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. 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 was reduced to 8 in October as the mitigations are in place and KRI being met, it has therefore be removed from the register. Following the review and report into RAAC, further areas requiring remedial work were identified; the risk was increased to 16 in October. 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. In December 23, the Target date for risks relating to the safe domain were reviewed and updated.				
Initial Date of Assessment	1st July 2022					
Last Reviewed	December 2023					

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December 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	March 24

Key Risk Indicators	Current Position	Controls and Plans to be 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. Sufficient compliance of contractors 5. 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 activities. New Risk Assessment templates created by H&S Team, now being used to create appropriate risk control and generate new content to be utilised on new system 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 • Initial risk assessment meetings have been held 51 teams across the 3 clinical directorates, which will then have follow up meetings to review draft assessments (Dec/Jan) This will be extended to Corporate teams in Jan/Feb 2024

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December Rating	Target Rating	Target Date
CRR75: CHS2 Health and Safety	**An Environment that promotes wellbeing**	**CHS2**: HDH Goods yard 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)	16	12	12	8	April 24

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. Review of storage of bikes in hospital buildings has been completed 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 waste segregating and disposal Updates following meeting with waste AE: a new waste management group is to be established to assist the process Backlog Maintenance consultation and introduction as packages of work

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December 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	March 24

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. Chubb have now taken over maintenance and replacement of fire-fighting equipment to address previous failure to ensure 12 month checks are completed.	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 separate 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 Meeting with Operations Directors to add clinical risk priority to Backlog Maintenance paper Recommendations of the Fire Authority being actioned Meetings to be held with clinical teams to progress the creation of suitable evacuation plans

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December 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	Sept 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 • Ligature assessment and training scheduled	• 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 continued 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 • Phase 2 work for Task and Finish group has started – looking at the management of patients with dementia/delirium • Business case for resource to increase Conflict Resolution – Breakaway Skills training

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December 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	16	16	8	March 24

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 scaffold 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 performance in the coming months.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	December 2023						

Corporate Risk ID	**Strategic Ambition**	Principle Risk:	**Initial Rating**	**November Rating**	**December 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	12	12	8	March 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 13.16% at the end of October. The Trust has seen a decreasing trend since October 2022. (This incorporates voluntary and involuntary turnover). Sickness - Target 3.9% - Sickness has seen a small decrease in November, from 5.34% to 5.03%. • Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to under a third of the overall sickness. The sickness rate due to this reason has decreased from 1.57% last month to 1.47% in November. Appraisals - Target 90%. The appraisal rate in November is 83.44%, which is a small increase of 2.31% compared to the previous month. Vacancy Rate (Target 7%) The Trust's vacancy rate in November is 4.85%, which is a decrease compared to last month, which was 5.85%. Mandatory training – The overall compliance rate for substantive staff in November is 90%, which is an increase from 89% last month and is now compliant against the target,	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 three Corporate Risks within this Domain. Autism Assessment (CRR34), this was reduced to 12 in August but increased to 15 in December 23. 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.				
Initial Date of Assessment	1st July 2022						
Last Reviewed	December 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**November Rating**	**December 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. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	12	12	15	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 Activity ■ To meet the monthly ICB target for number of assessments ■ Meet the annual planned target for assessments	We have modelled the impact of the funded Waiting List Initiative (WLI) for 2023/24 and it will only slow the growth of the waiting list. The projected wait for assessment by end August 24 is now 43 months; this has increased due to the 6 month average monthly referral rate of 86 and the higher current waiting list numbers. Mobilisation of WLI and newly agreed pathway changes 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: 1375 (target 120) • Longest wait: 71 weeks (target 13) • Activity - 57 completed assessments in Nov against ICB plan of 50, YTD 355 against plan of 350. (9 additional assessments for military completed YTD – funded separately).	The 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	November Rating	December 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

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23 (prov)
Total incomplete RTT pathways	25,951	25,876	25,860	25,831	25,802	23,093	22,799	*22,869*	*23,254*
> 52 weeks	998	1,001	1,020	1,033	1,124	673	640	*663*	*613*
> 65 weeks	202	197	210	208	259	154	145	*154*	*141*
> 78 weeks	5	0	0	1	4	2	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.

Clinical prioritisation and reviews continue for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded.

RTT waiting list has remained stable for this calendar year.

104+ week waiters

HDFT currently have no 104 week patient waits

78 week waiters (clearance target March 2023)

Zero position achieved by end of March 23. A number of patients remain over 78 weeks who have chosen to do so – they have dates for treatment compatible with their choice.

65 week waiters (clearance March 2024)
We currently have:
- o 116 patients over 65 weeks on the PTL
- o 59 patients over 65 weeks are awaiting a TCI (1 Gen Surg, 4 Urology, 44 T&O, 2 Max Fax and 8 Gynae)

Longest waiters without a TCI date are at 72 weeks
Gynae trajectory has improved however does still sit just over target level, therefore they continue to remain at risk of not eliminating 65 week waits by March 2024.

Controls and Plans to implemented

Additional theatre lists at a weekend

Trade union action has impacted recovery with YTD loss of 1000 outpatient contacts, 6 I/P and 100 Day case patients.
Clinicians continue to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery, Ophthalmology and Urology.

Awaiting confirmation from commissioners around funding of waiting list initiative into next financial year for Community Dentistry

Additional capacity will become available for treating patients through the Wharf dale theatres (TIF1 Scheme) - however the timelines for this opening have slipped into 23-24.

The independent sector support is continuing with circa 500 cases being delivered in this way.

None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, having patients waiting this long. Recovery plans in gastroenterology are in place and a significant improvement in booking has occurred.

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 out coming has now been ordered with implementation across Q3 of 2023- this project has now commenced

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	November Rating	December 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	16	8	March 23

Key Targets

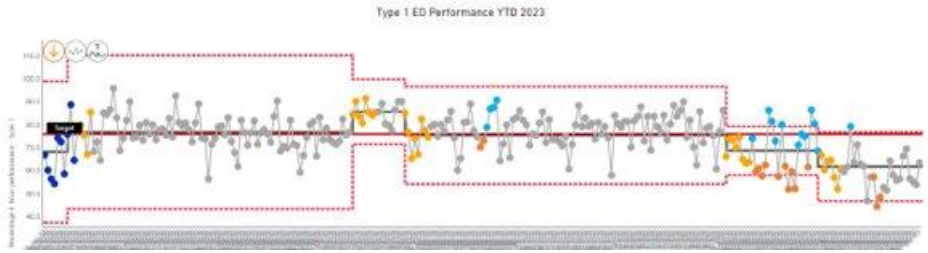
A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches

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. This has continued into October and November as bed occupancy has increased. Year to date performance is currently 76%

	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	Oct
Type 1 & 3	72%	71%	67%	64%	68%	66%	63%	72%	81%	78%	83%	81%	80%	82%	73%	65%	70%



In October 2023 there were 1,273 patients who spent longer than 6 hours in the department.

12 hour waits

	12 Hour DTA	12 Hour total wait
July 23	0	33
August 23	0	65
September 23	1	119
Oct 23	14	167

Ambulance handover breaches
There had 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
Oct 23	34	11

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

	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 2 Corporate Risks are link to this domain. Agency Usage (CRR71) has been reviewed, the risk relates to not meeting the ICB target for agency spend. We are aiming to reduce the spend to meet the target over the FY. If the plans suggested are implemented the spend will reduce, however if the spend is not reduced the possibility of between 100k-1m of overspend on agency is likely. The reduction in score is not to reflect the reduction in risk; it is reflecting the refinement of the risk with further context. 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	December 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**November Rating**	**December Rating**	**Target Rating**	**Target Date**
CRR 71: Agency Usage	**Overarching**	Agency Usage - If the trust continues to incur premium costs for staffing where vacancies exist, there is a risk it will exceed the agency price cap for the financial year the consequences for this will be breach of regulations, and a negative impact on the overall financial position.	15	12	12	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	ICB Target 657k Trust Target 468k Required to meet ICB target 536k Average of actual spend 743k 1. The Trust has spent less than the Trust target (£468k per month). – Month 8 spend in month was, £544k. This is an improvement from month 7, which was £670k. 2. The Trust is currently spending in excess of the 2019/20 pro-rata agency spend – YTD £5.7m against 2019/20 £3.7m pro rated 3. The Trust is now reporting performance to NHSE on a monthly basis. The Trust will not be able to deliver the 19/20 rate of expenditure plan, however with continued focus on reducing agency spend for the remainder of the year the trust will be able to deliver the ICB ceiling target.	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**	**November Rating**	**December Rating**	**Target Rating**	**Target Date**
CRR 76: Underlying Financial Position	**Overarching**	If the current in year performance continues as is, the trust will continue to increase its YTD deficit and therefore not reach its projected breakeven position. Over the longer term, this will result in the overall financial position of the trust being effected, which will affect the financial standing of the trust.	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 4. Cash position	The Trust remains dependant on non-recurrent funding to achieve a breakeven position. Pressures relate to non-recurrent funding sources supporting the operational position of the Trust, the impacts of capital charges following an increased capital programme, and the impact of inflation on non-pay. Inflation is affecting many areas, there is also an underlying issue with drug expenditure. In year performance in 2023/24 is currently not at the levels anticipated, and therefore the risk scoring below remains at 15. Pressures in year related to – • Performance against the efficiency requirement for the Trust • Use of temporary, premium rate staffing • Inflation above the levels outlined above and within planning • Strike costs • Drug expenditure, again above the levels described above. 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. **Currently reporting a deficit position of £3.9m.** 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%. See agency risk Whilst cash remains positive, the deficit position is having an impact. **Cash has reduced by £22m since March 23.** The Trust is still expected to deliver the planned surplus, 6m however based on current run rate it without any recovery plans it would result in £6m deficit.	1. Continued discussions with ICB regarding underlying position – NHSE submission expected late summer 2. Recovery plans at directorate level – see appendix

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	November 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**November Rating**	**December Rating**	**Target Rating**	**Target Date**
CRR87 **Community Dental**	Provide person centred, integrated services through string partnerships	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 patients waiting to start treatment over 52weeks, 65weeks and 78weeks. Current position for RTT waiters – 0 patients over 78 weeks, 2 patients between 65-77 weeks, 9 patients between 52-64 weeks. Current position for Non RTT waiters — 14 patients over 78 weeks, 123 patients between 65-77 weeks, 357 patients between 52-64 weeks. • No of overdue continuing care patients. Current position – 2697 patients overdue. Longest waiters 4 years overdue (due in Oct 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. In the interim, we have moved across patients from RTT pathways to non-RTT pathways in line with acute specialities i.e. only those on consultant caseload or requiring consultant-led care on an intubated GA list will remain on an RTT pathway. This will not resolve waiting times but will support our reporting being in line with other CDS providers. 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.

	The latest communication, from the Dental Contract Manager in the ICB, states that the ICB's Finance Director has asked for further information regarding all CDS contracts for 2023/24 and 2024/25, so that he can map out and make a decision around funding. In the meantime the service continues to receive concerns from patients about the waiting times. To help mitigate this risk we need to re-review the previous proposal to stop accepting routine new patient referrals. We would still accept urgent referrals during this time, but it would allow us to focus on our current backlog challenge. This decision could then be reviewed if/when an agreement is made about the 18 month service provision.	

Harrogate and District NHS Foundation Trust Corporate Risk Register Dec 2023

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**

HDFT Trust IBR – static view for January 2024

Live view:

INTEGRATED BOARD REPORT - Power BI

INTEGRATED BOARD REPORT

Filter by keyword | Compact view (preview) | + New

✓ Metrics 75 | SPC Breach- Action re... 3 | Within business rules-... 67 | Not started 5

Name	Assigned to	Status	Progress	Trend	Due	Target	Change
1.4 Infection control - Hospital acquired C.difficile cases, lapse in care identified SAFE	AE	SPC Breach- Action ...	5.00/0.00		18/11/24	0.00	↑ 3.00 MoM
1.8.2 Safer staffing levels - CHPPD SAFE		Not started	8.20		18/11/24		↑ 1.23% MoM
5.11 Cancer - 28 days faster diagnosis standard (suspected cancer referrals) RESPONSIVE		SPC Breach- Action ...	66.54%/75%		18/11/24	75%	↑ 6.86% MoM
5.14 Children's Services - Safeguarding caseload RESPONSIVE		Not started	1.04K		18/11/24		↓ 23.83% MoM
5.2.2 RTT waiting times - by level of deprivation- differential median wait in weeks (negative gap refle...		SPC Breach- Action ...	3.00		18/11/23		↑ 146.99% YoY
6.2 Surplus/ Deficit and variance to plan EFFICIENCY & FINANCE	MJ SK	Not started	£ 235.00		18/11/24		↑ 107.58% MoM
6.3 Capital spend EFFICIENCY & FINANCE	MJ SK	Not started	£9.15K		18/11/24		↑ 4.94% MoM
6.4 Cash balance EFFICIENCY & FINANCE	SK MJ	Not started	12M		18/11/24		↓ 17.22% MoM

1.1 Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days SAFE	Q1		Within business rule...	0.97/0.00		18/11/24	0.00	↑ 0.09 MoM
1.11 Infant health - % women smoking at time of delivery SAFE	Q1	+2	Within business rule...	1.49%/0%		18/11/24	0%	↓ -1.45% MoM
1.12 Infant health - % women initiating breastfeeding SAFE	Q1	+2	Within business rule...	91.1%/95%		18/11/24	95%	↓ -2.2% MoM
1.13 VTE risk assessment - inpatients SAFE	Q2		Within business rule...	87.79%/100.00%		18/11/24	100.00%	↑ 0% weekly change
1.14.1 Sepsis screening - inpatient wards SAFE	Q1		Within business rule...	96.21%/90%		18/11/24	90%	↓ 0.95% MoM
1.14.2 Sepsis screening - Emergency department SAFE	Q1		Within business rule...	91.9%/90%		18/11/24	90%	↑ 0.23% MoM
1.2 Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts SAFE	Q1	+2	Within business rule...	0.65/0.00		18/11/24	0.00	↓ -0.15 WoW
1.3 Inpatient falls per 1,000 bed days SAFE	Q3		Within business rule...	8.59/5.00		18/11/24	5.00	↑ 2.37 MoM
1.5 Infection control - Hospital acquired MRSA cases, lapse in care identified SAFE	Q2		Within business rule...	0.00/0.00		18/11/24	0.00	↑ 0.00 MoM
1.6 Incidents - ratio of low harm incidents SAFE	Q1		Within business rule...	47.88/75.00		18/11/24	75.00	↑ 0.00 monthly
1.7.1 Incidents - comprehensive serious incidents (SI) SAFE	Q1		Within business rule...	0/0		18/11/24	0	↓ -1 MoM
1.7.2 Incidents - Never events SAFE			Within business rule...	0/0		18/11/24	0	↑ 0 MoM
1.8.1 Safer staffing levels - fill rate SAFE	Q2		Within business rule...	95.80 %/98.00 %		18/11/23	98.00 %	↑ 0.18 % MoM
1.9 Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d SAFE	Q1		Within business rule...	96.6%/95%		18/11/24	95%	↑ 4.7% MoM

2.1.1Friends & Family Test (FFT) - All Patients CARING	Within business rule...	92.12%/90%		18/11/23	90%	↑ 0.21% MoM
2.1.2 Friends & Family Test (FFT) - Adult Community Services CARING	Within business rule...	91.67%/90%		18/11/24	90%	↑ 0.95% MoM
2.2.1 Complaints - numbers received CARING	Within business rule...	20.00		18/11/23		↑ 17.65% MoM
2.2.2 Complaints - % responded to within time CARING	Within business rule...	88%/95%		18/11/24	95%	↓ 12% MoM
3.2 Mortality - SHMI EFFECTIVE	Within business rule...	0.992/1.000		18/11/24	1.000	↓ 1.34% MoM
3.3.1 Readmissions to the same specialty within 30 days - following elective admission - as % of all ele...	Within business rule...	2.32%/100%		18/11/24	100%	↓ 31.72% YoY
3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission - as % of ...	Within business rule...	9.92%/6%		18/11/24	6%	↑ 20.94% YoY
3.4 Returns to theatre EFFECTIVE	Within business rule...	6.00/0.00		18/11/24	0.00	↓ 25% YoY
3.5 Delayed Transfer of Care - % inpatients not meeting the criteria to reside EFFECTIVE	Within business rule...	0.44/0.20		18/11/24	0.20	↓ 6.39% MoM
4.1 Appraisal rate - Non Medical and Medical Staff WORKFORCE	Within business rule...	87.1%/90.0%		18/11/24	90.0%	↑ 32.88% MoM
4.2 Mandatory and Essential Skills Training rate WORKFORCE	Within business rule...	88.68%/90.00%		18/11/24	90.00%	↑ 1.40% WoW
4.3 Staff sickness rate WORKFORCE	Within business rule...	5.77%/3.90%		18/11/24	3.90%	↑ 11.79% MoM
4.4 Staff turnover rate WORKFORCE	Within business rule...	14.41%/12.00%		18/11/24	12.00%	↑ 0.25% MoM
4.5 Vacancies WORKFORCE	Within business rule...	8.79%/7.00%		18/11/24	7.00%	↑ 7.68% MoM

5.1.1 RTT Incomplete pathways performance - median weeks wait RESPONSIVE		Within business rule...	13/8		18/11/24	8	↑ 18.18% YoY
5.1.2 RTT Incomplete pathways performance - 92nd centile RESPONSIVE		Within business rule...	40.00/18.00		18/11/24	18.00	↑ 5.26% YoY
5.1.3 RTT Incomplete pathways - total RESPONSIVE		Within business rule...	24.03K/14.00K		18/11/24	14.00K	↑ 6.55% YoY
5.1.4 RTT Incomplete pathways - 52-<104 weeks RESPONSIVE		Within business rule...	605/0		18/11/24	0	↑ 1% YoY
5.1.5 RTT Incomplete pathways - 104+ weeks RESPONSIVE		Within business rule...	0.00/0.00		18/11/23	0.00	↑ 0% MoM
5.10 Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals RE...		Within business rule...	0.77/0.93		18/11/24	0.93	↑ 1.27% MoM
5.12 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers RESPONSIVE		Within business rule...	97.75%/96%		18/11/24	96%	↑ 2% MoM
5.13.1 Children's Services - 0-12 months caseload RESPONSIVE	-2	Within business rule...	2.12K		18/11/24		↑ 0.09% MoM
5.13.2 Children's Services - 2-3 years caseload RESPONSIVE	-2	Within business rule...	2.20K		18/11/24		↑ 7.32% MoM
5.15 Children's Services - Ante-natal visits RESPONSIVE		Within business rule...	91.77%/90%		18/11/24	90%	↓ 0.49% MoM
5.16 Children's Services - 10-14 day new birth visit RESPONSIVE		Within business rule...	88.82%/90%		18/11/24	90%	↑ 0.13% MoM
5.17 Children's Services - 6-8 week visit RESPONSIVE		Within business rule...	90.72%/90%		18/11/24	90%	↓ 0.28% MoM
5.18 Children's Services - 12 month review RESPONSIVE		Within business rule...	96.78%/90%		18/11/24	90%	↑ 1.35% MoM
5.19 Children's Services - 2.5 year review RESPONSIVE		Within business rule...	91.07%/90%		18/11/24	90%	↑ 2.28% MoM
5.2.1 RTT waiting times - by ethnicity(gap between BME & White (positive is shorter wait for BME) RE...		Within business rule...	4.91		18/11/23		↑ 6.21% MoM
5.2.3 RTT waiting times - learning disabilities differential in median weeks wait (gap between those w...		Within business rule...	2.00		18/11/23		↓ 81.95% YoY
5.23 Community Care Adult Teams - performance against new timeliness standardsRESPONSIVE		Within business rule...	88%/70%		18/11/24	70%	↓ 6.73% MoM
5.27 Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritis...		Within business rule...	22%/95%		18/11/24	95%	↓ 25.42% MoM
5.28 Home visit: Face to face consultations started for URGENT cases within 2 hrs RESPONSIVE		Within business rule...	84.9%/95%		18/11/24	95%	↓ 4.18% MoM

5.3 Diagnostic waiting times - 6-week standard RESPONSIVE			Within business rule...	67.38%/99%		18/11/24	99%	↑ 1.59% MoM
5.5 Data quality on ethnic group - inpatients RESPONSIVE			Within business rule...	0.92/0.99		18/11/24	0.99	↑ 1.06% MoM
5.6 A&E 4 hour standard RESPONSIVE			Within business rule...	76.486/0.810		18/11/24	0.810	↑ 2.051 MoM
5.7 Ambulance handovers - % within 15 mins RESPONSIVE			Within business rule...	100%/95%		18/11/24	95%	↑ 4.70% WoW
5.8 A&E - number of 12 hour trolley waits RESPONSIVE			Within business rule...			13/01/24		
5.9.1 Cancer - 62 day wait for first treatment from urgent GP referral to treatment RESPONSIVE			Within business rule...	58/1		18/11/24	1	↓ 9.38% DoD
6.1 Agency spend EFFICIENCY & FINANCE			Within business rule...	£503.00/£500.00		18/11/24	£500.00	↓ 7.54% MoM
6.10 Day case conversion rate EFFICIENCY & FINANCE			Within business rule...	1.21%/1.5%		18/11/24	1.5%	↓ 34.70% MoM
6.5.1 Long stay patients - stranded (>7 days LOS) EFFICIENCY & FINANCE			Within business rule...	/65.00		18/11/24	65.00	
6.5.2 Long stay patients - superstranded (>21 days LOS) EFFICIENCY & FINANCE			Within business rule...	138.00/95.00		18/11/24	95.00	↑ 3.76% MoM
6.6 Occupied bed days per 1,000 population EFFICIENCY & FINANCE			Within business rule...	59.29/60.00		18/11/24	60.00	↑ 1.62% MoM
6.7.1 Length of stay - elective EFFICIENCY & FINANCE			Within business rule...	2.43/2.50		18/11/24	2.50	↑ 0.83% MoM
6.7.2 Length of stay - non-elective EFFICIENCY & FINANCE			Within business rule...	4.49/4.00		18/11/24	4.00	↑ 3.21% MoM
6.8 Avoidable admissions EFFICIENCY & FINANCE			Within business rule...	201.00/270.00		18/11/24	270.00	↓ 16.25% MoM
6.9 Theatre utilisation (elective sessions) EFFICIENCYN& FINANCE			Within business rule...	80.8%/90%		18/11/24	90%	↓ 1.82% MoM
7.1 GP Referrals against 2019/20 baseline ACTIVITY			Within business rule...	108.65%/95%		18/11/24	95%	↓ 10.71% MoM
7.2Outpatient activity (consultant led) against plan (new and follow up) ACTIVITY			Within business rule...	1.28/1.00		18/11/24	1.00	↑ 8.88% MoM
7.3 Elective activity against plan			Within business rule...	0.92/1.00		18/11/24	1.00	↑ 6.68% MoM
7.4 Non-elective activity against plan ACTIVITY			Within business rule...	114.12%/100%		18/11/24	100%	↑ 1.67% MoM
7.5 Emergency Department attendances against plan			Within business rule...	1.06/1.00		18/11/24	1.00	↓ 0.63% MoM

Harrogate and District NHS Foundation Trust

3

Board Meeting Held in Public
January 31st 2024

Title:	Learning from Deaths Quarterly Report 3: Oct-Dec 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.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
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

31 January 2024

Learning from Deaths Quarterly Report 3

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.

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

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

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, 189 deaths were recorded in Q3, up from 168 in the preceding Q2 but down from Q2 in 22/23 which had 225 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.

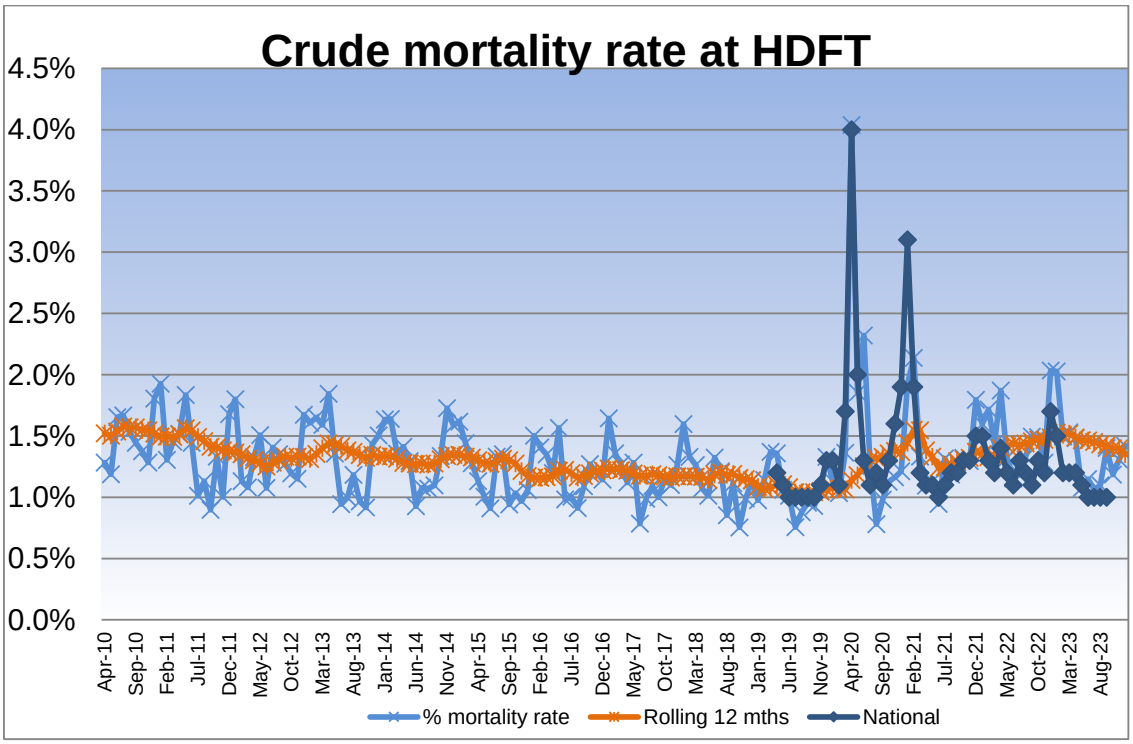


Figure 1: Crude mortality rates over the last 13 years (%deaths per qualifying episode)

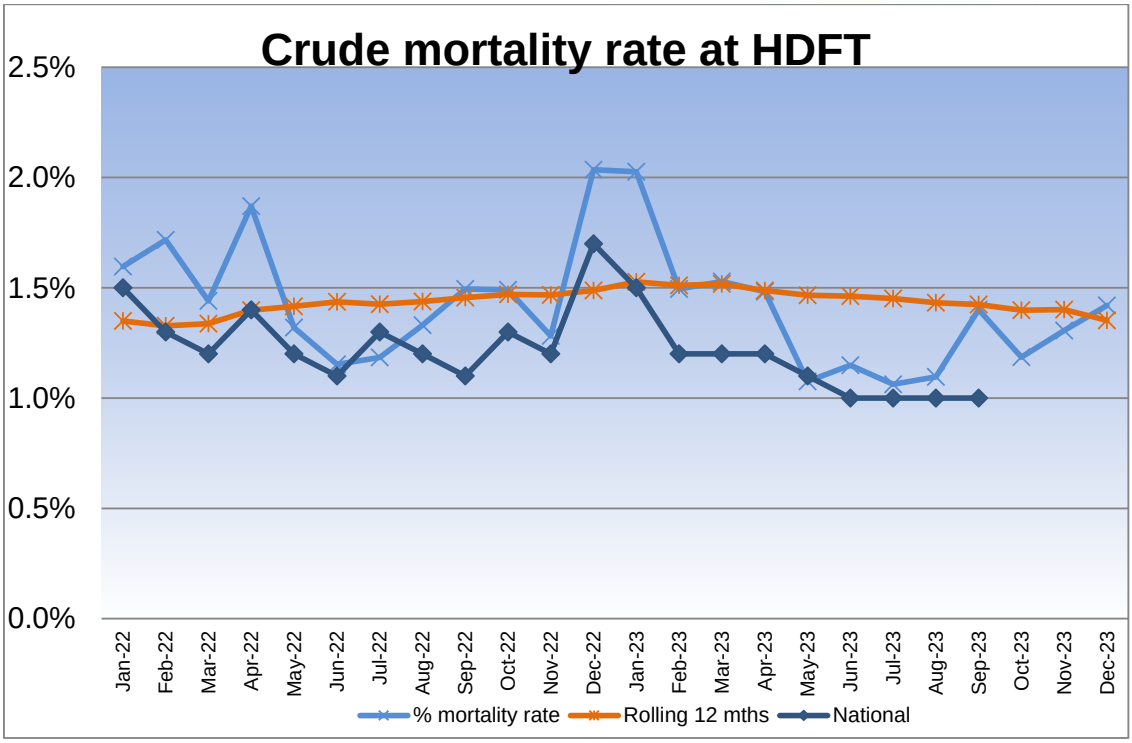


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

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.

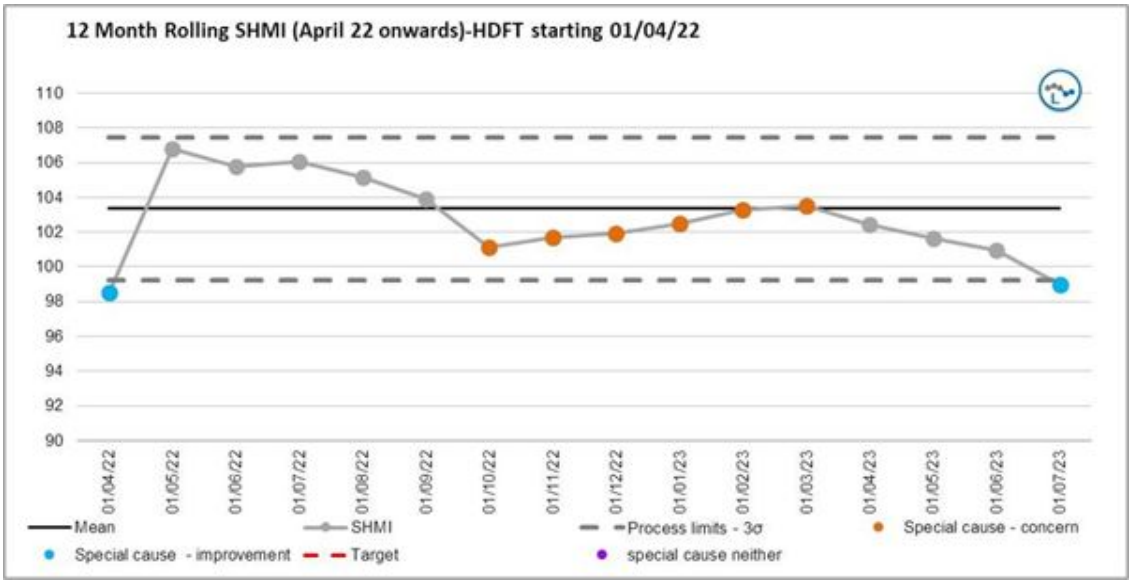


Figure 3: HDFT SHMI since April 2020

Harrogate and District NHS Foundation Trust

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 levelled off around March 2023 and have since slowly declined.

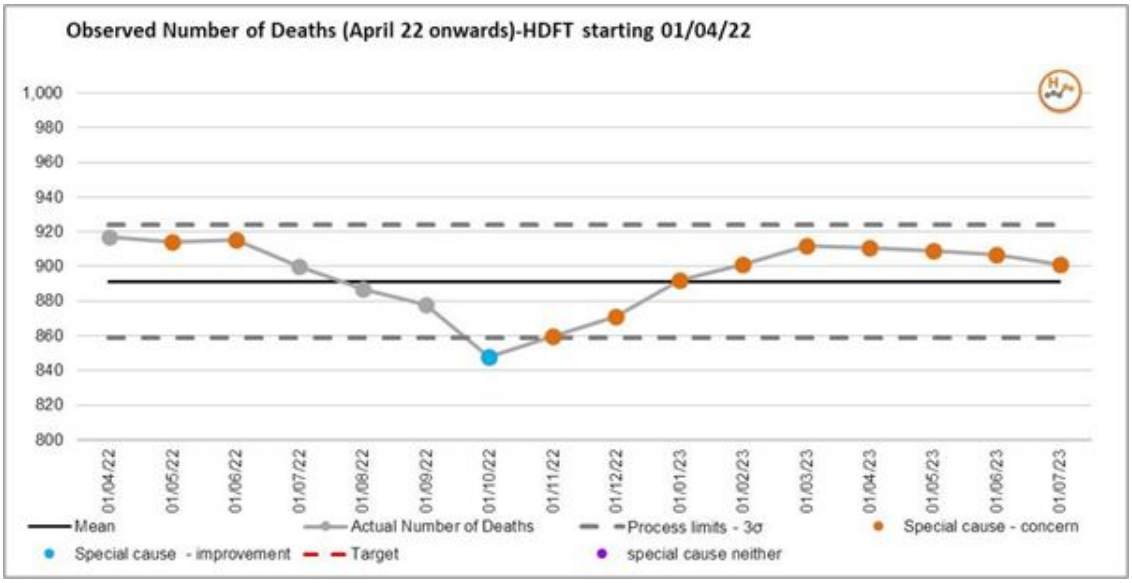


Figure 4: Observed deaths included into SHMI

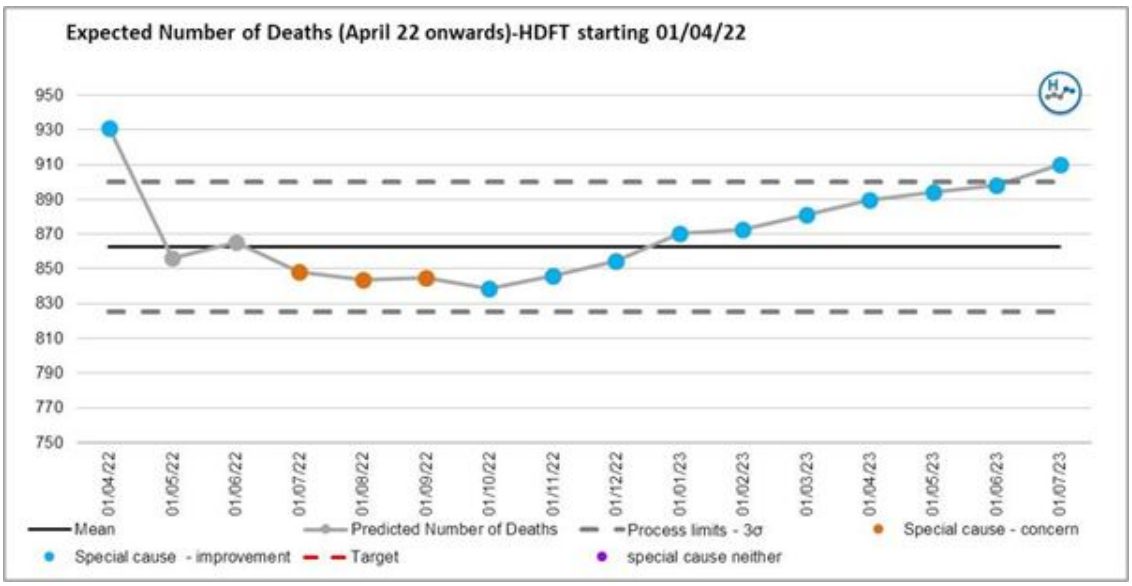


Figure 5: Expected deaths as predicted by SHMI. Note this has still not returned to pre-Covid levels

Harrogate and District NHS Foundation Trust

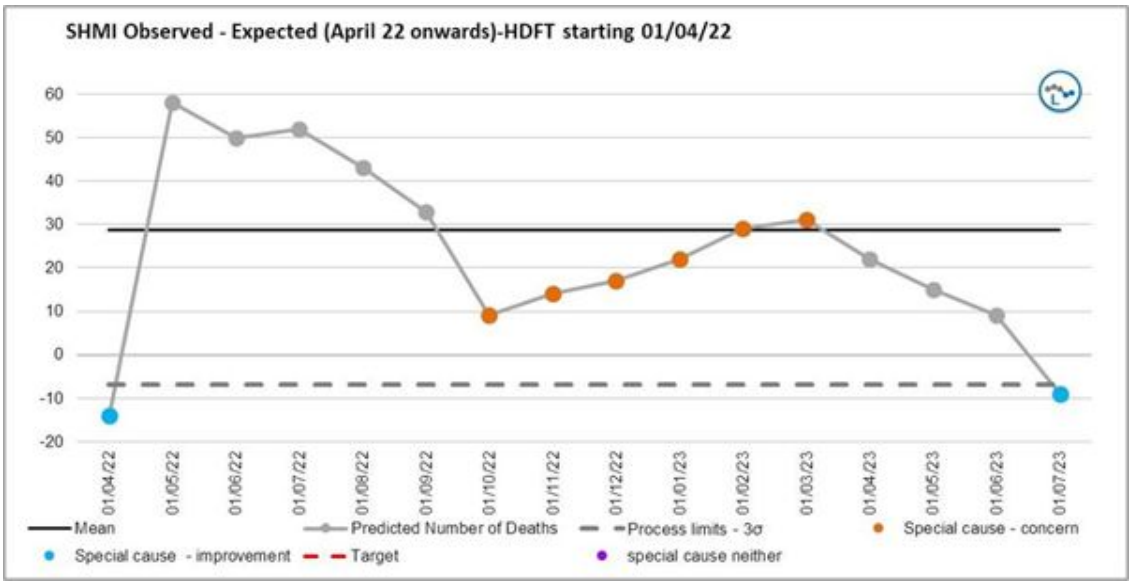


Figure 6: Observed-Expected Deaths, as predicted by SHMI

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

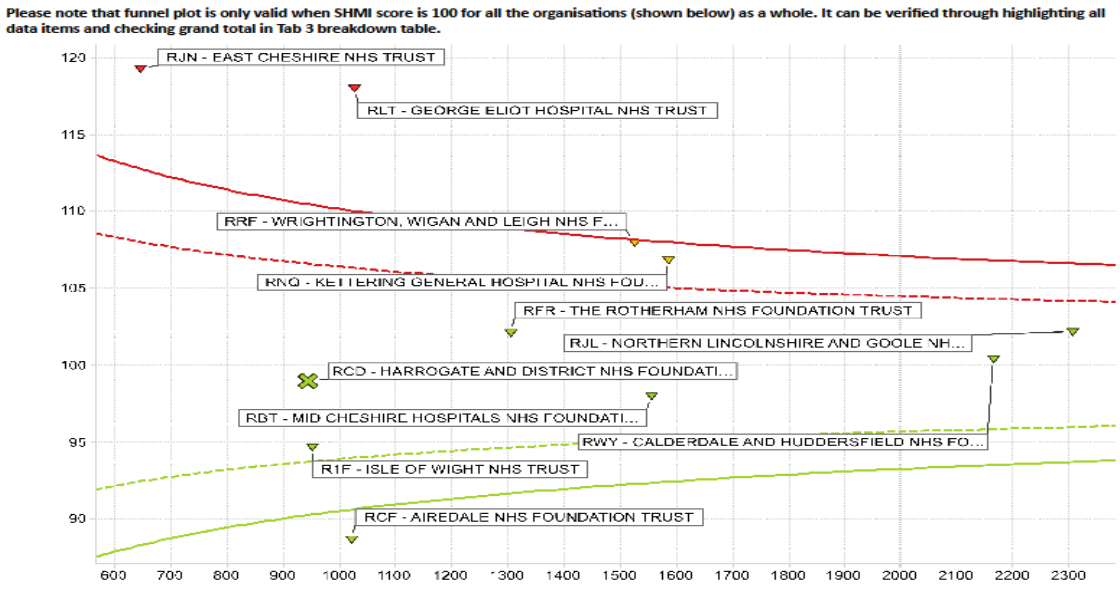


Figure 7: SHMI data for national peer organisations

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

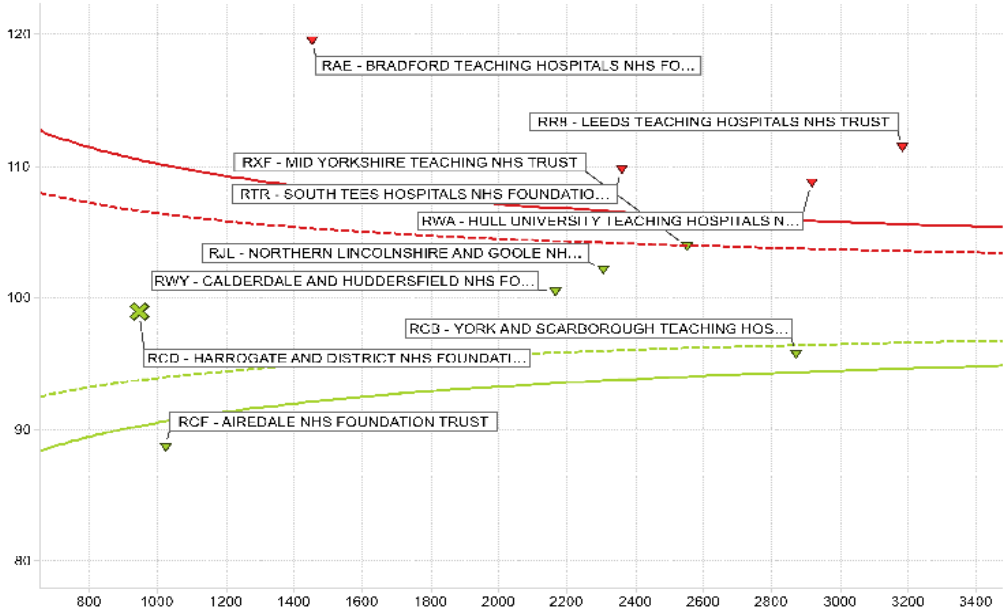


Figure 8: SHMI monthly data for regional peer organisations

Harrogate and District NHS Foundation Trust

3.3 Structured judgement reviews (SJR)

20 cases have been reviewed in this quarter with 4 relating to deaths in this quarter, 4 from Q2 and the remainder preceding that.

In this quarter's report I have added the reason why each case was selected for review. "Specialty Choice" means that the clinical team have selected a case for their own internal review processes. The overall assessment of standard of care of all cases is shown in Table 1:

Case ID	Admission Date	Learning Disability(LD) or Severe Mental health (MH)	Reason for SJR	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	Jul 23	No	Elective Surg, ME request	5/4	2/3	3/4	3/4	3/4
2	Sep 22	No	Stroke	5	4	4	4	4
3	May 23	No	Stroke	4	5	5	4	5
4	Oct 23	No	Datix, 48hr review and ME	3	N/A	4	3	4
5	Aug 23	No	Datix,SI	3	4	4	4	4
6	Aug 23	LD	LD	3	3	4	3	5
7	Apr 23	No	Specialty Choice	4	5	5	4	5
8	Nov 23	LD	LD	4	4	4	4	4
9	Sep 22	No	Stroke	3	4	4	4	4
10	Oct 23	No	Specialty Choice	4	3	2	3	3
11	Nov 22	No	Stroke	4	4	5	4	4
12	Apr 23	No	Stroke	4	4	4	4	4

13	Sept 23	No	Specialty Choice	4	N/A	4	4	4
14	Mar 23	No	Stroke	5	5	5	5	5
15	Jun 23	No	Stroke	4	4	4	4	3
16	Apr 23	No	Stroke	4	4	4	4	4
17	Oct 22	No	Specialty Choice	3	3	3	3	3
18	Jan 23	MH	MH, Specialty Choice	5	4	5	4	4
19	May 23	No	Stroke	4	5	5	4	4
20	Oct 23	LD	LD	5	5	5	5	5
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.

In case number 1, the initial reviewer scored the ongoing care as a 2 (poor care). This triggered a review by a second consultant who scored the ongoing care as 3 (adequate). The case has been discussed at the specialty team's Morbidity and Mortality meeting for reflection.

