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
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 2024

Summary:
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.
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.
CHS5: Violence and aggression against staff has been a high importance risk for the trust, mitigations have reduced the rating to 12 in March
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 reduced to 16 February 24. This risk has the sits highest outside the risk appetite.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS2: HDH Goods yard	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR75: CHS2 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	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.	Minimal	16	12	12	8	July 24

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

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS3: Managing the risk of injury from fire	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR75: CHS3 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	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.	Minimal	20	15	15	10	Sept 24

Key Risk Indicators	Current Position	Controls and Plans
Updated Fire Safety Policy and associated management protocols Completion of fire assessments Appointment of competent Fire Manager and Authorising Engineer Completion of assessments Implementation of fire procedures and policies Communication of fire procedures to all employee Audits and reviews of the above conditions at appropriate intervals.	Fire risk assessments are not currently available for all areas of HDH Fire safety measures have been identified and are in the process of being implemented fully, of these fire compartmentation and fire door safety measures are inadequate. There is no clear picture of the Fire safety standards in properties leased by the Trust As part of Backlog Maintenance report – HDH site Fire Alarm system has been identified as being in need of urgent investment, Protec have provided a quotation in excess of £1.6m to replace the existing fire system Review of all compartmentation and fire doors at HDH. With an action plan in place to carry out identified remedial work. New Fire Policy and Fire Management Procedures in place. SLA with Leeds Teaching Hospitals NHS Trust (LTHT) is fully implemented. Mark Cox attending site weekly to carry out a range of activities (including review of all fire risk assessments, review of fire strategy in relation to current construction work, delivery of ad hoc training) Fire safety group established with monthly meetings, this provides actions from all risk assessments. The group will monitor the actions and escalate actions through the health and safety committee. Following two fire incidents fire reviews indicated all measures were in place. Chubb have now taken over maintenance and replacement of fire-fighting equipment to address previous failure to ensure 12 month checks are completed.	Review of all current fire safety provisions Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. Production of evacuation plans and training on evacuation. Mott MacDonald have produced a Fire and Life Safety Strategy Report – this details a number of urgent issues which require remedial action. To separate fire risk in to individual risk entries – General Fire (RA's/Evac Plans/Training), Fire Alarm System, Fire strategy for HD site, including compartmentation/fire doors/remedial work to fire dampers. These will be added to the H&S Risk Register and escalated where appropriate. Work on this will be reported via the Fire Safety Group/H&S Committee/Environment Board. Costs for the remedial work for compartmentation, fire doors and fire dampers are being obtained - Initial fire door remedial work to take place in medical records, due to high risk nature of the area, using existing 23/24 backlog funds – approx. £15k Meeting with Operations Directors to add clinical risk priority to Backlog Maintenance paper Recommendations of the Fire Authority being actioned Meetings to be held with clinical teams to progress the creation of suitable evacuation plans New Monthly Acute and Community Fire Checklist being produced to completed by all teams / departments / community locations

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS5: Violence and aggression against staff	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR75: CHS5 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	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.	Minimal	16	16	12	8	May 24

Key Targets	Current Position	Controls and Plans
Suitable and sufficient assessments of risk Trust / HIF activities. Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	• Current policies for Violence & Aggression, Security and Lone Working are out of date and do not reflect the current makeup of the Trust, the services it provides, locations and resources. • Risk assessments, where available, are generic and do not provide clear identification of hazard or control measures. • Security presence in the Acute setting is limited - Security guard in place on ED 6pm - 6am, currently single LSMS supporting entire Community footprint. • Training is limited and is not currently provided to staff on a risk based approach. • Conflict Resolution (Breakaway Skills) training provided to approximately 220 staff • Escalation procedures for staff in response to incidents and the procedures to follow when dealing with patients is limited and not consistently applied. • Reports on a daily basis of incidents of violence and aggression against staff across the Trust, both physical and verbal (20-30 Datix reports per month). • Trust supports and promotes a zero tolerance approach to V&A, however there is a culture of accepted levels. • Trust Security Forum in place – now reports directly to the Trust H&S Committee • Ligature assessment and training scheduled	• Task and Finish group established (led by Head of H&S and HON LTUC) – broad remit to review all existing policies, procedures and implement improvements where required. • Phase 1 work reviewing managing Patients who may self-harm / those suffering with mental health issues. New policy- in draft • New environmental assessments and creation of green spaces to allow safe areas for patients and staff (complete in Farndale and Oakdale) – to be continued across Acute setting • Provision of ligature training • Increase in provision of Breakaway Skills training to staff based on risk. • Mandatory elearning Conflict Resolution training for all HDFT staff • Visits to all Community teams/locations to identify current security, lone working procedures • Phase 2 work for Task and Finish group has started – looking at the management of patients with dementia/delirium • Business case for resource to increase Conflict Resolution – Breakaway Skills training

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS8:RAAC	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR75: CHS8 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	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.	Minimal	16	20	20	8	June 24

Key Targets	Current Position	Controls and Plans to implemented
Structural inspection / surveying Health & Safety Committee surveying and ultimately to record plank condition Results from Regular progress reports to board and sub committees of the current position on RAAC Plans and the Risks	The HDH sit has been surveyed by WSP and an identification and deflection survey is on going.Some temporary safety measures have been implemented to support the roof. Areas of immediate action have been identified and at risk areas have also been identified. (ALL initial RAAC emergency work is complete) Funding of £490k secured from NHSE for 22/23, which will cover costs already incurred, surveying and remedial work being carried out. Additional bid made for 23/24 Responses from community landlords are being received (reminder email sent by Director of Strategy)- Data Collection Questionnaire for NHSE has been completed and sent The trust is expecting to hear about the funding arrangements imminently Year 1 report indicates increased likelihood of a panel collapse – assessment of risk of collapse vs risk of harm cancelling clinical services in those areas required B3 Corridor (Farndale to ITU) has had significant water ingress – increasing likelihood of panel collapse Year 1 Report now received from WSP – analysis shows significant areas of remedial work required. Further meetings with WSP to identify course of action Relocation of teams and services are being implemented and monitored through fortnightly meetings.	To undertake and annual survey of every plank; or more frequently as advised by your structural engineer Be part of a communications approach led by NHS England, cognisant of: SCOSS Guidance; Duty of Candour; and duties under the Health and Safety at Work etc. Act 1974Strategic plan in place to identify remedial action needed, with long term plan to eliminate RAAC from site by 2035. Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead – initial discussions with EPRR manager held Business Case being developed to implement RAAC eradication plan, including additional funding from NHSE – intention is to incorporate backlog maintenance work where possible. Work to carried out includes temporary stalls, netting and a scaffold crash deck in addition to relocation of services Year 1 Report now received from WSP – analysis shows significant areas of remedial work required. Further meetings with WSP to identify course of action

Harrogate and District NHS Foundation Trust Corporate Risk Register

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)
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)
Initial Date of Assessment	1st July 2022
Last Reviewed	March 2024

Summary in Month:
CRR93 is focused on the Caring Domain, aiming to ensure workforce wellbeing and deliver quality care.
CRR93 emphasizes the risk to patient safety and colleague wellbeing due to low staffing levels, particularly in North Yorkshire's 0-19 Service. Challenges include high turnover, sickness rates, and difficulty recruiting Band 6 roles. Mitigation efforts include recruitment strategies, support for SCPHN students, and consultation for virtual team implementation.

CRR93 has been added to the risk register in March 24, further development of the key metrics and plans is required.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR93:	At Our Best – Making HDFT the Best Place to Work	Workforce; Supply and retention	Risk to patient safety due to low staffing levels Risk to colleague health and wellbeing due to sustained work pressures	Cautious	12	12	12	4	Sept 25

Key Targets	Current Position	Controls and Plans to implemented
Band 6 Availability to work to increase to 80% each day **• Turnover rate** **• Stability index of team** **• Long term sickness rate** **Short term sickness rate**	The service model in North Yorkshire differs greatly to other 0-19 models due to reduction in public health grant and financial envelope of the contract, transformation of the service to meet the specification and financial envelope, some colleagues do not want to deliver the model. This combined with national challenges to recruit and retain Health Visitors has led to reduced Band 6 availability to lead the delivery of the Healthy Child Programme. Consequence – Low staff morale impact on health and wellbeing of the workforce, challenges to meet KPIs Cause- increased work pressures due to high turnover and sickness, gaps in workforce due to difficulty recruiting to Band 6 roles. The North Yorkshire 0-19 Service has reduced availability of Band 6 workforce to assess, plan and deliver and co-ordinate delivery of the Healthy Child Programme to the population of North Yorkshire. The service covers a geographical area covering 3100 square miles with limited estate, a reduction in the availability of band 6 practitioners delays timely delivery of mandated contacts and planned targeted and specialist support. Health Visitors and Public Health Nurses have higher than average caseloads with some Health Visitors having in excess of 1000 children they are the named Health Visitor, when the service was modelled with the reduced public health grant it was expected Health Visitors would have approx. 420 children on their caseload, numbers are currently high due to vacancy and sickness. Universal contacts provide an opportunity to deliver early intervention and prevention thus ultimately increasing pressures within the health and social care system.	Ongoing recruitment and retention work as part of the Workforce workstream and recruitment strategy • Increased number of SCPHN students supported in 24/25 • Consultation for Virtual Team implementation commences 2/4/24 • Review of standards of roster creation and agreed staffing level

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

Lead Committee	Resource Committee
Executive Committee	Operational Management Group (OMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	April 24

Summary in Month:

This area of the Corporate Risk Register is linked to the Responsive Domain.

1. **CRR34: Autism Assessment**
   - **Description:** Risk to quality of care by not meeting NICE guidance regarding the commencement of autism assessment within 3 months of referral. Risk includes potential lack of access to appropriate support without a formal diagnosis, leading to deterioration in condition.
   - **Current Status:** Backlog of referrals exceeds NICE standards, with projected wait time of 43 months by end August 24.
   - **Controls and Plans:** Efforts to reduce waiting list, increase assessment capacity to meet demand, and standardize referral criteria. Lack of funding for capacity gaps poses a challenge.
2. **CRR41: RTT (Referral to Treatment) – De-escalated in March 24**
3. **CRR61: ED 4-hour Standard**
   - **Description:** Risk of increased morbidity/mortality due to failure to meet the 4-hour standard in Emergency Departments.
   - **Current Status:** Performance below local target, with ongoing challenges such as building works limiting space and streamlining pathways.
   - **Controls and Plans:** Capital works to improve ED infrastructure, streaming initiatives, and plans for improvement likely to take 3-6 months to address contributing factors.
4. **CRR90: Haematology Service Delivery – The rating has been reduced to 8 in May. This risk has been removed from the register**
   - **Description:** Risk to patient safety from failure to provide full haematology service due to staffing gaps in consultant workforce.
   - **Current Status:** Thorough review of rota to highlight future gaps, challenges with recent departure of planned locum cover.
   - **Controls and Plans:** Seeking new locum consultant, considering pausing 2-week wait referrals, recruitment of consultants and trainee ACPs, and streamlining clinic capacity.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CRR34**: Autism Assessment	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR34: Autism Assessment	Great Start in Life	Clinical; Patient Safety	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)	Minimal	12	15	15	8	May 26

Key Targets	Current Position	Controls and Plans to implemented
Waiting list would have to be reduced to 120 and longest wait to 13 weeks. Baseline capacity would need to meet the referral rate. Numbers on the waiting list Longest wait of CYP having commenced assessment Longest projected wait of CYP joining the waiting list Activity ■ To meet the monthly ICB target for number of assessments ■ Meet the annual planned target for assessments	We have modelled the impact of the funded Waiting List Initiative (WLI) for 2023/24 and it will only slow the growth of the waiting list. The projected wait for assessment by end August 24 is now 43 months; this has increased due to the 6 month average monthly referral rate of 86 and the higher current waiting list numbers. 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. 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 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	Type	Principle Risk: CRR61 ED 4-hour Standard Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR61: ED 4-hour Standard	Best Quality, Safest Care	Clinical; Patient Safety		Minimal	12	12	12	8	November 24

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%

	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	Jan 24	Feb 24
Type 1 & 3	68%	66%	63%	72%	81%	78%	83%	81%	80%	82%	73%	65%	70%	68.7%	66.9%	71.1%	71.8%

In Feb 24 there were 1,153 patients who spent longer than 6 hours in the department.

12 hour waits

	12 Hour DTA	12 Hour total wait
May 23	1*	30
June 23	1	38
July 23	0	33
August 23	0	65
September 23	1	119
October 23	14	167
November 23	46	226
December 23	71	332
January 24	124	344
February 24	42	202

	30 Min HO (including 60+ mins)	60+ Min HO
May 23	6	0
June 23	9	0
July 23	12	0
August 23	22	3
September 23	15	1
October 23	34	11
November 23	36	11
December 23	36	10
January 24	4	1
February 24	7	3

Ambulance handover breaches
Ambulance delays have increased significantly during January and February. This is due to overall delays in the ED due to numerous factors including bed occupancy, flow and winter pressures. There are significant discrepancies between HDFT internal data re ambulance handover times and YAS data.

From 10th May 2023 a boundary change was agreed to increase the postcodes from which patients are brought by YAS to Harrogate ED instead of going to York. This was an effort to support York in a more consistent way, however there is an ongoing request for ad hoc diverts from York. This was extended further in October 23.

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	**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) has seen a considerable change in March 24 with the PDC draw down resulting in the target rating being met. A financial risk to the Trust's long term objectives is due to be accepted to the register in June
Executive Committee	Operational Management Committee (OMG)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	March 24	

Harrogate and District NHS Foundation Trust Corporate Risk Register

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
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	March 24

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.

Two corporate risks, CRR87 and CRR88, pose significant challenges to meeting NHS standards and patient safety.
CRR87 highlights the risk of failing NHS planning targets for RTT wait times in Community Dental Services, with an investment of £1.5 million underway. However, operational pressures and funding queries remain, impacting productivity and causing cancellations.
CRR88 addresses delays in diagnosing bowel cancer due to a shortage of endoscopists and list capacity, exacerbated by retiring consultants. With Metrics for CRR88 being consistently met the likelihood score reduced. The risk rating was accepted as 9 in May and removed from the register.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	April Rating	May Rating	Target Rating	Target Date
CRR87 **Community Dental**	Provide person centred, integrated services through strong partnerships	Clinical; Patient Safety	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.	Minimal	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. •No of overdue continuing care patients. Current position – 2532 patients overdue. Longest waiters 4 years overdue (2 in total, due in Oct 2019).	. 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). 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). Key actions agreed that are being implemented already: 1) Waiting list initiative (WLI) clinic sessions for December and the rest of the financial year 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. 3) Progression of the SOEL Health dental IT system replacement – procurement has commenced. SOEL is not supported from April 2024 onwards. 4) Capital kit replacement progressed – dental chairs and X-ray kit etc. 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 Escalation beds, this reduces our productivity through lists with numbers having to be reduced at short notice/on the day cancellations. 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. Notification from Service to ICB commissioners that we will not be able to sign the contract while we have this discussion at Trust Board. Follow up with ICB at Exec to Exec level to explain the current risk and to follow up previous place level agreement to meet to discuss a joint solution to the issue.

