE Budget	WTE In post	Head Count
Sister / Charge Nurse	7	0	0	0
Deputy Sister / Charge Nurse or Senior Staff Nurse	6	3.01	2.81	6
Staff Nurse QIS	5 QIS	5.26	5.36	7
Subtotal QIS		**8.27**	**8.17**	**13**
Staff Nurse NON QIS	5 NON QIS	3.55	3.14	4
Subtotal Non QIS		**3.55**	**2.14**	**4**
Nursing Associate	4	0	0	0
Nursery Nurse	4	0.77	0.77	1
Healthcare Support Worker	3	0	0	0
Subtotal Non-Reg		**0.77**	**0**	**1**
TOTAL DIRECT PATIENT CARE		**12.59**	**10.31**	**18**

ADDITIONAL DATA				
	From	To	WTE	Head Count
New Starters	01/07/2023	30/09/2023	2.84	3
Leavers	01/07/2023	30/09/2023	0	0
Net Gain / Loss	01/07/2023	30/09/2023	**2.84**	**3**
Turnover	01/07/2023	30/09/2023	**0%**	**0%**
Vacancy Rate	01/07/2023	30/09/2023	**24%**	
Sickness rate (%) in quarter	01/07/2023	30/09/2023	**9.68%**	
Maternity Leave rate (%) in quarter	01/07/2023	30/09/2023	**7.87%**	
			WTE	Cost in £'s
Bank Usage (WTE) in quarter	01/07/2023	30/09/2023	**4.44**	**28571**
Agency Usage (WTE) in quarter	01/07/2023	30/09/2023	**0.08**	**7297**

BAPM (2019) states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care. IN order to manage the fluctuations in activity cot occupancy should be set at 80% and QIS nurse staffing at 70%. The below table demonstrates that Harrogate SCBU have maintained compliance within these requirements.

Activity calculations (HRG 2016)							
	Activity	For calculations		Commissioned cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	31	*0.1*	*6.07*	0		1	-1
HRG 2	49	*0.2*	*3.04*	0		0	0
HRG 3	1,294	*4.4*	*1.52*	7	50.65%	4	3
Total	**1,374**			**7**	**53.78%**	**5**	**2**

Nursing workforce calculations (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 16.69, of which 11.68 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	12.59	10.31	13.95	-1.36	-3.64
Total reg nurses	11.82	10.31	12.14	-0.32	-1.83
Total QIS	8.27	8.17	8.50	-0.23	-0.33
Total non-QIS	3.55	2.14	3.64	-0.09	-1.50
Total non-reg	0.77	0.00	2.02	-1.25	-2.02
Reg nurses as % nursing staff	93.9%	100.0%	87.0%		
QIS as % reg nurses	70.0%	79.2%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependency care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

BAPM also states that in relation to Paediatric Medical staff the following is required –

Recommended numbers of staff for a Special CU:

• Tier 1: Rotas should be European working time directive (EWTD) compliant (58) and have a minimum of 8 whole-time equivalent (WTE) staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery.

• There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7.

• Tier 2: Shared rota with paediatrics comprising a minimum of 8 WTE staff.

• Tier 3: A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology.

The action plan below demonstrates the actions that are being taken to meet this requirement. There currently is 1 in 7 Tier 1 and Tier 3 doctors on the rota however there is cover for the unit 24 hours a day.

References

BAPM (2019) - Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity, October 2019. Accessed at Calculating Unit Cot numbers and Nurse Staffing Establishment and Determining Cot Capacity

BAPM (2022) - The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK, November 2022. Accessed at BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)

Appendix D – BAPM Action Plan

BAPM Action Plan 2023 - 2024

ID no.	Root Cause/Contributory Factor	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	Current Status (Complete, Ongoing and on Track, Ongoing and Off-track)	Evidence of Progress/Completion	Further action/s to ensure completion	New target date if original passed
1	BAPM standard for medical staffing - Tier 1 should have a minimum of 1 in 8	Low	As of August 2024 we will have 8 Tier 1 Doctors. We currently have 1 in 7 on the rota however we have cover for the units 24 hours a day	Dr P Gilbertson	Dr Patricia Gilbertson	01 August 2024	ON track, Ongoing			
2	Lack of "shift co-ordinator" on every shift as per BAPM guidelines.	Low	Review BAPM requirements against SCBU activity	SCBU Ward Manager	Matron, Paediatric Services	N/A	Complete	The unit has a maximum of 7 level 1 cots therefore professional opinion is that the unit does not require 3 registered nurses on every shift. Band 7 Unit Manager on site Monday - Friday 08:00-16:00 to support shift responsibilities. Cross cover provided from co-located Paediatric ward in event of unwell baby being born.		
3	BAPM standards for medical staffing - Tier 2 should have a minimum of 1 in 8 on the rota	Low	Review BAPM requirements against SCBU activity	Dr P Gilbertson	Dr Patricia Gilbertson	N/A	Complete	We currently have 1 in 7 on the rota. We are compliant with the working time directive, and have cover 24 hours a day.		

Appendix E – Midwifery Staffing report

Bi Annual Staffing Report	
	Time Period of data **1st April 2023- 30th September 2023**
Name & designation of person completing the summary	**Rachael Fawcett, Matron for Maternity Service and EPAU and Emma Barker, Recruitment and Retention Midwife**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, BirthRate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (1st April 2023- 30th September 2023) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the NHS Resolution Maternity Incentive Scheme, safety action 5.

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

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

Midwifery Establishment

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly

recommends using BR+ to undertake a systematic assessment of workforce requirements since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3). It must however be recognised that one of the Ockenden (2022) recommendations was that

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

A BR+ establishment review was last completed in 2021 utilising two months data for March and April 2021 and annual data from 2020/21. The total births in 2020/21 was 1725, in 2022/23 the total births remains unchanged at 1718. The Birthrate Plus establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. The 2021 BR+ establishment review recommended a total Clinical, Specialist and Management whole time equivalent (WTE) of 76.21 midwives. The HDFT funding for midwives is 75 WTE (including NHSE funded posts) and there is currently 73.06 WTE in post as at the end of September 2023 (not including those on maternity leave, career break or external secondment). The budget is currently under review with the finance manager for the Directorate and the Operations Director. It is recommended that establishment setting is reviewed every three years unless there are significant changes in the service provision and a BR+ establishment review is therefore scheduled to be completed in 2024.

In addition to establishment setting BR+ also provide an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018 and information from this tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward). It has recently been explored with BR+ whether there is an acuity app for Maternity Assessment Centre (MAC) further to the CQC inspection in November 2022. Unfortunately there isn't currently any system available to monitor acuity in a triage area like MAC.

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

Establishment Deficits

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

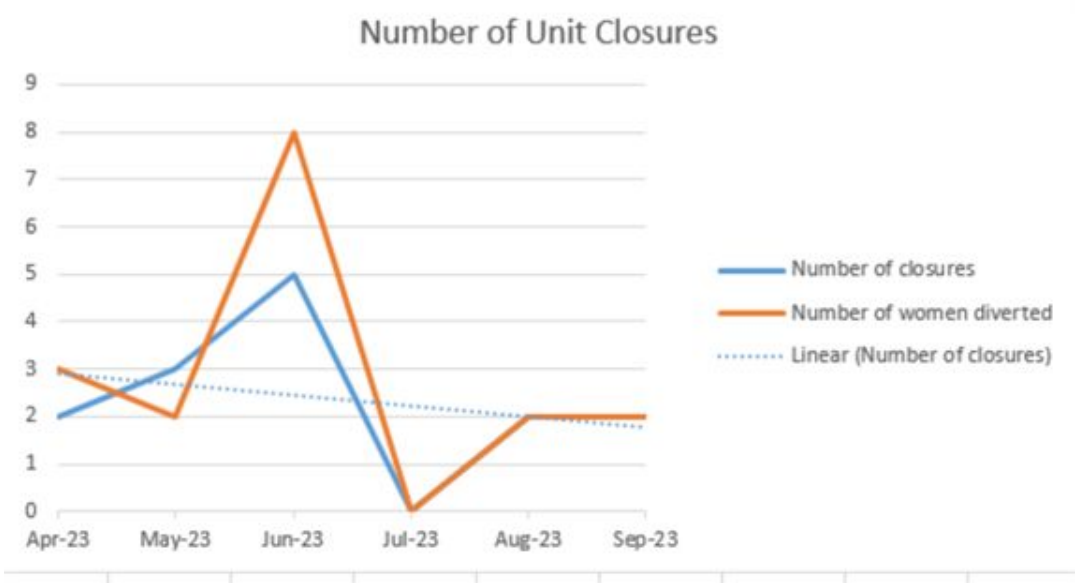
- There is an escalation policy for staff to use in the event of staffing short falls.
- A gap analysis will be completed against the recommended staffing levels in the BR+ report with any deficit being identified and actions taken to mitigate in the short and long term.