3 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 not received any such feedback since the Q2 report.

Nine cases reviewed this quarter were selected following a statistical mortality alert in the diagnostic category of "Acute cerebrovascular disease". The specific cases chosen for review were selected on the basis of having the lowest predicted mortality I,e, those which the model predicted had a higher likelihood of surviving their illness. No lapses in care were found. 7 of the 9 cases had significant intracranial bleeding which has a very poor prognosis, suggesting issues with either coding or the model itself rather than the quality of care delivered. The 2 cerebral infarcts were both admitted with low conscious levels (one repatriated from the hyper-acute regional stroke centre), and both were appropriately received end of life care soon after arrival.

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

The trust continues towards 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.

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.

New legislation has been announced which will significantly alter the roles of the Medical Examiner, Coroner and Registrar from April 2024. National dissemination of how this will work in practice is continuing, and communications will be sent to HDFT staff and GP practices once our new operating procedures are finalised. From the start date, no death in England can be registered without either Medical Examiner or Coronial scrutiny. The changes will also replace existing documents required for cremation, which should reduce unnecessary delays for the bereaved.

Prior to the statutory implementation, the Harrogate office has joined a regional pilot to provide access to a Medical Examiner 365 days of the year. This is to ensure that the new system does not introduce new delays into the prompt release of the deceased when requested for faith reasons. The funding for the pilot is fully reimbursed from the national team (in line with all Medical Examiner Office expenses).

5.0 Recommendation

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

Harrogate and District NHS Foundation Trust

4

Strengthening Maternity and Neonatal Safety Report

SMT

December 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 December 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 December 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

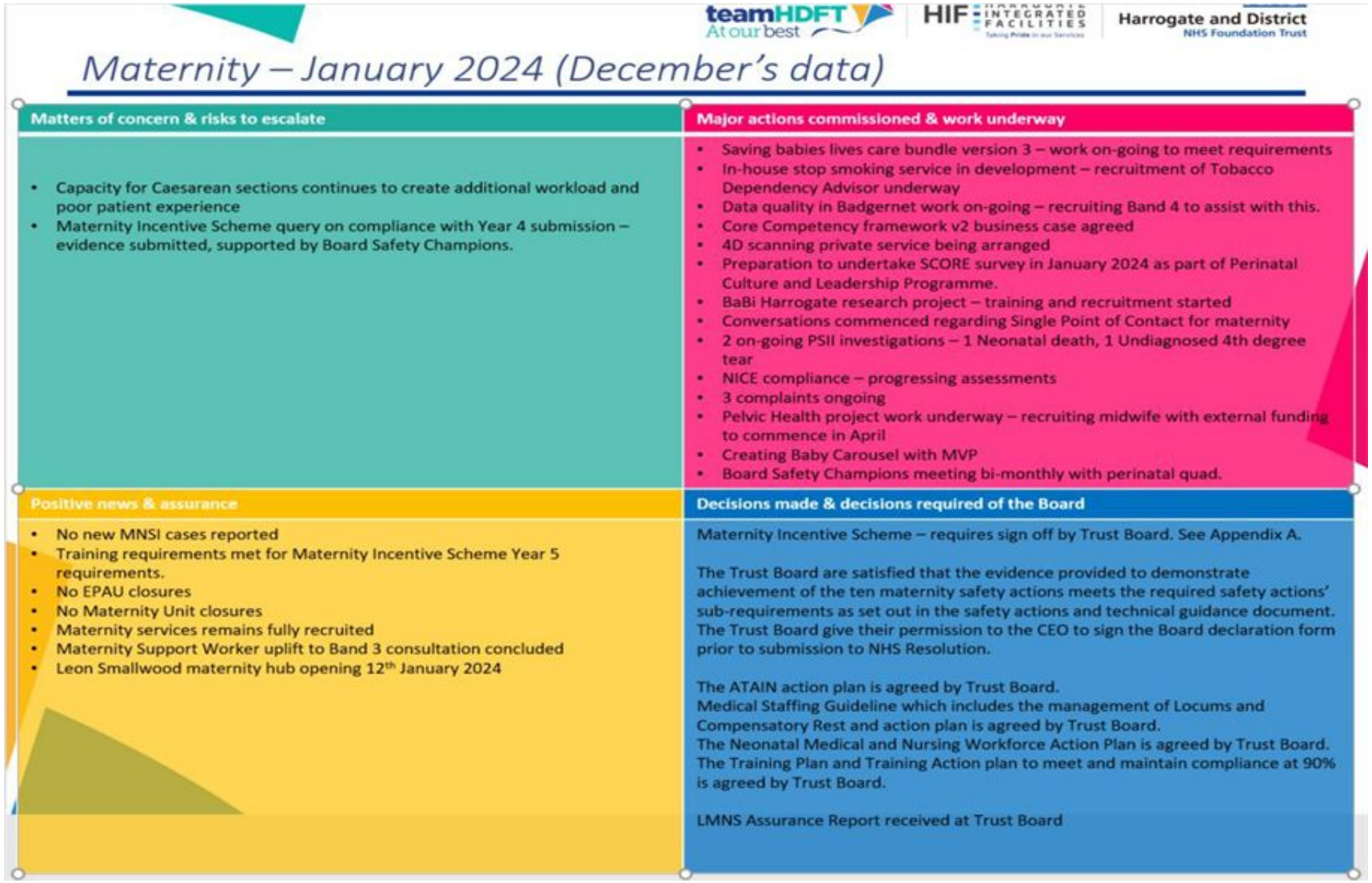
4.1 Not applicable

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.



Maternity – January 2024 (December's data)

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Capacity for Caesarean sections continues to create additional workload and poor patient experience • Maternity Incentive Scheme query on compliance with Year 4 submission – evidence submitted, supported by Board Safety Champions.	• Saving babies lives care bundle version 3 – work on-going to meet requirements • In-house stop smoking service in development – recruitment of Tobacco Dependency Advisor underway • Data quality in Badgernet work on-going – recruiting Band 4 to assist with this. • Core Competency framework v2 business case agreed • 4D scanning private service being arranged • Preparation to undertake SCORE survey in January 2024 as part of Perinatal Culture and Leadership Programme. • BaBi Harrogate research project – training and recruitment started • Conversations commenced regarding Single Point of Contact for maternity • 2 on-going PSII investigations – 1 Neonatal death, 1 Undiagnosed 4th degree tear • NICE compliance – progressing assessments • 3 complaints ongoing • Pelvic Health project work underway – recruiting midwife with external funding to commence in April • Creating Baby Carousel with MVP • Board Safety Champions meeting bi-monthly with perinatal quad.
Positive news & assurance	**Decisions made & decisions required of the Board**
• No new MNSI cases reported • Training requirements met for Maternity Incentive Scheme Year 5 requirements. • No EPAU closures • No Maternity Unit closures • Maternity services remains fully recruited • Maternity Support Worker uplift to Band 3 consultation concluded • Leon Smallwood maternity hub opening 12th January 2024	Maternity Incentive Scheme – requires sign off by Trust Board. See Appendix A. The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document. The Trust Board give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The ATAIN action plan is agreed by Trust Board. Medical Staffing Guideline which includes the management of Locums and Compensatory Rest and action plan is agreed by Trust Board. The Neonatal Medical and Nursing Workforce Action Plan is agreed by Trust Board. The Training Plan and Training Action plan to meet and maintain compliance at 90% is agreed by Trust Board. LMNS Assurance Report received at Trust Board

Narrative in support of the Provider Board Level Measures – December 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 December 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 –
3.58 WTE sickness absence (no theme identified). Increase noted since previous month.
2.66 WTE maternity leave

Unavailability of Maternity support worker hours –
0.84 WTE sickness absence

3.2 Vacancy position

Currently there is zero midwifery and maternity support work vacancy.

3.3 International Midwifery Recruitment

Both internationally recruited midwives have started working with the Trust. Both midwives have received their NMC PIN number and are working supernumerary.

3.4 NHSP provision

Midwives -
2.5 WTE NHSP midwifery staffing used in December 2023.

Support workers –
3.9 WTE NHSP maternity support worker staffing has been used across maternity in December 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.

Three homebirths were booked for the month of December 2023. One women was attended at home, two women were still pregnant at the end of the month.

In the period 1/12/23 – 31/12/23, the home birth provision was not suspended. On seven 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.
1.38 WTE nurse long term sickness absence

4.2 Neonatal Vacancy

No neonatal vacancy at present.

4.3 Neonatal Recruitment

1 WTE QIS recruited but not yet in post
Two 0.92 WTE QIS nurses left in November / December 2023

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.

November QIS compliance was 77.1%.

5.0 Birthrate Plus Acuity Staffing Data

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

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

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

5.1 Delivery Suite Staffing

There were 186 scheduled assessment periods, of these 176 were completed. Staffing met the acuity 67% of the time.

91% (160 occasions) of the time no clinical actions were required. 9% (16) of the occasions clinical actions were required, these included:
· Delay in continuing induction of labour 13 occasions
· Delay in commencing induction of labour 2 occasions (Inpatient)
· Postponed induction of labour (at home) 2 occasions
· Delivery Suite Coordinator not supernumerary 1 occasion

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. Three women had a baby born before the arrival of a midwife.

5.2 Pannal Ward Staffing

During December 95% of Midwifery day shifts and 98% of night shifts were covered with contracted hours. 5% of Midwifery day shifts and 2% night shifts were covered with NHSP. MSW day shifts were covered 98% with contracted hours and 2% with NHSP. MSW night shifts were covered 71% with contracted hours and 29% with NHSP.

Birthrate plus Acuity Ward Tool remained under review during December, resulting in unavailability for data entry. However there was one Datix report submitted relating to staffing levels on two night shifts, resulting in clinical actions being taken and red flags raised in the delaying of induction of labour on two occasions. The Ward Acuity App was reintroduced on the 31st December – which will enable data entry throughout January 2024 and analysis within the January staffing report.

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 due to a delay between admission for induction and beginning of process was identified from the Birthrate Plus data during December.

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 01/12/2023 to 31/12/2023

MA1	Redeploy staff from Pannal	**9**	**38%**
MA2	Staff unable to take breaks	**3**	**13%**
MA3	Review of staff on management time	**2**	**8%**
MA4	Use of specialist midwife	**2**	**8%**
MA5	Use of staff on training days	**0**	**0%**
MA6	Use of ward/department managers	**1**	**4%**
MA7	Staff sourced from wider Trust (theatre & CSW's)	**1**	**4%**
MA8	Use of hospital MW on call	**4**	**17%**
MA9	Use of community MW	**0**	**0%**
MA10	Unit on Divert	**2**	**8%**
MA11	Patient diverted	**0**	**0%**
	Total	**24**	

6.3 Pannal Ward Red Flags

Red flags were raised following the delaying of induction of labour on two occasions during December 2023.

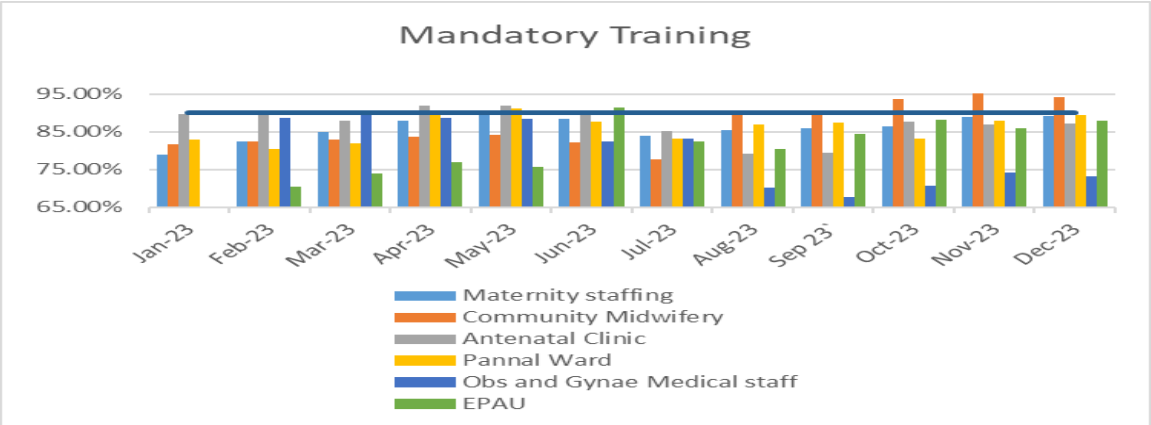
7.0 Appraisals

Department	Assignments Appraised	Assignment Count	Percentage Compliance
Ante Natal Clinic	9	12	75%
Community Midwifery	20	21	95%
Maternity Staffing	43	46	93%
Obs & Gynae - Medical Staffing	13	15	87%
Pannal Ward	17	20	85%

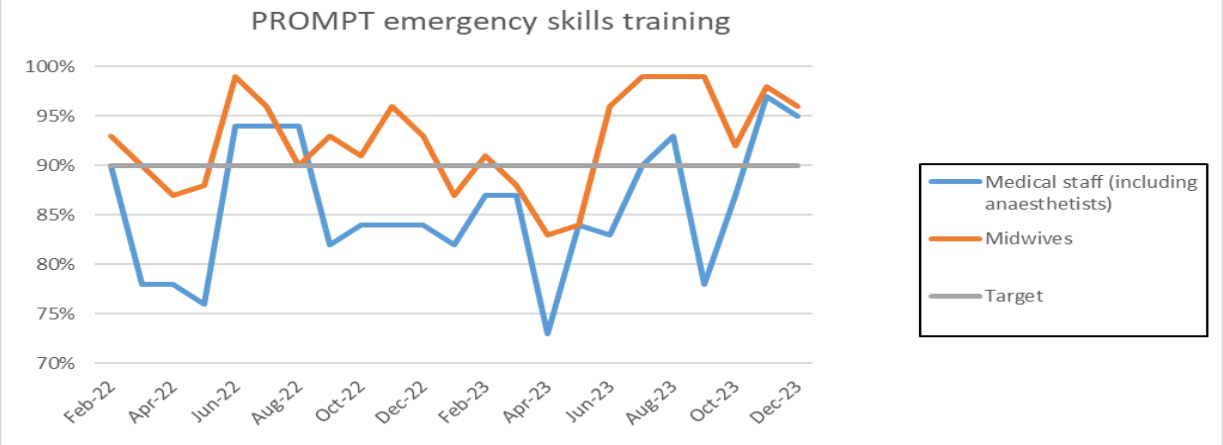
Overall	90	114	78.9%

8.0 Training Compliance For All Staff Groups in Maternity Related to Core Competency Framework And Wider Job Essential Training

7.1 Mandatory training (as at 02/01/24)

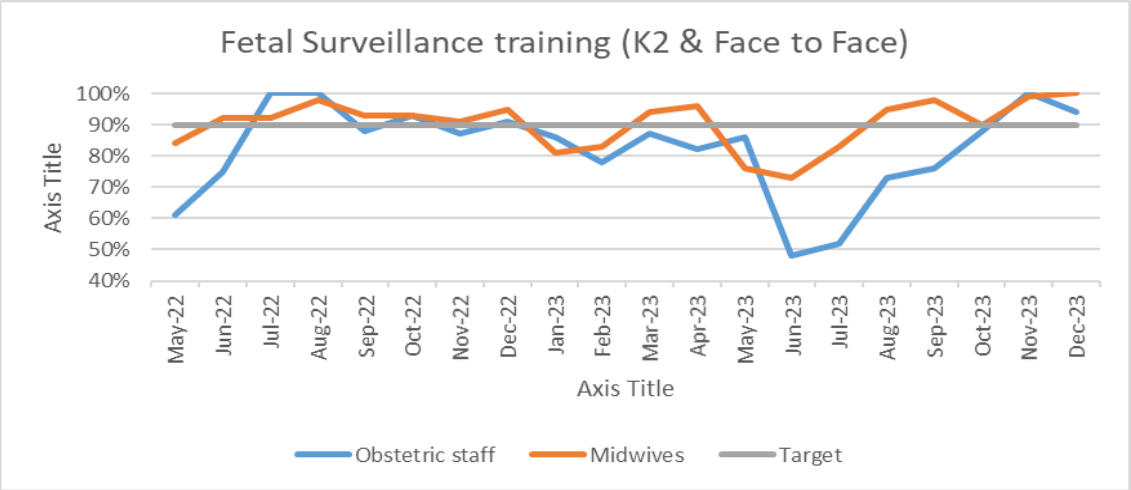


7.2 Prompt emergency skills training



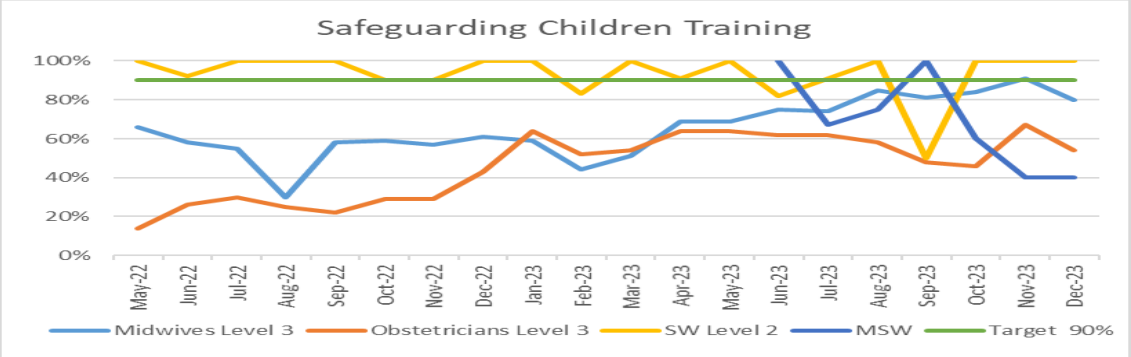
7.3 Fetal surveillance training

Compliance with training includes both K2 online package with a competency assessment test, and face-to-face training with local learning and case studies.



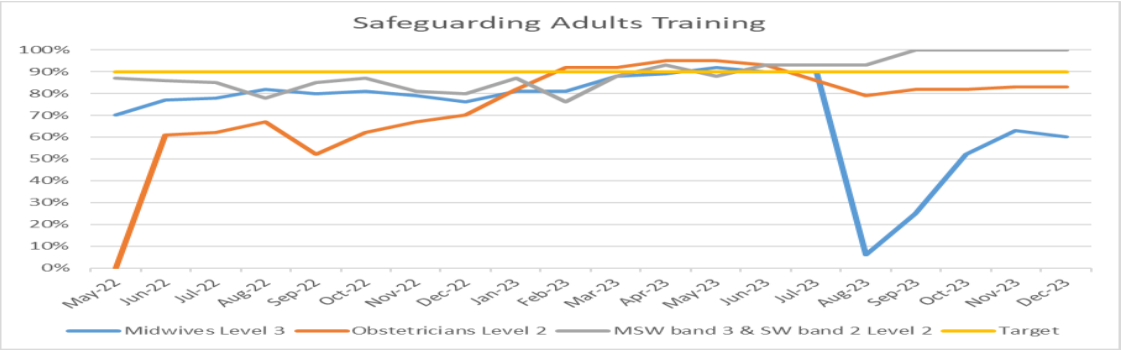
7.4 Safeguarding Children training

Maternity support workers figures have dropped due to newly recruited staff joining the team and the small numbers. All MSWs are booked to attend training.



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 three months and this is planned to continue along this trajectory to meet 90% by the end of the financial year.

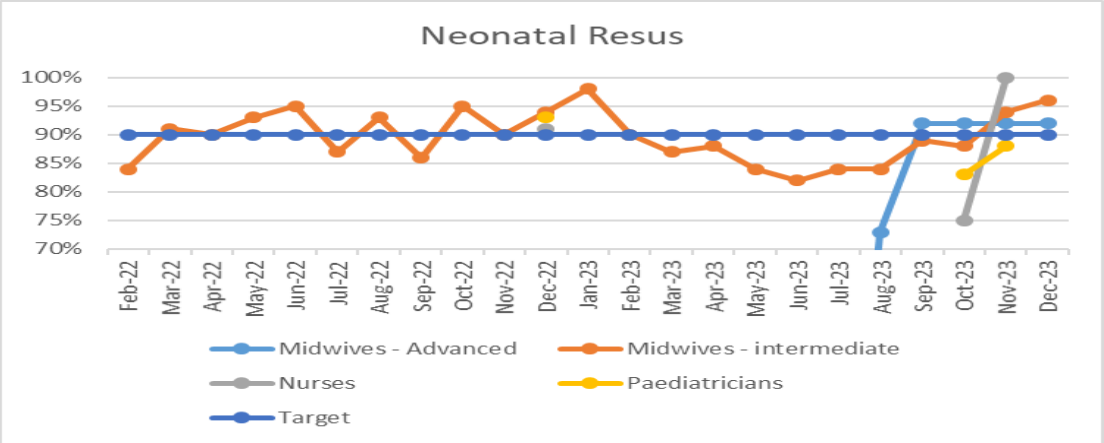


7.6 Safeguarding Supervision

Community midwives - 95%

Acute midwives - 95%

7.7 Neonatal resuscitation



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.

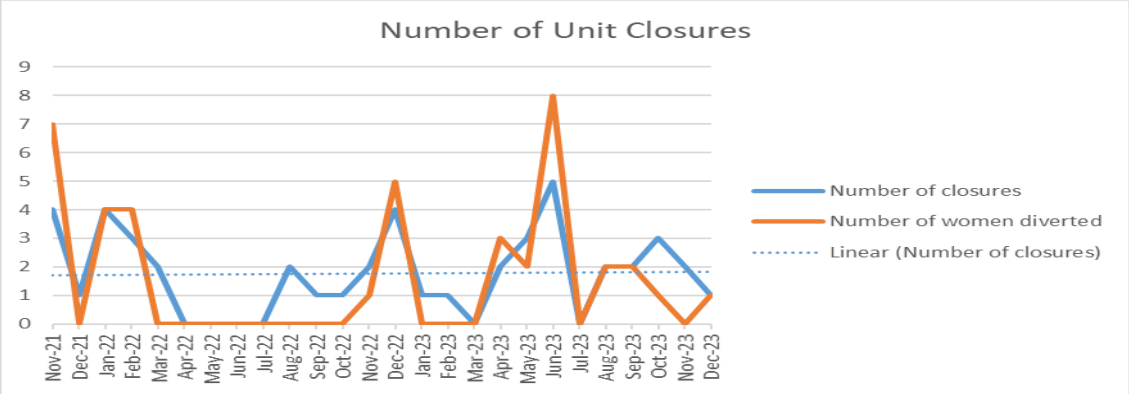
7.8 SCBU Training Compliance

Certification Name	Required	Not Achieved	Compliance %
Adult Basic Life Support with paediatric modifications	15	4	73%
RCUK Newborn Life Support Face to Face	5	1	80%
Harrogate Newborn Advanced Life Support (HNALS)	14	3	79%
Harrogate Newborn Intermediate Life Support (HNILS)	1	1	0%

8.0 Risk and Safety

8.1 Maternity unit closures

There has been one event of closure of the unit in December 2023 related to activity and ward capacity. One women was transferred out.



8.2 Maternity Accepted Diverts

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. A daily (Monday – Friday) regional meeting has been developed, supported by the Local Maternity and Neonatal System, to review staffing, activity and the number of women awaiting induction of labour across the region.

8.3 Maternity Risk register summary

Nine 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 6). Some improvements with new line management structure and new Clerical Team Leader in post. Appear to be some improvements. Risk downgraded.
- 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. No change.
- 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 into 2024. No change.
- 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 being implemented. 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 and good progress against target. Action plan in place. Risk level currently remains unchanged.
- Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 4). Policies and procedures now updated by Named Midwife for Safeguarding. Risk previously downgraded
- 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 presence. Risk reduced due to limited consequence.
- Risk to compliance with Ockenden and Maternity Incentive scheme requirements for audit (Score 2). Good completion of audit deficit against Saving Babies' Lives and compliance achieved. Good progress again MIS requirement. Risk downgraded to target and planned archive.

8.4 Maternity Incidents

In December 2023 there were 55 total incidents reported through Datix.

No incidents have been reported as Moderate Harm or above.

Two current PSII investigations completed (previously reported); one for neonatal death and one relating to missed diagnosis of 4th degree tear.

Additional incidents of note include:

- 11 Readmissions of mothers & babies (9 readmissions of babies for jaundice, weight loss and feeding issues)

- 7 incidents relating to incorrect treatment/tests/procedures.
- 3 incidents of 3rd degree tear (one additional duplicate)

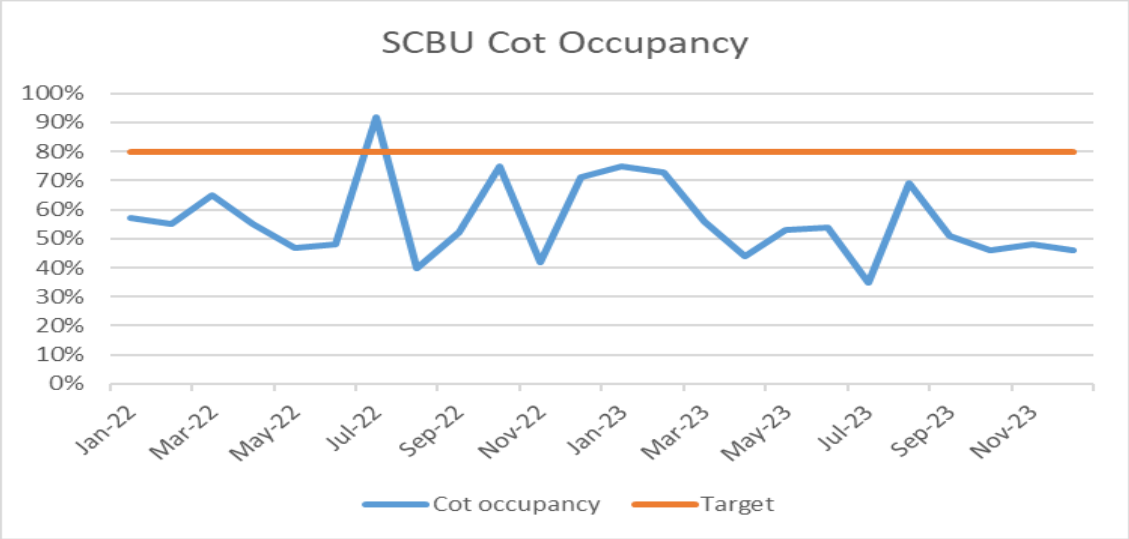
8.5 SCBU Incidents

No moderate harm incidents.

8.6 SCBU Risk Register

No new risks.

8.7 Cot occupancy and babies transferred out



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

One new PMRT notification this month, reported as neonatal death due to known fetal abnormality incompatible with life. Ongoing action plan in relation to promotion of cervical length scanning risk factors and preterm birth risk factors, domestic abuse questioning, offering the opportunity to take their baby home.

10.0 Service User feedback

Maternity service user feedback –

- What was good about your experience with maternity services in Harrogate?
  - All the staff have been so supportive and caring. Nothing is too much trouble no matter how many times you contact- it genuinely feels like they are invested in your health and wellbeing.
  - First appointment with midwife was helpful and informative
  - Midwives are lovely, its nice to be listened to and not feel judged when you come in with concerns
  - Gina and Odile have been very supportive throughout our 2nd pregnancy due to needing further tests. MAC were also excellent when we have had to attend.
  -
- What would you have liked to been different about your experience –
  - Sometimes I'm not sure what appointments are for/where they are (GD test for example). Also I've seen a different midwife at every app – some consistency would be good!
  - More on time appointments
  - Personally – the more info the better. E.g. how long should a scan take, just any info to help anxiety and whole process
  - not having to wait over an hour for appointments
  - better communication between Leeds and Harrogate

SCBU feedback –

The parents loved the festive spirit on SCBU during the Christmas period: "The decoration made the unit feel homely and welcoming!"

11.0 Staff feedback

Awaiting results from NHS Staff Survey.

12.0 Complaints

One new formal complaint received to the unit in December in relation to inappropriate NHS charge for prescription as FW8 not provided. Additional concern relating to inappropriate comments being discussed by staff within patient earshot.

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 on 30th October 2023 relating to declaration of compliance with Maternity Incentive Scheme year four, in light of CQC report. Response and relating evidence submitted. Awaiting confirmation if reverification has been agreed.

The CQC action plan is now complete. 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 is now complete. The actions in relation to audit have now been completed.

15.0 Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported in December 2023. No open cases. Action plans are in place for previous HSIB cases and these are being monitored via Maternity Quality Assurance Meeting. A MNSI Quarterly review meeting is planned for January 2024.

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 full report is in Appendix A. A summary of the current compliance is as follows –

Safety Action	RAG rating and narrative (if not green)
SA1 - Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Delayed reporting of a fetal loss – one twin demised at 19 weeks but was delivered at 35 weeks with twin. Demise not reported until one month later when identified. Guidance states *'Where the death of a baby is confirmed before 20+0 weeks gestation but the baby is delivered at 22+0 weeks gestation or later AND the birthweight is less than 200g, you will only be required to complete the initial notification.'* This may affect compliance reporting.
SA2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
SA3 - Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
SA4 - Can you demonstrate an effective system of medical workforce planning to the required standard?	
SA5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6 - Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle version three?	
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?	
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**	Continuity of carer not in place but 'building blocks' continue to be developed.
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**	

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.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 11 - Data to inform learning**	Data review with consideration of inequalities
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 Ockenden

17.2.1 Local Maternity and Neonatal System Assurance Visit

The Ockenden Report (2020 and 2022), and the Reading the Signals report (Kirkup 2022) identified that trusts were not implementing sustained change in response to independent enquiries and recommendations. In response to this, assurance and support visits were carried out during 2022 and 2023 in each trust to assess and confirm progress towards the implementation of the seven immediate and essential actions of the Ockenden Interim

Report 2020. These visits were led by NHS England regional maternity teams, supported by the local maternity & neonatal system (LMNS) team.

17.2.2 Informed Consent

The Regional Chief Midwifery Officer has advised that Immediate and Essential Action 7 - Informed consent should be moved to amber on all Ockenden status representation. This is due to concerns being raised nationally from service users.

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.
All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care
Women's choices following a shared and informed decision-making process must be respected.

Collaborated action plans are to be developed once further details are released regarding the concerns which will enable appropriately targeted actions to be generated.

17.3 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.

17.4 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. Continuity of Carer remains paused in Harrogate Maternity Services.

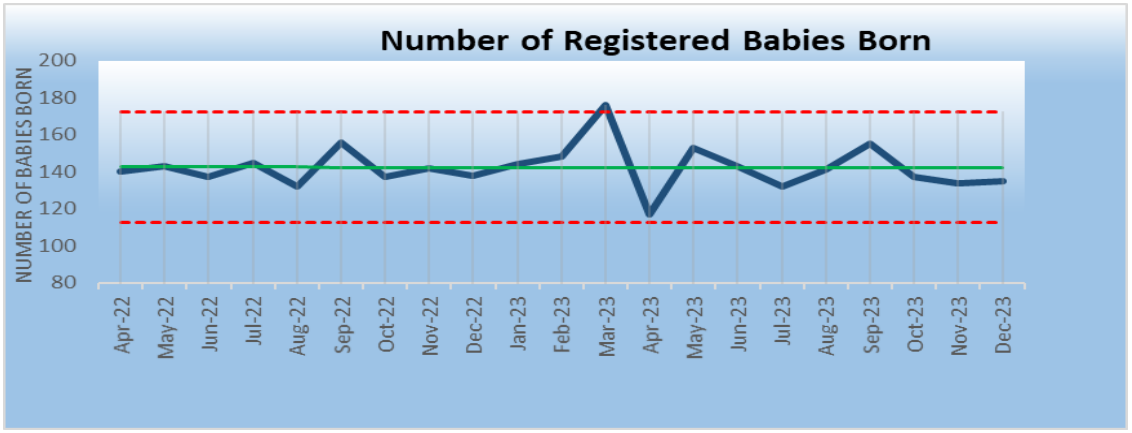
Maternity Training 2023-2024 KMcC / COD

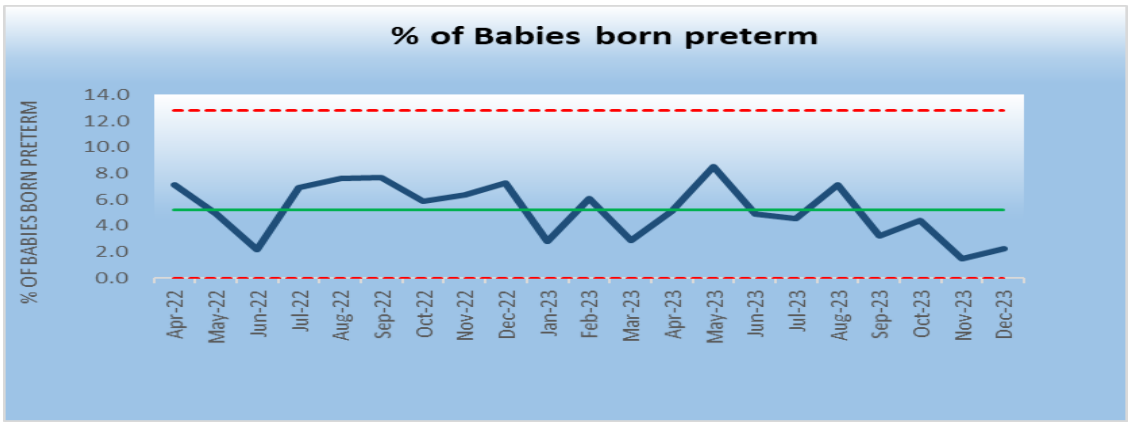
18.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

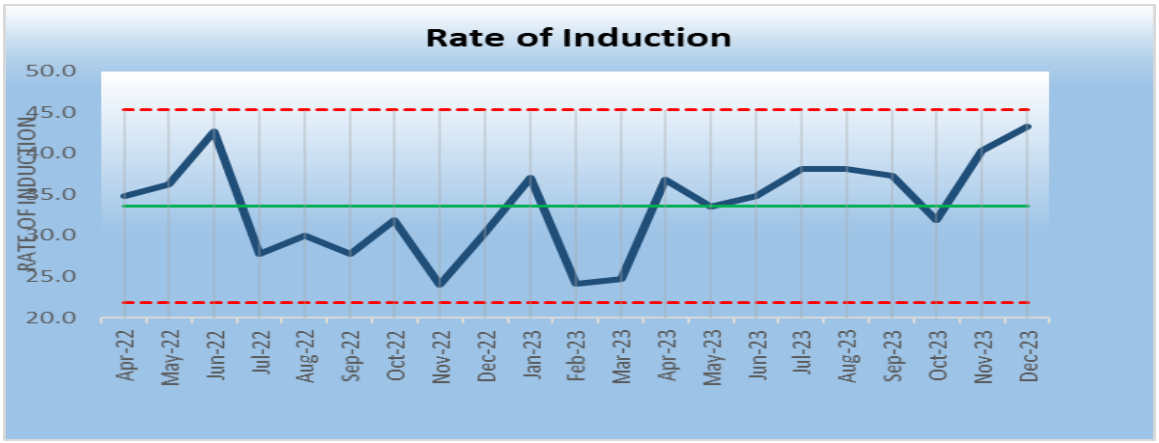
Quarter Three data is due in March 2024.

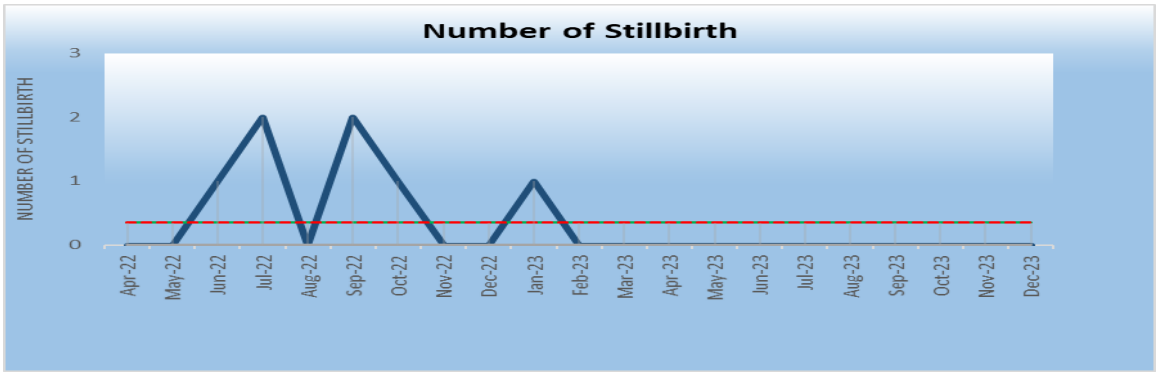
19.0 Local HDFT Maternity Services Dashboard

The metrics currently available demonstrate that there are no statistically significant outlying metrics this month although it can be noted that an increased number of inductions, shoulder dystocia and Obstetric Anal Sphincter Injuries (OASI) have occurred.








Number of Stillbirth
NUMBER OF STILLBIRTH
0
1
2
3
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
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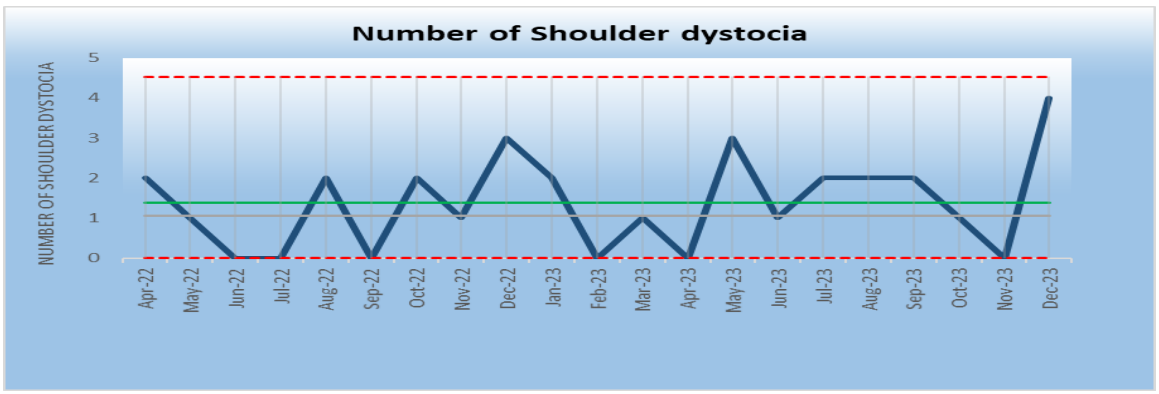
Dec-23


Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
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1
2
3
4
5
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
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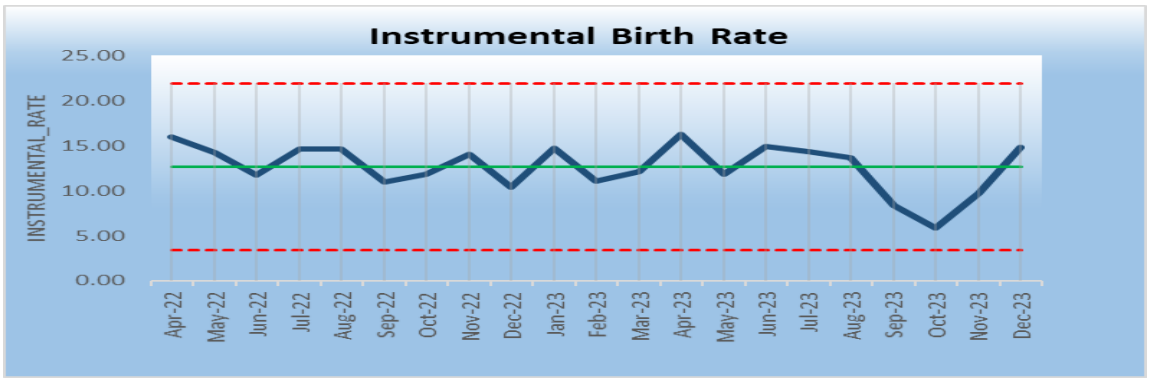
Instrumental Birth Rate
INSTRUMENTAL_RATE
0.00
5.00
10.00
15.00
20.00
25.00
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
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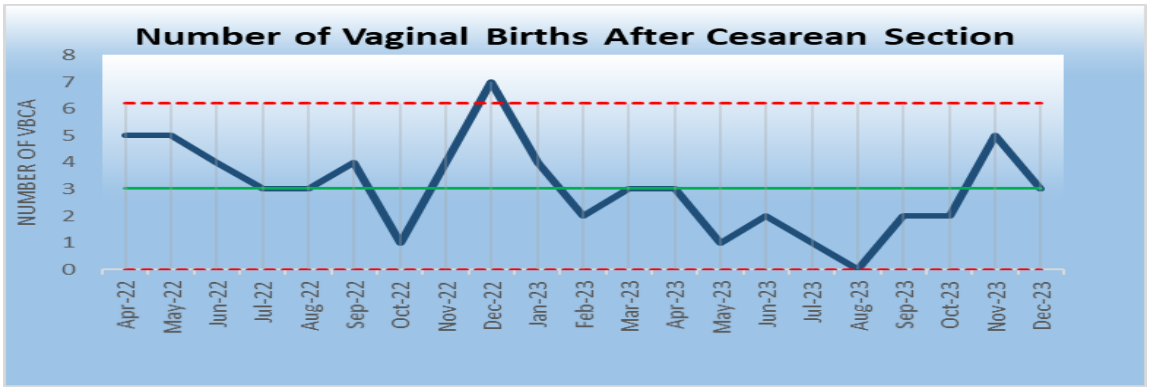
Number of Vaginal Births After Cesarean Section
NUMBER OF VBCA
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1
2
3
4
5
6
7
8
Apr-22
May-22
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Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
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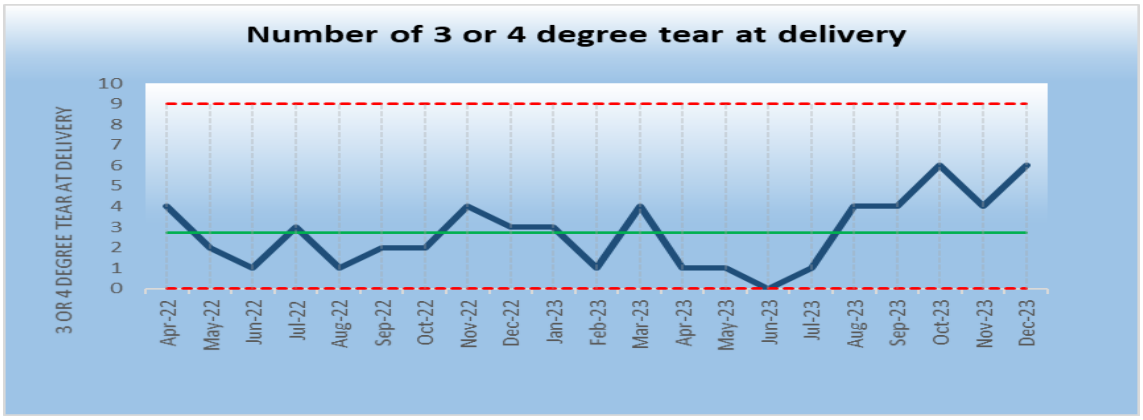
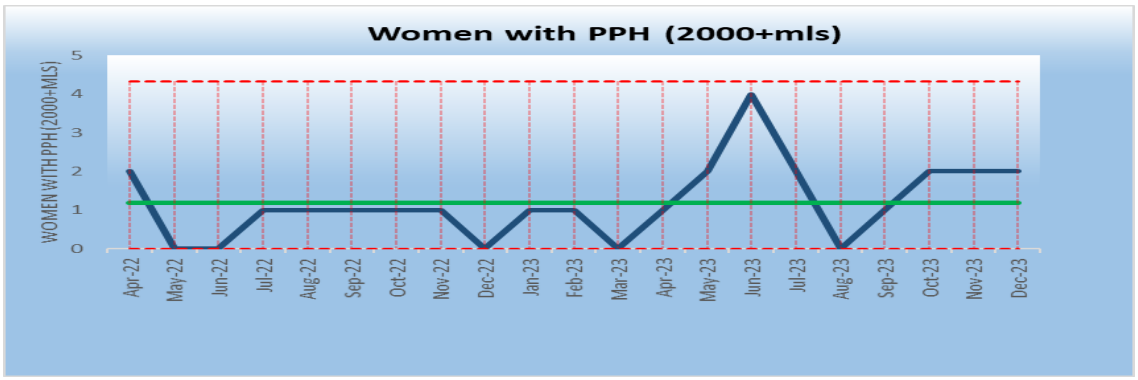
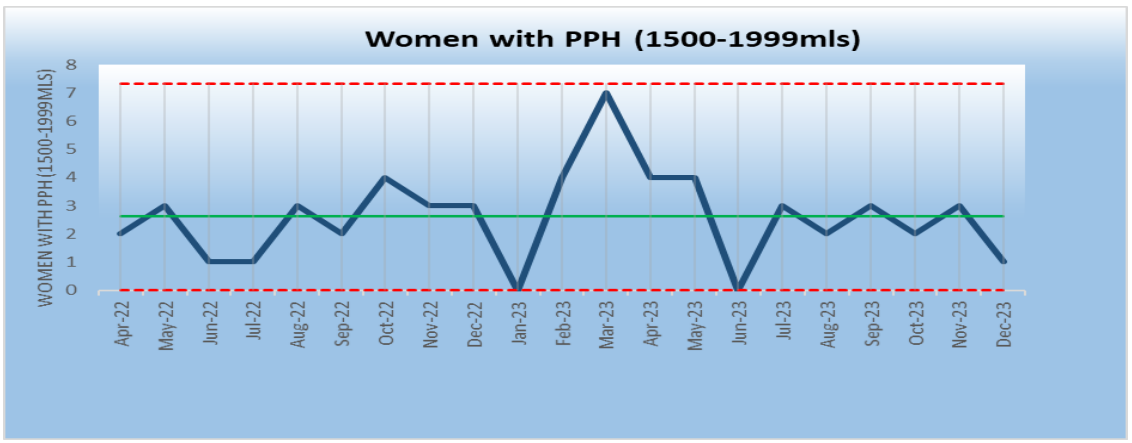

