**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:**<br>**CHS1** Was removed from the corporate risk register in Jan 2024. The KRI are being met and the rating for January was 8.<br>**CHS2**: The risk of accidents and unauthorized access at the HDH Goods Yard necessitates immediate attention. While temporary security measures are in place, a more comprehensive approach, including capital investment for long-term solutions, is required to ensure safety.<br>**CHS3**: Ensuring compliance with fire safety regulations is critical to prevent potential harm to employees, patients, and others. Immediate action, including policy updates and infrastructure investment is necessary to address fire-related risks effectively.<br>**CHS8**: The risk associated with RAAC roofing presents a significant threat to safety and requires immediate action. While ongoing inspections and funding for remedial work are in place, a comprehensive plan for roofing replacement is necessary to ensure the safety of employees, patients, and others. The rating was increased to 20 in January 24, this was to reflect the re-consideration of the possible consequences of the risk materialising. | | | | |
| **Initial Date of Assessment** | 1st July 2022 | | | | | |
| **Last Reviewed** | February 2024 | | | | | |

| **Corporate Risk ID** | **Strategic Ambition** | **Principle Risk:** **CHS2**: HDH Goods yard | **Initial Rating** | **January Rating** | **February Rating** | **Target Rating** | **Target Date** |
|---|---|---|---|---|---|---|---|
| **CRR75**: CHS2 Health and Safety | **An Environment that promotes wellbeing** | Unauthorized access and safety hazards in the HDH Goods Yard may result in major injuries, fatalities, or permanent disability due to inadequate security measures, non-compliance with safety regulations, and improper use of the area, posing a risk to the objective of maintaining a safe and secure environment for employees, patients, and others within the hospital premises. | 16 | 12 | 12 | 8 | April 24 |

| **Key Risk Indicators** | **Current Position** | **Controls and Plans** |
|---|---|---|
| Board level lead for Health and Safety<br><br>Annual Audit programme for Health and Safety<br><br>Health & Safety Committee | Risk assessment completed for the goods yard.<br>Temporary measures have been implemented:<br>Security guard (Mon-Fri 8am – 6pm)<br>Temporary heras fenced walkway to access Pharmacy lift and stairwell.<br>Instruction to all Trust staff made via email and Team talk.<br>Use of his-vis clothing for those that need to routinely access the yard as part of their duties.<br>Review of storage of bikes in hospital buildings has been completed<br><br>Instruction to contractors that the yard area is not to be used as a car park, delivery drop off / collection only.<br>Loading bay entrance remains unsecure 24/7 as doors do not close.<br>Particular security issue on an evening / during the night when staff presence is limited and access remains open to patients and others.<br>New pedestrian crossing markings provided July 2023 at entrance to goods yard / car park<br><br>• Recent incident involving T3 security guard and member of HDFT staff, has led to urgent review of provision within the Goods Yard.<br>• 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.<br><br>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<br><br>Risk assessment is to be reviewed every quarter reporting to H&S committee<br><br>Review of access arrangements for catering entrance.<br><br>Review of waste segregating and disposal<br><br>Updates following meeting with waste AE: a new waste management group is to be established to assist the process<br><br>Backlog Maintenance consultation and introduction as packages of work |

| Corporate Risk ID | Strategic Ambition | Principle Risk: | Initial Rating | January Rating | February Rating | Target Rating | Target Date |
|---|---|---|---|---|---|---|---|
| **CRR75:** CHS3 Health and Safety | **An Environment that promotes wellbeing** | **CHS3**: Managing the risk of injury from fire<br>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 |
|---|---|---|
| Updated Fire Safety Policy and associated management protocols<br><br>Completion of fire assessments<br><br>Appointment of competent Fire Manager and Authorising Engineer<br><br>Completion of assessments<br><br>Implementation of fire procedures and policies<br><br>Communication of fire procedures to all employee<br><br>Audits and reviews of the above conditions at appropriate intervals. | Fire risk assessments are not currently available for all areas of HDH<br><br>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.<br><br>There is no clear picture of the Fire safety standards in properties leased by the Trust<br><br>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.<br><br>New Fire Policy and Fire Management Procedures in place.<br><br>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)<br><br>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.<br><br>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<br>Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work.<br><br>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.<br><br>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.<br><br>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<br><br>Meeting with Operations Directors to add clinical risk priority to Backlog Maintenance paper<br><br>Recommendations of the Fire Authority being actioned<br><br>Meetings to be held with clinical teams to progress the creation of suitable evacuation plans |

| Corporate Risk ID | Strategic Ambition | Principle Risk: | Initial Rating | January Rating | February Rating | Target Rating | Target Date |
|---|---|---|---|---|---|---|---|
| **CRR75**: CHS5 Health and Safety | **An Environment that promotes wellbeing** | **CHS5:** Violence and aggression against staff<br>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 |
|---|---|---|
| Suitable and sufficient assessments of risk Trust / HIF activities.<br><br>Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created.<br><br>Risk assessments, policies and control measures actively monitored and reviewed.<br><br>Use of available data sources, such Datix, sickness absence as part of the monitoring and review process.<br><br>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.<br><br>• Risk assessments, where available, are generic and do not provide clear identification of hazard or control measures.<br>• Security presence in the Acute setting is limited - Security guard in place on ED 6pm - 6am, currently single LSMS supporting entire Community footprint.<br>• Training is limited and is not currently provided to staff on a risk based approach.<br>• Conflict Resolution (Breakaway Skills) training provided to approximately 220 staff<br>• Escalation procedures for staff in response to incidents and the procedures to follow when dealing with patients is limited and not consistently applied.<br>• 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).<br>• Trust supports and promotes a zero tolerance approach to V&A, however there is a culture of accepted levels.<br>• Trust Security Forum in place – now reports directly to the Trust H&S Committee<br>• 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.<br><br>• Phase 1 work reviewing managing Patients who may self-harm / those suffering with mental health issues. New policy- in draft<br>• 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<br>• Provision of ligature training<br>• Increase in provision of Breakaway Skills training to staff based on risk.<br>• Mandatory elearning Conflict Resolution training for all HDFT staff<br>• Visits to all Community teams/locations to identify current security, lone working procedures<br>• Phase 2 work for Task and Finish group has started – looking at the management of patients with dementia/delirium<br>• Business case for resource to increase Conflict Resolution – Breakaway Skills training |

| Corporate Risk ID | Strategic Ambition | Principle Risk: | Initial Rating | January Rating | February 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 | 20 | 20 | 8 | March 24 |

| Key Targets | Current Position | Controls and Plans to implemented |
|---|---|---|
| Structural inspection / surveying<br><br>Health & Safety Committee surveying and ultimately to record plank condition<br><br>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)<br><br>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<br><br>Responses from community landlords are being received (reminder email sent by Director of Strategy)- Data Collection Questionnaire for NHSE has been completed and sent<br><br>The trust is expecting to hear about the funding arrangements imminently<br><br>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<br>B3 Corridor (Farndale to ITU) has had significant water ingress – increasing likelihood of panel collapse<br><br>Year 1 Report now received from WSP – analysis shows significant areas of remedial work required. Further meetings with WSP to identify course of action<br><br>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<br><br>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.<br><br>Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead – initial discussions with EPRR manager held<br><br>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<br><br>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)<br>Workforce Committee (Workforce) | **Summary in Month:**<br>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** | February 2024 | | | | | | |

| **Corporate Risk ID** | **Strategic Ambition** | Principle Risk: | **Initial Rating** | **January Rating** | **February Rating** | **Target Rating** | **Target Date** |
|---|---|---|---|---|---|---|---|
| **CRR6**:<br>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.<br>Risk of:<br>• potential increase in lapses in delivery of safe and effective care to patients and service users<br>• 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:<br><br>• The right numbers of competent and qualified colleagues present and fit to work in the workplace.<br><br>• Colleagues having the right environment/equipment/tools to enable them to fulfil their roles effectively.<br><br>• Colleagues feeling valued and appreciated for the work they are doing.<br><br>Metrics to be considered:<br><br>Staff Engagement – Survey Scores (Benchmark Group Acute & Community Trusts)<br>Turnover<br>Sickness<br>Appraisals<br>Vacancy rate | Staff Engagement – The scores for staff engagement over kindness, teamwork, integrity and kindness are higher than the benchmark for a fourth continuous month<br><br>Turnover - Turnover (Target 12%) Turnover had seen a decreasing trend since February 2023, it increased slightly in December 13.17% in January 2024. (This incorporates voluntary and involuntary turnover).<br><br>Sickness - Sickness has seen an increase in December, from 5.61% to 5.92%.<br>• "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to a quarter of the overall sickness. Sickness due to 'Cold, Cough, Flu – Influenza' has seen a percentage increase of 34% in January compared to the previous month and 353 employees were absent during the month<br><br>Appraisals - Target 90%. The appraisal rate in January 2024 is 82.77%, which is a slight fall from last month.<br><br>Vacancy Rate (Target 7%)<br>The Trust's vacancy rate in December is 5.42% in January 2024, which is a slight reduction from last month.<br><br>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: Efforts include local handling of Inpulse survey feedback to boost morale, with a 3% increase in survey participation in July. Notable reduction in negative emotions from 45% in January 2022 to 32% in July 2023, coupled with an increase in positive emotions from 31% to 48%. Directorates instructed to achieve 90% appraisal compliance, with uploaded career conversation resources and improved NHS staff survey response rates.<br><br>Turnover Reduction: Initiatives target reasons for voluntary resignations, including work/life balance concerns. Changes to NHS Pension Scheme aim to attract and retain staff. People Plan, career pathways development, and equality & diversity initiatives support recruitment and retention. Financial support addresses dissatisfaction with pay, with ongoing exit interviews and retention group activities.<br><br>Sickness Absence Reduction: Organizational stress audit and policy development aim to address stress-related absences. Health & wellbeing provisions and Just and Learning Culture project improve employee support and relations.<br><br>Appraisals: Directorates aim for 90% appraisal compliance, with plans to review the appraisal format as part of the HDFT Impact program.<br><br>Vacancy Rate Reduction: Workforce planning, international recruitment, and apprenticeship utilization strategies target vacancy reduction.<br><br>Training Compliance: Teams maintain compliance with training requirements. |

| | 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*<br><br>• **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.<br>• **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.<br>• **Providing information -** We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.<br>• **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.<br>• **Equity in access -** We make sure that everyone can access the care, support and treatment they need when they need it.<br>• **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.<br>• **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:**<br>This area of the Corporate Risk Register is linked to the Responsive Domain. Currently there are three Corporate Risks within this Domain.<br>Autism Assessment (CRR34), this was reduced to 12 in August but increased to 15 in December 23, the group also reviewed and changed the consequence in consideration of new data.<br>RTT (CRR41) remains a risk at 12 due to performance against the national standards. However, a wide range of mitigation in place, zero 104, and 78-week waits are noted.<br>CRR61 Was reduced to 12 in January 24 from 16. | | | |
| **Initial Date of Assessment** | 1st July 2022 | | | | | |
| **Last Reviewed** | February 24 | | | | | |

| **Corporate Risk ID** | **Strategic Ambition** | **Principle Risk:** | **Initial Rating** | **January Rating** | **February 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 | 15 | 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.<br><br>Baseline capacity would need to meet the referral rate.<br><br>Numbers on the waiting list<br><br>Longest wait of CYP having commenced assessment<br><br>Longest projected wait of CYP joining the waiting list<br><br>Activity<br><br>■ To meet the monthly ICB target for number of assessments<br>■ 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.<br><br>Non-recurrent funding challenges service management due to lead times for capacity acquisition and staff training, exacerbated by national shortages. Loss of a key clinical team member impacts medium-term assessment capacity.<br><br>Support provided to the team; commissioners informed. ICB-wide autism and ADHD group supersedes previous locality-based group, aiming to standardize referral criteria. No extra funding available for capacity gaps. Stabilizing waiting lists requires increased capacity, costing £490k annually. Modeling shared at CC Resources Review and escalated to place ICB meeting for executive consideration. No agreed plan for long-term resource provision is currently agreed and in place. | The progress with PLACE based work. Mobilisation of WLI and new pathways<br><br>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 | January Rating | February 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 | *Jan-24* |
|---|---|---|---|---|---|---|---|---|---|---|
| Total incomplete RTT pathways | 25,951 | 25,876 | 25,860 | 25,831 | 25,802 | 23,093 | 22,799 | 22,549 | 22,486 | *22,826* |
| > 52 weeks | 998 | 1,001 | 1,020 | 1,033 | 1,124 | 673 | 640 | 599 | 557 | *590* |
| > 65 weeks | 202 | 197 | 210 | 208 | 259 | 154 | 145 | 140 | 129 | *135* |
| > 78 weeks | 5 | 0 | 0 | 1 | 4 | 2 | 0 | 0 | 0 | *0* |
| RTT new clock starts | 5,756 | 6,788 | 6,955 | 6,706 | 6,636 | 6,092 | 6,222 | 6,029 | 5,081 | *5,865* |
| RTT clock stops | 4,552 | 5,367 | 5,565 | 5,487 | 4,367 | 5,112 | 5,516 | 5,425 | 4,356 | *4,497* |

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**
**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

**65 week waiters (clearance March 2024)**
We currently have 252 patients on the Admitted PTL who have already breached over 65 weeks wait or are set to breach 65 weeks by the end of March (down 3,488 from Jan 2023).

**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.

**Update on Eliminating 52 weeks by March 2025**
There are 4,023 patients who are set to breach 52 weeks by the end of March 2025 and this number will only continue to grow until we hit 1st April. Currently 3,476 of those require TCI dates. This is similar to the size of the reduction that has been achieved in since Jan'23 for over 65 weeks.

**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 | December Rating | January Rating | Target Rating | Target Date |
|---|---|---|---|---|---|---|---|
| **CRR61**: ED 4-hour Standard | **Best Quality, Safest Care** | Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard | 12 | 12 | 12 | 8 | March 23 |

**Key Targets**

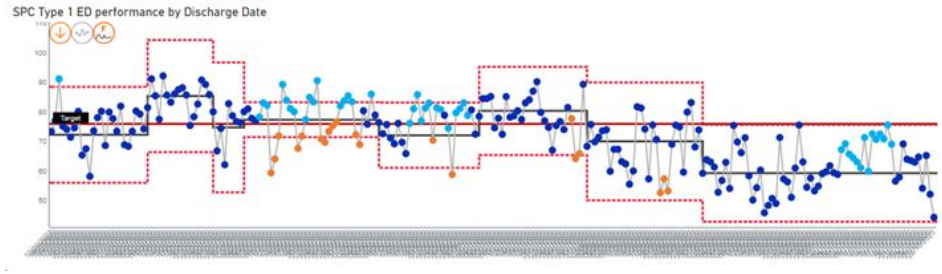
A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches

**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%. This has continued into November and December as bed occupancy has increased. Year to date performance is currently 74.33%

| | 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 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Type 1 & 3 | 67% | 64% | 68% | 66% | 63% | 72% | 81% | 78% | 83% | 81% | 80% | 82% | 73% | 65% | 70% | 68.7% | 66.9% |




In Dec 2023 there were 1,494 patients who spent longer than 6 hours in the department.

**12 hour waits**

| | 12 Hour DTA | 12 Hour total wait |
|---|---|---|
| **September 23** | 1 | 119 |
| **October 23** | 14 | 167 |
| **November 23** | 46 | 226 |
| **December 23** | 71 | 332 |

**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 |
|---|---|---|
| **September 23** | 15 | 1 |
| **October 23** | 34 | 11 |
| **November 23** | 36 | 11 |
| **December 23** | 36 | 10 |

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) | | | | | | |
| **Initial Date of Assessment** | 1st July 2022 | | | | | | |
| **Last Reviewed** | February 24 | | | | | | |

**Summary in Month:**
This area of the Corporate Risk Register is linked to the Use of Resources Domain.
Agency Usage (CRR71) – The target score of 9 was met in January 24 therefore the risk has been removed from the CRR.
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.

| Corporate Risk ID | Strategic Ambition | Principle Risk: | Initial Rating | January Rating | February 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<br>2. NHSE productivity analysis<br>3. Agency Expenditure<br>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.<br><br>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 –<br>• Performance against the efficiency requirement for the Trust<br>• Use of temporary, premium rate staffing<br>• Inflation above the levels outlined above and within planning<br>• Strike costs<br>• Drug expenditure, again above the levels described above.<br>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.<br>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.<br><br>**Currently reporting an in month deficit £-3.6m and a YTD position of £6.3m.**<br>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%.<br>The current run rate is having a detrimental impact on the cash balance.<br><br>**Cash has reduced to £5m as at the end of January 24.**<br>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 a considerable deficit. | 1. Continued discussions with ICB regarding underlying position – NHSE submission expected late summer<br><br>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 CRR88 was escalated in Jan 24 and added to the CRR is Feb 24. | | | | | |
| **Initial Date of Assessment** | 1st July 2022 | | | | | | |
| **Last Reviewed** | February 24 | | | | | | |

| **Corporate Risk ID** | **Strategic Ambition** | **Principle Risk:** | **Initial Rating** | **January Rating** | **February Rating** | **Target Rating** | **Target Date** |
|---|---|---|---|---|---|---|---|
| **CRR87**<br><br>**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, 8 patients between 52-64 weeks. Current position for Non RTT waiters -– 27 patients over 78 weeks, 170 patients between 65-77 weeks, 335 patients between 52-64 weeks.<br><br>• No of overdue continuing care patients. Current position – 2532 patients overdue. Longest waiters 4 years overdue (2 in total, due in Oct 2019). | .<br>The ICB has agreed a plan to invest an additional £1.5million into the CDS service at HDFT. An updated service specification and contract have been sent through to HDFT but there are some queries being worked through to enable sign off – this contract extension would be retrospectively applied from 1st October 2023 for 18months (in line with the other regional 18month contract extensions).<br><br>The funding envelope is not in line with the business case that was submitted so the operational team and service manager are agreeing the plan for how that investment is best used, modelling the impact on waiting times for both RTT patients, non-RTT patients (including surveillance patients).<br><br>Key actions agreed that are being implemented already:<br>1) Waiting list initiative (WLI) clinic sessions for December and the rest of the financial year<br>2) WLI GA sessions at Harrogate Hospital for paediatric intubated and exodontia cases – two dates in February planned so far (coordinated with ENT paediatric sessions to make best use of additional paediatric and anaesthetic resource required) and dates tentatively agreed for March.<br>3) Progression of the SOEL Health dental IT system replacement – procurement has commenced. SOEL is not supported from April 2024 onwards.<br>4) Capital kit replacement progressed – dental chairs and X-ray kit etc.<br><br>Key risk is the operational pressures at York impacting on GA work. List cancellation due to industrial action has been avoided in Dec and Jan but due to York regularly using day surgery unit for medical<br><br>Escalation beds, this reduces our productivity through lists with numbers having to be reduced at short notice/on the day cancellations.<br><br>Key action for February is the IT procurement exercise and continuing the capital process for kit replacement, plus the recruitment process for additional dental capacity. | Discussion at Trust Board of the three options and agreed next steps / approach.<br><br>Notification from Service to ICB commissioners that we will not be able to sign the contract while we have this discussion at Trust Board.<br><br>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. |

| Corporate Risk ID | Strategic Ambition | Principle Risk: Failure to meet Bowel Cancer Screening Programme (BCSP) targets<br><br>There is a risk of causing patient harm as a consequence of the trust delaying diagnosis of bowel cancer due to availability of lists in Leeds, Harrogate and York. As such, we are failing to meet national standards for 28 and 62 day targets for Bowel Cancer Screening patients. Lists at Harrogate are reduced due to health reasons of one of the Nurse Endoscopists not being able to fulfil full lists, this may be long term. | Initial Rating | January Rating | February Rating | Target Rating | Target Date |
|---|---|---|---|---|---|---|---|
| **CRR88**<br><br>**Bowel Cancer Screening** | Provide person centred, integrated services through string partnerships | | **12** | **12** | **12** | 6 | **August 25** |
| **Key Targets** | | **Current Position** | | | **Controls and Plans to implemented** | | |
| The national target for bowel cancer screening diagnostics waits is 100%. However, it is recognised that this would not be achievable due to patient choice. The directorate would therefore accept a compliance of 90% as long as there was list availability. This would then be managed locally within the BCSP team. | | The risk, previously scored 8 on the PSC Care Group 2 register, has escalated to 12 due to a shortage of accredited endoscopists and list capacity, hindering our ability to meet demand. Bowel Cancer Screening Programme (BCSP) patients, requiring timely assessment, face delays amid diagnostic breaches and staffing challenges.<br><br>While temporary support from Harrogate has aided, York's inability to provide sufficient lists adds to the risk, exacerbated by retiring consultants. Despite efforts to extend services and manage referrals, demand surpasses available slots, leading to backlog and heightened pressure on service providers. Pathology turnaround times have deteriorated, further straining the BCSP. Current controls include utilizing independent providers and conducting breach analysis meetings. However, meeting the Faster Diagnosis Standard (FDS) remains a challenge without additional support.<br><br>York are unable to provide required monthly lists; high risk due to retiring consultants.<br>Next age extension cohort started on Dec 4, 2023, with plans for further extension. Leeds and York ran out of lists in December, delaying patient bookings until January 2024. The program ran out of lists in January, causing further delays. Limited slots in February; Leeds and York can't offer additional lists. Harrogate's Saturday lists unavailable. Pathology turnaround times worsened, backlogs likely to persist. BCSP cases prioritized despite staffing issues. CTC demand in Leeds reduced; reporting delays due to strikes and holidays.<br><br>Plans:<br>Bank Nurse Endoscopists decline due to low wages; regular communication with commissioners and QA ongoing.<br>• Insourcing support initiated for Bowel Cancer Screening Centers at Harrogate, Leeds, and York.<br>• Advertisements for two additional Nurse Endoscopists underway; interviews scheduled for end of February.<br>• Monthly reports on performance indicators to be provided.<br>• Discussions ongoing regarding consultant support for additional lists; one gastro consultant unable to assist due to workload.<br>• Nurse Endoscopist job planned to scope in York every Friday from February.<br>• Efforts to secure more lists from insourcing provider for timely appointments; additional lists secured for March.<br>• Four extra Saturday lists sourced in York for February, utilizing NE from Harrogate and paying overtime to SSPs. | | | Current controls:<br>1. Using independent providers<br>2. Continue to use the bank Nurse Endoscopist to support where possible<br>3. Look at Harrogate's NE job plan to be able to scope at York subject to SLA arrangements.<br>4. The BCSP manager is working with each Trust to try to improve staffing who is working with each trust<br>5. Breach analysis meeting being conducted to review those patients who have breached and identify if any harm - no harm identified as of<br>6. There is also the expectation to work towards meeting the faster diagnosis standard (FDS) – to reduce the time wait for diagnosis to 28 days. With current workforce and capacity, without the support of insourcing, we will continue to perform under the acceptable threshold. | | |

**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 Feb 2024

Live view:

INTEGRATED BOARD REPORT - Power BI

## INTEGRATED BOARD REPORT

Filter by keyword | List view | + New

| Metrics 79 | ✓ BO DRIVER Breach of ... 1 | BO DRIVER - Stable or... 4 | WATCH -SPC Breach ... 5 | WATCH -Within busin... 69 |
|---|---|---|---|---|

| Name | Status | Progress | Trend |
|---|---|---|---|
| Staff Availability - Breakthrough Obj - Person Centred, Integrated Care; Strong Partnerships | BO DRIVER Breach of Threshold ... | 81.75% ↓ 4.88% MoM | |

## INTEGRATED BOARD REPORT

Filter by keyword | List view | + New

| Metrics 79 | BO DRIVER Breach of ... 1 | ✓ BO DRIVER - Stable or... 4 | WATCH -SPC Breach ... 5 | WATCH -Within busin... 69 |
|---|---|---|---|---|

| Name | Status | Progress | Trend |
|---|---|---|---|
| 62 day wait for first treatment from urgent GP referral to treatment RESPONSIVE - Breakthrough Obj- Best Quality and Safest Care | BO DRIVER - Stable or Improving | 45 ↑ 0% WoW | |
| Moderate Harm and above - Breakthrough Obj - Best Quality and Safest Care | BO DRIVER - Stable or Improving | 22 ↓ 15.38% MoM | |
| Improved ED Waiting Times - Number of patients waiting longer than 90 mins for clinical assessment by a clinical decision maker - Breakthrough Obj - Best Quality and Safest Care | BO DRIVER - Stable or Improving | 355 ↓ 23.82% WoW | |
| RTT - percentage of patients on an RTT pathway under 18 weeks - Breakthrough Obj - Best Quality and Safest Care | BO DRIVER - Stable or Improving | 65.03% ↑ 0.59% WoW | |

## INTEGRATED BOARD REPORT

Filter by keyword | List view | + New

| Metrics 79 | BO DRIVER Breach of ... 1 | BO DRIVER - Stable or... 4 | ✓ WATCH -SPC Breach ... 5 | WATCH -Within busin... 69 |
|---|---|---|---|---|

| Name | Status | Progress | Trend |
|---|---|---|---|
| 1.6 Incidents - ratio of low harm incidents SAFE - Best quality Safest Care | WATCH -SPC Breach Action refe... | 33.56<br>↑ 0% MoM |  |
| 1.7.1 Incidents - comprehensive serious incidents (SI) SAFE - Best quality Safest Care | WATCH -SPC Breach Action refe... | 1<br>↑ 0% WoW |  |
| 2.2.2 Complaints - % responded to within time CARING - Person Centred, Integrated Care; Strong Partnerships | WATCH -SPC Breach Action refe... | 79%<br>↑ 68.09% MoM |  |
| 3.4 Returns to theatre EFFECTIVE - Best Quality Safest Care | WATCH -SPC Breach Action refe... | 10.00<br>↑ 42.86% MoM |  |
| 4.1 Appraisal rate - Non Medical and Medical Staff WORKFORCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -SPC Breach Action refe... | 80.4%<br>↓ 4.86% MoM |  |

## INTEGRATED BOARD REPORT

Filter by keyword | List view | + New

| Metrics 79 | BO DRIVER Breach of ... 1 | BO DRIVER - Stable or... 4 | WATCH -SPC Breach ... 5 | ✓ WATCH -Within busin... 69 |
|---|---|---|---|---|

| Name | Status | Progress | Trend |
|---|---|---|---|
| 1.1 Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days - SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 0.92 ↑ 0% MoM | |
| 1.2 Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 0.43 ↓ 33.33% MoM | |
| 1.3 Inpatient falls per 1,000 bed days SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 7.98 ↑ 0% MoM | |
| 1.4 Infection control - Hospital acquired C.difficile cases, lapse in care identified SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 2 ↓ 66.67% MoM | |
| 1.5 Infection control - Hospital acquired MRSA cases, lapse in care identified SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 0.00 ↑ 0% MoM | |
| 1.7.2 Incidents - Never events SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 0.00 ↑ 0% MoM | |
| 1.8.1 Safer staffing levels - fill rate SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 95.48 % ↓ 1.98% MoM | |
| 1.8.2 Safer staffing levels - CHPPD SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 8.70 ↑ 8.75% MoM | |
| 1.9 Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 99.3% ↑ 7.47% MoM | |
| 1.11 Infant health - % women smoking at time of delivery SAFE - Great Start in Life | WATCH -Within business rules- ... | 4.57% ↑ 206.71% MoM | |
| 1.12 Infant health - % women initiating breastfeeding SAFE - Great Start in Life | WATCH -Within business rules- ... | 92.5% ↑ 1.54% MoM | |

| | | | |
|---|---|---|---|
| 1.13 VTE risk assessment - inpatients SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 89.18% ↑ 0% WoW |  |
| 1.14.1 Sepsis screening - inpatient wards SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 97% ↑ 0.82% MoM |  |
| 1.14.2 Sepsis screening - Emergency department SAFE - Best quality Safest Care | WATCH -Within business rules- ... | 92.5% ↑ 0.65% MoM |  |
| 2.1.1Friends & Family Test (FFT) - All Patients CARING - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 92.53% ↓ 0.15% MoM |  |
| 2.1.2 Friends & Family Test (FFT) - Adult Community Services CARING - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 91.49% ↓ 4.99% MoM |  |
| 2.2.1 Complaints - numbers received CARING - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 15 ↓ 68.09% MoM |  |
| 3.2 Mortality - SHMI EFFECTIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 0.992 ↓ 1.34% MoM |  |
| 3.3.1 Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions EFFECTIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 2.32% ↓ 12.27% MoM |  |
| 3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions EFFECTIVE- Best Quality Safest Care | WATCH -Within business rules- ... | 9.08% ↑ 1.29% MoM |  |
| 3.5 Delayed Transfer of Care - % inpatients not meeting the criteria to reside EFFECTIVE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 0.39 ↓ 7.83% MoM |  |
| 4.2 Mandatory and Essential Skills Training rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 89.66% ↑ 1.11% MoM |  |
| 4.3 Staff sickness rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 5.08% ↓ 16.37% MoM |  |
| 4.4 Staff turnover rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 13.01% ↓ 4.68% MoM |  |
| 4.5 Vacancies WORKFORCE -Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 4.58% ↓ 13.92% MoM |  |

| | | | |
|---|---|---|---|
| 5.1.1 RTT Incomplete pathways performance - median weeks wait RESPONSIVE- Best Quality Safest Care | WATCH -Within business rules- ... | 12 | 0% WoW |
| 5.1.2 RTT Incomplete pathways performance - 92nd centile RESPONSIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 39.00 | 0% WoW |
| 5.1.3 RTT Incomplete pathways - total RESPONSIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 22.724K | 1.45% WoW |
| 5.1.4 RTT Incomplete pathways - 52-<104 weeks RESPONSIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 510 | 9.09% WoW |
| 5.1.5 RTT Incomplete pathways - 104+ weeks RESPONSIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 0.00 | 0% MoM |
| 5.2.1 RTT waiting times - by ethnicity(gap between BME & White (positive is shorter wait for BME) RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 4.91 | 6.21% MoM |
| 5.2.2 RTT waiting times - by level of deprivation- differential median wait in weeks (negative gap reflects high deprivation waiting a shorter time) RESPONSIVE- Person Centred, Integrated | WATCH -Within business rules- ... | 2.00 | 0% MoM |
| 5.2.3 RTT waiting times - learning disabilities differential in median weeks wait ( gap between those with LD flag and those without- negative indicates a shorter wait for those with LD flag | WATCH -Within business rules- ... | 6 | 100% MoM |
| 5.3 Diagnostic waiting times - 6-week standard RESPONSIVE - Best Quality Safest Care | WATCH -Within business rules- ... | 71.91% | 3.74% MoM |
| 5.5 Data quality on ethnic group - inpatients RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 90.62% | 0% MoM |
| 5.6 A&E 4 hour standard RESPONSIVE -Best Quality Safest Care | WATCH -Within business rules- ... | 79.167 | 5.13% WoW |
| 5.7 Ambulance handovers - % within 15 mins RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 99.66 % | 0.34% MoM |
| 5.10 Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals RESPONSIVE - Best Quality and Safest Care | WATCH -Within business rules- ... | 73.66% | 0.37% MoM |
| 5.11 Cancer - 28 days faster diagnosis standard (suspected cancer referrals) RESPONSIVE - Best Quality and Safest Care | WATCH -Within business rules- ... | 72.28% | 1.85% MoM |
| 5.12 Cancer - 62 days maximum wait from diagnosis to treatment for all cancers RESPONSIVE - Best Quality and Safest Care | WATCH -Within business rules- ... | 95.73% | 1.29% MoM |

| | | | |
|---|---|---|---|
| 5.13.2 Children's Services - 2-3 years caseload RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 2.05K | 0% MoM |
| 5.14 Children's Services - Safeguarding caseload RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 1.29K | 0% MoM |
| 5.15 Children's Services - Ante-natal visits RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 92.8% | 0% MoM |
| 5.16 Children's Services - 10-14 day new birth visit RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 89.76% | 0% MoM |
| 5.17 Children's Services - 6-8 week visit RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 93.1% | 0% MoM |
| 5.18 Children's Services - 12 month review RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 86.54% | 0% MoM |
| 5.19 Children's Services - 2.5 year review RESPONSIVE - Great Start in Life | WATCH -Within business rules- ... | 94.56% | 0% MoM |
| 5.23 Community Care Adult Teams - performance against new timeliness standards RESPONSIVE- Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 88.9% | 0% MoM |
| 5.27 Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation RESPONSIVE- Best Quality Safest Care | WATCH -Within business rules- ... | 30.7% | 0% MoM |
| 5.28 Home visit: Face to face consultations started for URGENT cases within 2 hrs RESPONSIVE Best Quality Safest Care | WATCH -Within business rules- ... | 89.5% | 0% MoM |
| 6.1 Agency spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | £470.00 | 0% MoM |
| 6.2 Surplus/ Defecit and variance to plan EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | £ 1.00 | 99.96% MoM |
| 6.3 Capital spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | £14.10K | 0% MoM |
| 6.4 Cash balance EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 12M | 0% MoM |

| | | | |
|---|---|---|---|
| 6.5.1 Long stay patients - stranded (>7 days LOS) EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 392.00 ↑ 0% MoM |  |
| 6.5.2 Long stay patients - superstranded (>21 days LOS) EFFICIENCY & FINANCE- Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 140.00 ↓ 7.89% MoM |  |
| 6.6 Occupied bed days per 1,000 population EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 51.27 ↑ 0% MoM |  |
| 6.7.1 Length of stay - elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 3.55 ↓ 29.42% MoM |  |
| 6.7.2 Length of stay - non-elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 9.56 ↓ 3.04% MoM |  |
| 6.8 Avoidable admissions EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 267.00 ↑ 0% MoM |  |
| 6.9 Theatre utilisation (elective sessions) EFFICIENCYN& FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 77.08% ↓ 4.21% MoM |  |
| 6.10 Day case conversion rate EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 0.02 ↑ 0% MoM |  |
| 7.1 GP Referrals against 2019/20 baseline ACTIVITY - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 1.08 ↑ 0% MoM |  |
| 7.2Outpatient activity (consultant led) against plan (new and follow up) ACTIVITY - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 1.30 ↑ 4.34% MoM |  |
| 7.3 Elective activity against plan - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 0.92 ↑ 0% WoW |  |
| 7.4 Non-elective activity against plan ACTIVITY - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 114.12% ↑ 0% WoW |  |
| 7.5 Emergency Department attendances against plan - Person Centred, Integrated Care; Strong Partnerships | WATCH -Within business rules- ... | 1.06 ↑ 0% WoW |  |
| 5.8 A&E - number of 12 hour trolley waits RESPONSIVE Best Quality Safest Care | WATCH -Within business rules- ... | 55.00 ↑ 0% WoW |  |


# Health & Safety Annual Report 2023

## Harrogate and District NHS Foundation Trust

# Table of Contents

# 1. INTRODUCING OUR ANNUAL HEALTH & SAFETY REPORT



The Annual Health & Safety Report reviews our performance and progress for the period December 2022 – November 2023, and will also set out our key health and safety priorities for the following 12 months. This report demonstrates our commitment to provide an environment that promotes wellbeing and to make HDFT the best place to work.