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

	Midwives	Maternity Support Workers (MSW's)
New Starters	2.6 WTE	2.0 WTE
Leavers	1.8 WTE	2.4 WTE
Career break	1.0 WTE	0.0 WTE
Maternity Leave	6.4 WTE	0.0 WTE
Secondment	1.0 WTE	0.0 WTE

From the data submitted over the six month period there were no relevant staffing factors identified for 62% of the time on delivery suite, the calculation for Pannal ward is not available due to Birthrate plus being under review. The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required. Mitigation to cover shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the Birthrate Plus acuity tool. Due to the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on 12 occasions with 17 women diverted to another hospital. A Datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All women diverted elsewhere are sent a letter apologising for the inconvenience of the diversion. All closures are reviewed by the Matron with the Labour Ward coordinator to discuss the activity, staffing and decision making before the escalation paperwork is signed off. There is an oversight of staffing issues through Maternity Risk Management Group (MRMG) meetings and monitored through Datix.

	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023
No. of times maternity unit closed to admissions	2	3	5	0	2	2
No. of women diverted to other units	3	2	8	0	2	2



Planned Versus Actual Midwifery Staffing Levels

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

Actions have been taken as per the Maternity Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives and team leaders working clinically " as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift.

NHS Professionals bank staff are requested to fill all roster gaps which the majority of the time are due to sickness. NHS Professionals demand and fill is demonstrated below.

Midwife: Birth Ratio

The monthly midwife to birth ratio is currently calculated by taking the total number of births per month, multiplying by 12 then dividing by the number of clinical midwives. This calculation does not take into account midwives who were unavailable for shifts due to sickness or absence. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour. The Associate Director of Midwifery or Matron are not included in the midwife to birth ratio however team leaders have their clinical time included.

HDFT midwife to birth ratio

Midwife to Birth ratio	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023
In Post	1:25	1:31	1:30	1:27	1:29	1:33

Specialist Midwives

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

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

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

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

- Bereavement 1.0 WTE (funded by NHSE)
- Infant feeding 0.8 WTE
- Quality and Safety Lead 1.00 WTE
- Professional development midwife 0.6 WTE
- Named Midwife for Safeguarding 1.0 WTE
- Antenatal and Newborn Screening 1.00 WTE
- Professional Midwifery Advocate 0.5 WTE
- Fetal Monitoring Lead Midwife 0.4 WTE
- Digital Midwife 1.0 WTE
- Midwife Sonographer 0.60 WTE
- Recruitment and Retention Midwife 1.00 (Funded by NHSE)
- Public Health Specialist Midwife 0.4 WTE

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

Data extracted from BR+ during the six months 1st April 2023 – 30th September 2023 show there was a compliance completion rate of the tool of 78.05% on delivery suite and no data is available for Pannal ward due to BR+ being under review. A higher compliance completion rate provides more assurance that the interpretation of the results is accurate.

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

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

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

All information was collated using the Birthrate Plus acuity tool. During this time period there were 19 occasions when the Delivery Suite coordinator was not supernumerary out of a completed 857 occasions which equates to 98% supernumerary status. There were 241 occasions when BR+ acuity app wasn't completed during this six month period. Each completion refers to a four hour period and the occasions of none supernumerary status may only occur for a small amount of time during each four hour period. Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialist's midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

During this time period 1:1 care in labour was achieved 99.7% of the time for women admitted to the unit.

- 817 women birthed
- 829 babies born (includes multiple births)
- 10 women experienced a baby being born before the arrival (BBA) of the midwife, one woman birthed on Pannal and one episode of 1:1 care not provided due to a midwife also caring for two postnatal women

Midwifery Continuity of Carer (MCoC)

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

In March 2023 it was recognised that the midwifery staffing at HDFT had reached target levels and as such that it should be possible for one team of midwives (eight headcount as per NHSE requirements) to safely work in a MCoC model. MCoC midwives are required to work with caseloads of 1:27 (compared to national caseload of 1:96 for traditional care community midwives) and provide care on Delivery Suite in an 'as required' model. This requires careful planning to ensure that the women not being cared for in the MCoC model continue to receive safe care. Work is ongoing on putting in place the 'building blocks' to enable a team to work in a continuity of carer model. A separate report provides further details.

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are available on the BirthRate Plus acuity tool. During the 6-month period between April 2023 and September 2023 the following red flag events were identified;

Delivery Suite 4 red flags were identified -

Number & % of Red Flags Recorded

From 01/04/2023 to 30/09/2023

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)	2	50%
RF2	Missed or delayed care >60 minutes for suturing (except after pool birth) See unit crib sheet	0	0%
RF3	Missed or delayed mediation > 30 mins Medication not given within 30 mins of prescription Low molecular weight heparins, anticoagulants Pain relief following surgery Antihypertensives Epileptic meds Glycaemic control IV Abx - mum or baby	0	0%
RF4	Delay in providing pain relief > 30 mins Delay of > 30 mins in providing pain relief where requested	0	0%
RF5	Delay between presentation and triage >30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	50%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output) Where the midwife has not escalated within 30 mins (not delay due to medical response time)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour 'labour' defined as 'any woman on a partogram'	0	0%
RF10	Midwife unable to provide 1:1 high dependency care for AN or PN patient	0	0%
	Total	4	

Download

The postnatal ward acuity tool is under development by BR+ and has been paused since May 2023. The main red flag on Delivery Suite relates to delay to induction of labour care. This is an appropriate clinical action to take in the majority of circumstances. The situation

is not acute and can therefore be appropriately delayed without untoward impact on outcomes. This does however impact on the service user's experience of maternity care. Work is required to consider the management of induction of labour to endeavor to protect the patient experience whilst ensuring the safety of the service provision. It has been suggested that the following elements should be considered; outpatient induction, mechanical induction, an allocated midwife for inductions on Pannal and capacity management.

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

Recommendations

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

Appendix F – Continuity of Carer report

Maternity Continuity of Carer

November 2023

Title:	Maternity Continuity of Carer
Responsible Director:	Emma Nunez
Author:	Eleanor Kaye, Community and Continuity Team Leader Rachel Askey, ANC Team Leader and Public Health Specialist Midwife Leanne Likaj, Associate Director of Midwifery

Purpose of the report and summary of key issues:	The purpose of this report is to provide a position update on Midwifery Continuity of Carer against the 'building blocks' – 1. Safe Staffing 2. Planning spreadsheet 3. Communication and engagement 4. Skill mix 5. Training 6. Team Building 7. Linked Obstetrician 8. Standard Operating Procedure 9. Pay 10. Estate and equipment	
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	Reputational risk from not offering continuity of carer across the full maternity pathway.	
Report History:	Maternity Risk Management Group	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

Maternity Continuity of Carer

Background

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

There is high quality evidence that Midwifery Continuity of Carer improves safety and outcomes, reduces interventions and improves women's experience (Sandall et all 2016) and that MCoC reduces pre-term birth (Medley et al 2018) and Stillbirth (Ota et al 2020).

Maternity services in Harrogate have strived to achieve the national ambition since late 2018. There has been a number of achievements as well as challenges during this time.

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

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

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

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

Current Position

Our MCoC provision remains at 0%. Community midwives continue to work together in four geographical mixed risk teams across Harrogate and District. Seven midwives are continuing to work as integrated midwives, working across both community and delivery suite, in order to maintain their skills in both areas. Reorganisation of existing teams into hubs in Leon Smallwood in Ripon and Mowbray Square in Harrogate aims to improve antenatal and postnatal continuity, increasing opportunities for personalised care planning and improved patient experience and safety.