Number of 3 or 4 degree tear at delivery
3 OR 4 DEGREE TEAR AT DELIVERY
0 1 2 3 4 5 6 7 8 9 10
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23


Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)
0 1 2 3 4 5
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 Nov-23 Dec-23


Women with PPH (1500-1999mls)
WOMEN WITH PPH (1500-1999MLS)
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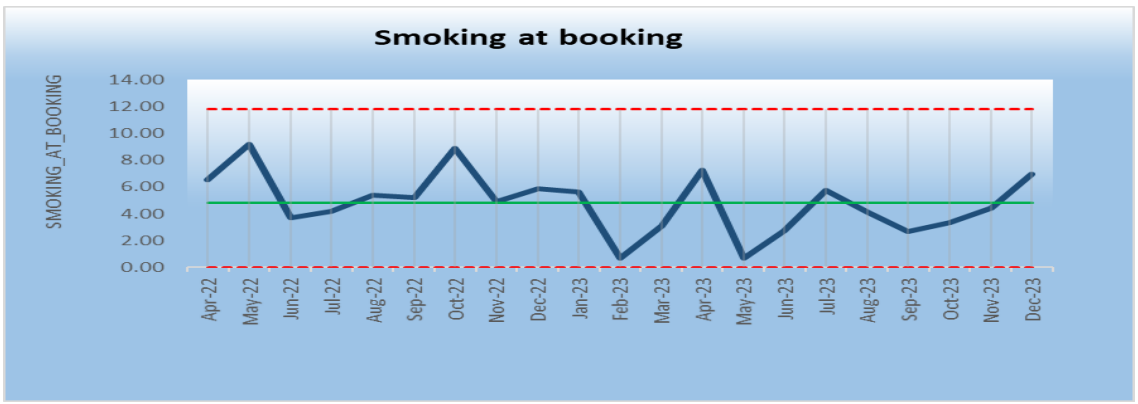
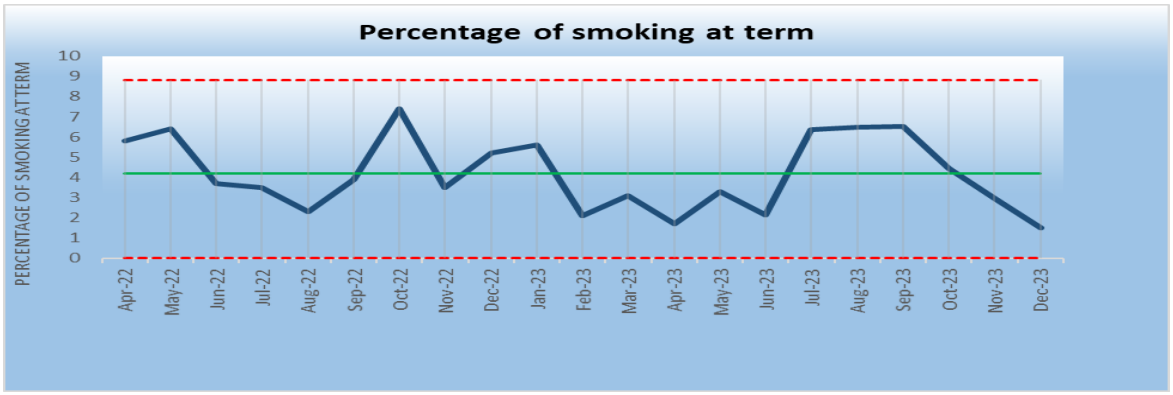
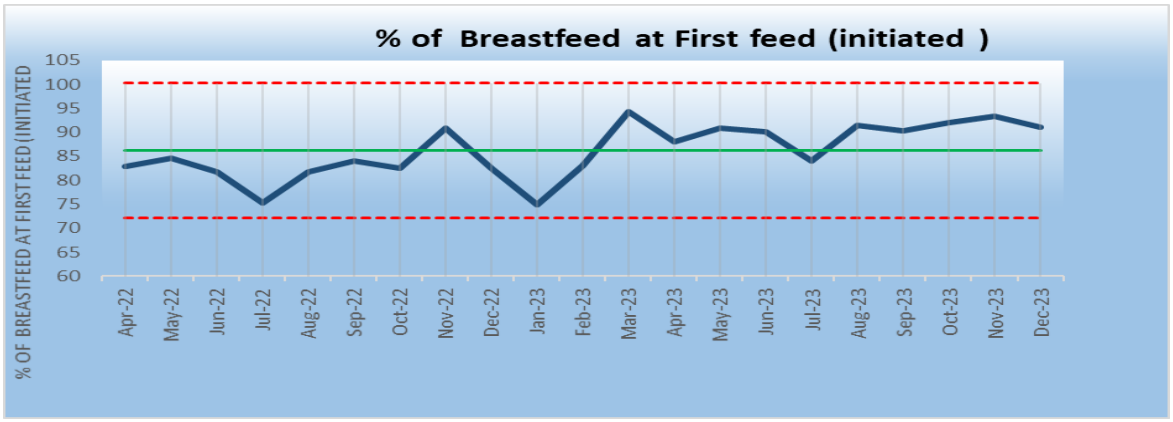
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23


Smoking at booking
SMOKING_AT_BOOKING
0.00 2.00 4.00 6.00 8.00 10.00 12.00 14.00
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 Nov-23 Dec-23





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.

20.1 Term Admissions to SCBU

Three incidents of Term baby admission to SCBU (one additional duplicate) during December.

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 • HGP commenced incorrectly (significant	Reinforcement of policy to midwifery and SCBU staff	In progress

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		
For neonatal staff to stay longer with stable babies on CLWS with borderline observations, whilst they transition to ex utero environment, in order to reduce avoidable admissions	• Education to neonatal staff • Embed RDS support chart for use on CLWS/Pannal • Facilitate simulation training for babies 'transitioning' to ex utero environment • Complete audit of use of vapotherm to confirm clinical justification	In progress
Issues with training of neonatal staff on insertion of i-gel	Insertion of i-gels being included within neonatal resus simulations	In progress
Delay in transfer of patients to theatre once decision made for operative delivery	For audit of time between decision and entry into theatre	In progress

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%) Now moved to integrated GROW 2.0 within Badgernet	
	Quarter 3 (July-Sept 2023)	December 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	0% (0/433) [<2nd, WHO centiles]	0.7% (1/140)
Percentage of babies <10th centile >39+6 weeks' gestation	1.6% (7/433)[WHO centiles]	2.86% (4/140)
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)	5 fetal loss born 16-23^{+6} weeks (3.57%, 5/140)
• Preterm (24^{+0}-36^{+6} weeks)	5.1% (live, 21/413)	2.14% (live, 3/140)

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. Executive and Non-executive Safety Champions walk around is next planned for 15th January 2024 and will be followed by a Safety Champions meeting.

23.0 Conclusion and recommendation

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

Appendix A - Maternity Incentive Scheme Report

Harrogate and District NHS Foundation Trust

Final Report for the Maternity Incentive Scheme – Year 5

Trust Board

January 2024

Title:	Final Report for the Maternity Incentive Scheme – Year 5
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), James Wright (Operations Director), Kat Johnson (Clinical Director),

Purpose of the report and summary of key issues:	The purpose of this report is to detail compliance against the ten Maternity Incentive Scheme safety actions and to highlight areas of potential non-compliance.	
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:	Senior Management Team Maternity Risk Management Group Safety Champions Meeting	
Recommendation:	Board are asked to review the evidence submission, note the compliance position against each of the standards and agree declaration of compliance.	

Final Report for the Maternity Incentive Scheme – Year 5

1.0 Executive Summary

This report details the standards required to demonstrate full compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year five.

2.0 Introduction

Year five of the Maternity Incentive Scheme was launched on 31st May 2023. The scheme supports the delivery of safer maternity care through an incentive element to Trust contributions to the Clinical Negligence Scheme for Trusts (CNST).

Provision for the maternity incentive scheme has been built into NHS Resolution CNST maternity pricing for 2022/23. The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet all ten safety actions will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against any actions they have not achieved. Such a payment would be at a much lower level their original ten per cent contribution.

Obstetric incidents can be catastrophic and life-changing, with related claims representing the CNSTs biggest area of spend. Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetrics claims represented 12 per cent of clinical claims by number, but accounted for 62 per cent of the total value of new claims; almost £6 billion.

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

This report provides detail of position and progress with compliance with the ten maternity safety actions, drawing the attention of the Board to the areas at risk of non-compliance.

3.0 Proposal

Trust Board is asked to review the evidence submitted, note the information provided in the report and discuss if sufficient assurance is gained to satisfy all of the requirements of the Maternity Incentive Scheme – year five.

4.0 Quality Implications and Clinical Input

4.1 This report provides information on position and progress with compliance with the ten maternity safety actions.

5.0 Equality Analysis

5.1 An equality analysis has not been undertaken

6.0 Risks and Mitigating Actions

6.1 One case where MBRRACE-UK was not notified of the eligible perinatal death within the expected time-frame of seven 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. The late reporting of the perinatal death represents a non-compliance with the required timescale for Safety Action One which will be externally verified via MBRRACE-UK data.

7.0 Recommendation

7.1 The Board is recommended to declare compliance with the Maternity Incentive Scheme Year Five Standards whilst recognising the one minor data capture issues which will be available to NHS Resolution on external verification.

7.2 The Board is required to give their permission to the CEO to sign the Board declaration form, and action plan if required, prior to submission to NHS Resolution.

7.3 The CEO of the Trust will ensure that the Accountable Officer (AO) for the Integrated Care System (ICB) is apprised of the MIS safety actions' evidence, action plan if required, and declaration form.

7.4 The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

Maternity Incentive Scheme

Matters of concern & risks to escalate

- Safety Action (SA) 1 – One delayed reporting of a 19 week fetal loss in February 2023.

Major actions commissioned & work underway

- Safety Action 3 (SA3) – work on-going to reduce the separation of mother and baby.
- SA 4 and 5 - Appropriate workforce planning for maternity services with action plans in place for staffing shortfalls.
- Safety Action 6 (SA6) – work on-going to meet the requirements of Saving Babies Lives Care Bundle version 3 by March 2024.

Positive news & assurance

SA 2 – Badgernet now fully embedded and providing MSDS reporting as per requirements.
SA 7 – Effective Maternity Voices Partnership in place enabling the service user voice to be heard and services to be co-produced.
SA 8 – Local training plan in place which meets all six core modules of the core competency framework. Over 90% of each maternity unit staff group have attended multi-professional training in maternity emergencies, fetal surveillance and newborn life support.
SA 9 Robust processes are in place to provide assurance to the Board on maternity and neonatal safety and quality issues.
SA 10 Appropriate processes in place to report cases to Maternity and Newborn Safety Investigations

Decisions made & decisions required of the Board

- Given the information provided, Board to decide if satisfied that the requirements of the maternity incentive scheme are being met.

Harrogate and District NHS Foundation Trust

Maternity Incentive Scheme – Year Five

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Trust submissions will be subject to a range of external verification checking points, these include cross checking with:

- MBRRACE-UK data (safety action 1 standard a, b and c),
- NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive),
- National Neonatal Research Database (NNRD) and HSIB/MNSI for the number of qualifying incidents reportable (safety action 10, standard a).
- Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Harrogate and District NHS Foundation Trust

The evidence for each Safety Action can be found in the following location -
W:\Labour\Maternity Incentive Scheme\2023

Safety Action One

1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?		***Required standard –*** ***Pages 8 – 14 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant as delayed reporting had no impact on patient safety or review of care provision.***

During the calendar year 2023 there have been six eligible reportable perinatal deaths. There was delayed reporting of a fetal loss in February 2023. In this case one twin demised at 19 weeks but was delivered at 35 weeks with the other live twin. The demise was not reported until one month later when the issue was 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.' The late submission of the notification represents a non-compliance with the required timescale for this metric however the late submission of this data does not pose a risk to patient safety. The remainder of the cases had notification and surveillance data completed within the timescale.

The multi-disciplinary team review the care using the perinatal mortality review tool (PMRT), draft reports are generated via the PMRT and the reports are published within the required timescales 100% of the time. Parents are informed of the PMRT and their perspectives about their care and that of their baby are sought 100% of the time. Reports on MBRRACE notification and PMRT reports, which include details of the deaths reviewed, any themes identified and the consequent action plans, are submitted monthly and quarterly to the Trust Board, within the Strengthening Maternity and Neonatal Safety Board Report.

Safety Action Two

2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		***Required standard –*** ***Pages 15 – 19 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

11 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. July 2023 data contained a valid ethnic category (Mother) for at least 100% of women booked in the month. MSDS submissions have been made within the appropriate timescales and two people are registered to submit MSDS data within the Trust as required.

Due to suspended Midwifery Continuity of Carer (MCoC) pathways, the MSDS submissions explicitly report that women are not being placed on MCoC pathways. This is a satisfactory response for safety action 2 criteria 3i, and criteria 3ii is not applicable and does not need to be completed. This action is focussed on data quality only and therefore Trusts pass or fail it

based upon record completeness for each metric and not on the proportion (%) recorded as the metric output.

Safety Action Three

3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		***Required standard –*** ***Pages 20 – 24 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Transitional Care is in place on Pannal Ward to reduce separation of mums and babies. Babies admitted to Transitional care are reviewed on a daily basis by a paediatrician as required and the care of babies admitted to Transitional Care are reviewed following the care provision. Joint maternity and neonatal reviews are in place and information regarding ATAIN is shared with the quadrumvirate, maternity, neonatal and Board level safety champions, Local Maternity and Neonatal System and ICB. An action plan is in place and is submitted to trust Board within the Strengthening Maternity and Neonatal Safety Board Report. Reports are available in the evidence folder which demonstrate the details of compliance with this safety standard.

Safety action 4

4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		***Required standard –*** ***Pages 25 – 36 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The Obstetric medical workforce is in line with RCOG guidance in relation to locums and a guideline is in place to implement compensatory rest however full compliance has not yet been achieved with this and therefore an action plan is in place (Appendix A – 2.7). The audit of compliance with consultant attendance for the clinical situations listed in the RCOG workforce document demonstrated 37 cases required a consultant present, on 31 of these occasions that was the case. The remaining cases have appropriate mitigation for why the consultant wasn't present. The Anaesthetic medical workforce provide appropriate availability to the obstetric unit at all times. The anaesthetic rotas are available in the evidence folder to demonstrate availability of anaesthetists. British Association of Perinatal Medicine (BAPM) standards are not met for neonatal medical and neonatal nurse staffing and an action plan is in place. Harrogate Special Care Baby Unit (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. For the neonatal medical workforce there currently is one in seven on the Tier 1 and Tier 3 doctors on the rota (rather than one in eight) however there is cover for the unit 24 hours a day. A neonatal staffing report and action plan are available in the evidence folder to demonstrate full compliance with this safety standard for neonatal medical and nursing staff.

Safety action 5

5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		***Required standard –*** ***Pages 37 – 40 of Maternity Safety Incentive Scheme Document*** ***Recommendation – Compliant***

Midwifery staffing establishment is calculated using BirthRate+ and the maternity budget is allocated in line with this. The Labour Ward Co-ordinator is supernumerary the majority of the time and all women receive one to one care in active labour. The bi-annual midwifery staffing report demonstrating compliance (Oct 2022 – Mar 2023 and Apr 2023 – Sept 2023) was submitted to the Board in May 2023 and November 2023 and is available in the evidence folder.

Safety action 6

6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		***Required standard –*** ***Pages 41 – 49 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

Harrogate maternity services have demonstrated implementation of 70% of the Saving Babies Lives Care Bundle interventions across all six elements overall, and implementation of at least 50% of interventions in each individual element. These percentages have been calculated within the national implementation tool and shared at two quarterly quality improvement discussions with the ICB/LMNS. The compliance report has also been shared with Trust Board. The report and implementation tool in the evidence folder provides more detailed information to support compliance with this safety standard.

Safety action 7

7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		***Required standard –*** ***Pages 50 – 52 of Maternity Safety Incentive Scheme Document*** ***Recommendation - Compliant***

The Maternity Voices Partnership works closely with maternity service leaders and service users to co-produce services and review service provision. Evidence is available in the evidence folder which demonstrates compliance with each requirement of this standard.

Safety action 8

8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		***Required standard –*** ***Pages 53 – 58 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

A training plan is in place to ensure that all six core modules of the Core Competency Framework version two are included the training programme. The plan has been agreed with the quadrumvirate and signed off by the Trust Board and LMNS. The training plan has been developed based on the 'How to' guide developed by NHS England. Over 80% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies. An action plan is in place to ensure compliance is reached within twelve weeks (see Appendix B). Over 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring. Over 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a RCUK Newborn Life Support (NLS) course with the exception of other paediatric doctors who are not consultants who were 87% compliant. Both of the non- consultant Paediatric doctors who were not compliant attended an update on 7/12/23.

Safety action 9

9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		***Required standard*** ***Pages 59 –66 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

A non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues as they arise. A monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).

The perinatal clinical quality surveillance model has been reviewed in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, and Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.

The Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan.

The Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme and are supporting the Perinatal Quadrumvirate to engage in this programme.

Safety action 10

10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?		***Required standard –*** ***Pages 67 – 71 of Maternity Safety Incentive Scheme Document*** **Recommendation - Compliant**

All eligible cases fitting the reporting criteria have been notified to HSIB/MNSI and NHS Resolution (where applicable). All patients where incidents have occurred which may require notification to HSIB/MNSI, a Duty of Candour letter is completed. Within this, information is provided about the role of HSIB/MNSI and potential future involvement of NHS Resolution.

Conclusion

This report provides the information required to demonstrate HDFT's level of compliance with the ten maternity safety actions in the Maternity Incentive Scheme – year five.

The Trust Board need to be satisfied that the information within this report and evidence folder satisfies these requirements prior to final sign off by the Chief Executive and submission to NHS Resolution by 12 noon 1st February 2024.

Harrogate and District NHS Foundation Trust

Appendix A

Medical Staffing Acute Obstetrics and Gynaecology

Version	Date	Purpose of Issue/Description of Change	Review Date
1.0	May 2010	Medical Staffing on the Delivery Suite (Including Consultant Presence on the Delivery Suite)	January 2011
1.1	Sept 2011	Review	Sept 2013
2.0	June 2015	Review and update	June 2017
2.1	October 2015	Re uploaded with correct title	
3.0	Sept 2017	Review and update	Sept 2020
4.0	Oct 2020	Review	Oct 2021
5.0	April 2022	Review and update in relation to SI and in response to second report from Shrewsbury and Telford (Ockenden Report)	April 2025
6.0	November 2023	Update to include guidance on locum doctor employment and compensaitory rest for consultants	April 2025

Status	Active	
Publication Scheme	HDFT Intranet	
FOI Classification	Release without reference to author	
Function/Activity	Medical staffing Guideline	
Record Type	Guideline	
Project Name	Medical Staffing Guideline	
Key Words	Consultant presence on delivery suite	
Standard		
Scope / Location	Delivery Suite	
Author	Kat Johnson	**Date/s**
Approval and/or Ratification Body	Maternity Risk Management Group	18/4/2022

CONTENTS

1. Introduction

1.1. Purpose

This guideline describes the expected medical staffing levels on delivery suite.

1.2. Scope

This document applies to the medical staff working in maternity services.

1.3. Definitions

Consultant presence – labour ward is covered by a consultant who has no other clinical commitment during that time (duties outlined in section 2.1.1)

2. Policy

2.1. Consultant Obstetricians

2.1.1. Role of the Consultant Obstetrician on Delivery Suite

The Safer Childbirth document describes the role of the consultant obstetrician on the labour ward as 'to ensure a high standard of care for women and their babies with complex medical or obstetric needs and to be available for the acute, severe and often life-threatening emergencies which are a feature of obstetric practice.'

All consultant obstetricians who work on the labour ward should:

- Provide clinical leadership and lead by example
- Train and educate staff in a multidisciplinary team
- Ensure effective teamwork
- Develop and implement standards of obstetric practice and have a major role in risk management
- Bring experience to clinical diagnosis and opinion
- Audit the effectiveness of practice and modify it as required

Safer Childbirth 2007

The RCOG 2021 document Roles and Responsibilities of the Consultant identifies the need for the consultant to 'promote positive team working, good information flow and clinical prioritisation'. It also identifies the link between shallow authority gradients and psychological safety, key to staff feeling able to raise concerns and learn from events.

The on call consultant is responsible for covering obstetrics and gynaecology including labour ward and is expected to resident on site during the following hours:

Monday – Friday 08:00 – 20:30h

Saturday/ Sunday 08:00 – 12:00h

Each morning starts with a thirty minute multi-professional handover, followed by a ward round. It is expected that the ward round will include a consultant review of all high risk

obstetric patients on labour ward, all obstetric antenatal patients, any postnatal readmissions and any gynaecology non-elective admissions. Elective gynaecology patients may be reviewed by the consultant of care or the middle grade on call, with the on call consultant reviewing where there are clinical concerns. Any staffing concerns should be discussed during the handover and it is the responsibility of the consultant on call to ensure appropriate contingency plans are made where there is staff absence. If the on call consultant is expected to change during the on call period, any contingency plans should be relayed to them as soon as known.

The multi-professional evening handover occurs at 20:00–20:30h. As a minimum a consultant review of all high risk patients on labour ward, any new postnatal readmissions and any new gynaecology admissions should occur before the consultant goes home. The consultant may choose to undertake the reviews before the ward round due to time constraints. This will ensure that all new admissions, antenatal, postnatal and gynaecological are reviewed by a consultant within 14 hours.

Where possible, the same consultant will be on call for the whole 24 hours. Where this is not possible, the incoming consultant must come to labour ward and undertake a ward round of any high risk patients. The on call consultant should be immediately available to offer advice and supervision of the junior medical staff. The on call consultant may sometimes change during the day, and it is expected that the incoming consultant comes to the labour ward and undertakes a board round and sees any patients as necessary.

At the weekend the on call consultant should undertake a morning ward round in person each morning and is expected to be resident between the hours of 08:00 and 12:30h. The exception to this would be where the on call consultant has been in after midnight and may need to take compensatory rest. Where this occurs, the consultant is responsible for ensuring appropriate delegated review of patients occurs and any concerns are appropriately escalated pending consultant presence on site. The frequency of subsequent ward rounds/ telephone rounds will depend on the level of activity in the unit.

The on call consultant is required to stay within 30 minutes of the hospital during the on call period. The following clinical conditions should be discussed with them:

- Fetal distress requiring delivery in theatre (trial of operative delivery or caesarean section)
- Failure to progress requiring delivery in theatre
- Fetal distress where a third fetal blood sample is being considered
- Significant/ ongoing antepartum haemorrhage
- Severe pre-eclampsia
- Sepsis
- Multiple pregnancy in labour
- Malpresentation in labour e.g. breech
- Preterm labour less than 34 weeks gestation
- Threatened preterm labour less than 34 weeks gestation
- Any other cause for concern

Usually the middle grade on call will liaise with the consultant on call. However, where this is not possible or where the midwifery staff have concerns it is appropriate for any member of the medical or midwifery staff to call the consultant directly.

In the following situations the consultant must attend in person:

Situations in which the consultant MUST attend in person
General
In the event of high levels of activity e.g. a second obstetric theatre being opened or unit closure
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
Obstetrics
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ ITU care is likely to become necessary
Caesarean birth for major placenta praevia/ abnormally invasive placenta
Caesarean birth for women with a BMI > 50
Caesarean birth <32 weeks
Caesarean section for premature twins <32 weeks
Vaginal twin delivery – consultant to be present for delivery
Vaginal breech birth
4th degree tear repair
Unexpected stillbirth – antepartum or intrapartum
Eclampsia
Maternal collapse eg septic shock, massive abruption

PPH > 2L where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated
Gynaecology
Laparotomy
Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2021

In the following situations the consultant should attend in person or be immediately available if the middle grade doctor on duty has not been assessed as competent (usually by OSATs where available):

Situations in which the consultant MUST attend in person, unless the most senior doctor present has documented evidence as being signed off as competent.
General
Any patient in obstetrics OR gynaecology with an EBL >1.5 litres and ongoing bleeding
Obstetrics
Trial of instrumental birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI > 40
Caesarean birth for transverse lie
Third degree tear repair
Gynaecology
Diagnostic laparoscopy*
Laparoscopic management of ectopic pregnancy*

Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2021

* note in these situations the consultant should attend the hospital in case of urgent obstetric cases even if not needed to supervise in the gynaecology theatre

2.1.2. Managing Competing Demands of Obstetrics and Gynaecology on Call

The consultant on call is responsible for the management of acute obstetrics and gynaecology. The size of the HDFT maternity unit means that separate on call for obstetrics and gynaecology is not sustainable.

The following mitigations are in place to mitigate against harm from competing demands:

- During the normal working week (08:00 – 17:00h) there is always a minimum of one consultant available in the building who can be called upon to assist if a time critical situation occurs and further consultant support is required. This consultant would be either undertaking SPA or working in the outpatient environment. Gynaecology emergency work should be prioritised to these times in week, where it is safe to do so
- There are two elective caesarean section lists per week, which are staffed separately to the on call team. The staffing plans should ensure that either the on call second on call doctor, or the doctor undertaking elective caesarean list are entrustible to work without a resident consultant
- The on call team should be vigilant and maintain situational awareness to reduce the likelihood of two time-critical events happening concurrently in obstetrics and gynaecology

2.1.3. Local Arrangements for Consultant Presence on the Delivery Suite

The unit is currently staffed by 7.5 substantive consultants.

Each consultant has a job plan which specifies a day of on call cover which consists of 08:00 – 20:30h on site presence followed by 20:30 – 08:00h on call overnight Monday – Friday.

At the weekend and on bank holidays the consultant is present 08:00 – 12:30h and then is on call from home as described above. The consultant then returns for the evening ward round at 20:00h.

Where the consultant on call is on leave their on call sessions are covered flexibly by another consultant either in their SPA time or by cancelling clinical commitments. The SPA time is taken flexibly at another opportunity and the additional DCC is remunerated as a prospective cover calculation.

Where a consultant is sick, the cover of the on call sessions is prioritised above all other work. Locum payment may be claimed where a consultant elects to cover hours in excess of their usual job plan.

2.1.4. Process for Producing an Annual Review of Prospective Consultant Obstetrician Presence on The Labour Ward

An electronic copy of the consultant labour ward presence rota is kept by the delivery suite lead over the year. Where there is unexpected short term absence the clinical lead will amend the rota accordingly.

An annual review of prospective consultant obstetrician presence is produced by the delivery suite lead at the end of the calendar year. The review will be submitted to the PSC board where there are shortfalls in the Consultant staffing and an appropriate business plan will be formulated to address the shortfall and also presented. Until the shortfall is addressed consultant staffing on the delivery suite will be added to the departmental risk register.

2.1.5. Second on call tier

There is a requirement for there to be a second on call resident doctor on call at all times. This doctor must have at least two years' experience in obstetrics and gynaecology and have established competencies equivalent to at least ST3. In practice the unit is staffed by three specialty trainees (ST3 or above), four full-time specialty doctors and one part-time specialty doctor.

Doctors at ST3 – ST5 level will work with a resident consultant Monday – Friday 08:00 – 20:30h and will only be permitted to work with a non-resident consultant when they have the required entrustibility to manage Delivery Suite with the consultant off site. Their educational supervisor will be responsible for review of when the required entrustibility is met.

Specialty doctors and locums will be expected to show evidence that they have the required competency to work with a non-resident on call consultant (see section 2.4 below)

The on call shift rota requires second on call cover 08:00h–20:30h and 20:00h–08:30h. The rota is European Working Time Directive compliant.

2.1.6. Role of Specialty Doctors/ Specialty Trainee (ST) year 3 - 7 on Delivery Suite

These doctors are responsible for managing medical problems on the labour ward and conducting high risk labours and complicated deliveries in conjunction with the sessional consultant or on call consultant.

The competency of the specialty doctors/ specialty trainees is established by a self-assessment document at induction. They should only attempt procedures unsupervised that they have proven competency in. The consultant on a session or on call should be called to supervise where the second on call does not have proven competency. It is the responsibility of the second on and the consultant on call to ensure that this guidance is followed.

Competency may vary over time as specialty doctors and specialty trainees acquire and develop their clinical skills. Also they may at require additional supervision or support e.g. following an adverse outcome.

For doctors who remain within the unit beyond 12 months the competency document will be renewed in August each year.

2.1.7. First On Call Tier

The first on call tier is covered by Foundation 2 doctors, GPVTS Specialty trainees and Obstetrics and Gynaecology Specialty trainees year 1 – 2.

There is always a resident 'First on call' designated to cover delivery suite as part of the on call commitment for obstetrics and gynaecology. They work a shift rota covering 08:00h–20:30h and 20:00h–08:30h. The rota is European Working Time Directive compliant.

2.1.8. Role of the First On Call Tier

The first on call tier is staffed by two FY2 doctors and five trainees in Obstetrics and Gynaecology (ST1/2) or GP specialty trainees. Many of these doctors will have little or no experience in obstetrics and gynaecology beyond medical school. They are responsible for working with the middle grade doctor to ensure safe and effective care for all women presenting to the obstetric service. The competency of these doctors is established by a self-assessment document at induction. They should only attempt procedures unsupervised that they have proven competency in.

2.1.9. Baton Bleep

The baton bleep arrangements are detailed below. Calling 2222 and asking for the obstetric emergency team will include all of these bleeps along with the delivery suite coordinator, obstetric anaesthetist and emergency theatre team.

First on call 0304 – carried 24 hours a day 7 days a week

Second on call 0305 – carried 24 hours a day 7 days a week

Consultant on call 3180 – carried Monday – Friday 08:00–16:30h (outside these times contact consultant on call via switchboard) (see Appendix 1).

2.2. Documentation of Cover Arrangements

The consultant labour ward rota is circulated to all consultants by email to ensure that all aware of their sessional commitments. A paper copy is displayed on the labour ward noticeboard and is regularly updated.

2.3. Contingency Plan for Short term Staffing Shortfalls

2.3.1. Consultants

Where there is an unanticipated absence of the consultant covering labour ward eg due to sickness the consultant rota should be reviewed with the aim of freeing up a consultant to cover labour ward. This may be made possible by substituting a middle grade doctor into clinic for example. Where necessary consideration should be given to cancelling clinical commitments in order to ensure labour ward is prospectively covered.

Where there is an unanticipated absence of the on call consultant an agreement should be reached that the on call is covered by a colleague who is compensated by the on call being paid back or paid at the agreed locum rate depending on the individual circumstance.

Where the shortfall is expected to be for a longer period the employment of a locum consultant should be considered (see 2.4)

A record should be kept of all consultant staffing shortfalls and the contingency followed.

2.3.2. First and Second On Call Tier

Where there is an unanticipated absence of the on call first or second on call, the rotas should be reviewed to ensure that the on call commitment is covered. Where the shortfall occurs out of hours the on call consultant should contact the other staff on that tier to ask if cover can be provided. In the extreme circumstance that it is not possible to find cover the consultant will have to remain resident on call until the end of the shift or until a replacement can be found.

Any change in the cover arrangements should be communicated to the on call consultant the change affects.

Where the shortfall is anticipated in advance all attempts should be made to find locum cover for the shift (see 2.4)

2.4. Compensatory Rest for Consultants Working On Call

The Royal College of Obstetricians and Gynaecologists (RCOG) guidance on compensatory rest recommends that organisations make provision for consultants to have compensatory rest following an on call period. The guidance makes reference to the BMA position which advises that consultants who are unable to take 11 hours of consecutive rest per day should be entitled to take compensatory rest. The RCOG recognise that full implementation of this is challenging, especially in smaller units, such as HDFT, but recommends that progress is made and reviewed each year as part of ongoing job planning.

Where a consultant is called back to the site overnight and are away from home after midnight, they should not attend for the planned morning clinical session the next day. They should report to the service manager or clinical lead for care group 1 and their session should be covered by a specialty doctor or specialty trainee with appropriate entrustibility for that session(s) or by a consultant, displacing SPA time. There will usually be a speciality doctor or specialty trainee on admin who can be redeployed (with an admin session provided at another time). The clinical lead/ service manager should establish whether it is safe for the doctor to return for the afternoon session, which will depend on the degree of disturbance overnight. Where it is deemed that the consultant should not return for clinical activity and it cannot be covered plans to cancel appropriate clinical activity should be made.

Where a consultant does not return to site overnight, but has multiple disturbances by phone it may be appropriate to also provide compensatory rest as detailed above.

The weekend on call covers a period of 48 hours and the consultant body have elected to not split the weekend. Where a consultant is discturbed overnight, they may decide to take compensatory rest and undertake a consultant ward round later in the day, after a review of the current workload.

The arrangements should be reviewed annually against a plan to schedule non-clinical work for all consultants following an on call period to allow compensatory rest to be taken without impact on clinical activity and for 11 hours of compensatory rest post on call to become the norm.

2.5. Employment of External Locum Doctors

2.5.1. Short Term (less than two weeks)

Doctors employed as locum on the second on call or consultant rota must have an NHS certificate of eligibility for locums in O and G. A list of doctors with an up-to-date certificate is available at: RCOG Locum Certificate search | RCOG Training

Locum doctors who have obtained CCT or CESR in obstetrics and gynaecology can be employed without a certificate of eligibility if they have current NHS experience within the past six months and they have not been out of clinical practice for more than two months. They must provide as a minimum references from pervious jobs and structured feedback from their last two employers.

O&G trainees will require a certificate when they undertake short term locum placements in the following locations:

Outside of their deanery/HEE Local Office

In a trust (within their deanery/HEE Local Office) where they have not previously worked as a ST3-7

The decision to approve a locum must be made by an obstetric consultant who is expected to:

- Review the CV and references, ensuring that there is appropriate current NHS experience and two references and structured feedback from their two previous jobs.
- Confirm that the locum has an up-to-date NHS certificate of eligibility at RCOG Locum Certificate search | RCOG Training with particular reference to feedback from previous employers or confirm that locum doctors who have obtained CCT/CESR/CESRCP

Prior to the locum shift the following needs to be in place:

- Appropriate departmental induction with the on call consultant on the commencement day
- Locum's CV cascaded to consultants doing non-resident on call with the locum doctor in a timely manner
- A consultant is named to support the locum (this could be the clinical lead or on-call consultant depending on circumstances and length of the locum attachment)
- A discussion takes place between the locum doctor and the on call consultant about clinical capabilities and escalation on starting the shift
- The locum doctor is given access to IT systems signposting to guidelines and training to be completed on the day of commencement

A record of the stipulations above needs to be kept.

At the end of the placement the named consultant is expected to give written feedback on performance to both the locum doctor and to the employing agency.

2.5.2. Long term (more than two weeks)

Locum doctors do not have to provide a CEL for locum placements of more than two weeks. However, the performance of the locum doctor should be reviewed and assessed in normal working hours, prior to allowing them to work out-of-hours, following the guidance found at: rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf.

ROLES AND RESPONSIBILITIES

Policy development is the responsibility of the members of the Guidelines Group and associated Specialist Practitioners. The guideline is then ratified by the Maternity Risk Management Group (MRMG) as part of the bi – monthly meeting or as a quorum of at least 6 members.

Once the guideline has been ratified, it is the responsibility of all staff within the Maternity Service and the Trust to ensure that the principles are adhered to in practice. In some circumstances it may be appropriate to deviate from the guidance but these decisions must be made at a senior level and the rationale documented in the notes.

The monitoring and review process is the responsibility of the Maternity risk Management Group to determine Audit requirements, with the support of the Clinical Effectiveness Department.

3. POLICY DEVELOPMENT

3.1. Identification of Stakeholders

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

3.2. Equality Impact Assessment

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

4. Review and revision arrangements

Review yearly by Clinical Director for Surgery, Obstetrics and Gynaecology, Clinical Lead for Obstetrics and Gynaecology and Lead for Labour Ward.

Additional review with any change in consultant job plans or new consultant appointment.

5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

5.1. Consultation Process

The consultation process is summarised in Appendix 2.

5.2. Approval Process

The guideline is approved by the MRMG and the stakeholders identified above.

5.3. Ratification Process

The guideline is ratified by the Maternity Risk Management Group, or a designated quorum of that committee.

6. DOCUMENT CONTROL

6.1. Publication

The guideline will be published in the Trust electronic document library. A hard copy is available in each clinical area within maternity services.

6.2. Archiving Arrangements

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

6.3. Access

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

7. DISSEMINATION AND IMPLEMENTATION

The publication of the guideline will be notified in the Maternity Services Newsletter which is produced on a quarterly basis. Any changes will be highlighted at the Joint Staff meetings and Medical Staff Education meetings.

A “publish and point” method of communication via the handover sheets, will be implemented, where relevant staff are informed about the publication of a new or revised document on the document library and that they are also available in the Clinical Guidelines folders.

7.1. Implementation

Changes in practice will be highlighted as per the Dissemination section above. Compliance with guideline practice will be monitored as per section 9. Where there is a lack of compliance with the guideline an action plan, to include training where necessary, will be formulated as per the Monitoring and Compliance section.

7.1.1. Training and Support

Training will be given as per the Maternity Specific TNA or where monitoring and audit of the guideline have found deficiencies in compliance with the guideline standards.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

The Clinical Lead for Obstetrics is responsible along with the MRMG for monitoring this guideline

8.1. Standards / Key Performance Indicators

- There should be prospective consultant presence for 40 hours on the delivery suite (Safer Childbirth; Healthy Ambitions)
- There should be a resident middle grade doctor and first on call doctor covering labour ward at all times

8.2. Process for Monitoring Compliance

8.2.1. Monitoring

Compliance with the use of the guideline for consultant presence on delivery suite will be monitored through the maternity dashboard on a monthly basis. The dashboard is reviewed at the Planned and Surgical Care Board on a monthly basis. Where deviations from the guideline occur an action plan will be drawn up and consultant presence on delivery suite added to the departmental risk register. Where the annual review shows a deviation from required consultant presence on delivery suite a business plan will be made. The business plan and contingency plans will be monitored via the Planned and Surgical Care Board.

8.2.2. Audit

An annual Review/audit of consultant Obstetric cover on delivery suite will be undertaken annually.

8.2.3. Feedback

Where monitoring has identified deficiencies, recommendations and an action plan will be developed. The results will be reported to appropriate groups and committees, and the recommendations and action plan approved. Progress in meeting the requirements of the action plan and implementing changes will be monitored.

The monitoring, audit and feedback process is summarised in Appendix 3.

9. REFERENCE DOCUMENTS

Department of Health. (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*. London: COI. Available at: www.dh.gov.uk

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press. Available at: www.rcog.org.uk

Healthy Ambitions Maternity and Newborn Pathway

Labour Ward Solutions. Good Practice No. 10 RCOG. Available at www.rcog.co.uk

Responsibility of Consultant On Call. Good Practice No. 8 RCOG. Available at www.rcog.co.uk

10. APPENDICES

Appendix 1: Contacting a Consultant for Delivery Suite

Appendix 2: Consultation Summary

Appendix 3: Monitoring, audit and feedback summary

10.1. Appendix 1: Contacting a Consultant for Delivery Suite

Do you need the consultant on duty for Delivery Suite?

Monday – Friday 08.00h – 16.30h

Baton bleep (3180) carried by duty consultant Monday – Friday 08.00h – 16.30h

Obstetric emergency 2222 calls will include 3180 consultant baton bleep automatically

Out of hours

Consultant on call can be contacted via switchboard

Out of hours obstetric emergency calls will not automatically include the consultant – if you need the consultant urgently out of hours, call directly via switchboard

10.2. Appendix 2: Consultation Summary

	List Groups and or Individuals Consulted
Those listed opposite have been consulted and comments/actions incorporated as required. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Obstetric consultants
	Head of Midwifery
	Maternity Matron
	Risk Management Midwife
	Maternity Risk Management Group

10.3. Appendix 3: Monitoring, Audit and Feedback Summary

KPIs	Audit / Monitoring required	Audit / Monitoring performed by	Audit / Monitoring frequency	Audit / Monitoring reports distributed to	Action plans approved and monitored by
Prospective 40 hours consultant presence on delivery suite	Annual audit	Labour ward lead	Annual	Maternity risk management Group Clinical effectiveness Planned and Surgical Care Board Planned and Surgical Care Board	Maternity risk management Group Clinical effectiveness Planned and Surgical Care Board
	Monitoring via maternity dashboard	MRMG	Bimonthly	Planned and Surgical Care Board	
	Progression of business plans, contingency plans and action plans	Clinical lead			
Continuous middle grade and first on call cover on delivery suite	Annual audit	Labour ward lead	Annual	Maternity service risk management team Clinical effectiveness	Maternity services risk management team Clinical effectiveness

Medical Staffing on the Delivery Suite

(Including Consultant Presence on Delivery Suite)

Requirement of consultant to attend in person	Annual audit	Labour ward lead	Annual	Maternity service risk management team Clinical effectiveness	Maternity service risk management team Clinical effectiveness

Maternity Training 2023-2024 KMcC / COD

Appendix B

Harrogate and District NHS Foundation Trust

Action plan

To ensure that essential training compliance in Maternity reaches 90% and is maintained at that level.

For Midwives, Maternity Support Workers Obstetricians, Anesthetists, Pediatricians and Neonatal Nurses

21st December 2023

Medical Staffing on the Delivery Suite

(Including Consultant Presence on Delivery Suite)

1. Background

On 1st December 2023 compliance was achieved for all staff groups in line with the training requirements of Safety Action 8 of the NHS Resolution Maternity Incentive Scheme (MIS) Year Five.