By providing a safe environment for staff and a positive safety culture it will positively impact on patient outcomes.

Welcome to the 2023 Annual Health and Safety Report.

During this period we have taken the opportunity to reset how all of us at HDFT look at health and safety and how we can focus our efforts on improving not only our legal compliance but achieving the best standards of health and safety for our staff, patients and any others.

In this report, we set out what we have achieved over the last 12 months in response to external and internal reviews, and also review existing data, feedback from staff and partners in order to identify our priorities for the next 12 months and beyond.

As we move into 2024 with a greater knowledge and understanding of the challenges we face and having established a clearer framework for managing and monitoring our performance, this will enable us to move forward proactively with the challenges and opportunities that the next 12 months will bring, to ensure that HDFT can implement the necessary changes for key initiatives such as:

- The NHS Violence, Prevention and Reduction Standards
- Implementation of the NHS Sexual Safety Charter
- Implementing the HSE Management Standards Approach to Work-Related Stress
- Moving and Handling
- Improving our Physical Environment

I can confirm that the Board of Directors has reviewed the 2023 Annual Health and Safety Report and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Health and Safety Report.

With best wishes

**Emma Nunez**
**Executive Director of Nursing, Midwifery & AHPs /**
**Deputy Chief Executive**

# 2. ABOUT HDFT



## Our Services

### Acute and Community Services for Harrogate and District and wider North Yorkshire:

- Harrogate District Hospital which includes an Emergency Department, comprehensive medical and surgical specialities, an oncology centre, maternity services and extensive outpatient facilities
- Community Services which includes podiatry, district and community nursing, therapy services and community dental services

### Children's Public Health (0-25) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 600,000 children
- The largest provider of 0 – 19 services in England

## HDFT in Numbers

| | | |
|---|---|---|
| LARGEST **EMPLOYER** IN HARROGATE AND DISTRICT<br>WITH OVER<br>**5,000**<br>COLLEAGUES | | |
| **118,000**<br>HOME VISITS | HOSPITAL CATCHMENT AREA<br>**c200,000** | **753,731**<br>COMMUNITY CONTACTS DELIVERED EACH YEAR |
| **1**<br>CORPORATE DIRECTORATE | **2**<br>ACUTE SETTINGS – HDH & RIPON COMMUNITY HOSPITAL | **3**<br>CLINICAL DIRECTORATES |
| OVER **180** PROPERTIES USED BY OUR COMMUNITY STAFF | **1**<br>ESTATES & FACILITIES PROVIDER - HARROGATE INTEGRATED FACILITIES (SUBSIDURY COMPANY) | |

# 3. OUR HEALTH & SAFETY SYSTEM / GOVERNANCE STRUCTURE



Our strategic priorities  to provide the best quality, safest care and making HDFT the best place to work include our aim to excel in health and safety. Harrogate and District NHS Foundation Trust (HDFT) will accomplish this by continually seeking to improve our health and safety management system so that it meets with our vision, values and the expectations of those affected by what we do. We will ensure that our responsibilities for health and safety are clearly allocated, understood, monitored, fulfilled and that legal requirements will be regarded as the minimum standard to be achieved.

The last 12 months has seen HDFT re-establish the key elements of a health and safety system appropriate for an organisation of our type and size, including a new Health & Safety Team, Health & Safety Committee, and clear governance structures for relevant Groups/Forums to report and escalate matters of concern.

This reflects our commitment to ensuring that health and safety at work is paramount and that effective health and safety actively contributes to our ongoing success in improving the health and wellbeing of our patients, children and communities and staff.

The Health & Safety Team at HDFT is led by the Head of Health & Safety, and supported by a Health & Safety Advisor (Acute) and Health & Safety Advisor (Community). The team reports in to the Associate Director of Quality and Corporate Affairs, with the Executive Director of Nursing, Midwifery and Allied Health Professionals/Deputy Chief Executive being the Executive lead for Health & Safety at HDFT.

Over the past 15 months, the newly formed Health & Safety Team has carried out a complete review of the position and structure of health and safety at HDFT/HIF, whilst also responding day to day concerns raised by teams and individuals and taking steps to implement remedial measures to ensure compliance with relevant health and safety legislation.

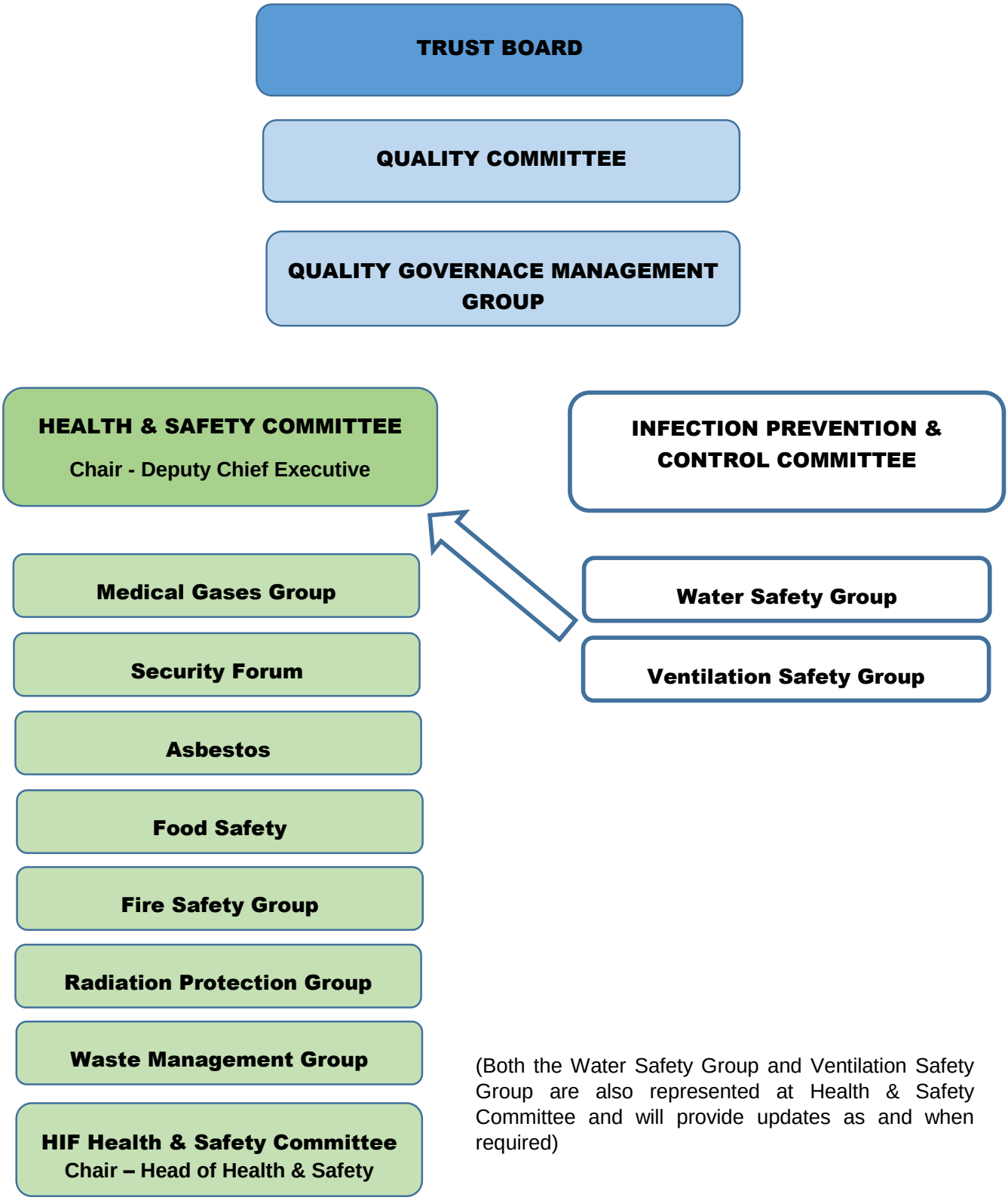
To achieve both legal compliance, and establish best practice in line with relevant guidance the Trust needs to implement a suitable and sufficient H&S system and establish a positive and proactive H&S culture based on the following Healthcare approved publications:

- HSG65 Managing for Health and Safety (published by Health & Safety Executive) Managing for health and safety (HSG65) (hse.gov.uk)
- Workplace health and safety standards (published by the NHS Staff Council's HSWPG) hswpg_workplace-health-safety-standards_may_2022_final.pdf (nhsemployers.org)

Both publications focus on the principal of Plan, Do, Check, Act, as outlined in the table below.

| | Conventional health and safety management | Process safety |
|---|---|---|
| **PLAN** | Determine your policy/Plan for implementation | Define and communicate acceptable performance and resources needed |
| **DO** | Profile risks/Organise for health and safety/Implement your plan | Identify and assess risks/Identify controls/Record and maintain process safety knowledge<br>Implement and manage control measures |
| **CHECK** | Measure performance (monitor before events, investigate after events) | Measure and review performance/Learn from measurements and findings of investigations |
| **ACT** | Review performance/Act on lessons learned | |

# HEALTH & SAFETY GOVERNANCE STRUCTURE




(Both the Water Safety Group and Ventilation Safety Group are also represented at Health & Safety Committee and will provide updates as and when required)

# 4. HEALTH & SAFETY IN HEALTHCARE AND THE POSITION AT HDFT



The Trust must ensure that we do all that is reasonably practicable to comply with the Health and Safety at Work etc. Act 1974, and all regulation stemming from it, such as the Management of Health and Safety at Work Regulations 1999, Control of Substances Hazardous to Health Regulations 2002, and the Construction (Design and Management) Regulations 2015.

Health and safety risks in healthcare do not greatly differ from those faced by many other industries, whether it be slips, trips and falls, the management of work-related stress or the control of substances hazardous to health.

As such the identification of hazards encountered in Healthcare settings are well known and easily identifiable. The challenge for any organisation is to assess who is exposed to the hazard, assess the level risk faced by an individual or group, and then implement suitable and sufficient control measures to either eliminate or reduce the level of risk to the lowest level practicable.

The primary hazards faced in healthcare are as follows:

- The management of health and safety, incorporating the Plan, Do, Check, Act model.
- Suitable and sufficient assessment of risk.
- Monitoring and review of working practices, control measures etc…
- Incident reporting (including RIDDOR, and appropriate investigation of incidents).
- Slips, Trips and Falls
- Manual Handling
- Violence and Aggression (including Security)
- Lone Working
- Work-related stress
- Control of hazardous substances
- Management of sharps
- Provision and use of work and lifting equipment
- Display Screen Equipment
- Legionella, Pseudomonas
- Asbestos
- Electricity
- Workplace Transport
- Radiation
- Control of Contractors
- Management of Construction / Capital Works Projects
- Welfare Provision
- Estates and Facilities (including Critical Infrastructure, management of RAAC)

# HEALTH AND SAFETY AT HDFT



In April 2022 a report on the current position of health and safety, and the management of, at HDFT and Harrogate Integrated Facilities was produced by external consultant. The report highlighted a number of issues (table below), and resulted in a new Health & Safety Team being recruited (September 2022) to address a previous function gap.

| | | |
|---|---|---|
| **1.** | To revise and review the existing Health and Safety Policy. | **HIGH/MEDIUM** |
| **2.** | To overhaul the Trust Health and Safety Committee including developing a revised Terms of Reference. The Committee should also be chaired by an Executive Director. | **HIGH/MEDIUM** |
| **3.** | To have an Executive Lead identified at board level for Health and Safety.<br>In addition it may be appropriate for the Trust Board to receive some training in relation to their H&S responsibilities such as IOSH Safety for Executives and Directors (1 day course). | **HIGH** |
| **4.** | To review the current audit system and use a new methodology for the completing of annual audits, ideally working to a percentage based score so that areas can be ranked and areas of concern addressed. | **HIGH/MEDIUM** |
| **5.** | To review the H&S support provided by SALUS. At the current time it is clearly not fit for purpose and we are paying for a service that is not being delivered. Going forward we should cease provision and look at the recruitment of our own Health and Safety provision. | **HIGH/MEDIUM** |
| **6.** | To develop a security strategy for the Trust. | **HIGH** |
| **7.** | To look at the implementation of a Risk Assessment training course for Managers. | **MEDIUM** |
| **8.** | To ensure that there is a Trust wide Health and Safety Risk Register available on Datix outlining corporate H&S risks. | **HIGH/MEDIUM** |
| **9.** | That as part of an assurance process, the annual Health and Safety report outlines the Health and Safety activity for the previous year and priorities going forward. | **LOW** |
| **10.** | For a system to be put in place for electronic COSHH assessments. | **MEDIUM/LOW** |
| **11.** | To understand the system for RIDDOR reporting to the HSE within the Trust and ensure information is cascaded out to all areas. | **MEDIUM/LOW** |

| | | |
|---|---|---|
| **12.** | To develop a Due Diligence questionnaire for those buildings that are not owned by HIF. | **HIGH** |
| **13.** | To ensure that Ligature Risk Assessments have been completed | **HIGH** |
| **14.** | To understand what is going on within the Trust in relation to Safer Sharps compliance. | **HIGH/MEDIUM** |
| **15.** | To review what Health and Safety Training is undertaken for staff. | **HIGH/MEDIUM** |
| **16.** | The goods yard for Estates and Facilities does not have marked pedestrian walkways and vehicles reverse into this yard. | **HIGH** |
| **17.** | To consider bringing the management of CDM in-house. | **MEDIUM/LOW** |

(action taken in response to these 17 points is provided in Section 6.)

Over a significant period of time the Trust had insufficient arrangements in place to establish, monitor or improve health and safety for its employees, patients or others, and in multiple areas lacked robust assurance in ensuring basic levels of compliance with Health and Safety legislation.

During this period the Trust:

- Relied heavily upon individuals who have attempted to lead on aspects of health and safety, but not as their primary role. (p.16)
- No clear Executive lead for health and safety. (p.17)
- Not produced a detailed annual health and safety plan and report.
- Health and Safety Policy structured around the use of SALUS (an external provider of health and safety advice). (p.16)
- Relied on SALUS folders to provide suitable and sufficient assessment of risk across the entire organisation. (p.25-26)
- Auditing / monitoring of health and safety has relied on infrequent external audits of health and safety documentation. (p.18, 36)
- No evidence on any internal auditing relating to legal compliance, industry guidance, adequacy of risk control. (p.18, 36)
- Identification of RIDDOR reportable incidents has been varied, with a reliance on individual knowledge of RIDDOR, nominally RIDDORS have been compiled by the Occupational Health Team, but there is no evidence of these being monitored / reviewed, or any monitoring of the incident database (DATIX) to ensure incidents that meet the RIDDOR criteria are being reported to HSE. (p.20)
- There is no evidence of any structured investigation or analysis of non-clinical incidents or subsequent actions taken to achieve legal compliance or general improvements. (p.20)
- Since 2017, Estates and Facilities services has been provided for the Trust by Harrogate Integrated Facilities, this has included the management of key health and safety risk including Fire Safety, Water safety (management of the risk from legionella) and Security. (p.26, 28)
- Although HIF is a wholly owned subsidiary of the Trust, there is no evidence of any auditing of the service being provided to ensure that compliance is being achieved. Nor has the Trust taken reasonable steps to ensure that suitable and sufficient measures,

including training, equipment and welfare are being provided to protect the health and safety of HIF employees who work solely for the Trust at its HDH site. (p.37-40)

- This ten year period has coincided with the Trust exponentially increasing the number of community based services it provides away from the HDH site, increasing both the size of its workforce and geographical footprint. This expansion has not been matched with the provision of additional resources to manage health and safety amongst its community settings, nor has it provided an Estates and Facilities support similar to that provided by HIF at the HDH site, for a number of private landlord properties where the Trust has responsibility for general maintenance, assurances etc…
- In relation to properties managed by NHS Property Services, Local Authorities, the Trust has not obtained assurances that landlords are ensuring health and safety compliance in matters such as fire safety, water safety, security etc… (p.36)

(page reference for action taken / progress to date)

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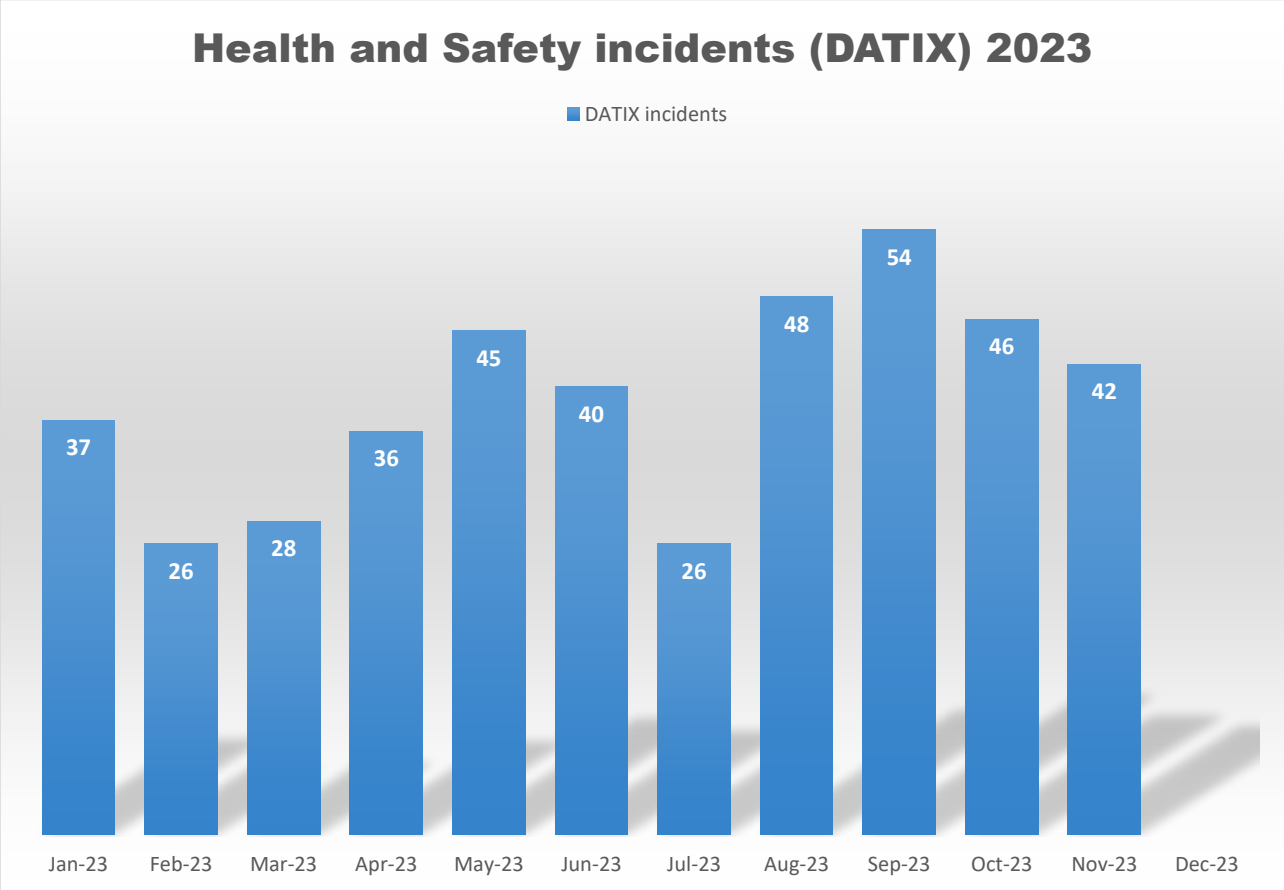
# 5. HEALTH & SAFETY – THE DATA



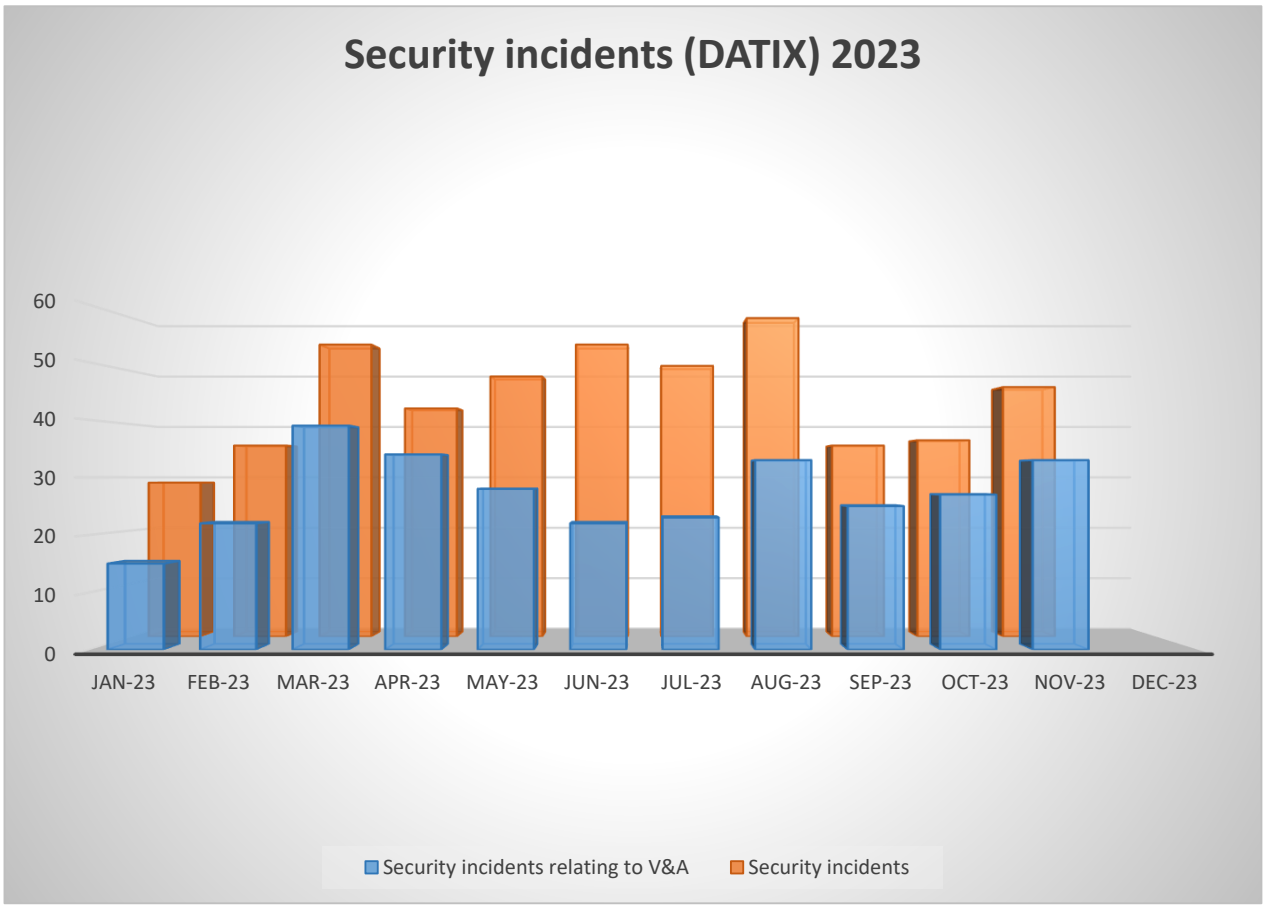
Effective reporting of incidents and near misses is vital in supporting the identification of hazards, targeting appropriate resources at higher risk areas, or individual teams /areas. As an employer we also have legal duties to report certain types of incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

As outlined in section 6 the health and safety culture at HDFT has not been proactive for a number of years, and it is difficult therefore to make any confident comparison to the data of the previous 10 years as there is likely to have been significant underreporting over the last 5-10 years. It is also expected that the creation of the new Health & Safety Team, and proactive promotion and visibility of health and safety across the Trust will result in an increase in reporting, as well as the correct identification and reporting of incidents that meet the RIDDOR criteria.

The data for the last 12 months does however lend weight to the selection of the work streams / priorities for 2024 (detailed in section 10), but it is right that we look at this data as establishing a benchmark going forward which will be added to over the ensuing months and years.



Security, Conflict & Valuables Incidents is a separate category to Health & Safety on DATIX, however a number of the sub-categories to this are health and safety related issues, and provides valuable data in identifying health and safety hazards and the related level of risk. Notably violence and aggression incidents, a number of community based hazards such as lone working, and those that may cause trauma to staff, such as attempted suicide or abscondment are recorded in this category.

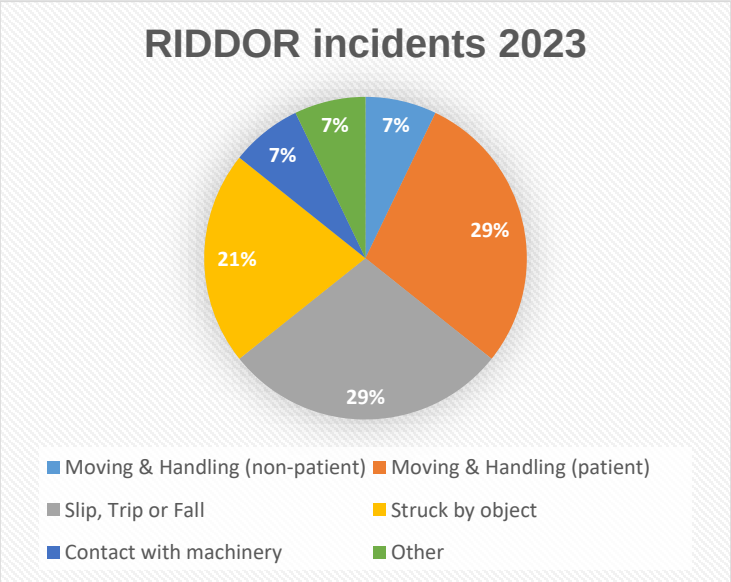


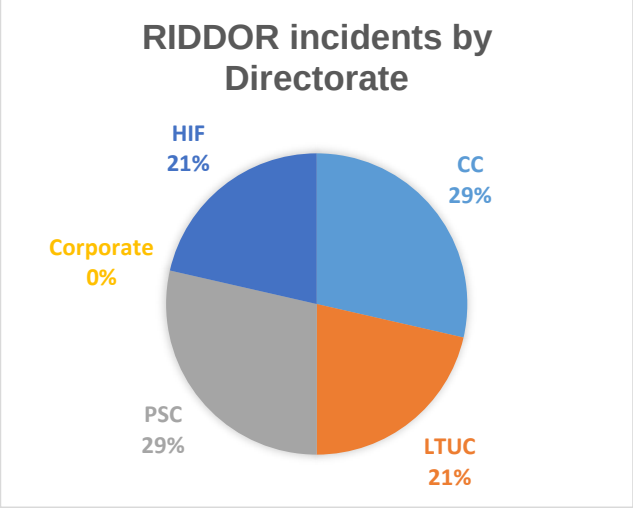
As outlined in the report of April 2022 the Trust was previously failing to identify all incidents that met the criteria for being reportable under RIDDOR. As such there has been a steep rise in RIDDOR reported incidents over the last 12 months, previous years rarely above 4-5.

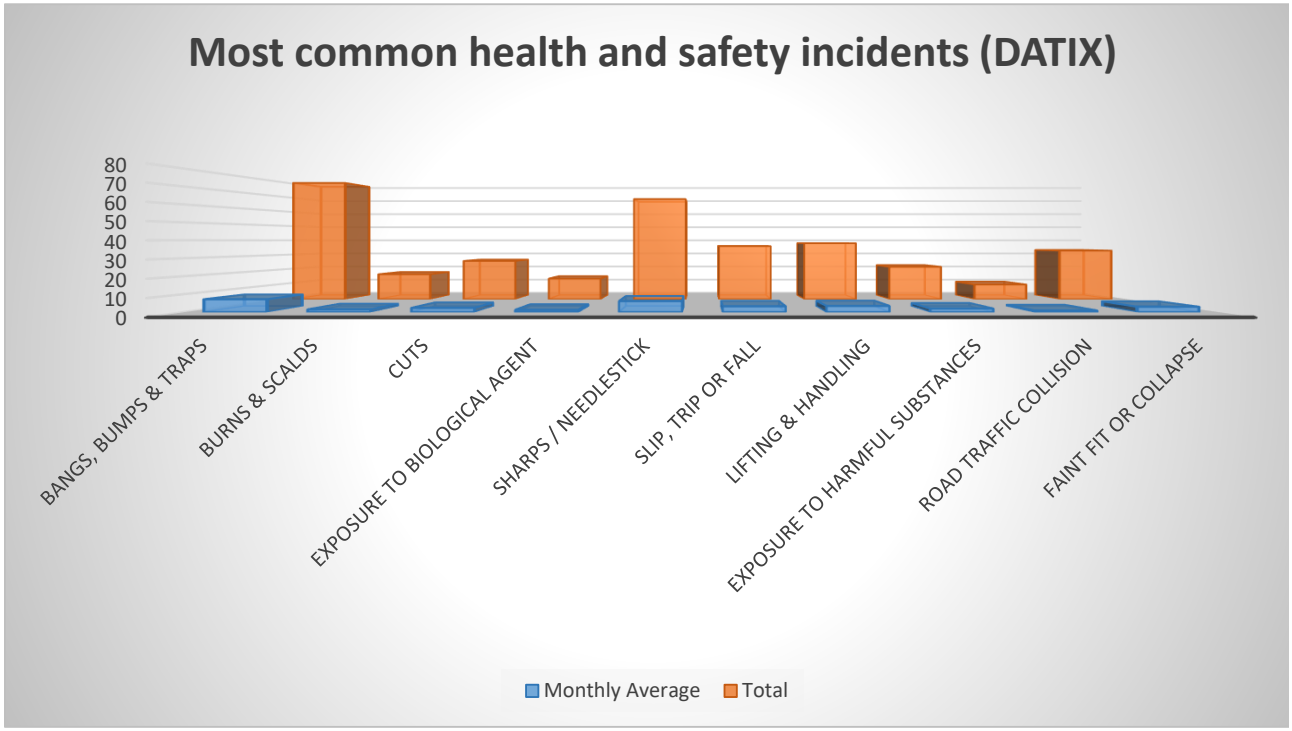
It is reasonable to attribute this rise in incidents to the increased visibility of health and safety, and the implementation of a robust system to monitor DATIX and identify those that meet the criteria.