Currently antenatal continuity with a community midwife is difficult to quantify into a percentage. Following the transition to the Badgernet Electronic Patient Record (EPR) the allocation of a named midwife has be omitted from being entered more often than not during this quarter. A communication email has been circulated to the community midwives regarding the value and importance of entering this information at the booking appointment. In addition, community data from other trusts is included within the EPR 'MCoC unit reports'. This needs to be understood and removed for accuracy for the next quarter.

Community midwives do their own clinics every week unless they are on annual leave or absent, or affected by a homebirth whilst on call. Women are usually booked back into their usual clinic day to see their named midwife. Postnatal continuity is impacted by the part time

work force, specific days postnatal women and babies need to be seen, and geographical area covered. For example, the named midwife may be working, but in her antenatal clinic all day so an alternative midwife from the team will visit her women. It is currently rare for a woman to be cared for in labour by a midwife who is known to her prior to the onset of labour.

Ten Building Blocks

1. Safe Staffing

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

Seven midwives (6.25 WTE) are currently working across both community and intrapartum areas. The preceptorship programme will ensure that all band 5 midwives will have an opportunity to consolidate their skills in the intrapartum area and they will undertake a community rotation to ensure they have the broad range of skills to offer care across the whole maternity pathway. The Retention and Support Midwife will support midwives of all bands to develop their clinical skills to ensure they are supported in the transformation of the workforce.

There are plans to repeat the Birthrate plus workforce establishment calculations early 2024. The previous report was completed in 2021 and the requirements of the workforce have change significantly since then in relation to the requirements of specialist roles.

2. Planning Continuity in Community

From the 6th November 2023, the antenatal community clinics are adapting the slot times with the aim of increasing clinic capacity to therefore increase continuity for individuals. The clinic days have been under-utilised and the changes enable a more time-efficient way of working. These implementations are applicable to all four HDFT Community Maternity Teams, two teams are four members, one team is six members, and one team is five members.

Six 20-minute slots have been allocated to the gestations that require less information giving. Thirty minutes slots have been maintained for the gestations/individuals that require more input. Feedback over time will inform whether further slots can be reduced to 20mins. Telephone booking appointments, which are currently placed at the end of the clinic, have been reduced from 90 minutes to 60 minutes. By making these changes this has effectively increased the volume of appointments in one clinic, enabling more women to be seen by their named midwife, minimising the patient being transferred to another clinic day with another midwife. In the instance that a patient can't be booked in to their named midwife's clinic, a Buddy System has been implemented within the teams, with the aim for a patient to effectively only have to see two community midwives throughout their pregnancy.

Additionally, increasing clinic capacity may provide the opportunity for midwives to invite postnatal women due a home visit, into their clinics if they are on their caseload, as often vital visits e.g. day 5 can fall on clinic days, this will provide options for continuity if they can attend their named midwife's clinic.

A future goal, once the midwives have adapted to the 60-minute telephone bookings, is to offer women the option of a telephone or face to face appointment with their named midwife, as an opportunity to meet their named midwife sooner. This will be offered when they attend for their First Contact appointment with a maternity support worker (MSW) and the MSW will

amend the appointment on System One so the midwife is aware if it is telephone or face to face.

To further improve both continuity and input of midwifery care for women with more medically and obstetrically complicated pregnancies, Antenatal Clinic (ANC) midwives who wish to develop specialist interest in an area of care will be rostered to work alongside the consultant. This will initially be trialled for Diabetes and Pre-Term Birth Clinics and will extend to other clinics including Twins, Maternal Medicine and Pelvic Health in the future.

3. Communication and engagement

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

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

4. Skill Mix

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

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

5. Training

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

6. Team Building

Work is on-going to continue to build the team working across community and the acute maternity areas. Staff being integrated and working across locations helps maintain good relationships and people having an appreciation for others roles. Midwives are also rotated to community as part of their initial preceptorship period and this too facilitates improved team working and mutual respect for one another. The Matron holds listening events monthly and this provides an opportunity for staff working in all areas to join together and to raise any concerns that they may have. They also receive an update on changes being made, recruitment and learning from incidents. This again helps team working as the same message is being communicated to all. Training continues to be held in a multi-disciplinary format with specific community PROMPT further supporting staff who work in community to feel confident in the event of an emergency. The PMA team also provide regular wellbeing events including Wellbeing walks and wellbeing Wednesday communications.

7. Link Obstetrician

Work is on-going to improve Obstetric Medical continuity by improving the triaging of clinic referrals so that women are referred to the appropriate consultant for their initial appointment and continue to be seen in the consultant clinic for all their follow up care. All Consultant clinics run with a named consultant and specialist doctor. At present there is not continuity of specialist doctor due the rostering system which means that different doctors are allocated difference days each week in each clinical area.

8. Standard operating procedure

Black Asian and mixed race women are more likely to experience poor outcomes during pregnancy and birth, having four times higher rates of maternal mortality and two times higher rates of stillbirths. At HDFT 3.9% of women booking their pregnancies are from Black, Asian and Mixed Ethnicity backgrounds. These women do not live in a clearly defined geographical area; however it is of note that Mowbray Square PCN has the highest proportion of Black, Asian and Mixed Ethnicity women (6.7% compared to 2.3-4.3% in other PCNs). An expression of interest for a Diversity Champion Midwife will be circulated for a midwife to work out of Mowbray Square and one in Ripon to incorporate women from these ethnicities and deprived areas on to their caseload. This could require an increase in flexibility of appointment time for these women to ensure there is time to have more in-depth discussions to overcome inequalities. These midwives will receive further training in overcoming inequalities.

9. Pay

No midwife should be financially disadvantaged for working in a continuity of carer model. This will be maintained and reviewed to avoid unintended consequences on pay as changes towards this model are implemented.

10. Estates and Equipment

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

Historically midwives have been linked to a GP surgery; however this posed significant problems with managing the flow of women through community services, ensuring adequate staffing to cover clinics in multiple locations and managing caseload sizes so midwives were working efficiently. Moving to Hubs facilitates the implementation of MCoC by significantly improving the efficiency of the existing community teams and facilitating better antenatal continuity for their women.

Progress has been made with the planned opening of the Leon Smallwood centre at Ripon as a base providing clinical and office space for our community midwives working in our rural team community. Our two Harrogate based teams are now located in Mowbray Square Medical Centre for their community clinics. Mowbray Square is located in Harrogate Centre and is easily access by our postcode area of highest deprivation

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

Evaluation

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

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

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

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

How is HDFT working towards meeting the requirement?

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

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

National survey

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

Conclusion

MCoC remains a challenging ask of maternity services. Work is ongoing to continue developing the building blocks to implement continuity when safe staffing is available across the Trust and region.