The following training requirements were reported –

- PROMPT – Maternity emergencies and multi-professional training
- Fetal monitoring training and competency assessment
- Newborn basic life support

In October 2023 NHS resolution published revised guidance related to Safety Action 8 -

'80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.

This action plan will detail the recovery of any staff group to 90% compliance by 22nd February 2024 and then will detail the plan to maintain compliance levels to at least 90% throughout 2024.

2. Training requirements

a. PROMPT – Maternity emergencies and multi-professional training

This training is essential for Midwives, Obstetric Consultants, Obstetric middle grade doctors, Obstetric trainees and junior doctors.

At 1/12/24 compliance was between 90-100% for the following staff groups –

Obstetric consultants – 100%

Obstetric junior doctors – 100%

Consultant Anaesthetists – 100%

Midwives – 98%

Compliance for junior anesthetists and Maternity support workers was reported at 89% and 88% respectively.

Action to recover to 90% compliance

1. The lead Consultant for anaesthetics, Will Emery, has been contacted and been asked to give assurance that the two junior anesthetists in question will be released to attend PROMPT on either 10th January 2024 or 15th February 2024.
2. Two Maternity support workers were not compliant for PROMPT on 1/12/23. One has attended on 14/12/23 and the other is rostered to attend on 10/1/24.

Actions to maintain compliance > 90%

1. All Midwives and Maternity support workers have been allocated a PROMPT date in 2024. All of these dates will be inputted onto the roster.
2. All Obstetric Consultants and registrars have been allocated a PROMPT date in 2024.
3. All members of the anesthetic team have been asked to sign up to a date for PROMPT in 2024. The Anaesthetic Lead has oversight of this.
4. From September at least one scenario on PROMPT is conducted on delivery suite. This means that by April 2024 we expect that at least 90% of all staff groups will have taken part in a 'live drill' in a clinical area.

b. Fetal Monitoring and surveillance training

Saving Babies Lives v3 element 4 has the following requirements -

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

The following staff groups are required to attend face to face training annually and complete a mandatory competency assessment – Obstetric consultants, all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor) and all Midwives.

At HDFT, junior doctors are not permitted to classify or 'buddy' a CTG. Wherever possible, junior doctors will be released to attend the fetal monitoring and surveillance training, although they will never be without the presence of a senior Obstetric colleague.

As at 01/12/23 excellent compliance was achieved for the elements detailed above.

Obstetric Consultants – 100%

Other Obstetric doctors – 100%

Midwives – 99%

Actions to maintain compliance > 90%

1. All Midwives and Obstetric Consultants have been allocated a date to attend Fetal monitoring training and surveillance ('MAT2 training day').
2. The rota co-ordinator for middle grade doctors and Obstetric trainees has been sent a list of when individuals need to attend training and asked to ensure they are released to attend before they go out of date.
3. All staff are prompted to complete the required competency assessments via K2 before they expire. Compliance is monitored every month by the fetal wellbeing leads and this information is escalated to individual staff members and line managers.

The Fetal Wellbeing Lead team at HDFT are currently part of an LMNS working group which is collaborating to co-produce an LMNS approved competency assessment. It is hoped that this will be completed and approved within the next three months. This will then replace the K2 online competency assessments.

c. Newborn Basic Life Support

Newborn life support (NLS) training is delivered to Midwives as part of the 'MAT1 training day'. The resuscitation department provides training to Paediatric and neonatal staff.

As of 01/12/23, 100% neonatal nurses, 98% Paediatric consultants and 94% Midwives were compliant with an annual update. Compliance for other paediatric doctors who are not consultants was 87%.

Action to achieve 90% compliance

1. Both of the non- consultant Paediatric doctors who were not compliant attended an update on 07/12/23.

Action to maintain compliance > 90%

1. All Midwives have been allocated to a 'MAT1 training day' in 2024 and this will appear on their roster.
2. The fetal wellbeing leads will monitor compliance monthly and escalate NLS training which is soon to expire both the individuals and to line managers. The aim is that all midwives will receive an annual update before that training expires.
3. The lead Neonatal Nurse for training and Lead Paediatrician will monitor compliance for neonatal and paediatric teams and report to the Associate Director of Midwifery.

3. Conclusion

The Maternity training team has worked diligently with all subject matter experts to deliver high quality training to the maternity teams at HDFT. All training is continually evaluated and any key points for learning and improvement are considered and training is adapted as appropriate.

Compliance for the essential training described in this action plan is reported at the beginning of every month to the Matron for Maternity and the Associate Director of Midwifery for submission to the Trust Board and Local Maternity and Neonatal System.

A trajectory for all statutory and mandatory training is also reported, with the assistance of the Trust Mandatory Training Lead, and this is presented at the bi-monthly Maternity Risk Management Group meeting.

We would like to thank the following subject matter experts / faculty for their continued support and assistance with the training detailed in this action plan –

Paula De Souza – Trust Resuscitation Lead

Siobhan Wilson – Consultant Obstetrician / Training Lead / Fetal Wellbeing lead

Will Emery – Lead Consultant (anaesthetics)

Stuart Cook and Davey Hogg – Clinical skills facilitators

Emily Leese – Mandatory Training Lead

Amy Howard – Neonatal Educator and Governance Lead

ID number	Root Cause/Contributory Factor	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	Update
1	Junior anaesthetists PROMPT compliance 89%	Low	Two junior anaesthetists in question will be released to attend PROMPT on either 10th January 2024 or 15th February 2024	Anaesthetic Lead	Clinical Director	15th February 2024	Complete – 2 junior anaesthetists in question- one no longer covers Obstetrics. The other is long term sick
2	MSW compliance 88%	Low	Roster the two outstanding MSWs to attend training in December 2023 and January 2024.	Maternity Matron	Associate Director of Midwifery	15th February 2024	Complete – 2 MSW – 1 attended in December and the other is rostered on 14/1/24
3	Non consultant paediatricians compliance 87%	Low	Two non- consultant Paediatric doctors who were not compliant to be released to attend an update in December 2023	Paediatric Lead	Clinical Director	15th February 2024	Complete - 2 non consultant paediatricians out of date Both attended on 07/12/23

Medical Staffing on the Delivery Suite

(Including Consultant Presence on Delivery Suite)

Harrogate and District NHS Foundation Trust

4

Strengthening Maternity and Neonatal Safety Report

SMT

November 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 November 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 November 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.

Maternity – December 2023 (November's data)

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Capacity for Caesarean sections continues to create additional workload and poor patient experience • Daily meetings with LMNS/regional trust reps to discuss movement of women around the region due to capacity issues across the region.	• Saving babies lives care bundle version 3 – work on-going to meet requirements • In-house stop smoking service in development – recruitment of Tobacco Dependency Advisor underway • Data quality in Badgernet work on-going – recruiting Band 4 to assist with this. • Core Competency framework v2 business case going through governance process • 4D scanning private service being arranged • Preparation to undertake SCORE survey in January 2024 • BaBi Harrogate research project – training and recruitment started • Conversations commenced regarding Single Point of Contact for maternity • 2 on-going PSII investigations – 1 Neonatal death, 1 Undiagnosed 4th degree tear • NICE compliance – progressing assessments • Maternity Incentive Scheme query on compliance – evidence submitted • 3 complaints ongoing – Safeguarding, scanning and perineal tear • Maternity Support Worker uplift to Band 3 in consultation period • Pelvic Health project work underway – recruiting midwife with external funding to commence in April • Leon Smallwood maternity hub due to open in January 2024 • Creating Baby Carousel with MVP • Moving elective activity out of MAC – review of place to be re-located to
Positive news & assurance	**Decisions made & decisions required of the Board**
• No new MNSI (previously HSIB) cases reported • LMNS assurance visit – positive report received (Appendix B) • Training requirements met for Maternity Incentive Scheme • Recruited to cover maternity leave of Maternity Matron • Maternity Voices Partnership 15 Steps report completed • Midwifery Diabetes Champion recruited • Pool evacuation training now launched on Learning Lab • Code Purple (baby abduction) simulation completed • Midwife now substantive in PLF role to continue improvements in student experience • No EPAU closures • MSW celebration day positively received	

Narrative in support of the Provider Board Level Measures – November 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 November 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 –
3.08 WTE sickness absence (no theme identified). Increase noted since previous month.
2.99 WTE maternity leave

Unavailability of Maternity support worker hours –
0.28 WTE sickness absence

3.2 Vacancy position

Currently there is zero midwifery and maternity support work vacancy.

3.3 International Midwifery Recruitment

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.

3.4 NHSP provision

Midwives -
2.18 WTE NHSP midwifery staffing used in November 2023.

Support workers –
3.7 WTE NHSP maternity support worker staffing has been used across maternity in November 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.

Two homebirths were booked for the month of November 2023. Two women were attended at home, one of which birthed in the maternity unit.

In the period 1/11/23 – 30/11/23, the home birth provision was not suspended. On twelve occasions staff provided flexibility to cover for short notice sickness. For November the service has moved back to the traditional on call system, meaning no third Midwife on Pannal on weekends to re-evaluate and for feedback from the integrated staff who have been doing these. An email has been circulated for ideas for improving homebirth on calls.

4.0 Neonatal services staffing, vacancies and recruitment update

4.1 Neonatal absence position

0.92 WTE nurse currently on maternity leave.
0.61 WTE nurse long term sickness absence
1.24 WTE short term 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.

November 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 170 were completed. Staffing met the acuity 64% of the time. This figure is reduced due to short term sickness which equated to 57%.

82% (140) of the time no clinical actions were required. 18% (30) of the occasions clinical actions were required, these included:
· Delay in continuing induction of labour 20 occasions
· Delay in commencing induction of labour 7 occasions (Inpatient)
· Delay in elective caesarean section (delivery suite) 1 occasions
· Postponed induction of labour (at home) 7 occasions
· Delivery Suite Coordinator not supernumerary 4 occasions

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

To delay an induction of labour or elective caesarean section is usually the most clinically appropriate action to take in periods of high activity. The impact of a clinically appropriate

delay is on patient experience. To mitigate the impact on patient experience staff ensure the women and families involved are fully informed of the delay, are regularly updated on the situation, and plan for their care provision.

99.3% of women received one to one care when labour within the unit. No women had a baby born before the arrival of a midwife.

5.2 Pannal Ward Staffing

During November 91% of Midwifery day shifts and 94% of night shifts were covered with contracted hours. 9% of Midwifery day shifts and 6% night shifts were covered with NHSP. MSW day shifts were covered 92% with contracted hours and 9% with NHSP. MSW night shifts were covered 82% with contracted hours and 18% with NHSP.

Birthrate plus Acuity Ward Tool remained under review during November, resulting in unavailability for data entry, however there were no Datix reports submitted related to any reportable features of the Birthrate plus tool. The Ward Acuity App is expected to be reintroduced during December 2023.

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 Birthrate Plus data during November - delay in providing pain relief > 30 mins.

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 01/11/2023 to 30/11/2023

MA1	Redeploy staff from Pannal	**9**	**28%**
MA2	Staff unable to take breaks	**6**	**19%**
MA3	Review of staff on management time	**2**	**6%**
MA4	Use of specialist midwife	**3**	**9%**
MA5	Use of staff on training days	**0**	**0%**
MA6	Use of ward/department managers	**1**	**3%**
MA7	Staff sourced from wider Trust (theatre & CSW's)	**0**	**0%**
MA8	Use of hospital MW on call	**6**	**19%**
MA9	Use of community MW	**0**	**0%**
MA10	Unit on Divert	**5**	**16%**
MA11	Patient diverted	**0**	**0%**
	Total	**32**	

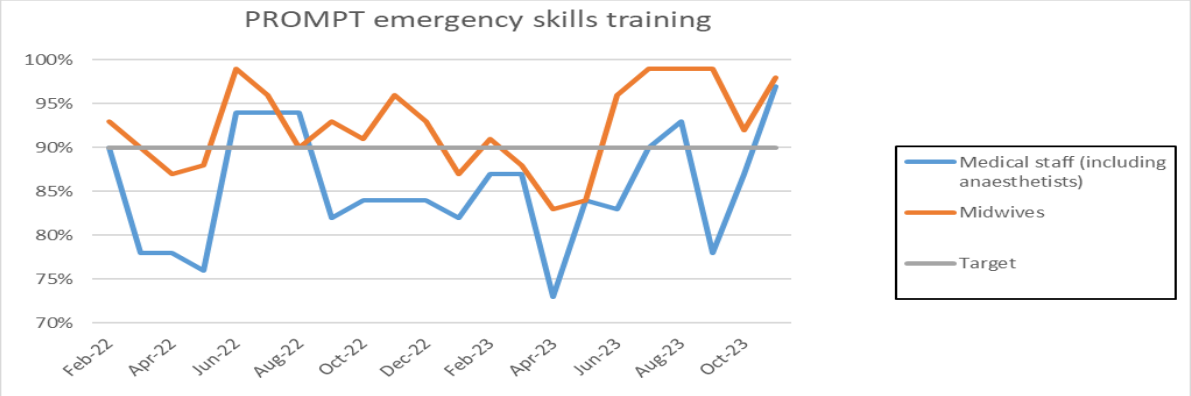
6.3 Pannal Ward Red Flags

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 Core Competency Framework And Wider Job Essential Training

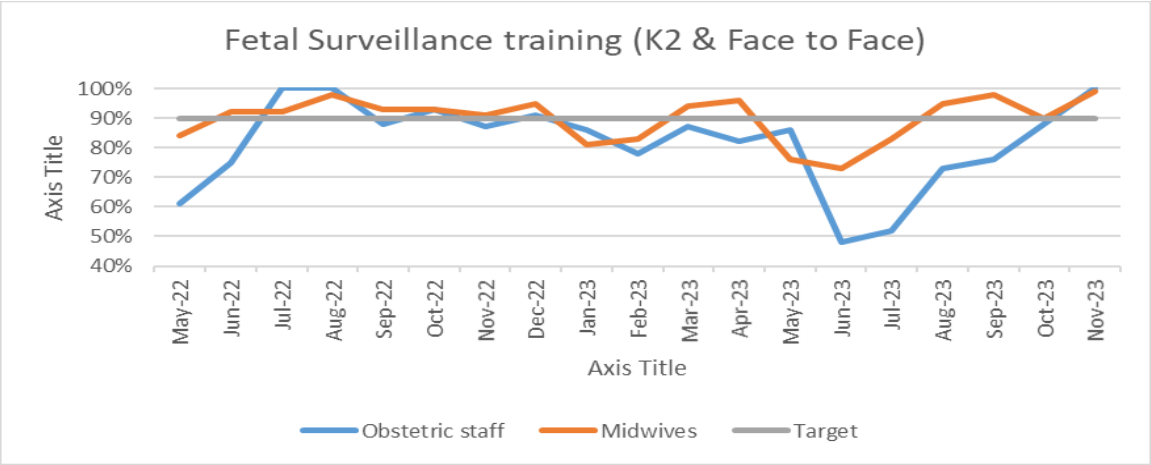
7.1 Mandatory training (as at 12/12/23)

7.2 Prompt emergency skills training



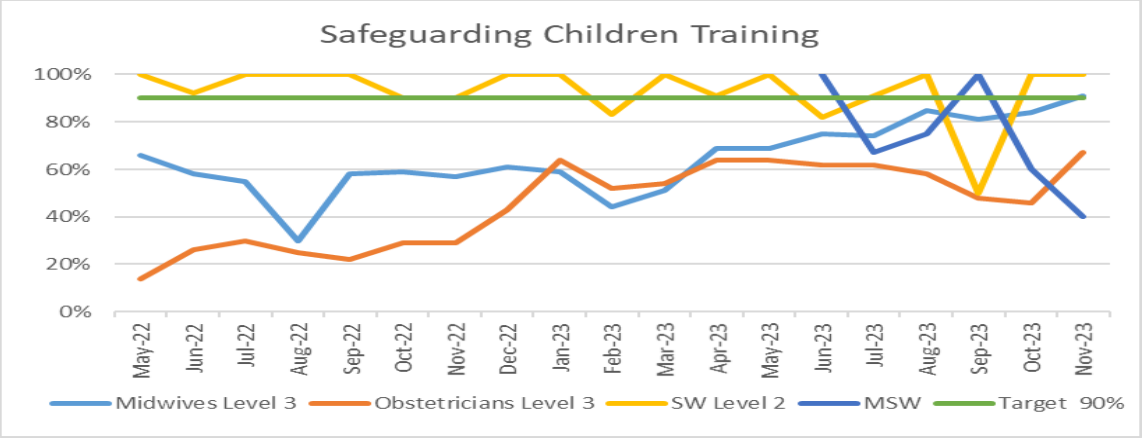
7.3 Fetal surveillance training

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.



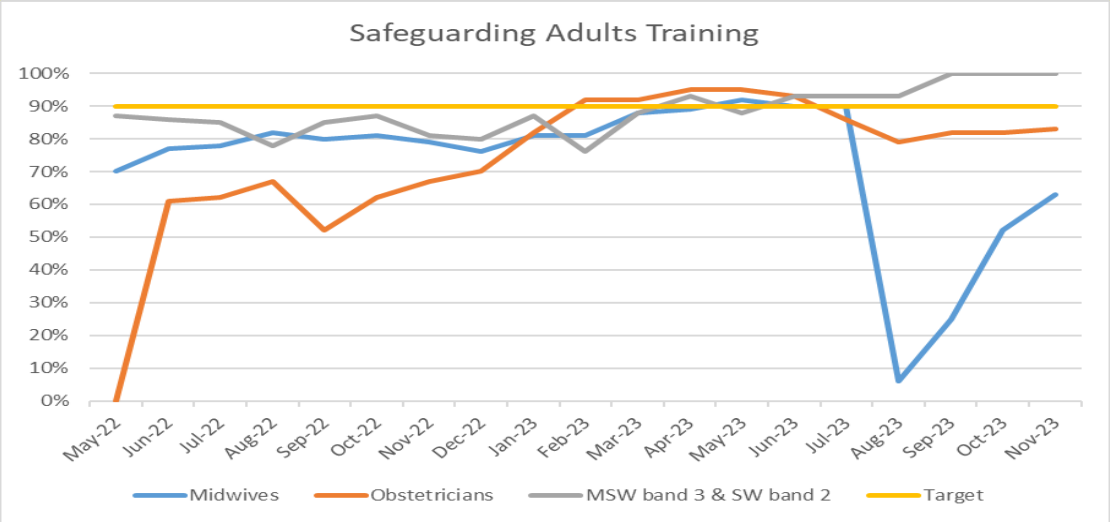
7.4 Safeguarding Children training

Maternity support workers figures have dropped due to newly recruited staff joining the team and the small numbers.

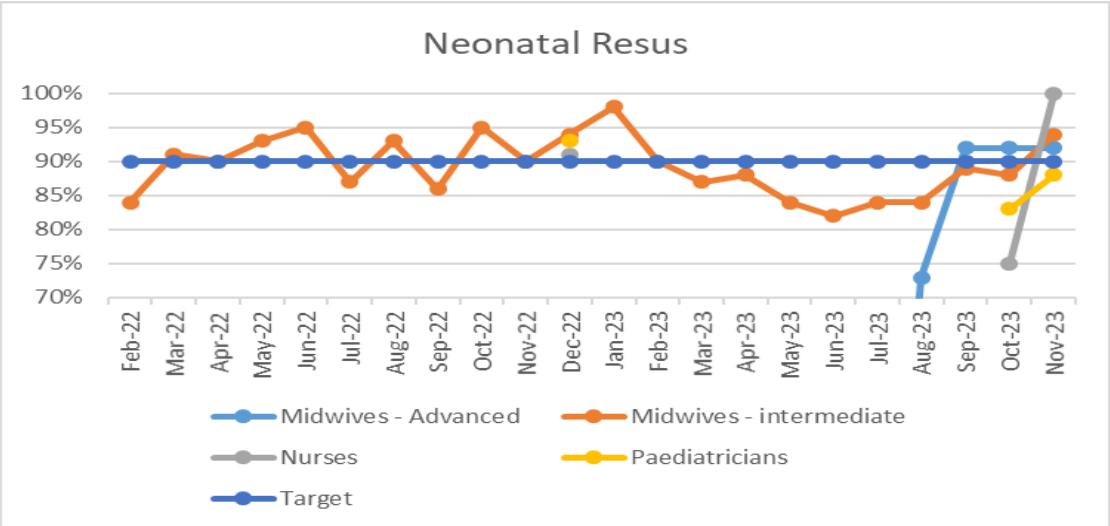


7.5 Safeguarding Adults training

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 three months and this is planned to continue along this trajectory to meet 90% by the end of the financial year.



7.6 Neonatal resuscitation



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

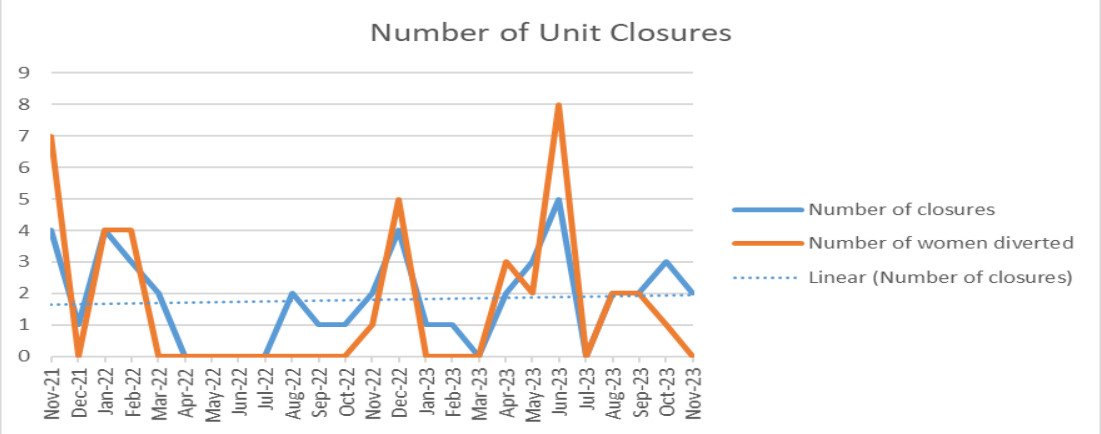
All staff out of date for their RCUK Newborn Life Support Face to Face are booked onto upcoming dates further afield due to a lack of availability of local training, all staff will have completed the RCUK training within the next year and are up to date with their local training. The staff who are identified as being out of date for adult basic life support will attend training within the next month.

Category	Certification Name	Required	Not Achieved	Compliance %
Mandatory Training	Adult Basic Life Support with paediatric modifications	17	3	82%
Mandatory Training	RCUK Newborn Life Support Face to Face	6	2	67%
Mandatory Training	Harrogate Newborn Advanced Life Support (HNALS)	16	1	94%
Mandatory Training	Harrogate Newborn Intermediate Life Support (HNILS)	1	0	100%

8.0 Risk and Safety

8.1 Maternity unit closures

Two events of closure of the unit in November 2023 related to activity and ward capacity. No women were diverted during the closures.



8.2 Maternity Accepted Diverts

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 November there were nine women transferred to Harrogate from across the region (Bradford, York, Hull and MidYorks) who laboured and birthed. A daily (Monday – Friday) regional meeting has been developed, supported by the Local Maternity and Neonatal System, to review staffing, activity and the number of women awaiting induction of labour across the region. This meeting has been well received by the Harrogate maternity team and has developed their awareness of the regional situation and improved communication between Trusts.

8.3 Maternity Risk register summary

No new risks added. Nine 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 6).** Some improvements therefore risk downgraded.

- **Risk to service provision for homebirths due to unreliable homebirth cover (Score 6).** Some issues of cover for short-notice sickness remains and further plans in consultation. No change.
- **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 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 being implemented. 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 and good progress against target. Action plan in place. Risk level currently remains unchanged.
- **Risk to patient safety, and compliance with national recommendations due to inadequacy of current safeguarding policies and procedures (Score 4).** Policies and procedures now updated by Named Midwife for Safeguarding. Risk downgraded
- **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 presence. Risk reduced due to limited consequence.
- **Risk to compliance with Ockenden and Maternity Incentive scheme requirements for audit (Score 2).** Good completion of audit deficit against Saving Babies' Lives and compliance achieved. Good progress again MIS requirement. Risk downgraded to target and planned archive.

8.4 Maternity Incidents

In November 2023 there were 64 total incidents reported through Datix. No incidents have been reported a Moderate Harm or above.

Two current PSII investigations ongoing (previously reported); one for neonatal death and one relating to missed diagnosis of perineal tear. Completed to final draft.

Additional incidents of note include:

- Thirteen incidents of Term baby admission to SCBU (two others rejected as duplicates). One due to apnoeic episode following vomiting; nine related to requirement for oxygen/respiratory support; two for hypoglycaemia; one not passing urine and requiring transfer to Leeds. This represents a significant increased reporting from October data.
- Eight readmissions of mothers & babies (six readmissions of babies for jaundice, weight loss and feeding issues; one maternal readmission for mastitis).
- Five incidents for referrals not being actioned. Four of these relate to issues with the booking of elective LSCS as referrals not sent correctly through Badgernet (user error), leading to issues in trying to schedule near to due date.
- Four incidents of PPH≥1500ml

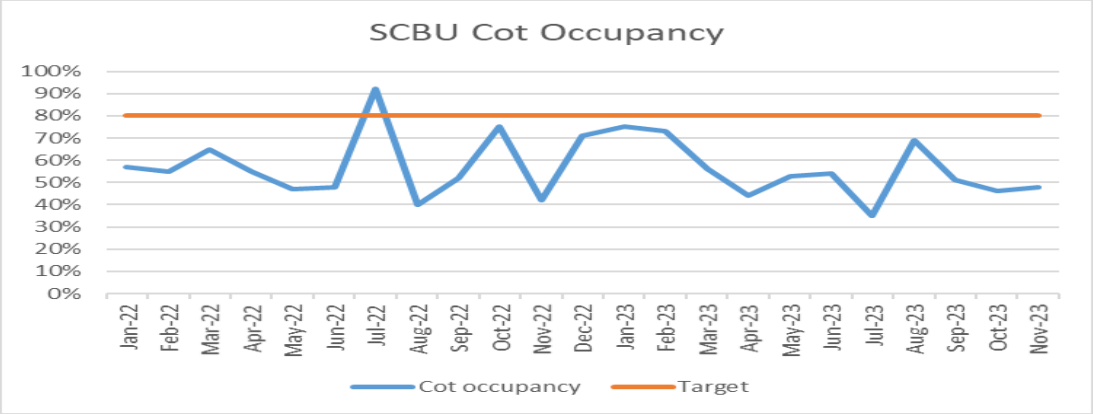
SCBU Incidents

No moderate harm incidents.

8.5 SCBU Risk Register

No new risks.

8.6 Cot occupancy and babies transferred out



One baby was appropriately transferred out during November 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

No new notifications were made for PMRT this month. Ongoing contributions are being made to cases where a death occurred at another Trust in which care was also provided by Harrogate maternity services.

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

10.0 Service User feedback

Maternity service user feedback –

- What was good about your experience with maternity services in Harrogate?
  - Always on point. Introducing the Badger app is amazing. In case of emergency its easy to contact someone. So far so good! Please keep up the hard work! We really appreciate.
  - The community midwife was amazing and lovely. They took my concerns seriously and explained everything.
  - Birthing experience. Quality of care on delivery unit
  - They look after you well and take care of you
  - Everyone is kind, explains things clearly and remain calm. All the midwives, doctors and nurses are super knowledgeable, personable and supportive! We feel lucky to have had our pregnancy journey in Harrogate
  - Staff communicate really well, sonographer and midwife answered all the questions patiently, very professional, good at their job
- What would you have liked to been different about your experience –
  - An additional scan between week 20 onwards
  - Information sharing with Leeds trust should be better.
  - There is a bit of training staff when doing scans which takes longer and don't tell us much info
  - Currently pregnant with baby no.2 At the start of my pregnancy I felt I was passed from pillar to post! I think when you register your pregnancy you should have to do a pregnancy test with a GP or midwife! Getting through to antenatal and maternity ward can be so difficult

SCBU feedback –

Thank-you so much for the last 8 weeks! I cannot explain how grateful I am for how amazing you have all been to me. You are such a good team and would be proud to be half of what you are. I won't forget this placement so thankyou again (oh and merry Christmas)

11.0 Staff feedback

Awaiting results from NHS Staff Survey.

12.0 Complaints

No new formal complaints have been received in November. There are three on-going (previously reported) complaints including one still awaiting formal consent.

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 and relating evidence submitted.

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 one outstanding action which is due to be complete by the end of December 2023. The actions in relation to audit have now been completed.

15.0 Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported in November 2023. No open cases. Action plans in place for previous HSIB cases and these are being monitored via Maternity Quality Assurance Meeting.

16.0 Maternity incentive scheme – year five (NHS Resolution)

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

Safety Action	RAG rating and narrative (if not green)
SA1 - Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Delayed reporting of a fetal loss – one twin demised at 19 weeks but was delivered at 35 weeks with twin. Demise not reported until one month later when identified. Guidance states *'Where the death of a baby is confirmed before 20+0 weeks gestation but the baby is delivered at 22+0 weeks gestation or later AND the birthweight is less than 200g, you will only be required to complete the initial notification.'* This may affect compliance reporting.
SA2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
SA3 - Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
SA4 - Can you demonstrate an effective system of medical workforce planning to the required standard?	
SA5 - Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
SA6 - Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle version three?	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?	

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?	Report included at Appendix A.

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**	Continuity of carer not in place but 'building blocks' continue to be developed.
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**	Implementation of Core Competency Framework Version Two from January
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**	Data review with consideration of inequalities
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 Ockenden

17.2.1 Local Maternity and Neonatal System Assurance Visit

The Ockenden Report (2020 and 2022), and the Reading the Signals report (Kirkup 2022) identified that trusts were not implementing sustained change in response to independent enquiries and recommendations. In response to this, assurance and support visits were carried out during 2022 in each trust to assess and confirm progress towards the implementation of the seven immediate and essential actions of the Ockenden Interim Report 2020. These visits were led by NHS England regional maternity teams, supported by the local maternity & neonatal system (LMNS) team.
Further assurance visits are being undertaken in 2023, led by the LMNS with support from ICB PLACE leads, Chief Nurses and Directors of Midwifery from neighbouring trusts providing peer review, members of the NHSE regional maternity team and, most importantly, supported by the voice of local service users via maternity voices partnership (MVP) leads. Harrogate maternity services assurance visit took place on the 13th November 2023. A full report is provided at Appendix B. In summary the visit was positive and there were no immediate safety concerns identified. There was evidence of the trust providing high quality, safe and personalised care to women and their families.

17.2.2 Informed Consent

The Regional Chief Midwifery Officer has advised that Immediate and Essential Action 7 - Informed consent should be moved to amber on all Ockenden status representation. This is due to concerns being raised nationally from service users.

Immediate and essential action 7: Informed Consent
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.
All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care
Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care
Women's choices following a shared and informed decision-making process must be respected.

Collaborated action plans are to be developed once further details are released regarding the concerns which will enable appropriately targeted actions to be generated.

17.3 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.

17.4 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. Continuity of Carer remains paused in Harrogate Maternity Services.

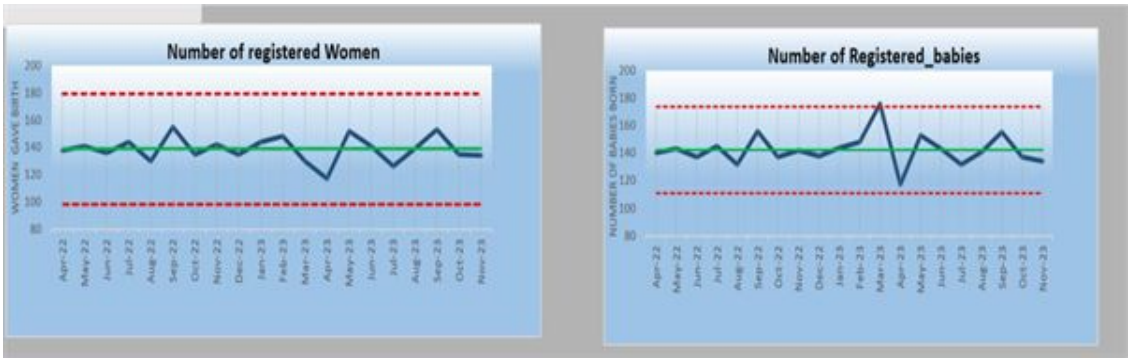
18.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

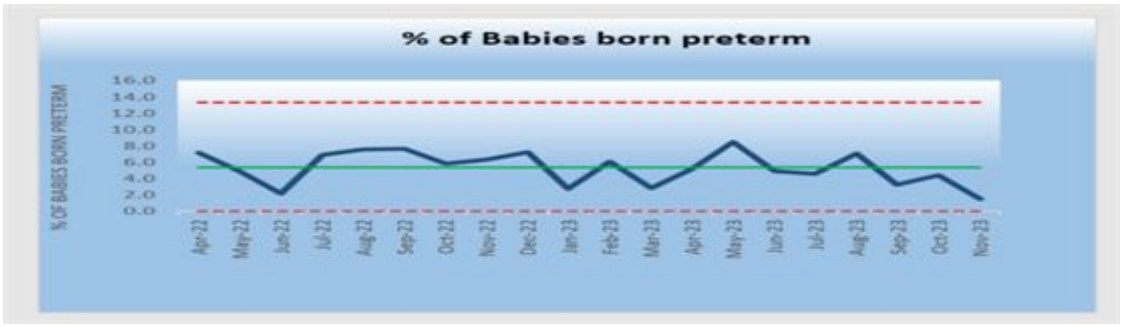
In summary for Quarter 2:
· Bookings less than 10 weeks are 68.7%. Y&H average 66.6%. No Y&H Trust has yet met the 90% target.
· 1:1 care in labour for HDFT was 95.4% in Q2. Y&H average 87.4%
· BBA rate 1.2% is comparable to the Y&H average of 1.0%.
· Homebirth rate currently 0.2%, against Y&H average of 1.5%
· Normal delivery rate was 49.4% in this quarter, against a regional average of 52.6%.
· Total Caesarean section rate was 35.6% in this quarter (compared to the regional average of 37.5%). Of these, there were 18.9% elective Caesarean sections (significantly higher than the 15.1% regional average). This remains the highest in the region.
· Induction rate in this quarter was 36.3%, and this is comparable to the Y&H average (35.5%), with the highest induction rate in the region being 46.8%.
· Significant PPH rate in this quarter (2.3%) is in accordance with the regional average (3.2%).
· Preterm birth rate <37 weeks in this quarter (7.5%), was lower than the regional average (8.2%).
· There were no stillbirths at HDFT in Q2. Annual antenatal stillbirth rate is currently 2.4 per 1000 births compared with the Y&H average of 3.7 per 1000.
· Breastfeeding initiation rates remain high at 81.1% compared with the regional average of 70.7%.
· Smoking rates at booking and time of birth are 4.7% and 6.2% respectively. This has increased since Q1 but is still low, compared with Y&H average of 10.0% and 9.7%.

The full dashboard is included in Appendix C.

19.0 Local HDFT Maternity Services Dashboard

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

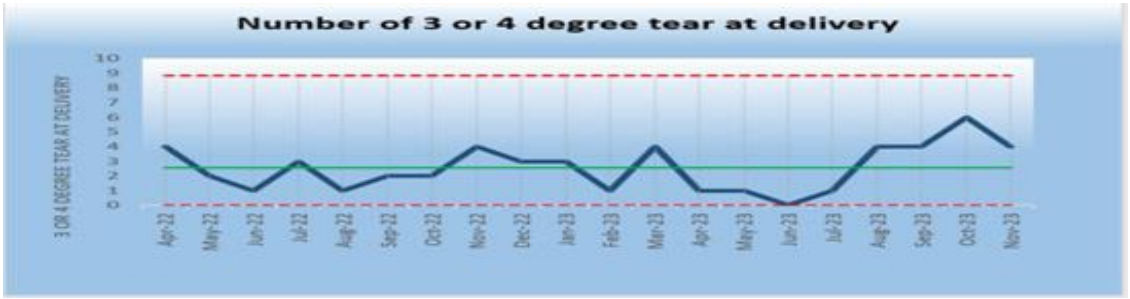

Number of registered Women
WOMEN GAVE BIRTH
Number of Registered_babies
NUMBER OF BABIES BORN

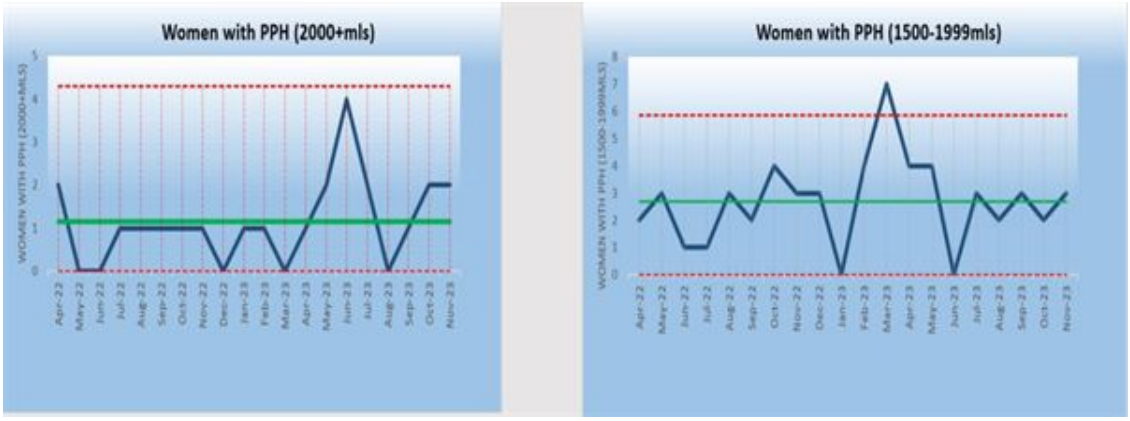

% of Babies born preterm
% OF BABIES BORN PRETERM

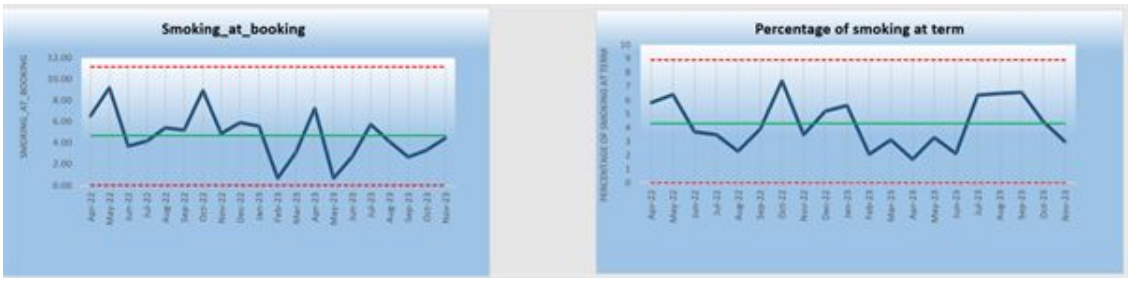

Rate of Induction

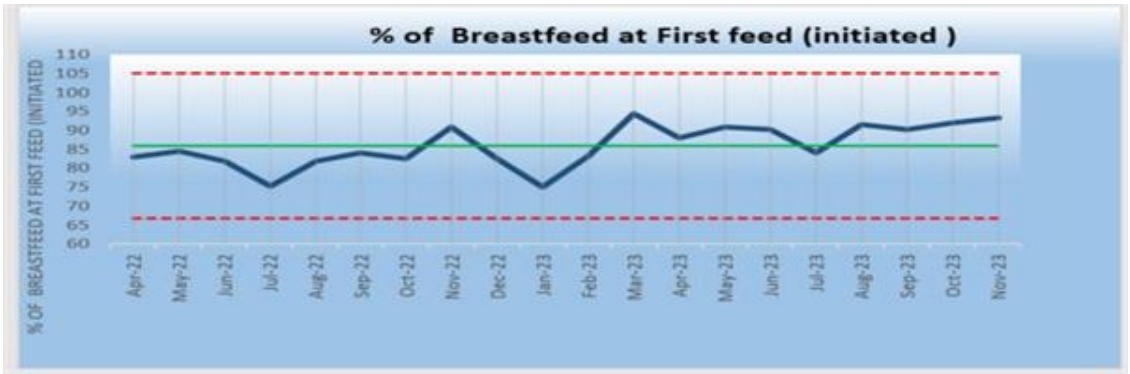

Number of Stillbirth
NUMBER OF STILLBIRTH
Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA


Instrumental Birth Rate
INSTRUMENTAL_RATE
Number of VBAC
NUMBER OF VBCA









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.

20.1 Term Admissions to SCBU

There were thirteen incidents of Term babies being admitted to SCBU in November. Nine of these admissions related to baby's requirement for oxygen/respiratory support. This represents a significantly increased reporting from October data. No specific concerns have been identified and it may represent a statistical anomaly. Additional work ongoing to reduce avoidable admissions due to short term respiratory issues which self-resolve within a couple of hours on SCBU.

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		
For neonatal staff to stay longer with stable babies on CLWS with borderline observations, whilst they transition to ex utero environment, in order to reduce avoidable admissions	• Education to neonatal staff • Embed RDS support chart for use on CLWS/Pannal • Facilitate simulation training for babies 'transitioning' to ex utero environment • Complete audit of use of vapotherm to confirm clinical justification	In progress

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.

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)	November 2023
Percentage of babies <3rd centile >37+6 weeks' gestation	0% (0/433) [<2nd, WHO centiles]	1.47% (2/136)
Percentage of babies <10th centile >39+6 weeks' gestation	1.6% (7/433)[WHO centiles]	2.94% (4/136)
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)	2 fetal loss born 16-23+6 weeks (1.47%, 2/136)
- Preterm (24+0-36+6 weeks)	5.1% (live, 21/413)	1.47% (live, 2/136)

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. Executive and Non-executive Safety Champions walk around occurred on 20th November 2023 and was followed by a Safety Champions meeting. The walk around feedback was that the staff are the happiest they have ever been!

23.0 Conclusion and recommendation

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

Appendix A

Compliance of reporting of HSIB and Early Notification Scheme 2023

Presented for:	Board Sign off
Report of:	Executive Director of Nursing, Midwifery and AHPs/Board Executive Safety Champion & Associate Director of Midwifery
Author (s):	Andy Brown (Lead Midwife for Safety, Quality & Clinical Governance)
Report History:	Board of Directors
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

Recommendation:
The information in this report is for review and approval.

Contents

1. Summary

This paper provides a summary of current compliance against Safety Action 10 of the Maternity Incentive Scheme (MIS).

***Safety action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) scheme from 6 December 2022 to 7 December 2023?*

2. Introduction

The NHS Resolution CNST Maternity Incentive Scheme (Year 5) incentivises Trusts by enabling recovery of the element of their financial contribution to the CNST maternity incentive fund by demonstrating achievement of ten specified safety actions. Safety action 10, relates to compliance with reporting of qualifying cases to HSIB (Healthcare Safety Investigation Branch, now MNSI) and the Early Notification Scheme.

Notification should be made to HSIB/MNSI for all cases fitting the criteria in Figure 1:

NHS Resolution criteria:

Term babies (≥37^{+0} weeks gestation) born following labour:

- Severe brain injury diagnosed in the first 7 days of life:
  - Grade III hypoxic ischaemic encephalopathy (HIE); or
  - Therapeutic cooling (active cooling only); or
  - Decreased central tone AND was comatose AND seizures of any kind

In addition to the above, HSIB eligibility criteria also includes:

- Early neonatal death in the first 7 days of life
- Intrapartum stillbirth
- Direct or indirect maternal deaths in perinatal period (during or within 42 days of the end of pregnancy)

Definition of labour

For purposes of notification, the definition of labour that applies to the EBC/HSIB programme includes:

- Any labour diagnosed by a health professional, including the latent phase of labour at less than 4 cm cervical dilatation.
- When the woman called the unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions or suspected ruptured membranes.
- Induction of labour.
- When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.