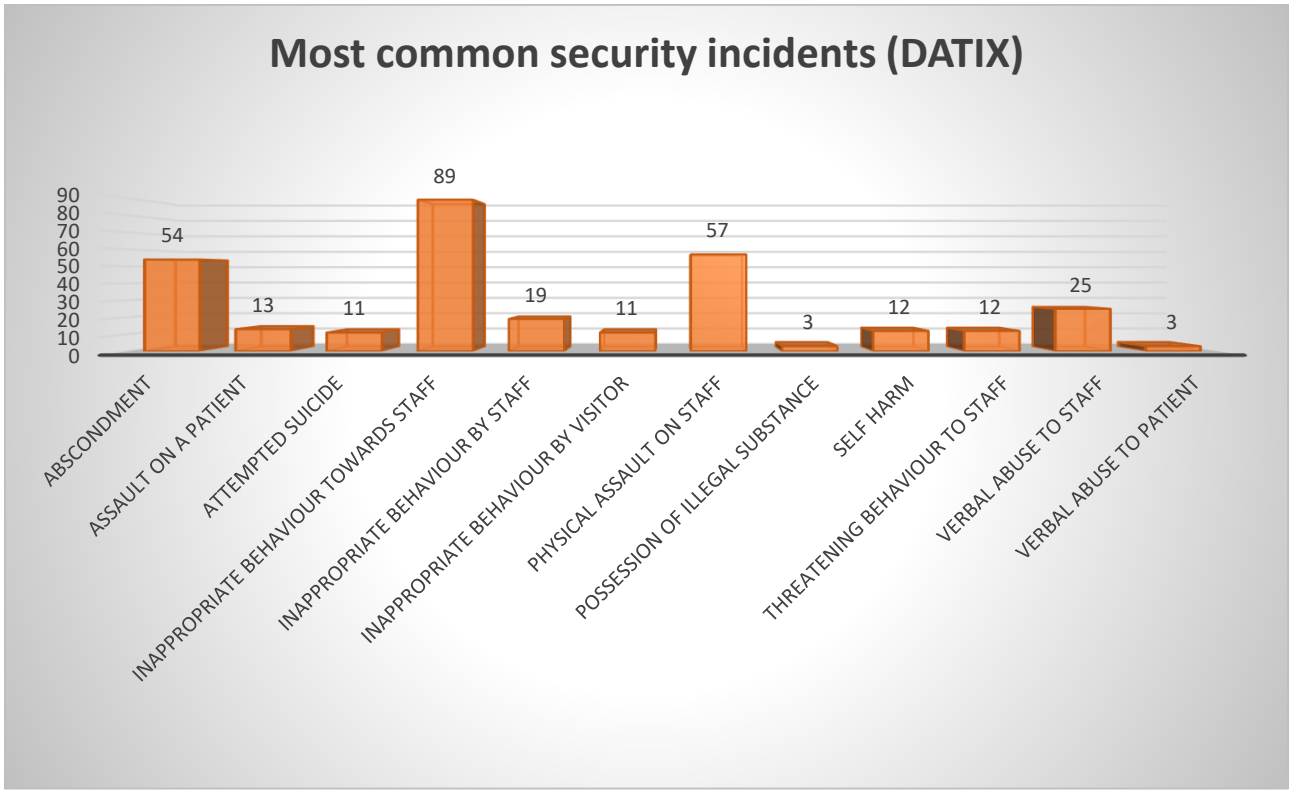
For the period December 2022 to November 2023 the Trust has reported 14 RIDDORs, none of which have resulted in serious harm. The breakdown of the RIDDOR incidents in the two pie charts show that the majority of the incidents relate to moving and handling and slips, trips or falls. These incident types are common in healthcare settings and indicate the need to focus attention on these themes going forward.

RIDDOR incidents are evenly spread across our three clinical directorates and HIF, with the corporate directorate not having a RIDDOR incident over the last 12 months.




Most common health and safety incidents (DATIX)
80
70
60
50
40
30
20
10
0
BANGS, BUMPS & TRAPS
BURNS & SCALDS
CUTS
EXPOSURE TO BIOLOGICAL AGENT
SHARPS / NEEDLESTICK
SLIP , TRIP OR FALL
LIFTING & HANDLING
EXPOSURE TO HARMFUL SUBSTANCES
ROAD TRAFFIC COLLISION
FAINT FIT OR COLLAPSE
Monthly Average
Total


Most common security incidents (DATIX)
90
80
70
60
50
40
30
20
10
0
54
13
11
89
19
11
57
3
12
12
25
3
ABSCONDMENT
ASSAULT ON A PATIENT
ATTEMPTED SUICIDE
INAPPROPRIATE BEHAVIOUR TOWARDS STAFF
INAPPROPRIATE BEHAVIOUR BY STAFF
INAPPROPRIATE BEHAVIOUR BY VISITOR
PHYSICAL ASSAULT ON STAFF
POSSESSION OF ILLEGAL SUBSTANCE
SELF HARM
THREATENING BEHAVIOUR TO STAFF
VERBAL ABUSE TO STAFF
VERBAL ABUSE TO PATIENT

Sickness Absence is powerful indicator of health and safety performance, as with our DATIX data we need to treat this collection of data as a baseline from which we can start to assess the impact of improved health and safety performance over the ensuing years.

The following sickness absence reason can be reasonably linked to health and safety performance, although it is not currently possible to identify every instance where work activity is the sole or primary cause of the injury / ill health.

HDFT's number one sickness absence reason for each month of 2023 was anxiety / stress / depression / other psychiatric illnesses. Although it is difficult to determine the level of work-related stress within these figures, it is reasonable to identify it as a contributory factor if not the main cause.

**HDFT data**

| Absence Reason | Average no. of absences per month | Total FTE Days Lost (monthly Average) | Average % of HDFT sickness absence per month | Estimated salary cost |
|---|---|---|---|---|
| **Anxiety/stress/depression/other psychiatric illnesses** | **116.3** | **16,433.24 (1825.92)** | **31.56%** | **£1,770,639.04** |
| **Other Musculoskeletal** | **37.4** | **3615.57 (401.73)** | **7%** | **£392,218.19** |
| **Back problems** | **21.11** | **1906.36 (211.81)** | **3.64%** | **£204,218.19** |

**HIF data**

HIF sickness absence data shows similar trends to that of the Trust, with the two main causes being anxiety / stress / depression / other psychiatric illnesses and other musculoskeletal problems.

| Absence Reason | Average % of HIF sickness absence per month | Total number of FTE days lost in 2023 | Estimated salary cost for 2023 |
|---|---|---|---|
| **Anxiety/stress/depression/other psychiatric illnesses** | **24.7%** | **1373.4** | **£91,248.61** |
| **Other Musculoskeletal** | **22.5%** | **1251.1** | **£83,121.21** |

An additional breakdown of the sickness absence data is included in section 7 under Work-related Stress and Moving & Handling.


# HDFT NHS STAFF SURVEY RESULTS 2022

In the last 12 months have you experienced musculoskeletal problems as a result of work activities? – Yes 29.1%

In the last 12 months have you felt unwell as a result of work-related stress? – Yes 42.9%

In the last 3 months have you ever come to work despite not feeling well enough to perform your duties? – Yes 53.5%

Have you felt pressure from your manager to come to work in the last 12 months? – Yes 17.7%

In the last 12 months have you experienced at least one incident of physical violence at work? – Yes 9%

The last time you experienced physical violence did you or a colleague report it? – No 29%

In the last 12 months have you experienced at least one incident of harassment, bullying or abuse at work? – Yes 50%

The last time you experienced harassment, bullying or abuse did you or a colleague report it? – No 49.2%

# 6. ADDRESSING THE APRIL 2022 REPORT



## Health & Safety Governance – items 1, 2, 3 & 9

### WHAT IS THE ISSUE(S)?

- Outdated Health & Safety Policy
- Ineffective H&S Committee with no clear governance structure in place.
- No Executive lead for Health & Safety in place. Lack of training at Board level
- Lack of Annual Health & Safety Report.

### WHAT ACTION HAS BEEN TAKEN/PLANNED?

### Health & Safety Policy (New policy approved April 2023)

The existing policy had been in place for a number years with no significant update to reflect the changes in the Trust, the services we provide, the nature of our workforce or the communities/settings we work in. A major revision of the policy has been produced to better reflect the Trust whilst also bringing the policy in line with that of NHS England.

The policy now clearly defines the arrangements we will establish and use to achieve our goals.

a) The development of procedures, protocols and guidance that meet the requirements of health and safety law as applicable to HDFT which will be made available via the staff intranet, or other appropriate means.

b) Ensuring management conduct suitable and sufficient risk assessments and controls for their areas of responsibility.

c) The use of a digital platform to provide management tools to both assist managers to implement the Health and Safety management system and to monitor their progress.

d) The provision of appropriate health and safety training such as Health and Safety Awareness, Display Screen Equipment Assessment etc. via our virtual learning environment (learningLab), or facilitator led courses.

e) The promotion of health, safety and welfare of all colleagues through campaigns, communications, seminars and questionnaires.

f) The review of all relevant HDFT policies.

g) The investigation of all RIDDOR reportable incidents, accidents and notifiable diseases, as well as non-reportable events or near misses that indicate failure to comply with statutory requirements.

h) The analysis of all Health and Safety incidents and other related data reported through established HDFT systems, to assist the formulation of appropriate work streams.

i) The provision of a range of occupational health and wellbeing services to all HDFT employees.

j) Engaging our recognised trade union colleagues in effective consultation and actively supporting Safety Representatives in the fulfilment of their role.

## Health & Safety Committee (New Committee 1st Meeting December 2022)

The Trust needed to establish a Health & Safety Committee to allow effective communication of health and safety issues from Board to front line, whilst also allowing for the suitable management and escalation of issues across the organisation.

To this end we have re-established a new committee, chaired by our Executive lead and meeting bi-monthly. The sub-groups detailed on page 5 are all represented on the committee, in addition Union colleagues and the Occupational Health Team are represented. Our next review of the Terms of Reference will include extending the membership of the committee to include Directorate representation.

In addition to the Trust Health & Safety Committee, we have also established a new HIF Health & Safety Committee to allow a more detailed focus on their core activities and risk. This committee also meets bi-monthly and is chaired by the Head of Health & Safety.

Output from this committee is reported to both HIF senior management and the Trust Health & Safety Committee, allowing faster and clearer communication and escalation of HIF risks to the Trust Board.

## Executive Lead and Board level training

Establishing an effective and positive health and safety culture at HDFT requires clear and informed leadership from the top of the organisation. To address this HDFT have appointed the Deputy Chief Executive as the executive lead, and they have taken over the role of Chair to the Health & Safety Committee.

In October 2023, the Board were provided with a short session on health and safety by the Head of Health & Safety, detailing their roles and responsibilities, the challenges of managing health and safety in a healthcare setting and data on sickness absence/financial impact of poor health and safety performance.

## Annual Health & Safety Report

This report establishes the template and reporting structure for Health and Safety at HDFT going forward, allowing scrutiny of our performance and improvement by the Board, as well as providing evidence to our partners and external stakeholders.

## IDENTIFICATION OF RISK – items 4,5,7,8 & 10

### WHAT IS THE ISSUE(S)?

- Audit system for health and safety limited and ineffective.
- Use of SALUS folders, and consultant audit not fit for purpose.
- Risk assessment training course for managers.
- Lack of Trust wide health and safety risk register.
- Electronic system for COSHH assessments

### WHAT ACTION HAS BEEN TAKEN/PLANNED?

### Auditing health and safety / SALUS folders

Audit of health and safety performance has relied previously on an external provider (SALUS) carrying out yearly audits of the SALUS folders (these folders contain generic risk assessments and checklists, held and managed internally by nominated staff). The last of these audits was carried out pre-Covid, and has focussed primarily on checking that documents are in date/been reviewed in the last 12 months by the SALUS book holder. There was no documented evidence that any of the actual documents within the folder have been checked to confirm they are suitable and sufficient or address the actual risks present.

The assessment of risk is a fundamental part of health and safety law, as required by Regulation 3 of the Management of Health and Safety at Work Regulations 1999.

> ***3.—(1) Every employer shall make a suitable and sufficient assessment of—***
> ***(a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and***
> ***(b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking,***

Evidence of speaking to those who have been nominated to manage the SALUS folders have confirmed that although minor checks and amendments have taken place, the main function has been to sign and date the folder annually.

In response the Health & Safety Team have reviewed a number of the existing SALUS folders, as well as carrying out a number of walk-around audits (in the acute setting), identifying hazards, current controls in place and assessing relevant training.

Initial audits of all community based teams assessing current health and safety provision / compliance have been completed, these have looked at both risk created by work activities and those created by the environments being worked in.

A priority for the following 12 months will be to create and implement a new audit process that can be managed centrally by the Health & Safety Team, which will align with existing audit processes within the Trust.

The use of SALUS folders will be phased out over the next 12 months to be replaced by a new digital system, which will allow for version control, central oversight by the Health & Safety Team, and allow for a consistent identification of risk and the appropriate control measures / remedial action. (page 25 provides further detail on risk assessment)

### Risk Assessment Training for Managers

Assessment of clinical risk is a day to day process for the majority of employees / managers at HDFT. Training specifically related to the identification of non-clinical risk has been limited, and on occasion has previously only been provided to the nominated SALUS book holders. The majority of those who have received this training have either changed role or no longer work at HDFT.

With the creation of new risk assessments nominated staff are being given face to face training by a member of the Health & Safety Team on how to identify the hazards, assess the associated consequences and likelihood, control measures / remedial actions and how to record this on the new risk assessment templates.

### Lack of a Trust wide Health and Safety Risk Register

A new Health and Safety risk register has been established, managed by the Head of Health & Safety and overseen by the Trust Health & Safety Committee, the register itself will be available on the upgraded DATIX CloudIQ. This register allows for the escalation of risks from the above detailed sub-groups to the Health & Safety Committee, as well as those identified through the work of the Health & Safety Team.

Further detail on the current risks on the register is provided in subsequent sections.

### Electronic system for COSHH (Control of Substances Hazardous to Health) assessments

The Trust presently has a number of COSHH assessments in place for products used across the Trust. These are currently accessible on the existing Trust Intranet pages to all employees.

As part of the new risk assessment process the suitability of these assessments will be reviewed and updated to reflect changes to safety data sheets for the products and that employees are using the products in an appropriate manner with the correct controls in place. The new / updated COSHH assessments will also be available through the new digital platform for risk assessments.

## MANAGEMENT OF CURRENT RISK – items 6, 11, 12, 13, 14 & 16

### WHAT IS THE ISSUE(S)?

- Develop a security strategy for the Trust.
- System for ensuring RIDDOR compliance at the Trust.
- Due diligence questionnaire for those buildings not owned by HDFT / HIF.
- Robust completion of Ligature risk assessments.
- Safer Sharps compliance.
- Goods Yard at HDH – associated risks to pedestrians.

### WHAT ACTION HAS BEEN TAKEN/PLANNED?

#### Security Strategy for HDFT

Security, based both in the acute setting and supporting the community teams, is provided through HIF, via 2 full time employees. In addition to this 2 security guards are contracted from an external company to provide a presence at the Goods Yard (HDH site, Monday – Friday 8am-4pm) and a security guard based in the HDH building supporting clinical teams (Monday – Sunday 6pm-6am). Additional support is provided through the portering team on an ad hoc basis.

The creation of a new security strategy will be based on a number of streams of work currently taking place (detailed in subsequent sections) looking at a range of issues, including Violence & Aggression, Lone Working, Managing Patients with Mental Health issues, and the provision of suitable training to all Trust employees.

Additionally work is underway through a newly established task and finish group to ensure the Trust is working towards the NHS Violence Prevention and Reduction Standards and NHS Sexual Safety Charter.

#### RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations)

The Trust has relied upon individual knowledge of the reporting requirements of RIDDOR in the past and has not had a robust system in place to identify those incidents (reported via Datix) that meet the RIDDOR criteria.

In response to this the Health & Safety Team now assess all relevant DATIX incidents on a daily / weekly basis, contacting the relevant people for additional information to ensure an informed decision can be made. All RIDDOR reports are made by the Health & Safety Team, and appropriate levels of investigation are completed to identify improvements and action to prevent a reoccurrence. (RIDDOR data since September 2022 is detailed in subsequent sections)

## Due diligence questionnaires for buildings not owned by HDFT / HIF

HDFT employees, predominantly within our Community Teams, are based or provide services from a variety of locations / properties. At present the Trust uses approximately 180 properties owned by others, this may be a clinic room in a GP surgery used once a week, or office space used 7 days a week.

HDFT has no formal process in place to gather the relevant assurances (such as legionella checks, fire assessments or security procedures for shared premises) from the various landlords or facilities management providers.

Steps taken by the Health & Safety Team have now ensured initial audits have taken place of all properties used by Trust employees, and conversations held with the relevant teams to identify what assurances have been received to date. Ad hoc support is also being provided by the Health & Safety Team to support the resolution of urgent issues, such as inadequate fire assessments. Additionally conversations are being had with our larger providers, such as NHS Property Services, to ensure documented assurances are provided at appropriate intervals and can be reviewed by the local team or Health & Safety Team.

## Ensure Ligature Assessments have been completed

To provide the right care to patients with mental health needs, and take effective action in preventing self-harm and suicide, we must ensure that staff are provided with the necessary skills and environment to deliver safe care. As part of this process ligature risk assessments and making the physical environment of HDH site, including buildings, fixtures, fittings and furniture as safe as possible, is also vital.

Working with colleagues across the Trust we have refined the ligature assessment and ensured that new assessments have been completed for at risk areas. Outcomes of these assessments have helped inform clinical colleagues in how they manage patient's needs. Further work through the Violence & Aggression task and finish group has reviewed the existing policy and drafted a new policy that focusses equally on environment and patient assessment to create the most appropriate solution for patient and staff. This policy will go through governance in early 2024

## Safer Sharps compliance

There is an existing Blood-Borne Virus and Inoculation Incident Policy, the management of which is carried out by the Occupational Health Team. This policy covers the actions of clinical colleague in relation to specific needlestick / sharps incidents, but does not address the general principles of Safer Sharps across all employees.

Needlestick / sharps incidents amongst HIF colleagues, predominantly waste and domestic teams has shown that the procedures and risk assessments are not current for all staff.

Immediate action has been taken via the HIF Health & Safety Committee to ensure all employees are aware of the steps to be taken in the event of a needlestick / sharps incident. A new general sharps policy will be developed in 2024 to support existing controls and identify new requirements.

### Goods Yard at HDH – associated risks to pedestrians

Every year, about 50 people are killed and more than 5000 people are injured in accidents involving workplace transport (www.hse.gov.uk/statistics). The Goods Yard at the HDH site is the main point of entry for the delivery and collection of items to the hospital. It is limited both in terms of space and the level of required use.

Access is required in relation to stores, medical gases, waste, catering, pharmacy, pathology and a number of other services, its entrance is also in close proximity to the staff multi-storey car park and a busy pedestrian route around the hospital. It has also historically been used as a short cut for staff coming to and leaving work, and as a pick up point for taxis.

Assessment of the yard has identified this area as a high risk to persons entering the area, and as such a number of control measures have been put in place to manage the risk:

- Access to the yard is now limited to staff who have a legitimate work activity in the area – no longer a general access in and out of the hospital.
- Temporary fencing installed to provide protection for pedestrian walkway.
- Security Guard positioned on the entrance Monday – Friday 8am – 4pm, to assist with the control of vehicles accessing the yard, and challenge individuals wanting to access the area.
- New guidelines issued to all contractors who require vehicle access to the yard, detailing health and safety rules / controls.
- Communications issued to all Trust explaining the restrictions.

As part of the site wide backlog maintenance work, plans and costs are being produced to address long term capital works, including permanent fencing, resurfacing, and vehicle control barriers.

## HEALTH & SAFETY TRAINING – item 15

### WHAT IS THE ISSUE(S)?

- Review of health and safety training provided to staff.

### WHAT ACTION HAS BEEN TAKEN/PLANNED?

Basic health and safety training is provided to all staff through a mandatory e-learning package on Learning Lab. This module is in line with the Clinical Skills Competency Framework and allows for the transfer of this module across healthcare providers.

As part of the wider review of health and safety, the training needs directly related to identified hazards are considered to ensure the training provided is suitable and tailored to the individual or group and the level of risk.

As already stated the new risk assessments process will be delivered with face to face training for all staff required to complete the new assessments. Other areas where training has already been reviewed and action taken include moving and handling of patients (content and style of delivery changed), and the creation of a new training package in relation to using ligature cutters.

Risk based analysis of the provision of Conflict Resolution training has been conducted. This will result in all staff being provided with a basic level of training through e-learning. Enhanced Breakaway Skills training (currently only provided to approximately 200 staff) being provided to staff on a risk based approach, and equipping staff with the skills to de-escalate situations and prevent violence and aggression incidents. (Approximately increasing staff training to 2000, business case to be produced by January 2024)

## THE MANAGEMENT OF CONSTRUCTION RELATED WORK
## Construction (Design and Management) Regulations 2015 – item 17

### WHAT IS THE ISSUE(S)?

- Construction and Capital Works projects are not being management in line with the Construction (Design and Management) Regulations 2015 (CDM).
- The Trust must ensure it is compliant with Client Duties in CDM,
- The impact and health and safety Implications of construction / capital works on operational activities / active hospital site not being fully considered or controlled.

### WHAT ACTION HAS BEEN TAKEN/PLANNED?

The HDH site currently has a number of significant construction projects taking place, as well as a number of smaller scale capital works projects. These projects are managed through a combination of the Trust Planning team and the Estates team within HIF.

Previously the Trust relied on the experience / knowledge of a few individuals and advice from an external consultant (CDM Advisor), compliance with CDM Regulations was not consistent, and did not proactively manage the shared risk of having construction work on a live hospital site and the hazards this creates, such as fire safety and workplace transport.

In the last 15-18 months the appointment of a new Head of Estates and Head of Health & Safety has allowed for closer monitoring of all construction work on site, and managing the impact of this work on the day to day operational needs of the HDH site, in particular:

- Attendance at all progress meetings by either/both Head of Estates and Head of Health & Safety.
- Contractors to ensure construction activities are planned to reflect the need to maintain a safe site for all persons at HDH.

- Fire procedures for the construction work also include impact on the HDH site, means for raising the alarm, hot works etc…
- Security checks taken daily to prevent unauthorised access to CDM areas.
- H&S audits carried out by contractors sent to Head of Health & Safety for review.
- External appointments made relating to the role of Principal Designer to ensure Client duties in CDM Regulations are complied with (previously the Trust took on this role).
- Future planning in place to allow adequate resource for the pre-construction phase, consideration of all enabling works, work to align with the principles of RIBA Plan of Work. All of which will ensure health and safety, operational and financial concerns are addressed prior to the construction phase.

# 7. HEALTH & SAFTEY WORKSTREAMS 2023



This section of the Annual Health and Safety Report provides an update on:

- Additional detail on the work that has taken place to address the external report of April 2022, and additional activity to expand on this.
- Work in other high risk areas, or those with significant non-compliance (in relation to health and safety legislation).
- Work to address health and safety risks added to the Trust Health and Safety Risk Register

## Identification and Management of Risk – Risk Assessment

| | |
|---|---|
| **Standard** | The carrying out of suitable and sufficient assessments of the risks to which employees and others might be exposed. |
| **Rationale** | To allow the Trust to identify and implement reasonably practicable measures to control significant risks. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999 |

### What action has been taken / planned

- Due to the existing SALUS risk assessments consistently not giving sufficient detail so to clearly identify suitable control measures, the risk assessment process for the entire Trust must be redone
- New risk assessment templates have been designed to allow for a consistent approach across the organisation.
- A general risk assessment template has been created that is pre-populated to allow for a more efficient completion of the form, whilst also ensuring that control measures are consistent for similar hazards.
- A more detailed template is then available to be used with more significant hazards or those that require more task or area specific detail.
- Further templates have been created to be used in the assessment of moving and handling activities both for patient and non-patient activities. These templates are based on the Health & Safety Executives MAC (Manual handling Assessment Charts) tool and National Back Exchange guidelines.
- Health & Safety Team is now systematically meeting with representatives of all teams across the Trust to explain the new process and provide structured training in how to complete the assessments.
- All of the new assessments will be reviewed by the Health & Safety Team as a means of assuring a consistent approach and allow the sharing of best practice and practical control measures.
- With the Trust moving towards a greater use of SharePoint that will be accessible through existing digital infrastructure, the Health & Safety Team will be creating a Health & Safety space where all documentation, guidance etc… will be stored, allowing central monitoring

easy access to all, and the removal of a reliance on paper forms which will support greater version control.

## Fire Safety – Assessment, Control Measures & Evacuation

| | |
|---|---|
| **Standard** | To manage the risks associated with Fire. |
| **Rationale** | To allow the Trust to carry out a suitable assessment of the risk from fire and implement reasonably practicable control measures, develop appropriate evacuation plans, and provide suitable information, instruction and training to all affected. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>The Regulatory Reform (Fire Safety) Order 2005<br>Management of Health and Safety at Work Regulations 1999 |

### What action has been taken / planned

The identification and management of risk associated with fire has been in a similarly dormant position as that of general risk assessment. Fire safety was not supported by sufficient or competent resource and the existing documentation (policies, procedures, assessments and training) were no longer suitable for the current position.

In response the general fire safety risk has been added to the H&S Risk Register and escalated to the Executive Risk Group, and the following remedial action has been taken/planned:

- New Fire Safety Policy, and supporting management procedure has been created and approved by the Trust SMT, with a new Executive Lead for Fire Safety appointed.
- The Fire Safety Group has been re-established with members across the Trust, allowing for close monitoring of fire performance and reporting directly to the Health & Safety Committee.
- An SLA has been created with Leeds Teaching Hospitals to provide the Trust with expert Fire Safety Management, and an external contractor is carrying out new fire risk assessments for all areas at HDH.
- External consultant Oakleaf are carrying out new fire risk assessments for each individual ward/department/area within the HDH site. This is approximately 150 individual assessments, and is 95% complete (December 2023 final completion date).
- The new assessments are generating action lists for all areas, support is then being provided to address the issues whether they be Estates related or require input from clinical teams or training needs. All actions will be monitored by the Fire Safety Group, and this data will be provided to the Health & Safety Committee for assurance and inclusion in all future Annual Health & Safety Reports.
- Day to day oversight of the assessments and related actions is being done by the new Fire Safety Manager, who will also review and address all training needs, including providing bespoke training such as the use of evacuation equipment.
- In response North Yorkshire Fire Service have carried out a limited audit of the HDH. The outcome of which was to reiterate the need for us to continue with the extensive list of actions we have already identified.
- All assessments are being reviewed by the new Fire Officer and action plans are being generated to address estate and clinical issues.
- New fire plans will be created for all areas – copies will be displayed for staff and others.
- The H&S Team are providing support to Community teams in relation to assessments provided by landlords and generating fire assessments for HDFT staff. Further work is

being done to provide additional fire support to teams in a small number of properties where HDFT are not the owner but hold full responsibility for Fire Safety.
- A site wide review of the fire alarm, fire doors, and compartmentation and fire strategies has been produced. This report is being used to inform the Backlog Maintenance programme across the HDH site, and will allow for remedial action to be carried out as either ad hoc projects or as part of larger construction projects on site.

## Workplace Transport – HDH Goods Yard

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|---|---|
| **Standard** | Effective arrangements in place to manage the risks from vehicle movements on site. |
| **Rationale** | The risk to pedestrians from vehicles at work is a major cause of accidents in the workplace. At HDH the Goods Yard is a high risk of pedestrian injury due to the physical constraints of the yard and the volume of vehicle movement. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999<br>Workplace (Health, Safety and Welfare) Regulations 1992<br>Provision and Use of Work Equipment Regulations 1998 |

### What action has been taken / planned

Every year, about 50 people are killed and more than 5000 people are injured in accidents involving workplace transport (www.hse.gov.uk/statistics). The HDH site is located in the centre of a busy urban area, with high volumes of traffic visiting both the HDH site and surrounding area. The delivery and collection of goods at HDH is serviced primarily by a single Goods Yard area, which also handles the sites main waste storage and collection.

The Goods Yard has been identified as a high risk area for workplace transport, with the risk added to the H&S Risk Register and escalated to the Executive Risk Group.

- Risk assessment completed for the goods yard with new temporary measures put in place to mitigate the level of risk.
- Security guard is now in place at the entrance to restrict access and control the movement of vehicles (Mon-Fri 8am – 6pm). All non-essential staff no longer allowed to access the yard.
- New pedestrian crossing markings provided July 2023 at entrance to goods yard / car park, with a protected walkway now in place to access the Pharmacy lift entrance.
- Instruction to contractors that the yard area is not to be used as a car park, delivery drop off / collection only.
- As part of the Backlog Maintenance Programme, further physical improvements will be scheduled going forward including a barrier controlled entrance, resurfacing and permanently marked / protected walkways.

Waste management audit carried out in July 2023 has further highlighted the issues with the Goods Yard, a newly formed Waste Management Group will monitor the response to this audit and provide a report to the Health & Safety Committee to include in all future Annual Health & Safety Reports.

## Violence & Aggression, Security & Lone Working

| | |
|---|---|
| **Standard** | Effective arrangements in place to manage the risks associated with violence and aggression. |
| **Rationale** | A safe and secure working environment provided to all, no matter the location. That the Trust ensures that neither it or any of its staff accept or tolerate incidents of violence and aggression and that measures, including adequate security and lone working procedures are in place to prevent and reduce risk. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999 |

### What action has been taken / planned

Reports via DATIX on a daily basis of incidents of violence and aggression against staff across the Trust, both physical and verbal, are at significant levels on a monthly basis. The management of these incidents, which predominantly involve patients, to ensure patients remain safe and receive the best care, whilst also protecting our staff and others is a significant challenge.
The risk associated with Violence & Aggression has been added to the Health & Safety Risk Register, and due to the level of assessed risk has been escalated to the Executive Risk Group.
The Health and Safety Executive has recently concluded phase one of an inspection programme looking at causes of ill health in healthcare focussing on musculoskeletal disorders and violence and aggression, which is stressor and major contributory factor to work-related stress.
HSE has highlighted the four main categories where management failings have been consistently identified – Risk Assessment, Training, Roles & Responsibilities and Monitoring & Review. In particular they found that although NHS employers generally have policies and procedures in place, these are not monitored or reviewed to ensure they work in practice or remain effective.

Our own DATIX data show that the most common security incidents relate to physical or verbal abuse towards our staff, and the following comments taken form staff accounts highlight the nature of these.

**Patient heavily intoxicated, attacking security, broke into front of ambulance…. Abusive language, stole a radio from ambulance, broke doors**

**Patient has racially and verbally abused multiple members of staff this afternoon. This has resulted in 1 member of staff going home….**

**Patient stood up grabbing my ponytail with left hand and right hand punched face …. Then put me in head lock I stepped back to get away**

**Called to aggressive patient who spat blood into my face**

A task and finish Group has been established, led by the Head of Health & Safety, with a membership representing all areas of the Trust. The broad remit of the group is to review the main policies, the systems / controls that are already in place and implement improvements where required, whilst creating a uniformed approach across the Trust. In addition HIF are carrying out a review of the Security provision currently at HDH, and the requirements going forward of an increased security presence at the HDH site.

- The task and finish group initially focussed on work around managing patients with mental health issues and linking this to an existing policy for managing the environmental risks associated with ligatures and self-harm. This has resulted in a new patient assessment procedure for triage being developed and trialled in the Emergency Department. New ligature / environmental assessments have been completed across the HDH site to support both patient care and staff safety. A draft new policy has been produced and will now go through the appropriate governance.
- To further support this work all refurbishment or alteration to existing patient facing areas will consider the environmental impact on patients and incorporate best practice installations such as ligature free fittings, doors etc… to create Safe Spaces.
- As well as supporting this work the group is also considering the management of patients with dementia or delirium, again to support the best quality and safest care whilst providing a safe working environment for our staff.

The NHS Violence Prevention and Reduction Standards were developed in 2020 and requires all NHS Organisations to review their status against it and provide board assurance that they have been met.

***The violence prevention and reduction standard provides a risk based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence***

Work has now started with the support of the violence and aggression group to consider the standard and develop a Trust strategy that can be implemented at HDFT and be the basis when providing assurance to the Board going forward.
The strategy will focus on 3 main themes, General violence & aggression, violence & aggression relating to existing medical conditions, and staff on staff violence & aggression. The strategy will look to build on existing external relationships, such as working closely with primary care colleagues.