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

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

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

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

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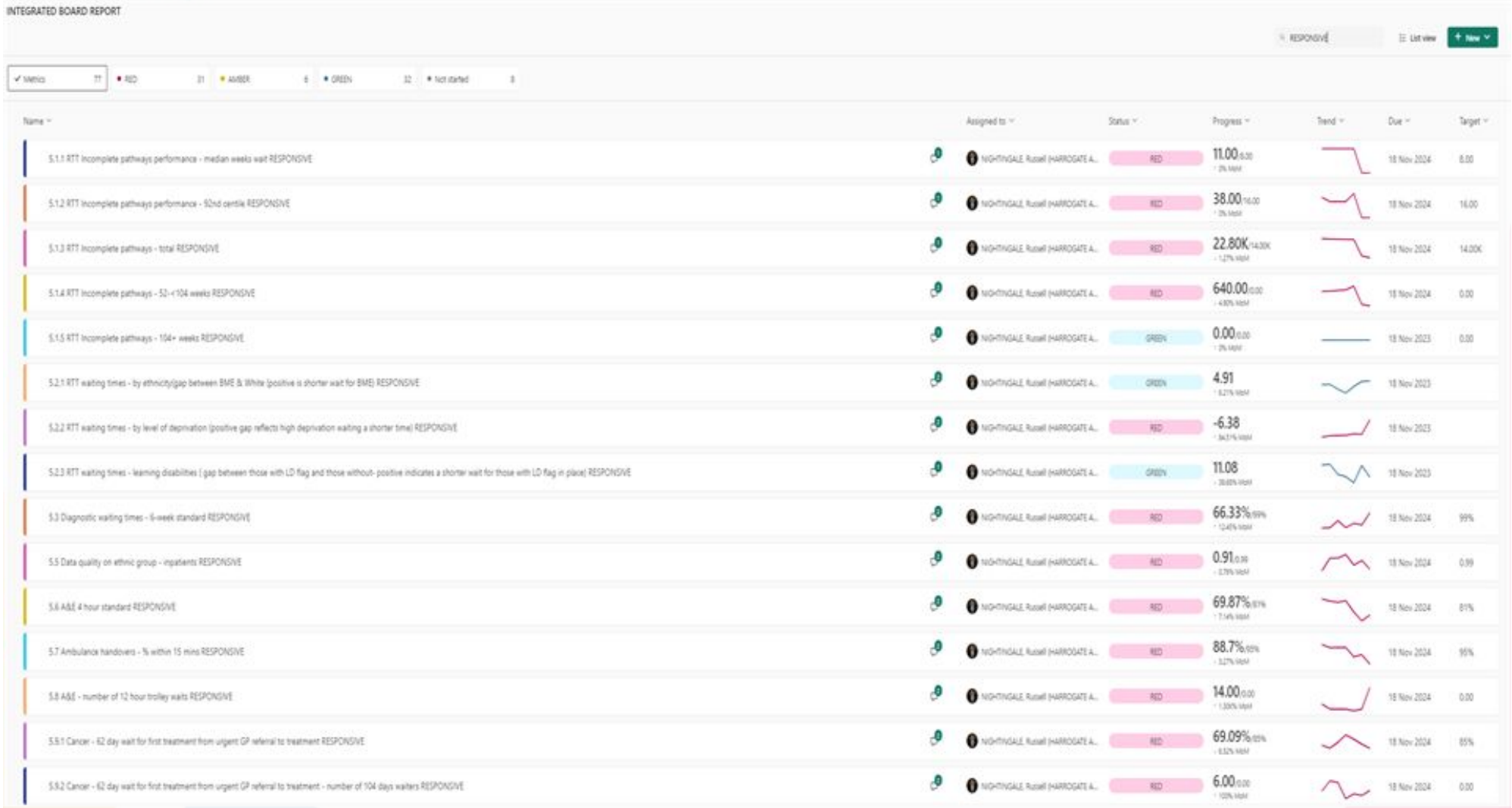
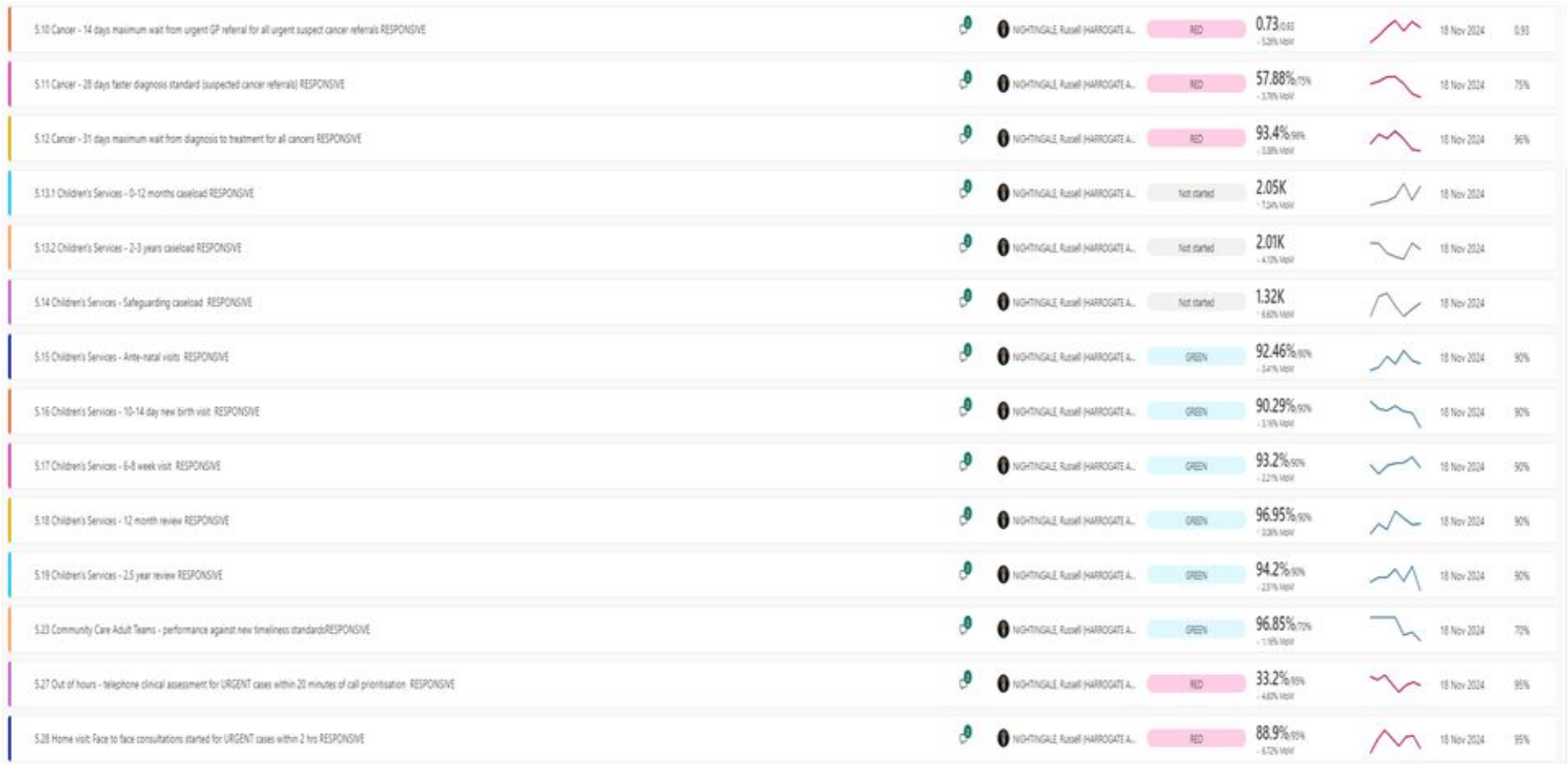
RESPONSIVE1 DOMAIN - IBR