CQC WELL-LED DOMAIN

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

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

Lead Committee	Trust Board
Executive Committee	Senior Management Committee (SMT)
Initial Date of Assessment	1st July 2022
Last Reviewed	March 24

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.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date

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

Static IBR – May 2024

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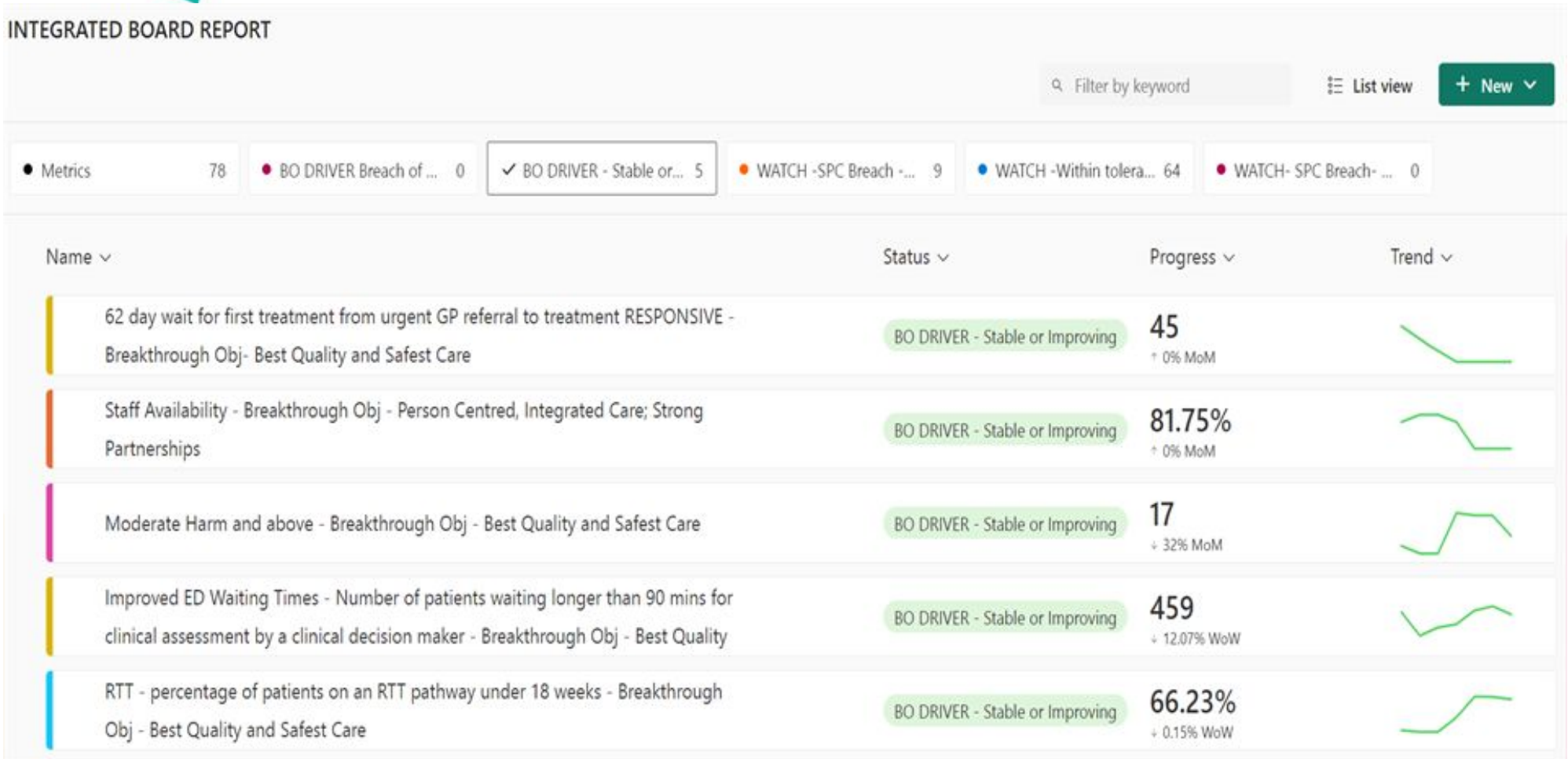

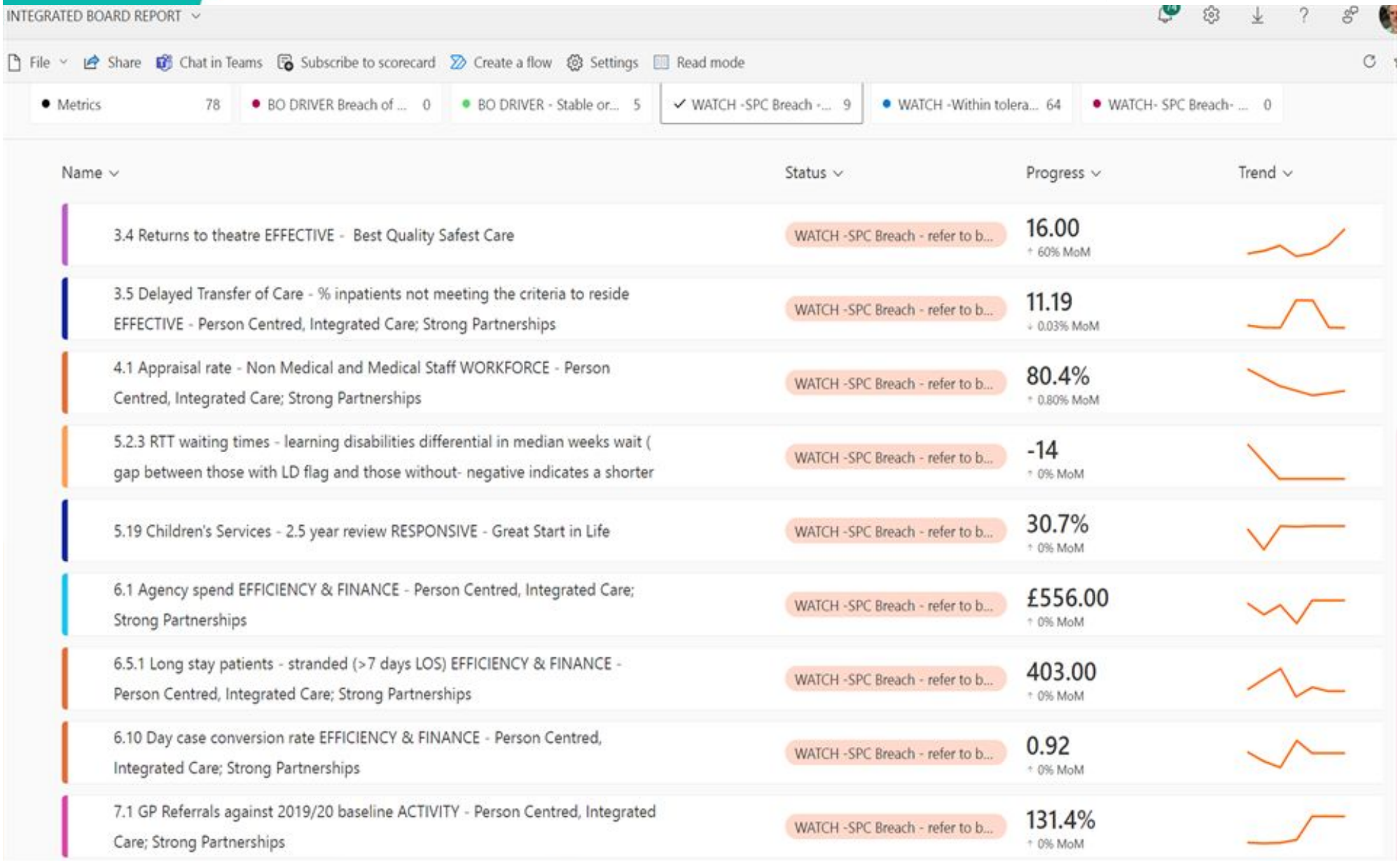
INTEGRATED BOARD REPORT
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Metrics 78
BO DRIVER Breach of ... 0
BO DRIVER - Stable or... 5
WATCH -SPC Breach -... 9
WATCH -Within tolera... 64
WATCH- SPC Breach- ... 0
Name
Status
Progress
Trend
3.4 Returns to theatre EFFECTIVE - Best Quality Safest Care
WATCH -SPC Breach - refer to b...
16.00
60% MoM
3.5 Delayed Transfer of Care - % inpatients not meeting the criteria to reside EFFECTIVE - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
11.19
0.03% MoM
4.1 Appraisal rate - Non Medical and Medical Staff WORKFORCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
80.4%
0.80% 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
WATCH -SPC Breach - refer to b...
-14
0% MoM
5.19 Children's Services - 2.5 year review RESPONSIVE - Great Start in Life
WATCH -SPC Breach - refer to b...
30.7%
0% MoM
6.1 Agency spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
£556.00
0% MoM
6.5.1 Long stay patients - stranded (>7 days LOS) EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
403.00
0% MoM
6.10 Day case conversion rate EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
0.92
0% MoM
7.1 GP Referrals against 2019/20 baseline ACTIVITY - Person Centred, Integrated Care; Strong Partnerships
WATCH -SPC Breach - refer to b...
131.4%
0% MoM

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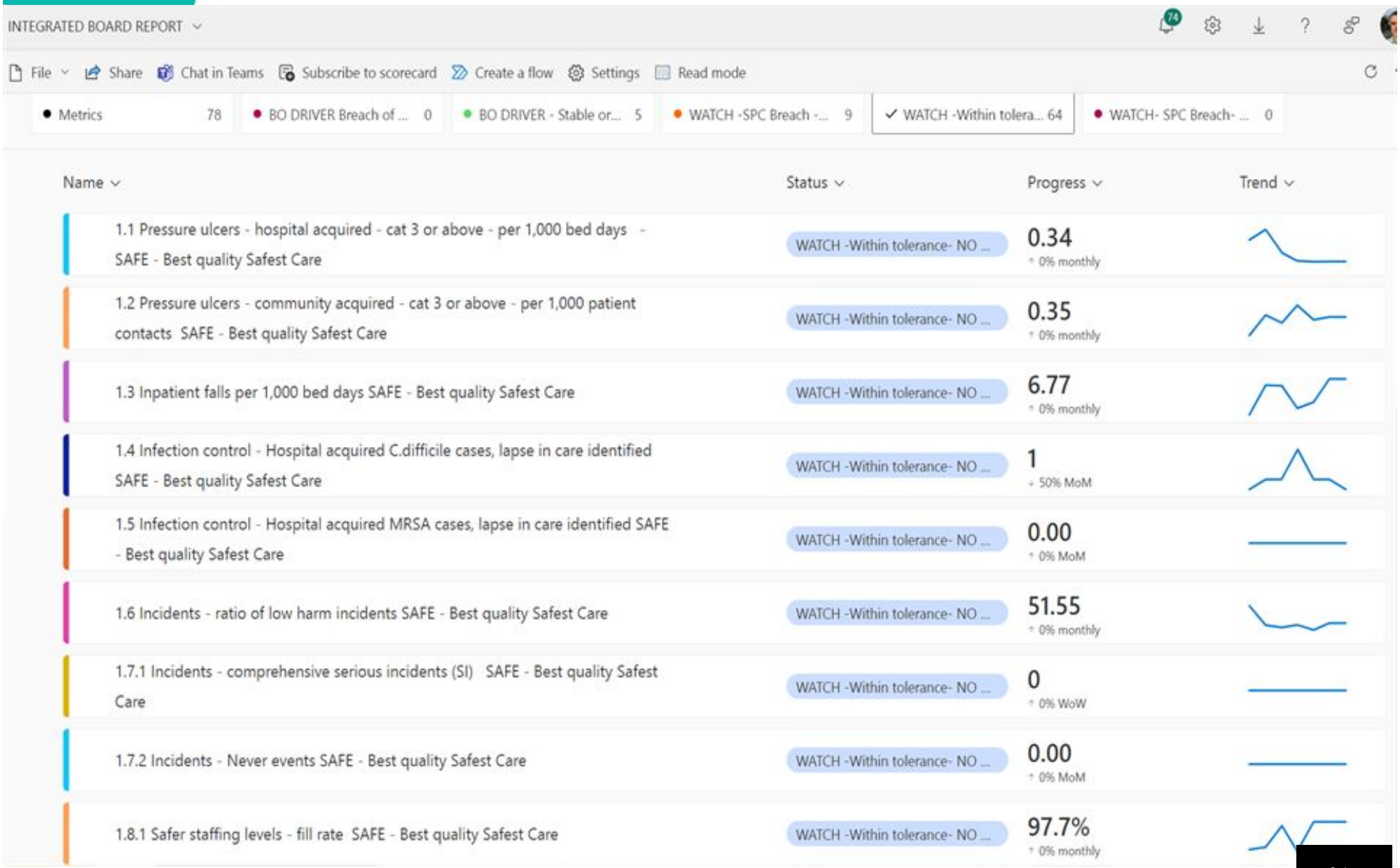