Progress has also been made on the following:

- Training has previously been based on staff group rather than on a risk based assessment. Conflict Resolution / Breakaway Skills training has been reviewed through recent corporate training reviews headed by Learning & Development. It has been agreed that level 1 e-learning will now be made mandatory for all Trust staff.
- Breakaway skills training will be provided to all nursing staff (business case being written to secure additional funding to train additional staff), training will focus on de-escalation of situations to prevent violence & aggression incidents.
- New policies for V&A, security and lone working will be produced during the next 6 months. A review of lone working procedures across the Trust in particular within Community teams is being carried out as part of team and building audits by the H&S Advisor (Community)
- The Trust will now build on excellent work already happening in relation to patients suffering from domestic violence, and extend this in line with recent guidance form NHS

England relating to domestic violence affecting staff, and the issue of sexual harassment/violence at work.

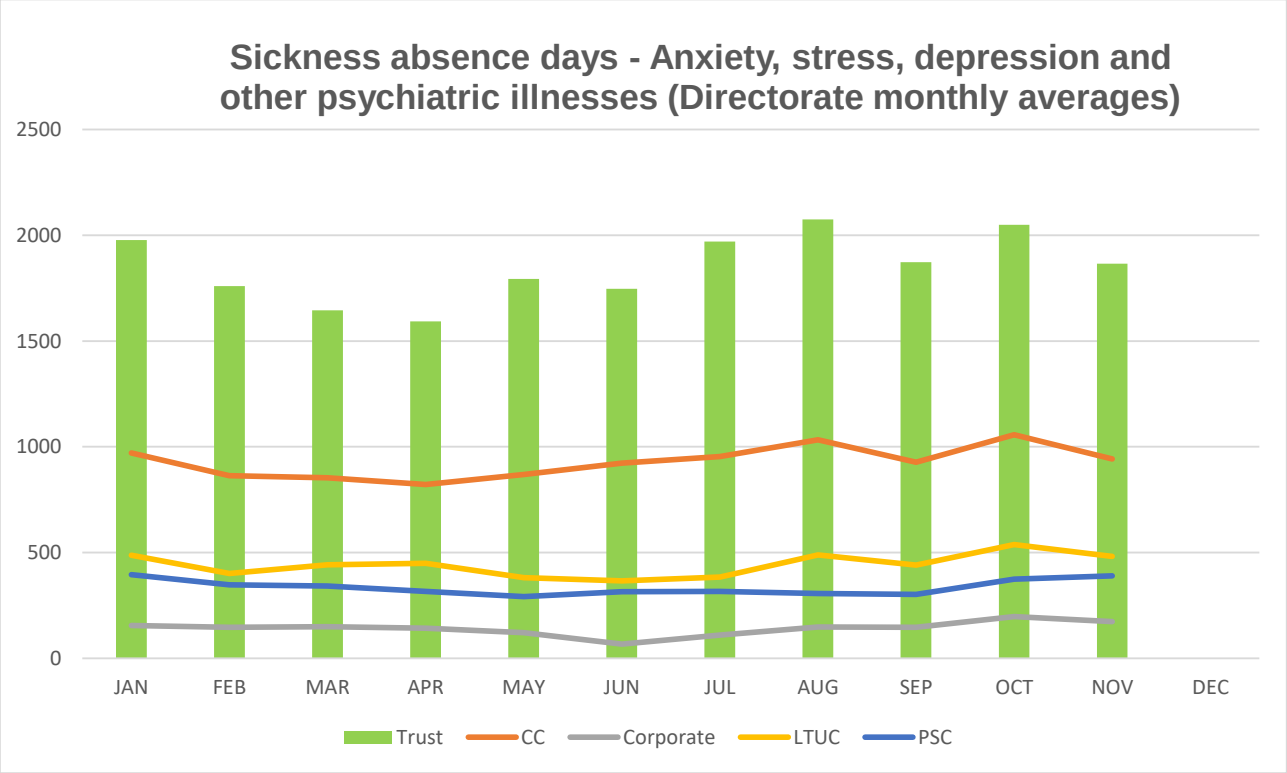
## Work-related Stress

| | |
|---|---|
| **Standard** | The Trust has effective arrangements in place to manage the risks related to work-related stress, with a focus on proactive prevention. |
| **Rationale** | The combined demands of work and home-life may result in staff at all levels being exposed to adverse levels of pressure / stress, leading to short and long term episodes of ill health, increased sickness absence, lower staff morale and poor patient care. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999 |

### What action has been taken / planned

As seen in section 5 Anxiety, stress and depression accounts for 31.56% of HDFT's monthly sickness absence. HSE statistics for 2021-2022 (across all industries) show that 51% of 1.8million new and longstanding cases of work-related ill health are as a result of stress, anxiety and depression, resulting in 17million lost days.

The NHS Staff Survey results for 2022 showed that 44.8% of staff have felt unwell as a result of work-related stress in the last 12 months, and HDFT mirrors this with 42.9%. HSE carried out a 4 year inspection campaign (2018-2022) across the NHS looking at work-related stress, the role of violence and aggression as a key stressor, and ill health outcomes such as musculoskeletal disorders.



- Trust provides a number of resources addressing wellbeing and 'domestic' stress, such as Occ. Health referrals, counselling, hardship grants, cost of living support, mental health champions etc.
- Numerous Trust policies support Health and Wellbeing practices.
- We gather a large amount of data such as sickness absence, staff turnover, employee surveys etc.
- We don't currently have a standalone policy for Managing Work-related stress, instead it is referenced in other policies.
- We have not completed a standalone Trust risk assessment for work-related stress, which could then be replicated at Directorate, division, department and where necessary on an individual basis.

In response a project has started on aligning the Trust to the Health and Safety Executives Management Standards Approach, which will allow us to address both the legal requirements of assessing the risk, creating a proactive approach to managing work-related stress, and ensuring all staff are correctly signposted to the support available.

A work-related stress workshop, run by the H&S and Occupational Health teams, has been developed and will be delivered to all teams at the Trust (the first of these took place in December 2023 and will continue in to 2024).

The workshop allows a local level identification of the causes of work-related stress based on the 6 keys areas of the Management Standards, and subsequent identification of the solutions. A post workshop evaluation and risk assessment will then determine and action plan for managing these causes on a local and wider Trust level.

## Moving & Handling

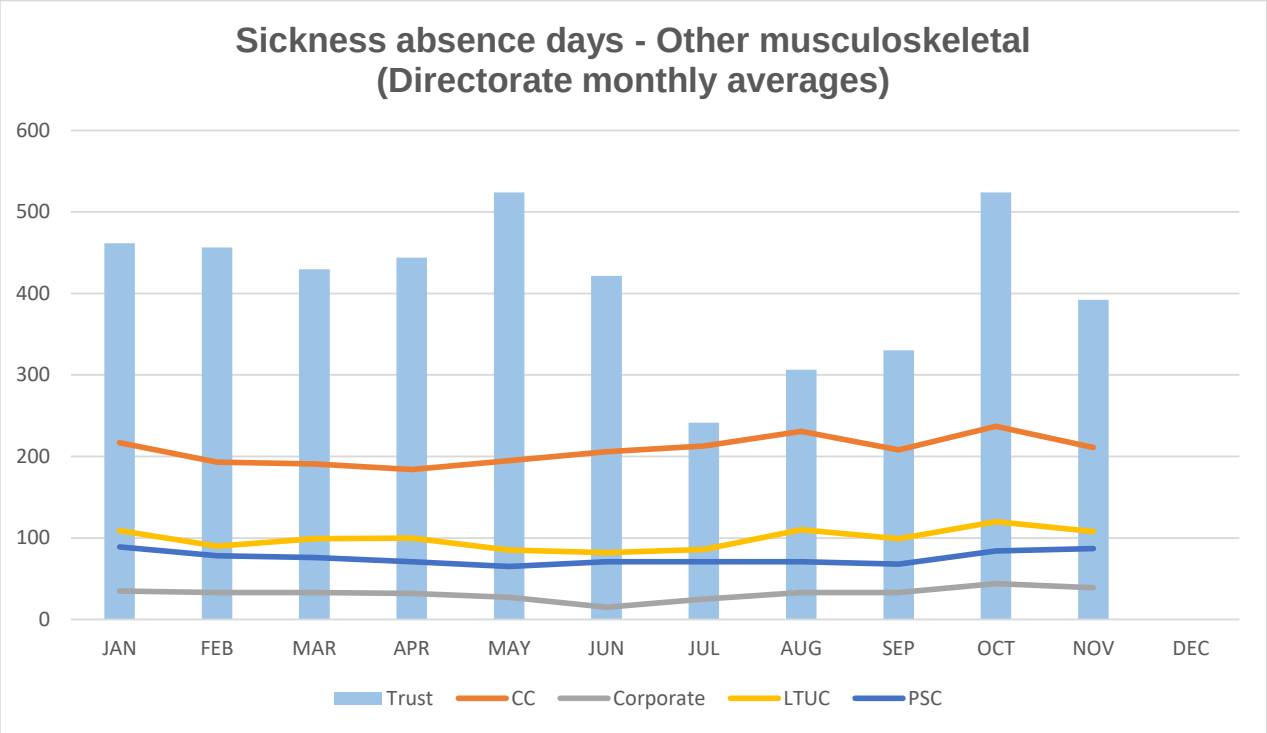
| | |
|---|---|
| **Standard** | Effective arrangements are in place to manage the risks from manual handling, both patient and non-patient related activities. |
| **Rationale** | All staff are exposed to certain manual handling activities, whether it be moving equipment, laundry, office supplies or waste to assisting in the movement of patients. Injuries and ill health relating to manual handling account for a significant amount of sickness absence at HDFT. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999<br>Manual Handling Operations Regulations 1992<br>Provision and Use of Work Equipment Regulations 1998<br>Lifting Operations and Lifting Equipment Regulations 1998 |

### What action has been taken / planned

Safe moving and handling is a significant challenge across all areas of the Trust, with the provision of suitable training and appropriate equipment to varied teams and widespread geographical locations an obstacle to ensuring patient and staff safety.

Limited resources have meant a significant backlog in Patient Moving and Handling training (both mandatory induction and refresher), uniformed types of lifting equipment are not currently in

place, and training space is limited, with particular difficulties for community based teams having to travel to Harrogate for training.



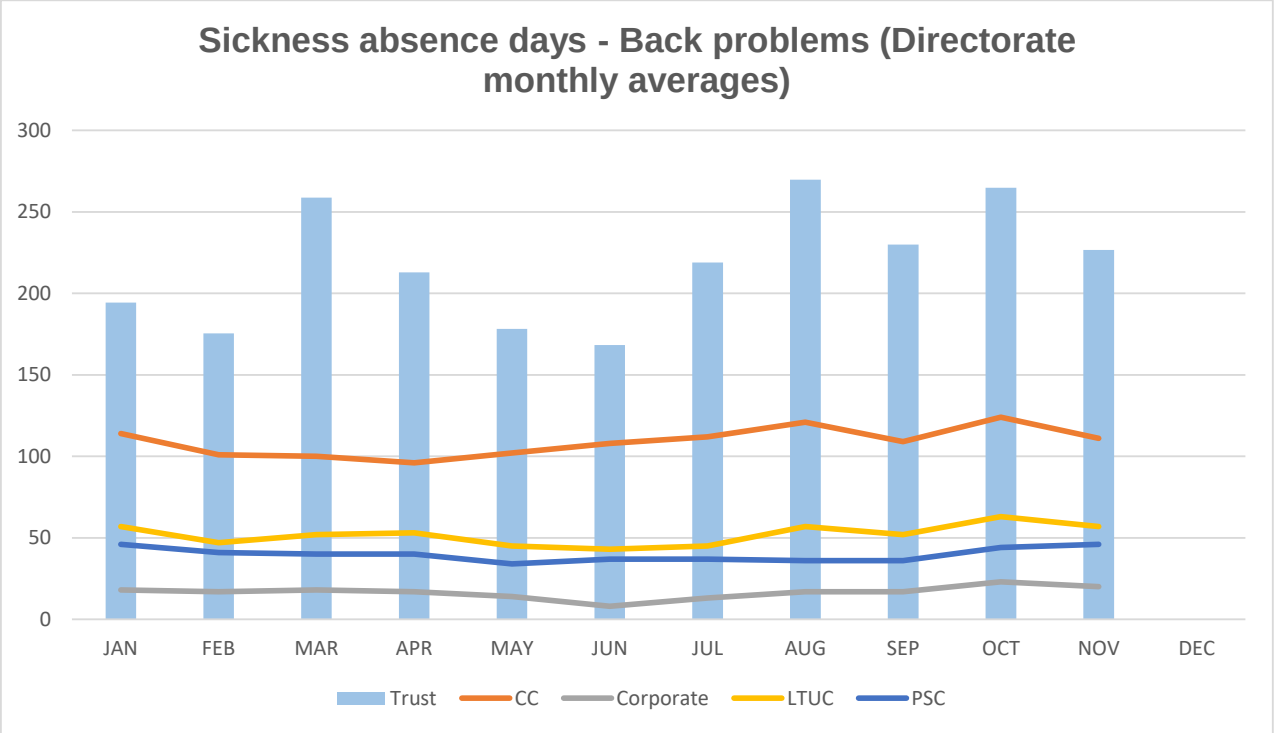

The Trust has had an independent review of the Moving & Handling Service conducted which has identified a number of recommendations:

- Frequency of MH training for clinical staff must change from 3 yearly to 2 yearly to align with the National approved CSTF Level 2 Training – now being implemented
- Provide certain high risk non-clinical staff with face-to-face MH training. However, the online learning element should take place during the induction process.
- Doctors to be removed from the Level 2 reporting and given a bespoke course every three years -with the exception of anaesthetists who should attend a practical course with emphasis on lateral transfers every two years-.
- A complete review of the content of the training must take place. All staff on induction should receive a robust face to face course and stop the online course for clinical staff on induction.
- The Moving and Handling Policy to be reviewed and updated to reflect the needs of HDFT.

In response to this review the Trust has appointed a new Moving & Handling Coordinator who took up post in September. This has resulted in an immediate review of lesson plans to align content to national standards, and best practice.

Compliance for mandatory training dropped below 70% in January 2023, this had increased to 84% in December 2023.

Changes to the delivery of some training to allow easier access for staff and attempt to reduce impact on operational activity.




Changes are also being made to develop task specific sessions, such as slide sheets and log rolling, which are supported by short video resources that can be accessed by staff through the intranet.

***In November a Slide Sheet training drop in session was held at HDH, these 15 minute sessions were attended by 61 members of staff, a further 52 were trained during ward visits by the M&H Coordinator. Two community sessions are planned before the end of 2023, and a further HDH drop in session will be held in January.***

DSE (Display Screen Equipment) assessments should be completed by all defined users and reviewed on an annual basis, there is currently no formal way of monitoring compliance, although the general acceptance is that compliance is limited, and the ways to access support are not clearly documented.

New risk assessment templates for moving and handling activities have been developed and have initially been trialled with facilities teams.

New training content for facilities teams is being produced and will be disseminated in early 2024.

## Management of Contractors

| | |
|---|---|
| **Standard** | Effective arrangements in place to manage, coordinate and supervise contractors working on behalf of HDFT |
| **Rationale** | Poorly managed contractors on site can result in fatalities, major injuries and ill health to staff, patients and visitors. |
| **Legal reference** | Health and Safety at Work etc. Act 1974 sections 2 & 3<br>Management of Health and Safety at Work Regulations 1999<br>Construction (Design and Management) Regulations 2015 |

### What action has been taken / planned

HDFT and HIF use the services of external companies to conduct work on Trust premises (approximately 130), these can range from short term contractors who may attend on an ad hoc `basis, to long term contractors who attend frequently or are based on site, such as Avensys. In addition to this there are significant Capital Works projects ongoing at this time with many others planned.

As part of these activities contractors are required to access a number patient facing areas, and at present the control of these contractors in relation to the risks their work poses to staff and patients, and the risks our work poses to them is sporadic. In addition there are concerns over patient privacy, and a lack of challenge to contractors by Trust staff as to why they are in certain areas.

Contractor incidents are not consistently reported, and supervision of the contractors work areas and behaviours is not reported centrally, audited or reviewed.

To support changes to this:

- A new Contractors Policy is being produced as well as enhanced induction procedures for all contractors attending site.
- Contractor management will also include clearly defined restrictions on access to patient facing areas, photo ID being issued for medium and long term contractors.
- Monitoring of the work will be recorded to ensure hazards are correctly managed, that contractors are following suitable risk assessments and method statements, and that impact on operational activity is considered as part of the planning process.
- DBS checks will be required as part of contractual arrangements
- HIF have recently purchased the Reset Compliance System which is a competence-verification product that will save time and resources for verifying the skills, qualifications, DBS status of contractor employees. It will also implement a required signing in process for every attendance, and allow for HDFT inductions to be carried out by contractors before arriving on site.
- The new policy and use of the Reset system will go live in early 2024.

Extensive work has been carried out by the new Estates and Health & Safety teams to put immediate controls in place for capital works projects, including reviewing contractor procedures and reviewing health and safety site audits of the work.

## Community Assurance & Support

| | |
|---|---|
| **Standard** | Effective arrangements are in place to ensure the risks to which community based teams / staff are exposed are adequately controlled. |
| **Rationale** | The geographical footprint of the community based services provided by HDFT mean that staff are exposed to a wide range of hazards in varied environments including buildings not owned/managed by HDFT and patient homes. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999<br>Workplace (Health, Safety and Welfare) Regulations 1992<br>Control of Substances Hazardous to Health Regulations 2002 |

### What action has been taken / planned

Whilst there are clear challenges in ensuring health and safety standards are met within our acute settings, this challenge is fully replicated at over 180 premises used to deliver services by our Community and Children's Directorate. This provides additional risk in how we deliver information, instruction, training, equipment and support to staff across a geographical footprint stretching from Wakefield to Berwick.

The nature of the work carried out by a number of these teams mean that many staff are experiencing in increased risk associated with lone working, home visits (challenging, uncontrolled and unpredictable environments), incidents of violence and aggression and work-related stress. This frequently leads to dissatisfaction, poor mental health, sickness absence and high staff turnover.

The initial response has focussed on:

- Face to face audits carried out by the H&S team to identify current health and safety practices in relation to their work activity, and the risks associated with the physical environment (buildings) they are working in.
- The new risk assessment process is being introduced to all community teams to ensure a consistent approach to risk management across the entire Trust.
- All immediate risks related to the environment / estate are reported monthly to the Community and Children's Estates Strategy Meeting, and escalated to the relevant landlord.
- Discussions with landlords of multiple properties, such as NHS Property Services are being held to create a standard reporting structure for routine assurance checks relating to fire safety, water safety, building security etc…
- A review of lone working procedures is being conducted by the H&S team and the Community Local Security Management Specialist, including the use of lone worker devices.

## Estates / Backlog Maintenance

| | |
|---|---|
| **Standard** | Effective arrangements in place to manage the risks associated with the physical workplace environment, and the provision of suitable welfare conditions. |
| **Rationale** | The hazards of workplace environments, such as asbestos, legionella, electricity, poor welfare (toilets, hand basins), temperature, or icy walkways can put staff, patients and others at risk of injury. |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999<br>Workplace (Health, Safety and Welfare) Regulations 1992<br>Construction (Design and Management) Regulations 2015<br>Control of Substances Hazardous to Health Regulations 2002<br>Control of Asbestos Regulations 2012<br>Electricity at Work Regulations 1989 |

### What action has been taken / planned

Establishing an accurate baseline for the site backlog position is a key driver for strategic investment planning. Backlog is also a mandatory return to NHS England as part of our annual Estates Return Information Collection (ERIC) submission.

To these ends Oakleaf Surveying Ltd carried out a backlog maintenance survey in 2022/23. The survey follows the methodology prescribed in NHSE “A Risk based Methodology for Establishing and Managing Backlog” and is in line with the requirements of HBN 00-08 “The Efficient Management of Healthcare Estates and Facilities”.

The results of the backlog survey, risk assessment and cost profile will inform the urgency of investment decisions as follows:

- Low risk elements can be addressed through agreed maintenance programmes or included in the later years of your estate strategy.
- Moderate risk elements should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- Significant risk elements require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
- High risk elements must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

A sub-group to the Environment Board is now leading on the backlog position (led by the Head of Estates and Head of H&S) to produce a detailed plan of action which will also inform our Capital Projects Planning for the next 5-10 years. Key objectives will be to:

- Correlate the identified Backlog risk score with that of the Operational impact – ongoing discussions with Operational Directors

- Focus on High and Significant risks, with the intention to address Low and Moderate risks whilst carrying out remedial action on High and Significant.
- Incorporate remedial action to address Backlog issues in all future Capital Projects.
- Breakdown large actions, such as site wide fire alarm replacement, or call bell systems, in to smaller packages that will reduce the impact on operational activity, not achieving regulatory compliance and financial constraints.

Specific work has also been begun on high risk areas, including fire, water and ventilation, roof coverings and RAAC (as detailed earlier in this section and below).

**Water Safety**

- The Trust has contracted an independent company to review and produce a new Water Safety plan and Policy, providing short term assurance and a long term plan to address the underlying backlog issues. This is now active and being implemented / monitored through the Water Safety Group.
- Hot water temperatures are not compliant for large parts of the site, and therefore additional controls have been established in the short term, including a more frequent testing and flushing regime.
- A design exercise for water quality and ventilation to validate the existing infrastructure in terms of configuration, installed equipment and alignment with current standards has commenced. This will include a cost plan for the replacement of ventilation plant, water storage and other items that have fell below an acceptable standard.

**Roof Coverings and Structural**

- Roof coverings have been a significant cause for concern and affect our theatres, A&E, Corridors and pitched roof areas during periods of inclement weather. This has the potential to significantly affect the quality of patient care and increase general site safety risks.
- Work has started in 2023 to inspect and resolve areas affected, with the focus on theatres and pitched roof areas to improve the site building integrity as part of a year on year investment programme.

## Management of RAAC

| | |
|---|---|
| **Standard** | Effective arrangements in place to manage the risks associated with the physical workplace environment |
| **Rationale** | To manage, monitor and mitigate the risks associated with the uncontrolled collapse of RAAC (Reinforced Autoclaved Aerated Concrete), and ultimately eradicate the presence of RAAC from HDFT premises (owned and |
| **Legal reference** | Health and Safety at Work etc. Act 1974<br>Management of Health and Safety at Work Regulations 1999 |

### What action has been taken / planned

RAAC planks are believed to have been used in the UK since the late 1950s, widely used for roofing but also for walls, partitions, and floors until 1982. In the early 1990s general concerns were raised over the structural adequacy of RAAC panels by some structural engineers and some national/local government bodies, particularly with regard to planks made before 1980.

Harrogate Hospital is understood to be constructed from second-generation RAAC panels, which have been known to perform better than their predecessors, but still have associated risks of excessive deflection and if installed or manufactured incorrectly, a risk of failure.

Following a RAAC roof collapse (at another NHS Trust) and the resulting safety reporting, NHSE has instructed the investigation of all healthcare estates with RAAC panel construction, with the following key objectives/deliverables:

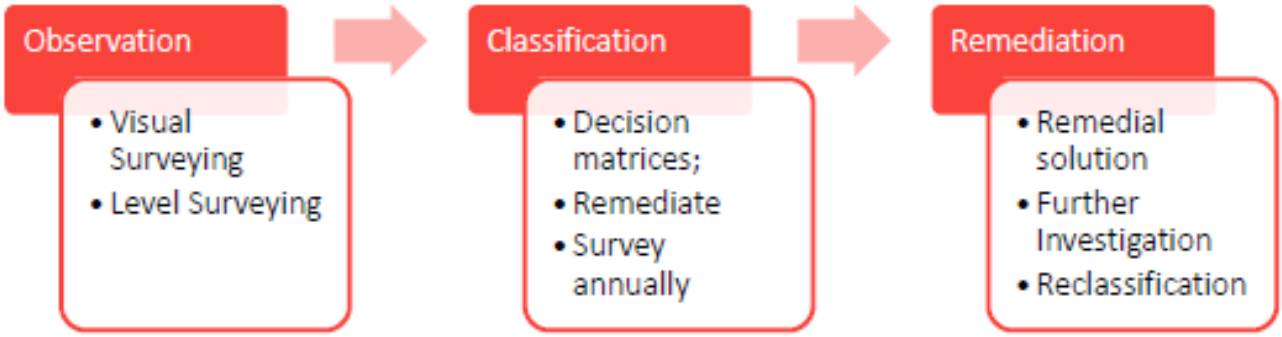
- Plan showing the location of every RAAC panel with a unique identifier
- Visual Inspection of every plank to determine:
    - Deflection
    - Spalling
    - Cracking
    - Water ingress
    - Non-standard panels

Year 1 surveying of the HDH site by a structural engineer was completed, including of deflection surveys. The resulting report has identified the need to take extensive remedial action to a number of areas in line with changing National Guidance.

Structural support work has been completed on a number of areas across the HDH site, with designs in place to carry out further work in line with the recommendations of the Year 1 report, including:

- Designs for new structural netting to be installed in the Energy Centre have been agreed and work will progress on this over the next 2-3 months.
- Work to eradicate RAAC from others areas is being designed and costed, intention to begin some of this work in early 2024.

In 2024 we will continue monitor and assess the condition of the RAAC panels, the mitigation measures installed and the carry out any newly identified remedial action with a view to eradicate RAAC from the HDH site by 2030, in line with the process below.




Due to the extent of RAAC in block C, detailed plans are being actioned to de-camp all service provision from Therapy Services and Silverdale, with some services being provided away from the HDH site, it is intended that these moves will be completed by March 2024. Work to then eradicate this area of RAAC will form part of the enabling works to allow for the development of this area going forward.

Additionally the landlords of all premises used by HDFT staff have been contacted to ascertain the RAAC status of these buildings, and if present what, if any, actions need to be taken to protect HDFT staff and others. Assurance has now been received from 90% of Community landlords regarding the RAAC status of these buildings.

## Health and Safety Risk Register Entries - December 2023

| | |
|---|---|
| **CHS1 – Identification and Management of Risk** | Organisational risk to compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others. |
| **CHS2 – HDH Goods Yard** | Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance. |
| **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 due to the failure to ensure that suitable and sufficent assessment of the risk from fire has been carried out, and that the necessary control measures are in place. |
| **CHS4 – Control of contractors / construction work** | Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises. |
| **CHS5 - Violence and Aggression** | 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. |
| **CHS6 – Moving & Handling** | Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others due to failure to provide suitable and sufficient training for moving and handling. |
| **CHS7 – Community Services** | Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others due to the failure to ensure H&S standards, procedures and control measures are in place for Community based staff/services. |
| **CHS8 – RAAC Roofing** | 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. |

# 8. HEALTH & SAFTEY PRIORITIES FOR 2024



### Commitment to a Culture of Continuous Improvement

At HDFT we are committed to ensure health and safety standards are raised to acceptable levels, achieving legal compliance and matching industry best practice, whilst also striving for Continuous Improvement that will ultimately lead to HDFT being an exemplar for health and safety management within the NHS and beyond. As an organisation we are implementing HDFT Impact which will provide the standard Continuous Improvement methodology to support all staff to take action at the right level to make improvements.

As such we have selected the following four key priorities for 2024 that will support our Trust Strategic Ambitions, whilst also targeting high risks activities faced by our staff and others.

- Work-Related Stress
- Moving and Handling
- Violence and Aggression
- Physical Working Environment

This does not mean that we will not continue to work towards improvement in other areas as shown in Section 7, however we will prioritise our effort in these four areas as those that can have the biggest impact on the health, safety and wellbeing of our staff, patients and others.

## WORK-RELATED STRESS

### Strategic Ambition Making HDFT the Best Place to Work

### Aims for 2023-2024

The aim for 2024 is to continue to progress implementation of the HSE Management Standards Approach across the Trust.

### Objectives

The objectives for 2023-2024 include:

- Work-related stress workshops delivered to all teams.
- Risk assessments and action plans produced locally for each team.
- Follow-up sessions held with teams to view progress and identify barriers to improvement.
- Workshop held with Senior Management Team to promote and support senior participation in the process and to embed change where appropriate.
- Collection and analysis of team feedback to identify common issues and to evidence wider organisational changes.
- Review of relevant policies / procedures to ensure they reflect the new approach.
- Review and develop the competencies of staff to better manage the causes of stress with a focus on prevention.

### Performance measures

- Sickness Absence Days and associated salary costs
- Impulse staff surveys

- NHS Staff Survey
- Datix incidents associated with trauma or known stressors such as violence and aggression

## MOVING AND HANDLING

### Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

### Aims for 2023-2024

The aim for 2024 is to continue the work of 2023 to implement changes in to the way provide the Moving and Handling service across the Trust.

### Objectives

The objectives for 2024 include:

- Implement changes to mandatory training to align with nationally approved CSTF Level 2 Training.
- Change the delivery of the training to reflect the diversity of the Trust, both in the types of services delivered and the geographical setting.
- Review the content / syllabus of the training provide to reflect the level of risk associated with the activity.
- Review the Moving and Handling Policy, changes to reflect the activities of HDFT staff.
- Implement new moving and handling risk assessments to all teams, and implement suitable and sufficient control measures consistently across the Trust.
- Ensure all moving and handling equipment / aids are maintained and safe to use.
- Continuing review of available data to target high risk areas, such as patient handling, and targeting training to address common activities.
- Review of policies and procedures in place to manage Plus Size Patients (previously called bariatric patients)
- Changes to the monitoring of Display Screen Equipment users assessments to improve workstation design and use.

### Performance measures

- Sickness Absence Days and associated salary costs
- Datix incidents
- Moving and handling training compliance
- Staff / Patient harm incidents
- RIDDOR reportable injuries

## VIOLENCE AND AGGRESSION

### Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

### Aims for 2023-2024

The aim for 2024 is to continue the work of 2023 to implement changes in to the way we manage the risks associated with violence and aggression.

### Objectives

The objectives for 2024 include:

- Review and update of all policies, including Violence & Aggression, Lone Working, Security and Managing patients at Risk from Self-harm.
- New procedures for supporting staff in providing care to patients with mental health issues and existing medical conditions such as dementia.
- New training provision for all staff on a risk based approach, with a focus on de-escalation skills.
- Escalation procedures for staff to follow in relation to V&A incidents.
- Lone working procedures fit for purpose for all staff groups in all locations.
- Benchmarking the Trust against the NHS Violence Prevention and Reduction Standards.
- Develop a new HDFT Violence Prevention and Reduction Strategy (3-5 year strategy, including collaboration with external partners / stakeholders)
- Create new risk assessments relating to violence and aggression.
- Support other reviews, including Lockdown Policy, Counter-Terrorism Training and response to Major Incidents.
- Deliver new training relating to ligature risk, safe use of ligature cutters and wellbeing support for traumatic events.

### Performance measures

- Sickness Absence Days and associated salary costs
- Datix incidents
- Violence & Aggression related training compliance
- Staff / Patient harm incidents
- RIDDOR reportable injuries

# PHYSICAL WORKING ENVIRONMENT

## Strategic Ambition Best Quality & Safest Care / Making HDFT the Best Place to Work

### Aims for 2023-2024

The aim for 2024 is to continue the work of 2023 to carry out improvements to the physical working environment through addressing the backlog maintenance position as well as identifying and controlling risk associated with fire, water safety and others.

### Objectives

The objectives for 2024 include:

- RAAC response – Year 2 surveying and monitoring, remedial work to at risk RAAC panels, management of service moves from Therapy Services and Silverdale.
- Planning of backlog maintenance schedules to be incorporated in to Capital Projects Strategy.
- Continuation of new fire risk assessments for all HDFT premises. Remedial action in response to assessments.
- Production of new evacuation plans for all areas.
- Remedial action / replacement of fire alarm system, fire doors, compartmentation across HDH site.
- Implementation of new Water Safety Policy, review of existing mitigation measures, monitoring of sampling results.
- Risk assessment of associated risks such as water leaks – slips, trips and falls, infection control etc…
- Increased training relating to fire, water safety.
- Improvements to general welfare provision for staff, temperature access to drinking water etc…

### Performance measures

- Datix incidents
- Fire safety training compliance
- Health and safety audits of capital works projects
- Contractor monitoring / job reviews

Harrogate and District NHS Foundation Trust

4

# Strengthening Maternity and Neonatal Safety Report

## SMT

## February 2024

| | |
|---|---|
| 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 February as set out in the Perinatal Quality Surveillance model (Ockenden, 2020). | |
| Trust Strategy and Strategic Ambitions | **The Patient and Child First**<br>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<br>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 February 2024 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 experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8). Regional survey received by LMNS indicating some issues at Trusts with completion of intimate examinations without appropriate consent. Request for downgrade of Ockenden compliance until assurance received. Some local patient feedback about insufficient informed consent and additional historic claims received about informed consent for mode of delivery, which is not supported by documentary evidence. Planned time out days to improve awareness, highlight and remove barriers and plan progress steps to be made.