Figure 1: HSIB/ENS notification criteria

Eligible cases should also be notified to the NHS Resolution Early Notification Scheme by the Trust in accordance with the Early Notification Scheme reporting guide below.

It will be noted that babies that do not meet the criteria under Step One and Step Two, are not reportable under the EN scheme.

NHS Resolution

Early Notification Scheme reporting guide

To be consider alongside wider Claims reporting guidelines and to establish whether a maternity incident should be reported to the Early Notification (EN) scheme please answer the questions and

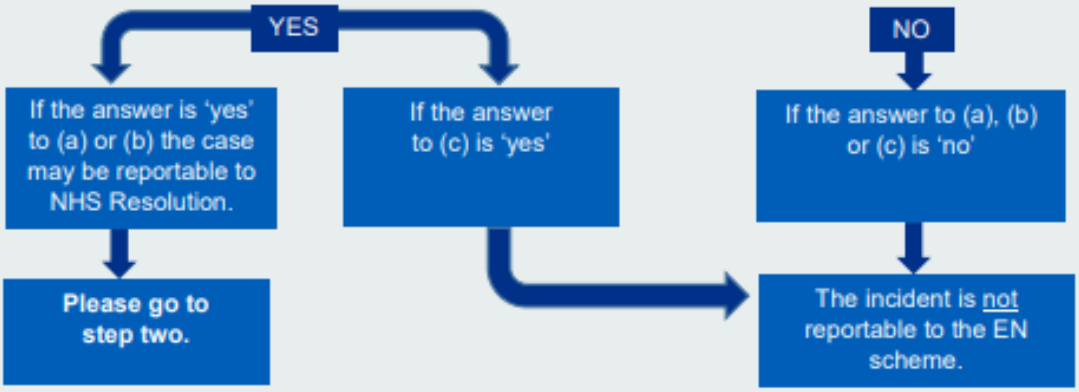
STEP ONE (HSIB factors)

Has one of the following occurred?

a. The maternity incident has been reported to and accepted by the Healthcare Safety Investigation Branch (HSIB) for investigation; or

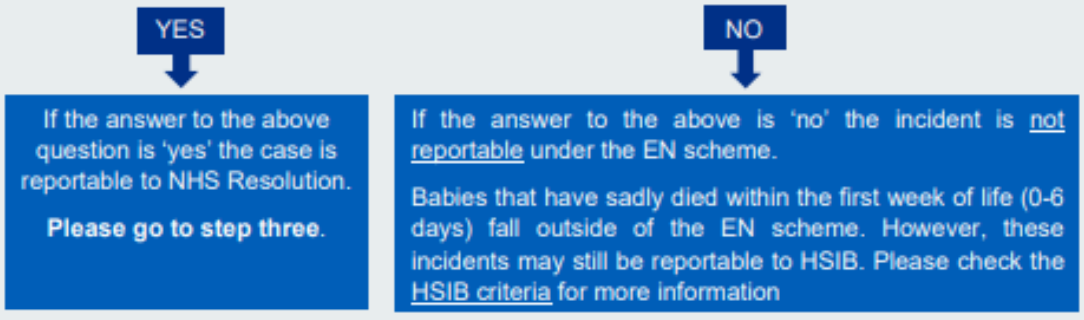
b. The family have declined an HSIB investigation but requested an EN investigation; or

c. The incident does not meet the HSIB criteria but due to family or Trust concerns they have requested that HSIB conduct an investigation and HSIB have agreed.



STEP TWO (EN entry criteria)

Does the maternity incident involve a baby that lived to day seven or beyond?



STEP THREE (Trust reporting actions for qualifying EN cases)

	Trust EN Reporting actions - Checklist	✓
1	Select Sangita Bodalia, Head of Early Notification at NHS Resolution on the Claims Reporting Wizard	
2	Provide a fully completed EN Reporting Form	
3	Provide the HSIB reference** number: • In the 'Any other comments' box set out in the Reporting Wizard **AND** • On the EN Reporting Form	
4	Confirm that you have undertaken statutory duty of candour conversations;	
5	Inform the family that the case has been reported to the EN Scheme and explain that the EN team will write to the family to advise on next steps once triage of the case has been completed. Please notify families that EN case triage takes place after receipt of the HSIB report. In the meantime, you may wish to direct families to EN's family facing web pages.	

**** EN cases reported without an HSIB reference cannot be progressed and you will be asked to resubmit the case with the HSIB reference**. The only exception to this applies when the family has declined an HSIB investigation but requested an EN investigation (this should be stated in the 'Any other comments' section of the Reporting Wizard).

A member of the EN team will write to the member Trust to acknowledge notification of the EN case and confirm the NHS Resolution reference number and the name of the assigned EN file handler.

Please note that there is no need to send any medical records or other documentation at this stage.

STEP FOUR (Trust next steps – Following receipt of the completed HSIB report ~6 months)

Within 30 days of receipt of the final HSIB report Trusts must ensure that the following documents are uploaded to the corresponding CMS file via DTS:

- A copy of the final HSIB report;
- A copy MRI report (if available);
- An updated EN report form (if there were any outstanding fields of information).

Once these items are received, the EN team will triage the case and acknowledge whether the matter will be taken forward for further investigation. At this point medical records and/or other documentation may be requested.

Good practice points:

- If the Trust has not received the HSIB report six months after reporting, Trusts should obtain an update from HSIB and pass on this information to the EN team and advise on likely timescale for receipt of the HSIB report.
- Trusts should avoid uploading HSIB reports in batches (e.g. waiting for a number of reports to be received before uploading to DTS).
- Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification Scheme and should be reported to the appropriate CNST Operational Team Leader.

For more information please visit the Early Notification webpage or contact the Early Notification team at nhsr.enteam@nhs.net or 020 7811 6263

3. Narrative and evidence around compliance with the recommendation

3.1 Requirements of the Maternity Incentive Scheme Safety Action 10

- Reporting of all qualifying cases to HSIB/MNSI from 6 December 2022 to 7 December 2023
- Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023
- For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:
  - the family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme; and
  - there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

3.2 Case identification

To identify qualifying cases and ensure accuracy, searches were undertaken within Datix and Badgernet systems.

The following search criteria were used and limited to the required timeframe:

- Search terms for reported incidents that have been reported to external organisations, including *Healthcare Safety Investigation Branch (HSIB)*, *STEIS*, *NHS Resolution*
- Search to identify all reported incidents that have severity of harm listed as *Moderate*, *Severe* or *Death*
- Search to identify all reported incidents that have subcategory of *maternal death*, *intrapartum death*, *neonatal death*, *unexpected Term admission to SCBU*, *hypoxic ischaemic encephalopathy/transfer for active cooling*
- Search to identify all reported incidents that contain search terms *cooling*, *HIE*, *hypoxia*, *hypoxic ischaemic encephalopathy*, *seizure*
- BadgerNet search to identify all babies born within the unit that have Diagnoses *HIE* or *seizures*, or Procedures *cooling*

Resulting incidents identified were then cross-referenced against cases that fit the reporting criteria (Figure 1) within the timeframe, and had been reported to HSIB.

After search, it was confirmed that there were 2 qualifying cases, within the relevant time period.

3.3 Notified investigations

Resulting incidents notified to HSIB are shown in Table 1.

Within the specified reporting period, two cases were notified to HSIB under the eligibility criteria. Both of these investigations have now been completed.

Reference	Criteria	Incident date	Reported date	HSIB Report completed	NHS-R ENS notification	Status
MI-021175	Neonatal Death	20/01/2023	24/01/2023	25/09/2023	Does not meet eligibility criteria under Step 2, as baby sadly died before Day 7. However, in view of the sad outcome, the case was reported to NHS-R EN. DAC Beachcroft have been instructed by NHS-R.	HSIB investigation complete
MI-025134	HIE/Cooling	31/03/2023	03/04/2023	13/10/2023	Notification not made as not meeting eligibility criteria Step 1(c). MRI showed no "definite evidence evidence of significant HIE insult", and cooling crtieria not strictly met. However, parental concerns about induction of labour for large-for-gestational age (LGA) so confirmed HSIB investigation	HSIB investigation complete

Table 1: Incidents notified to HSIB and NHS Resolution Early Notification Scheme

For clarity, in their letter of 24th March 2020, HSIB indicated that in view of Covid pressures, they would *"no longer routinely investigate maternity events involving cooled babies where there is no apparent neurological injury confirmed following therapy. This would normally mean an MRI showing no hypoxic or neurological damage and the baby demonstrating no ongoing neurological signs or symptoms."* But that they *"may choose to investigate any of these after assessing individual circumstances, including specific concerns from the Trust and affected families."* Though case MI-025134 identified no sign of HIE (hypoxic ischaemic encephalopathy) on MRI scan, parental concerns were expressed about the decision for induction of labour (commenced at another Trust), and so HSIB investigation was undertaken.

Safety Action 10: HISB Reporting
Compliance report
2023

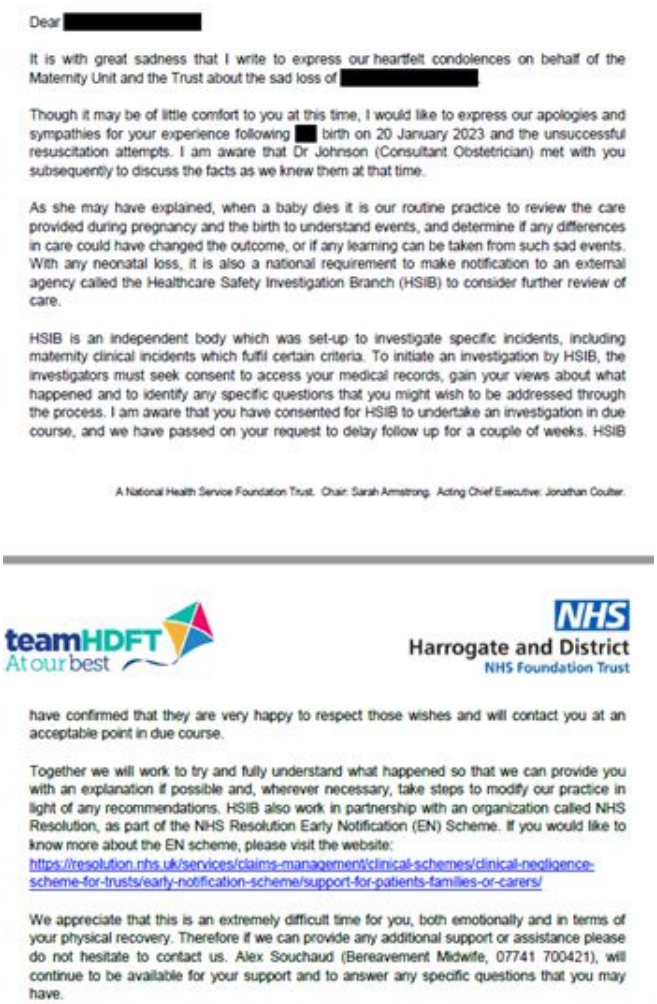
3.4 Notes on compliance

Following the procedure detailed above, it has been confirmed that all eligible cases fitting the reporting criteria have been notified to HSIB and NHS Resolution (where applicable).

Though neither case strictly met eligibility criteria for reporting under the NHS-R EN Scheme, in view of the sad outcome the case MI-021175 was reported anyway, and DAC Beachcroft were instructed by NHS-R. Confirmation has been received from the Quality Team Claims & Administration Officer that EN reporting for this case was undertaken.

- *For all qualifying cases which have occurred during the period* 6 December 2022 to 7 December 2023*, the Trust Board are assured that:*
    - *the family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme; and*
    - *there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.*

All patients where incidents have occurred which may require notification to HSIB/MNSI, a Duty of Candour letter is completed. Within this, information is provided about the role of HSIB and potential future involvement of NHS Resolution (see example in Figure 2).



Dear [redacted]

It is with great sadness that I write to express our heartfelt condolences on behalf of the Maternity Unit and the Trust about the sad loss of [redacted]

Though it may be of little comfort to you at this time, I would like to express our apologies and sympathies for your experience following [redacted] birth on 20 January 2023 and the unsuccessful resuscitation attempts. I am aware that Dr Johnson (Consultant Obstetrician) met with you subsequently to discuss the facts as we knew them at that time.

As she may have explained, when a baby dies it is our routine practice to review the care provided during pregnancy and the birth to understand events, and determine if any differences in care could have changed the outcome, or if any learning can be taken from such sad events. With any neonatal loss, it is also a national requirement to make notification to an external agency called the Healthcare Safety Investigation Branch (HSIB) to consider further review of care.

HSIB is an independent body which was set-up to investigate specific incidents, including maternity clinical incidents which fulfil certain criteria. To initiate an investigation by HSIB, the investigators must seek consent to access your medical records, gain your views about what happened and to identify any specific questions that you might wish to be addressed through the process. I am aware that you have consented for HSIB to undertake an investigation in due course, and we have passed on your request to delay follow up for a couple of weeks. HSIB

A National Health Service Foundation Trust. Chair: Sarah Armstrong. Acting Chief Executive: Jonathan Coulter.

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

have confirmed that they are very happy to respect those wishes and will contact you at an acceptable point in due course.

Together we will work to try and fully understand what happened so that we can provide you with an explanation if possible and, wherever necessary, take steps to modify our practice in light of any recommendations. HSIB also work in partnership with an organization called NHS Resolution, as part of the NHS Resolution Early Notification (EN) Scheme. If you would like to know more about the EN scheme, please visit the website:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-patients-families-or-carers/

We appreciate that this is an extremely difficult time for you, both emotionally and in terms of your physical recovery. Therefore if we can provide any additional support or assistance please do not hesitate to contact us. Alex Souchaud (Bereavement Midwife, 07741 700421), will continue to be available for your support and to answer any specific questions that you may have.

Safety Action 10: HISB Reporting
Compliance report
2023

Figure 2: Extract of Duty of Candour letter giving detail of HSIB and NHS Resolution EN scheme

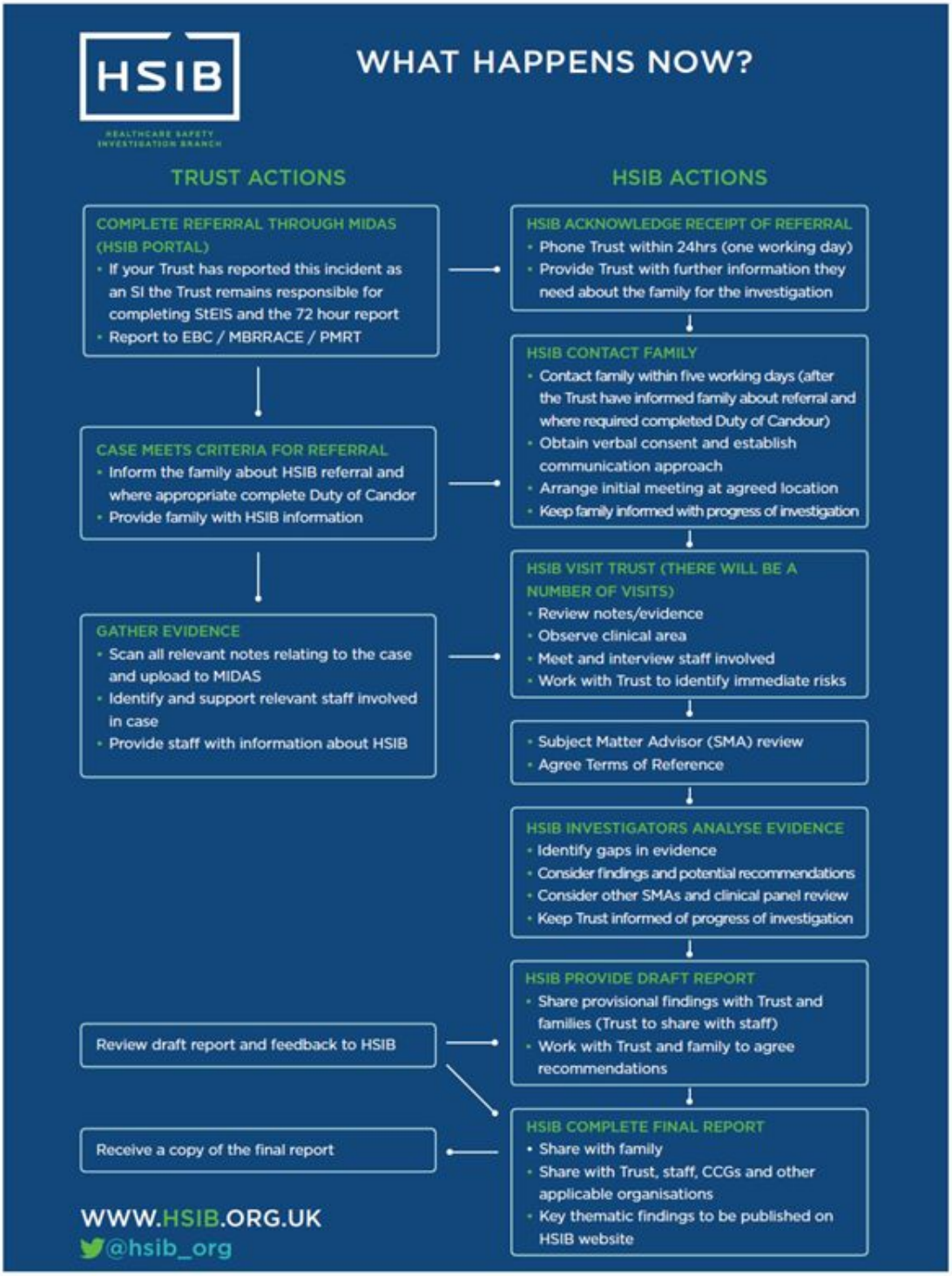
It has been confirmed that both reported cases have been supported by Duty of Candour letter in accordance with Regulation 20, and which gives additional detail of HSIB/MNSI and NHS Resolution ENS. It is also routine practice for these patients to be provided with an information leaflet with further information about the HSIB/MNSI process as in the files below.


MNSI Family Information


MNSI Information for Families

3.5 Appendix 1: HSIB Process

HSIB Investigation Process



Appendix B

West Yorkshire & Harrogate Local Maternity & Neonatal System

Assurance Visit 2023 - Trust report

Harrogate District Hospital

13th November 2023

Visiting team:

- Debi Gibson, Senior Midwife, West Yorkshire & Harrogate Local Maternity & Neonatal System
- Emma Brown, Admin Support Officer, West Yorkshire & Harrogate Local Maternity & Neonatal System
- Sonya Ainley, Project Manager, West Yorkshire & Harrogate Local Maternity & Neonatal System
- Jen Baldry, MVP Lead
- Ann Marie Robinson, LMNS Safety and Quality Lead, NHS Humber And North Yorkshire ICB
- Lindsay Rudge, Chief Nurse Calderdale & Huddersfield NHS Foundation Trust
- Becky Case, Local Maternity and Neonatal System Programme Lead, Humber and North Yorkshire
- Becky Maltby, Non-executive member of NHS WY ICB
- Heather McNair, Interim Director of Midwifery, Humber & North Yorkshire LMNS

1 Contents

2 Introduction

The Ockenden Report (2020 and 2022), and the Reading the Signals report (Kirkup 2022) identified that trusts were not implementing sustained change in response to independent enquiries and recommendations. Prior to the Ockenden Reports trusts had consistently self-assessed as being compliant with recommendations for earlier reports including the Morecambe Bay Investigation report (Kirkup 2015). The findings of the subsequent reports suggested that not all trusts were as compliant as assessed.

In response to this, assurance and support visits were carried out during 2022 in each trust to assess and confirm progress towards the implementation of the 7 immediate and essential actions of the Ockenden Interim Report 2020. These visits were led by NHS England regional maternity teams, supported by the local maternity & neonatal system (LMNS) team.

Further assurance visits are being undertaken in 2023, led by the LMNS with support from ICB PLACE leads, Chief Nurses and Directors of Midwifery from neighbouring trusts providing peer review, members of the NHSE regional maternity team and, most importantly, supported by the voice of local service users via maternity voices partnership (MVP) leads.

2.1 Aims and objectives of the visit:

Aim

To gain insight and assurance of safe, effective and responsive Maternity & Neonatal services, identifying and sharing innovative practice.

Objectives

- To triangulate information and evidence in relation to implementation and embedding of the initial 7 Immediate and Essential Actions, from the interim Ockenden Report (December 2020).
- To understand and learn how the 3 year delivery plan is being implemented across the service.
- To gain knowledge on the Trusts response to their recent CQC inspections and reports.
- To celebrate successes and for staff to gain greater awareness of the work of the LMNS, clinical networks and MatNeoSIP.
- Enable identification of priorities for system transformation.

2.2 Process

The trust were asked to provide evidence in advance of the visit which was reviewed by the LMNS team. In addition, information already submitted to the LMNS through perinatal quality surveillance was reviewed.

On the day the visiting team met with trust staff in focus groups and visited clinical areas, speaking to staff and service users where possible. An open questioning technique was used to probe the key lines of enquiry.

Initial findings were discussed in an open forum with members of the maternity senior leadership present. High level summary feedback was given to the maternity and neonatal team before the visit ended, and then expanded in this report.

3 Findings

3.1 Overall impression

The evidence submitted in advance was comprehensive and of a high standard. It demonstrated a commitment to safety, managing risk, learning, quality improvement and maternity transformation.

Staff were seen to be extremely passionate about their service and the care they gave to women and their families. They were proud to work at Harrogate and shared multiple examples of how they were working hard to ensure services were the best they could be for the communities they serve.

There was demonstration of clear commitment to team working and mutual respect, within the maternity services and neonates. There was a commitment to learning and improving and ensuring staff and service users were at the forefront of any change.

3.2 Feedback on the day

High level feedback was given on the day using the bullet points below:

Key Headlines

- The evidence submitted in advance was of good quality
- Positive motivated staff – staff felt valued, and there was obviously a culture of support and wellbeing in place
- Clear line of sight from ward to board
- Good teamworking throughout and all parts of the service felt included
- Autonomy of practice supported
- Commitment to training and development
- Welcoming environment
- Women / family centred
- All feedback valued and valuable
- Excellent MVP engagement
- Clear commitment to quality improvement
- Good evidence of feedback to action
- Visible leadership
- Clear commitment to personalised care although it was acknowledged there was more to do on informed choice.

Even better if

- The service were better supported by business intelligence to enable further review of data and release time of senior clinicians
- Strengthen staff awareness of local data and suggest how it could be applied for further improvement across the units and ward areas

- Further develop use of appropriate and sensitive language; we did review examples of working on information boards and feedback from women in relation to obstetrician language, but it was felt this could still be blunt and unthinking in some instances and particularly with service users from more diverse backgrounds
- Greater engagement and shared work with primary care for complex women to ensure greater safety in that care across the entire perinatal journey and beyond.

3.3 Implementation and embedding of the 7 IEA's of the interim Ockenden report

The trust submitted their action plan template in relation to the 7 IEA's which includes details of audits and monitoring of compliance. All actions are recorded as complete. The trust maternity service assurance visit in June 2022 identified some outstanding actions and gave the following recommendations:

- Consider inviting the MVP chair to the governance meetings, safety forums and complaint reviews
- Consider reviewing job plans to ensure adequate PA's are allocated
- Consider expansion of the midwifery leadership team to meet the ask of the RCM leadership manifesto
- Ensure maternity incentive scheme money is ringfenced for maternity
- Ensure learning is embedded and strengthen the impact on clinical change
- Ensure thematic analysis is effective
- Strengthen audit to demonstrate effectiveness of interventions
- Strengthen coproduction by inviting MVP members to be involved at the beginning of any quality improvement projects

Through review of the evidence, participation in local quality surveillance and key lines of enquiry at the visit; clear improvement in audit quality, triangulation of learning, and investment in the service was evident. The engagement with the local MVP lead was exceptional and there was evidence of service user voice and coproduction throughout all quality improvements. Feedback from the MVP identified good evidence of supporting women to make informed choices and personalising care, but it was recognised that fully evaluating the provision of informed choice requires further development. The recent transition to Badgernet delivers an online personalised care and support plan for women, it was acknowledged that this is quite limited and further exploration of how personalised care and support plans can be implemented is being considered. The trust have a comprehensive guideline on supporting women's choices, it has clear roles and responsibilities and uses decision aids and flowchart which are clear. The trust shared that they have many women who make choices different to usual pathways, which are supported. They are planning on exploring why more women are making different choices, to help tailor services.

There was a strong team of specialist midwives, obstetricians and neonatal leads with specialist roles who were committed to driving forward quality improvements. In addition, the trust have recruited an Audit and Clinical Effectiveness Lead Midwife to support the governance leads in reviewing data and identifying quality improvements.

The quality of audits seen in relation to the IEA's and the requirements for the saving babies lives care bundle version 3 were very high. Thorough audits with clear methodology, findings and actions where applicable were seen. Audits were viewed as an opportunity to learn or identify good practice.

3.4 Progress towards implementation of the 3 year delivery plan

A comprehensive 3 year maternity improvement plan was submitted in advance. This was coproduced with the MVP. Progress towards the ambitions were clear.

3.5 Response to the Trust CQC report

The maternity service was inspected in November 2022 and graded as Requires Improvement, (well-led – good; safe – requires improvements). Actions in response to the report are incorporated into the 3 year improvement plan. The service leads have implemented a RAG rated system in maternity triage with updated guidance. There is oversight from a lead consultant and red flags are escalated at least weekly. The service has implemented a manger of the day role who has oversight of staffing and acuity issues as well as compliance with safety checks. It was reported that compliance had improved, the visiting team did not ask to see any evidence of this. During visits in one of the clinical areas a resuscitaire was found to have a sellotaped note attached and was visibly dusty on top. The labour ward managers took action on these findings immediately. Further embedding of the implemented changes appear to be required.

3.6 Triangulation and embedding learning from incidents, claims and complaints as well as national reports, guidance and recommendations

The trust maternity improvement plan includes benchmarking against national guidance. Alternate month governance meetings are held which are multidisciplinary including specialist midwives. There is evidence of discussing service risk and developing actions in response, which are then followed up and reported on as well as sharing learning. There was evidence of cohesive team working between governance leads and with the wider maternity team.

There is a team of specialist midwives and midwifery managers who are integrated in governance processes and enable clear communication from clinical teams to the maternity forums. They work clinically as well as in their specialist roles as required, supporting communication between teams and identification of areas of concern in clinical areas. In addition, midwifery and obstetric leaders were clearly visible to the clinical and non-clinical teams and a culture of open communication was evident.

The service utilises multiple methods of sharing learning with staff. Quality improvements were often led by the specialist midwives and managers. There were some examples of the wider clinical teams being involved in quality improvements and open invitations to case review meetings were reported.

The service have recently introduced the Badgernet maternity information system which should improve communication with women and release more time for professionals to provide clinical care.

The service articulated a clear commitment to listening to women and families following incidents or as part of the PMRT process. Staff used compassionate language and further development of the use of language across the service is being implemented to ensure it is empathetic and supportive of all women.

3.7 Perinatal clinical quality surveillance model in practice

The trust undertake alternate month ‘Maternity Risk Management Group’ meeting where quality, safety and risks are reviewed. This is attended by Humber & North Yorkshire (HNY) LMNS leads and the non-executive director.

The trust notifies WY&H LMNS of serious incidents and engages well with the LMNS Safety & Learning Group to share and receive learning. The Director of Midwifery attends Trust Board

and presents maternity data, reports and papers. There is evidence of good communication between maternity service and trust board with clear line of sight from floor to board.

Harrogate & District Hospital NHS Foundation Trust sits within H&NY ICB and the maternity service engages with their LMNS for information and support. In addition, Harrogate Maternity Services sits within the footprint of WY&H LMNS and engages well with this LMNS. Both LMNS programme management teams communicate regularly with each other and share knowledge and assurance responsibilities where applicable.

3.8 MNVP engagement and coproduction

The engagement with the local MVP lead was exceptional. The MVP lead shared multiple examples of obtaining service user feedback and sharing this with the service which has enable quality improvements. There were several examples of co production including the development of the core competency framework for staff training and the development of an induction of labour pack for women. The MVP had regular contact with the maternity services matron and was also named as a contact from specialist midwives. It was clear her role was valued and utilised throughout the service.

The MVP have completed some work with neonatal services. National guidance on the role of the MNVP is still awaiting publication. Once this has been released a further review of the MVP provision may be required to ensure it is able to cover all the requirements.

3.9 Staff engagement, communication, implementing and embedding change

Staff in clinical areas were keen to talk about their services. There was evidence of feeling included in service change and a commitment to personalised care. Staff were proud to give high quality care to women and their families. The team of specialist midwives and midwifery managers were integrated with the clinical midwifery teams. It was clear they worked alongside clinical staff regularly and shared best practice and service improvements, there was also evidence of clinical staff being listened to and responded to. The matron holds monthly listening events which were valued by staff and enabled clear escalation of concerns. Many staff were able to articulate the multiple benefits the new Badgernet information system was providing, whilst acknowledging that transitioning is always challenging. Some staff were less positive about the new system but were unable to describe what they did not like at that time.

There were multiple examples of how learning is shared with staff including newsletters, 2 minute messages, learning on a page, listening events and the utilisation of the PADLET platform. There was a clear commitment to supporting staff to be adequately trained and competent to fulfil their roles as well as a commitment to staff well-being.

Staff knew how to escalate concerns and reported accessible leadership. They were able to name some safety champions but were not clear on the role responsibilities.

3.10 Examples of external funding allocations and expenditure

The service have utilised external funding for specialist midwife roles including recruitment and retention, maternity support worker development and bereavement as well for additional training provision. The specialist roles were valued by staff and the midwifery workforce is currently at establishment with good retention rates.

3.11 Assessment of service risk and mitigation

The service were aware of their risks and identified capacity for elective caesarean section as a current concern. They are working with theatre teams to develop capacity and in addition

are reviewing their birth choices clinics to ensure women are being supported to make fully informed choices. Data was utilised well to assess the service, further development of this and additional support from the wider trust may enhance this.

3.12 Addressing inequalities

The service are aware of their local demographics and have small numbers of women from deprived backgrounds. There is ongoing work to support young mothers.

The service links with local charities are promoted to provide additional support to vulnerable families.

3.13 Working collaboratively with the wider system and network

The service engages well with both West Yorkshire & Harrogate and Humber & North Yorkshire LMNS's. They contribute to joint meetings and share valuable learning with the system. The service values the support of the wider system.

The service utilises local charities and support groups where appropriate including bereavement charities and charities for specialist conditions.

The service request support from the LMNS in

- Clarifying the fetal medicine referral process,
- Development of PSIRF plans to support alignment ,
- Fetal monitoring training competency assessment alignment
- Communication between trusts, for women being transferred between services, cross boundary care and when intrauterine transfers occur
- Celebrating success across the system

3.14 Recommendations

The visit was positive and there were no immediate safety concerns identified. There was evidence of the trust providing high quality, safe and personalised care to women and their families.

Some areas that could be considered to further improve:

Further expansion of data analysis and business intelligence to support continuous quality improvement. It was noted that the governance lead midwife was responsible for a large amount of data gathering and analysis; therefore, that support from trust business intelligence may be of benefit to enable release of senior midwifery time. Strengthening analysis of the impact of interventions could be of benefit to the service in continuing to improve.

Consider how local data is shared with clinical teams and how this may be strengthened to help them to understand their service and subsequent requirements for quality improvements where applicable.

Further develop the work on use of language to ensure all staff are using language that is sensitive, supportive and enabling women to make informed choices.

Work to ensure local General Practice and Primary Care organisations are aware of and integrated in care pathways for women with complex care needs

4 Appendix:

4.1 Agenda

AGENDA			
Time	**Details**		**Lead**
09:15	**Pre meet for visiting team**		**DG**
09:30	**Welcome & Introductions**		**Trust**
09:40	**LMNS purpose of visit**		**DG**
Focus groups – visiting teams split into two teams			
	Team 1 led by Becky Case	**Team 2** led by Debi Gibson	
09:50	**Quadrumvirate**	**Governance Leads and Professional Development Leads (Midwifery, Obstetric & Neonatal)**	
10:40	**Refreshment break**		
10:45	**Safety Champions and NED** This meeting will likely finish earlier than 11:45, team 1 will likely commence clinical visits earlier	**Clinical teams - Including Specialist Midwives (e.g. Public Health, Bereavement, Digital, Training, Infant Feeding) Clinical Managers, Community Midwives, MSW's, Other Support Staff, Doctors in training, Student Midwives and Neonatal staff**	
11:45	**Visiting clinical areas small groups from visiting teams of 2 or 3** Delivery suite, Triage, ANC, Ward areas (AN/PN/NNU), Community Midwives,		

12:45	**Lunch**	
13:30	**Further visits to clinical areas not yet seen / additional focus groups with clinical teams**	
14:30	**Time for visiting team to debrief (DoM's/CDs welcome to attend this)**	
15:30	**Feedback to trusts (CEO / CN attendance expected)** • What is going well • Areas to consider for further development • Any potential gaps and support requirements	BC/DG
16:00	**Closing remarks and next steps**	

Appendix C – Yorkshire and The Humber Maternity Dashboard

Indicator	Measure	Trust/Site Quarterly Data		Y&H Average (Sites)	Y&H Range (Sites)	Y&H Interquartile Range (Sites)
		Previous	Latest			
ACTIVITY INDICATORS						
Number of Bookings	Number of women booked	393	467	770.8	0 to 1574	473.5 to 1220
Bookings <10 weeks	Number of women booked <10 weeks	265	321	487.5	0 to 1101	297.25 to 756.5
% Bookings <10 weeks	% of women booked <10 weeks	67.4%	68.7%	66.6%	58.2% to 75.3%	64.2% to 68.7%
Women birthed	Number of all women birthed	410	433	661.8	0 to 1427	353.5 to 1068.5
Women who birthed a live baby	Number of women who birthed with a live baby	410	433	657.5	0 to 1419	351.5 to 1064
Total births	Number of all babies born	413	438	670.1	0 to 1441	359.5 to 1080.5
Live births	Number of live babies born	413	438	667.6	0 to 1434	358 to 1076
Live births at term	Rolling annual number of live babies born at term	1587	1582	2430.4	0 to 5052	1264 to 4044.5
Total births	Rolling annual number of all babies born	1694	1691	2652.9	0 to 5560	1392 to 4323.5
Planned homebirths	Number of women who planned and birthed a term baby at home	1	1	9.9	0 to 88	1.5 to 10.5
Planned homebirths	% of planned homebirths	0.2%	0.2%	1.5%	0.2% to 80.0%	0.4% to 1.5%
1:1 Care in labour	Number of women who have received 1:1 care in labour	301	330	511.8	0 to 1034	273 to 896.25
1:1 Care in labour	% women who have received 1:1 care in labour	100.0%	95.4%	87.4%	86.5% to 100.0%	100.0% to 100.0%
BBAs (Born Before Arrival)	Number of women who have a BBA.	6	5	7	0 to 16	2 to 12
BBAs (Born Before Arrival)	% of women who have a BBA.	1.5%	1.2%	1.0%	0 to 0	0 to 0
MATERNAL CLINICAL INDICATORS						
Normal births	Number of women with a vaginal birth	192	214	348.3	0 to 725	191 to 589
Normal births	% of women - normal births	46.8%	49.4%	52.6%	43.6% to 100.0%	51.5% to 57.5%
Assisted vaginal births	Number of women with an instrumental birth	58	50	65.7	0 to 161	21 to 104
Assisted vaginal births	% of women - assisted vaginal births	14.1%	11.5%	9.9%	0.0% to 13.4%	7.0% to 11.3%
Elective C/S births	Number of women - El C/S	103	82	100.2	0 to 262	61 to 145
Elective C/S births	% of women - El C/S	25.1%	18.9%	15.1%	0.0% to 18.9%	13.1% to 17.6%
Emergency C/S births	Number of women - Em C/S	57	72	147.7	0 to 378	70 to 214.5
Emergency C/S births	% of women - Em C/S	13.9%	16.6%	22.3%	0.0% to 33.3%	18.4% to 24.5%

Appendix C – Yorkshire and The Humber Maternity Dashboard

Number of C/S births	No. of women - Total all C/S	160	154	247.9	0	to	640	131	to	361.5
C/S deliveries	% of women - Total all C/S	39.0%	35.6%	37.5%	0.0%	to	44.8%	33.3%	to	40.2%
3rd/4th degree tear - normal birth	Number of women with 3rd and 4th degree tear following a normal birth	2	4	5.8	0	to	19	1	to	8
3rd/4th degree tear - normal birth	% women with 3rd and 4th degree tear following a normal birth	1.0%	1.9%	1.7%	0.0%	to	3.1%	1.1%	to	2.2%
3rd/4th degree tear - assisted birth	Number of women with 3rd and 4th degree tear following an assisted birth	0	1	2.7	0	to	9	1	to	4
3rd/4th degree tear - assisted birth	% women with 3rd and 4th degree tear following an assisted birth	0.0%	2.0%	4.1%	1.1%	to	6.9%	2.9%	to	5.3%
Induction of Labour	Number of women commenced induction of labour	146	157	235.3	0	to	471	138.5	to	372.5
Induction of Labour	% women commenced induction of labour	35.6%	36.3%	35.5%	0.0%	to	46.8%	28.9%	to	40.9%
PPH ≥ 1500ml	Number of women who have birthed with PPH ≥ 1500ml	15	10	21.3	0	to	62	6.5	to	34.5
PPH ≥ 1500ml	% women who have birthed with PPH ≥ 1500ml	3.7%	2.3%	3.2%	0.0%	to	5.0%	2.2%	to	3.4%
NEONATAL CLINICAL INDICATORS										
Preterm births <37 weeks	Number of preterm births <37 weeks	26	33	54.5	0	to	119	30.5	to	80.5
Preterm birth rate < 37 weeks	% preterm births <37 weeks	6.3%	7.5%	8.2%	0.0%	to	10.9%	7.1%	to	9.1%
Preterm births 32 weeks to 36+6 weeks	Number of preterm births 32 weeks to 36+6 weeks	23	33	44.4	0	to	95	25	to	66
Preterm birth rate 32 weeks to 36+6 weeks	% preterm births 32 weeks to 36+6 weeks	5.6%	7.5%	6.7%	0.0%	to	9.1%	5.6%	to	7.7%
Number of preterm births 27 weeks to 31+6 weeks	Number of preterm births 27 weeks to 31+6 weeks	3	0	7.4	0	to	24	0	to	12
Preterm birth rate 27 weeks to 31+6 weeks	% preterm births 27 weeks to 31+6 weeks	0.7%	0.0%	1.1%	0.0%	to	2.5%	0.3%	to	1.4%
Preterm birth <27 weeks	Number of preterm births <27 weeks	0	0	2.7	0	to	14	0.0	to	2.0
Preterm birth rate < 27 weeks	% preterm births <27 weeks	0.0%	0.0%	0.4%	0.0%	to	1.3%	0.0%	to	0.3%
Rolling annual number of low birth weight at term - live births	Rolling annual number of live babies at term < 2200g	1	2	14.7	0	to	51	0.5	to	27.5
Low birth weight at term - live births	Rolling annual % live babies at term < 2200g	0.1%	0.1%	0.6%	0.0%	to	1.3%	0.1%	to	0.8%
STILLBIRTHS										
Stillbirths - Rolling annual total	Annual number of ALL stillborn babies	4	4	9.7	0	to	29	4	to	14
Stillbirth rate - Total	Annual rate for ALL stillborn babies / 1000 births	2.4	2.4	3.7	0.0	to	5.8	2.4	to	3.8
Stillbirths	Number of all babies stillborn	0	0	2.5	0	to	7	0.5	to	4.5
Stillbirths - antenatal	Rolling annual number of babies stillborn, diagnosed during antenatal period	4	4	8.9	0	to	26	4	to	14
Stillbirth rate - Antenatal	Annual rate for antenatal stillborn babies / 1000 births	2.4	2.4	3.4	0.0	to	5.5	2.2	to	3.8
Stillbirths - intrapartum	Rolling annual number of babies stillborn, diagnosed during intrapartum period	0	0	0.7	0	to	5	0	to	1

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Stillbirth rate - Intrapartum	Annual rate for intrapartum stillborn babies / 1000 births	0.0	0.0	0.3	0.0	to	1.0	0.0	to	0.5
HSIB reportable births	Rolling annual number of reportable births	3	2	2.4	0	to	10	0	to	4
HSIB reportable births	Rolling annual % reportable births	0.2%	0.1%	0.1%	0.0%	to	0.4%	0.0%	to	0.1%
Stillbirths - excluding those with lethal abnormalities	Rolling annual number of babies stillborn, excluding those with lethal abnormalities	4	4	6.9	0	to	23	0	to	8
Stillbirth rate - adjusted to exclude lethal abnormalities	Annual stillborn babies / 1000 births excluding babies with lethal abnormality	2.4	2.4	2.6	0.0	to	4.5	2.1	to	3.3
Stillbirths at term	Rolling annual number of babies stillborn at term	1	0	1.9	0	to	9	0	to	2
Stillbirths at term with low birth weight	Rolling annual number of babies stillborn at term < 2200g	0	0	0.3	0	to	2	0	to	0
Stillbirths at term with low birth weight	Annual % of stillborn babies < 2200g	0.0%	N/A	13.9%	0.0%	to	50.0%	0.0%	to	13.3%
All losses under 24+0 weeks gestation	Number of all losses under 24+0 weeks gestation	5	5	28	0	to	218	0	to	17
Hold for %		0.0%	0.0%	0	0	to	0	0	to	0
PUBLIC HEALTH INDICATORS										
Breastfeeding Initiation	Number of women who breastfed their baby/ies for their first feed	341	351	465.1	0	to	1153	235	to	766
Breastfeeding Initiation	% of women commenced breastfeeding	83.2%	81.1%	70.7%	59.1%	to	100.0%	63.0%	to	81.1%
Smoking at time of booking - self reported	Number of women who were smokers at time of booking	15	22	76.7	0	to	157	53.5	to	105.5
Smoking at time of booking	% of women who smoke at booking	3.8%	4.7%	10.0%	4.7%	to	17.1%	8.4%	to	12.5%
Smoking at time of birth - self reported	Number of women who were smokers at time of birth	8	27	63.9	0	to	121	34.5	to	99.5
Smoking at time of birth - self reported	% of women who smoke at time of birth	2.0%	6.2%	9.7%	0.0%	to	14.9%	7.2%	to	12.2%
Carbon Monoxide monitoring at time of booking	Number of women who received CO testing with a measurement ≥ 4ppm at booking	57	87	76.8	0	to	167	55.5	to	107
Women received CO testing at booking	Number of women who received CO testing at booking	399	490	619.7	0	to	1362	365.5	to	1066.5
Carbon Monoxide monitoring at time of booking	% women who received CO testing with a measurement ≥ 4ppm at booking	14.3%	17.8%	12.4%	7.9%	to	22.5%	11.2%	to	15.7%