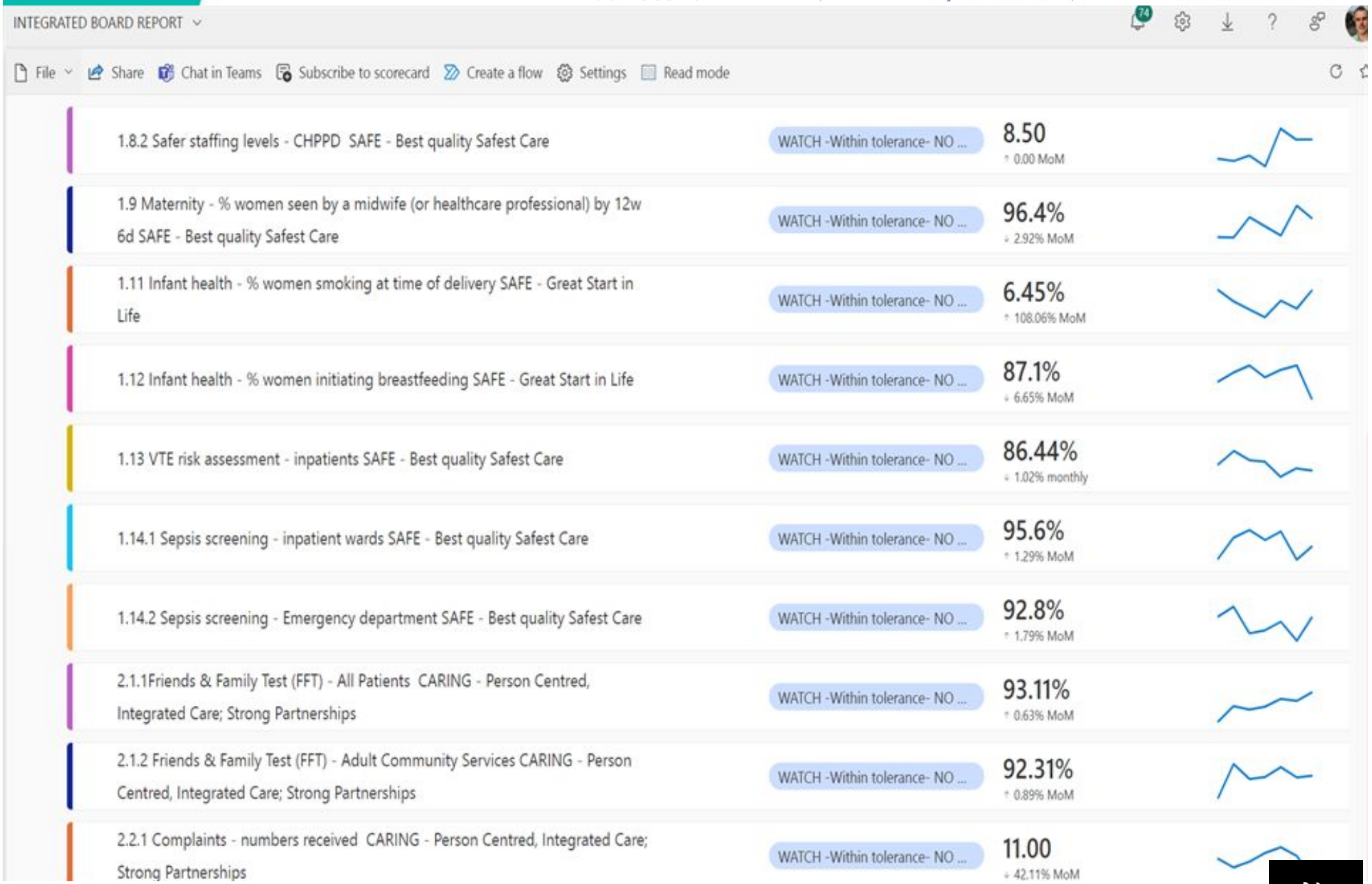
INTEGRATED BOARD REPORT
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1.8.2 Safer staffing levels - CHPPD SAFE - Best quality Safest Care
WATCH -Within tolerance- NO ...
8.50
0.00 MoM
1.9 Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d SAFE - Best quality Safest Care
WATCH -Within tolerance- NO ...
96.4%
2.92% MoM
1.11 Infant health - % women smoking at time of delivery SAFE - Great Start in Life
WATCH -Within tolerance- NO ...
6.45%
108.06% MoM
1.12 Infant health - % women initiating breastfeeding SAFE - Great Start in Life
WATCH -Within tolerance- NO ...
87.1%
6.65% MoM
1.13 VTE risk assessment - inpatients SAFE - Best quality Safest Care
WATCH -Within tolerance- NO ...
86.44%
1.02% monthly
1.14.1 Sepsis screening - inpatient wards SAFE - Best quality Safest Care
WATCH -Within tolerance- NO ...
95.6%
1.29% MoM
1.14.2 Sepsis screening - Emergency department SAFE - Best quality Safest Care
WATCH -Within tolerance- NO ...
92.8%
1.79% MoM
2.1.1Friends & Family Test (FFT) - All Patients CARING - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
93.11%
0.63% MoM
2.1.2 Friends & Family Test (FFT) - Adult Community Services CARING - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
92.31%
0.89% MoM
2.2.1 Complaints - numbers received CARING - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
11.00
42.11% MoM

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2.2.2 Complaints - % responded to within time CARING - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	88%	↑ 11.39% MoM
3.2 Mortality - SHMI EFFECTIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	0.973	↓ 1.27% 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 tolerance- NO ...	2.92%	↑ 28.50% 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	WATCH -Within tolerance- NO ...	8.2%	↓ 8.47% MoM
4.2 Mandatory and Essential Skills Training rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	90.07%	↑ 0.46% MoM
4.3 Staff sickness rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	5.08%	↓ 16.37% MoM
4.4 Staff turnover rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	13.01%	↓ 4.68% MoM
4.5 Vacancies WORKFORCE -Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	4.58%	↓ 13.92% MoM
5.1.1 RTT Incomplete pathways performance - median weeks wait RESPONSIVE- Best Quality Safest Care	WATCH -Within tolerance- NO ...	12	↑ 0% WoW
5.1.2 RTT Incomplete pathways performance - 92nd centile RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	39.00	↑ 0% WoW

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5.1.3 RTT Incomplete pathways - total RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	24.171K	↑ 0.45% WoW
5.1.4 RTT Incomplete pathways - 52-<104 weeks RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	480	↓ 1.88% WoW
5.2.1 RTT waiting times - by ethnicity(gap between BME & White (positive is shorter wait for BME) RESPONSIVE - Person Centred, Integrated Care; Strong	WATCH -Within tolerance- NO ...	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-	WATCH -Within tolerance- NO ...	-12.00	↑ 0% MoM
5.3 Diagnostic waiting times - 6-week standard RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	70.79%	↓ 2.96% MoM
5.5 Data quality on ethnic group - inpatients RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	96.69%	↑ 0% MoM
5.6 A&E 4 hour standard RESPONSIVE -Best Quality Safest Care	WATCH -Within tolerance- NO ...	72.800	↑ 0.75% WoW
5.7 Ambulance handovers - % within 15 mins RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	100.00 %	↑ 0.75% 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 tolerance- NO ...	72.29%	↑ 0% MoM
5.11 Cancer - 28 days faster diagnosis standard (suspected cancer referrals) RESPONSIVE - Best Quality and Safest Care	WATCH -Within tolerance- NO ...	73.62%	↑ 0% MoM

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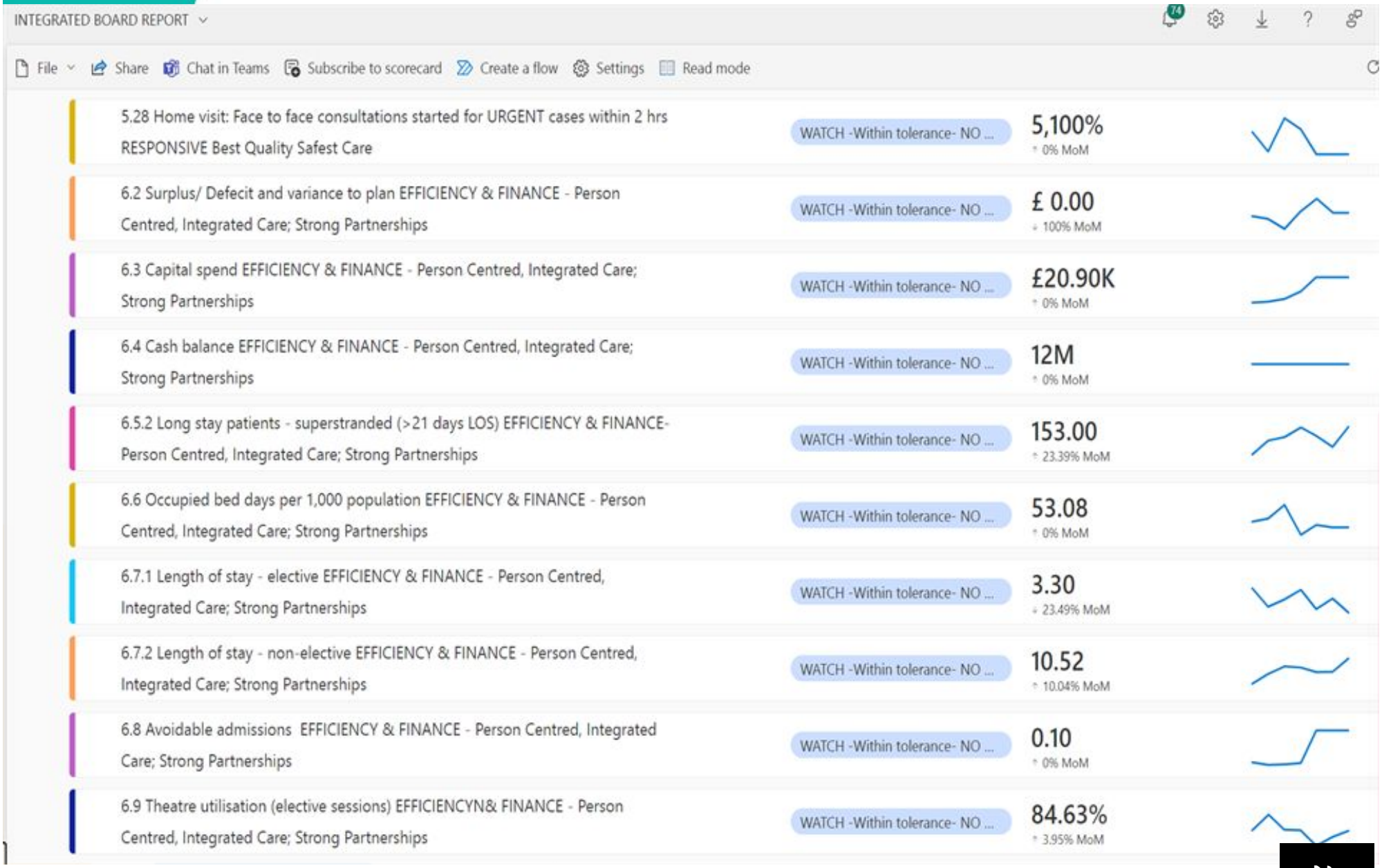
5.12 Cancer - 62 days maximum wait from diagnosis to treatment for all cancers RESPONSIVE - Best Quality and Safest Care	WATCH -Within tolerance- NO ...	95.44%	0% MoM
5.13.1 Children's Services - 0-12 months caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	0.92	0% MoM
5.13.2 Children's Services - 2-3 years caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	0.93	0% MoM
5.14 Children's Services - Safeguarding caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	1.46	0% MoM
5.15 Children's Services - Ante-natal visits RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	130.95%	0% MoM
5.16 Children's Services - 10-14 day new birth visit RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	98.01%	0% MoM
5.17 Children's Services - 6-8 week visit RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	93.29%	0% MoM
5.18 Children's Services - 12 month review RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	96.08%	0% MoM
5.23 Community Care Adult Teams - performance against new timeliness standards RESPONSIVE- Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	95.9%	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 tolerance- NO ...	12,900%	0% MoM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5.28 Home visit: Face to face consultations started for URGENT cases within 2 hrs RESPONSIVE Best Quality Safest Care
WATCH -Within tolerance- NO ...
5,100%
0% MoM
6.2 Surplus/ Defecit and variance to plan EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
£ 0.00
100% MoM
6.3 Capital spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
£20.90K
0% MoM
6.4 Cash balance EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
12M
0% MoM
6.5.2 Long stay patients - superstranded (>21 days LOS) EFFICIENCY & FINANCE- Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
153.00
23.39% MoM
6.6 Occupied bed days per 1,000 population EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
53.08
0% MoM
6.7.1 Length of stay - elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
3.30
23.49% MoM
6.7.2 Length of stay - non-elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
10.52
10.04% MoM
6.8 Avoidable admissions EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
0.10
0% MoM
6.9 Theatre utilisation (elective sessions) EFFICIENCYN& FINANCE - Person Centred, Integrated Care; Strong Partnerships
WATCH -Within tolerance- NO ...
84.63%
3.95% MoM

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6.9 Theatre utilisation (elective sessions) EFFICIENCYN& FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	84.63% ↑ 3.95% MoM	
7.2Outpatient activity (consultant led) against plan (new and follow up) ACTIVITY - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	124.22% ↑ 9.22% MoM	
7.3 Elective activity against plan - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	106.71% ↑ 0% MoM	
7.4 Non-elective activity against plan ACTIVITY - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	114.12% ↑ 0% WoW	
7.5 Emergency Department attendances against plan - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	106.15% ↑ 0% MoM	
5.8 A&E - number of 12 hour trolley waits RESPONSIVE Best Quality Safest Care	WATCH -Within tolerance- NO ...	69.00 ↑ 0% WoW	

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INTEGRITY
TEAMWORK
EQUALITY
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NHS Harrogate and District NHS Foundation Trust

ADULT INPATIENT SAFER NURSING CARE TOOL (SNCT) OUTCOME PAPER: 2023

Brenda McKenzie: Workforce Lead

Contents

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date: November 2023

Author: Brenda Mckenzie (Workforce Lead)

Situation

The Board of Directors are required to receive a Nurse Establishment Review twice a year. This requirement is underpinned by the direction of NHS Improvement (2018) who, in conjunction with the National Quality Board (NQB) (2016), provide a guidance framework containing the key components that should be considered as part of safe staffing review and analysis and in turn enable their nationally endorsed expectations to be met.

HDFT undertook its bi annual adult inpatient safer staffing review using the licenced SNCT during the months of May and September 2023.

Background

The NQB guidance framework (2016) is central in supporting us to develop a workforce that is fit for purpose in the context of it being safe, sustainable and productive. It comprises of a principle document which is supplemented by a suite of additional publications that collectively act as improvement resources.