## 6.0 Recommendation

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

# Maternity – March 2024 (February's data)

| Matters of concern & risks to escalate | Major actions commissioned & work underway |
|---|---|
| • Informed consent – emerging theme from concerns/complaints/claims/regional team | • Saving babies lives care bundle version 3 – work on-going to meet requirements<br>• In-house stop smoking service in development – Tobacco Dependency Advisors in post in March<br>• Data quality in Badgernet work on-going –Band 4 started in post in March<br>• Core Competency framework v2 business case undergoing further development<br>• 4D scanning private service commencing in March<br>• SCORE culture survey circulated as part of NHSE Perinatal Culture and Leadership Programme.<br>• BaBi Harrogate research project –recruitment to study commenced<br>• Single Point of Contact for maternity to be launched in March<br>• NICE compliance – progressing assessments – 2 remain to be reviewed.<br>• Pelvic Health project work underway – recruited midwife with external funding to commence in April<br>• Creating Baby Carousel with MVP<br>• Birthrate Plus establishment setting review commenced<br>• Creating Annual Leave SOP<br>• NHSE Estates survey<br>• Initial update received from NHSR regarding requirements of Maternity Incentive Scheme Year 6. |
| **Positive news & assurance** | **Decisions made & decisions required of the Board** |
| • No new MNSI cases reported<br>• No on-going PSII investigations | |

**Narrative in support of the Provider Board Level Measures – February 2024 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 Patient Safety Incident Investigations (PSIIs) 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-about
    - MNSI/NHSR/CQC concerns
    - Coroner Regulation 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 February 2024.

## 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). A Birthrate plus establishment setting review is planned to be completed in spring 2024.

### 3.1 Absence position

Unavailability of midwifery staff hours –
5.71 WTE sickness absence (theme – cough/cold/flu/ENT) (7.5%)
4.39 WTE maternity leave (5.8%)

Unavailability of Maternity support worker hours –
1.01 WTE sickness absence
1.16 WTE Maternity leave

### 3.2 Vacancy position

Currently there is zero midwifery and maternity support work vacancy.

### 3.3 Turnover

January twelve month rolling rates –
Midwives 6.5%
Maternity support workers 29.78%

### 3.4 International Midwifery Recruitment

Both internationally recruited midwives have received their NMC PIN number and continue working supernumerary.



### 3.5 NHSP provision

Midwives -
3.5 WTE NHSP midwifery staffing used in February 2024


Support workers –
3.42 WTE NHSP maternity support worker staffing has been used across maternity in February 2024.


### 3.6 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.

Thirteen homebirths were booked for the month of February 2024. Four women were attended and birthed at home, three women choose to birth in the hospital and six women were still pregnant at the end of February.

In the period 01/02/24 – 29/02/24, the home birth provision was suspended for a 36 hour period 24-25th due to high activity.



**4.0 Neonatal services Special Care Baby Unit (SCBU) staffing, vacancies and recruitment update**

**4.1 Neonatal absence position**

0.92 WTE nurse currently on maternity leave.
0.77 WTE nurse long term sickness absence

**4.2 Neonatal Vacancy**

No neonatal vacancy at present.

**4.3 Neonatal Recruitment**

1 WTE Qualified in Speciality (QIS) nurse recruited but not yet in post.

**4.4 Qualified in Speciality (QIS) Nurses**

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

Staffing met the acuity 56% of the time during February 2024. 60% (97 occasions) of the time no clinical actions were required. 40% (64) of the occasions clinical actions were required, these included:

| | | | |
|---|---|---|---|
| **CA1** | Delay in commencing IOL (Inpatient) | **13** | **17%** |
| **CA2** | Delay in continuing IOL | **54** | **69%** |
| **CA3** | Delay in EL LSCS (delivery suite) | **1** | **1%** |
| **CA4** | Postponed IOL (at home) | **6** | **8%** |

| | | | |
|---|---|---|---|
| **CA5** | Delivery Suite coordinator not supernumerary | **4** | **5%** |
| | Total | **78** | |

Delivery Suite Coordinator not supernumerary on one occasion but quickly escalated and use of specialist midwife implemented.

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. No women had a baby born before the arrival of a midwife.

### 5.2 Pannal Ward Staffing

The Birthrate plus Ward Acuity App was reintroduced on the 31st December. This enabled data entry throughout February 2024 and found a 60% confidence level in the data submitted. The minimal suggested level of compliance is 85% to enable confidence in the data and for representative interpretation to be made. Completion of the data has reduced this month due to an increased acuity however communications have been circulated to reiterate the importance of completion.

During February 91% of Midwifery day shifts and 90% of night shifts were covered with contracted hours. 9% of Midwifery day shifts and 10% night shifts were covered with NHSP.

MSW day shifts were covered 60% with 75% of them with contracted hours and 25% with NHSP. MSW night shifts were covered 69% with contracted hours and 31% with NHS.

Staffing versus workload and Red Flag functions remained unavailable as this is under development by the Birthrate Plus team.

## 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, sometimes numerous Red Flags can occur at the same time. There were five Red Flags recorded during February 2024 as follows -

| | | | |
|---|---|---|---|
| **RF1** | **Delayed or cancelled time critical activity**<br>MROP Em LSCS (Cat 1,2 as per National guidance) 3rd/4th degree tear Delay in continuing with IOL process (in-patient) | **0** | **0%** |
| **RF2** | **Missed or delayed care**<br>>60 minutes for suturing (except after pool birth) See unit crib sheet | **2** | **40%** |

| | | | |
|---|---|---|---|
| **RF3** | **Missed or delayed medication > 30 mins**<br>Medication not given within 30 mins of prescription Low molecular weight heparins, anticoagulants Pain relief following surgery Antihypertensives Epileptic meds Glycaemic control IV Abx - mum or baby | **0** | **0%** |
| **RF4** | **Delay in providing pain relief > 30 mins**<br>Delay of > 30 mins in providing pain relief where requested | **0** | **0%** |
| **RF5** | **Delay between presentation and triage >30 mins** | **0** | **0%** |
| **RF6** | **Full clinical examination not carried out when presenting in labour** | **0** | **0%** |
| **RF7** | **Delay between admission for induction and beginning of process** | **1** | **20%** |
| **RF8** | **Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)**<br>Where the midwife has not escalated within 30 mins (not delay due to medical response time) | **0** | **0%** |
| **RF9** | **Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour**<br>'labour' defined as 'any woman on a partogram' | **0** | **0%** |
| **RF10** | **Midwife unable to provide 1:1 high dependency care for AN or PN patient** | **2** | **40%** |
| | Total | **5** | |

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. Please note that although unit on divert is noted on six occasions this related to two episodes of unit diversion.

Number and percentage of management actions taken from 01/02/2024 to 29/02/2024 –

| | | | |
|---|---|---|---|
| **MA1** | Redeploy staff from Pannal | **30** | **57%** |
| **MA2** | Staff unable to take breaks | **8** | **15%** |
| **MA3** | Review of staff on management time | **1** | **2%** |
| **MA4** | Use of specialist midwife | **2** | **4%** |
| **MA5** | Use of staff on training days | **0** | **0%** |
| **MA6** | Use of ward/department managers | **2** | **4%** |
| **MA7** | Staff sourced from wider Trust (theatre & CSW's) | **0** | **0%** |
| **MA8** | Use of hospital MW on call | **4** | **8%** |
| **MA9** | Use of community MW | **0** | **0%** |
| **MA10** | Unit on Divert | **6** | **11%** |
| **MA11** | Patient diverted | **0** | **0%** |
| | Total | **53** | |

### 6.3 Pannal Ward Red Flags

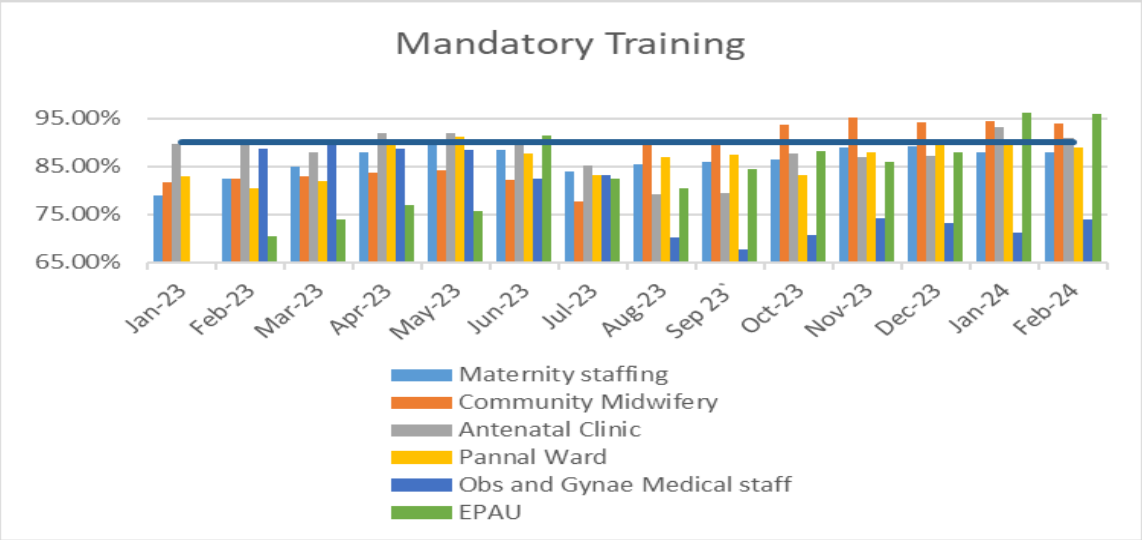
Three Red flags were raised following delay in induction of labour.

## 7.0 Appraisals

| Department | Assignments Appraised | Assignment Count | Percentage Compliant |
|---|---|---|---|
| Obs & Gynae - Medical Staffing | 10 | 15 | 67% |
| Ante Natal Clinic | 9 | 12 | 75% |
| Community Midwifery | 17 | 20 | 85% |
| Maternity Staffing | 43 | 49 | 88% |
| Pannal Ward | 17 | 19 | 89% |
| Early Pregnancy Assessment Unit | 5 | 5 | 100% |
| Total | 101 | 120 | 84% |

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

### 8.1 Mandatory training (as at 01/03/24)

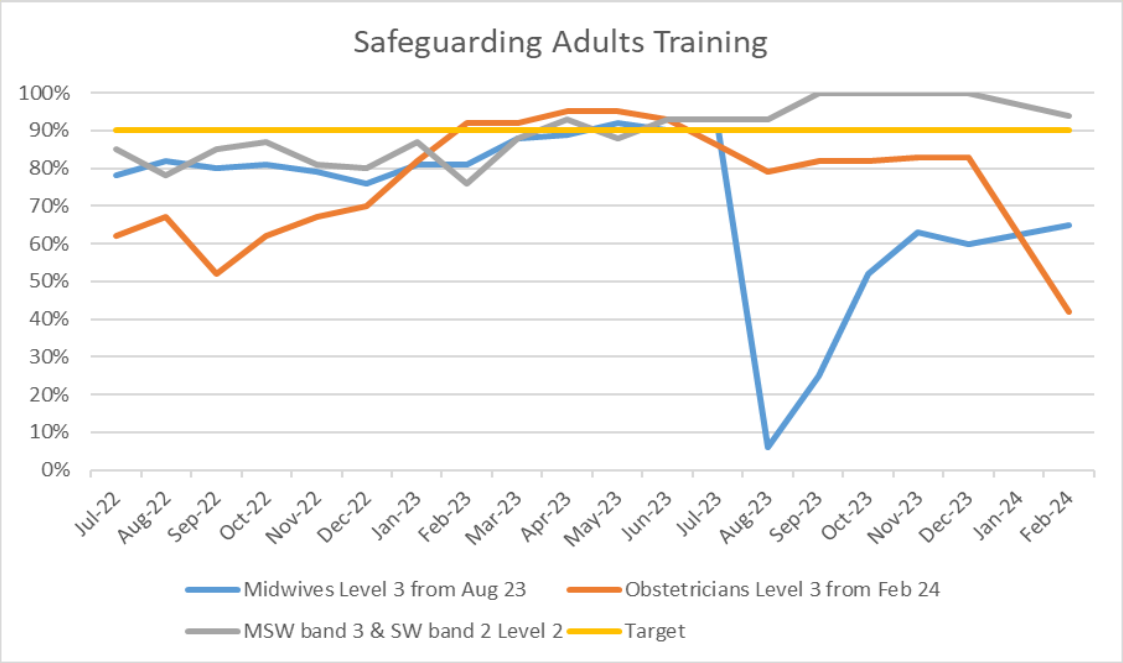


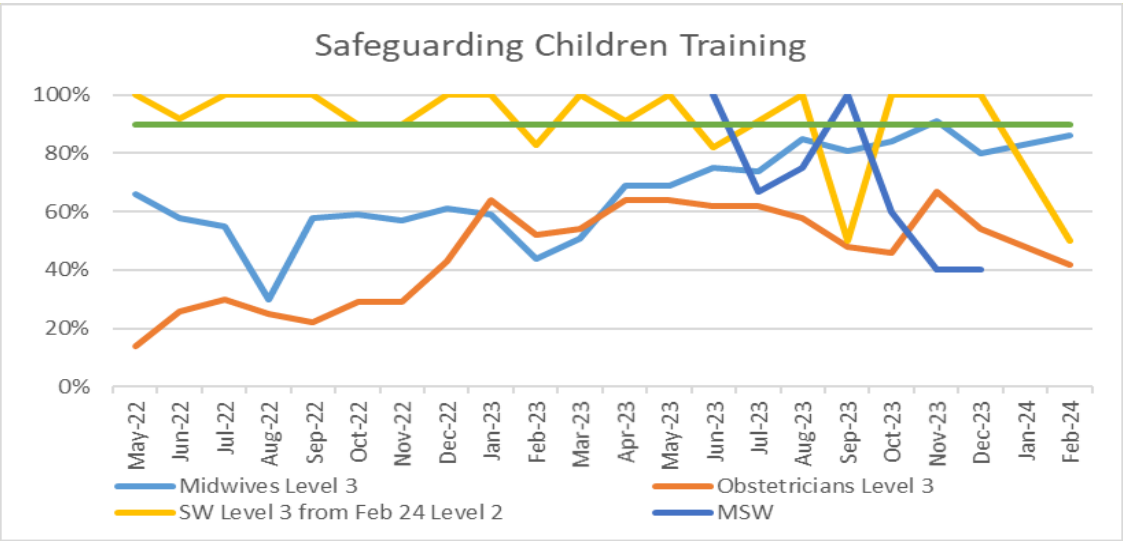

### 8.2 Maternity Incentive Scheme and Core Competency version 2 Training Compliance

| Courses to include: | Obstetric Consultants / 8 | Obstetric other | Midwives / 89 | MSW 18 | Anaesthetists Consultant 11 | Anaesthetists other 9 |
|---|---|---|---|---|---|---|
| Adult Basic Life Support with paediatric modifications | 6/8 75% | 70% | 62/65 95% | 100% | n/a | n/a |
| Harrogate Newborn Advanced Life Support (HNALS) | n/a | n/a | 9/10 90% | n/a | n/a | n/a |
| Harrogate Newborn Intermediate Life Support (HNILS) | n/a | n/a | 92% | n/a | n/a | n/a |

| | | | | | | |
|---|---|---|---|---|---|---|
| MAT - Growth Assessment Protocol (GAP) | 5/8 62% | 6/8 75% | 88% | n/a | n/a | n/a |
| MAT – K2 CTG | 100% | 100% | 97% | n/a | n/a | n/a |
| MAT – Maternity Training Day 2 | 6/8 75% | 100% | 99% | n/a | n/a | n/a |
| MAT - Prompt | 100% | 14/17 82% | 94% | 94% | 100% | 100% |
| MAT - Saving Babies Lives | 7/8 87% | 7/8 87% | 85/91 93% | n/a | n/a | n/a |






### 8.3 Additional requirements

Birthing pool evacuation training 74% compliance.
Safeguarding supervision is now at 80%.

### 9.0 Risk and Safety

### 9.1 Maternity unit closures

There has been two events of closure of the unit in February 2024. Three women were transferred to other units for care during these closures, Two women went on to give birth.

### 9.2 Maternity Accepted Diverts

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. During the month of February one woman was captured in local paper records as being transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process and labour care. This figure is reduced this month due to increased staff sickness affecting our ability of offer mutual aid. Work is on-going to see if this data can be more accurately captured from the electronic systems in place.

### 9.3 Maternity Risk register summary

One new risk has been added to the risk register in February. Three risks have been archived. Six pre-existing risks remain.

New Risk:

- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8)**. Regional survey received by LMNS indicating some issues at Trusts with completion of intimate examinations without appropriate consent. Request for downgrade of Ockenden compliance until assurance received. Some local patient feedback about insufficient informed consent and additional historic claims received about informed consent for mode of delivery, which is not supported by documentary evidence.

Pre-existing risks:

- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).** Joint work continuing to support administrative team. Ongoing support plans in place.
- **Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 9).** Plans ongoing for increased capacity with planned theatre expansion in October/November. Pressure on lists remain but being managed as required. No change at present.
- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 6).** For assurance of WebV training compliance and process for inpatient checking of WebV. No current change in risk level.
- **Risk to patient safety through lack of midwife compliance with Level 3 safeguarding training requirements (Score 6).** Good improvement in compliance rates. Action plan in place. Risk to remain active until evidence of sustained compliance over 90%. Risk level currently remains unchanged.
- **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. Situation currently unchanged. For future discussions about being able to support.
- **Risk to ability to diagnose preterm labour due to national shortage of Hologic fetal fibronectin (FFN) cassettes (Score 4).** Additional FFN tests received. Attempts to rationalise use with prior qualitative test. Stocks were suggested to be available by end Jan 2024. Risk downgraded but to keep open until assurance that stocks back to normal.

### 9.4 Maternity Incidents

In February 2024 there were 53 total incidents reported through Datix (one rejected as duplicate). One incident reported as Moderate Harm (return to theatre for repair of a broken down episiotomy); one incident reported as Severe Harm (hysterectomy following undiagnosed placenta accreta).

One current PSII investigation (previously reported), for neonatal death of a 35+2 week baby still awaiting finalisation.

Additional incidents of note include:

- 7 unexpected Term Admissions to SCBU [one duplicate] (including two Datixes submitted relating to baby admitted following collapse in skin-skin 35 minutes post-birth. Additional work planned in relation to signage, and plan for mandatory discussion of safe skin-skin. Baby required prolonged period of respiratory support for diagnosis of PPHN and RDS, and 5 days antibiotics for suspected sepsis; three babies admitted for oxygen support due to grunting and low saturations; one baby admitted for intensive phototherapy for jaundice at 15 hours of age)
- 5 Readmissions of mothers & babies (all relating to readmissions of babies – four with weight loss, one baby readmitted with jaundice). Recent issues have been noted with incorrect documentation and measurement of birthweight resulting in unnecessary readmission.
- 5 incidents relating to Incorrect treatment/tests/procedures. Includes one incident relating to management of growth chart [actually correct management]; two with incorrect birthweight documented; one with missed postnatal care as send to out-of-area team; one with lack of jaundice documentation and inpatient biliflash
- 4 incidents of PPH≥1500ml
- 3 Elective LSCS undertaken in Delivery suite theatre due to lack of capacity and main theatre list overrun
- 2 issues of delayed induction of labour
- 1 incident of placenta accreta diagnosed at elective LSCS (for breech/placenta praevia) and requiring hysterectomy to manage.

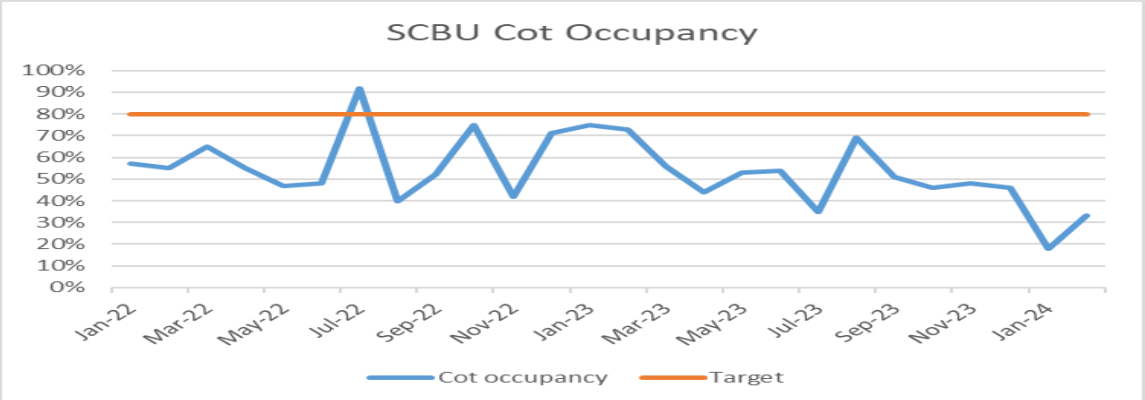
### 9.5 SCBU Incidents

No moderate harm incidents.

### 9.6 SCBU Risk Register

No new risks.

### 9.7 Cot occupancy and babies transferred out




Twins born at 28 weeks transferred out for ventilation.

## 10.0 Perinatal Mortality Review Tool (PMRT)

### 10.1 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 <500g if the gestation at birth is not known;
- 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.

### 10.2 HDFT PMRT Information

One PMRT review and report completed for previous case of neonatal death subsequent to known fetal abnormality. No outstanding PMRTs.

## 11.0 Service User feedback

**11.1 Maternity service user feedback –**

A Maternity Voice Partnership service user focus group was held on the 8th February with a specific focus on caesarean section. A couple of members of staff were noted to be ‘brilliant’ and ‘amazing’ and community midwives were also noted to be ‘lovely’. There were a number of suggestions for how care could be improved and actions will be taken to resolve the issues raised. Examples of suggestions made include having a chair in the bathroom, having hooks on the doors for clothes, and having access to a full length mirror if wished. It was noted that women wanted staff to introduce themselves, be given more information on recovery and aftercare, and for the staff to consider the psychological effects of having a caesarean section on the woman and family.

**11.2 SCBU feedback** –

Absolutely blown away by the care from the SCBU team. We couldn’t have got through it all without them and will be sad to leave them. Although we are super happy to be going home and they have given us so much confidence as parents.

10/02/2024 10:51

It is very scary being told your baby is going into ‘specialist’ care but the staff on the ward are very reassuring and professional.

### 12.0 Staff feedback

The Maternity Transformation Programme is providing each maternal and neonatal team with an opportunity to undertake an assessment of their safety culture as part of the Perinatal Culture and Leadership Programme.

Everyone working in and with maternity services have been invited to complete a 'culture survey' which asks what it feels like to work in maternity services in HDFT and what our culture feels like to them.
Following the survey an independent Culture Coach will support us to hold cultural conversations. Cultural conversations are facilitated group discussions held with teams with the aim of:

- Sharing the culture survey results and allowing teams to reflect on and discuss a collective picture of what they have said about the work culture
- Facilitating collective sense-making, by allowing staff to share and hear different perceptions to build understanding and connection around the results

The survey closes on the 17th March 2024.

### 13.0 Complaints

No formal complaints received in February. One patient concern for feedback to local MP requesting update of actions following CQC inspection. Additional concerns logged with Patient Experience Team relating to inability to contact ANC clerks and follow up about scan appointments. Two complaints awaiting formal consent, including one follow up from patient meeting about discrimination around her care in labour and postnatally (patient meeting has already been conducted with Consultant and Associate Director of Midwifery).

### 14.0 Coroner 28 made directly to Trust

No Regulation 28 notifications have been received.

### 15.0 Request for action from external bodies – NHS Resolution, MNSI, CQC

No new requests for action have been received from NHS Resolution, MNSI or the CQC.

### 16.0 Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents reported in February 2024. No open cases. A MNSI Quarterly review meeting occurred January 2024.

### 17.0 Maternity incentive scheme – year five (NHS Resolution)

Work continues to embed the actions taken for tear five of the scheme. Initial communication has been received regarding year six requirements however the full released of requirements is due to be released in April 2024.

## 18.0 National priorities

### 18.1 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<br><br>**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<br><br>**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<br><br>**Objective 3 - Work with service users to improve care** | |
| Theme 2: Growing, retaining and supporting our workforce<br><br>**Objective 4 - Grow our workforce** | |
| Theme 2: Growing, retaining and supporting our workforce<br><br>**Objective 5 - Value and retain our workforce** | |
| Theme 2: Growing, retaining and supporting our workforce<br><br>**Objective 6 - Invest in skills** | |
| Theme 3: Developing and sustaining a culture of safety, learning and support<br><br>**Objective 7 - Develop a positive safety culture** | |
| Theme 3: Developing and sustaining a culture of safety, learning and support<br><br>**Objective 8 - Learn and improve** | |
| Theme 3: Developing and sustaining a culture of safety, learning and support<br><br>**Objective 9 - Support and Oversight** | |
| Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care<br><br>**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<br><br>**Objective 11 - Data to inform learning** | |
| Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care | |

| | |
|---|---|
| **Objective 12 - Make better use of digital technology in maternity and neonatal services** | |

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

**18.2** **Ockenden** – No update this month

**18.3** **Continuity of Carer** – No update this month

**18.4** **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 was included in the requirements for Maternity Incentive Scheme Year 5. The programme included a series of workshops and action learning sets which commenced in October 2023 and provided 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 has commenced and feedback sessions are planned for Quarter 1.

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

Regional data for Harrogate for Quarter 2 (2023/24) shown against other Y&H Trusts can be found at Appendix A.

In summary:

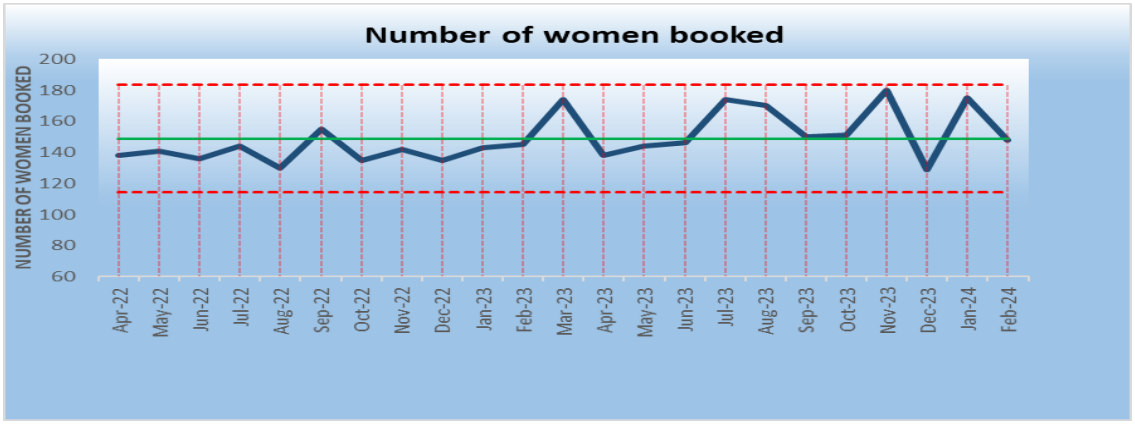
- Bookings less than 10 weeks are 68.7%. Y&H average 66.6%. No Y&H Trust has yet met the 90% target.
- 1:1 care in labour for HDFT was 95.4% in Q2. Y&H average 87.4%
- BBA rate 1.2% is comparable to the Y&H average of 1.0%.
- Homebirth rate currently 0.2%, against Y&H average of 1.5%
- Normal delivery 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%).

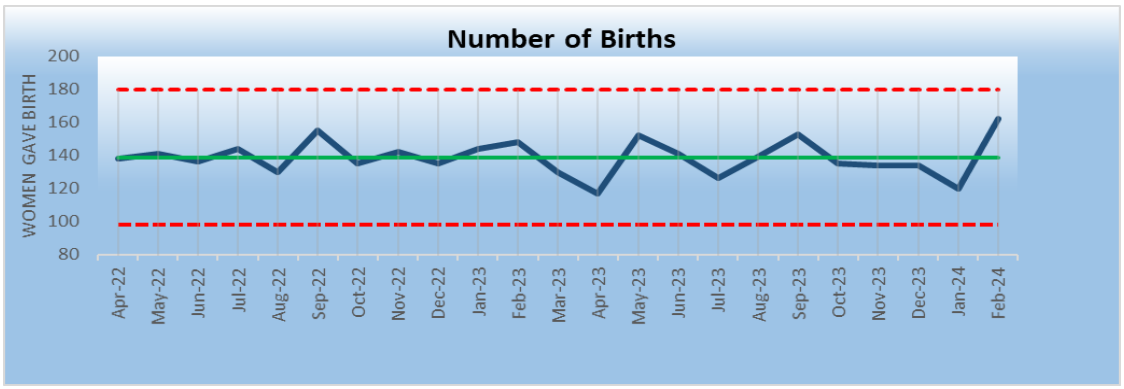
- There were no stillbirths at HDFT in Q2. Annual antenatal stillbirth rate is currently 2.4 per 1000 births compared with the Y&H average of 3.7 per 1000.
- Breastfeeding initiation rates remain high at 81.1% compared with the regional average of 70.7%.
- Smoking rates at booking and time of birth are 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%.