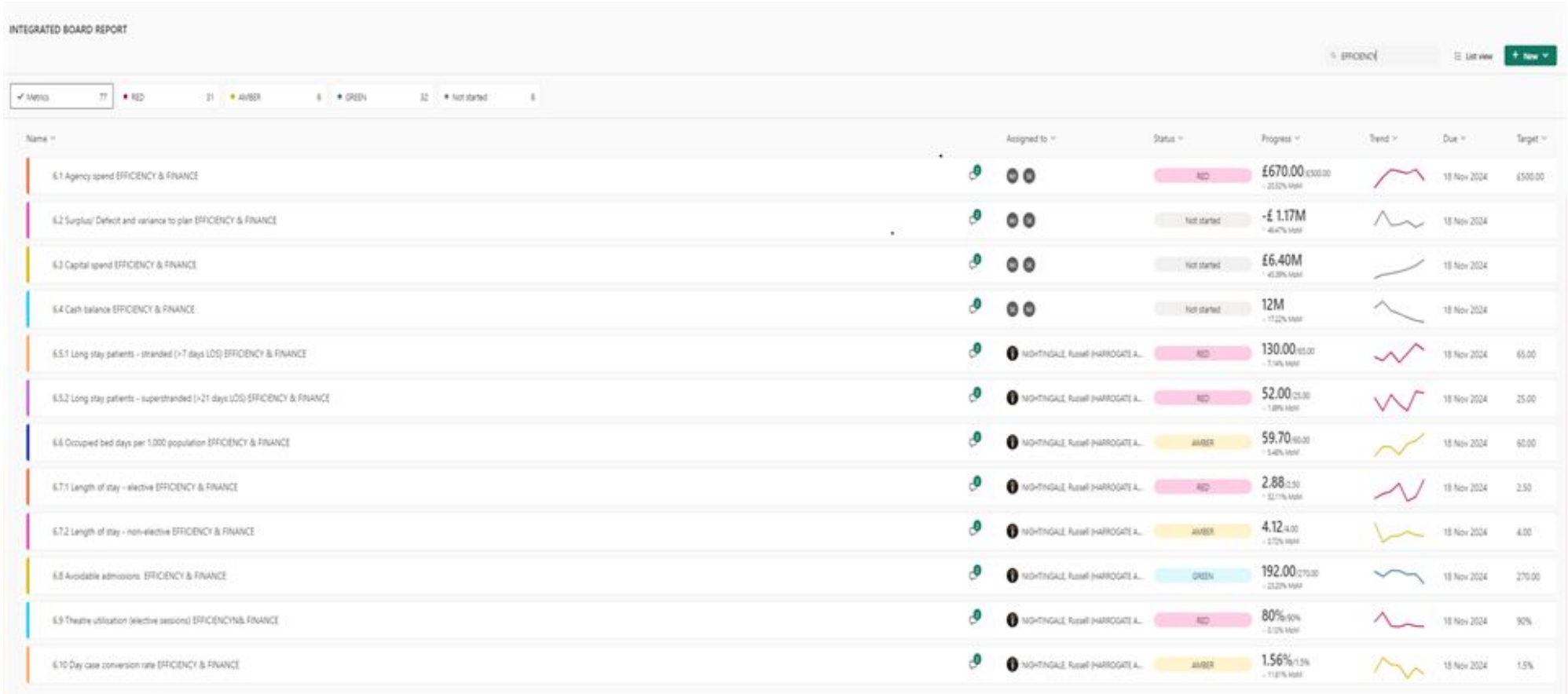


RESPONSIVE2 DOMAIN - IBR

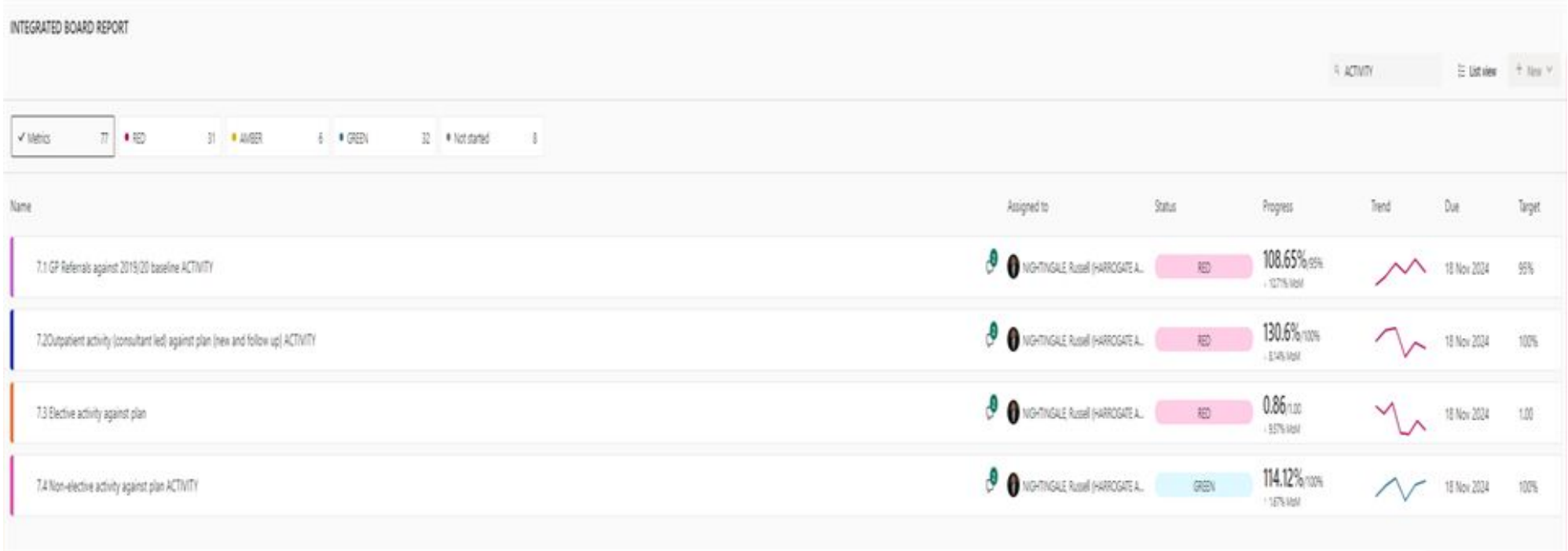


5.10 Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	RED	0.73 (0.93) -5.26% Mean	18 Nov 2024	0.93
5.11 Cancer - 28 days faster diagnosis standard (suspected cancer referrals) RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	RED	57.88% (75%) -3.78% Mean	18 Nov 2024	75%
5.12 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	RED	93.4% (96%) -0.38% Mean	18 Nov 2024	96%
5.13.1 Children's Services - 0-12 months caseload RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	Not started	2.05K +1.24% Mean	18 Nov 2024	
5.13.2 Children's Services - 2-3 years caseload RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	Not started	2.01K -4.10% Mean	18 Nov 2024	
5.14 Children's Services - Safeguarding caseload RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	Not started	1.32K +6.82% Mean	18 Nov 2024	
5.15 Children's Services - Ante-natal visits RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	92.46% (90%) -3.41% Mean	18 Nov 2024	90%
5.16 Children's Services - 10-14 day new birth visit RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	90.29% (90%) -3.16% Mean	18 Nov 2024	90%
5.17 Children's Services - 6-8 week visit RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	93.2% (90%) -2.21% Mean	18 Nov 2024	90%
5.18 Children's Services - 12 month review RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	96.95% (90%) -0.38% Mean	18 Nov 2024	90%
5.19 Children's Services - 2.5 year review RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	94.2% (90%) -2.51% Mean	18 Nov 2024	90%
5.23 Community Care Adult Teams - performance against new timeliness standardsRESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	GREEN	96.85% (70%) -1.99% Mean	18 Nov 2024	70%
5.27 Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	RED	33.2% (95%) -4.60% Mean	18 Nov 2024	95%
5.28 Home visit: Face to face consultations started for URGENT cases within 2 hrs RESPONSIVE	NIGHTINGALE, Russell (HARROGATE A...	RED	88.9% (95%) -6.72% Mean	18 Nov 2024	95%

EFFICIENCY & FINANCE DOMAIN - IBR



ACTIVITY DOMAIN - IBR



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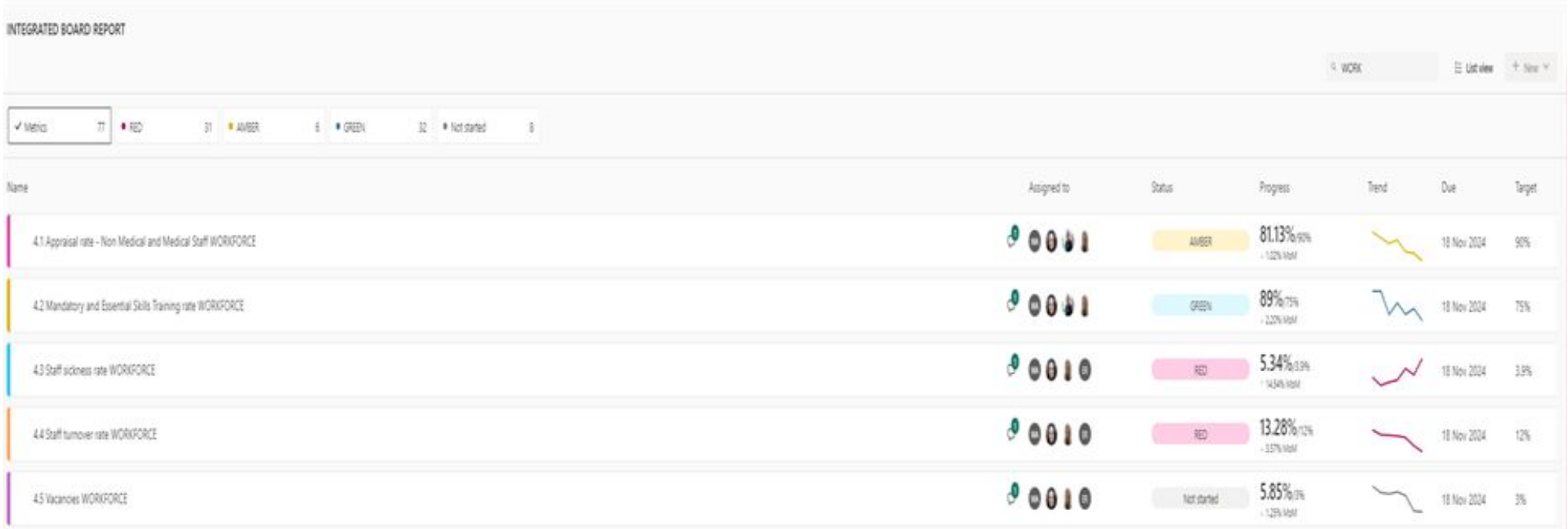
WORKFORCE DOMAIN - IBR