The principle structure of the NQB expectations are illustrated below and together form a framework that facilitates and supports care to be underpinned by;

• delivery of the right care, first time in the right place

• minimising avoidable harm

• maximising the value of available resources

<table>
<tr><th colspan="3">Safe, Effective, Caring, Responsive and Well- Led Care</th></tr>
<tr><td colspan="3">Measure and Improve
-patient outcomes, people productivity and financial sustainability-
-report investigate and act on incidents (including red flags) -
-patient, carer and staff feedback-</td></tr>
<tr><td colspan="3">-implement Care Hours per Patient Day (CHPPD)
- develop local quality dashboard for safe sustainable staffing</td></tr>
<tr><th>Expectation 1</th><th>Expectation 2</th><th>Expectation 3</th></tr>
<tr><td>Right Staff
1.1 evidence based workforce planning
1.2 professional judgement
1.3 compare staffing with peers</td><td>Right Skills
2.1 mandatory training, development and education
2.2 working as a multi-professional team
2.3 recruitment and retention</td><td>Right Place and Time
3.1 productive working and eliminating waste
3.2 efficient deployment and flexibility
3.3 efficient employment and minimising agency</td></tr>
</table>

The scope for this Safer Nursing Care Tool (SNCT) data collection encompasses the adult in patient wards. This is the first data that has been collected since the establishment changes that were supported after the first three data collections and subsequent review.

Teams are reporting increasing levels of enhanced care requirements on a daily basis. Enhanced care relates to; *patients who require an increased level of care to prevent them harming themselves, others or absconding.* NHSE together with the Shelford Group, have made adaptations to the SNCT tool to incorporate this level of dependency within our patients. However, these will not come in to effect until 2024 data collections.

The new levels of care will breakdown the 'Enhanced Care' requirements, which will enable us to better monitor and manage how we care for these patients, in addition to aligning establishments to allow for this level of care.

AIPW AAU SNCT Matrix A4 2023.pdf

Ward budgets were increased to match the outputs of the SNCT in early 2023 and recruitment in to these registered nurse vacancies is well underway. This new establishment aligns HDFT to a 60/40 skill mix ratio and will increase our Care Hours Per Patient Day to between 8-9.

The May and September data collections ran for the full months. Prior to these collections, the Workforce Lead facilitated an extensive training programme; a one and a half hour training session, that was conducted via MS Teams. All attendees were assessed and were required to pass the inter-rater scoring pass levels. This information is stored on the corporate nursing 'shared drive'. It is essential that all scorers are trained to ensure that high quality, reliable data is collected. All the data was peer reviewed by the Matrons to validate and add assurance that the data was an accurate reflection of the patients on the ward and activity during the time of the audit.

The SNCT was used with a 60:40 ratio Registered Nurse (RN) to Care Support Worker (CSW) for all wards with exception of Farndale, our medical admissions ward. For this ward a ratio of 70:30 was used to take into account the additional registered nurse input required when admitting acutely unwell patients, which is recommended by the tool with regards to assessment areas.

Assessment

All wards have daily safety huddles where all staff, including medical and AHP colleagues come together on the ward at a set time to discuss any patient safety risks; for example patients who are risk of falls and consider preventative measures to be put in place.

A detailed description of each ward and specific staffing, agency and quality indicators were available at the review meetings. As recommended by the SNCT; data collected

must be triangulated with quality indicators and professional judgement before any changes to establishments are agreed.

The SNCT recommendation is to review the required staffing establishment for each ward bi annually at differing periods/times of the year.

As part of the SNCT process, the Deputy Director of Nursing, Midwifery and AHP's, Head of Nursing (HoN) for Planned and Surgical Care and Long Term and Unscheduled Care, Matron and Ward Manager from each ward and the Lead for Workforce Assurance and Compliance met face to face to review the SNCT results, quality data, patient flow information, environmental factors (including PLACE inspection results), and apply professional judgement.

The discussions have been found to be useful in identifying support roles that would enhance patient care and improve the working lives of each team. Mainly, Nutritional Assistant roles and Ward Clerk hours.

Acuity data was provided via the ward managers and all other supportive data was provided by analytics, sitereps, Tendable, finance, NHSP and ESR

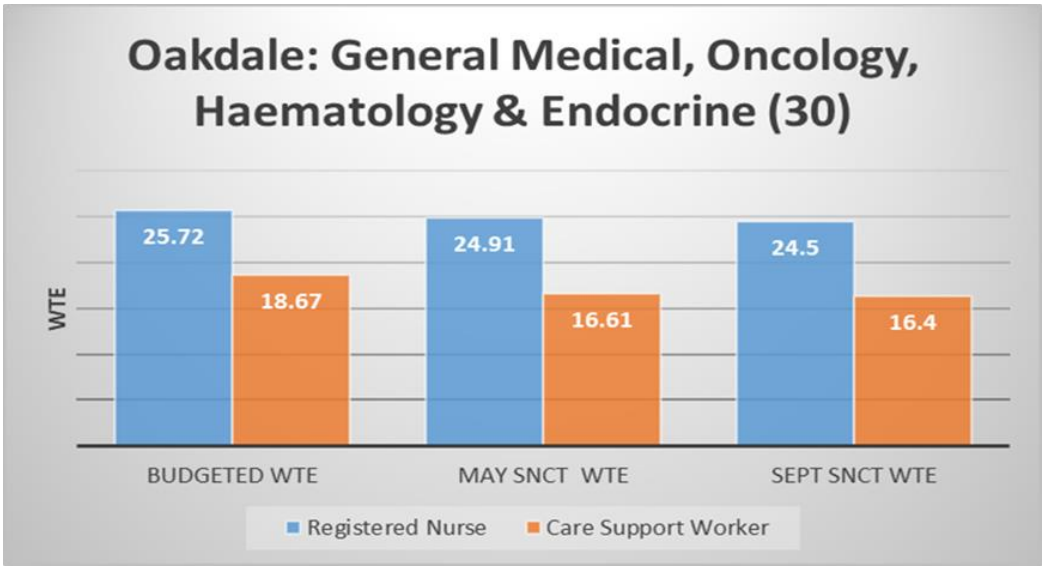
All clinical areas recognised the challenges and understood the results. Where there were perceived anomalies, these were discussed and professional judgement applied. This was pertinent to some smaller wards, wards with more than 50% side rooms, those with assessment areas and those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a high observation/critical care environment at HDFT.

Headroom for each ward is calculated at an overall 21% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness.

Results

Oakdale



The revised staffing template for Oakdale:

	Early	Late	Night
RN	5	5	4
CSW	4	3	3
Nutritional Assistant	1.4 WTE (over 7 days)		
MD	22.5 hours (0.6 WTE)		

Oakdale is a 30 bedded General Medical, Oncology, Haematology & Endocrine ward.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

However , there was a skill mix change highlighted; to uplift 1.39 WTE band 5 to band 6. Giving the ward a total band 6 establishment of 4.0 WTE.

No RN or CSW changes to staffing template were identified.

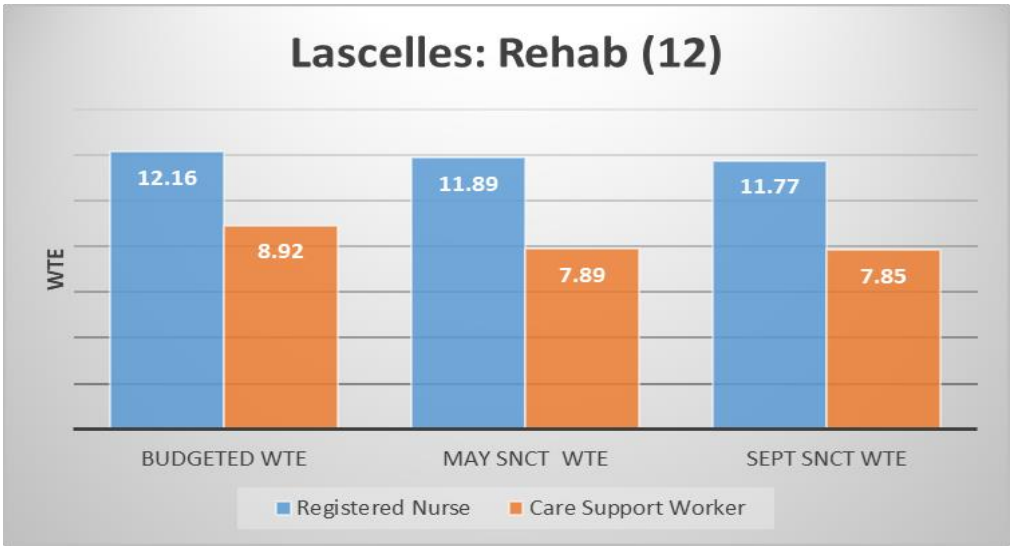
Nutritional Assistant currently working Mon – Fri. However, there was a recognised requirement to increase to 7 day cover.

Next Steps

Uplift 1.39 WTE to achieve overall 4.0 WTE band 6 and increase Nutritional Assistant cover to 7 days. (already agreed at review panel)

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool.

Lascelles



This is the revised staffing template for Lascelles:

Lascelles: Rehab 12 beds

	Early	Late	Night
RN	**3**	**2**	**2**
CSW	**2**	**2**	**1**
Nutritional Assistant	**37.5 hours 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Lascelles is a 12 bedded Rehab ward, that is based off the main HDFT site.

The SNCT data confirmed the over establishment of RN's due to reduction in beds (since moving off site).

Therefore, a skill mix and template change has been recommended;

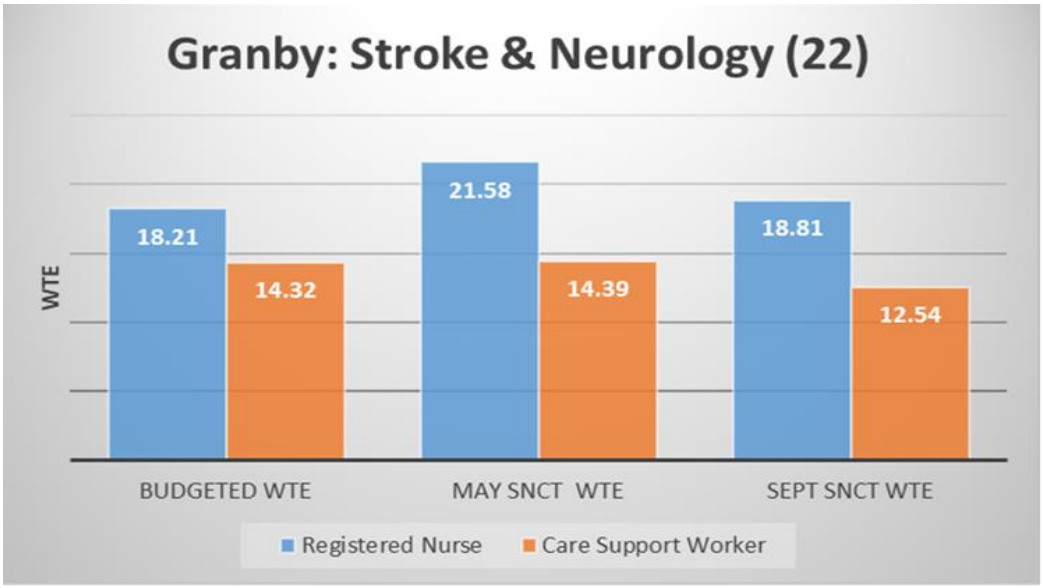
- Uplift 1.04 WTE band 5 to band 6 to achieve overall 2.0wte Band 6
- Introduce 1.0 WTE Nutritional Assistant (Mon – Fri).
- Reduce by 1 RN on a late shift

Next Steps

Support skill mix and establishment changes as described above (already agreed at review panel due to the risk to quality).

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Granby



This is the revised staffing template for Granby:

	Early	Late	Night
RN	**3**	**3**	**3**
CSW	**3**	**3**	**3**
RN	**Early on Mon Thurs & Fri**		
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Granby is a 22 bedded Stroke & Neurology ward.

The SNCT data & triangulation suggests an increase of the RN establishment and skill mix changes;

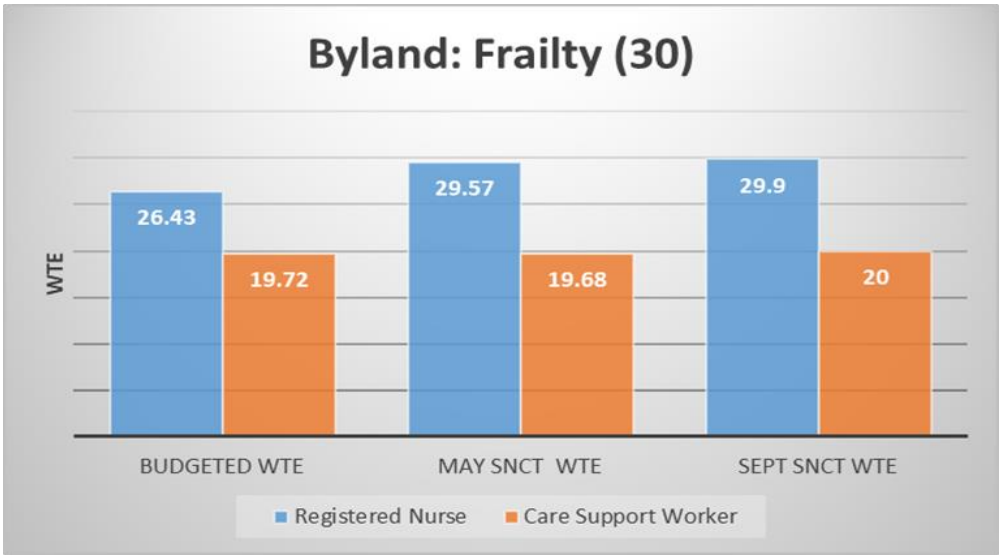
- Uplift 1.36 WTE Band 5 to Band 6 to achieve overall 3.7 wte Band 6
- Additional Band 2 CSW each Night Shift
- Additional Band 5 E Mon, Thu & Fri (ward round days)
- Nutritional Assistant (NA) currently working Mon – Fri. Business case in progress to increase to 7 day cover

Next Steps

Support the skill mix and template changes as highlighted above (agreed in November 2023).

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Byland



This is the revised staffing template for Byland:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**1.4 WTE (over 7 days)**		
MD	**22.5 hours (0.6 WTE)**		

Byland is a 30 bedded Frailty ward.

The SNCT data and triangulation indicates that the RN establishment is slightly low. However, the review agreed that additional data, using the updated SNCT tool, would be required to make any adjustments. Specifically around enhanced care requirements.

There were skill mix changes highlighted; to uplift 0.94 WTE band 5 to band 6 to achieve overall 4.0 wte Band 6.

Additionally it was agreed that an increase in Nutritional Assistant (NA)provision to 7 days was required.