Appendix C – Yorkshire and The Humber Maternity Dashboard

Operational Update

January 2024

Russell Nightingale
Chief Operating Officer

Children's and Community

Metrics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
% of antenatal contacts									
Darlington	95.3%	94.9%	96.4%	98.3%	90.5%	95.0%	97.8%	100.0%	98.6%
Durham	87.9%	87.7%	89.6%	82.9%	88.0%	85.8%	84.4%	86.0%	84.7%
Gateshead	92.1%	91.9%	96.5%	92.1%	98.5%	92.9%	98.6%	95.2%	96.9%
Middlesbrough	92.9%	84.7%	93.9%	97.1%	94.4%	98.9%	92.6%	94.4%	95.5%
North Yorkshire	90.1%	89.3%	87.8%	93.6%	98.4%	97.0%	95.8%	95.6%	96.3%
Northumberland	86.0%	83.1%	86.8%	82.1%	88.4%	91.5%	82.0%	86.0%	88.1%
Stockton	90.6%	94.8%	97.2%	96.4%	98.5%	94.8%	98.5%	97.7%	96.5%
Sunderland	93.8%	96.1%	94.7%	195.1%	98.9%	96.2%	95.7%	95.5%	90.6%
Wakefield	97.1%	97.1%	95.2%	93.2%	87.9%	87.6%	86.3%	87.4%	84.5%
% New Birth Visits completed by 14 days									
Darlington	98.7%	97.7%	100.0%	98.5%	100.0%	97.4%	99.1%	98.9%	100.0%
Durham	95.7%	96.1%	96.4%	96.8%	96.1%	96.4%	96.2%	83.2%	80.0%
Gateshead	90.9%	98.7%	98.4%	90.9%	99.4%	98.4%	94.3%	90.0%	92.8%
Middlesbrough	97.0%	97.8%	95.3%	98.6%	99.3%	98.3%	97.3%	97.3%	93.9%
North Yorkshire	95.4%	92.9%	91.6%	97.2%	98.3%	93.3%	89.2%	89.0%	92.4%
Northumberland	92.9%	93.0%	95.0%	91.0%	94.6%	91.5%	77.8%	89.7%	92.3%
Stockton	94.4%	96.0%	94.0%	95.8%	97.3%	92.1%	95.4%	89.9%	94.7%
Sunderland	99.0%	99.5%	100.0%	99.1%	97.6%	99.5%	96.7%	99.5%	98.7%
Wakefield	94.8%	78.5%	74.9%	74.6%	67.9%	69.1%	71.5%	74.7%	74.4%
% Infants Breastfeeding at 10-14 days									
Darlington	59.0%	43.7%	52.1%	56.1%	62.2%	48.7%	51.9%	57.4%	61.9%
Durham	44.5%	43.2%	43.4%	41.9%	40.3%	46.8%	41.8%	49.3%	42.1%
Gateshead	50.8%	62.5%	58.9%	50.8%	59.6%	53.5%	53.2%	61.0%	52.3%
Middlesbrough	56.3%	54.0%	62.2%	62.0%	52.8%	54.7%	50.0%	63.9%	52.1%
North Yorkshire	66.8%	66.8%	66.3%	70.6%	66.9%	70.7%	67.5%	66.0%	68.4%
Northumberland	60.1%	52.3%	60.0%	56.6%	46.9%	54.4%	53.5%	51.7%	56.4%
Stockton	45.0%	47.6%	52.7%	49.7%	49.7%	53.4%	49.3%	46.8%	47.6%
Sunderland	48.2%	43.3%	45.7%	52.5%	44.6%	51.4%	47.3%	48.0%	43.0%
Wakefield	57.3%	53.1%	55.7%	51.9%	54.2%	50.2%	51.3%	53.2%	53.3%
% infants breastfeeding at 6-8 weeks									
Darlington	44.1%	37.0%	34.1%	40.8%	47.8%	39.8%	36.7%	39.8%	41.3%
Durham	30.4%	34.5%	29.7%	31.7%	26.5%	29.8%	36.5%	31.2%	34.0%
Gateshead	50.8%	33.9%	49.3%	50.8%	45.0%	47.1%	43.7%	41.7%	45.9%
Middlesbrough	43.7%	47.5%	49.7%	44.6%	50.0%	46.4%	41.4%	42.6%	49.4%
North Yorkshire	57.7%	52.7%	52.7%	54.7%	57.6%	55.0%	56.3%	56.5%	54.1%
Northumberland	41.6%	43.4%	36.4%	42.5%	40.9%	39.6%	39.5%	43.8%	45.5%
Stockton	40.0%	31.9%	35.2%	37.7%	39.0%	41.9%	39.8%	37.2%	37.7%
Sunderland	25.5%	33.8%	29.4%	37.4%	39.2%	31.6%	37.6%	33.8%	39.3%
Wakefield	32.9%	36.1%	37.4%	39.7%	37.0%	37.5%	36.5%	39.9%	44.0%

Metrics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
% of 6-8 week reviews completed by the time the infant is 8 weeks old									
Darlington	98.5%	94.0%	95.3%	100.0%	97.0%	98.9%	98.9%	99.0%	98.9%
Durham	95.2%	91.9%	92.1%	93.1%	91.4%	92.5%	92.2%	76.8%	77.8%
Gateshead	97.7%	98.4%	97.3%	97.7%	98.0%	97.4%	93.0%	92.9%	91.3%
Middlesbrough	90.1%	90.8%	97.9%	90.0%	94.3%	95.2%	88.4%	88.5%	93.4%
North Yorkshire	93.0%	88.1%	85.8%	94.3%	95.8%	94.9%	93.6%	95.2%	93.5%
Northumberland	87.1%	82.5%	91.6%	83.8%	90.3%	94.2%	84.3%	84.2%	83.3%
Stockton	93.4%	95.9%	98.6%	95.3%	96.7%	96.7%	88.3%	98.6%	96.4%
Sunderland	98.0%	98.1%	98.5%	97.1%	96.0%	97.7%	99.1%	98.6%	98.2%
Wakefield	82.6%	98.5%	95.4%	90.6%	91.5%	92.1%	95.7%	96.8%	96.8%
% of 12 month reviews completed by the time the child is 15 months old									
Darlington	100.0%	98.8%	98.9%	100.0%	100.0%	98.8%	97.4%	100.0%	100.0%
Durham	92.1%	94.8%	97.0%	96.2%	94.1%	93.8%	92.8%	94.5%	93.3%
Gateshead	99.3%	98.0%	98.7%	99.3%	100.0%	95.5%	98.6%	98.8%	98.4%
Middlesbrough	96.2%	98.3%	100.0%	96.1%	95.2%	98.5%	100.0%	99.3%	97.6%
North Yorkshire	97.3%	97.9%	95.2%	99.2%	100.0%	98.3%	99.0%	98.9%	98.1%
Northumberland	95.2%	82.5%	92.3%	91.9%	94.6%	93.2%	92.7%	99.1%	95.2%
Stockton	96.5%	97.2%	99.3%	100.0%	98.8%	99.3%	98.2%	98.8%	99.4%
Sunderland	97.2%	96.6%	96.4%	98.1%	96.4%	97.9%	94.4%	98.3%	97.6%
Wakefield	94.3%	94.6%	88.73%	97.3%	97.5%	97.1%	98.3%	98.9%	95.9%
% of 2-2.5 year reviews completed by the time the child is 2.5 years old									
Darlington	100.0%	97.7%	97.8%	91.9%	97.2%	98.8%	100.0%	97.5%	100.0%
Durham	90.9%	92.6%	95.1%	93.7%	90.6%	94.4%	95.3%	81.2%	76.4%
Gateshead	97.2%	97.4%	99.2%	97.2%	97.2%	96.6%	94.3%	91.2%	90.8%
Middlesbrough	98.6%	95.5%	95.7%	97.4%	99.1%	95.8%	99.2%	81.4%	89.4%
North Yorkshire	96.2%	98.0%	91.5%	97.2%	98.2%	98.2%	97.3%	98.1%	98.2%
Northumberland	89.2%	91.8%	90.4%	92.9%	91.5%	91.0%	76.7%	77.8%	81.8%
Stockton	92.8%	97.0%	97.1%	97.0%	99.2%	94.5%	89.5%	95.7%	96.3%
Sunderland	94.8%	93.8%	94.6%	97.7%	95.1%	94.3%	93.6%	94.1%	96.5%
Wakefield	90.9%	89.9%	93.91%	97.6%	95.3%	97.7%	96.8%	89.6%	95.8%
% of 2 to 2.5 year reviews completed in the month with a completed ASQ3									
Darlington	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	98.9%	100.0%	100.0%
Durham	90.9%	92.6%	95.1%	93.7%	90.6%	94.4%	95.3%	96.5%	96.2%
Gateshead	100.0%	97.7%	97.5%	100.0%	97.5%	97.1%	96.1%	89.6%	91.3%
Middlesbrough	100.0%	99.2%	99.3%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%
North Yorkshire	99.8%	100.0%	98.7%	99.8%	99.5%	100.0%	99.5%	99.1%	99.7%
Northumberland	97.3%	97.5%	96.5%	95.3%	97.5%	97.0%	96.8%	98.5%	99.6%
Stockton	96.1%	97.5%	98.5%	94.6%	95.1%	94.9%	94.2%	93.6%	96.9%
Sunderland	96.0%	93.3%	96.2%	96.3%	96.0%	94.5%	95.5%	97.4%	96.8%
Wakefield	98.1%	99.5%	100.00%	99.3%	100.0%	99.7%	100.0%	99.7%	99.7%

% Antenatal contacts

- Northumberland – Action plan in place and under regular review with Locality and Service Managers.
- Durham - Main issue non notifications and late notification which is being picked up with Maternity
- Middlesbrough – Data being re run as validations inputted incorrectly.
- Wakefield – Targeted antenatal offer as agreed with commissioners.

% new Birth Visits by 14 days

- Wakefield – Due to high health visitor vacancies. Service at OPEL 3 so timescales flexed to 10 to 20 days. Recovery linked to recruitment.

% Infants Breast Feeding

- Durham – Increased focus on antenatal care including family hub developments and insights work commissioned by LA. Currently reviewing at locality level the issues.

Planned Care Recovery

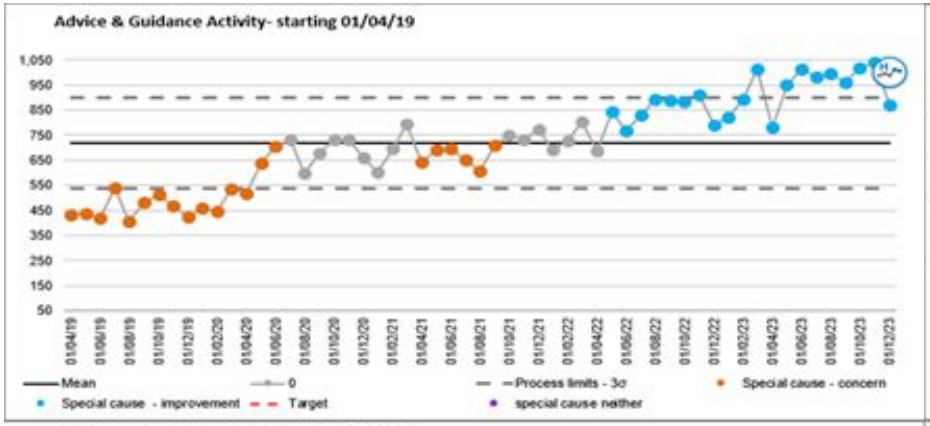
Outpatients	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	341	344	355	473	383	441	491	464	416	481	426	370
Actual	883	1,002	1,066	985	1,147	863	854	837	759			
Consultant-led first outpatient attendances (Spec acute) - Plan	3,623	3,658	3,778	5,032	4,075	4,691	5,223	4,931	4,419	5,112	4,528	3,929
Consultant-led first outpatient attendances (Spec acute) - Actual	4,037	4,946	4,917	4,505	4,683	4,913	5,053	5,022	3,832			
Consultant-led follow up outpatient attendances (Spec acute) - Plan	5,352	5,653	5,280	7,167	6,166	6,585	7,850	7,075	6,168	7,494	6,407	6,121
Consultant-led follow up outpatient attendances (Spec acute) - Actual	8,980	10,617	10,615	9,321	9,905	9,860	10,524	10,406	8,556			
Elective Admissions												
Total number of specific acute elective spells in period -Plan	2,103	2,480	2,270	2,977	2,878	2,711	3,035	2,957	2,499	2,944	2,691	2,057
Total number of specific acute elective spells in period -Actual	2,318	2,546	2,579	2,477	2,364	2,593	2,623	2,725	2,277			
Total number of specific acute elective day case spells in period -Plan	1,944	2,283	2,076	2,687	2,644	2,491	2,795	2,711	2,307	2,664	2,485	1,915
Total number of specific acute elective day case spells in period -Actual	2,161	2,322	2,349	2,287	2,207	2,379	2,389	2,483	2,114			
Total number of specific acute elective ordinary spells in period -Plan	159	197	194	290	234	220	240	246	192	280	206	142
Total number of specific acute elective ordinary spells in period -Actual	157	224	230	190	157	214	234	242	163			
RTT												
Number of completed admitted RTT pathways - Plan	840	986	897	1,161	1,142	1,076	1,208	1,171	996	1,151	1,074	828
Number of completed admitted RTT pathways - Actual	1,063	1,144	1,242	1,203	1,048	930	909	977	761			
Number of completed non-admitted RTT pathways - Plan	3,439	3,472	3,586	4,776	3,869	4,453	4,958	4,681	4,195	4,852	4,298	3,730
Number of completed non-admitted RTT pathways - Actual	3,486	4,487	4,423	4,284	4,405	4,179	4,607	4,448	3,595			
Number of New RTT pathways (clock starts) - Plan	5,339	5,534	5,622	7,688	6,738	7,136	8,152	7,576	6,756	7,824	6,949	5,688
Number of New RTT pathways (clock starts) - Actual	5,756	6,788	6,955	6,706	6,636	6,063	6,222	6,029	5,081			
Number of RTT incomplete pathways waiting +52 weeks - Plan	1,200	1,200	1,200	1,190	1,180	1,170	1,160	1,150	1,100	1,100	1,050	1,000
Number of RTT incomplete pathways waiting +52 weeks - Actual	998	1,001	1,020	1,033	1,124	673	640	599	557			
Number of RTT incomplete pathways waiting +65 weeks - Plan	470	470	470	450	440	430	390	370	350	300	200	0
Number of RTT incomplete pathways waiting +65 weeks - Actual	202	197	210	208	259	154	145	140	129			
Total number of RTT incomplete pathways - Plan	25,500	25,300	25,100	24,900	24,700	24,500	24,300	24,100	23,900	23,700	23,500	23,200
Total number of RTT incomplete pathways - Actual	25,951	25,876	25,860	25,831	25,802	23,093	22,799	22,549	22,488			
Cancer												
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Plan	65	65	60	60	55	55	50	50	50	50	50	50
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Actual	88	64	56	39	54	59	96	81	58			

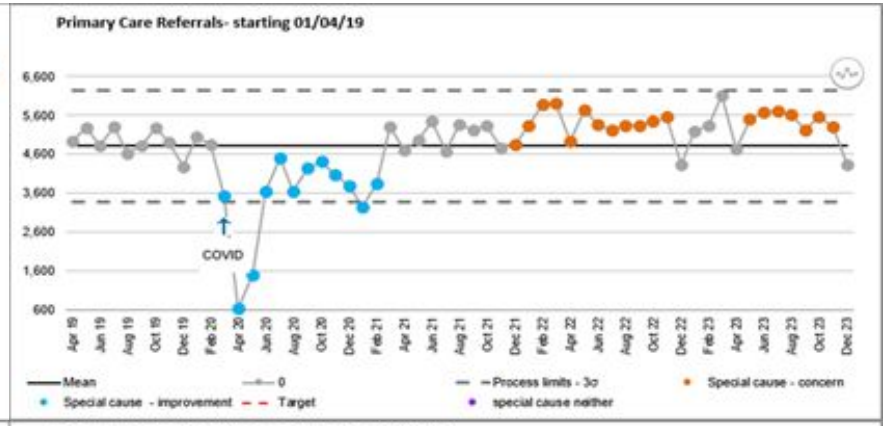
Increasing elective capacity to 2019/20 levels continues to be the key focus. 12% of 2019/20 was delivered through premium out of core sessions which may not be replicable.

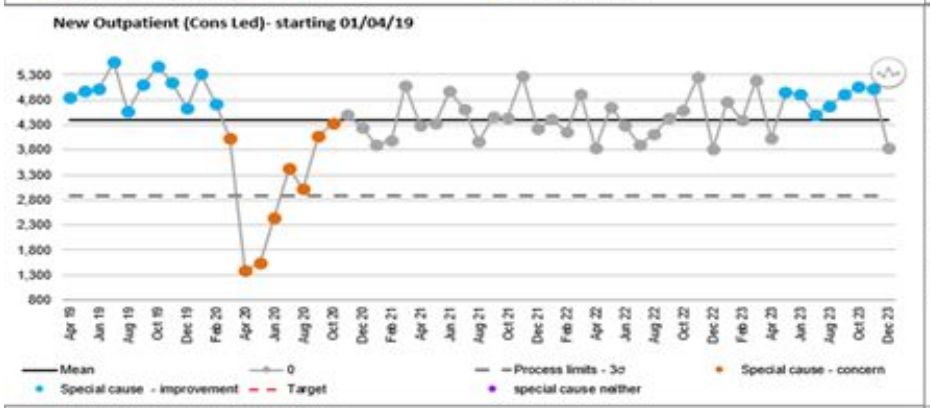
Follow up activity continues to over deliver – further focus is needed on switching up routine follow up of patients after inpatient episodes/ treatments. This is hampered by the need to continue to 'catch up' on follow ups delayed by the pandemic and from industrial action.

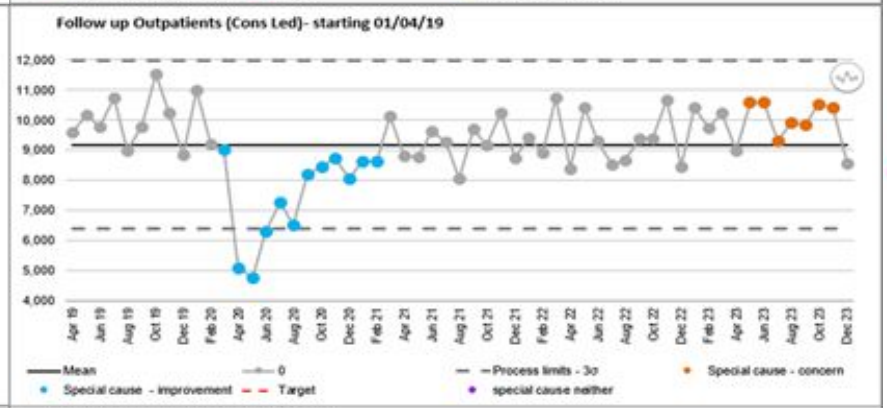
Significant increases in advice and guidance activity from 2019/20 which do not get reflected in above figures (baseline of 450/month now up to 1,000/month) – technically we have been unable to bring this into our activity figures so far. Two episodes of industrial action impacted

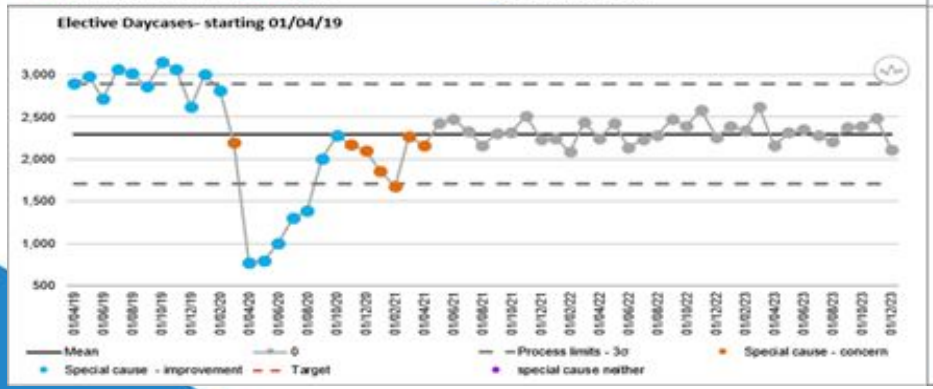
Elective Recovery

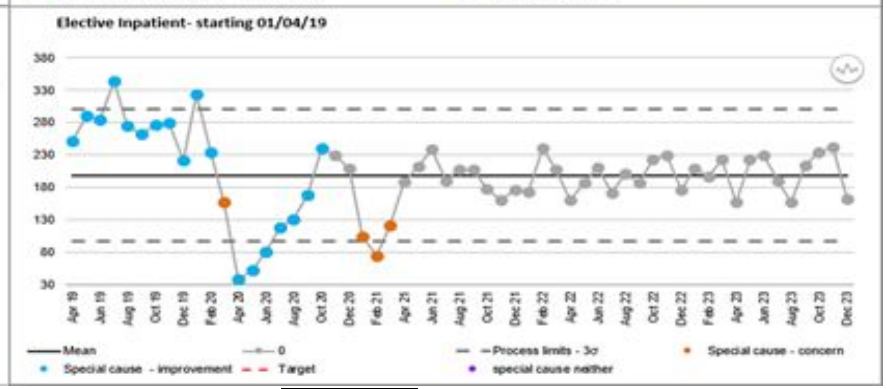












Referral to Treatment (RTT)

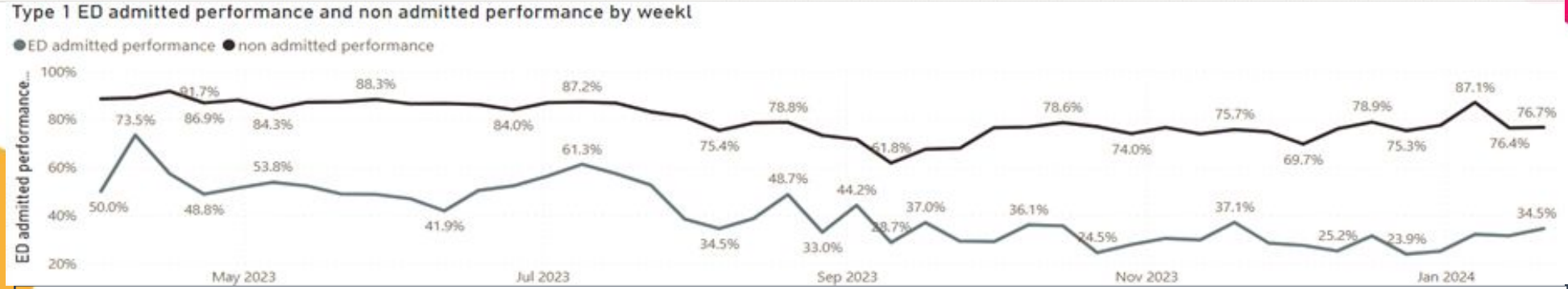
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total incomplete RTT pathways	25,951	25,876	25,860	25,831	25,802	23,093	22,799	22,549	22,488
Under 52 weeks	24,953	24,875	24,840	24,798	24,678	22,420	22,159	21,950	21,931
> 52 weeks	998	1,001	1,020	1,033	1,124	673	640	599	557
> 65 weeks	202	197	210	208	259	154	145	140	129
> 78 weeks	5	0	1	1	4	2	0	0	0
> 104 weeks	0	0	0	0	0	0	0	0	0

RTT – 22,488 patients waiting at the end of December. Total incomplete pathways continues to reduce, ahead of plan for over 52 and 65 week waits.

There were no patients waiting 78+ weeks at end December.

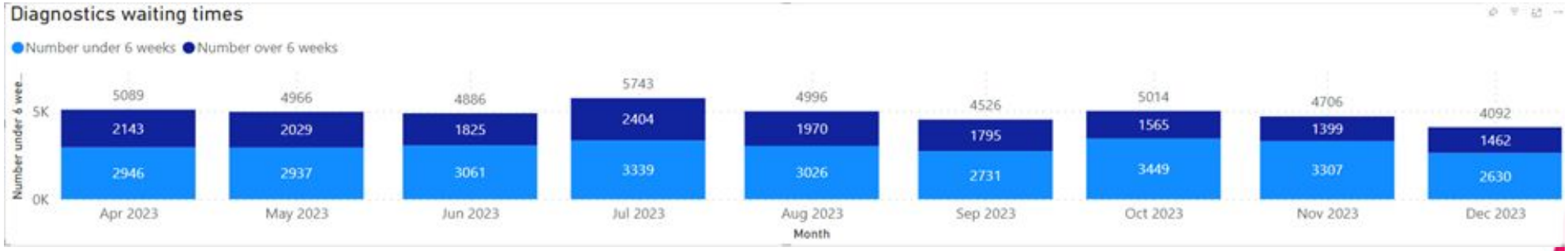
Of the patients waiting for a procedure on our waiting list, 40% are Orthopaedics and 14% are Ophthalmology.

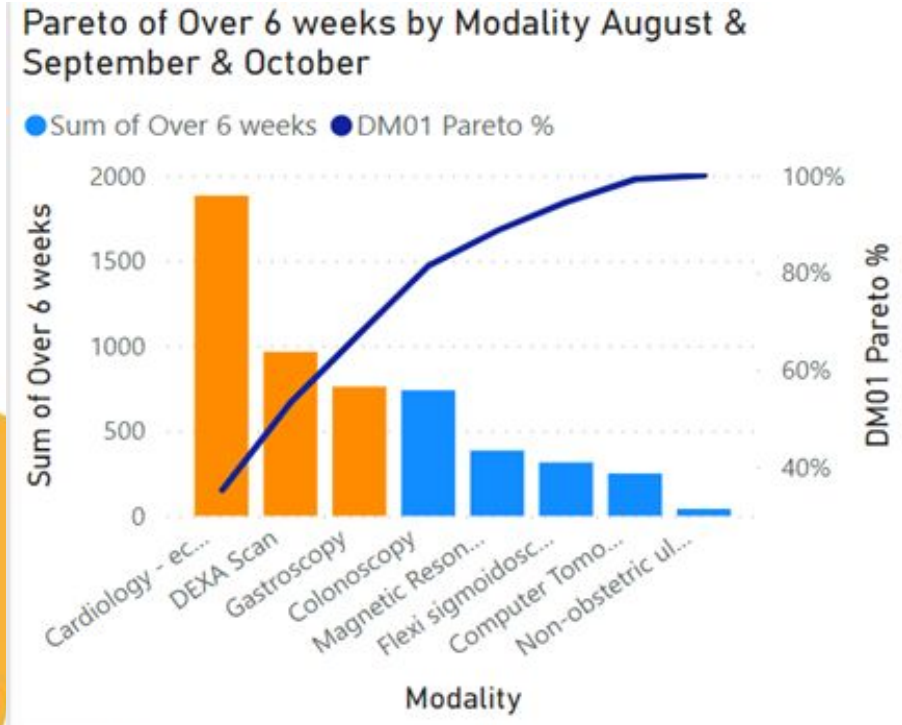
Urgent Care

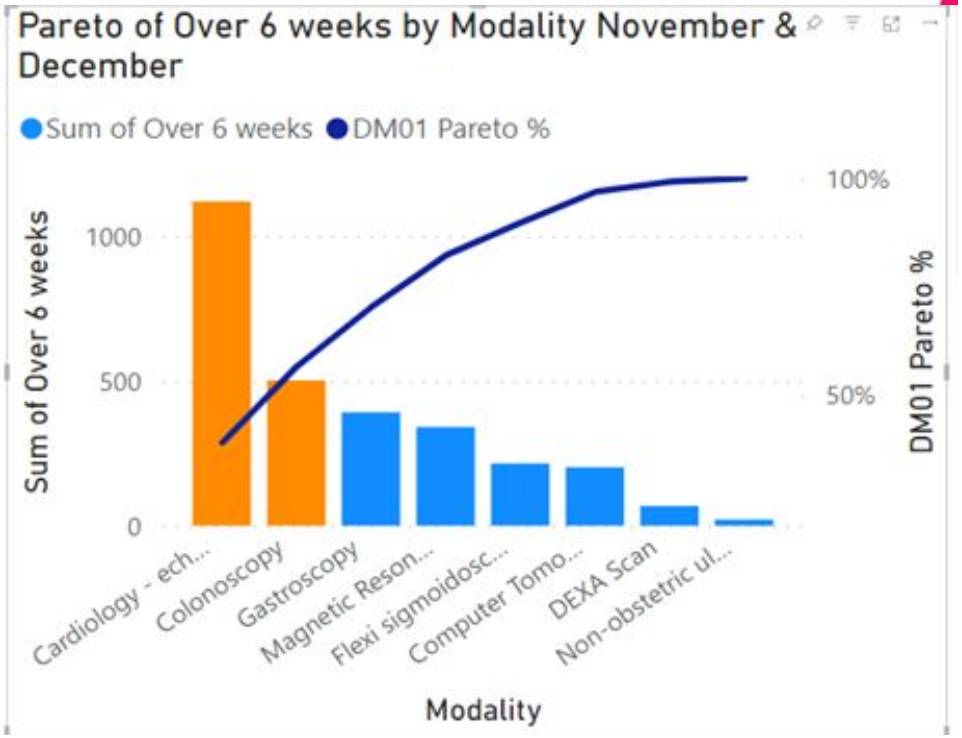


- Performance against the A&E 4-hour standard was at 66.2% in December, remaining below the new performance standard of 76%. The re-opening of refurbished ED2 has seen a re-establishing of improving non admitted performance. Early January performance has risen significantly.
- There were 73 over 12-hour trolley wait breach in December (46 in November)- this compares favourably to 152 in December 2022.
- There was 36 over 30-minute ambulance handover breaches in December (38 in November) and 12 (11 in November) over 60 minutes.
- ED attendances are now back in line with 2019/20 levels.

Diagnostics

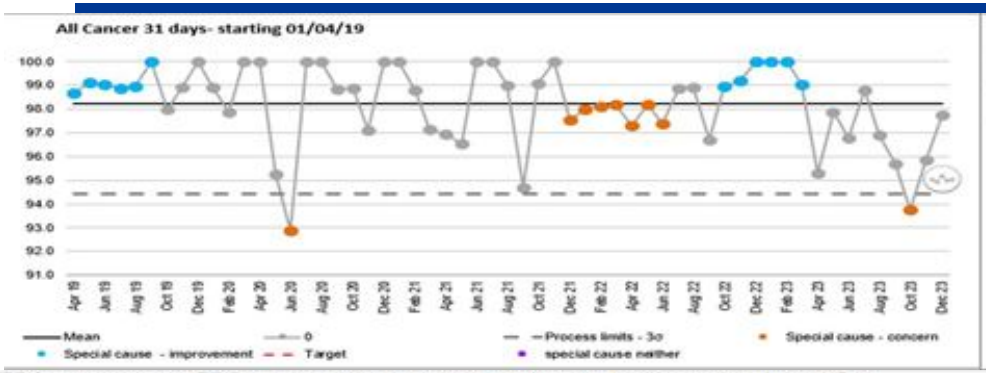






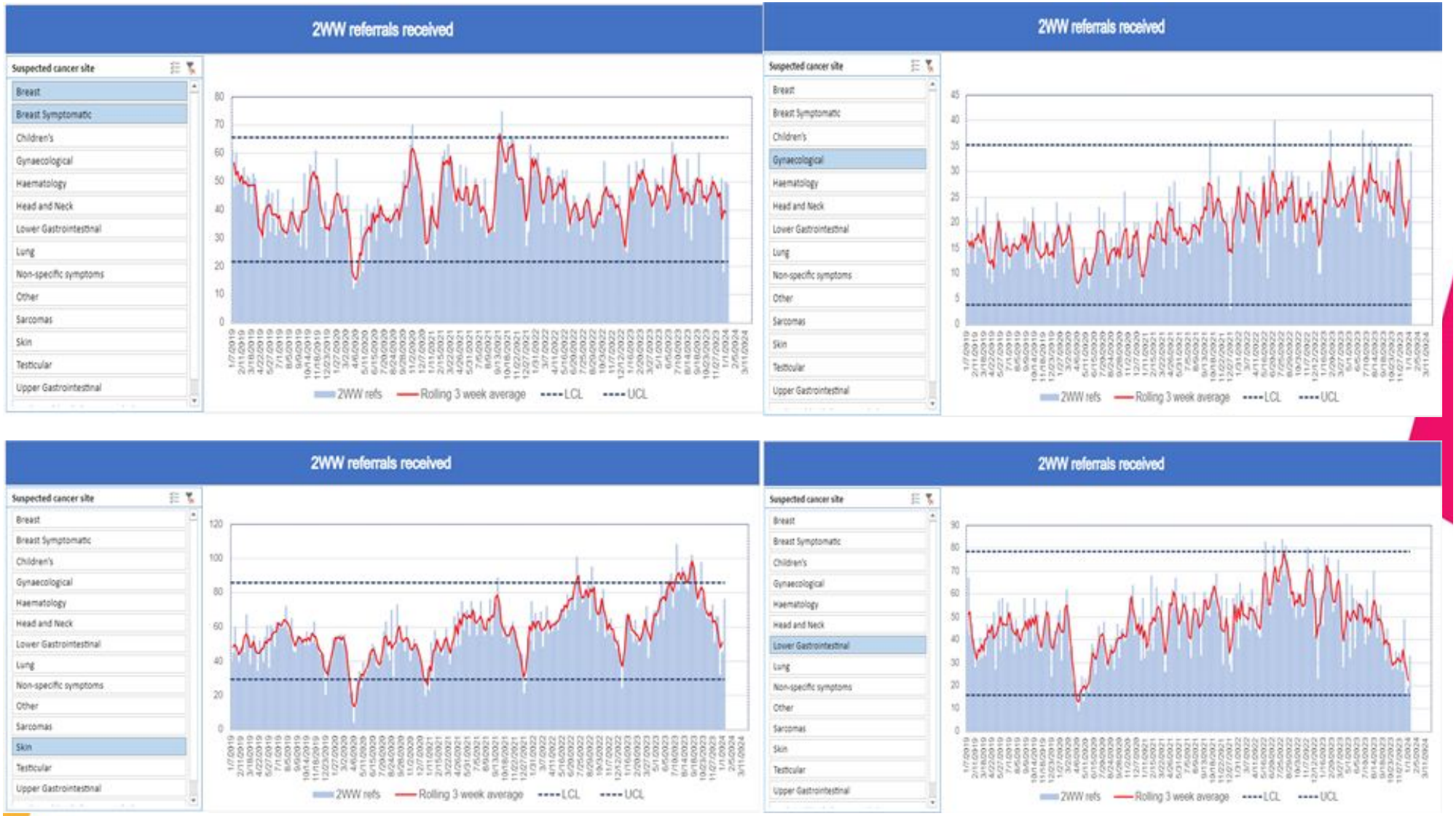
DEXA have seen improvements in number of patients waiting for diagnostics and thus a reduction in the overall diagnostic waiting list. The percentage under 6 weeks has increased to 67% in November (66% in October). December position is 64.3% but with a significant reduction in the overall numbers waiting (614 fewer)

Cancer Performance



- The 62-day standard was not met in December with a performance of 63.1% against the 85% standard.
- The 31-day standard was achieved in December with a performance of 97.8% against the 96% standard.
- The number of patients remaining on the PTL (i.e. treatment no complete) has come down to 58 ahead of the end of year trajectory to be at 50 or fewer.
- Both LTUC and PSC who deliver the Breast pathway (radiology and surgical elements respectively) have agreed short and medium term actions to address the capacity issues with Breast which is driving the 28 & 62 day performance issues. There are ongoing additional clinics arranged (2 per month)
- For the faster diagnosis standard (75% within 28 days), the standard was delivered for 66.3% of pathway[illegible]ber.

Cancer Performance



- Performance against the 2WW Cancer standard was at 76.9% in December.

Finance Report Month 9
December – 2023/24

Author
Director of Finance – Jordan Mckie
Deputy Director of Finance – Karen Scarth

23/24 Finance summary as at December

teamHDFT At our best

£-3.7M

DEFICIT YTD

CIP DELIVERED

(COST IMPROVEMENT PLANS/EFFICIENCES)

65%

£20M TARGET

£-3.8M

UNDER PERFORMANCE

ERF

(Elective Activity Recovery)

REDUCING

CASH IN THE BANK

£35M (APR 2023)

↓

£12.5M (DEC 2023)

£2.2M

AGED DEBT

(OUTSTANDING OVER 30 DAYS)

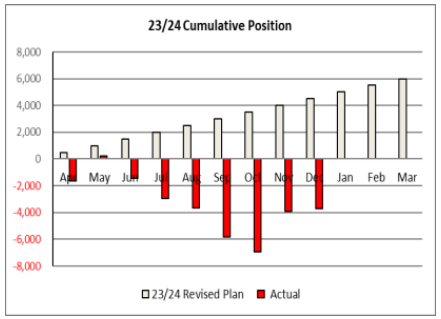
AGENCY SPEND

£6.2M

23/24 Plan to deliver £6M surplus, 100% CIP, 100%+ ERF

YTD Summary

£0.2M
IN MTH SURPLUS
£-3.7M
DEFICIT YTD



The year to date position has mildly improved by £0.2k in comparison to the previous month resulting in a year to date deficit, £-3.7m.

The top five most significant contributing drivers include, Wards £2.1m, undelivered CIP £1.9m, ED £1.1m, Doctors in Training £965k and the Pathology Joint Venture £656k.

There are a number of items that were not part of the original plan and there are ongoing discussions on how this may be addressed across the system, inflationary pressures £1m, drugs £517k and Nidderdale patient £152k.

The current position excludes no impact from the current under performance of ERF however we are confident after identifying a number of underlying issues this will pose no impact to the bottom line.

The cash balance has maintained at £12m but the cash forecast does highlight cash support is required in February, submissions have already been made to NHSE to request this.

High Level Analysis	Annual Plan £000's	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's	Forecast Actual £000's
Commissioner Income	**295,730**	**24,600**	**25,597**	**997**	**221,704**	**234,317**	**12,614**	**301,412**
Directorate Income	**49,857**	**3,803**	**4,570**	**767**	**37,056**	**40,059**	**3,003**	**52,707**
Pay Costs	-236,652	-19,834	-19,919	-85	-178,759	-185,628	-6,869	-246,104
Non Pay Costs	-108,935	-10,037	-10,060	-23	-89,980	-91,896	-1,916	-122,749
Expenditure	**-345,587**	**-29,871**	**-29,979**	**-108**	**-268,740**	**-277,524**	**-8,785**	**-368,853**
Surplus / (Deficit)	**0**	**-1,468**	**187**	**1,656**	**-9,980**	**-3,148**	**6,832**	**-14,734**
Budget Phasing		**1,968**			**14,480**			**0**
Salix Grant						**-599**		**-599**
Donated Assets/Depreciation			**48**			**46**		**46**
Revised Surplus/(Deficit)	**6,000**	**500**	**235**	**-264**	**4,500**	**-3,702**	**-8,201**	**-15,287**

65% of the £20m efficiency program has been delivered but the remaining balance is proving challenging.

Capital spend YTD £9.1m, there are a number of large schemes that will be completed over upcoming months.

Further work is needed to address recovery plans. The current forecast excludes the improvement in run rate expected from no further strike action and recovery actions Directorates are undertaking.

Directorate Summary

CC - Although CC is underspent, there are pressures within the directorate including Durham 0-19 contract, £505k overspent and undelivered CIP £446k. Staffing vacancies are the main contributing factor to the underspend, Wakefield 22wte, Northumberland 20wte and Adult Community 30wte vacancies.

LTUC - The most significant overspend is being driven in LTUC by a combination of arears, Wards £1m, ED £1.1m, Drs in Training £965k, Pathology £656k and Imaging £862k.
Wards have incurred high levels of bank and agency spend whilst vacancies have been recruited alongside mental health support requirements. There is a promising recruitment pipeline for ward nursing but this is unlikely to have any impact until Feb 24.
Ongoing work to understand the Drs in Training overspend, a number of initiatives undertaken are contributing to this (Ward reconfiguration and Discharge support).
ED have a number of contributing factors including, activity increases, staff absence and industrial action however plans are in place to manage staffing within the agreed revised budget.
Pathology is being driven by inflation increases, agency and Biofire testing.
Imaging, ongoing work to control pay expenditure, £657k Agency Radiographer spend YTD.
Unidentified CIP also contributing, £765k.

PSC - Industrial Action has contributed to the overall position however there are a number of other contributing factors which include Wards £715k, Waiting list initiative £689k (including LLP), Gen Surgery, Orthopedics Med Staff, £799k and Theatres £689k.
Work is under away to maximize ERF opportunities.
Nidderdale did have a mental health patient that incurred, £152k additional supervision costs.
Unidentified CIP also contributing, £578k.

CORP – Corporate should deliver a balanced position however there are pockets of pressures such as Finance (Lease Cars/Procurement/Audit fees), Estate charges, HIF contract (Contract Variations) and Chief Exec. There are a number of actions underway to address these arears.

Community &Childrens	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's	Forecast Budget £000's	Forecast Actual £000's	Forecast Variance £000's
Income	**2,922**	**2,161**	**2,004**	**-157**	**2,922**	**2,846**	**-76**
Pay Costs	-79,943	-59,997	-58,310	1,687	-79,943	-77,923	2,020
Non Pay Costs	-4,644	-3,332	-4,319	-987	-4,644	-5,818	-1,174
Expenditure	**-84,587**	**-63,329**	**-62,629**	**701**	**-84,587**	**-83,741**	**846**
Total	**-81,665**	**-61,168**	**-60,625**	**544**	**-81,665**	**-80,895**	**770**

LTUC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's	Forecast Budget £000's	Forecast Actual £000's	Forecast Variance £000's
Income	**7,182**	**5,405**	**5,797**	**392**	**7,182**	**7,673**	**491**
Pay Costs	-78,196	-58,729	-62,479	-3,751	-78,196	-82,359	-4,164
Non Pay Costs	-28,526	-21,422	-24,733	-3,311	-28,526	-32,802	-4,277
Expenditure	**-106,721**	**-80,151**	**-87,212**	**-7,062**	**-106,721**	**-115,161**	**-8,440**
Total	**-99,539**	**-74,745**	**-81,416**	**-6,670**	**-99,539**	**-107,488**	**-7,949**

PSC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's	Forecast Budget £000's	Forecast Actual £000's	Forecast Variance £000's
Income	**803**	**610**	**719**	**109**	**803**	**903**	**100**
Pay Costs	-55,821	-41,702	-43,843	-2,141	-55,821	-58,667	-2,846
Non Pay Costs	-15,076	-11,255	-12,956	-1,701	-15,076	-17,461	-2,385
Expenditure	**-70,897**	**-52,957**	**-56,799**	**-3,842**	**-70,897**	**-76,127**	**-5,231**
Total	**-70,094**	**-52,348**	**-56,080**	**-3,733**	**-70,094**	**-75,224**	**-5,131**

Corporate	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's	Forecast Budget £000's	Forecast Actual £000's	Forecast Variance £000's
Income	**8,815**	**6,134**	**8,028**	**1,894**	**8,815**	**10,253**	**1,438**
Pay Costs	-24,739	-18,645	-18,463	181	-24,739	-24,407	332
Non Pay Costs	-42,737	-31,638	-32,926	-1,288	-42,737	-43,902	-1,165
Expenditure	**-67,476**	**-50,283**	**-51,389**	**-1,106**	**-67,476**	**-68,309**	**-832**
Total	**-58,662**	**-44,148**	**-43,361**	**788**	**-58,662**	**-58,056**	**606**

HIF	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's	Forecast Budget £000's	Forecast Actual £000's	Forecast Variance £000's
Income	**25,280**	**19,098**	**19,945**	**847**	**25,280**	**26,357**	**1,076**
Pay Costs	-11,065	-8,426	-8,682	-255	-11,065	-11,413	-348
Non Pay Costs	-14,216	-10,522	-11,239	-717	-14,216	-14,886	-671
Expenditure	**-25,280**	**-18,948**	**-19,921**	**-973**	**-25,280**	**-26,300**	**-1,019**
Total	**0**	**150**	**24**	**-126**	**0**	**57**	**57**
Plan Surplus	**200**	**150**	**24**	**-126**	**200**	**57**	**-143**

Forecast/Recovery Plans

£4.4M
BEST CASE
£0
MOST LIKLEY
£-6M
WORSE CASE

Forecast has been adjusted to include the impact of Industrial Action in December and January, £1.6m (direct staffing costs/lost efficiency and income).