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

Date	**1 August 2023**	**Location**	MS Teams
Chair	**Mel Pickup**	**Minutes prepared by**	Geraldine Morris
Attendees	Foluke Ajayi, Mel Pickup, Jonathan Coulter, Len Richards, Phil Wood Lucy Cole, Ben Roberts, Sal Uka, Jonny Waddington		
Apologies	Brendan Brown		

Agenda

ITEM		WHO
1	Welcome and apologies	Chair
2	Minutes and Actions	All
3	CEO Updates	All
4	Collaborative Report and WY HCP Report	LC
5	Haematology Update	Sal Uka and Jonny Waddington
6	LIMS escalation report	JB
7	CiC follow-up discussion • Senior Leadership Programme • Regional sign-off and assurance processes • Non-exec engagement • YAS and community collaborative engagement	LC
8	AOB	All
9	Close	Chair

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
Review previous meeting minutes and action points	Mel Pickup (MP) welcomed all and informed them she was chairing the meeting today on behalf of Brendan Brown, who has given apologies. The minutes from the previous meeting were approved as an accurate record. **The action log was reviewed, and the following updates were given:**	

	• *Action 112:* Haematology – SU to bring progress update on haematology to meeting in August 2023 – Agenda item 5 • *Action 115: Collaborative Report & WY HCP Report – LC to update on CDC proposal* – Agenda item 4 • *Action 124: Specialised commissioning – LC to meet with Ian Holmes* – LC confirmed she had a meeting with IH scheduled for later that week. • The remaining actions were noted as not yet due for completion. Lucy Cole (LC) noted the Action Log circulated with papers was incorrect. The correct copy will be circulated after the meeting.	
CEO Updates	MP updated that preparations are under way for the next industrial action (IA). Len Richards (LR) questioned if other Trusts are experiencing significant levels of attendances and admissions currently noting that MYTT will go to OPEL 4 given bed pressures, even after opening additional capacity. Foluke Ajayi (FA) shared that attendances in the last week have been middling; it did spike but has not been extreme. ANHSFT admission rate is high though and it's feeling pressurised. The usual summer 'lull' hasn't transpired. MP stated that school holidays have begun, with higher levels of staff annual leave, and attendances at BTHFT are standard, but discharge rates are a concern. Jonathan Coulter (JC) shared that the position at HDFT and has been reasonable for several weeks, with nothing unusual noted. Both JC and FA cautioned on the normalising of levels of high pressure and therefore anything below the significant levels of winter pressure being judged to be positive. Phil Wood (PW) updated that it's not too bad at LTHT, though ED is busy, which seems to be the new normal. LTHT currently has 95/96% occupancy, which although high, is better that it has been. PW confirmed that the combination of staff on leave and IA has resulted in increased pressure.	
Collaborative Report and WY HCP Report	LC updated on Collaborative Highlight report. • CDC - agreed at diagnostic board last week, will devolve implementation into Place level and reduce WYAAT /WY governance of this to keeping place leads for CDCs connected locally and to the regional. Will step down some steering group structure. Working with the Region and place leads to agree proportional reporting and communication structures.	

	• Imaging – originally had digital funding for a CDC booking system but this has been re-purposed and distributed across trusts which will raise our ability to digitise diagnostics booking across the board. The Diagnostics Board has agreed this change of funding. • Image-sharing - moving forward with issues with supplier related to replacement of the voice recognition software. Contracts are signed and implementation under way. Legal support is in place to support managing the relationship and the final payment has not been released as the system has not yet delivered. PACS replacement is looming. AGFA contracts start to end in 3-4 years. Need to plan for re-procurement of PACS. Good to have discussion early and engaging with CIOs on this. • Pharmacy - finalising outstanding asks on aseptics business case, Ben Roberts (BR) picking up on these, this week. All issues have been discussed and just need to be formalised in a written response. Expectation that this will be approved following our response. There is no need to escalate further. • Theatre workforce – some really good work being done by theatre workforce leads. Engagement around careers in surgery through promotion in schools. Have 82 schools signed up already. • Endoscopy training centre – progressing now the hosting arrangements have been agreed and updated that an advert for clinical lead is out. This role does not need to be held by a medic. Have revenue funding for next couple years to support this post. A new ERCP specification expected from NHSE - national lead for this is one of the LTHT clinicians who is engaging with our steering group, which will review when the final version is released to understand any changes to practice, or provision required as a result of the new guidance. • NSO – engagement events are happening; turnout has not been as hoped. May need targeted work to ensure engagement requirements are effectively met. • Pathology - increasing national focus on histopathology, turnaround times and cancer pathways. Chief Operating Officers highlighted this as a priority in the context of diagnostics productivity. Workshop session on 8 August will be the start of opportunity identification. LC handed over to Ben Roberts (BR) who gave the following update on ERF mutual and efficiency group: • ERF mutual aid - principles have been agreed with Directors of Finance (DOFs). Affordability is an issue, with concern around lack of incentive due to costs. There's a desire for a fair way to recompense people. This will be finalised with DOFs this week. Agreeing charges is an obstacle; caution is needed so we're not profiteering. This is being worked through with DOFs this week, not far off getting agreed and arranged. LC confirmed this would then be shared with FA as SRO. • ICS efficiency transformation group – had initial meeting to agree what will be reviewed. It's essential this includes working more collectively as a system to effect change. BR noted the need to expand beyond just finance representation. James Thomas, Medical Director at ICS is on there, want to widen pool of expertise	

	available. MP asked if Jonathan Webb chaired it. BR confirmed it will be James Thomas and Carol McKenna to alternate as Chair. LC confirmed the HCP report was for noting. There has been no response to the letter sent by WYAAT to the ICB re the operating model, but this is expected imminently.	**ACTION: LC to update on discussion with Ian at future meeting.**
Haematology Update	*JW joined the meeting*. *LR left the meeting* JW presented an update on haematology (slide deck circulated with meeting papers) • JW summarised that we're on the precipice of a solution to on-call and out-of-hours it's hoped we'll get the support the clinical and operational teams engaged to date. MP thanked JW for his presentation. SU updated that clinicians are engaged positively. He noted there are some tensions to navigate through but was optimistic we can move in right direction. Some early obstacles are not insurmountable, but some work to be done yet. JC noted that we should support the process and identify if more senior input was required after the workshop on Thursday and if a sustainable on-call model could be proposed. SU commented that on-call for specialist advice would be doable. More understanding of the practicalities of completing ward rounds over several sites in new world is required. Easier to do when we have an idea of what we're aiming for. MP reflected that you might arrive at a preferred option and offer alternatives. She added that the wider implications should be considered. MP thanked JW and SU for their update. *JW left the meeting* *MP shared that LR had temporarily left the meeting due to the fire alarm sounding*	
LIMS escalation report	*Janine Bontoft (JB) joined the meeting* JB introduced herself and presented an update on LIMS (slide deck circulated with meeting papers)	**ACTION: JB to share specific context and challenges with each CEO for their trust**

	• JB updated that a single laboratory information management system for WYAAT Trusts is being implemented. The original completion date of August 2023, which has since been revised to April 24. One issue has been the supplier completely underestimating the complexity of the build given the network is not in its end state operationally. In pathology, resourcing is a continuous issue balancing operation of the labs with the need to release staff time to undertake testing. The mitigation of further delay is to use NHSE digital diagnostics fund for contract resource for testing element, which will start on Monday. Amended delivery to be more agile, and review regularly. • The main impacts are that we're now looking at finishing no earlier than the end 2024, possibly Q1 2025, which is 12-15 months later than the original estimate. Every delay costs around £100k a month and costs may rise if delayed further. The ask is for CEOs to support ensuring provision of resource and be aware of the priority of LIMS. LC updated that she took this through Diagnostic Board last week and LR suggested raising any escalation through here. LC noted that this was a significant piece of work and in many cases, trusts have bene keeping old systems running for two-three decades. The challenge and scale of the work required is new to people. PW thanked JB for the update and requested assurance in relation to the interdependency management between the MSC, new laboratory at SJUH and LIMS. JB updated that all leads continue work together on these things. LTHT has been the priority given the new laboratory and balancing the risk at ANHSFT and BTHFT. She shared that the plan is for the LIMS to be live Leeds in March/April 24 which will be in time for the build and MSC equipment installation. MP asked if JB could share the specific issues impacting BTHFT to help her progress within the trust. The other CEOs agreed that this trust-level insight would be helpful for each of them. *LR re-joined the meeting* MP confirmed Programme Executive was there to act as a point of escalation and resolution should further deployment or resourcing issues be encountered. MP welcomed LR back to the meeting. She updated LR that members were agreeing with recommendations and what would help in our own organisations to try and make them happen.	
CiC follow up discussion	LC highlighted key discussion points and actions to follow-up from WYAAT CiC.	