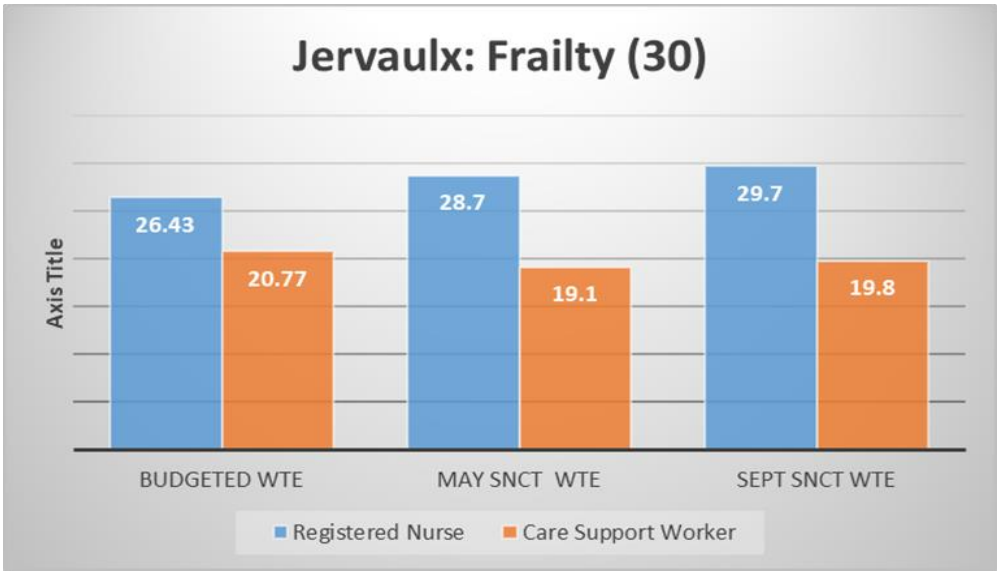
Next Steps

Support uplift 0.94 WTE to achieve overall 4.0 WTE Band 6

To increase NA funding to 7 days (1.4 WTE).

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Jervaulx



This is the revised staffing template for Jervaulx:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**1.4 WTE (over 7 days)**		
MD	**22.5 hours (0.6 WTE)**		

Jervaulx is a 30 bedded Frailty ward.

The SNCT data shows that the acuity and dependency of patients has increased. However, following triangulation of the data and discussion regarding enhanced care, it was agreed that the current establishment, with the skill mix changes, should remain and to re-review following the next SNCT data collection using the updated tool.

The skill mix change highlighted, was to uplift 1.13 WTE band 5 to Band 6 to achieve overall 4.0wte Band 6

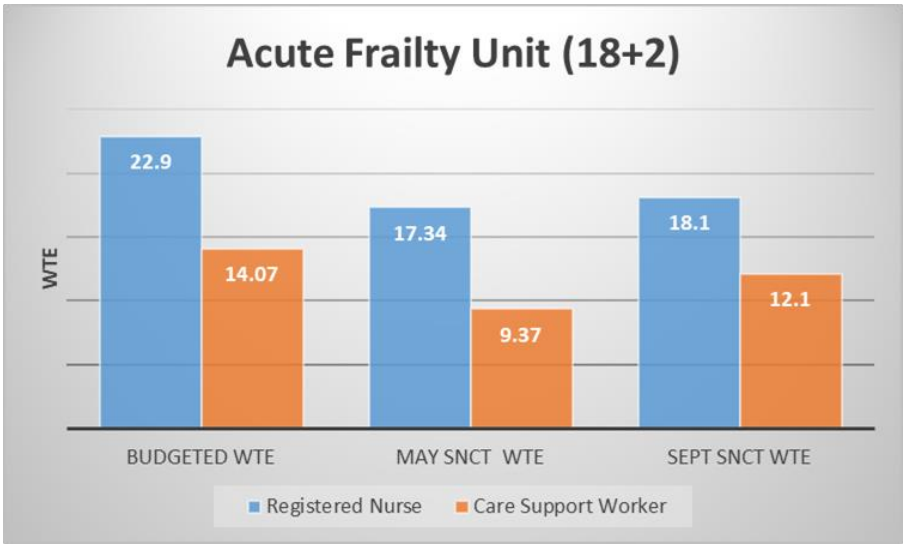
Additionally it was agreed that Nutritional Assistant cover should be increased from 5 day to 7 day cover.

Next Steps

To support the uplift of 1.13 WTE to achieve overall 4.0 WTE band 6.

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Acute Frailty Unit (AFU)



This is the revised staffing template for AFU:

	Early	Late	Night
RN	**4**	**4**	**3**
CSW B2	**2**	**3**	**2**
CSW B3	**1**	**0**	**0**
Nutritional Assistant	**1.4 WTE (over 7 days)**		
MD	**22.5 hours (0.6 WTE)**		

AFU is a 20 bedded Frailty ward; 18 beds and 2 assessment beds.

The SNCT data and triangulation indicates an over establishment of RN's and demonstrates requirement for band 3 Clinical Support Worker skills.

The skill mix and establishment changes highlighted;

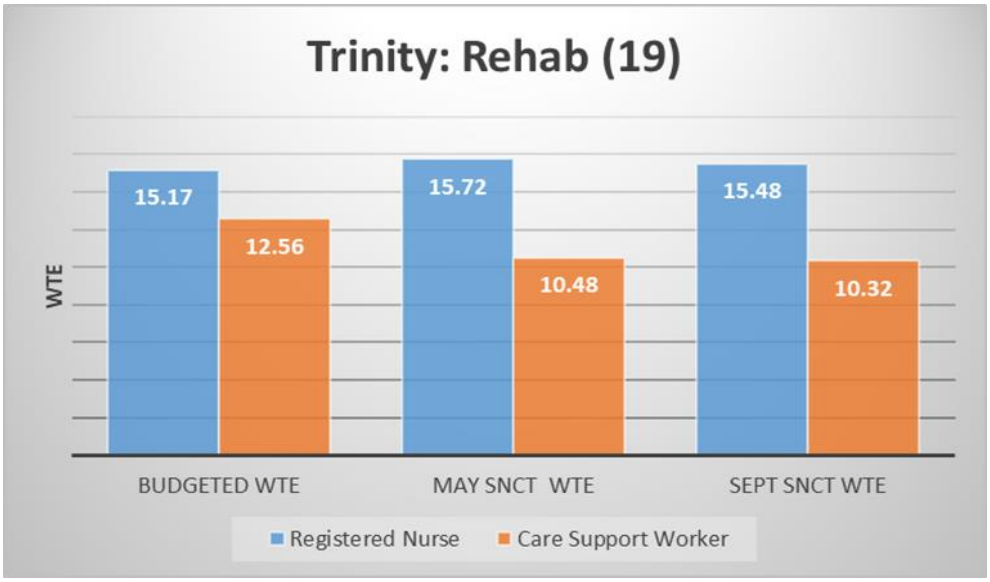
- a reduction of 1 RN (band 5) each night shift.
- An uplift of 1 Band 2, on an Early (7 days) to band 3.
- Keep Band 6 establishment at 4.38 WTE
- Nutritional Assistant to increase to 7 day cover (1.4 WTE)

Next Steps

Support skill mix and establishment changes as described above.

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Trinity



This is the current staffing template for Trinity:

	Early	Late	Night
RN	**3**	**3**	**2**
CSW	**3**	**2**	**2**
Additional RN on a Wednesday	**1 E**		
MD	**22.5 hours (0.6 WTE)**		

Trinity is a 19 bedded rehab ward, based at Ripon Hospital.

The SNCT data and triangulation supports current nursing establishment.

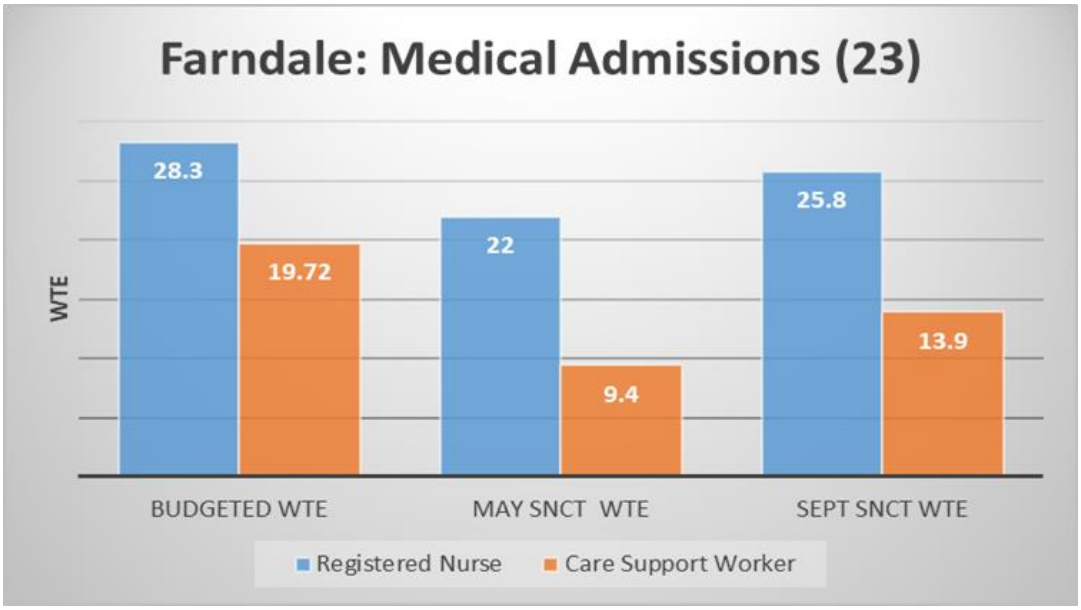
There were no changes to staffing template required. However, the skill mix needed minor changes. This was to fund the current Band 6 establishment at 2.64wte.

Next Steps

Support skill mix and establishment changes as described above.

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Farndale



This is the revised staffing template for Farndale:

	Early	Late	Night
RN	**5**	**5**	**5**
CSW	**4**	**4**	**3**
Nutritional Assistant	**1.4 WTE (over7 days)**		
MD	**22.5 hours (0.6 WTE)**		

Farndale is a 23 bedded Medical Admissions ward, with a large proportion of single side rooms.

The SNCT data and triangulation supports the current nursing establishment.

No change to staffing template will be considered until the new Wensleydale ward is opened and NIV patients are admitted directly to Wensleydale.

Once Wensleydale has opened the Farndale template will need remodelling.

The review agreed that 7 day Nutritional Assistant cover was required. cover

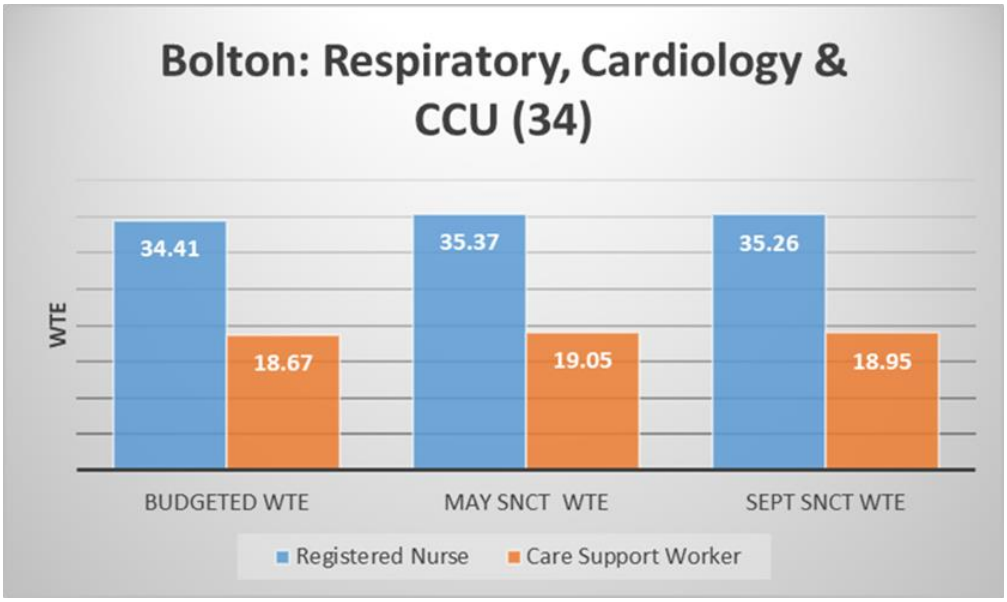
Next Steps

Increase Nutritional Assistant cover to 7 days (1.4 WTE).

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

The new SNCT also includes provision for single side rooms.

Bolton



This is the current staffing model:

Bolton: Respiratory, Cardiology & CCU 29 beds

	Early	Late	Night
RN	**5**	**5**	**5**
CSW	**4**	**3**	**2**
Nutritional Assistant	**37.5 hours 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Bolton is a 34 bedded Respiratory, Cardiology & CCU ward.

The SNCT data and triangulation supports current nursing establishment.

It was discussed that no change to staffing template until the new Wensleydale ward is opened – establishment paper written.

Wensleydale Workforce Model.doc

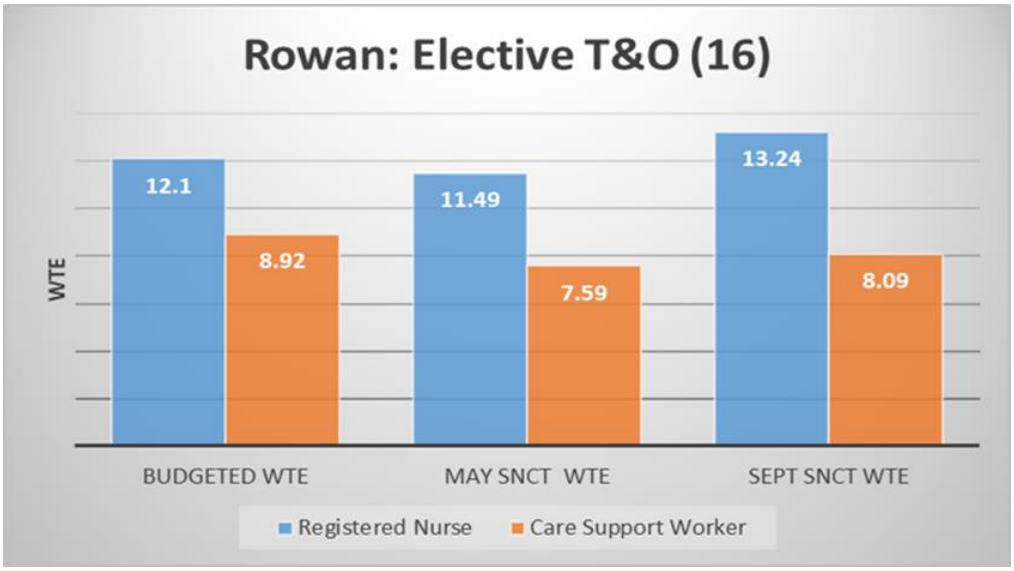
Next Steps

No current changes

New modelling for move to Wensleydale

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Rowan



This is the current staffing model:

	Early	Late	Night
RN	2	2	2
CSW Band 2	2	2	1
MD	22.5 hours (0.6 WTE)		

Rowan is a 16 bedded elective Trauma and Orthopaedic ward.