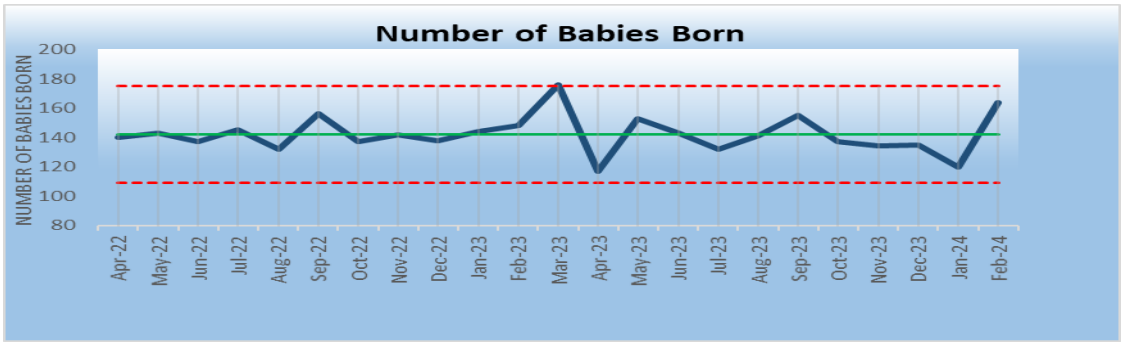


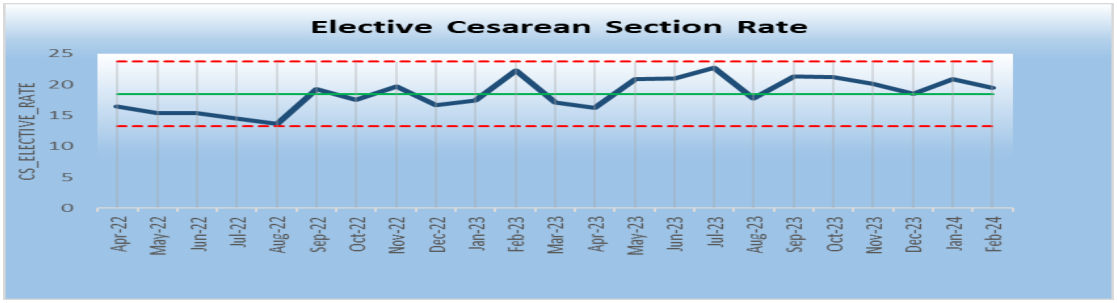
### 20.0 Local HDFT Maternity Services Dashboard

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




Elective Cesarean Section Rate
CS_ELECTIVE_RATE
25
20
15
10
5
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
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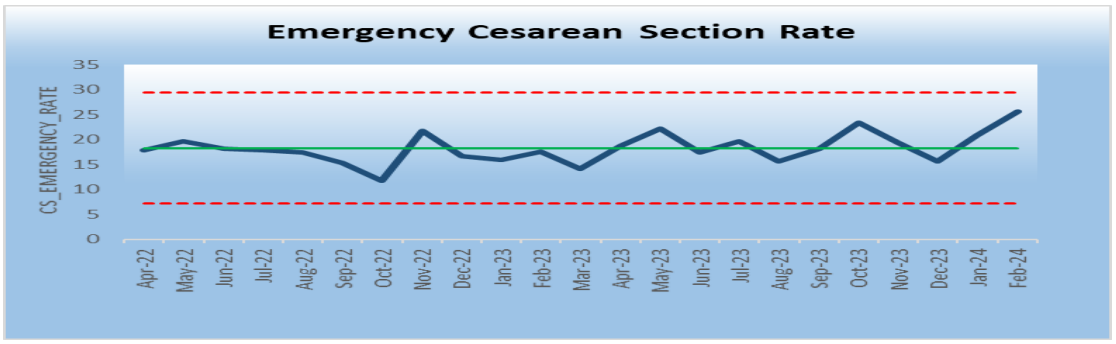
Dec-23
Jan-24
Feb-24


Emergency Cesarean Section Rate
CS_EMERGENCY_RATE
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30
25
20
15
10
5
0
Apr-22
May-22
Jun-22
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Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
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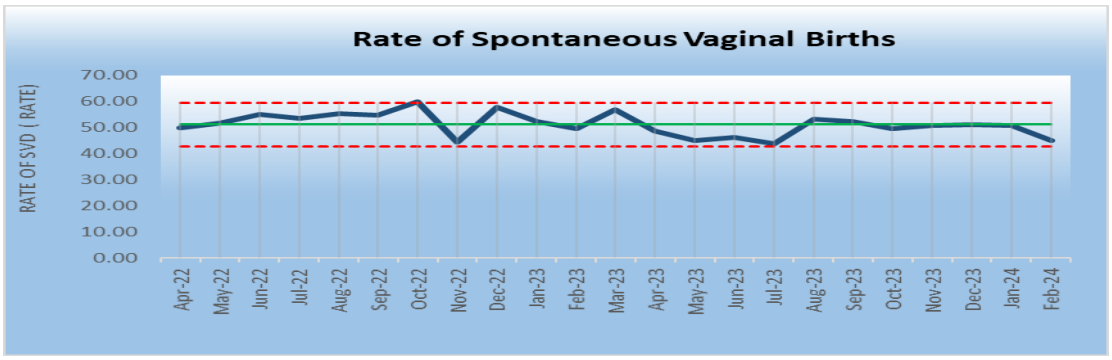
Rate of Spontaneous Vaginal Births
RATE OF SVD ( RATE)
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
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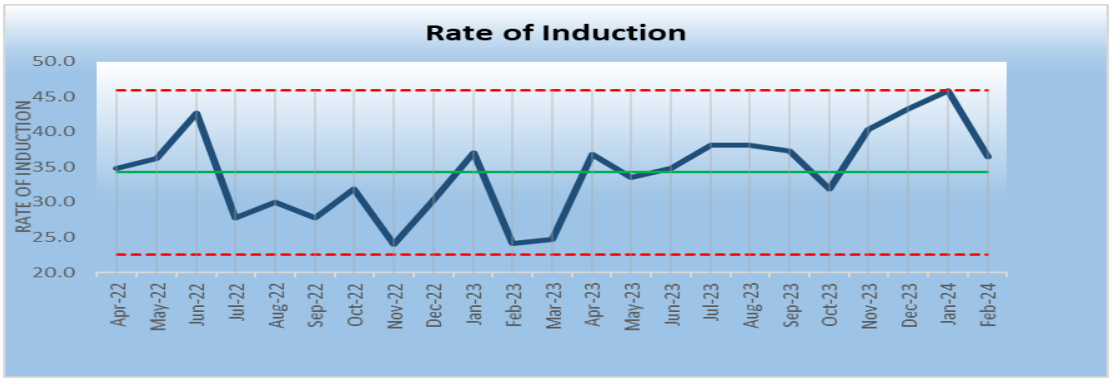
Jan-24
Feb-24


Rate of Induction
RATE OF INDUCTION
50.0
45.0
40.0
35.0
30.0
25.0
20.0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
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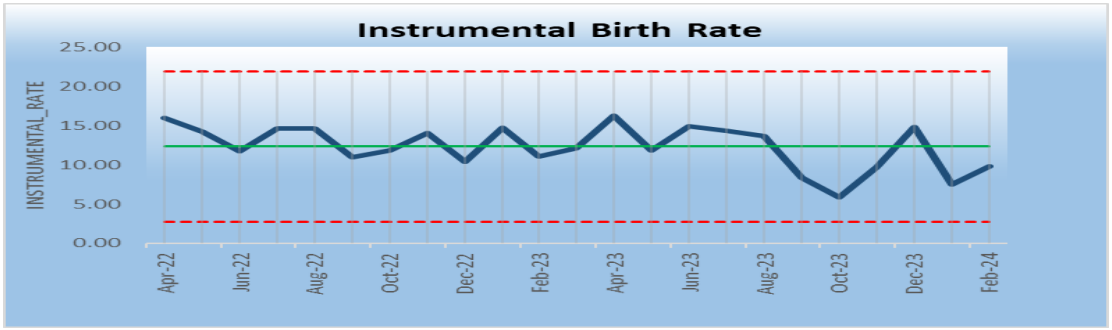
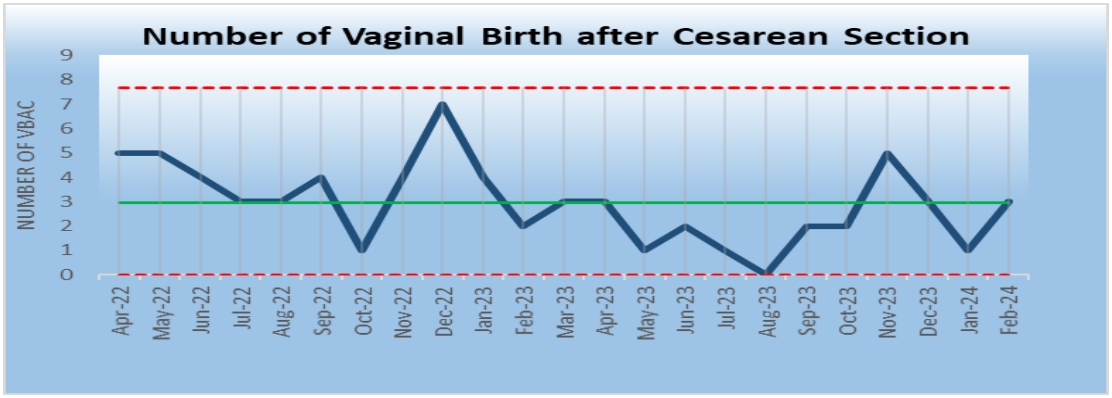
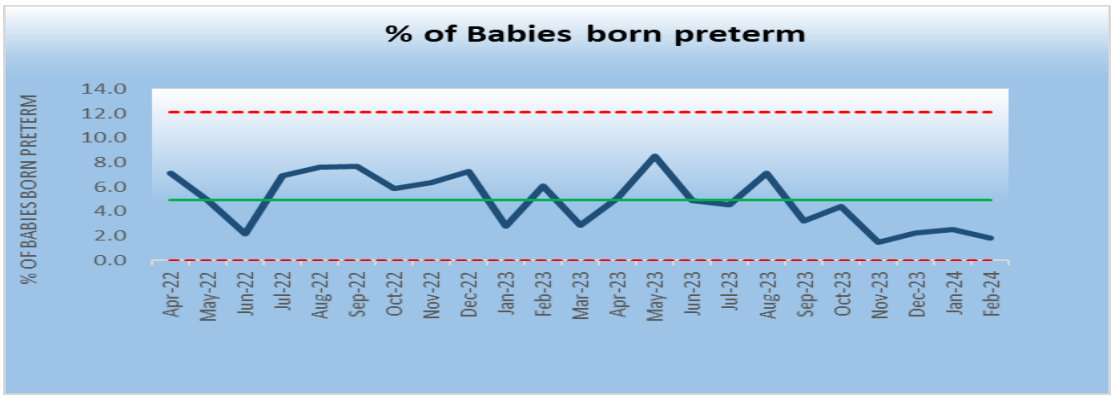
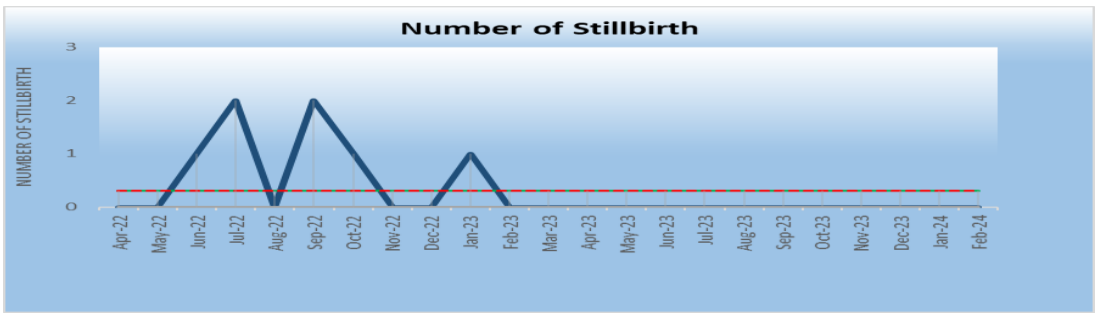
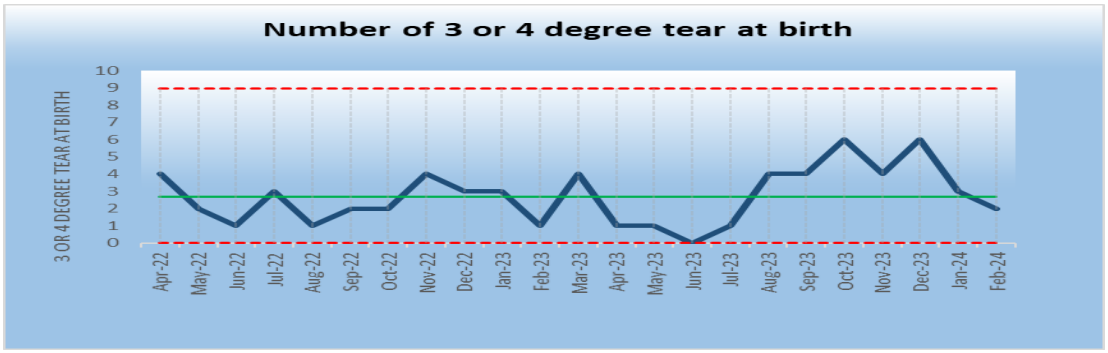
Jan-24
Feb-24

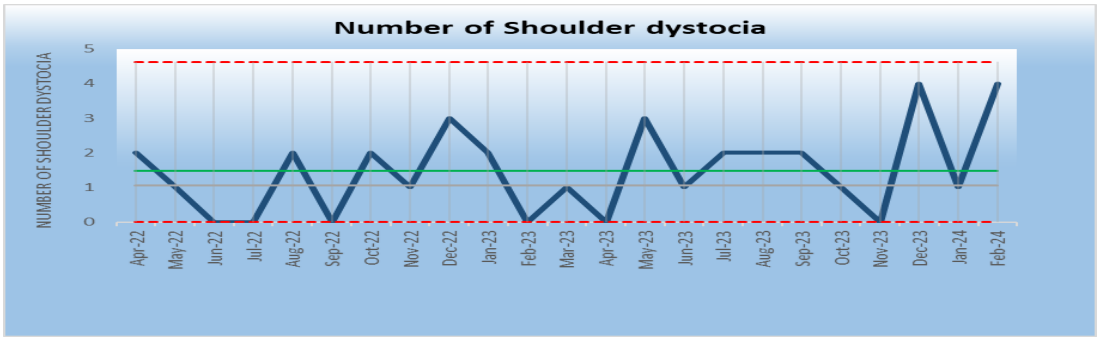

Instrumental Birth Rate
INSTRUMENTAL_RATE
25.00
20.00
15.00
10.00
5.00
0.00
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24

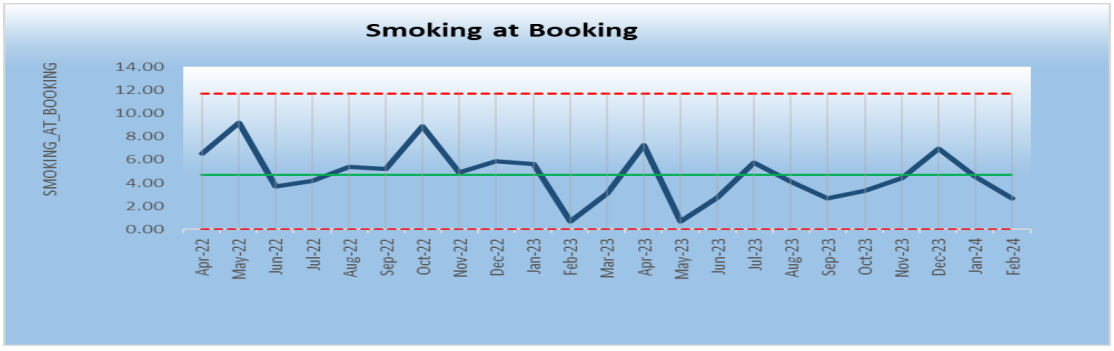

Number of Vaginal Birth after Cesarean Section
NUMBER OF VBAC
0 1 2 3 4 5 6 7 8 9
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

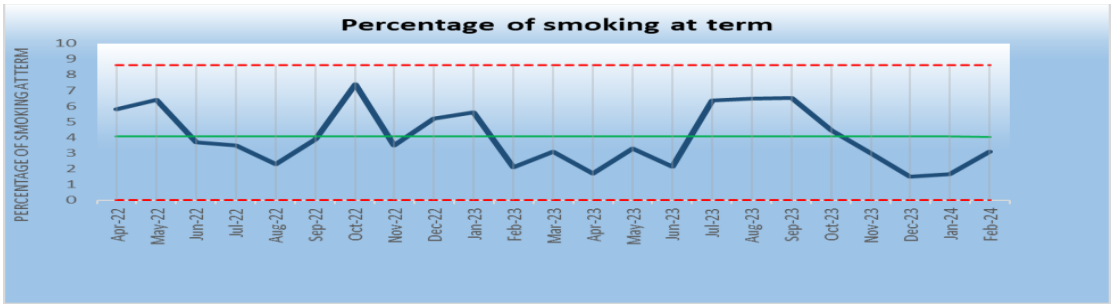

% of Babies born preterm
% OF BABIES BORN PRETERM
0.0 2.0 4.0 6.0 8.0 10.0 12.0 14.0
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

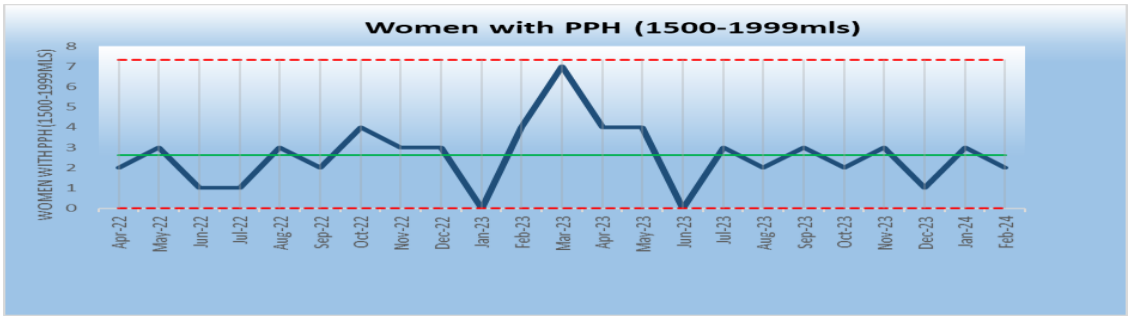

Number of Stillbirth
NUMBER OF STILLBIRTH
0 1 2 3
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

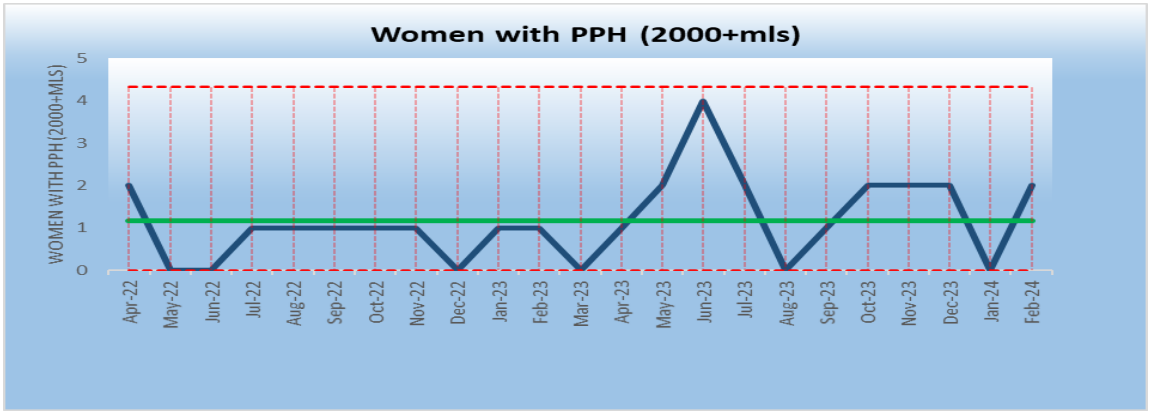

Number of 3 or 4 degree tear at birth
3 OR 4 DEGREE TEAR AT BIRTH
0 1 2 3 4 5 6 7 8 9 10
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

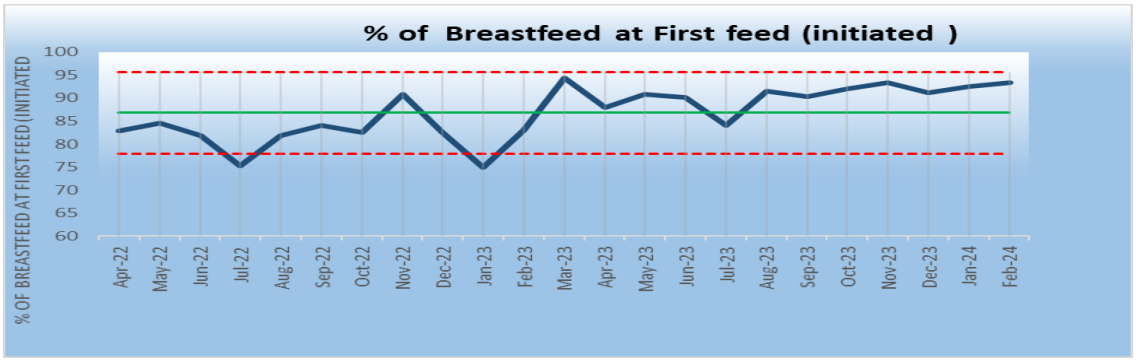

Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
0 1 2 3 4 5
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

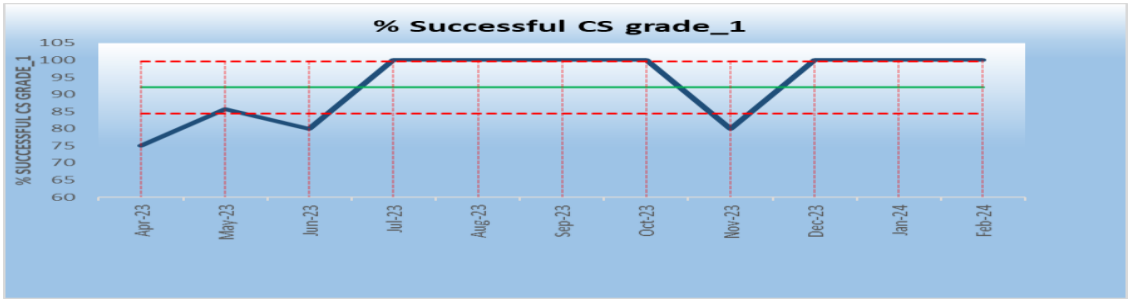

Smoking at Booking
SMOKING_AT_BOOKING
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24


Percentage of smoking at term
PERCENTAGE OF SMOKING AT TERM
10
9
8
7
6
5
4
3
2
1
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24


Women with PPH (1500-1999mls)
WOMEN WITH PPH (1500-1999MLS)
8
7
6
5
4
3
2
1
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24


Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)
5
4
3
2
1
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24


% of Breastfeed at First feed (initiated )
% OF BREASTFEED AT FIRST FEED (INITIATED
100
95
90
85
80
75
70
65
60
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
Jan-24
Feb-24




A sucessful grade one cesarean section is when a baby is born within 30 minutes of the decision for a grade one cesarean section.



## 21.0 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.

### 21.1 Term Admissions to SCBU

There were six unexpected term admissions to SCBU in February. One was for collapse in skin-skin with underlying respiratory distress/persistent pulmonary hypertension of the newborn/suspected sepsis (required 5 days antibiotics and prolonged period of respiratory support); additional cases of requirement for oxygen support due to grunting and low saturations, and case of requirement for intensive phototherapy.

### 21.2 ATAIN actions

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

| Issue | Action | Due |
|---|---|---|
| Lack of adherence to hypoglycaemia policy | For clarification and education of Medical Staff | 26/3/24 |
| Formula via NGT should be 1st line treatment for hypoglycemia (unless <1.0) on SCBU, instead of IV fluids | | |
| Short term vapotherm use considered unnecessary | Complete audit of use of vapotherm to confirm clinical justification | 26/3/24 |
| Delay in transfer of patients to theatre once decision made for operative delivery | For audit of time between decision and entry into theatre | 26/3/24 |
| Resuscitaire gas bottles rapidly draining when used in Main Theatre | To discuss with resuscitation team about whether piped oxygen can be installed in PACU for NEONATAL USE ONLY | 26/3/24 |
| Lack of documentary evidence of senior review prior to neonatal admission to SCBU | Registrar or higher must review baby prior to admitting patient. | 26/3/24 |
| Neonatal collapse in skin to skin contact | Implementation of mandatory discussion with mothers about safe skin to skin on PNW & SCBU | 26/3/24 |

## 22.0 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 | Q4 (calendar): 26.9%* detection (<10th centile; 7 cases)<br>(National average 42.7%, Top 10 average 57.1%)<br>Q4 (calendar): 37.5%* detection (<3rd centile; 3 cases)<br>(National average 60.5%, Top 10 average 74.5%)<br><br>*Likely inaccurate data following move to GROW 2.0 within Badgernet | |
| | Quarter 4 (Oct-Dec 2023) | February 2024 |
| Percentage of babies <3rd centile >37+6 weeks' gestation | 1.2% (5/413) | 3.0% (5/166) |
| Percentage of babies <10th centile >39+6 weeks' gestation | 2.7% (11/413) | 7.3% (12/166) |
| 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) | 6 fetal loss born 16-24 weeks (1.47%, 6/407) | 1 fetal loss born 16-23+6 weeks (0.6%, 1/162) |
| • Preterm (24+0-36+6 weeks) | 2.7% (live, 11/407) | 1.2% (live, 2/162) |

A current position of compliance with the requirements of SBLCBv3, verified by the Local Maternity and Neonatal System (LMNS) on 8th March 2024, is detailed below. An action plan is in place and compliance is reassessed by the LMNS quarterly. The ask of the 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) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 30% | Partially implemented | 70% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 80% | Fully implemented | 100% | CNST Met |
| Element 3 | Reduced fetal movements | Partially implemented | 50% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Partially implemented | 85% | Partially implemented | 81% | CNST Met |
| Element 6 | Diabetes | Partially implemented | 50% | Partially implemented | 50% | CNST Met |
| All Elements | TOTAL | Partially implemented | 73% | Partially implemented | 84% | CNST Met |

### 23.0 Maternity Safety Champions

Bi-monthly walk around and meetings continue. Executive and Non-executive Safety Champions walk around is next planned to occur in community on 18th March and will be followed by a Safety Champions meeting.