Directorates have been given specific targets to improve their run rate to ensure we can successfully deliver the planned £4.4m surplus.

Spend over £10k, TRAC requests and Discretionary spend are being monitored on a weekly basis.

Top schemes identified summarised below (Risk adjusted values used).

1.5M PSC

- Over delivery ERF, amount TBC
- Reduction in Agency 0.4m

1.5M LTUC

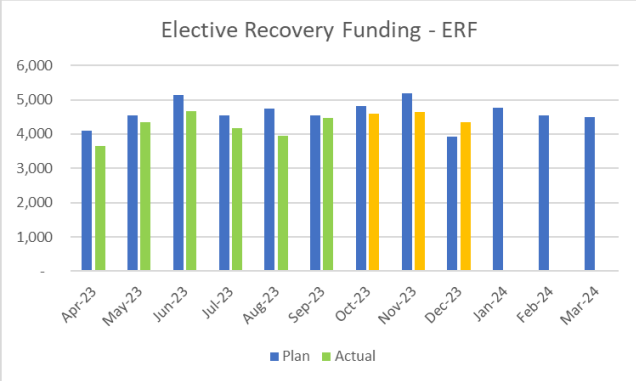
- Pathology 0.2m
- Imaging 0.3m
- Ward staffing 0.2m

1M CORP/C C/HIF

- CORP - Procurement 60k. Apprenticeship 70k.
- CC - Reduction in Bank 0.1m. Stockton Pay 50k and Travel 50k

Elective Recovery Funding - ERF

£-2.7M
RISK YTD
£3M
OVER DELIVERY FORECAST (ONCE CODING CHANGES CORRECTED)



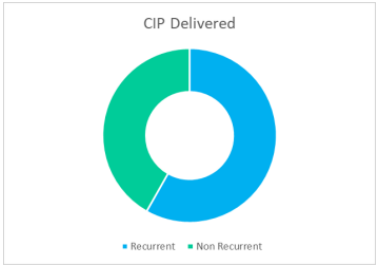
Baselines have now been adjusted to reflect all industrial action to date as at October.

Unfortunately further strikes have since happened (Dec and Jan) which has resulted in 363 outpatient appointments and 9 Inpatient appointments cancelled.

- There are a number of areas which require changes to the way they are recorded and then subsequently coded including Ophthalmology, Gynae, T&O and Rheumatology. Discussions continue with Silverlink to address the backlog changes needed. Further work needed to ensure future coding is rectified.
- There is still a 6 week delay to 'cashing' up clinic information which is also being reviewed.
- Plans are being delivered to address all of the above.
- Advice and guidance funding has been confirmed for the year, £650k

Cost Improvement Program

65%
DELIVERED
£20M
TARGET



The 6% CIP target has been challenging however 65% has been achieved to date. 58% has been delivered recurrently. A full review of NR Schemes will be undertaken to reduce the carry forward value.

Target	Actioned	Low	Medium	High	Unidentified
20,832,000	13,499,750	69,950	46,000	615,000	6,601,300
Cost Reduction	1,870,742				
% of target	**65%**	**0%**	**0%**	**3%**	**32%**

The below table summaries the carry forward of CIP to 24/25.

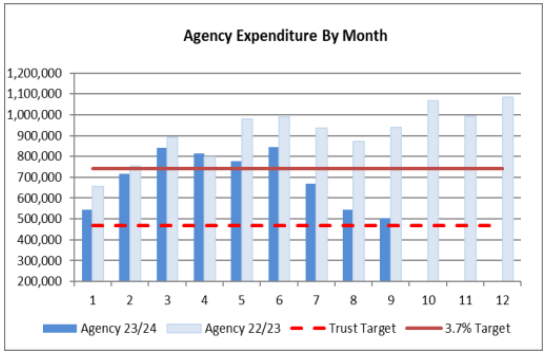
Directorate	Carry Forward
COMMUNITY AND CHILDRENS	-472,800
CORPORATE SERVICES	-361,500
PLANNED AND SURGICAL CARE	-1,469,300
LONG TERM AND UNSCHEDULED CARE	-2,668,200
HIF	-401,400
Total Carry Forward to 24/25	**-5,373,200**

To note 24/25 Targets will be based on benchmarking information to target focus on the main opportunities rather than a flat % increase to all Directorates.

A 3% target would equate to, £9,600 the balance would sit centrally and be managed by the Exec team, £2,965.

Agency

£6.2M
SPEND YTD



Agency spend has reduced further by £40k in comparison to the previous month. Positively there has been continued reduction in agency use across the wards but it is one of the main drivers of agency nursing spend. All agency accruals were reviewed in M8 resulting in a number of historic ones being dropped which impacted the medical staffing in month actuals.

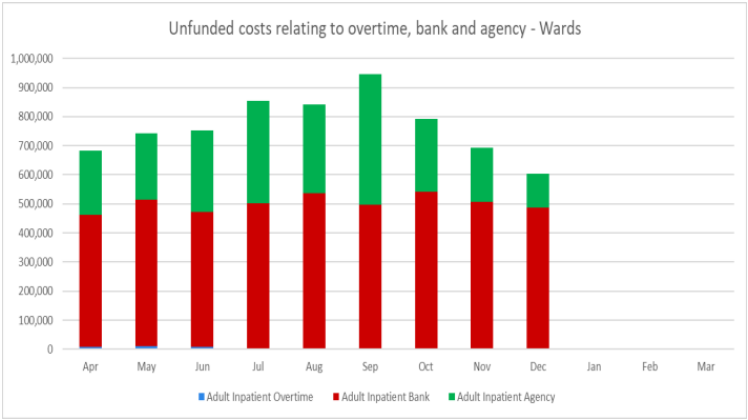
The main arears utilising Medical and Dental agency include

- Radiology £681k YTD (Radiographers and Med Staff)
- Elderly £294k YTD (Consultant)
- Cardiology £262k YTD (Consultant)
- General Surgery £176k (SPR's)

The main area for agency nursing is

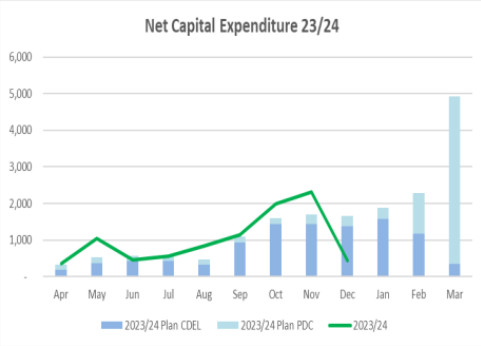
- Wards £2.4m YTD
- Emergency Department £618k YTD

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Medical and Dental (Agency)	109,182	284,559	308,073	299,343	341,387	249,478	251,049	114,847	202,573
Non-Medical - Non-Clinical (Agency)	85,987	50,921	146,029	63,222	37,420	47,253	50,107	102,609	61,586
Registered Nurses (Agency)	308,794	351,058	365,608	443,601	394,912	524,990	355,867	306,931	221,983
Scientific, Therapeutic and Technical (Agency)	0	0	0	-291	3,525	20,698	11,973	19,857	13,594
Support To Clinical Staff (Agency)	39,987	28,168	20,697	7,141	684	936	1,477	203	3,370
Grand Total	**543,950**	**714,707**	**840,408**	**813,017**	**777,929**	**843,355**	**670,473**	**544,447**	**503,106**
Agency Trust Target	468,160	468,160	468,160	468,160	468,160	468,160	468,160	468,160	468,160
Variance	**-75,790**	**-246,547**	**-372,248**	**-344,857**	**-309,769**	**-375,195**	**-202,313**	**-76,287**	**-34,946**
Agency 3.7% Target (as per guidance)	740,000	740,000	740,000	740,000	740,000	740,000	740,000	740,000	740,000
Variance	**196,050**	**25,293**	**-100,408**	**-73,017**	**-37,929**	**-103,355**	**69,527**	**195,553**	**236,894**



Capital

£9.2M
SPEND YTD
£19M
SPEND FORECAST



The capital plan has been phased towards the final quarter due to completion timescales for the larger schemes, including Wensleydale and Aseptics. Both schemes costs have escalated since the plan was finalised.

PDC Schemes have increased during the year as further funding has been made available and successfully bid for.

Confirmation has been received for the £2m RAAC monies to support the initial design work and preventative measures that have been put into place.

YTD spend includes the impact of transferring £1m of funds to Leeds Teaching Hospital that has been previously been allocated to HDFT for TIF1 (Wharfedale scheme).

		Plan	Actual	Forecast
CDEL Assumption	**Sch ID**	**9,999**		
Schemes Carry Forward from 2022/23 (lifts & plant rooms)	HIF PRIOR	804	329	908
CT Scanner Install/Radiology Reconfiguration	IMAGING	1,000	613	1,158
ED2 Refurbishment	ED	1,000	209	284
Asceptics Refurbishment	ASCEPTIC	1,404	1,139	1,709
HIF Depreciation	DEPN 23/24	327	80	389
Estate Maintenance (Backlog)	BACKLOG 23/24	684	442	635
Wensleydale/Digital/Medical HoB Ward	WENSLEYDALE	2,004	2,631	2,577
HIF MGT FEE	HIF MGT	0	162	162
Schemes Carry Forward from 2022/23 (other misc)	PRIOR	0	1,488	1,858
Contingency	CONT	500	149	220
Health and Wellbeing (Working Environment)	H&W	0	0	0
Clinical Equipment Replacement	CLINICAL EQT	276	0	0
Trustwide EPR - Trust Contribution	EPR TRUST	1,000	0	0
Electrical Infrastructure	ELEC INFRAS		0	0
TIF 1 - Allocate capital to LTHT	**TIF1**	1,000	936	936
IFRS16 - Leases	LEASES	0	0	1,000
Additional CDEL from ICB		**3,500**	0	0
~Breathe		0	0	1,000
Total Plans Against CDEL		**13,499**	**8,177**	**12,837**
PDC Schemes (Non CDEL)				0
Trustwide EPR	EPR	4,800	1,543	4,800
TIF2	TIF2	2,000	174	2,000
e Diagnostic recovery and renewal programme.	*EDIAGNOSTIC*	*456*	*0*	456
Community Diagnostic Centre	*CDC*	*1,049*	*6*	1,049
Cyber Risk Reduction	*CYBER*	*30*	*0*	30
Bowel Sceening Scope/Laptop/Monitor	*BOWEL*	*54*	*0*	54
RAAC	*RAAC*	*2,000*	*0*	2,000
Robotic Automation	RPA		-30	0
Total Non CDEL Schemes		**10,389**	**1,694**	**10,389**
Grant Schemes				
Salix Next Phase	SALIX	599	817	817
Grant Schemes		**599**	**817**	**817**
Total Capital		**24,487**	**10,688**	**24,044**
Total Capital less TIF 1 Allocation			**9,752**	**23,108**

Cash

£35M(APR 2023)

↓

£12.5M(DEC 2023)

December		
31-60 Days Past Invoice Due Date	**61-90 Days Past Invoice Due Date**	**Over 90 Days Past Invoice Due Date**
677,748	95,938	1,372,193

Cash has significantly reduced this year, cash support requests have been submitted to NHSE as the forecast suggests we will incur problems in February.

It is important to note there are a number of large capital payments due December onwards as schemes are completed.

To assist with HIF's cash balance the HIF contract has been paid up to March 24 already, whilst the treatment of fixed assets is worked through.

Outstanding Debts have increased by £0.15m in comparison to the previous month.

Over 90 Days
£235k relates to ICB – disagreement around LAC charges. No expected charges as seen as low value activity as per guidance.
£98k relates to HEE – relates to a private patient from a number of years ago who original contributed small payments on a monthly basis, this is unlikely to be fully recovered.

Despite the above we are currently maintaining 93% of invoices being paid within 30 days.

Balance Sheet

£'000	Actual 31-Mar-23	Actual 30-Nov-23	Actual 31-Dec-23	In month movement
Non-Current Assets				
Intangible Assets	6,759	5,706	5,706	0
Property, Plant and Equipment	145,482	153,911	154,078	(167)
Right of Use Assets	9,292	8,031	7,874	157
Trade and Other Debtors	832	357	395	(38)
Total Non-Current Assets	**162,365**	**168,005**	**168,053**	**(48)**
Current Assets				
Inventories	2,443	2,429	2,060	369
Trade and Other Debtors	23,580	23,372	19,630	3,742
Cash	35,113	14,502	12,572	1,930
Total Current Assets	**61,136**	**40,303**	**34,262**	**6,041**
Current Liabilities				
Trade and Other Creditors	(49,926)	(35,698)	(29,687)	(6,011)
Borrowings	(3,089)	(2,800)	(2,801)	1
Provisions	(104)	(65)	(65)	0
Other Liabilities	(2,840)	(1,089)	(687)	(402)
Total Current Liabilities	**(55,959)**	**(39,652)**	**(33,240)**	**(6,412)**
Net Current Assets/(Liabilities)	**5,177**	**651**	**1,022**	**(371)**
Non-Current Liabilities				
Borrowings	(15,274)	(14,822)	(14,543)	(279)
Provisions	(662)	(668)	(668)	0
Total Non-Current Liabilities	(15,936)	(15,490)	(15,211)	(279)
Total Assets/(Liabilities) Employed	**151,606**	**153,166**	**153,864**	**(698)**
Financed by Taxpayers' Equity:				
Public Dividend Capital Reserve	116,818	116,818	117,328	(510)
Revaluation Reserve	15,166	15,181	15,181	0
Income and Expenditure Reserve	19,622	21,167	21,355	(188)
Total Taxpayers' Equity	**151,606**	**153,166**	**153,864**	**(698)**

Risks

As discussed in the report the Trust has reported a continued deficit position at month 9.

There are number of risks to be updated on the risk register relating to 2023/24.
The below risks have been escalated to Executive Risk Review Group

CRR76 – Underlying Financial Position, Risk scoring of 15

Principle Risk Description: Underlying financial position
If the current in year performance continues as is, the trust will continue to increase its YTD deficit and therefore not reach its projected breakeven position. Over the longer term, this will result in the overall financial position of the trust being effected, which will affect the financial standing of the trust.

	Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood
Initial Score	5	3	Oct	5	3	Nov	5	3	Target: 03/2024	5	1
	15			15			15			5	

Key Risk Indicators What are the key indicators to evidence the target is met	Current Position What is the current position and measures already in place to mitigate / reduce the risk	Plans and Actions What needs doing to reduce the risk, what extra controls need to be put into place?	Due When are the actions due by and who
1. Monthly financial reporting – Break even operational plan 2. NHSE productivity analysis 3. Agency Expenditure 4. Cash position	The Trust remains dependant on non-recurrent funding to achieve a breakeven position. Pressures relate to non-recurrent funding sources supporting the operational position of the Trust, the impacts of capital charges following an increased capital programme, and the impact of inflation on non-pay. Inflation is affecting many areas, there is also an underlying issue with drug expenditure. In year performance in 2023/24 is currently not at the levels anticipated, and therefore the risk scoring below remains at 15. Pressures in year related to – • Performance against the efficiency requirement for the Trust • Use of temporary, premium rate staffing • Inflation above the levels outlined above and within planning • Strike costs • Drug expenditure, again above the levels described above. 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. **Currently reporting a deficit position of £3.7m.** NHSE productivity analysis outlines the Trust being below the median against 2019/20 productivity levels, as measured by NHSE. Month 12 2022/23 is 12.6% against ICB at 8.6% and region at 11.3%.	1. Continued discussions with ICB regarding underlying position – NHSE submission expected late summer 2. Recovery plans at directorate level – see appendix	1. Leadership Team – Director of Finance 2. Various

CRR71 – Agency Expenditure, Risk scoring of 9 reduced from prior month

Principle Risk Description:
If the trust continues to incur premium costs for staffing where vacancies exist, there is a risk it will exceed the agency price cap for the financial year the consequences for this will be breach of regulations, and a negative impact on the overall financial position.

	Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood		Consequence	Likelihood
Initial Score	3	5	Dec	3	4	Jan	3	3	Target: 03 / 24	3	3
	15			12			9			9	

ey Risk Indicators hat are the key indicators to evidence the target is et	Current Position What is the current position and measures already in place to mitigate / reduce the risk	Plans and Actions What needs doing to reduce the risk, what extra controls need to be put into place?	Due When are the actions due by and who
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 - £468k a month. 3. Monthly price cap compliance	1. The Trust has spent less than the Trust target (£468k per month). – Month 9 spend in month was, £503k. This is a continued improvement from month 8, which was £544kk. 2. The Trust is currently spending in excess of the 2019/20 pro-rata agency spend – YTD £6.2m against 2019/20 £2m pro rated 3. The Trust is now reporting performance to NHSE on a monthly basis. The Trust will not be able to deliver the 19/20 rate of expenditure plan, however with continued focus on reducing agency spend for the remainder of the year the trust will be able to deliver the ICB ceiling target.	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 2024/25 5.Target levels of agency compliance based on monthly return to be developed	1.ongoing 2.ongoing 3.monthly 4.Medical e-rostering project group 5. Finance managers with directorate colleagues

Controls

PAYROLL OVERPAYMENTS

£9k IN TOTAL
13 OCCASSIONS

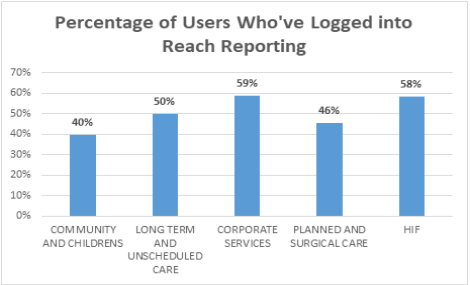
HEALTH ROSTER

HOURS OVER PLAN

ED 1,611 HOURS
ADULT COMMUNITY 1,282 HOURS

REACH REPORTING

BUDGET REPORTS



No PO & INVOICE R/C

NUMBER 40
VALUE £521k

DISCRETIONARY SPEND

£29.6K PREVENTED YTD

BUDGET HOLDER ENGAGEMENT

CC 100%
CORP 58%
PSC 94%
LTUC 72%

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

Date	**5 September 2023**	**Location**	MS Teams
Chair	**Brendan Brown**	**Minutes prepared by**	Geraldine Morris
Attendees	Foluke Ajayi, Mel Pickup, Brendan Brown, Jonathan Coulter, Len Richards, Lucy Cole, Ben Roberts, Clare Smith, Esther Ashman, Visseh Pejhan-Sykes, Rachel Gillott		
Apologies	Phil Wood		

Agenda

ITEM		WHO
1	Welcome and apologies	Chair
2	Minutes and Actions	All
3	Specialised Commissioning delegation update	Esther Ashman / Visseh Pejhan-Sykes
4	Collaborative Report and WY HCP Report	LC
5	WY ICB Operating Model • Letter from RW and next steps • Draft SLA / Responsibility Agreement	 BB LC
6	ICS Capital top slice proposal and WYAAT position	BR
7	Break	
8	ERF mutual aid proposal • Sign-off	 BR
9	YAS Strategy development	Rachel Gillott
10	WYAAT R&I development	BB / LC
11	Plan for October all exec session • New date • Session structure	 LC
12	AOB • Regional elective event	 All
13	Close	Chair

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
	Agenda items were taken out of sequence of the circulated agenda, therefore are recorded in order/flow of discussion, thus noting the sequencing of numbers to the minutes below.	
3. Specialised Commissioning delegation update	*Esther Ashman (EA) and Visseh Pejhan- Sykes (VPS) joined the meeting* *Len Richards joined the meeting* • EA gave an overview of the pre-delegation assessment framework (PDAF) developed to support Integrated Care Boards (ICBs) prepare for delegation arrangements, which underpins assessment of system readiness. It's been tailored specifically for specialised commissioning (Spec Comm) services. Underneath the joint committee is a partnership and collaboration group that Lucy Cole (LC) and Tim Hiles are involved with, which has various sub-groups beneath it. EA discussed staffing for commissioning and specialised services. It's intended staff will move to act as a hub under an ICB, however there will also be staff in the hub dealing with retained services with NHS England (NHSE). Discussions around who will host the hub have been challenging, resulting in NHSE delaying the move until April 2025. EA sought to understand the risks around that delay in terms of having responsibility for the services whilst the staff are still with NHSE. EA invited members to forward any comments to her on the PDAF after today's meeting. Work on PDAF will be ongoing until 20 September. NHSE to make final decision in December. Work has begun in WY on establishing governance, with an initial meeting tomorrow where working together collectively will also be discussed. As part of this work, EA was asked to have a priority pathway through which to do specific work with each ICB. This will be renal dialysis. • VPS explained that Barnsley as a PCT once held the Spec Comm budget for Yorkshire and the Humber, distributing the spend to PCTs. She further explained the desire to emulate this, as risk sharing and moderating fluctuations in the first year made sense. The formula is being reviewed and VPS is happy with how things are progressing. Over the past year VPS has been involved with Sarah Halstead, who acts as commissioner for WY and other ICBs, around strategy and planning. Strong relationships with colleagues across the patch are being built upon. *Mel Pickup (MP) joined the meeting* Brendan Brown (BB) thanked EA and VPS for their overview and asked what this would mean for service delivery.	

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

	Clare Smith (CS) - queried what this meant for activity and understanding gaps. VPS - explained from a finance perspective, a major tension with Spec Comm is amount of interface, citing spinal as one area. Decisions made at one end of pathway could impact the other end, and costs shift. Mel Pickup (MP) – raised the frustration felt around the facelessness of this as a function from NHSE's perspective. EA - responded MP's comments would help with delegation checklist work. She highlighted that questions around relationship support, infrastructure and governance were in the detail of the delegation checklist; the PDAF is a high-level governance and quality document. She added having LC in the group to support working through detail was helpful. LC – stated the PDAF felt like old style commissioning which isn't how we work in WY. Understanding how that works is challenging. Aside from the benefits, risks need managing. BB – asked how WYAAT could expedite some of the work and how members could help and support. He agreed with MP's point on the facelessness of this being unhelpful. VPS - consideration is needed on how to set it up. CS - acknowledged MP's and BB's points around demand profile and examined the financial pressures this year, highlighting the importance of managing discussions with some framework to track activity. BB – suggested members could help facilitate WYAAT colleagues willing to help with this discussion. EA – agreed to share copy of draft delegation checklist with LC. BB - acknowledged the opportunity to capitalise on the already strong relationship. VPS - thanked members for their feedback, which will assist with their meeting tomorrow. *EA and VPS left the meeting* LC - agreed to form a group of engagement. A wider discussion followed around likely cohort members and lead. BB – proposed that names be forwarded to LC to form group for dialogue with EA and VPS. LC - agreed that EA and VPS be invited to November meeting to give an update. It's hoped the proposed new group would help with NHSE's delegation process. BB- reflected on the disparity in how this is transacted and asked that LC update Simon Worthington (SW), and that Ben Roberts (BR) and CS join the new group. He summarised that the new group could call out the inequity that has existed for past several years and steer conversation to communities we serve.	**ACTION: EA to share latest draft delegation checklist with LC.** **ACTION: LC to form a group of engagement to discuss. Members to provide LC with suggested names for the cohort.** **ACTION: PMO to schedule EA and VPS update at November meeting.**

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

1. Attendance & Apologies	Apologies noted and accepted for Phil Wood.	
2. Review previous meeting minutes & actions	The minutes from the previous meeting were approved as an accurate record. **The action log was reviewed, and the following updates were given:** • *Action 111 WYVaS options, WYVaS team to bring overview of outcomes to meeting in October 2023* – deferred to November. • *Action 116 Collaborative Report & WY HCP Report, AA to update on workforce, deferred to November due to all exec session in October* • *Action 120 WYAAT Strategy, LC to update4 on WYAAT Strategy work at October meeting* • *Action 121 Neurology Update, SU to pick up considerations in relation to acute physicians* • *Action 122 Neurology Update, further neurology update to be added to the agenda in October* • *Action 126 CiC follow up discussion, LC to consolidate suggestions and remap SLP model* • *Action 128 CiC follow up discussion, LC to look at service configuration and update at future meeting* **The following actions are complete:** • *Action 117 ERF proposal – BR to update on feedback from national meetings* – on agenda • *Action 118 ERF proposal – LC to invite clinical networks to September meeting* – on agenda, Clinical networks were invited to the all-exec session, which has since been affected by the consultants and junior doctors strikes, will be rescheduled – will pick up strategy work as part of today's agenda discussion • *Action 124 Specialised Commissioning – LC to meet with Ian Holmes* – on agenda and discussed – can pick up as part of operating model discussion under agenda item 5 • *Action 125 Collaborative Report & WY HCP Report – LC to update on discussion with Ian Holmes at future meeting – on agenda* • *Action 127 CiC follow up discussion – LC to invite YAS to future meeting – on agenda with YAS joining us later to discuss strategy and how we engage with that* • *Action 129 AOB LC to update on proposal for an all-executive in September or October – on agenda* • *Action 130 LIMS – JB to share specific context and challenges with each CEO for their trust* -Janine Bontoft covered this at last meeting; if other issues arise, she'll escalate to this group if needed BB thanked LC for the update and noted the YAS drop-in session coincided with doctors' strike.	
4..	LC updated on the WYAAT Collaborative report	

Collaborative Report and WY HCP Report	• Community Diagnostic Centres - met with NHSE, agreed a reporting arrangement that feels practical and scheduled monthly network meeting with CDCs with NHSE colleagues. It's now managing itself. Will become place-based focussed in terms of implementation. • Imaging – A bid has been generated for national AI programme to help with chest imaging. LC thanked everyone involved in the bid. Bid was submitted in draft and will need some signatures in due course. Had good support, with strong chance of success. The £1.1m covers capital and revenue for two years. AI pilots being done locally have started on a good footing. November date established for shared reporting. Should complete and working by November, then take into testing, then live. • LIMS - testing resource for additional capacity working well and getting through bulk of regional work somewhat ahead of plan. Trying to understand impact of the fix. Have people working day and night. • Aseptics - final queries dealt with, been through regional process. Confident of national process success. Should have MOU in next few weeks. • Workforce – request to map current work against long-term workforce plan is under way, will bring this back and highlight at all-exec session. • SLP - final event next month, participants will present at it. • Planned care – patients waiting 65 weeks or longer received outpatient letter to book for October. Self-assessment work being done locally. ICB doing a check on that, which is unhelpful. LC is trying to manage it with what's taken through System Oversight and Assurance Group (SOAG). LC's been quite clear it can't be another assurance layer. CS – stated that WYAAT COO will ask WYAAT elective recovery group to produce strike impact summary, for a clearer understanding at ICS level. It may assist with conversations on whether we as WY want to put together something stronger in terms of impact for NHSE. BB – agreed this would assist LC with SOAG conversation and suggested everyone included the cost of strikes to help with consistency. Len Richards (LR) – raised that MYTT will not complete everything by end of October but is committed and focussed to resolve long waiters by end of March. MP – suggested emphasising the impact of strikes. BB – highlighted that winter, Countess of Chester Hospital events, reinforced autoclaved aerated concrete (RAAC) and money were areas of focus over next couple of months, requesting LC share this in a paper.	**ACTION: LC to request CEO signatures for AI bid via PAs.**

	LC – agreed to find a way to quantify it. If we can do that as WY it might be helpful, then push through Julian Hartley at NHS Providers to aggregate nationally. Foluke Ajayi (FA) – referenced the request to follow up outpatient on waiting list and raised it needs to be quantified as part of work we're doing. LC – highlighted that glaucoma clinical teams have workshop later this month, with clinicians keen for more sustainable solution. A half time public health consultant has been secured to focus on longer term 10-15 years planning and demand on specialities and aid proactive conversation and configuring services in future. LC – advised the HCP report was just to note. BB – raised it would help to have the half time consultant's opinion on inequity of funding and the impact longer-term. LC – agreed it would be good to expose the half time consultant to different things, who should have capacity for this. BB – thanked LC and BR, adding that members appreciated the work being done on this.	
5. WY ICB Operating Model - Letter from RW and next steps - Draft SLA / Responsibility Agreement	5a – letter from RW and next steps BB – thanked everyone for comments received on Rob Webster's operating model letter and confirmed a series of conversations were scheduled with Rob Webster and ICB executive team over next couple of months. MP – updated that place leads to share proposed structures on 8 September; there's an all staff meeting on 11 September; a further meeting 15 September and a consultation is likely on 26 September. Ahead of that, jobs/job descriptions need matching. 5b – Draft SLA / Responsibility Agreement LC – shared that planned care resource will move to WYAAT with associated funding. Stroke network conversation is ongoing; host interface with trusts needs to improve. Maternity and cancer being pushed into option five conversation in terms of moving into place-based delegation. Draft agreement, which was included in the pack, has been discussed in greater detail. LC welcomed comments via email. BB - thanked LC for putting this together. CS – raised that the diagnostic hub type work in the report related more to primary care. We should be mindful of it taking us into a different way of working. The last bullet point seems a catch all for everything else but doesn't mention emergency care. It needs to be clear, so expectation of the ICS is understood.	

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

	LC – agreed the statement is broad brush and confirmed work has been done around fragile services. LC thanked CS for comments and suggested they discuss what needs to be included in terms of UEC. JC – examined the view in North Yorkshire (NY) that the collaborative is not part of the ICB. HDFT are quite a long way behind working through what a collaborative means, which Humber and NY are struggling with. UEC was part of a collaborative initially and there's support for it to return to being led by Places. HDFT are struggling with stroke in terms of clinical network. There was a wider discussion around grading, with MP stating that BTHFT have challenged cancer alliance to integrate more and reach out to the five Places. BB – summarised that LC has tacit support for SLA and responsibility agreement; redeployment is something to keep an eye on; we will help JC with ongoing conversations if needed and some technical UEC pieces to work through with CS and some clinical pathways. LC - happy to take any comments at 1-1s. CS – discussed 26 September consultation, urging it's done in efficient and timely way, as people will be worried about their livelihoods.	
6. ICS Capital top slice proposal and WYAAT position	BR presented the proposal to put 10% of operational capital into central pot for strategic or emergency need across ICS annually. Paper on July workshop going to SOAG this month. LTHT, MYHT, BTHFT DOFs do not support proposal, ANHSFT and CHFT support it in principle, but not at 10%. The ask is whether members are comfortable for position to go in a letter and be fed back into process. If it does move forward and ICB wish to pursue, a second view would be sought on how it would work in practical terms. BB – noted the paper says what we don't want but should also include what we do want. BR - agreed with this. FA – felt comfortable with what paper says, stating it's important to stress ANHSFT support it in principle but can't entertain it in next few years. An indication of agreement has been given in principle but sign off needed by ANHSFT board at the point a decision is made. LR – stated what we want and ICS and ICB should lobby hard for, is more strategic capital to be devolved to local organisations, to develop services to meet demands. BB – thanked LR for point well made.	

	MP – declared an interest as Mike Woodhead originally raised the need for Bradford District Care Trust (BDCT) to have a plan B. There's urgent need for Lynfield Mount and BDCT to have capital support to solve their issues, but BTHFT also have capital problems. BB – summarised that members support the paper but with addition of more strategic focus, and inclusion of what we do want. LR – asked if FA's point about what ICB can decide and what our statutory position is could be checked, as it's important to understand. A consistent understanding of what rules say about statutory organisations and ICB in general would be helpful. BB – asked FA to provide information on what ANHSFT will do and what the rest of us should be doing. BR - will re-word proposal and circulate the document today. A general discussion followed around NHS meeting in London tomorrow, with expectations that Countess of Chester Hospital, capital and RAAC might be discussed. Members agreed to update those unable to attend.	**ACTION: BR to feed back to CEOs on statutory decision making for Trusts and ICBs in respect of capital expenditure.** **ACTION: BR to update proposal and circulate to members.**
7. Break		
8. ERF mutual aid proposal - Sign-off	BR discussed the agreed five principles of ERF mutual aid proposal. The FAQs have been updated and he will work through any issues JC has as he's on a different payment system. BR sought to gain agreement from members that they're comfortable with the proposal. BR - highlighted an underlying question on agreeing to absorb patients into clinic, and the costs. BB - anticipated it would be escalated to COOs collectively. CS – raised it would be unhelpful to wait until March, so will add to WYAAT COO agenda in a couple of weeks. FA – welcomed clarity for HDFT, and for ANHSFT's large border area. BR – will include clarification, move proposal out of draft and meet with elective care group. The document will remain live for FAQs. Will recirculate, but this is just about those principals at this point. CS – clarified that the proposal doesn't need to return to COOs for further agreement. BB – thanked all and recapped that FA's query needed to be addressed.	**ACTION: CS to add to WYAAT COO agenda in a couple of weeks' time.** **ACTION: BR to circulate updated proposal to include clarity on HDFT, and for ANHSFT's border**
12. AOB	LC – asked members who they would like to field when elective recovery event, postponed due to Industrial Action (IA), is rescheduled.	

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

Regional elective event	BB – felt right people were fielded last time and proposed same again. He questioned if all board needed to attend. FA – suggested inviting just CEOs, COOs and MDs LC – noted the invite did include Chairs BB – proposed FA and LC and Russell Nightingale deliver presentations. LC – Chairs will be well-briefed if strike impact added to October CiC Agenda. BB – summarised that MDs, COOs, CEOs and Chairs be invited and bring this together around IA and sign off for response to Jim Mackey letter to play back into October CiC. CS – raised that LTHT have placed ANHSFT RAAC risk on corporate risk register. Unclear if adequate evacuation plan in place across WY for where evacuated patients would go. CS felt it shouldn't just sit with ANHSFT to do that. She questioned if decision to close would be sudden, or if it would take a different level of pace to pull together those plans. FA – advised responsibility sits with ICS around the emergency plan response. Anthony Kealy (AK) has the lead on "pressing the button" to evacuate, but she will check this. Guidance is being followed, with daily reviews. MP – sought to understand if there is an evacuation plan with AK having responsibility for "pressing the button", or if we are saying there isn't an evacuation plan. FA – confirmed there is an evacuation plan, but responsibility for it and to initiate is with ICS, nevertheless ANHSFT would initiate if it was needed. ICB are to coordinate response. FA – confirmed the evacuation plan is broader than WY. FA – supported BB's suggestion to add RAAC to agenda item for next time. It was proposed and agreed that the next meeting on 3 October be at the later and shorter time of 10:00-11:30 given industrial action on that date.	**ACTION: LC to ensure MDs, COOs, CEOs and Chairs are invited to elective recovery event** **ACTION: PMO to add RAAC to November agenda**
9. YAS Strategy development	*Rachel Gillott (RG) joined the meeting* RG outlined that YAS are creating a five-year strategy 2024-2029. They are keen for engagement from system partners, to help shape the strategy going forward. Their information gathering culminates with an in-person event on 27 September at Village Hotel south Leeds. Members are invited – or can cascade down – as well as LC and colleagues for dissemination. It's an informal drop- in event, world café form, with on the hour/every hour presentation by a YAS Director. As it's a drop-in, there's no requirement to stay the full three hours. RG highlighted events elsewhere in South Yorkshire and in Humber and North Yorkshire if more convenient. Information received will be refined during October and November, shared, and refined further, ready to finalise strategy in December for launch early 2024. Will get mechanisms online and other avenues to contribute. Can share presentation with LC. BB - thanked RG for her update and asked what YAS needed from WYAAT to make this work.	

	RG – updated that YAS have made recent structural changes and want to develop as system partners, working better together and developing strategy. JC - asked what WYAAT could do better, suggesting YAS tell us when we are / are not doing ok. It should be a two-way process. RG – supported this suggestion. BB – summarised that YAS has WYAAT's support, with our various organisations attending drop-in sessions. LC – proposed doing something through WYAAT Directors of Strategy to make it easier for YAS, with a mechanism to feedback. LC further proposed that when this has progressed a bit, invite YAS to Directors of Strategy conversation and use that as the link. RG – accepted this great offer and an opportunity to share material and for a more informative session. She shared that YAS would be happy to attend Directors of Strategy meeting and/or returning to future Programme Executive meeting to update on how the YAS strategy is taking shape. She'll be in touch and get something in the diary. *RG left the meeting.* BB – updated that the YAS 27 September event coincides with when CHFT's new ED opens.	**ACTION: LC to invite YAS to future Directors of Strategy meeting.**
10. WYAAT R&I development	LC - explained she and BB met with various organisations to explore a collaborative approach around R&I. The innovation hub conversation was about their offer in partnering WYAAT, with three bundles. First is spread and scale of best practice in WYAAT and their support in identifying that, including possible funding; second is around AHSN that others in WY are doing that we could adopt in short/medium term; third is us being clear on R&I solving longer-term problems such as glaucoma surgery. LC summarised there's a plan forming which she'll come back with. LC and BB welcomed thoughts on whether anything was missing, or if they disagreed with any of it. She added that members' respective Heads of R&I will have a major role in this. BB – stated that LC'S suggestion was to have a CEO SRO to help take this forward. LC – people are trying to do the right things, but the connections are missing. MP – understood this to be a notoriously difficult area. She discussed that Bradford District and Craven have plethora of research architecture and proposed having a single point of contact to connect into WY if it helps. LC – accepted this would be helpful. LR – stated it would be a good start if we pull together the portal whereby all contribute and share what we're doing. There's a lot we can learn from each other's collective WYAAT systems. He explored WYAAT's attractiveness to industry to try new products because of our collective size and population we cover. LR happy to be SRO and work with LC on this.	**ACTION: LC to update on R&I collaborative plan at future meeting.** **ACTION: LR and LC to discuss requirements of SRO role.**

	LC – updated that the portal is being reviewed. She'll talk to Rob Birkett this week. She proposed a five-year strategy for this to discuss how to scale it across five years. CS – proposed using the innovation district at LTHT, incorporating it for the region. BB – suggested reviewing this again in November and proposed LR and LC discuss the SRO role. LC – agreed to discussing again in November. She updated that University of Leeds are looking to bid to be an academic health science centre and are very interested in having all WYAAT organisations as partners. It will bring prestige to Yorkshire region.	**ACTION: PMO to add R&I to November Agenda.**
11. Plan for October all exec session - New date - Session structure	LC updated on the all-executive session planned for October, which was cancelled due to proposed IA on the same day. The intention was for this to be before Committee in Common (CiC) on 31 October and for any input to final strategy document for sign off at CiC. LC proposed taking overall strategy document in October and complete the detail subsequent to CiC. LC invited views on this, adding it's more about the nuts and bolts, with each executive group identifying three or four priorities. FA – suggested taking pragmatic approach of having an overall strategy - working through detail and how to operationalise that would be an approach. BB – supported FA's view and suggested a different review date early next year, due to IA impacting outputs. JC – agreed the ideal of reviewing before CiC was no longer practical, therefore push CiC review back and explain why. LC – will reschedule after CiC. BB – suggested members have individual conversations with their Chairs before of CiC to brief on what's happened. *Move to item 12. AOB*	**ACTION: LC to reschedule all-executive session after October**

OTHER ISSUES TO NOTE

N/A

NEW RISKS/ISSUES RAISED

N/A

Next Meeting	**WYAAT Programme Executive**		
Date	3 October 2023, 10:00-11:30	**Location**	MS Teams

Insourced Reporting Working Group

Date	**3 October 2023**	**Location**	MS Teams
Chair	Brendan Brown	**Minutes prepared by**	Geraldine Morris
Attendees	Foluke Ajayi, Mel Pickup, Brendan Brown, Jonathan Coulter, James Goodyear, Len Richards, Lucy Cole, Ben Roberts		
Apologies	Phil Wood		

Agenda

ITEM		WHO
1	Welcome and Introductions	Chair
2	Minutes & Actions	All
	CEO Updates	All
	Elective Recovery • Impact of industrial action • ERF • Elective event 25/10/23	LC/BR
	Sexual Safety Charter	All
3	Collaborative Report and WY HCP Report	LC
	CiC Agenda	LC
4	AOB • All exec session	All
5	Time and date of next meeting	Chair

Insourced Reporting Working Group

MEETING NOTES		
Agenda Item	**Main Points and Decisions from Discussions**	**Agreed Follow-Up Actions**
Welcome and Introductions	Apologies were noted and accepted for Phil Wood.	
Minutes & Actions	The minutes from the previous meeting were approved as an accurate record. **The action log was reviewed, and the following updates were given:** • *Action 111: WYVaS options, WYVaS team to bring overview of outcomes to meeting in October 2023* – deferred to November due to IA on October programme exec. • *Action 116: Collaborative Report & WY HCP Report, AA to update on workforce* - deferred to November due to IA on October programme exec. • *Action 121: Neurology Update, SU to pick up considerations in relation to acute physicians* • *Action 122: Neurology Update, further neurology update to be added to the agenda in October* – deferred to November due to IA on October programme exec. • *Action 126: CiC follow up discussion, LC to consolidate suggestions and remap SLP model* – To be included within evaluation report and recommended next steps. • *Action 128: CiC follow up discussion, LC to look at service configuration and update at future meeting* **The following actions are complete:** • *Action 131: Specialised Commissioning delegation update - EA to share latest draft delegation checklist with LC.* • *Action 132: Specialised Commissioning delegation update - LC to form a group of engagement to discuss. Members to provide LC with suggested names for the cohort.* • *Action 133: Specialised Commissioning delegation update – PMO to schedule EA and VPS update at November meeting.* – Specialised commissioning delegation delayed. Action closed until new timeline agreed. • *Action 134: Collaborative Report & WY HCP Report – LC to request CEO signatures for AI bid via PAs.* • *Action 135: ICS Capital top slice proposal and WYAAT position – BR to update proposal and circulate to members.* • *Action 137: ERF mutual aid proposal – CS to add to WYAAT COO agenda in a couple of weeks' time.* – On forward plan for 17/10. • *Action 138: ERF mutual aid proposal – BR to circulate updated proposal to include clarity on HDFT, and for ANHSFT's border arrangements.*	

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	• *Action 139:LC to ensure MDs, COOs, CEOs and Chairs are invited to elective recovery event.*	
CEO Updates	MYTT • Having issues around what Christmas Day cover definition with BMA, which has created some uncertainty over what the cover now is. Stocktake being completed at start of each shift. Numbers are down and bed occupancy is down. The trust is on OPEL 2. Feels comfortable. Making progress on industrial action (IA) recovery. ANHSFT • IA includes radiology at the trust. BTHFT and LTHT are thanked for their support when MRI scanner went down. No different to others with challenges IA causes. All okay otherwise. HDFT • IA is going fine. Still have some electives running. Challenges around urgent care. Two-three ambulance diversions per day - 18,000 in the last year - are a constant issue. Have redrawn boundary for ambulances and working with YAS. JH confirmed Martin Barkley, new Chair of York, is in post from 1 November 2023. Receiving increased interest from Members of Parliament around what the trust is doing to resolve its RAAC issue. LTHT • New interim Chief Nurse (CN) Jackie Murphy joined the trust this week for three months until CN Rabina Tindale starts in January. Rabina is doing drop-in days until then. New Chief Medical Officer Magnus Harrison joined three weeks ago. IA is well-managed. Finances are challenging. BTHFT • All okay, apart from IA impact on electives. Continuing with outpatients, but no day cases or non-urgent electives. CHFT • Confirmed the position was similar in respect of IA, urgent care pressures and financial challenges.	
Elective Recovery - Impact of industrial action	Lucy Cole (LC) presented a verbal update on the impact of IA, ERF and Elective event. • LC updated she is working through the ask last time to quantify the impact of IA on elective activity and will be talking to elective coordination group this week for a sense check. LC confirmed the	

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- ERF - Elective event 25/10/23	Regional event would take place on 25 October to reflect on progress to date. The work is using the RAIDr data to create the same view as NHSE and looking at how we factor in the broader productivity impact of cancelling/rebooking/repeating. Information is being gathered on what turnout is looking like and whether it impacts particular specialities. James Thomas is looking at potential harm. LC confirmed this analysis would be shared ahead of 25 October event. BB – referenced the harm piece and queried if periods after IA were also being reviewed, as well as long shadows list. LC – confirmed yes, we need to review each on a speciality-by-speciality basis. This will include impact on P3 and P4 patients and long waiters, which isn't seen on radar data. Gynaecology and ENT are challenged at present. Ben Roberts (BR) – From the West Yorkshire (WY) perspective we are up in our alternative system. Our system performance is good and improving and we're working with ICB to keep within our own system. Main risk area is MYTT's 52-week position which is sizeably over target. We received an adjustment to our trajectory. The 4,000 52-week waiters have been increasing since IA. Some of these risks will be highlighted through the Board. There are risks around MYTT and ANHSFT that we also need to keep an eye on. LC – we need to build up the narrative on this, to be consistent across WY and focussed on the right thing. It's important how we play this back to ICB and other forums. BB – agreed that the right thing is being done for the right reasons.	**ACTION: LC to share assessment on impact of IA ahead of 25 October elective recovery event.**
Sexual Safety Charter	LC – drew attention to an open letter from MDs, particularly for JDs on rotation, where, if they can't raise an issue in one organisation, they can raise it in another. There was an ask from ICB to do something on this. LC asked members if there was any requirement for further collaborative action. James Goodyear (JG) – spoke with HRD Jenny Lewis prior to this meeting as she is executive lead on this. Jenny suggested as WY partners we get relevant leads to get active learning conversation going and to think about how we respond to this really complex set of issues. BB agreed that long-term actions needed to be discussed and asked for views from the group. Len Richards (LR) asked the group if they were seeing an increase in reporting on these issues. JC - not seeing increase, but not sure if people are not reporting. JG - not seeing increase, but it is relatively common.	