The SNCT data and triangulation supports current nursing establishment. To note, this is the first SNCT data collection since ward moved from Fountains to Rowan and a minimum staffing numbers apply due to small ward (max 16 beds).

When Rowan move back to Fountains this will increase bed capacity to accommodate Trauma and Orthopaedic elective activity.

Activity fluctuates throughout the week and therefore, staff are move using the Safecare system to aid decision making.

1.0 WTE Band 2 Nutritional Assistant was funded at the start of the financial year. However, this is not required due to the reduction in bed base.

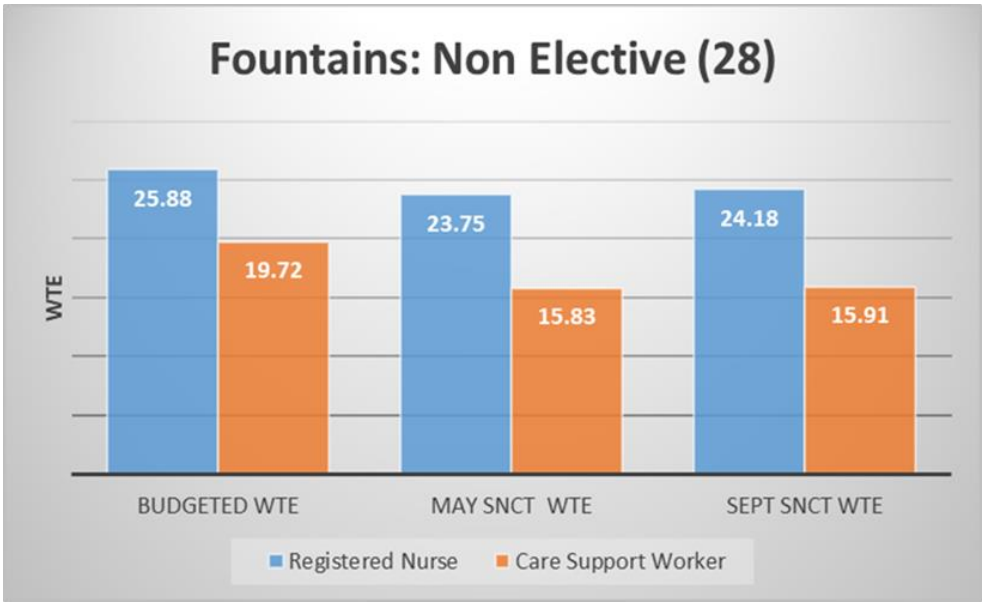
No change to nursing establishment required until the move back to Fountains (28 beds).

Next steps:

Plan modelling for 28 beds after next SNCT data collection using the new levels of care SNCT tool.

Remove Nutritional Assistant funding from the Rowan template.

Fountains



This is the current staffing model:

	Early	Late	Night
RN	5	5	4
CSW Band 2	4	4	3
Nutritional Assistant	37.5 hours 1.0 WTE		
MD	22.5 hours (0.6 WTE)		

Fountains is a 28 bedded Trauma and Orthopaedics ward (Non elective).

The SNCT data and triangulation supports current nursing establishment and skill mix. (Leadership skill mix 1.0 WTE band 7 & 3.0 WTE band 6).

Band 3 (1.0WTE) Patient Liaison position currently funded above establishment (fixed term) until November 2023. To be funded out of CSW reduction.

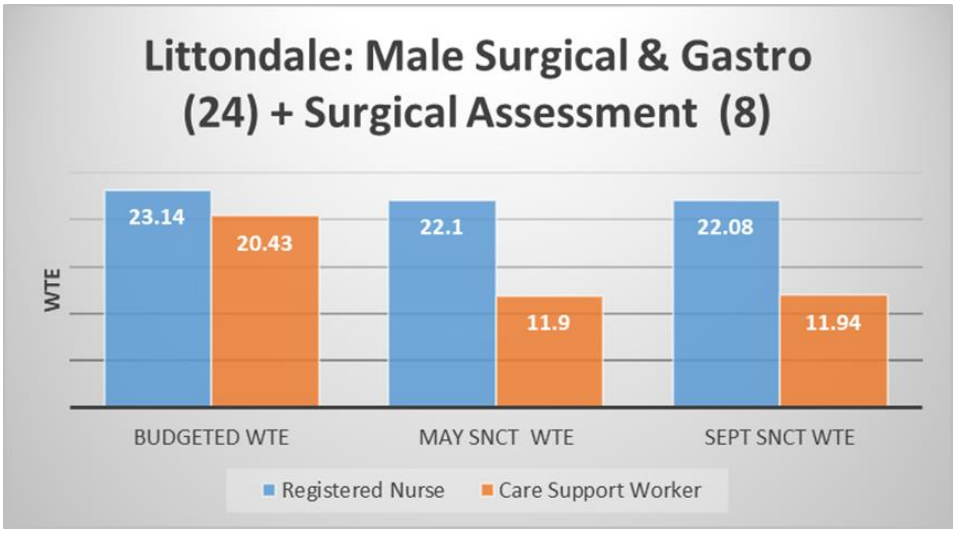
Reduction of 1 CSW from the late shift Monday to Friday.

Next Steps:

To fund the Patient Liaison position substantively.

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Littondale



This is the current staffing model:

	Early	Late	Night
RN	5	5	3
CSW Band 2	3	3	2
CSW Band 3	1	1	1
Nutritional Assistant	37.5 hours 1.0 WTE		
MD	22.5 hours (0.6 WTE)		

Littondale is a 24 bedded ward and 8 bedded Surgical Assessment Unit (SAU).

The SNCT data and triangulation supports current nursing establishment and skill mix.

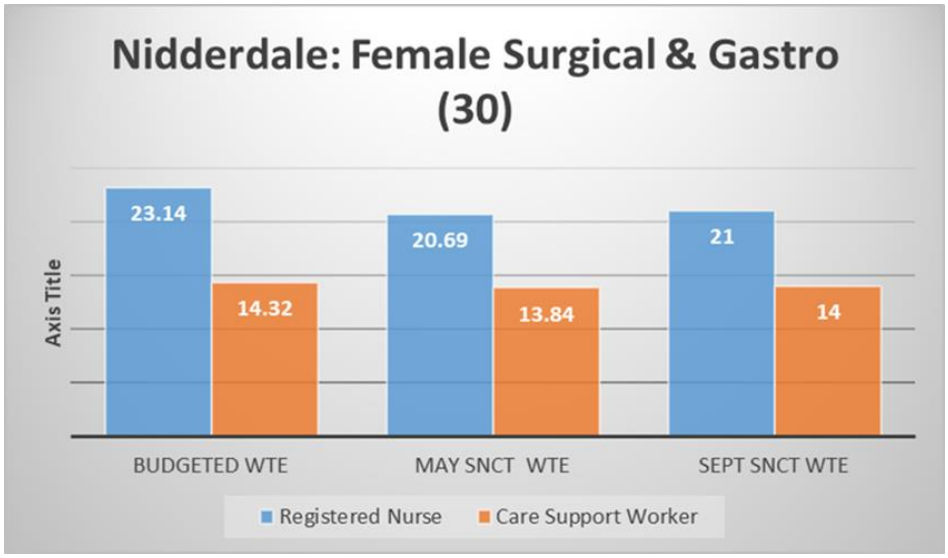
Band 3 requirement within SAU was accidentally missed off during the establishment review in April 2023. Littondale requires Band 3 cover on SAU for a LD and N each day.

No other skill mix or template changes required at this time.

Next Steps

Continue to collect bi annual SNCT data, using the updated acuity and dependency tool.

Nidderdale



	Early	Late	Night
RN	5	5	3
CSW Band 2	3	3	2
Nutritional Assistant	37.5 hours 1.0 WTE		
MD	22.5 hours (0.6 WTE)		

Nidderdale is a 30 bedded Female Surgical & Gastro ward.

The SNCT data and triangulation supports current nursing establishment and skill mix. Therefore, there are no establishment or skill mix changes required.

The review group discussed regarding an increased requirement for mental health knowledge and skills (due to a recent long term patient requiring enhanced care requirements 2:1). The updated SNCT tool will include these new levels of care and improve the validity, reliability and usability of the data with regards to enhanced care.

Next Steps

Mental Health resource to be considered centrally (pan trust). However, enhanced care requirements should continue to be reviewed biannually using the updated SNCT tool.

Harrogate and District NHS Foundation Trust

Quality Committee – Wednesday 24th April 2024

Board Meeting Held in Public
Wednesday 29th May 2024

4

Title:	Learning from Deaths Quarterly Report Q4: Jan-Mar 2024
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	Paper also submitted to Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Wednesday 29th May 2024

Learning from Deaths Quarter 4 Report

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national trends but with an overall downwards trend.

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

23 cases have undergone a structured judgement review since the last report. Median score for overall care was “good”. Thematic review has identified failure to access a number of guidelines/pathways in patients with liver disease. Plans to promote their use are in development by the specialty teams.

Harrogate and District NHS Foundation Trust

2.0 Introduction

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

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 181 deaths were recorded in Q4, down from 189 in the preceding Q3 and substantially down from Q4 in 22/23 which had 242 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the 12 month rolling mortality is the lowest since 2010. It should remembered that the denominator for this data is the number of hospital episodes, so as we increase elective work (including endoscopies), the percentage of deaths would be expected to fall.

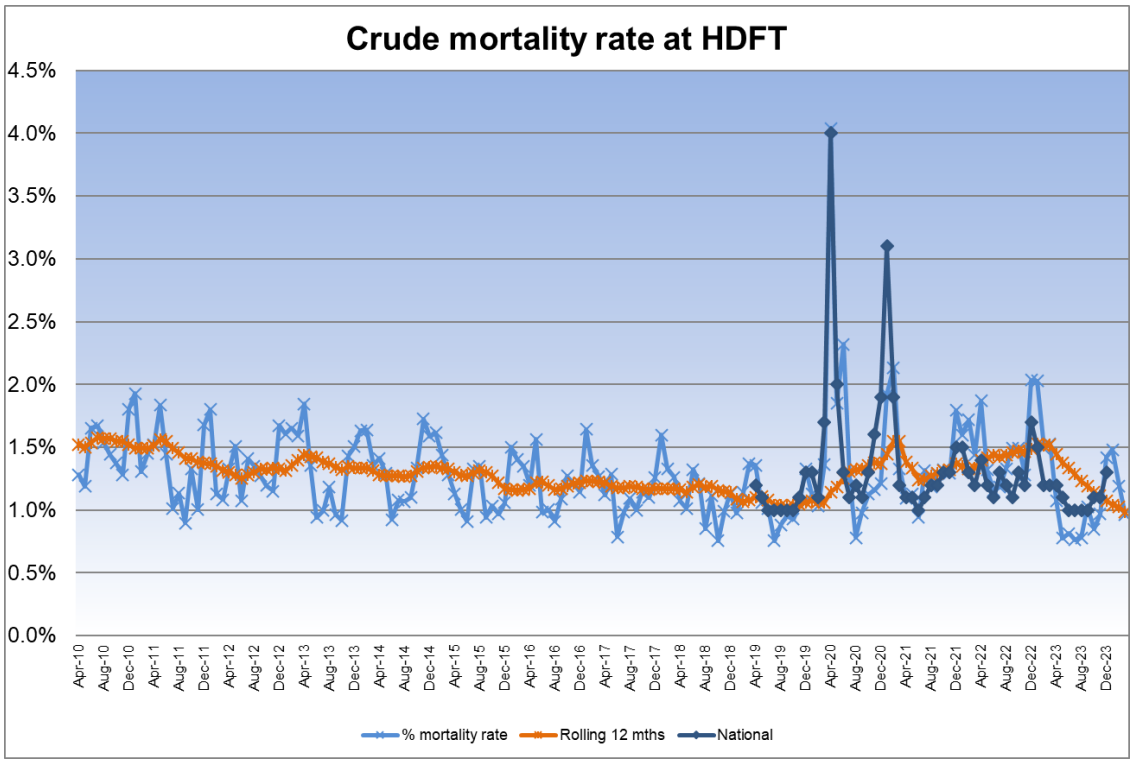


Figure 1: Crude mortality rates over the last 14 years (%deaths per qualifying episode)