### 24.0 Conclusion and recommendation

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

# Appendix A – Yorkshire and Humber Dashboard

## YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - CORE INDICATORS

Jul-Sep (Q2) 2023/24

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

| | Indicator | Measure | Threshold | Airedale Maternity Unit | Bradford Women's and Newborn Unit | Calderdale Royal Hospital | Huddersfield Birth Centre | *Calderdale & Huddersfield NHS FT* | Harrogate District Hospital Maternity Unit | Leeds General Infirmary | St James University Hospital | *Leeds Teaching Hospitals NHS FT* | Bronte Birth Centre | Friarwood Birth Centre | Pinderfields Hospital | *Mid Yorkshire Hospitals NHS Trust* | Y&H Total Numbers (Sites) | Y&H Average (Sites) | Y&H Range (Sites) | Y&H Interquartile Range (Sites) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **ACTIVITY INDICATORS** | | | | | | | | | | | | | | | | | | | |
| 1 | Number of Bookings | Number of women booked | | 539 | 1482 | 1229 | N/A | *1229* | 467 | 1211 | 1277 | *2488* | 522 | 480 | 851 | *1853* | 8058 | 895.3 | 467 to 1482 | 522 to 1229 |
| 2 | Bookings <10 weeks | Number of women booked <10 weeks | ≥90% | 367 | 1025 | 754 | N/A | *754* | 321 | 823 | 764 | *1587* | 304 | 320 | 546 | *1170* | 5224 | 522.4 | 0 to 1025 | 320 to 762 |
| 3 | % Bookings <10 weeks | % of women booked <10 weeks | ≥90% | 68.1% | 69.2% | 61.4% | N/A | *61.4%* | 68.7% | 68.0% | 59.8% | *63.8%* | 58.2% | 66.7% | 64.2% | *63.1%* | | 64.8% | 58.2% to 69.2% | 61.4% to 68.1% |
| 4 | Women birthed | Number of all women birthed | | 450 | 1261 | 1058 | N/A | *1058* | 433 | 1064 | 1073 | *2137* | 3 | 5 | 1252 | *1260* | 6599 | 733.2 | 3 to 1261 | 433 to 1073 |
| 5 | Women who birthed a live baby | Number of women who birthed with a live baby | | 448 | 1253 | 1054 | N/A | *1054* | 433 | 1057 | 1071 | *2128* | 3 | 5 | 1250 | *1258* | 6574 | 730.4 | 3 to 1253 | 433 to 1071 |
| 6 | Total births | Number of all babies born | | 453 | 1270 | 1066 | N/A | *1066* | 438 | 1071 | 1090 | *2161* | 3 | 5 | 1271 | *1279* | 6667 | 740.8 | 3 to 1271 | 438 to 1090 |
| 7 | Live births | Number of live babies born | | 452 | 1264 | 1062 | N/A | *1062* | 438 | 1064 | 1088 | *2152* | 3 | 5 | 1269 | *1277* | 6645 | 738.3 | 3 to 1269 | 438 to 1088 |
| 8 | Live births at term | Rolling annual number of live babies born at term | | 1670 | 4684 | 4034 | N/A | *4034* | 1582 | 4055 | 3812 | *7867* | 10 | 13 | 4748 | *4771* | 24608 | 2734.2 | 10 to 4748 | 1582 to 4055 |
| 9 | Total births | Rolling annual number of all babies born | | 1817 | 5158 | 4316 | N/A | *4316* | 1691 | 4331 | 4220 | *8551* | 11 | 14 | 5232 | *5257* | 26790 | 2976.7 | 11 to 5232 | 1691 to 4331 |
| 10 | Planned homebirths | Number of women who planned and birthed a term baby at home | 2.4% | 4 | 14 | 14 | N/A | *14* | 1 | 16 | 2 | *18* | 1 | 4 | 6 | *11* | 62 | 6.9 | 1 to 16 | 2 to 14 |
| 11 | Planned homebirths | % of planned homebirths | 2.4% | 0.9% | 1.1% | 1.3% | N/A | *1.3%* | 0.2% | 1.5% | 0.2% | *0.8%* | 33.3% | 80.0% | 0.5% | *0.9%* | | 0.9% | 0.2% to 80.0% | 0.5% to 1.5% |
| 12 | 1:1 Care in labour | Number of women who have received 1:1 care in labour | | 376 | 970 | 894 | N/A | *894* | 330 | 897 | 904 | *1801* | 3 | 5 | 1034 | *1042* | 5413 | 601.4 | 3 to 1034 | 330 to 904 |
| 13 | 1:1 Care in labour | % women who have received 1:1 care in labour | | 100.0% | 86.5% | 98.6% | N/A | *98.6%* | 95.4% | 100.0% | 100.0% | *100.0%* | 100.0% | 100.0% | 100.0% | *100.0%* | | 96.8% | 86.5% to 100.0% | 98.6% to 100.0% |
| 14 | BBAs (Born Before Arrival) | Number of women who have a BBA. | | 1 | 15 | 12 | N/A | *12* | 5 | 16 | 14 | *30* | 0 | 0 | 14 | *14* | 77 | 8.6 | 0 to 16 | 1 to 14 |
| 15 | BBAs (Born Before Arrival) | % of women who have a BBA. | | 0.2% | 1.2% | 1.1% | N/A | *1.1%* | 1.2% | 1.5% | 1.3% | *1.4%* | 0.0% | 0.0% | 1.1% | *1.1%* | | 1.2% | 0.0% to 1.5% | 0.2% to 1.2% |
| | **MATERNAL CLINICAL INDICATORS** | | | | | | | | | | | | | | | | | | | |
| 16 | Normal births | Number of women with a vaginal birth | | 232 | 725 | 606 | N/A | *606* | 214 | 586 | 574 | *1160* | 2 | 5 | 592 | *599* | 3536 | 392.9 | 2 to 725 | 214 to 592 |
| 17 | Normal births | % of women - normal births | | 51.6% | 57.5% | 57.3% | N/A | *57.3%* | 49.4% | 55.1% | 53.5% | *54.3%* | 66.7% | 100.0% | 47.3% | *47.5%* | | 53.6% | 47.3% to 100.0% | 51.6% to 57.5% |
| 18 | Assisted vaginal births | Number of women with an instrumental birth | | 37 | 119 | 87 | N/A | *87* | 50 | 136 | 144 | *280* | 0 | 0 | 140 | *140* | 713 | 79.2 | 0 to 144 | 37 to 136 |
| 19 | Assisted vaginal births | % of women - assisted vaginal births | | 8.2% | 9.4% | 8.2% | N/A | *8.2%* | 11.5% | 12.8% | 13.4% | *13.1%* | 0.0% | 0.0% | 11.2% | *11.1%* | | 10.8% | 0.0% to 13.4% | 8.2% to 11.5% |
| 20 | Elective C/S births | Number of women - El C/S | | 73 | 125 | 139 | N/A | *139* | 82 | 151 | 155 | *306* | 0 | 0 | 204 | *204* | 929 | 103.2 | 0 to 204 | 73 to 151 |
| 21 | Elective C/S births | % of women - El C/S | | 16.2% | 9.9% | 13.1% | N/A | *13.1%* | 18.9% | 14.2% | 14.4% | *14.3%* | 0.0% | 0.0% | 16.3% | *16.2%* | | 14.1% | 0.0% to 18.9% | 9.9% to 16.2% |
| 22 | Emergency C/S births | Number of women - Em C/S | | 108 | 292 | 226 | N/A | *226* | 72 | 196 | 203 | *399* | 1 | 0 | 318 | *319* | 1416 | 157.3 | 0 to 318 | 72 to 226 |
| 23 | Emergency C/S births | % of women - Em C/S | | 24.0% | 23.2% | 21.4% | N/A | *21.4%* | 16.6% | 18.4% | 18.9% | *18.7%* | 33.3% | 0.0% | 25.4% | *25.3%* | | 21.5% | 0.0% to 33.3% | 18.4% to 24.0% |
| 24 | Number of C/S births | No. of women - Total all C/S | | 181 | 417 | 365 | N/A | *365* | 154 | 347 | 358 | *705* | 1 | 0 | 522 | *523* | 2345 | 260.6 | 0 to 522 | 154 to 365 |
| 25 | C/S deliveries | % of women - Total all C/S | | 40.2% | 33.1% | 34.5% | N/A | *34.5%* | 35.6% | 32.6% | 33.4% | *33.0%* | 33.3% | 0.0% | 41.7% | *41.5%* | | 35.5% | 0.0% to 41.7% | 33.1% to 35.6% |
| 26 | 3rd/4th degree tear - normal birth | Number of women with 3rd and 4th degree tear following a normal birth | ≤ 4.1% (prim'ips) ≤ 1.5% (multips) | 5 | 8 | 7 | N/A | *7* | 4 | 7 | 8 | *15* | 0 | 0 | 16 | *16* | 55 | 6.1 | 0 to 16 | 4 to 8 |
| 27 | 3rd/4th degree tear - normal birth | % women with 3rd and 4th degree tear following a normal birth | ≤ 4.1% (prim'ips) ≤ 1.5% (multips) | 2.2% | 1.1% | 1.2% | N/A | *1.2%* | 1.9% | 1.2% | 1.4% | *1.3%* | 0.0% | 0.0% | 2.7% | *2.7%* | | 1.6% | 0.0% to 2.7% | 1.1% to 1.9% |
| 28 | 3rd/4th degree tear - assisted birth | Number of women with 3rd and 4th degree tear following an assisted birth | ≤ 7.3% (prim'ips) ≤ 4.6% (multips) [trust average 6.05%] | 2 | 6 | 6 | N/A | *6* | 1 | 4 | 4 | *8* | 0 | 0 | 7 | *7* | 30 | 3.3 | 0 to 7 | 1 to 6 |
| 29 | 3rd/4th degree tear - assisted birth | % women with 3rd and 4th degree tear following an assisted birth | ≤ 7.3% (prim'ips) ≤ 4.6% (multips) [trust average 6.05%] | 5.4% | 0 | 6.9% | N/A | *6.9%* | 2.0% | 2.9% | 2.8% | *2.9%* | N/A | N/A | 5.0% | *5.0%* | | 4.2% | 2.0% to 6.9% | 2.9% to 5.2% |
| 30 | Induction of Labour | Number of women commenced induction of labour | 34% | 184 | 443 | 366 | N/A | *366* | 157 | 411 | 442 | *853* | 0 | 0 | 471 | *471* | 2474 | 274.9 | 0 to 471 | 157 to 442 |
| 31 | Induction of Labour | % women commenced induction of labour | 34% | 40.9% | 35.1% | 34.6% | N/A | *34.6%* | 36.3% | 38.6% | 41.2% | *39.9%* | 0.0% | 0.0% | 37.6% | *37.4%* | | 37.5% | 0.0% to 41.2% | 34.6% to 38.6% |
| 32 | PPH ≥ 1500ml | Number of women who have birthed with PPH ≥ 1500ml | | 11 | 38 | 26 | N/A | *26* | 10 | 37 | 32 | *69* | 0 | 0 | 62 | *62* | 216 | 24.0 | 0 to 62 | 10 to 37 |
| 33 | PPH ≥ 1500ml | % women who have birthed with PPH ≥ 1500ml | | 2.4% | 3.0% | 2.5% | N/A | *2.5%* | 2.3% | 3.5% | 3.0% | *3.2%* | 0.0% | 0.0% | 5.0% | *4.9%* | | 3.3% | 0.0% to 5.0% | 2.3% to 3.0% |
| | **NEONATAL CLINICAL INDICATORS** | | | | | | | | | | | | | | | | | | | |
| 34 | Preterm births <37 weeks | Number of preterm births <37 weeks | National target is to reduce all Preterm Birth (delivery under 37 weeks) from 8% to 6% by 2025 | 32 | 113 | 60 | N/A | 60 | 33 | 70 | 92 | *162* | 0 | 0 | 115 | *115* | 515 | 57.2 | 0 to 115 | 32 to 92 |
| 35 | Preterm birth rate < 37 weeks | % preterm births <37 weeks | | 7.1% | 8.9% | 5.6% | N/A | *5.6%* | 7.5% | 6.6% | 8.5% | *7.5%* | 0.0% | 0.0% | 9.1% | *9.0%* | | 7.8% | 0.0% to 9.1% | 5.6% to 8.5% |
| 36 | Preterm births 32 weeks to 36+6 weeks | Number of preterm births 32 weeks to 36+6 weeks | | 31 | 84 | 55 | N/A | *55* | 33 | 42 | 88 | *130* | 0 | 0 | 95 | *95* | 428 | 47.6 | 0 to 95 | 31 to 84 |
| 37 | Preterm birth rate 32 weeks to 36+6 weeks | % preterm births 32 weeks to 36+6 weeks | | 6.9% | 6.6% | 5.2% | N/A | *5.2%* | 7.5% | 3.9% | 8.1% | *6.0%* | 0.0% | 0.0% | 7.5% | *7.4%* | | 6.4% | 0.0% to 8.1% | 3.9% to 7.5% |
| 38 | Number of preterm births 27 weeks to 31+6 weeks | Number of preterm births 27 weeks to 31+6 weeks | | 0 | 21 | 5 | N/A | *5* | 0 | 14 | 4 | *18* | 0 | 0 | 16 | *16* | 60 | 6.7 | 0 to 21 | 0 to 14 |
| 39 | Preterm birth rate 27 weeks to 31+6 weeks | % preterm births 27 weeks to 31+6 weeks | | 0.0% | 1.7% | 0.5% | N/A | *0.5%* | 0.0% | 1.3% | 0.4% | *0.8%* | 0.0% | 0.0% | 1.3% | *1.3%* | | 0.9% | 0.0% to 1.7% | 0.0% to 1.3% |
| 40 | Preterm birth <27 weeks | Number of preterm births <27 weeks | | 1 | 8 | 0 | N/A | *0* | 0 | 14 | 0 | *310* | 0 | 0 | 4 | *226* | 27 | 3.0 | 0 to 14 | 0 to 4 |
| 41 | Preterm birth rate < 27 weeks | % preterm births <27 weeks | | 0.2% | 0.6% | 0.0% | N/A | *0.0%* | 0.0% | 1.3% | 0.0% | *14.4%* | 0.0% | 0.0% | 0.3% | *17.7%* | | 0.4% | 0.0% to 1.3% | 0.0% to 0.3% |
| 42 | Rolling annual number of low birth weight at term - live births | Rolling annual number of live babies at term < 2200g | | 5 | 46 | 33 | N/A | *33* | 2 | 51 | 49 | *100* | 0 | 0 | 22 | *22* | 208 | 23.1 | 0 to 51 | 2 to 46 |
| 43 | Low birth weight at term - live births | Rolling annual % live babies at term < 2200g | | 0.3% | 1.0% | 0.8% | N/A | *0.8%* | 0.1% | 1.3% | 1.3% | *1.3%* | 0.0% | 0.0% | 0.5% | *0.5%* | | 0.8% | 0.0% to 1.3% | 0.1% to 1.0% |
| | **STILLBIRTHS** | | | | | | | | | | | | | | | | | | | |
| 44 | Stillbirths - Rolling annual total | Annual number of ALL stillborn babies | | 5 | 28 | 13 | N/A | *13* | 4 | 25 | 7 | *32* | 0 | 0 | 20 | *20* | 102 | 11.3 | 0 to 28 | 4 to 20 |
| 45 | Stillbirth rate - Total | Annual rate for ALL stillborn babies / 1000 births | | 2.8 | 5.4 | 3.0 | N/A | *3.0* | 2.4 | 5.8 | 1.7 | *3.7* | 0.0 | 0.0 | 3.8 | *3.8* | | 3.8 | 0.0 to 5.8 | 1.7 to 3.8 |
| 46 | Stillbirths | Number of all babies stillborn | | 1 | 6 | 4 | N/A | *4* | 0 | 7 | 2 | *9* | 0 | 0 | 2 | *2* | 22 | 2.4 | 0 to 7 | 0 to 4 |
| 47 | Stillbirths - antenatal | Rolling annual number of babies stillborn, diagnosed during antenatal period | | 4 | 23 | 13 | N/A | *13* | 4 | 24 | 6 | *30* | 0 | 0 | 20 | *20* | 94 | 10.4 | 0.0 to 24.0 | 4.0 to 20.0 |
| 48 | Stillbirth rate - Antenatal | Annual rate for antenatal stillborn babies / 1000 births | | 2.2 | 4.5 | 3.0 | N/A | *3.0* | 2.4 | 5.5 | 1.4 | *3.5* | 0.0 | 0.0 | 3.8 | *3.8* | | 3.5 | 0 to 6 | 1 to 4 |
| 49 | Stillbirths - intrapartum | Rolling annual number of babies stillborn, diagnosed during intrapartum period | | 1 | 5 | 0 | N/A | *0* | 0 | 1 | 1 | *2* | 0 | 0 | 0 | *0* | 8 | 0.9 | 0.0 to 5.0 | 0.0 to 1.0 |
| 50 | Stillbirth rate - Intrapartum | Annual rate for intrapartum stillborn babies / 1000 births | | 0.6 | 1.0 | 0.0 | N/A | *0.0* | 0.0 | 0.2 | 0.2 | *0.2* | 0.0 | 0.0 | 0.0 | *0.0* | | 0.3 | 0.0 to 1.0 | 0.0 to 0.2 |
| 51 | HSIB reportable births | Rolling annual number of reportable births | | 2 | 10 | 8 | N/A | *8* | 2 | 5 | 2 | *7* | 0 | 0 | 0 | *0* | 29 | 3.2 | 0 to 10 | 0 to 5 |
| 52 | HSIB reportable births | Rolling annual % reportable births | | 0.1% | 0.2% | 0.2% | N/A | *0.2%* | 0.1% | 0.1% | 0.0% | *0.1%* | 0.0% | 0.0% | 0.0% | *0.0%* | | 0.1% | 0.0% to 0.2% | 0.0% to 0.1% |
| 53 | Stillbirths - excluding those with lethal abnormalities | Rolling annual number of babies stillborn, excluding those with lethal abnormalities | | 5 | 23 | 9 | N/A | *9* | 4 | 0 | 0 | *0* | 0 | 0 | 20 | *20* | 61 | 6.8 | 0 to 23 | 0 to 9 |
| 54 | Stillbirth rate - adjusted to exclude lethal abnormalities | Annual stillborn babies / 1000 births excluding babies with lethal abnormality | | 2.8 | 4.5 | 2.1 | N/A | *2.1* | 2.4 | 0.0 | 0.0 | *0.0* | 0.0 | 0.0 | 3.8 | *3.8* | | 2.3 | 0.0 to 4.5 | 0.0 to 2.8 |
| 55 | Stillbirths at term | Rolling annual number of babies stillborn at term | | 0 | 5 | 2 | N/A | *2* | 0 | 9 | 1 | *10* | 0 | 0 | 2 | *2* | 19 | 2.1 | 0 to 9 | 0 to 2 |
| 56 | Stillbirths at term with low birth weight | Rolling annual number of babies stillborn at term < 2200g | | 0 | 1 | 1 | N/A | *1* | 0 | 1 | 0 | *1* | 0 | 0 | 0 | *0* | 3 | 0.3 | 0 to 1 | 0 to 1 |
| 57 | Stillbirths at term with low birth weight | Annual % of stillborn babies < 2200g | | N/A | 20.0% | 50.0% | N/A | *50.0%* | N/A | 11.1% | 0.0% | *10.0%* | N/A | N/A | 0.0% | *0.0%* | | 15.8% | 0.0% to 50.0% | 0.0% to 20.0% |
| 58 | All losses under 24+0 weeks gestation | Number of all losses under 24+0 weeks gestation | | 1 | 15 | 218 | N/A | *218* | 5 | 4 | 0 | *4* | 0 | 0 | 17 | *17* | 260 | 28.9 | 0 to 218 | 0 to 15 |
| | Hold for % | | | | | | | | | | | | | | | | | | | |
| | **PUBLIC HEALTH INDICATORS** | | | | | | | | | | | | | | | | | | | |
| 59 | Breastfeeding Initiation | Number of women who breastfed their baby/ies for their first feed | ≥ 75% | 307 | 794 | 700 | N/A | *700* | 351 | 812 | 812 | *1624* | 3 | 5 | 938 | *946* | 4722 | 524.7 | 3 to 938 | 307 to 812 |
| 60 | Breastfeeding Initiation | % of women commenced breastfeeding | ≥ 75% | 68.5% | 63.4% | 66.4% | N/A | *66.4%* | 81.1% | 76.8% | 75.8% | *76.3%* | 100.0% | 100.0% | 75.0% | *75.2%* | | 71.8% | 63.4% to 100.0% | 68.5% to 81.1% |
| 61 | Smoking at time of booking - self reported | Number of women who were smokers at time of booking | ≤ 6% by end 2022 | 52 | 157 | 98 | N/A | *98* | 22 | 112 | 120 | *232* | 44 | 62 | 99 | *205* | 766 | 85.1 | 22 to 157 | 52 to 112 |
| 62 | Smoking at time of booking | % of women who smoke at booking | ≤ 6% by end 2022 | 9.6% | 10.6% | 8.0% | N/A | *8.0%* | 4.7% | 9.2% | 9.4% | *9.3%* | 8.4% | 12.9% | 11.6% | *11.1%* | | 9.5% | 4.7% to 12.9% | 8.4% to 10.6% |
| 63 | Smoking at time of birth - self reported | Number of women who were smokers at time of birth | ≤ 6% by end 2022 | 55 | 121 | 88 | N/A | *88* | 27 | 96 | 114 | *210* | 0 | 0 | 118 | *118* | 619 | 68.8 | 0 to 121 | 27 to 114 |
| 64 | Smoking at time of birth - self reported | % of women who smoke at time of birth | ≤ 6% by end 2022 | 12.2% | 9.6% | 8.3% | N/A | *8.3%* | 6.2% | 9.0% | 10.6% | *9.8%* | 0.0% | 0.0% | 9.4% | *9.4%* | | 9.4% | 0.0% to 12.2% | 6.2% to 9.6% |
| 65 | Carbon Monoxide monitoring at time of booking | Number of women who received CO testing with a measurement ≥ 4ppm at booking | ≤ 6% by end 2022 | 51 | 156 | 167 | N/A | *167* | 87 | 115 | 97 | *212* | 64 | 78 | 120 | *262* | 935 | 103.9 | 51 to 167 | 78 to 120 |
| 66 | Women received CO testing at booking | Number of women who received CO testing at booking | ≤ 6% by end 2023 | 444 | 1362 | 1186 | N/A | *1186* | 490 | 1021 | 1112 | *2133* | 462 | 416 | 691 | *1569* | 7184 | 798.2 | 416 to 1362 | 462 to 1112 |
| 67 | Carbon Monoxide monitoring at time of booking | % women who received CO testing with a measurement ≥ 4ppm at booking | ≤ 6% by end 2022 | 11.5% | 11.5% | 14.1% | N/A | *14.1%* | 17.8% | 11.3% | 8.7% | *9.9%* | 13.9% | 18.8% | 17.4% | *16.7%* | | 13.0% | 8.7% to 18.8% | 11.5% to 17.4% |

# Operational Update

## March 2024

Russell Nightingale
Chief Operating Officer

# Children's and Community

| Metrics | Q1 | Q2 | Q3 | Q4 YTD |
|---|---|---|---|---|
| % of antenatal contacts | | | | |
| Darlington | 95.5% | 94.6% | 98.8% | 98.6% |
| Durham | 88.4% | 85.6% | 85.0% | 87.0% |
| Gateshead | 93.5% | 96.5% | 96.9% | 93.3% |
| Middlesbrough | 90.5% | 96.8% | 94.2% | 95.7% |
| North Yorkshire | 89.1% | 96.3% | 95.9% | 96.0% |
| Northumberland | 86.0% | 87.3% | 85.4% | 94.1% |
| Stockton | 96.1% | 96.6% | 97.6% | 96.0% |
| Sunderland | 94.9% | 130.1% | 93.9% | 94.4% |
| Wakefield | 96.5% | 89.6% | 86.1% | 87.1% |
| % New Birth Visits completed by 14 days | | | | |
| Darlington | 98.8% | 98.6% | 99.3% | 100.0% |
| Durham | 96.1% | 96.4% | 86.5% | 85.7% |
| Gateshead | 96.5% | 98.6% | 92.4% | 96.9% |
| Middlesbrough | 96.7% | 98.7% | 96.2% | 95.6% |
| North Yorkshire | 93.3% | 96.3% | 90.2% | 91.1% |
| Northumberland | 91.5% | 92.4% | 88.5% | 97.1% |
| Stockton | 94.8% | 95.1% | 93.3% | 95.9% |
| Sunderland | 98.8% | 98.7% | 98.3% | 98.4% |
| Wakefield | 75.6% | 70.5% | 73.5% | 72.0% |
| % Infants Breastfeeding at 10-14 days | | | | |
| Darlington | 51.6% | 55.7% | 57.1% | 59.0% |
| Durham | 43.7% | 43.0% | 44.4% | 45.0% |
| Gateshead | 53.6% | 56.0% | 55.5% | 60.5% |
| Middlesbrough | 50.6% | 56.5% | 55.3% | 59.3% |
| North Yorkshire | 67.4% | 69.4% | 67.3% | 65.9% |
| Northumberland | 54.8% | 52.6% | 53.9% | 55.3% |
| Stockton | 49.8% | 50.9% | 47.9% | 52.9% |
| Sunderland | 47.4% | 49.5% | 46.1% | 48.9% |
| Wakefield | 53.5% | 52.1% | 52.6% | 53.9% |
| % infants breastfeeding at 6-8 weeks | | | | |
| Darlington | 40.6% | 42.8% | 39.3% | 41.1% |
| Durham | 31.4% | 29.3% | 33.9% | 30.5% |
| Gateshead | 45.7% | 47.6% | 43.8% | 47.4% |
| Middlesbrough | 45.6% | 47.0% | 44.5% | 43.4% |
| North Yorkshire | 55.2% | 55.8% | 55.6% | 54.7% |
| Northumberland | 42.1% | 41.0% | 42.9% | 45.2% |
| Stockton | 36.2% | 39.5% | 38.2% | 41.7% |
| Sunderland | 31.5% | 36.1% | 36.9% | 32.5% |
| Wakefield | 36.5% | 38.1% | 40.1% | 37.4% |

| Metrics | Q1 | Q2 | Q3 | Q4 YTD |
|---|---|---|---|---|
| % of 6-8 week reviews completed by the time the infant is 8 weeks old | | | | |
| Darlington | 95.9% | 98.6% | 98.9% | 97.0% |
| Durham | 93.1% | 92.3% | 82.3% | 79.9% |
| Gateshead | 96.4% | 97.6% | 92.4% | 93.8% |
| Middlesbrough | 92.9% | 93.2% | 90.1% | 92.8% |
| North Yorkshire | 89.0% | 95.0% | 94.1% | 94.1% |
| Northumberland | 87.1% | 89.4% | 84.2% | 92.5% |
| Stockton | 96.0% | 96.2% | 94.4% | 97.9% |
| Sunderland | 97.9% | 96.9% | 98.6% | 97.7% |
| Wakefield | 93.7% | 91.4% | 96.4% | 95.4% |
| % of 12 month reviews completed by the time the child is 15 months old | | | | |
| Darlington | 99.2% | 99.6% | 99.1% | 100.0% |
| Durham | 94.6% | 94.7% | 93.5% | 93.7% |
| Gateshead | 98.8% | 98.3% | 98.6% | 99.4% |
| Middlesbrough | 98.2% | 96.6% | 99.0% | 98.9% |
| North Yorkshire | 96.8% | 99.2% | 98.7% | 99.6% |
| Northumberland | 93.2% | 93.2% | 97.0% | 97.3% |
| Stockton | 97.7% | 99.4% | 98.8% | 98.7% |
| Sunderland | 97.0% | 97.5% | 96.8% | 97.1% |
| Wakefield | 96.3% | 97.3% | 97.70% | 98.36% |
| % of 2-2.5 year reviews completed by the time the child is 2.5 years old | | | | |
| Darlington | 96.9% | 96.0% | 99.2% | 99.3% |
| Durham | 93.1% | 92.9% | 84.3% | 84.7% |
| Gateshead | 95.1% | 97.1% | 92.1% | 93.8% |
| Middlesbrough | 96.8% | 97.4% | 90.0% | 88.3% |
| North Yorkshire | 95.7% | 97.9% | 97.9% | 98.1% |
| Northumberland | 91.1% | 91.8% | 80.0% | 97.3% |
| Stockton | 95.7% | 96.9% | 93.8% | 96.8% |
| Sunderland | 95.2% | 95.7% | 94.7% | 96.3% |
| Wakefield | 94.9% | 96.9% | 94.07% | 98.41% |
| % of 2 to 2.5 year reviews completed in the month with a completed ASQ3 | | | | |
| Darlington | 100.0% | 99.6% | 99.6% | 98.9% |
| Durham | 92.9% | 92.9% | 96.0% | 96.0% |
| Gateshead | 95.9% | 97.1% | 92.3% | 98.5% |
| Middlesbrough | 99.5% | 100.0% | 99.8% | 99.4% |
| North Yorkshire | 99.5% | 99.8% | 99.4% | 99.4% |
| Northumberland | 96.9% | 96.6% | 99.0% | 97.7% |
| Stockton | 97.4% | 94.9% | 94.9% | 94.2% |
| Sunderland | 95.5% | 95.6% | 96.6% | 94.4% |
| Wakefield | 99.5% | 99.7% | 99.80% | 99.23% |

**% 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.

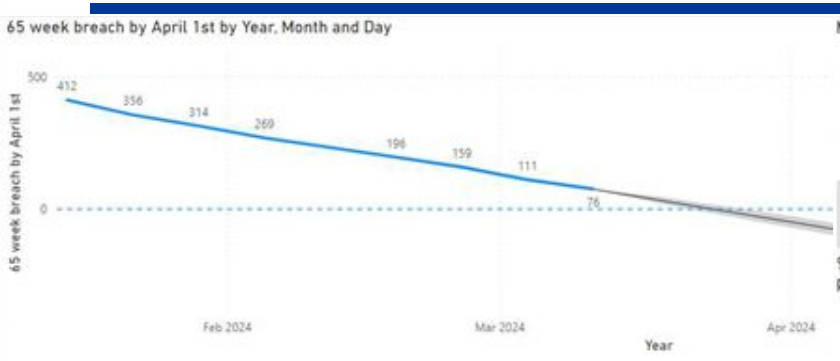
**% new Birth Visits by 14 days**

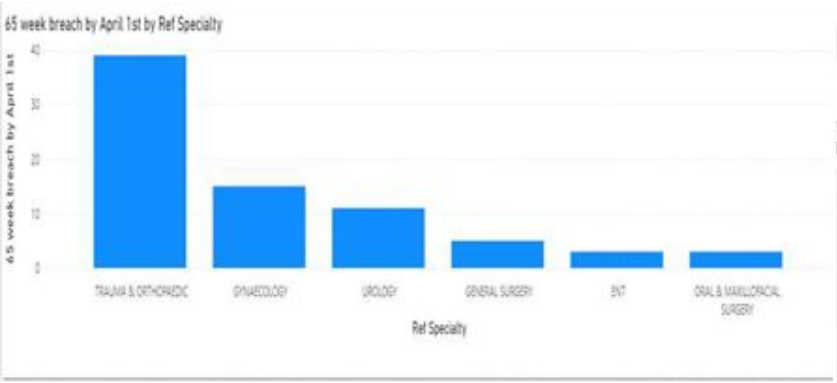
- Wakefield – Due to high health visitor vacancies. Service at OPEL 3 so timescales flexed to 10 to 20 days. Recovery linked to recruitment.

**% Infants Breast Feeding**

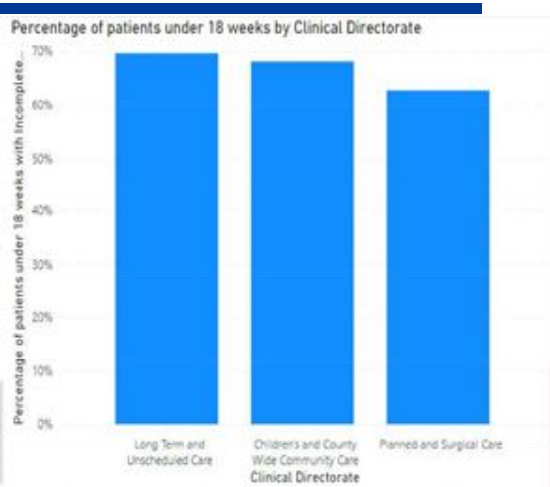
- Durham – Increased focus on antenatal care including family hub developments and insights work commissioned by LA. Currently reviewing at locality level the issues.

# Planned Care Recovery





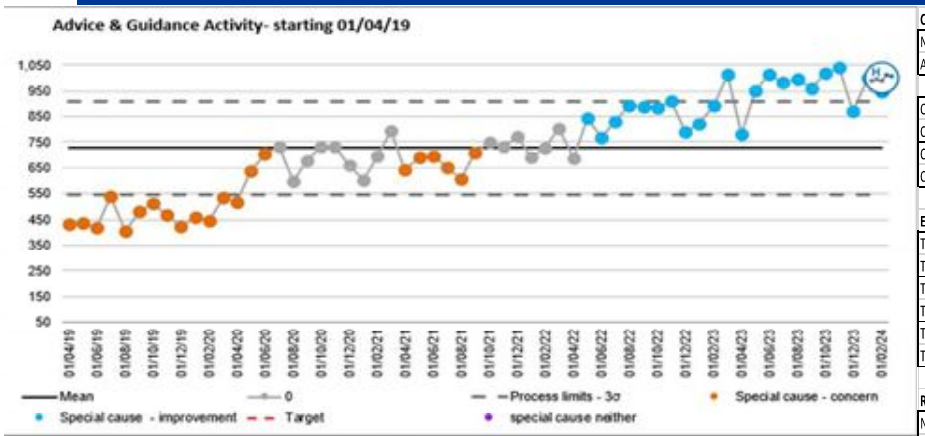


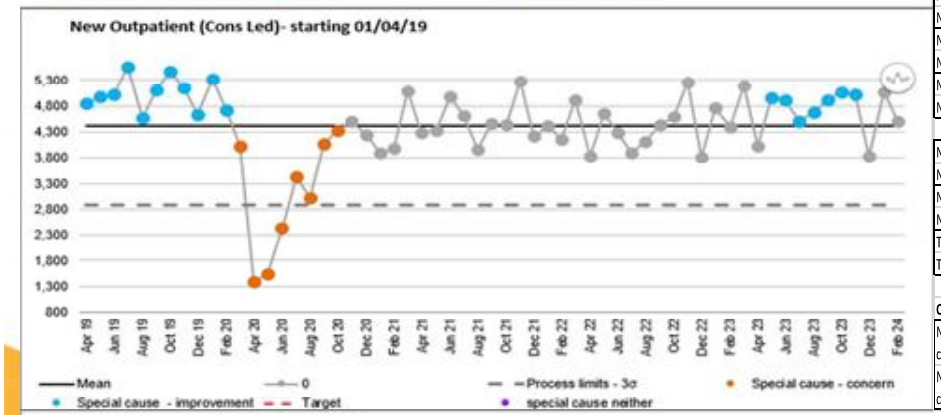


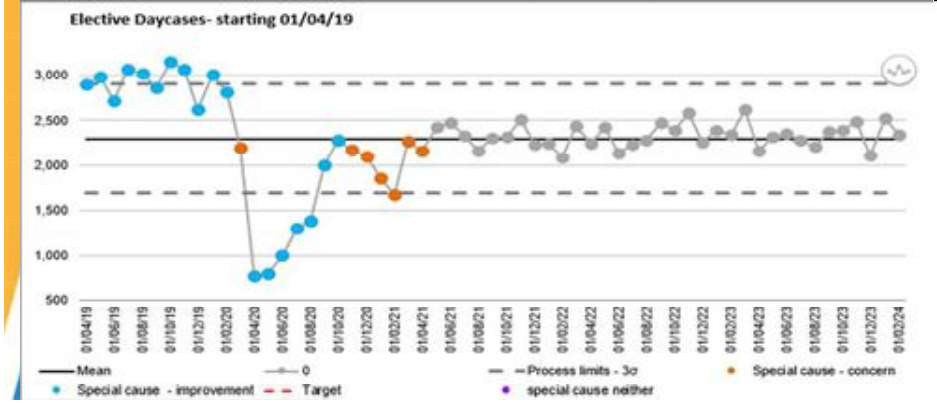


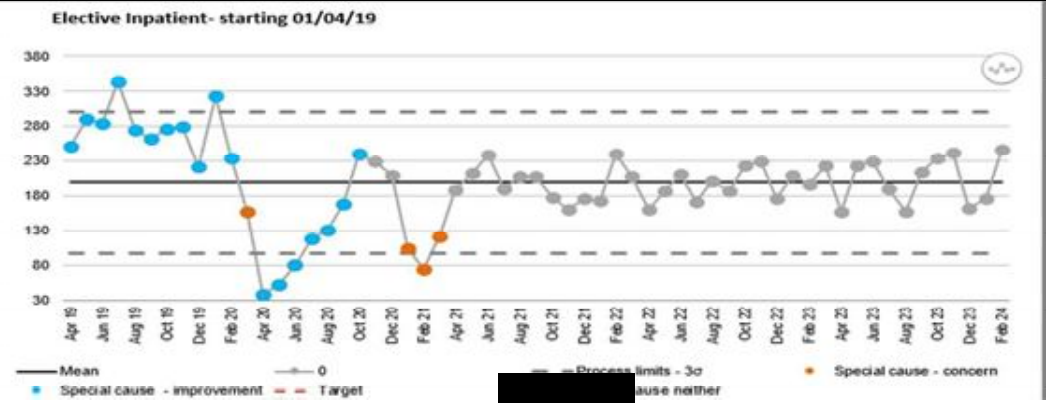
Waiting list stable, long waiters reducing. On target for zero 65 weeks by end of March.

# Elective 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 | 813 | 1,134 | |
| | | | | | | | | | | | | |
| 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 | 5,066 | 4,506 | |
| 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 | 10,589 | 9,663 | |
| | | | | | | | | | | | | |
| **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 | 2,702 | 2,584 | |
| 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 | 2,525 | 2,337 | |
| 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 | 177 | 247 | |
| | | | | | | | | | | | | |
| **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 | 878 | | |
| 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 | 4,607 | | |
| 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 | 5,885 | | |
| | | | | | | | | | | | | |
| 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 | 561 | | |
| 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 | 126 | | |
| 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 | 22,383 | | |
| | | | | | | | | | | | | |
| **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 | 55 | 41 | |

# Referral to Treatment (RTT)

| | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 |
|---|---|---|---|---|---|---|
| **Total incomplete RTT pathways** | 25,951 | 25,876 | 25,860 | 25,831 | 25,802 | 23,093 |
| **Under 52 weeks** | 24,953 | 24,875 | 24,840 | 24,798 | 24,678 | 22,420 |
| **> 52 weeks** | 998 | 1,001 | 1,020 | 1,033 | 1,124 | 673 |
| **> 65 weeks** | 202 | 197 | 210 | 208 | 259 | 154 |
| **> 78 weeks** | 5 | 0 | 1 | 1 | 4 | 2 |
| **> 104 weeks** | 0 | 0 | 0 | 0 | 0 | 0 |

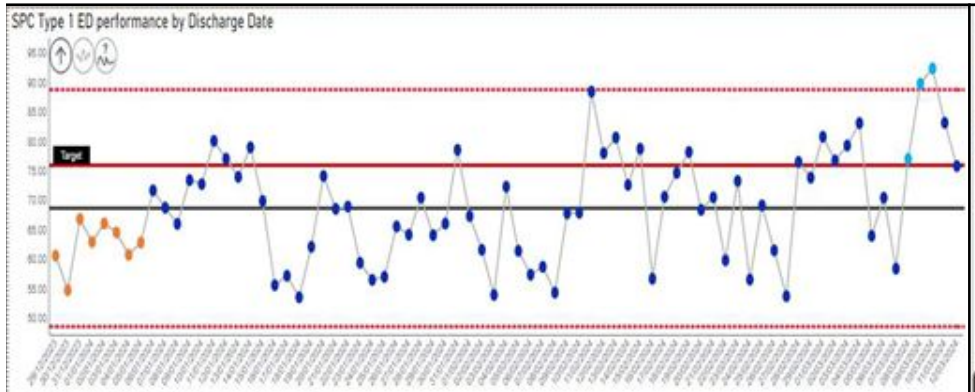
| | Oct-23 | Nov-23 | Dec-23 | Jan-24 | *Feb-24 (provisional)* |
|---|---|---|---|---|---|
| **Total incomplete RTT pathways** | 22,799 | 22,549 | 22,488 | 22,383 | *22,345* |
| **Under 52 weeks** | 22,159 | 21,950 | 21,931 | 21,822 | *21,846* |
| **> 52 weeks** | 640 | 599 | 557 | 561 | *499* |
| **> 65 weeks** | 145 | 140 | 129 | 126 | *66* |
| **> 78 weeks** | 0 | 0 | 0 | 0 | *0* |
| **> 104 weeks** | 0 | 0 | 0 | 0 | *0* |

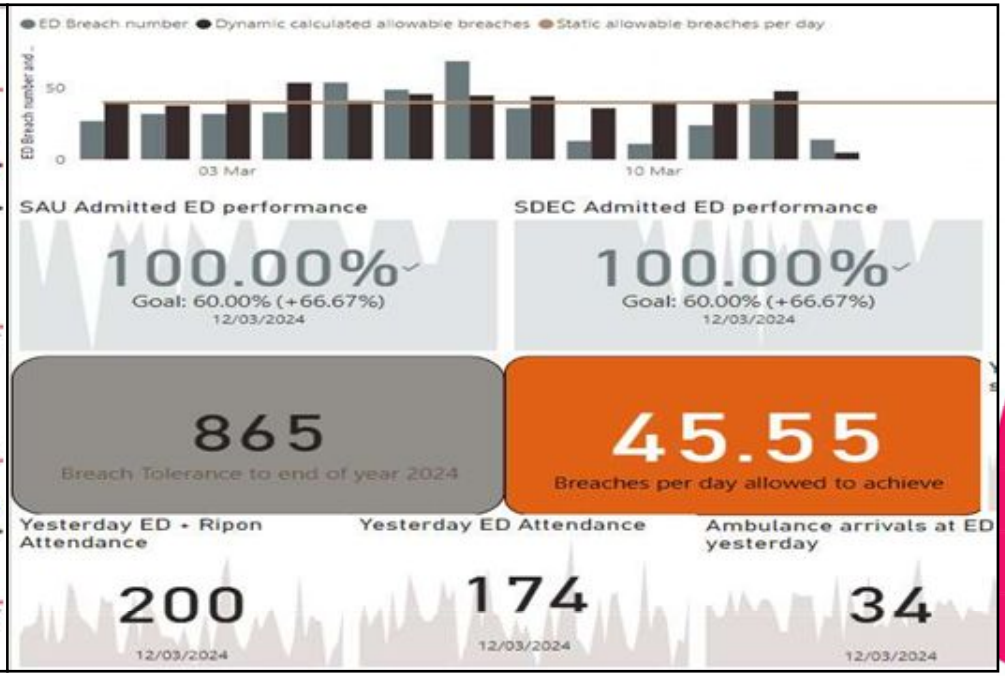
**RTT –** provisional figures suggest 22,345 patients waiting at the end of February. Total incomplete pathways continues to reduce, ahead of plan for over 52 and 65 week waits. February position will be confirmed by 18/03/24.