	Senior Leadership Programme (SLP) • There has been discussion and support for doing something and continuing in the future with this, given that there is nothing happening nationally. It's at the evaluation stage currently. The programme ends in October, with a full evaluation then. Soundings are being sought for the next phase. The feedback so far is that the SLP is very positive. Some participants have found placements more challenging than others. We could do something similar again based on evaluation, within WYAAT only or broaden to include other NHS providers, or more broadly to organisations across the ICS. LC invited members' views on this, as it would help in getting something prepared for next year. PW was very supportive of the programme but stated that we needed to be clear on the unique selling point of the programme and relationship between programmes within individual organisations. LR had similar view. He would advocate that at system level, bring in others such as social care, local authority - there could be something different. He recognised there's real value in learning to be a leader in the system, rather than in a hospital. He wondered whether a system-wide programme would be the next step, as leadership in that context will become more commonplace. JC felt the unique selling point was about the networks that exist across WYAAT and suggested members and participants getting together over a six-month period, working in each other's organisations on projects and receiving mentoring. He referenced LR's comments on a system-wide programme and raised the difficulty of managing the logistics of it. He noted that there were also regional programmes in place and asked that we review existing programmes to ensure we're not duplicating what others are offering. He noted a preference to expand slowly, perhaps first to the MHLDA and community collaboratives. FA discussed the USP, noting the system leadership aspects are well embedded at an executive level but that she has observed the penetration further down in the trusts was more limited and therefore this programme offered an opportunity for people to engage in system leadership. She agreed with JC comment on taking things slowly with this and starting by broadening to the MHLDA and community collaborative colleagues. SU updated that James Thomas at ICS is leading a clinical forum, with workstreams looking at leadership development across the system. It's taking some time, happening at different pace. The SLP at WYAAT is more about the doing than theorising. MP summarised there's a consensus to do something. She reflected we should have it in mind to build in the time to make changes on the back of the evaluation from the current cohort. She suggested offering some of today's ideas to the	

	cohort and ask for their views. MP discussed there's nothing established to develop 3-5 people from one place, so it would be unique, but perhaps an ambitious step too far for the second cohort, therefore maybe start with collaboratives. Regional sign off and assurance processes • LC noted the discussion at CiC regarding the rigour of regional assurance processes in relation to Aseptics and use of cancer alliance funding by ANHSFT and queried if any further follow-up was required. JC discussed how feedback could be given to people that could influence process and behaviour in the regional team. MP agreed it would be good to get Steve Russell to attend a meeting to support insight on the NHSE operating model and restructure. LC confirmed he's offered to do that and is currently trying to agree a date that works. Non-executive engagement • LC noted that WYAAT-wide non-exec engagement had been raised at CiC in respect of strategy engagement and reflected that this had been discussed previously. FA noted that the Chairs are engaged and therefore well placed to support wider non-executive engagement. MP noted that it had worked well previously when LC had attended each board development seminar and that this had been well received by boards. It was agreed that it would be good to do this periodically and avoid the need to get a very large group of people together. YAS and community collaborative engagement • LC queried if there were any specific follow-up actions that Programme Executive wished to follow up from the sessions with YAS and the Community Collaborative. MP felt really encouraged listening to Peter and Martin from YAS at the CiC and agreed that it would be useful to invite Peter to a future Programme Executive meeting, after the Winter Plan was agreed (around November time). LR agreed and noted engagement with YAS locally was positive. LR raised that one other issue discussed at CiC, considering the financial environment we're working in, was the prospect of service configuration driven by efficiency and asked if members saw it as realistic prospect? If it's being done from an efficiency point-of-view, a more stringent line around cost of services would be taken at the beginning. The way service configuration is carried out leads to the potential of increasing costs. MP agreed with LR's point, stating it would be good to frame it in that way right at the outset.	**ACTION: LC to include review of existing leadership programmes as part of the evaluation of the SLP.** **ACTION: LC to invite YAS to future meeting**

	JC agreed with LR and also noted that if we don't rescue fragile service the cost of agency would be high. He highlighted the current narrative around finances was discussed. He raised that a system narrative on what's happening would be helpful. LR referenced JC's comments and considered if service configuration is being viewed from an efficiency perspective, it would not be from a fragile service one, it would be from high volume mainstream services, citing orthopaedics as an example. LC agreed there's an opportunity driving this, with five targeted investment fund (TIF) investments and three new hospitals and noted it was unclear whether this conversation was being led at an ICB level. MP shared that the limiting factor may be our internal capacity and there could be other things to organise when the letter from Rob Webster regarding the ICB operating model is received. MP asked if LC could consider how we could collectively look at opportunities for service configuration to support efficiency. PW agreed that this was the right approach but noted the necessity of engagement with the ICB and Places to ensure support for any proposals that we may develop through WYAAT.	**ACTION: LC to look at service configuration and update at future meeting**
AOB	JC asked if the meeting in September might include all executives. LC updated that the logistics are being explored, but one issue is there's a Partnership Board in the afternoon which may hamper CEO attendance. She noted that September and October were looked at to see which is more feasible. She will be checking this today and will confirm.	**ACTION: LC to update on all-executive meeting**

OTHER ISSUES TO NOTE
N/A

NEW RISKS/ISSUES RAISED
N/A

Next Meeting	**WYAAT Programme Executive**		
Date	5 September 2023, 09:30-12:30	**Location**	MS Teams

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

Humber and North Yorkshire Health and Care Partnership

Humber and North Yorkshire Collaboration of Acute Providers (CAP) CEO Group
Monday 21 August 2023, 10.00am – 11.30am
via Microsoft Teams

Those Present: Simon Morritt (SM), Chief Executive, YSTFT (Chair)
Jonathan Coulter (JC), Chief Executive, HDFT
Jonathan Lofthouse (JL), Group Chief Executive, HUTH & NLaG
Wendy Scott (WS), Managing Director, HNY CAP

In Attendance: Ivan McConnell (IMc), Joint Director of Strategic Development, HUTH & NLaG
Kerry Carroll (KC), Deputy Director of Strategic Development, NLaG
Melissa Page (MP), Personal Assistant, HNY CAP (Note Taker)
Lynette Smith (LS), Deputy Managing Director, HNY CAP

1 Welcome and Apologies

The Chair welcomed all members to the meeting.

W Scott provided an overview of the Collaboration of Acute Providers (CAP) governance arrangements. Three meetings of the CAP Programme Executive Group (PEG) had taken place and the group met monthly. The PEG escalated to the Chief Executives through the CEO Group and CAP Board, and these respective forums tasked the PEG. WS confirmed she was the Chair of the PEG.

There were programme boards for each of the clinical programmes (urgent and emergency care (UEC), diagnostics, elective and cancer) and the Programme Directors were members of the PEG. The invitation had also been extended to Penny Gray (Director of Commissioning, Humber and North Yorkshire (HNY) Integrated Care Board (ICB)) and Alex Bell (Deputy Director of Data, BI & Analytics, HNY ICB).