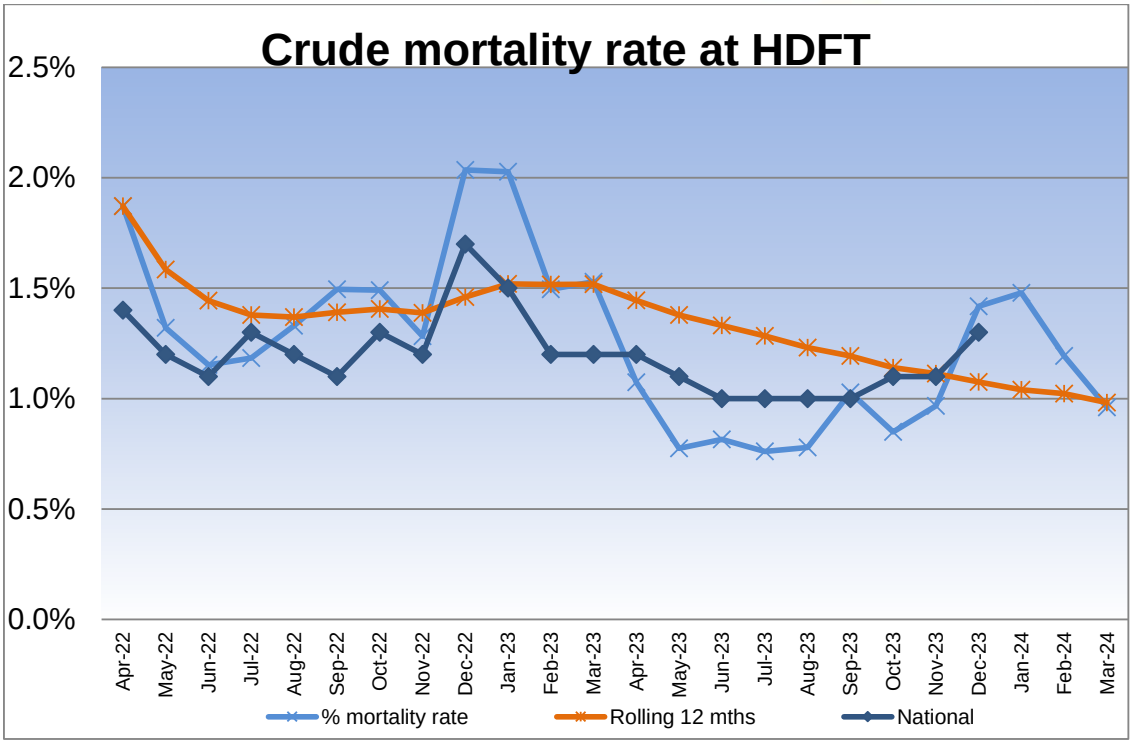


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

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

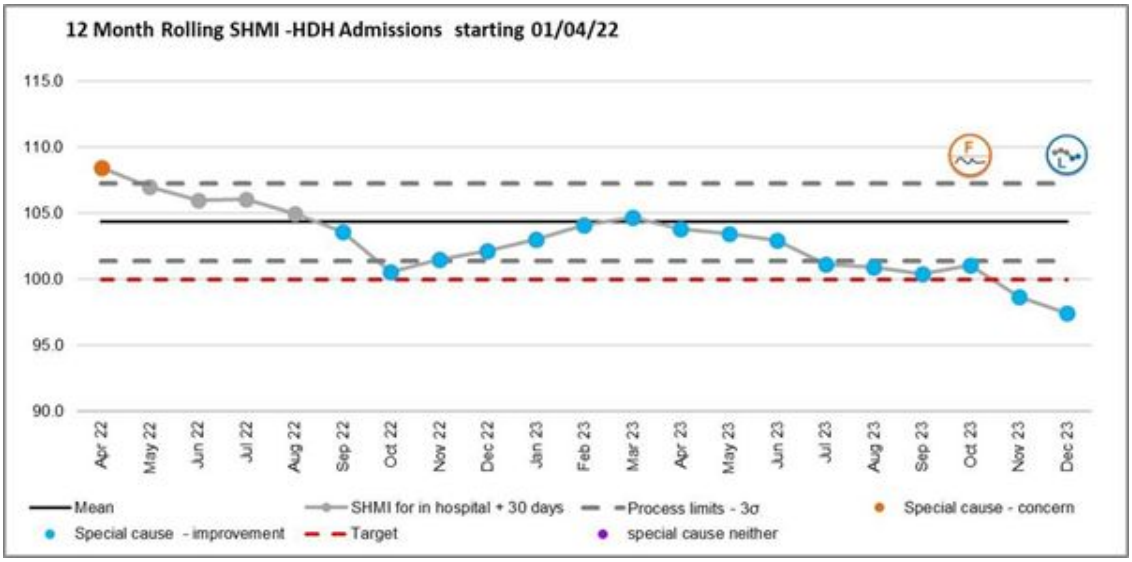


Figure 3: HDFT SHMI since April 2020

Harrogate and District NHS Foundation Trust

Figures 4 and 5 demonstrate the observed and expected death predicted by the SHMI model, with Figure 6 demonstrating the difference between these two values. The number of expected deaths rose to a peak in November 2023 whereas the observed numbers levelled off around March 2023 and have since slowly declined.

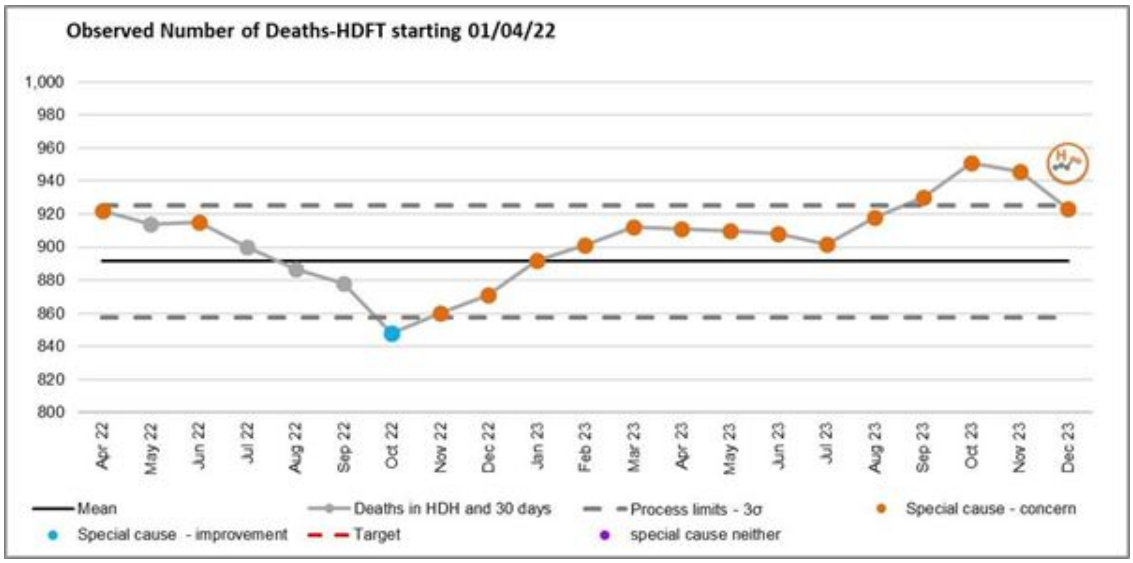


Figure 4: Observed deaths included into SHMI

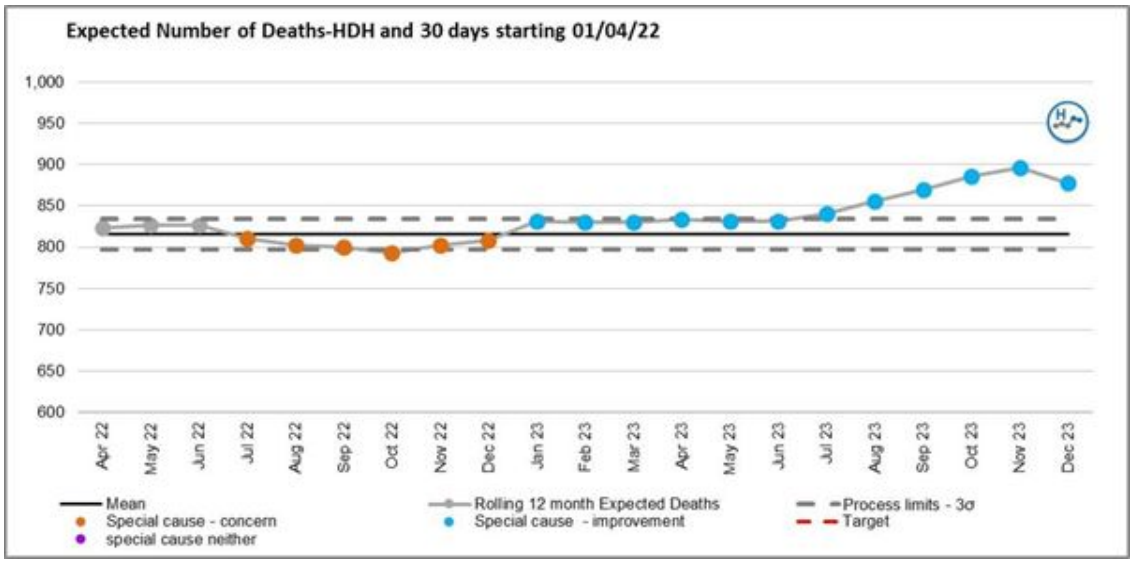


Figure 5: Expected deaths as predicted by SHMI.

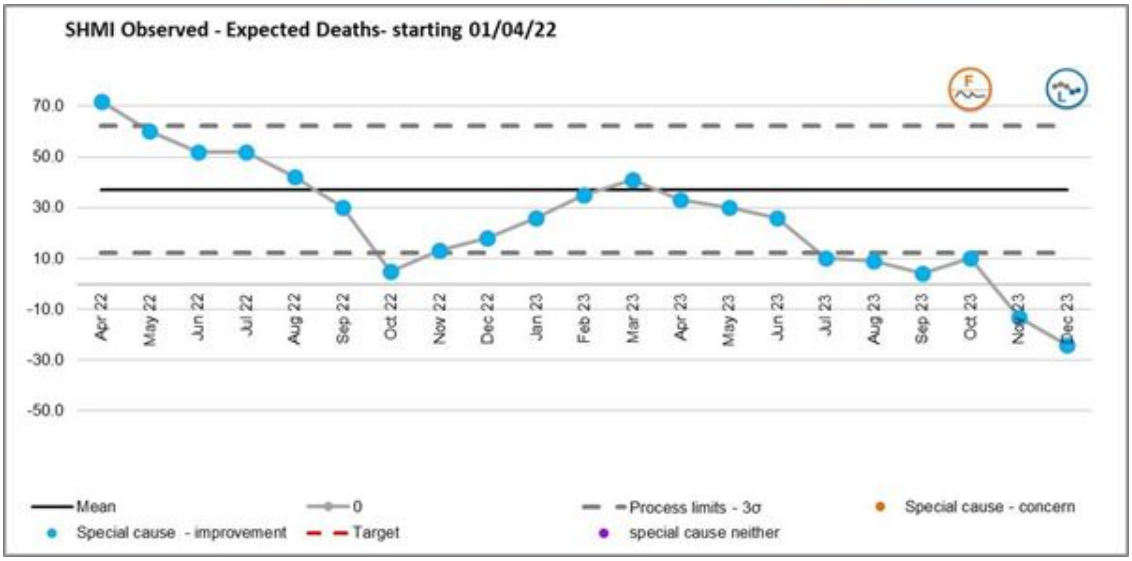


Figure 6: Observed-Expected Deaths, as predicted by SHMI

Figures 7 and 8 demonstrate our 12 month rolling SHMI against that of national peer and regional trusts:

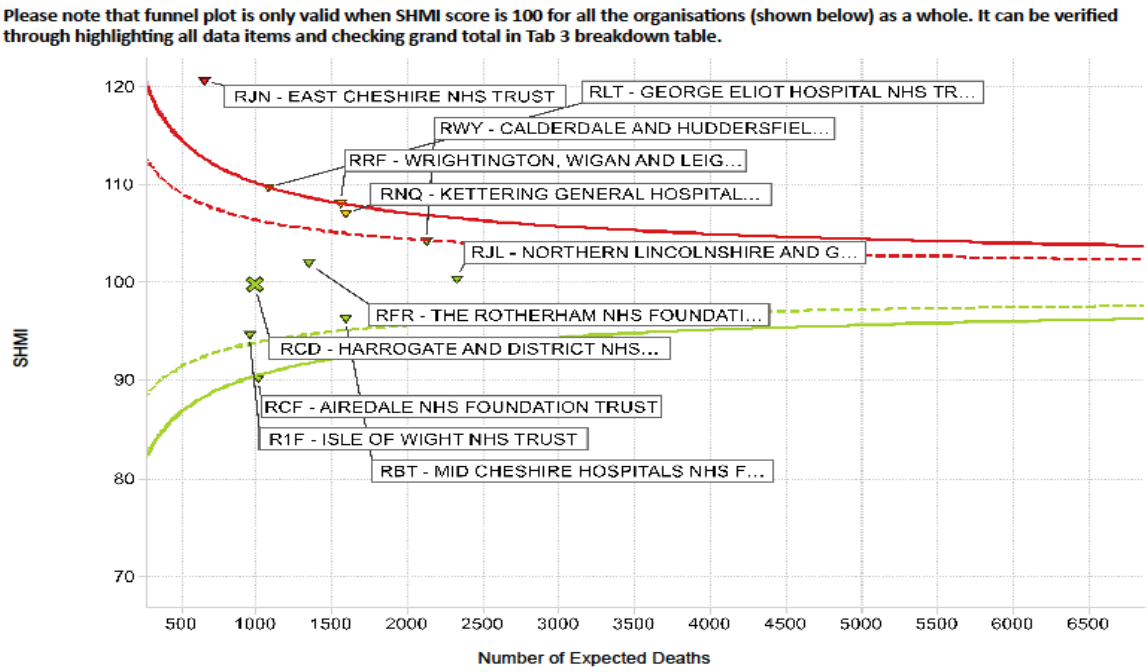


Figure 7: SHMI data for national peer organisations

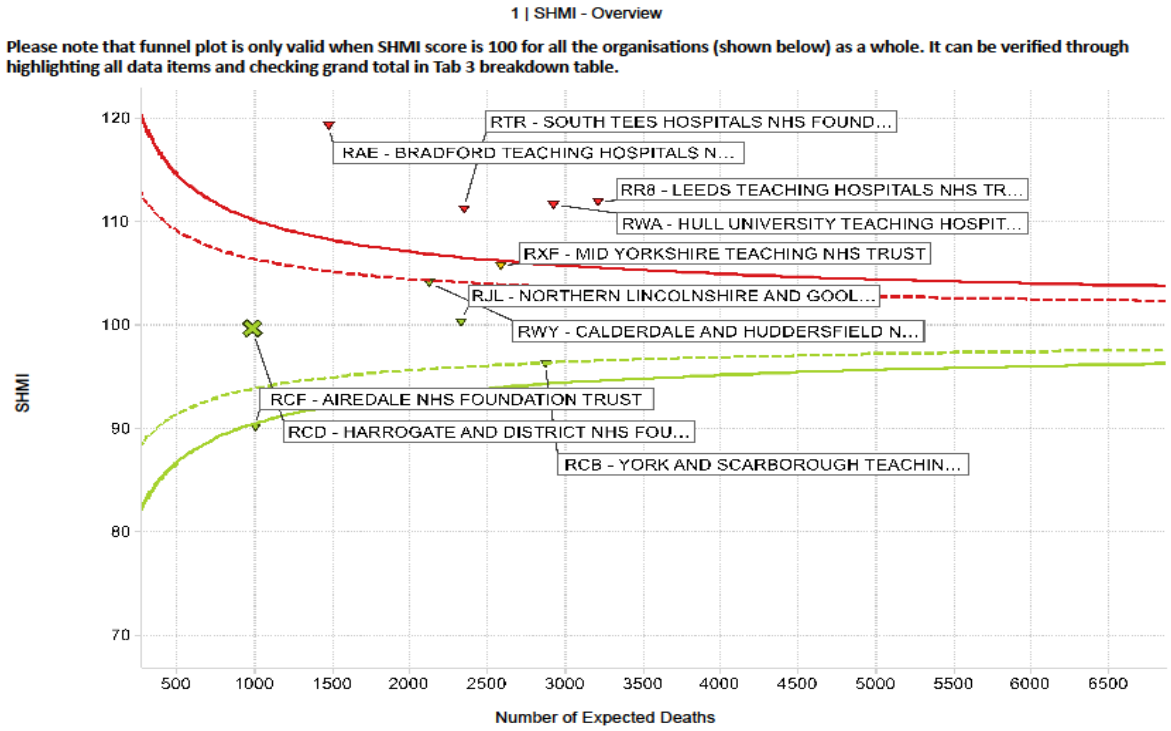


Figure 8: SHMI monthly data for regional peer organisations

From May 2024 (reflecting discharges from January-December 2023), NHS England are making a number of methodological changes to how SHMI is calculated. Firstly, activity related to Covid-19 will now be included, having been specifically excluded since the start of the pandemic. Episodes going back to September 2021 will now be recalculated, as this is when Covid mortality stabilised.