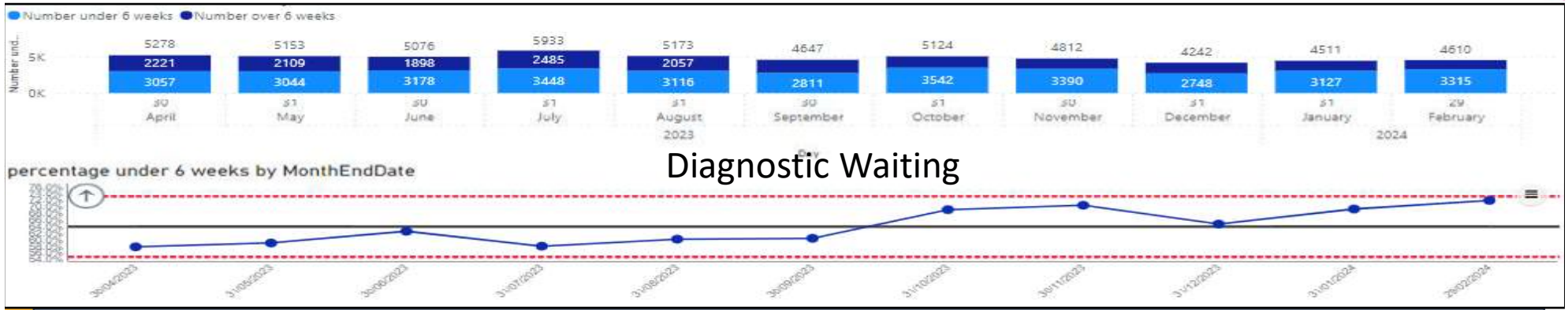
There were no patients waiting 78+ weeks at end February.

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

# Urgent Care and Diagnostics



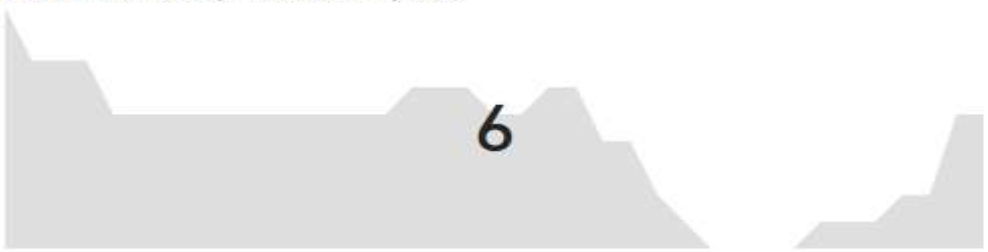




- Performance against the A&E 4-hour standard was at 73% in February, a further improvement but remaining below the new performance standard of 76%. The re-opening of refurbished ED2 has seen a re-establishing of improving non admitted performance.
- There were 42 over 12-hour trolley wait breach in February (124 in January).
- ED attendances are now back in line with 2019/20 levels.
- DEXA have seen continued improvements in the number of patients waiting for diagnostics and thus a reduction in the overall diagnostic waiting list. The percentage under 6 weeks has increased to 69% in February (64% in January).

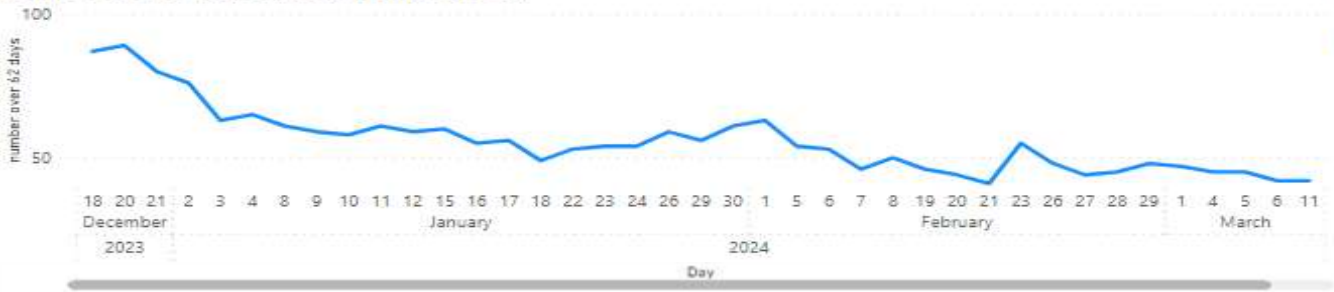
# Cancer Performance

LTUC - Over 62 days (historical) by Date

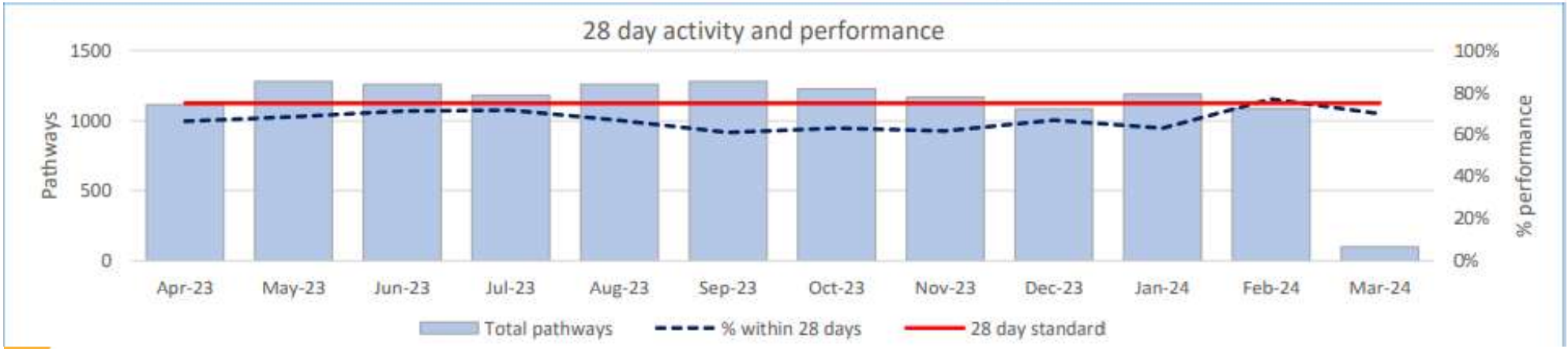



PSC Over 62 days (historical) by Date


number over 62 days by Year, Month and Day

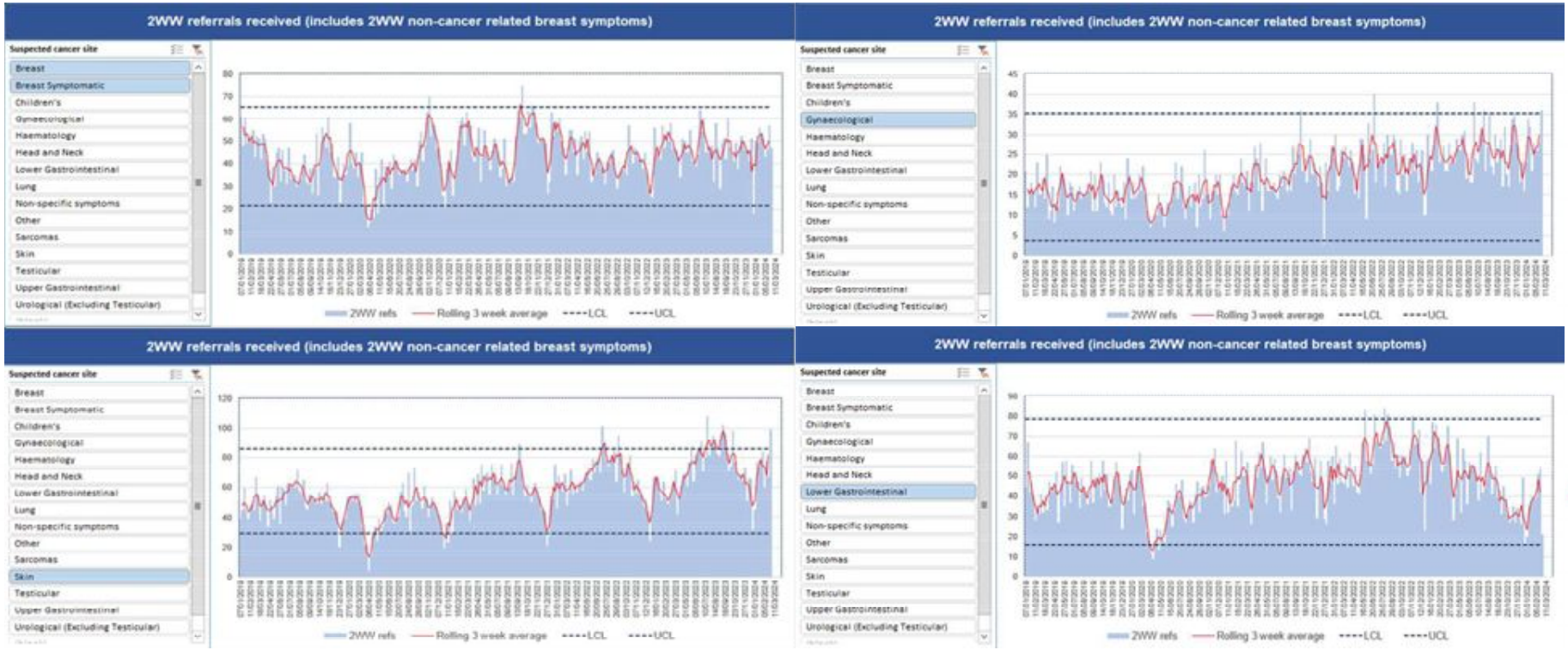



Pareto of cancer sites contributing to over 62 day count


- The 62-day standard was not met in February with a performance of 81.8% against the 85% standard.
- The 2-week wait standard continues to show improvement with the additional breast clinics impacting.
- The number of patients remaining on the PTL over 62 days (i.e. treatment no complete) has reduced to 45.
- The Faster Diagnosis Standard (FDS) shows improvement was achieved in February with performance at 78.6% against the 75% standard.

# Cancer Performance




- Performance against the 2WW Cancer standard was at 86.8% in February, an improvement on last month.

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

| | | | |
|---|---|---|---|
| **Date** | **9 January 2024** | **Location** | MS Teams |
| **Chair** | Brendan Brown | **Minutes prepared by** | Geraldine Morris |
| **Attendees** | Foluke Ajayi (FA), Mel Pickup (MP), Brendan Brown (BB), Jonathan Coulter (JC), Phil Wood (PW), Len Richards (LR), Lucy Cole (LC), Ben Roberts (BR), Sal Uka (SU), Angie Craig (AC), Jason Pawluk (JP), Asifa Ali (AA) | | |
| **Apologies** | None. | | |

**Agenda**

| ITEM | | WHO |
|---|---|---|
| **1** | Attendance & Apologies | Chair |
| **2** | Minutes & Actions | All |
| **3** | NSO update | AC |
| **4** | Impact of strike / current position | All |
| **5** | Collaborative Report and WY HCP Report<br>• ERF, mutual aid, and long waiters | LC |
| **6** | Imaging Network Maturity: Commercial model | LC |
| **7** | RAAC | FA |
| **8** | Break | |
| **9** | Five Year Strategy and 24/5 Annual Delivery Plan | LC |
| **10** | Neurology update | SU / AA |
| **11** | Haematology update | SU |
| **12** | CiC Agenda | LC |
| **13** | AOB | All |
| **14** | Close | Chair |

## MEETING NOTES

| Agenda Item | Main Points and Decisions from Discussions | Agreed Follow-Up Actions |
|---|---|---|
| **1. Attendance & Apologies** | There were no apologies noted for this meeting. | |

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| **2.**<br>**Minutes & Actions** | The minutes from the previous meeting were reviewed and one change was noted:<br><br>LC noted the following amendment from EN to previous minutes on page 5:<br>• *"We had interface with 3 ICBs (HNY, WY and NCNE) and all had slightly different approaches as we have different commissioners for different parts of our provision (NCNE are mainly local authorities and this works well), our West Yorkshire WYAAT arrangement works well, however the HNY model is where we have issues with boundaries and borders."*<br><br>**The action log was reviewed, and the following updates were given:**<br>• ***Action 153:*** *Strategy and 24/5 Plan – LC to schedule further all execs session in the new year* – It was agreed that the next all executives meeting would be held in March, ahead of the WYAAT conference which will be held in May<br>• ***Actions 140*** *(RAAC),* ***142*** *(neurology)* ***and 151*** *(funding)* - all on today's agenda.<br><br>**The following actions are complete:**<br>• ***Action 156 and 157:*** *WYAAT SRO Roles* – FA agreed to be deputy Chair / JC agreed to be SRO for Stroke & Neurology - LC thanked FA and JC for accepting these roles.<br><br>All other Action items were noted to have been completed or not yet due. | **ACTION: PMO to amend previous Minutes.** |
| **3.**<br>**NSO update** | *Angie Craig (AC) and Jason Pawluk (JP) joined the meeting*<br>• JP - discussed the position. Engagement is favourable, but not many options available. Public/private engagement going well after nine events, with good feedback. Transport, travel, and access are a key concern; primary care access was a significant theme.<br>• AC – Outlined efforts in respect of international recruitment and the learning from the process. There were 6 candidates interested. Support/sponsorship process from HEE / NHSE was not as expected. Has resulted in two potential candidates. AC commented there were unfilled training places - possibilities are being explored with the deanery.<br><br>PW – noted that the discussion was highlighting medical oncology and RCR. This was primarily focused on medical oncology provision - need to make the distinction.<br><br>JP / AC continued:<br>• Chemotherapy prescribing system has been a slow process, should know where we are in process by end April. Working towards procuring the same version of the same system currently; hoping for | **ACTION: AC to provide further update at future meeting (April).** |

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| | this to continue. Have good financial commissioning group, chaired by BR, which helps with business case, identifies current costs and availability of funds going forward. Outline business case ready by October this year. Having everything in one pathway is better for finance. Reduce time patients come to hospital. some patients well and don't need to come to hospital. Chemotherapy capacity across patch has become clear – looking to ease pressure. South sector progressing but this has been hard work. Team developing governance structure. When in place will drop some programme governance structure as won't be needed. North – still not quite signed off. Clinical oncologists have not felt engaged - meeting with them tomorrow to understand their concerns. Need to get it right to get TOM over the line. Programme lead in the North has appointed rest of her team, leading on capacity and demand.<br><br>Members commented:<br>• LR is SRO, but members will collectively support this. Need to include clinical staff - south sector did this well, enabling progress. Meetings in north vitally important, needs time to work through. October seems long way off for business case, but lot of work still to do which will provide clearer future for all. JHOSC next week - hope for green light.<br><br>MP – queried if members needed to do anything members in a targeted way.<br><br>JP / AC replied:<br>• Need to support clinicians to articulate any concerns. Hamish McLure is Chair in north; WF is his portfolio and he's assisting. With enough time/effort/energy spent listening hard enough, we should secure the right engagement and support. There's very little disagreement from communities, who noted patients didn't mind travelling to specialist care for access to experts, but complicated/expensive travel arrangements and wanting to take a friend was picked up on. Place-based meetings with ICB locality staff noted concern about flows. Patients were reassured experts are still in Leeds and patients will still go there, but service more robust in south sector. Patients not concerned about model, more about mechanisms.<br><br>BB – this is helpful so we can reinforce message and support on travel infrastructure.<br><br>JP / AC replied:<br>• Background discussions ongoing with WY combined authority for travel passes for patients on low-income background, and their immediate family. | |

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| | • Should have better idea of chemotherapy capacity and demand around April-time.<br><br>Members commended AC/JP on this great piece of work.<br><br>*SU joined the meeting*<br>*AC/JP left the meeting* | |
| **4.**<br>**Impact of strike / current position** | Trusts gave the following updates:<br>**ANHSFT**<br>• Industrial Action (IA) impact is similar to most; was at OPEL 4 last week, but at OPEL 2 by weekend; very little movement out of beds; lots of ED demand, level of escalation beds half of last year's due to RAAC position; A&E performance did fare badly; elective had to stand down or cancel - big impact; other thing observed is clinicians are really tired - unsure consultants can sustain more IA.<br>**LTHT**<br>• Coming out of new year weekend had significant pressure pre-strike with usual flow problems; better position to last year with NCTR, which helped; flow last week was tough as social, community and primary care slow to get going after the break; schools going back this week had variance for Leeds; IA had 60-70% out with a lot of elective stood down; agree that consultants are tired from covering medical ward and unable to do their own work. The winter was better than last; COVID-19 not been terrible – notably more staff than patients off sick with it. Overall, not as bad as could be for first week of January.<br>**HDFT**<br>• Almost identical to ANHSFT position; frustration around social care action; as with LTHT it wasn't as bad as last winter; had 50% out on IA.<br><br>**BTHFT**<br>• Had around 68% striking which impacts on senior decision-making on flow; need to think about consultant-led service in longer-term - very different way of working - how appealing would it be to consultants? It may mean less beds needed and a more economical solution if we can get medical staff.<br>**MYTT**<br>• Had higher levels out on IA than being reported by others. Had only 4 Junior Doctors in the hospital on one day; going into normal working pattern now; A&E footfall is down; concern over 1k expected in A&E going into this weekend; better flow/organisation is a better environment for doctors, but easier to say than do. | |

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| | **CHFT**<br>• Reflected a similar position to the other trusts.<br><br>BB – attention needs to be paid to YAS dynamic – raised an issue of a change to the stroke pathway which was not communication. COOs are aware; have asked LC to raise if anything members need to do.<br>LC – will pick up this afternoon with COOs. Propose we invite Peter Reading/YAS to this meeting in due course for a chat.<br><br>Members agreed with LC's suggestion to invite YAS to future meeting. | **ACTION: LC to raise YAS stroke pathway change with COOs.**<br><br>**ACTION: LC to invite YAS to future Programme Executive meeting** |
| **5. Collaborative Report and WY HCP Report**<br><br>• **ERF, mutual aid, and long waiters** | LC presented a brief update on WYAAT Collaborative Highlight Report *(circulated with meeting papers)*, as some items on today's agenda:<br><br>**Imaging**<br>• Testing/shared reporting solution going pretty well; radiologists happy with how it's testing – go live on track; looking to use shared reporting with CDCs; had call from NHSE in December offering funds for AI deployment. This has a lot of clinical support; disappointment over not receiving it initially; reviewing how to maximise the funds, but it's a challenge.<br>**Planned Care**<br>• Have GIRFT visit tomorrow with Tim Briggs at CHFT; improvement on metrics; day cases performing well; theatre utilisation going ok but had some data quality issues; trauma/orthopaedics had some issues - expect it to be picked up; have clinical network Chairs joining us, should be good session, but with points to focus on.<br>**Planning guidance**<br>• Don't have planning guidance - COOs/DOFs meeting in a couple of weeks on how to achieve key targets. BR doing detailed work with ERF.<br>**Pathology**<br>• Service contract Lot 2 – supplier identified; slightly behind but doesn't affect implementation.<br>**SLP Cohort 2**<br>• Will be seeking mentors/nominations from executive teams. Will include community and mental health providers.<br><br>LC presented an update on WY HCP (West Yorkshire Health and Care Partnership) Report *(circulated with meeting papers)* | |

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| | • Nothing significant; working on next steps on operating model outcome; consultation with TUPE on small number of staff impacted (ICB-to-WYAAT); clarifying through HR; BB/LC SOAG in December, need to get signed to form basis of transfer of staff in 2024/2025; had early December session looking at option 5 of ICB operating model - outputs awaited and will be reported back to this group.<br><br>Members commented:<br>BR – from ERF perspective, still discussing with the Centre; almost at point to agree it; £19m coming into system. We are slightly better off on alternative system if we ignore strike adjustments. There's something about balance performance/finance. There's enough spend in cancer alliance to cover as a back stop, which will be avoided, if possible, but it's there as support if needed.<br>LR – PBR vs current system: in a number of our organisations, we've created high volume/low complexity centres, will give them capability to do more work next year. Not sure where discuss taking place<br>BR – will form part of DOF/COO conversation. If they reset us to 2023/2024 it will change our thinking. Will challenge DOFs/COOs.<br>JC – we need to be able to demonstrate if the pilot means we're more productive and providing better care.<br>BR – will discuss with Mark Liddington (elective care group). BR / LC doing review paper in next month on this and will pick all these bits up. It's a key pledge.<br>BB – noted a couple of programs running at green, couple at amber and offered LC support if needed in getting things moving along.<br>LC – imaging is on track, just on amber currently as original go live date not realised. | **ACTION: LC to feed back at future meeting outputs from December meeting on Option 5/ICB Operating Model.**<br><br>**ACTION: ERF review to be reviewed by Programme Executive when complete.** |
| **6.**<br>**Imaging Network Maturity: Commercial Model** | LC updated on Imaging Network Maturity: Commercial Model<br>• This is similar to vascular conversation a few months ago. For context, original imaging case has changed since 2017; very much talking about single service; business case being developed to review that model; not touched it - haven't needed to as found a way to work outside of that; will continue to implement business case on insourcing outsourcing work; scope in there to look at job plan specialist reporting; flip side NHSE maturity matrix to assess six-monthly, maturity expected March 2025 but already there. Commercial entity – push on joint venture/LLP/hosted organisation options. The existence of this causes anxiety amongst teams about grand plan to create one unified department across WYAAT.<br>• The ask of this group is to formally say 2017 ask is no longer required - looking for support for that to communicate to teams to close it. | |

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| | PW – we must have had some benefits articulation business case; would be helpful to be clear we no longer need it; nervousness around this going in the "too difficult box" - how bad are finances going to get and are we wise at the moment to take it off the table? It will be impossible to put back on once it's taken off and may set precedent to other services, re-centralise functionally; must have efficiency/other opportunities for us.<br>MP – queried if CiC would view this as a retrograde step.<br>LC – really helpful comments; benefits that describe case for change – we can evidence how we're doing this. Happy to go back and do assessment to ensure we're not missing out.<br>LR – the paper says maximum collaboration/working together in network, without structural change. It's consistent with the style and approach we operate with.<br>LC – it's absolutely about that - philosophy has been the least disruption. In reply to PW/MP comments, it's to do assessment against originally prescribed to ensure not missing out anything significant. At northeast aseptics meeting lAP so everyone's a partner. It's not previously been raised with us as people feel assured with how we work.<br>PW – the messaging is key here; we're aware radiology is a shortage speciality; we've been reactive re: work we've done so far, as driven by WF shortages/pressures. Want to keep the door open, to deter challenges in -5 years.<br>BB – we'll bring this back next month. | **ACTION: LC to do assessment of the benefits outlined in the original case for change and feedback at February PE meeting.** |
| **7.**<br>**RAAC** | FA updated on the RAAC position at ANHSFT<br>• There are over 50,000 RAAC planks with many at risk of structural failure; only hospital with concrete structural frame – challenges compound the problem. In 2023 the Institute of Structural Engineers issued updated guidance which flagged RAAC in schools. We're now at critical status, monitoring monthly to ensure we take right action. Not had any additional incidents in last twelve months. Have seen impact of work we're doing. Had to decant endoscopy to enable works/now back in original location. Two wards decanted to enable additional works this year. Focus is now on next year - £50m agreed to focus on RAAC to accelerate decant problem, to enable completion of structural work, medical engineering, discharge lounge, medical storage and office. Hope to complete early spring, so UTC available. Work ongoing, no new significant risk identified. Looking beyond 24/25 at the £75m needed while we focus on new hospital. Happy to provide papers if needed. RAAC funding comes separate from NHSE estates. For 2024/2025, asked for £10m but not sure if it'll be granted, due to other hospitals finding RAAC. Feels relatively ok at this time. Natalie is SRO and seconded – looking at it being substantive for continuity<br><br>BB – keep us posted, we'll respond to any request for help | **ACTION: FA to share papers on RAAC improvement works with members.** |

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| **9.**<br>**Five Year Strategy and 24/5 Annual Delivery Plan** | LC gave an update on the Five-Year Strategy (circulated with meeting papers)<br>• The high-level document to remain in date over five years; there's a slight change to reframe so the focus is on six core elements of Strategy - working together appears in final section. Research/ innovation/improvement – design/build academic science centre – a real opportunity for us to shape our approach is reflected in there, which PW will update on. Approach – if members are broadly happy with content, we can do work on design for CiC. Additional priorities divided up for people to lead. Directors of Strategy have proposed approach on peer support and learning framework. Hopefully it brings together various elements we've talked about. Anything fundamentally missing or not clear enough needs to be flagged so LC can take to CIC.<br><br>Members commented:<br>BB – thanked PW for agreeing to lead on research, innovation and improvement.<br>PW – commended LC on the annual plan/5-year Strategy. He emphasised it was to help define the future pieces of work we want to be thinking about and our ambition of where we want to get them to.<br>LC – it's about finding the right level to do it/metrics to show we're successful – a combination of these two things. This will be discussed with executives at March session where we'll review what our processes and measures are to demonstrate we've done it.<br>JC – are we using collaborative to improve WF design? We have the portability stuff allowing people to move that want to move. He commended this piece of work.<br>LC – we do some of that already. We couldn't train in single organisations e.g., for consultant clinical scientists in pathology, but networks give us the opportunity to do this. There's a development session at CiC on 30 January. In terms of where there are more opportunities to learn from, at greater scale, we could put a line in there to signal there's intent/ ambition, without committing ourselves.<br>JC – agreed the Strategy could be worded to describe what the future looks like.<br>LC – there's value in clubbing together in broader range of organisations, which might help us in terms of spending externally with particular suppliers.<br>BB – commended LC, adding the work gone into this should not be underestimated. He proposed that LC, SU and BR should be included alongside the CEOs and Chairs noted at the front of the Strategy document to demonstrate it's not just about us.<br>LC – good point and will review it. Also, think about associated communications to go with-it; think about what key bits to pick out for web site, people leading it to front the work, spread culture of collaboration, use context to support that.<br>BB – it's futureproofing us to a future state. | **ACTION: 5-year Strategy to be discussed at all-executives meeting on 5 March.**<br><br>**ACTION: LC to amend Strategy wording on workforce to influence the supply side.**<br><br>**ACTION: LC to present/discuss Strategy with Boards** |

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| | LC – will speak to CoSecs for Trust board sign off. Once it's been through CiC, happy to come and present to boards. | |
| **10. Neurology update** | *Asifa Ali (AA) joined the meeting.*<br><br>• AA and SU presented an update on neurology and transformation program *(paper circulated with meeting papers)* and a short slide presentation. The paper discusses progress to date; there's no ask today, other than acknowledgement that progress is noted. AC noted the WYNN and CRG steering group have endorsed networked model of hub/spoke approach; she highlighted the preferred model and the priorities of four Workstreams being worked on. In summary prioritising operational framework for end of February, followed by Programme Executive approval and then CiC.<br>• SU – this has been a really challenging programme of reengagement. On-call is a sticking point, with weekend demands. Option appraisal future employees - existing employees are leaving as they want to be part of a network model, so pace is needed. Need to work on sticking points over next 3-6 months, but there's optimism.<br><br>BB – asked for slides to be shared.<br><br>Members commented:<br>• It's the right direction to go; we'll get trainees to see WY is the place to be as we get this model connected; new training leading to qualification is on the radar, leading to future staff having dual qualifications; formation of neurosciences is sensible - we're 3-5 years away from that model but in good position; it's realistic that neurology/stroke sit together rather than general medicine; some benchmarking has been carried out around reducing on-call – WY conversation need on how we do this as some consultant haven't done on-call in 25 years; there was a question of whether there's a demand for on-call and if formalising it was needed.<br><br>Members commended the work and asked if anything else was needed.<br><br>AA – the on-call piece is in draft; today is to ensure you're happy with approach we're taking.<br>BB – good to have you back for update, it's a concerning service for all reasons described.<br><br>*AA left the meeting* | **ACTION: AA to share slides on neurology networked model and workstreams.** |
| **11. Haematology update** | SU gave a verbal update on haematology | |

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| | • There's still a move to support a buddy system; HDFT is in precarious position, with only two substantive consultants this month; meeting the needs during IA has been challenging; has given catalyst to review long term plan. We're picking up that mantle, with reviews diarised to support HDFT with design and model. ANHSFT and BTHFT clinical relationships have been challenging. Will hold session and pick up with Ray Smith/David Crampsey; things are picking up, with less fragility and we remain optimistic; support needed to get clinicians to right head space. CHFT and MYTT are stable, but there's a difference between the two in terms of performance, patient experience and outcomes. Flow needs review in acute and cancer; operations leads are leading work around NSO and struggling around haematology as a result; planning needs building into overall work plan; meetings scheduled for mid-February, want to consolidate plan to present back to you in March.<br><br>Members commented:<br>• SU was thanked for his work on this. The challenges ANHSFT clinicians are presenting is acknowledged and conversations will continue to ensure Ray/David are connected on it. A line needs to be drawn and ways of working agreed to make us sustainable. This feels more positive than six weeks ago. It's a step change in thinking how to push this forward. It was acknowledged that it's not been easy getting here.<br><br>BB – summarised that the work on NSO speaks to all of us. He asked SU to please continue with this work and come back in March with an update on where we are. | **ACTION: SU to report back on haematology work plan at future meeting.** |
| **12.**<br>**CiC Agenda** | LC discussed the draft CiC agenda (circulated with meeting papers)<br>• As agreed, the second half focus will be a development session on workforce, to include case studies – NSO and how to relieve pressure – and Aseptics; innovative work to recruit local community to hub. There has been good work happening in Leeds, with nice examples of work being done and opportunity to spread to other areas; will pitch some key questions; HRD and aseptics leads will be there and hope to generate some good discussions around that; will include some information in the pack.<br>• Main items – usual stuff in first half; Strategy for approval; will pick up in the paper proposed approach of CiC and make sure focus on Strategy; cover in covering paper.<br><br>BB – all Chairs are supportive - let's try and get some of that into the conversation; it's good to call out workforce here as there's a lot of work going on.<br><br>LC – confirmed CiC is scheduled for 30 January. | |

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| **13.**<br>**AOB** | PW – LC mentioned it, noting he has taken over Chair of Academic Health Partnership in Leeds as of January, which should provide a strong link with the research, innovation and improvement work across WYAAT.<br>BB – Noted there is an ICB deep dive WYAAT focus in March 24. | |

## OTHER ISSUES TO NOTE

**INSERT SLIDE PACK IF AVAILABLE:**

## NEXT MEETING

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| **Date Time** | 6 February 2024, 09:30-12:30 | **Location** | *MS Teams* |