A discussion ensued on terminology going forward now JL was in post as the Group Chief Executive for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). It was noted the Joint Working Agreement (JWA) and responsibility agreement with the ICB had four signatories, however the language used going forward in regards to the three or four organisations needed to be worked through by JL, his Board and team.

It was agreed to hold an informal face to face conversation with Stephen Eames (Chief Executive, HNY ICB) to discuss the way forward. Invitees would be S Morritt, J Coulter, J Lofthouse, W Scott and Michele Moran (Chief Executive, Humber Teaching NHS Foundation Trust (HTFT)).

ACTION: SM's office to arrange an informal meeting with S Eames.

2 Minutes from the Last Meeting

The minutes from the HNY CAP Board meeting held on 4 July 2023 were taken as a true and accurate record.

3 Action Log

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

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W Scott provided an update on the Artificial Intelligence (AI) bid. The bid had a strict criteria relating to chest pathways and the total national funding amount was £21 million. The region had requested for a completed bid to be received by the 31 August 2023 with a national submission of 4 September 2023. W Scott had discussed the bid with Shauna McMahon (Chief Information Officer (CIO), HUTH and NLaG) in relation to digital teams and support, and wider conversations had taken place with North East and North Cumbria, South Yorkshire and West Yorkshire Association of Acute Trusts (WYAAT). There was a national costing template and guidance around integration and installation costs, and evaluation was also being built in from the Academic Health Science Networks (AHSNs) costing circa £50,000. Discussions had taken place with Finance Directors regarding any ongoing revenue consequences and Andy Bertram (Finance Director, York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTFT)) was liaising with colleagues. The finalised bid would be shared with the CAP CEO Group.

A discussion took place on the single workforce plan and joining up all elements. The Community Diagnostics Centre (CDC) work assumed 483 new staff which was a significant number. Conversations had been held with the ICB regarding if this sat within the workforce programme at ICB level which had eleven different workstreams, a sub-set of that programme or with the CAP and Acute Trusts. It was noted it was believed this piece of work was part of the ICB's eleven workstreams.

In regards to Electronic Patient Records (EPR), it was confirmed the CIO for HUTH and NLaG was leaving the role and this could mean a loss of momentum in regards to the piece of work being undertaken. It was noted all organisations needed a functioning EPR that worked and it was important to not lose the resources that had been allocated in the system.

ACTION: WS to share the final AI Bid with CAP CEO Group members.

4 HNY Draft Accountability and Responsibility Framework

A general discussion took place regarding the draft accountability and responsibility framework. It was agreed an informal meeting needed to take place with S Eames before continuing the conversation and this would be scheduled for the end of October 2023 / beginning of November 2023 (as previously discussed under Agenda Item 1).

5 Diagnostics Update

L Smith provided a comprehensive update on the diagnostics programme, which was noted by CAP CEO Group members.

The ICB had gifted funding (£715,000 per year) to the CAP to lead on the diagnostics programme on the ICB's behalf. Areas of delivery included CDC implementation, continuation of imaging and pathology networks development, and development of network arrangements for endoscopy and physiological sciences. A concern raised by the region was in regards to CDC implementation and fortnightly meetings were scheduled with the regional team until this was resolved.

An overview was provided on the current performance position across HNY. MRI remained challenging for YSTFT and NLaG and lobbying was taking place through the programme to ensure the mobile scanners were kept at the hospitals for patients. New pathology turnaround times would be reported on from October 2023, however due to the current turnaround position, the programme would not be compliant. Analysis was being undertaken ahead of the next HNY Diagnostics Board.

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A conversation ensued on the funding limitations in regards to the mobiles which meant they were not being used to treat patients, despite the equipment and capacity being in place. It was noted a concerted effort needed to be undertaken to lobby for more flexibility. From a York perspective, the funding was being sought through a different mechanism (an underspend in cancer). A strong view from the system would be welcomed to champion this.

An update was also provided on CDCs including delivery and the planned service locations. There were nine key capital builds which included three Hubs and six Spokes. There was a broader ICB allocation of £40 million and £63.6 million had been secured to build them. 147,000 more additional tests had been planned for, however 60% of the plan was being delivered. 95% of the plan needed to be delivered in order to access revenue for the second half of the year and therefore the focus had been on mobilisation to secure the revenue.

In regards to the March 2024 deadline, it was confirmed HNY were closely aligned to the national team and they were becoming more flexible on where activity was being delivered as long as some activity was being undertaken.

Fortnightly assurance meetings were taking place due to high risks in regards to mobilisation. Scarborough Hub was a high risk due to the proposed site demolition works being a risk for contractors and three provisional alternative sites were being looked at. Withernsea Spoke was one of the most complicated sites due to it being a rural area with limited access and the site did not have a sufficient amount of due diligence. It was also a highly political area however the MPs had been briefed and communications were being managed.

The CDC Finance and Activity Group, which had representatives from all organisations and the ICB, had been tasked to look at scenario modelling. The three scenarios being looked at were a) being back on plan by quarter 2, b) being back on plan by quarter 3 or c) undertaking the same amount of activity. If all activity in the plan was delivered, there would be a £3 million surplus. HUTH owned the mobiles which cost £1.5 million and a lot of the work being undertaken was regarding how that risk was shared. LS concluded the presentation by talking through the risks and issues for the CDCs.

SM thanked LS for the diagnostics programme update.

I McConnell reported conversations had taken place regarding accessing the national kit on the South Bank and further discussions were required with the ICB regarding the possibility of this. There was also a construction and planning risk, particularly for the Hubs, and part of this was due to construction capacity and capability. It would be important to ensure the message was managed.

6 Planned Care Strategy – Update and Discussion re Next Steps

I McConnell presented an update on the planned care five year strategy / framework, which was noted by CAP CEO Group members.

I McConnell proceeded to talk through the current position for Phase 1 and areas to consider. There were now agreed data sharing protocols across all acute Providers, an internal team was in place and the outputs had been agreed. An integrated power BI dashboard of performance across the acute Providers by speciality had been developed. The data outputs could be filtered by performance and by Provider in an integrated way to support with identifying multiple fragile specialities. There was a commonality across

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the fragility of services that had been identified. Financial data had been manually extracted to correlate with performance to provide an extensive picture of where the problems were. Work was underway in HUTH and NLaG and the same platform had been used to link into the ICB workforce piece to ensure a correlation of the data sets. Areas to consider included how the data was used and how would there be an integrated view of multiple data sets. It was important to acknowledge that a data sharing agreement was in place.

There was the opportunity to start looking at fragile services either as HNY or two sub-systems and to start the strategy piece that focusses on not only the sustainability of services and estates, but also to start thinking about the activity to undertake and where.

A lengthy discussion ensued on the planned care strategy and next steps. I McConnell confirmed the work had been shared with the Elective Recovery Group to join up objectives. It was also confirmed there was not model health system data sets for all Providers.

S Morritt conveyed if there was the view that there was potential and opportunities on the footprint as a whole, then there was value in undertaking the work. Any data gathered that was common and shared across the system which could be utilised to reach conclusions was a sensible place to be. Further thought was also required on how facilities were used in areas such as Bridlington and Goole.

J Lofthouse noted there was power in the single version of the truth and there was also a debate to be had in terms of how long it could take before the system had a single patient tracking list (PTL). J Lofthouse proceeded to provide an overview on the work undertaken in a previous role as Executive Senior Responsible Officer (SRO) for theatre productivity and how the referral to treatment (RTT) tool would be adopted.

It was also noted further thought was required on what was meant by a single PTL and whether it was ICB wide or sub-system, however it should be more than the individual statutory organisations.

In terms of next steps, I McConnell noted the model system piece would take place for YSTFT and Harrogate and District NHS Foundation Trust (HDFT). This would support with achieving a single version of the truth and also determining where to direct attention in the short and medium term. The internal team would lead on this. All CAP CEO Group members agreed this was the way forward.

7 Any Other Business

W Scott confirmed the first HNY CAP Committee in Common (CiC) was scheduled for Wednesday 4 October 2023, 3.00pm – 5.00pm and a discussion was required regarding the Chair of the meeting. J Lofthouse noted he would ask Sean Lyons (Joint Chair, HUTH and NLaG).

8 Date and Time of Next Meeting

HNY CAP CEO Group
18 September 2023, 10.00am – 11.00am

HNY CAP Committee in Common
4 October 2023, 3.00pm – 5.00pm