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	Mel Pickup (MP) - not aware of increase. Foluke Ajayi (FA) – the impression is that people feel more able to speak up, and action taken helps them to do this. People should be made to feel comfortable to speak up and encouraged to do so. JG – summarised there's probably support for a group to get together, not just for surgery, but for whole misappropriation of power. Members' helpful comments will be fed back Jenny. BB – happy for leads to come together and support but look at this longer term. MP – shared she was served papers from BMA around taking legal action against Health Education England over choosing who goes onto training. The deanery had not raised awareness that this was such a contentious issue that legal action would be taken. MP will circulate papers to members who were also unaware of this. BB – commented that this may need to be revisited and something reported to Committee in Common, as it may be of interest to some Chairs.	**ACTION: MP to circulate BMA communication about legal action against Health Education England**
Collaborative Report and WY HCP Report	LC gave the following collaborative report updates: **Endoscopy** • Interviews took place for training lead for MYTT training centre, role to be split between medical and non-medical. Good for taking forward immersion training. Moving in right direction. **Imaging** • Good progress on image sharing solution. Images being successfully shared between trusts. Shared reporting expected from new year. Unfortunately, letter received yesterday notifying we were unsuccessful in chest AI bid, which was unexpected. This is on reserve list. LC to investigate to understand why this happened, as she feels we're in a good position. **Pathology** • New lab completed at SJUH; good engagement at the opening. Managed service contract signature is complete. Good recognition of work done by team. An issues has been found in the live LIMS for which a fix has been issued by the Supplier. This is currently subject to two weeks of testing, which takes away clinical risk and barrier to further implementation. Go live in Harrogate will be in November. On track in terms of microbiology and blood sciences next year. Some noise with dates and knock-on impact if dates not met. Working through, will become clear in next couple months. **Aseptics**	

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	• Not rubber-stamped this yet. Currently working through national system; should then progress to lease signature. **Workforce** • Midpoint evaluation for SLP to be fed into final session. Cohort leading on that on their own experiences, which will inform future programmes. BR – provided an update on the Chemo system procurement and the future procurement model: • It's hoped there will be a contract in March. Market engagement on the system specification is progressing well. Procurement as part of ICB model - have been looking at model with Directors of Finance (DOFs) and are down to the final three options. The approach has been to engage the teams involved in delivering the services to achieve buy-in for the options. Feedback to date has acknowledged the benefits of a more unified model. Len Richards (LR) – questioned if this could be debated as a leadership team. BR – the request from DOFs was to involve people, with the leadership question coming in on the timescales for pursuing an alternative model. In terms of the benefits to be obtained, BR cited a figure of 2% savings working individually, which would rise to 5% if we did things collectively. How we structure ourselves to deliver that is what we want to engage with. Manchester is already working in a unified way, which gives purchasing power. Our pace is where a leadership conversation would help. FA – for us it sits in a wholly owned subsidiary, so let's do some work on this. JC – agreed there are some huge benefits in doing it this way, adding there must be a model out there to maximise the benefits. BB – confirmed that members were collectively behind BR on this. He reflected that we need to pay attention to the wholly owned subsidiary debate. BR – to update on this at future meeting. LC – suggested that this be placed on December's agenda. LC gave the following WY HCP report updates: • Operating Model launched on 26 September, movement of small number of posts to WYAAT and Planned Care. Not unexpected. Proposal to transfer stroke network to WYAAT, which is currently in	**ACTION: BR to report back on procurement future models at December meeting.**

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	James Thomas's portfolio. There are ongoing talks on option 5 proposal, with different collaboratives taking leadership roles. A session that was due today will now be in December, to discuss how to take this forward – specific impact for WYAAT in this area is in respect to cancer and maternity. The consultation is in 45 days and will close in November. NHSE restructure will impact local teams and affect outpatients and GIRFT. These are not on same timescales, so we're having to work out how to manage this. LC will keep members updated. • Specialised commissioning – formally delayed for a year, from April 2024 to April 2025 based on a decision by NEY ICBs. However, work is continuing. Discussed with Esther Ashman and ICB colleagues to ensure that preparatory work is continuing. Will start group meeting this afternoon to work through main concerns as providers to services and feedback from this. MP – when this was discussed at WY, our feedback to region was that we didn't want to go as quickly as that. Ours at WYAAT feels like the right more measured approach. BB - agreed with the WYAAT approach LC – recently attended a session run by London and South-East systems which have been piloting a spec comm approach for a year. There have been significant challenges in ensuring the basics e.g., provider payment. Agree with MP that we've done the right thing to delay. BB – explored if there were any red flags in WYAAT's programmes that we need to have site of in relation to the national picture and operating model. LC – nothing noted as unmanageable; we're in a good position with ongoing work on our programmes.	**ACTION: LC to update on NHSE and ICB restructure at future meeting** **ACTION: LC to feed back at future meeting from the specialised commissioning group**
CiC Agenda	LC – noted there were no major items in terms of decisions or business case reviews. • Cancer and elective event on 25 October provides an opportunity to feedback on position and further work. • SLP representatives attending to talk about experience, evaluation and next steps. It will be good for CiC to get direct feedback. • Annual report (AR) is a reduced and straightforward version, given we're doing the WYAAT Strategy. It's a reflection of 2022/2023 - we don't want to take AR into 2024. It includes a foreword from Chairs covering the programmes. BB – suggested Chairs will need to pay attention to the AR and proposed it be listed as a separate agenda item. All agreed.	

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	BB – suggested feedback on recovery event. LC – this will be included as item 7.	
AOB	All-executive session LC – discussed rescheduling the all-executive meeting that was cancelled on 3 October due to IA and asked if this should be convened at the planned session in November, or later than that, highlighting that we're heading into winter, and likely further IA as well. There was a wider discussion around the suitability of holding an all-executive meeting before the end of the year, or at the start of the new year. The consensus was to have the meeting sooner rather than later and all agreed that it should take place on 7 November. LC – will schedule the all-executive meeting on 7 November using the Programme Executive slot and will ensure it's attended by someone from a clinical perspective. All executives are to be invited. LC will send briefing note to attendees for the session on 25 October.	**ACTION: PMO to diarise 7 November for all executive session and book venue.** **ACTION: LC to send briefing note to all, including Chairs, on positions being taken**

OTHER ISSUES TO NOTE

INSERT SLIDE PACK IF AVAILABLE:

NEXT MEETING

Date Time	7 November 2023	**Location**	Junction 25; Armytage Road; Brighouse; West Yorkshire; HD6 1QF.

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

Date	**5 December 2023**	**Location**	MS Teams
Chair	Brendan Brown	**Minutes prepared by**	Geraldine Morris
Attendees	Foluke Ajayi (FA), David Crampsey (DC), Mel Pickup (MP), Brendan Brown (BB), Emma Nunez (EN) representing Jonathan Coulter (JC), Clare Smith (CS), Len Richards (LR), Lucy Cole (LC), Ben Roberts (BR)		
Apologies	Jonathan Coulter, Phil Wood		

Agenda

ITEM		WHO
1	Attendance & Apologies	Chair
2	Minutes & Actions	All
3	Collaborative Report and WY HCP Report	LC
4	Pharmacy Aseptics • Site selection (For Approval)	Phil Deady Charlotte Cleveland
5	Strategy and 24/5 plan • Review outputs from all exec session • CiC • Programme Exec and assurance groups	LC
6	WYAAT SRO Roles • Current roles • Future approach	LC
7	Specialised commissioning	LC
8	Workforce – Senior Leadership Programme • Cohort 2 Proposal (For Approval)	LC
9	Updated operational and financial plan • Process review • Position	BR
10	AOB	All
11	Close	Chair

MEETING NOTES		
Agenda Item	**Main Points and Decisions from Discussions**	**Agreed Follow-Up Actions**
Attendance & Apologies	Apologies were noted and accepted for Jonathan Coulter and Phil Wood.	
Minutes & Actions	The minutes from the previous meeting were approved as an accurate record. **The action log was reviewed, and the following updates were given:** • ***Action 111****: WYVaS options, WYVaS team to bring overview of outcomes to meeting in October 2023* – Deferred to February 2024. • ***Action 122****: Neurology Update, further neurology update to be added to the agenda in October* – Deferred to January 2024. • ***Action 140****: AOB, PMO to add RAAC to October Agenda* – Deferred to January 24 • ***Action 145****: Collaborative Report & WY HCP Report – BR to report back on procurement future models at December meeting* – Deferred to January 24 **The following actions are complete:** • ***Action 116****: Collaborative Report & WY HCP Report, AA to update on leadership programme* – Agenda item 8 • ***Action 121****: Neurology Update, SU to pick up considerations in relation to acute physicians – Discussed at WYAAT MDs* • ***Action 126****: CiC follow up discussion, LC to consolidate suggestions and remap SLP model* – Agenda item 8 • ***Action 128****: CiC follow up discussion, LC to look at service configuration and update at future meeting* – Strategic planning exercise to commence in New Year with support from Public Health Consultant. Scoping work underway through Directors of Strategy group. • ***Action 141****: Elective Recovery, LC to share assessment on impact of IA ahead of 25 October elective recovery event* • ***Action 142****: Elective Recovery, LC to send briefing note to all, including Chairs, on positions being taken* • ***Action 143****: Elective Recovery, MP to circulate BMA communication on legal action against Health Education England* • ***Action 144****: Elective Recovery, JG to feedback to Jenny Lewis re bringing together trust leads on sexual safety*	

	• ***Action 146**: Specialised Commissioning, LC to update on impact of NHSE and ICB restructure at future meeting* – Agenda item 3 • ***Action 147:** Specialised Commissioning, LC to feed back at future meeting with update from the specialised commissioning group* – Agenda item 7 • ***Action 148**: AOB, PMO to diarise 7 November for all executive session* LC - noted that most Actions are either complete or on the agenda - Vascular has been deferred to February, Neurology, RAAC and Procurement have been deferred to January.	
Collaborative Report and WY HCP Report	**WYAAT Collaborative Highlight Report** LC presented an update on the WYAAT Collaborative Report (circulated with meeting papers). **Endoscopy** • Progress on training academy is good, management recruitment is under way, handover expected around April time. Clinical lead Chris Healy retires at end of year - new lead being sought and they'll cover gastro/endoscopy role combined. **Imaging** • Shared reporting - all six trusts connected to live environment. Training taking place in December for pilot reporters. Testing expected in January, as well as live reporting on cases early in new year. Good progress being made, with just a couple of technical issues to resolve with supplier. **Pathology** • Had another go live last week. Leeds took transfusion live in LIMS which went really well. Main issue was with blood tracking system. The go live went smoothly demonstrating that learning is being built in from the previous deployments and we're getting better as we go. **Planned Care** • There has been good engagement work around "careers in surgery" in schools, which has received a good response. In person events planned for early in the new year. **Pharmacy** • Colleagues will join us today to discuss site selection. The business case was approved by National Aseptics Board. Memorandum of Understanding not available yet to draw down the capital but expected imminently. **Vascular** • We have clinical leads for east and west to help embed the work and take it forward. **LIMS**	

	• For awareness, we're trying to change our approach to deployment. We'll need to nuance our approach if we can't make the go live slot e.g., move it further back so we don't impact everyone. A default position needs to be established where if slot's missed, it's given to next person - we're seeking support on this approach. David Birkenhead's keen to maintain integrity of programme's timeline. MP – would value input on anything that can be more targeted to avoid disrupting the programme. LC – it's been an across-board challenge. The board meets monthly, perhaps they could provide each board with a plan RAG rating, enabling trust boards to seek further information if required. MP - agreed with this suggestion. LR – to reinforce the point, if an organisation is unable to deliver on its programme, it could be raised with the CEO to reinforce internal comms channels. BB – suggested pathology governance be discussed in the New Year. LC – agreed to include this in a future agenda**.** BB – asked if there was anything to think about around imaging. LC – explained there will be some anxiety until we reach the point it's working. Although we're being cautious, there's optimism we're closer than we've ever been to getting the system live. DC – confirmed Chris Healy is due to leave at the end of March. It's expected an updated position on imaging work will be available following the YIC programme board meeting this week. **WY HCP (West Yorkshire Health and Care Partnership) Report** LC presented an update on the WY HCP • Nothing major to mention. Operating model consultation closed on 24 November, with a period of review of responses. ICB are expected to make decision later in December. Where we're affected around Planned Care and Stroke, there has been nothing fundamental received during the consultation to challenge the proposal. Subject to outcome of consultation, we'll arrange individual TUPE consultation. LC proposed a session on Stroke with a range of providers to agree clear set of priorities around pathway in terms of prevention/discharge/ acute. It will be an opportunity to refocus and explore clinical leadership and engagement and how to deliver on priorities. She suggested the clinical engagement aspect of this be discussed at MDs. BB – raised the following points: • COOs met on Friday and are trying to manage the performance element of Cancer.	**ACTION: Pathology governance to be included in a future agenda.** **ACTION: Clinical engagement on Stroke to be discussed at future MD meeting.**

	• Mike Farrar session on how ICB are moving forward. What the operating model looks like is scheduled for next week, with BB/LC/MP attending. • One paper at last week's board meeting highlighted a non-executive member had been allocated to shadow WYAAT, but this was challenged due to it not having been discussed with WYAAT first. LC – noted the draft SLA with ICB, which has been amended based on feedback, will be discussed at SOAG in December. BB – remarked the document was reviewed and collectively supported by all. He asked EN about HNY being in a different place with their operating model. EN – noted there were issues around borders with HNY, Cumbria and Northeast. BB – asked FA/DC if there was anything around East Lancashire. FA – responded that Lancashire and Cumbria want ANHSFT as sleeping partners, which is fine, but need to continue to keep an eye on PBR income. BB – asked LC if there was anything to add around the cancer piece. LC updated on cancer: • Sajid Azeb hosted a group session on Friday for cancer managers, directors of operations and others, reviewing the 62-day backlog - skin is the most significant challenge, particularly in Leeds. There's a desire to return to planned backlog position. Interventions across organisations can be made to reduce backlog but requires investment of around £500-750k. An email was sent to Jonathan Webb stating the need for the system to consider how this is funded. We've been unable to access additional national investment as we're not in tiering system. It may assist if Rob and Jonathan could lobby on this. The group will meet regularly (similar to ECG and UEC) to identify issues, but the 62-day backlog will be the focus. A more transformational approach is being explored e.g. consideration of AI in the skin pathway. LC asked members for their support on this approach. Members were all in agreement with the suggested approach. BB – asked if any performance improvement had been seen in areas receiving investment. LC – there has been some, but it's hard to know. She agreed to look into this. BB – commented if it has had an impact, it might help the debate. He asked BR to update on funding following his conversations with DoF.	**ACTION: BR to update on funding position at January meeting.**

	BR – there may be funds that still haven't been committed. Will keep pushing that we need the money – not anticipating a refusal - if/when granted, will ensure it's in writing.	
Pharmacy Aseptics Phil Deady	*Charlotte Cleveland (CC) and Phil Deady (PD) joined the meeting* PD presented on pharmacy aseptics and site selection (circulated with meeting papers): • It's fantastic news that NHSE approved our business case in November - PD thanked BR for his support in getting this over the line. • Expecting MOU to be issued imminently, meaning we can proceed with regional hub design and Leeds base. • Teams have been working hard on implementation. • Had significant discussion at programme board meeting around finances and futureproofing it - the preferred option is noted at the end of the circulated paper. LC – LTHT will sign lease on behalf of all trusts. It will go to the LTHT Board in January to ensure all are happy with site selection process. Board sign-off is anticipated following this. Members gave their approval for the preferred option. PD - will keep members updated on progress. *CC and PD left the meeting* BB – commended PD and CC's work on this.	
Strategy and 24/5 plan • **Review outputs from all exec session** • **CiC** **Programme Exec and assurance groups**	**Review outputs from all execs session** LC discussed the 7 November all execs (all-executives) session paper (circulated with meeting papers) and summarised the paper's recommendations: 1. support continuation of programmes 2. additional priorities and support for those outlined in section 4 and associated oversight arrangements through each exec group 3. identify Chair for HRD group to ensure parity with other groups 4. discuss periodically inviting Chairs of these groups to this group 5. review CiC structure and any suggested changes to its format 6. support for LC in reorganisation of team resources to support delivery	

	Members supported LC's reorganisation of team resources proposal. BB – noted there was mixed feedback from the 7 November all execs session. There is a question of what we would want in bringing another group of executives together. LC – noted that there was some feedback questioning what "the next big thing" might be and if there was anything we're currently not articulating as part of the plan. DC – this meeting would be the vehicle for the delivery of any "next big thing". He commented that the items we agreed to work on in section 4 are really important and suggested the inclusion of legal services provision. There may be opportunities here for deputies, especially those involved with the SLP (Senior Leadership Programme). EN – discussed if we're being bold enough on maternity issues around LMNS; the process lacks consistency. She suggested it might help if it came under WYAAT. BB – proposed Bev Geary (BG), who chairs LMNS, be invited to update on this around springtime. MP – advised she represents WYAAT on LMNS – it's a work in progress, but has found more focus around direction, critique, and challenge since BG has taken the chair. BB – summarised there was broad agreement around the review. A further all execs meeting will be scheduled in the new year. LC will reshuffle to help meet demands we're facing. He asked for members' view on frequency of exec group Chairs attending. Members agreed that exec group Chairs be invited to attend this meeting biannually. LC – asked if Chair for HRDs should self-nominate BB – agreed if other groups have self-selected, with a rotating chair, HRDs should also do so. *Claire Smith (CS) joined the meeting* **CiC** BB – asked if CiC was running the way we want it to. Members discussed further, there was a suggestion of lifting the CiC into a more strategic space, with Chairs providing feedback to set strategic context. Members explored if this group was doing all it needs to in terms of accountability. Having Chairs influencing the ICB would help, e.g., supporting us with the operating model. It was noted Cathy meets regularly with Chairs and WYAAT should make use of this.	**ACTION: Bev Geary to be invited to provide LMNS update at future meeting.** **ACTION: LC to schedule further all execs session in the new year.** **ACTION: LC to invite executive group Chairs to Programme Executive meeting twice a year.**

	BB – agreed it would be appropriate for Cathy and/or Rob to attend CiC, suggesting these ideas be raised at January's CiC. LC – suggested focussing on Strategy in one half and BAU in other half of CiC meeting. WYAAT was first established around small number of programmes which the TOR doesn't quite cover now. She agreed an update through the Chairs network would bring more balance and Chairs to be aligned to aspects of the Strategy. BB – summarised it would be help if Chairs/NEDs were involved at WY and place-based committees and proposed discussing this further at CiC. LC – suggested including the feedback at CiC for information, and only be discussed by exception. BB – asked if workforce was the subject matter for January's CiC. LC – updated she's not asked yet and was thinking about a slightly broader group to give some highlights. BB – agreed this was a good idea and explored inviting someone to talk about the community offer.	
WYAAT SRO Roles • **Current roles** **Future approach**	**SRO Roles** • LC stated we've always had CEO SRO roles for programmes and reviewed this when new CEOs have joined WYAAT. We established some interim roles when Julian left, it feels timely to review SRO roles now substantive appointments have bene made. The TOR discusses electing Chair and Deputy Chair annually; we need to follow this process - ICB have asked about the arrangements. The TOR states the Chair of this group doesn't have to be ICB rep, but the custom is that it is for consistency. LC drew attention to three options set out in paper 4. We need to agree our preferred option and who does what. We need to elect a Programme Executive Chair to coincide with the new finance and planning year from April 2024. BB – offered to leave the meeting while members voted. He suggested to recommend to ICB that this be a permanent role, regardless of who we at WYAAT choose as our Chair. *BB briefly left the meeting while members voted on the position of Programme Executive Chair.* LC - asked if anyone would be interested in the role of Chair. There was a wider discussion where members agreed that BB retain the position of Chair. There was support for the WYAAT Chair to also be the WYAAT rep at ICS as briefing someone else would be challenging. For future voting, it was suggested that people be given an opportunity to flag if they're interested in the Chair position ahead of the annual meeting to vote on it. LC shared that PW advised her he	

	had no interest in being Chair at this time and endorsed BB to continue. LC confirmed that we would review at each December meeting. The position of Deputy Chair was discussed, with MP suggesting if Chair is unavailable for a meeting, that an available member could cover on the day. CS countered it might be better to have a definite Deputy Chair, as they would be better prepared for the meeting. FA offered to be deputy chair if others did not want to take the position. LC to check back with JC on the Deputy position. With discussions concluded, LC invited BB to return to the meeting. *BB re-joined the meeting* LC – declared BB as Programme Executive Chair from April 2024. BB - accepted and agreed the position should be reviewed annually. He'll inform ICB in writing. LC – advised BB to include in the letter that whoever is Chair is also the ICS rep, if this changes we'll inform ICB. She informed him there was no decision yet on Deputy Chair position. BB – recommended a formal arrangement for a Deputy Chair, suggesting it be trialled as a six-month post. He requested nominations be put forward and to review this again around June/July time. **Views on options** LC – recommended option 2 which keeps CEOs on big priorities, provides SRO opportunities for exec priorities and keeps CEOs from being spread too thinly. BB – suggested an SRO lead be nominated for health inequalities. CS – added that health inequalities should be included as core business. She would be happy to continue as SRO for emergency care if members agree. Members discussed and agreed that CS retain her position as SRO for urgent and emergency care. BB – noted members' agreement for option 2, pending some amendments, including a lead for health inequalities. LC – agreed to add to the list and sort offline. BB/EN – asked about EQIAs (Equality Impact Assessments) and if there was some way of measuring it.	**ACTION: LC to write to ICB to confirm chairing arrangements and representation on the ICB.** **ACTION: Members to put forward deputy Chair nominations.** **ACTION: LC to confirm CEO SRO leads after speaking to each CEO.**

	LC – EQIAs have been done previously but have evolved, with more proactive health inequality impact assessments now. BB – when recruiting to executive posts, we should include that as part of this role you automatically assume WYAAT leadership role.	
Specialised commissioning	LC updated on spec comm (specialised commissioning): • At September's meeting the proposed delegation of spec comm services to ICB in April 24 was discussed. The four regional ICBs won't be ready for April 2024 and propose deferring to April 2025. Some key people from provider organisations have discussed what the opportunities and risks might be. More understanding is needed of the circa 70 service lines that could be delegated via joint committee. LC has agreed with counterparts in NEY on things to do once. Support is sought on progressing next steps. CEOs are asked to consider how much they want WYAAT to push this forward and if ICB should lead with WYAAT contributing, or if WYAAT should take an active leadership role - we might desire a more active role around pathways and service design. CS – was concerned about this sitting with ICB, saying it must sit with providers. She would support this being in WYAAT with appropriate governance. FA – clarity is required on preparing for April 2025 transition. We need to get the balance right to ensure integration. EN – shared that she's previously worked nationally on this and offered help in unpicking some of it. LC – the current concern is we don't know what we don't know. ICB are supportive on this being provider-led. Baseline assessment from both sides is required and a shortlist of things we need to explore further in WY as a priority for our patients, e.g., renal analysis. CS – there's a massive understanding gap around what ICB thinks it will be commissioning through spec comm. She recommended a full assessment on resource. MP – explained spec comm have been reviewing the BTHFT neonatal service, revealing an astounding gap in their understanding of what neonatal does. LC – sought clarification from BB on whether to inform ICB of anything. It was agreed a baseline be done from our perspective behind the scenes to test later with ICB. She will check with colleagues across the patch and pick up the finance aspect through DoFs. BB – summarised that LC to start baseline at lowest level denominator; he accepted EN's offer of background knowledge; he suggested discussing at February's meeting.	**ACTION: Spec comm to be discussed at future meeting.**

Workforce – Senior Leadership Programme Cohort 2 Proposal (For Approval)	LC presented an update on SLP (circulated with meeting papers). • SLP cohort 1 completed and evaluated well. Some proposed minor tweaks are outlined in the paper, looking at a longer lead time for application and selection to allow people to bed in before they get started with the programme. Some people found placement a struggle with their day job - this can now be used as a dual option as part of programme. It's proposed we increase the cohort to 20 and include people from mental health/LD/community providers, with split of 12 for WYAAT and 8 for other providers, noting WYAAT providers' size and number of integrated trusts. This does not compete with regional level talent pool; both can be done and are complimentary, a view that's shared by Leadership Academy. ICB funding bid is in place. Will ask other providers to contribute. BB – commended the SLP programme and confirmed members were supportive of the proposal. EN – regarding the panel and selection process; as momentum and interest builds, we need to be transparent around selection. LC – agreed with this and noted the feedback demonstrated the importance of diverse range and background experience. We need to be very clear on messaging and who we involve in that process.	
Updated operational and financial plan • **Process review** **Position**	BR - been through rapid review on finances – we've got ourselves to position we needed to. There's still around £10m of risk, but agreement that this can be collectively managed. Surplus is currently sat in ICB. A sizeable amount, currently in an organisation's balance sheet, could be used. Jonathan Webb is ensuring finance is in place to cover two new issues around 65w wait deteriorating; we need to manage this to get it over line re forecasting protocol. Moving off forecast is an issue. Members went on to discuss the following: • The skin backlog; 65-week breaches; the financial impact of having a young patient in the children's hospital for nearly three months; the £14m underspend and how to retrieve and make use of it; the costed plan and lack of fully met financial model to deliver it; the delay to delivery caused by delay in decision making and funds being released; the £32m payment for industrial action and £14m for ERF; the true size of the reported £10m risk; the risk of double-counting where ANHSFT are dependent on CHFT and HDFT and triangulating this with LTHT. BB – confirmed funding and 65w wait were put forward at a meeting yesterday. BR – updated £11m has been declared to make a balance on cancer alliance. We've agreed not reject money for anything to carry into new year whilst we're trying to do things for patients. BB – proposed the £14m underspend be raised with DoFs and COOs.	

	BR – confirmed a costed plan was submitted in the last 24 hours. CS - referencing double-counting - patients sent to HDFT would be sent to independent sector, with bill coming back to the city. Independent sector activity commissioning is being done via LTHT. Patients cannot be sent until finance is signed off. This needs to be quickly agreed, before mid-January, so avoid losing the opportunity. BR - We have verbal support but need to push Jonathan Webb for it in writing. CS – we discussed at board last week we may have to decide on whether to treat patients or deliver the financial bottom line we're being driven to do. Don't want to put board in that position but might have to. BB – asked BR to follow up on this with Simon Worthington. LC – there is something about what we practically do going into 2024/2025 planning and whether a different conversation is needed with COOs/DoFs and others on how to tackle this. CS – noted that COOs are meeting next week, to see if COOs need to collectively say this is the position in a united WYAAT way. BB – advised BR that the priority at this point is to the obtain agreement from the LTHT and ANHSFT boards, in order to release the funding.	**ACTION: BR to follow up on costed plan with Simon Worthington**.
AOB	There were no AOBs raised. The date of the next meeting will be 9 January.	

OTHER ISSUES TO NOTE

INSERT SLIDE PACK IF AVAILABLE:

NEXT MEETING

Date Time	9 January 2024, 09:30-12:30	**Location**	*MS Teams*

Humber and North Yorkshire Collaboration of Acute Providers (CAP) CEO Group
Monday 18 September 2023, 10.00am – 11.30am
CEO Office, York Hospital, YO31 8HE

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: Lucy Turner (LT), Managing Director, HNY CA
Lynette Smith (LS), Deputy Managing Director, HNY CAP
Melissa Page (MP), Personal Assistant, HNY CAP (Note Taker)
Russell Nightingale (RN), Chief Operating Officer, HDFT

1 Welcome and Apologies
The Chair welcomed all members to the meeting.

2 Minutes from the Last Meeting
The minutes from the HNY CAP CEO Group held on 21 August 2023 were taken as a true and accurate record.

It was confirmed Sean Lyons (Joint Chair, Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) had agreed to Chair the Humber and North Yorkshire (HNY) Collaboration of Acute Providers (CAP) Committee in Common (CiC).

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

4 Feedback from NHSE / ICB Assurance Meeting & Efficiency at Scale – Next Steps
S Morritt provided a verbal update on his recent attendance at the HNY Integrated Care Board (ICB) Board Meeting, which was noted by CAP CEO Group members. The HNY Leaders Forum was taking place on 20 September 2023 and the agenda was shared. It was reported interviews were taking place for the HNY ICB Executive Director of Strategy and Transformation on 18 September 2023.

S Morritt also updated on the meeting attended in the role as CAP CEO Chair with the Regional team and ICB Executives. The focus of the meeting was on quality and finance in which Teresa Fenech (Executive Director of Nursing and Quality, HNY ICB) and Jane Hazelgrave (Executive Director of Finance and Investment, HNY ICB) provided an update on their respective work areas. A discussion proceeded on the ICB Board model and geographies and it was agreed to discuss this at the informal meeting with S Eames.

A conversation ensued on Electronic Patient Records (EPR) and the discussions that had taken place regarding this, including the challenges in regards to capital and resources.

It was noted Provider Finance Directors, Medical Directors and Chief Operating Officers (COOs) were not part of the HNY Quality, Efficiency and Productivity (QEP) meetings. Each Collaborative Managing Director had been invited and the meeting provided the opportunity for Place Directors to present their plans. It was noted there was work being undertaken within the Trusts and Providers which did not link into the QEP and there

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needed to be a single efficiency piece. W Scott noted the QEP highlighted duplication between work at Place and Providers, and it needed to be identified where the programmes of work were being held.

5 Escalations from the Programme Executive Group (PEG)

Elective

R Nightingale provided an update on the Elective Programme, which was noted by CAP CEO Group members. Three delivery objectives had been agreed for 2023/24 which were zero 65 week waits by March 2024, reduction of follow ups to 88.6% and achieving theatres utilisation above 85%. The Elective Programmes for 2023/24 were formed of Outpatient Transformation, Waiting Well, Planned Care Strategy, the weekly Tactical / Operational meeting and Elective Clinical Networks.

Positive progress was being made and work was currently ahead of plan in regards to 65 weeks wait. All providers were providing mutual aid and working together. The reduction of follow ups currently sat at 93% in comparison to the 88.6% target to be achieved by March 2024. An overview was also provided on the work being undertaken in response to the letter from Sir Jim Mackey. As of 12 September 2023, Providers had reduced the risk cohorts by circa 5,000 patients to 1,722 however key risks remained in specific specialities. The presentation was concluded with an update on the Elective Clinical Networks.

W Scott noted it was important to recognise that significant progress had been made within the Elective Programme. The Clinical Networks were still in their infancy and there were a number of networks to be established.

J Coulter asked about how the conversations joined up with wider ICB discussions on the clinical productivity piece. W Scott noted for each of the networks three to four priorities had been identified linked to Getting It Right First Time (GIRFT). Each network had a GIRFT pack specific to their speciality and this had been discussed through the networks which was where the priorities, actions and timescales had emerged. S Morritt noted this should drive the work around quality and efficiency. W Scott had raised with ICB colleagues to share this work first before proceeding with setting up a separate group with clinicians.

J Lofthouse proceeded to provide an update on the tool developed at Kings College Hospital NHS Foundation Trust. It would cost £110,000 to undertake the same piece of work across HUTH and NLaG and it was questioned if this could be purchased for the acutes and ran as a system. All CAP CEO Group members agreed it would be useful for there to be a show and tell of the tool. It was noted COOs should also be invited to this meeting.

W Scott confirmed she was meeting with Fiona Howgego (Managing Director, South East London Acute Provider Collaborative) on 27 September 2023.

A discussion took place on the orthopaedic hub at Goole. There were limited patients attending the hub, however there was no restrictions in terms of availability and it was a decision made by the patient to not attend. A small number of patients were also being received from York and Scarborough Teaching Hospitals NHS Foundation Trust (YSTFT) for urology. Utilising Bridlington for orthopaedic patients was noted which may be more convenient for the East Riding cohort.

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A conversation ensued on nominating Executive Senior Responsible Officers (SROs) for the CAP programmes of work. J Coulter noted it would be helpful to undertake a stocktake of all programmes and for executive directors to be part of the process. It was agreed to review all programmes of work at the October 2023 CAP CEO Group to identify where SRO executive leadership was required and to also consider if there was the capacity and capability within the system to deliver the programme.

ACTION: All to undertake a stocktake of the programmes at the next meeting.

Cancer

L Turner provided an update on cancer performance. The ICB and Region would be implementing an ICB system tiering meeting for cancer. This would be scheduled for once a month and on the opposite week the organisational tiering meeting would take place.

L Turner confirmed S Eames had expressed an interest in Chairing the meeting and L Turner had suggested to arrange the meeting as a task and finish for six months until the end of the financial year. A brief conversation took place on the meeting governance and L Turner noted this would be fed back to Shaun Jones (Interim HNY Locality Director, HNY Locality Team).

The system was in receipt of £8.3 million SDF and £4 million for targeted lung health checks. The ICB had asked if the Cancer Alliance (CA) could pull £1 million of the £8.3 million based on quarter one outturn and, if this would be difficult, then it would be requested to transact £1 million from QEP. L Turner had been flagging this as a risk regionally and nationally, and a RAG rated table had been produced to identify where this amount would come from. Discussions were held at the last ICB Board regarding demonstrating that reinvesting £1 million would be directly attributable to the 62 day performance backlog.

Diagnostics

L Smith provided an update on the Community Diagnostic Centres (CDCs) and talked through the key points in the report circulated prior to the meeting.

The CDC Finance and Activity Group had been assessing the financial implications and risks. Additional funding had been requested which was approved. The current analysis of the forecasted position was in surplus, however this had not been accounted for due to the risk of not reaching the level, but this would be reviewed by Finance Directors by December 2023.

The deadline for the Hull and East Riding CDC Hub business case submission was 1 October 2023, however there would be the opportunity to resubmit in November 2023.

The CDC Programme posed high risks however there were gains to be had if the plan was delivered. A CDC Steering Group had been established which would look at a strategy and sustainability for the future, as well as ensuring coordination on specific work areas and sharing learnings. In terms of progression, the Place teams would be encouraged to move forward on the clinical pathways and to engage with broader teams.

L Smith summarised by noting the CDC Programme was in a better position in comparison to when the CAP inherited the Programme. NHS England (NHSE) had proposed to stand down the national assurance meetings from October 2023.

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A brief overview was provided on the Artificial Intelligence (AI) Bid. The bid would be for circa £1 million with the focus on lung health diagnostics, specifically CT thorax. There was concern regarding digital capacity which had been reflected in the bid as well as not achieving national timescales. A broader piece of work was required on influencing digital prioritisation and how this was undertaken collectively. Digital capacity and capability was an issue across the system and initial conversations had taken place regarding digital prioritisation.

6 HNY CAP Committee in Common Planning – 4 October 2023

The first meeting of the HNY CAP CiC was scheduled for 4 October 2023.

It was agreed for the first meeting to include the Terms of Reference (ToR), detail on the programmes of work, the medium term financial plan and the winter plan. W Scott would be meeting with S Lyons prior to the meeting.

7 CAP Employment Liability Agreement – To Note

CAO CEO Group members acknowledged the paper and noted it had been signed off by Finance Directors.

8 Any Other Business

No further business was raised.

9 Date and Time of Next Meeting

HNY CAP CEO Group
16 October 2023, 10.00am – 11.00am

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

Humber and North Yorkshire
Collaboration of Acute Providers

Humber and North Yorkshire Collaboration of Acute Providers (CAP) CEO Group
Monday 20 November 2023, 10.00am – 11.30am
Board Room, York Hospital, YO31 8HE

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: Andrew Bertram (AB), Finance Director, YSTFT
Deborah Mitchell (DM), Diagnostics Programme Director, HNY CAP
Karen Bunker (KB), Head of Finance, HUTH
Melissa Page (MP), Personal Assistant, HNY CAP (Note Taker)

1 Welcome and Apologies
The Chair welcomed all members to the meeting.

2 Minutes from the Last Meeting
The minutes from the HNY CAP CEO Group held on 18 September 2023 were approved via email and taken as a true and accurate record.

3 Action Log
The action log would be updated accordingly prior to the next meeting.

4 Finance
Operational Guidance (8 November 2023) – Response to Immediate Actions
The operational guidance letter dated 8 November 2023 outlined the response to the financial challenges created by industrial action in the 2023/24 financial year. All Integrated Care Boards (ICBs) and Providers had a deadline of 22 November 2023 to sign-off key finance, performance and capacity requirements. Particular focus would be made to urgent and emergency care (UEC), elective and cancer.

A Bertram talked through the system financial position as of 15 November 2023. The risk to the delivery of the plan was £20.841 million which accounted for the inclusion of agreed allocations and variants to plan.

A lengthy discussion ensued on the system financial position and the response to the operational guidance. A Bertram provided an overview of the wider system context and a conversation followed on what activity could be stopped in the final four months of the financial year. It was noted there was a significant amount of activity that could not be stopped due to contractual obligations. The regional and national team were expecting to see the difficult decisions which had been considered and delivery plans in line with the guidance.

W Scott asked if there was a way of presenting information for the high drugs cost. A Bertram confirmed benchmarking review work was being undertaken. Conversations had taken place with clinicians and compliance was required with NICE guidelines.

A Bertram noted a finance template was required to be completed and included in the 22 November 2023 submission. From a Humber and North Yorkshire (HNY) ICB governance perspective, the ICB would need to be informed of each organisational response and they would then take a view.

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The HNY Collaboration of Acute Providers (CAP) were not required to sign-off or make any collective decisions, however the CEOs agreed to proceed with the work with the caveats that there was not a plan and there was high risks around the existing plan. This would be fed back to the Finance Director Group.

Medium Term Financial Plan – Efficiencies at Scale
At the October 2023 CAP Committee in Common (CiC), it was agreed to present an update on the progress made on the efficiencies at scale piece at the January 2024 CiC.

A Bertram proceeded to talk through the presentation circulated prior to the CAP CEO Group. This included an overview of the system financial performance at month 6, the national efficiency programmes which the system were expected to participate in and the Integrated Care system (ICS) deployment of an advisory partner. It was noted savings had already been made in regards to procurement and circa £6 million had been saved which was expected to increase.

It was agreed that the advisory partner should attend the January 2024 CiC to present an update on efficiencies at scale. The selection meeting was on 27 November 2023 and confirmed panel members included A Bertram and Lee Bond (Group Chief Financial Officer, Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) with ICS representatives to be confirmed. A discussion followed on the role of the advisory partner and their initial objectives including confirming and validating the current financial position.

5 CAP Update

Managing Director's Report
W Scott talked through the Managing Director's report which was noted by CAP CEO Group members. The paper included updates on:

- Key messages including headline access position, items of significant progress, business cases / bids in progress and system updates / discussions across the wider system;
- Delivery update on CAP priorities including improving outcomes for patients through clinical programmes and reducing unwarranted variation through clinical support programmes. A risk register with risks fifteen and over for each programme was circulated prior to the meeting;
- Provider Collaborative development;
- Key actions for the following month.

A health inequalities underspend had been identified by the ICB. Jack Lewis (Consultant in Public Health, HNY ICB) had approached the CAP Team asking if the CAP could develop a process to bid against £2 million allocated for additional proposals. Lynette Smith (Deputy Managing Director, HNY CAP) was leading on the submission to the ICB.

Conversations were ongoing regarding digital strategy, including digital prioritisation, as there were no links to any Committees at Trust or ICB level.

CAP CEO Group members agreed the Managing Director's report was valuable.

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CAP Communications Approach
W Scott noted meetings had taken place with Richard Chew regarding developing a CAP communications strategy. This would ensure broader stakeholders were engaged with the CAP and aware of the work being undertaken. The cost of the additional resource would be circa £25,000 per year.

CEOs approved the appointment of Richard Chew and were supportive of developing the CAP communications strategy.

CAP Dashboard
A new CAP performance dashboard had been developed with ICB colleagues which was circulated with the meeting papers. This ensured alignment between CAP reporting and ICB board reporting.

Executive Advisory Groups
Terms of Reference (ToR) had been drafted for the Clinical Executive Advisory Group and the Strategic and Operational Executive Advisory Group. These were under development and feedback had been requested.

6 Escalations from the Programme Executive Group (PEG)

Diagnostics – CDC Programme Activity 2024/25
Deborah Mitchell (Diagnostics Programme Director, HNY CAP) and Karen Bunker (Head of Finance, HUTH) presented an update on the diagnostics programme. The two areas of escalation were the Community Diagnostic Centre (CDC) Programme 2024/25 activity and Withernsea Spoke.

An overview was provided on the key CDC Programme changes for 2024/25 which included CDC activity only being undertaken at designated sites and only one modality being allowed as acceleration prior to a site going live. Key dates, key risks and next steps were noted. The deadline for the template submission to the NHS England (NHSE) regional team was 17 November 2023, the CDC activity paper was being submitted to the HNY ICB Board on 28 November 2023 and the deadline for the template submission to the NHSE national team was 30 November 2023. .

J Coulter noted concerns regarding workforce for the CDC Programme and ensuring there was enough capacity.

An update was also provided on the Withernsea Spoke review which had taken place between July 2023 – November 2023. A summary was provided on the findings, outcomes and next steps.

A discussion followed on the suitability of Withernsea Spoke. It was noted the review evidenced that Withernsea did not meet the criteria due to a number of issues. The cost to rectify the issues would be in excess of £500,000 and the time to do this would significantly extend the timescales. It had therefore been agreed that the site was not suitable.

In terms of next steps, it was agreed to schedule a meeting with Chris Jewesbury (Head of Cancer and Diagnostics, NHSE – North East and Yorkshire) and Simon Cox (East Riding of Yorkshire Place Director, HNY ICB). Following this meeting, it was agreed to meet with the national team to determine an outcome for Withernsea.

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D Mitchell noted an audit piece of work should be undertaken in the future to review the suitability of all CDC sites.

K Bunker confirmed the finance risk of phase 1 and phase 2 submission of activity was £2.4 million. The tariff income associated with the activity had been submitted in phase 2 and that was the income at risk. A further piece of work to be undertaken was identifying the resources already committed as part of delivering the activity including the mobiles purchased by HUTH.

7 Any Other Business

No further business was raised.

8 Date and Time of Next Meeting

HNY CAP CEO Group
18 December 2023, 10.00am – 11.30am

HNY CAP Committee in Common
10 January 2024, 12.00pm – 2.00pm