Also, the number of episodes of care used in the calculation are being modified. Patients often will have at least 3 episodes of care if they are admitted under medical teams – an initial Emergency Department episode, one under the Acute Medical team and a third under the final specialty. It is not uncommon that the diagnosis is not confirmed until the third episode, with the first two either being presumptive or a symptom or sign (such as collapse or confusion). From May, definitive diagnoses made in the third episode will now be used, which should improve the accuracy for this group of patients.

Therefore, there may be a slight shift in data in the next report, as amendments to the model will undoubtedly affect our data to a currently unknown degree.

3.3 Structured judgement reviews (SJR)

23 cases have been reviewed in this quarter with 4 relating to deaths in this quarter, 1 from Q3 and the remainder preceding that.

The reason why each case was selected for review is documented in the table 1. 3 areas had been highlighted by "HED" alerts as having a mortality higher than expected. These were urinary tract infection (UTI), other genitourinary problems (GU) and liver failure (Liver). "LD" indicates a patient with learning disabilities. "Specialty Choice" means that the clinical team have selected a case for their own internal review processes. The overall assessment of the standard of care of is shown in Table 1:

Case ID	Admission Date	Learning Disability(LD) or Severe Mental health (MH)	Reason for SJR	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Jan 23	No	UTI	3	N/A	3	3	4
2	Apr 23	No	UTI	4	4	4	4	4
3	Dec 22	No	GU	3	4	4	4	4
4	Jul 23	No	Liver	4	3	2	3	4
5	Sep 23	No	GU	2	3	N/A	3	2
6	Sep 23	No	Liver	3	4	4	4	4
7	Dec 22	No	UTI	3	N/A	4	4	4
8	Aug 23	No	UTI	4	4	3	4	2
9	Apr 23	No	GU	3	4	3	4	3
10	Sep 23	No	Liver	3	3	4	3	4
11	June 23	No	Speciality Choice	4	4	4	4	4
12	Jul 23	No	Liver	4	4	4	4	4

13	Mar 24	LD	LD	4	N/A	N/A	4	4
14	Dec 23	No	UTI	4	4	4	3	3
15	Jan 23	No	Liver	4	4	3	4	4
16	Jan 24	LD	LD	4	3	3	3	3
17	Aug 23	No	UTI	3	4	4	4	3
18	Sep 23	No	UTI	4	4	4	4	4
19	Feb 24	LD	LD	4	4	N/A	4	3
20	Feb 24	LD	LD	4	4	3	4	4
21	Dec 22	No	Liver	3	N/A	3	3	4
22	Mar 23	No	Liver	3	4	4	4	4
23	May 23	No	Liver	3	3	4	3	4
Median Score				**4**	**4**	**4**	**4**	**4**

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

In case number 5, the reviewer scored the care in the first 24 hours as a 2 (poor care). This related to a combination of debate about which specialty would admit the patient and failure to perform blood cultures in a patient with presumed infection. The reviewer (and an independent Medical Examiner) did not think that these lapses contributed in any way to the later death. The case has been referred to the specialty team's Quality of Care meeting for reflection.

No thematic issues were identified in cases related to urinary tract infection or genitourinary problems. Within the cases related to liver failure, a general theme of failure to access guidelines/ checklists was identified. A meeting has been held with the relevant Clinical Lead, and an action plan to improve availability of guidelines on WebV is underway.

4 cases were identified as having a Learning Disability. These will be subject to external review as part of the LeDeR process, and feedback from that will be provided when available in a future report. Since the last Learning from Deaths report we have received feedback from the LeDeR reviewer on 1 case which is shown below. This case involved a patient looked after by our Community Dental team, and the reviewer highlighted the capacity assessment by the team as an example of best practice:

Review 3: (Focused review)
Middle-aged gentleman who resided within residential care sadly passed away unexpectedly at home.

Positive Practice Identified within the Review:
- Placement enabled this gentleman to live a full and independent life.
- Evidence of well completed capacity assessment.
- Holistic management of this gentleman's epilepsy.

Areas for Improvement Identified within the Review:
- Some documentation errors noted within the information provided.

Overall, the quality of care being delivered during this period remained of a good standard, although it should be noted that the deaths cover a broad timescale. The Medical Examiner team have not identified any themes relating to poor care, although they have identified an issue with incorrect syringe driver assembly at both HDFT and in the community. This has been escalated to the Palliative Care team.

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

4.0 Recommendation

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

Harrogate and District NHS Foundation Trust

Strengthening Maternity and Neonatal Safety Report

SMT

April 2024

5

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)

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 April as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	√
	Person Centred, Integrated Care; Strong Partnerships	√
	Great Start in Life	√
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	√
	Digital transformation to integrate care and improve patient, child and staff experience	√
	Healthcare innovation to improve quality	√
Corporate Risks		
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of April 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 No new risks

6.0 Recommendation

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

Maternity – May 2024 (April's data)

Matters of concern & risks to escalate	Major actions commissioned & work underway
	• Saving babies lives care bundle version 3 – work on-going to meet requirements • Core Competency framework v2 business case undergoing further development • 4D scanning private service - launch delayed • SCORE culture survey results received. Listening sessions arranged • NICE compliance – progressing assessments – 2 remain to be reviewed. • Baby Carousel arranged with MVP – 'Maternity and More' 22nd May • Birthrate Plus establishment setting review on-going • Planning round with ICS/LMNS • Placental Growth Factor Testing agreement progressing • Plans to move Daycare activity from MAC to ANC – space being sought • Liaising with Airedale re combined triage calls • MAC call monitoring project commencing • Web V implementation on-going • BFI Gold accreditation reassessment of Neonatal services
Positive news & assurance	**Decisions made & decisions required of the Board**
• No new MNSI cases reported • No on-going PSII investigations • Pool evacuation training now above 90% • Single Point of Contact for maternity launched	Bi-annual midwifery staffing report – awaiting results of Birth Rate Plus establishment review Baby Friendly Initiative annual report 2024 submitted for assurance ATAIN Quarterly Report submitted fro assurance

Narrative in support of the Provider Board Level Measures – April 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 April 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 73.06 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 underway.

3.1 Absence position

Unavailability of midwifery staff hours –
3.82 WTE sickness absence (theme – stress)
5.89 WTE maternity leave
2.29 WTE study
2.89 WTE other leave (carers/compassionate/phased return)

Unavailability of Maternity support worker hours –
1.62 WTE sickness absence – increased this month. Main cause - back problems
1.31 WTE Maternity leave

3.2 Vacancy position

Currently there is 1WTE midwifery vacancy which is out to advert. There are no maternity support work vacancies.

3.3 Turnover

January twelve month rolling rates –
Midwives 6.67%
Maternity support workers 21.49%

3.4 International Midwifery Recruitment

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

3.5 NHSP provision

Midwives -
3.64 WTE NHSP midwifery staffing used in April 2024

Support workers –
2.35 WTE NHSP maternity support worker staffing has been used across maternity in April 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.

Five homebirths were booked for the month of April 2024. Three women have not yet given birth. One woman choose to birth in the hospital for medical reasons and one woman had a homebirth.

In the period 01/04/24 – 30/04/24, the home birth provision was suspended on two occasions due to sickness.

Conversations are on-going about how best to cover the homebirth service provision. The plan to increase weekend daytime cover to aim to improve on call cover reliability at a weekend is being trialled in June however it has not been possible to reliably cover each weekend with increased staffing.

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.
0.54 WTE nurse short term sickness absence

4.2 Neonatal Vacancy

Zero vacancy currently however 0.92 WTE QIS nurse is leaving in May 2024 and 0.61 WTE non-QIS nurse is rotating to Woodlands.

4.3 Neonatal Recruitment

1 WTE Band 5 Nurse out to advert.

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. April 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 four 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

Of the 180 scheduled assessments in Birthrate plus acuity app, 144 were completed in the required timescale on Delivery Suite giving the data a 80-% confidence factor. An additional

29 entries were completed outside of the required timescale giving additional evidence to the staffing data. Staffing met the acuity only 50% of the time during April 2024. This was due to an increased staff absence as described in section 3.1.
77% (125 occasions) of the time no clinical actions were required. 28% (48) of the occasions clinical actions were required, these included:

CA1	Delay in commencing IOL (Inpatient)	**9**	**16%**
CA2	Delay in continuing IOL	**38**	**67%**
CA3	Delay in EL LSCS (delivery suite)	**2**	**4%**
CA4	Postponed IOL (at home)	**2**	**4%**
CA5	Delivery Suite coordinator not supernumerary	**6**	**11%**
	Total	**57**	

Delivery Suite Coordinator was not supernumerary on six occasions over the course of the month. This was quickly escalated and management actions occurred as described in 6.2.

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

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

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

5.2 Pannal Ward Staffing

The Birthrate Plus Ward Acuity App had a 73% confidence level in the data submitted on Pannal. The minimal suggested level of compliance is 85% to enable confidence in the data and for representative interpretation to be made. Work is on-going to ensure staff complete the tool as required to capture the staffing against activity.

During April 88% of Midwifery shifts were covered with contracted hours on Pannal ward. All shifts remaining shifts were released to NHSP resulting in 12% of Midwifery shifts covered by NHSP. 72% of MSW shifts were covered with contracted hours and 12% of shifts were undertaken by MSWs on NHSP.

Staffing versus workload and Red Flag details remained unavailable in April due to being 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 two Red Flags recorded during April 2024 which were both due to the delay between admission for induction of labour and the beginning of the process.

The following management actions were taken to ensure these clinical red flag situations, and staffing situations described above, were promptly resolved without the occurrence of harm.

Number and percentage of management actions taken from 01/04/2024 to 30/04/2024 –

MA1	Redeploy staff from Pannal	17	53%
MA2	Staff unable to take breaks	7	22%
MA3	Review of staff on management time	1	3%
MA4	Use of Specialist Midwife	2	6%
MA5	Use of staff on training days	0	0%
MA6	Use of ward/department managers	1	3%
MA7	Staff sourced from wider Trust (theatre & CSW's)	0	0%
MA8	Use of hospital MW on call	2	6%
MA9	Use of community MW	0	0%
MA10	Unit on Divert	2	6%
MA11	Patient diverted	0	0%
	Total	32	

6.3 Pannal Ward Red Flags

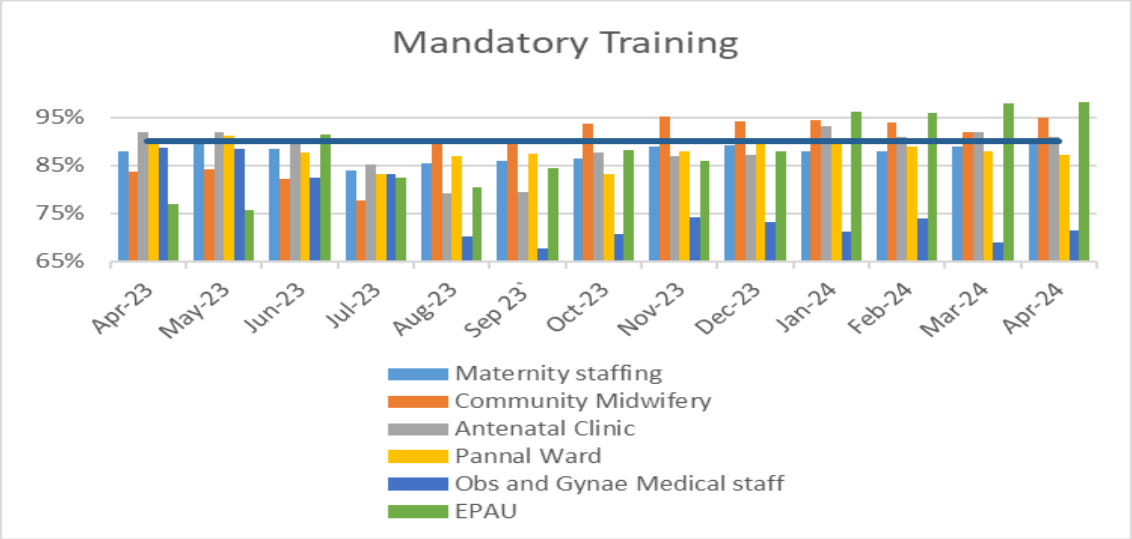
In April there were two elective caesarean sections which were undertaken in Strayside theatre due to lack of elective caesarean section capacity. There was one elective section delayed for over 24 hours due to acuity following being allocated for birth in Strayside theatre.
On two occasions due to acuity the ward manager was pulled to support clinically.
During April there were four delays of induction of labour for over 24 hours, all were accommodated one day later that planned due to unit acuity.

7.0 Appraisals

Department	Assignments Appraised	Assignment Count	Percentage Compliant
Obs & Gynae - Medical Staffing	12	15	80%
Ante Natal Clinic	9	13	69%
Community Midwifery	21	23	91%
Maternity Staffing	44	52	85%
Pannal Ward	16	18	89%
Early Pregnancy Assessment Unit	5	5	100%
Total	107	126	85%

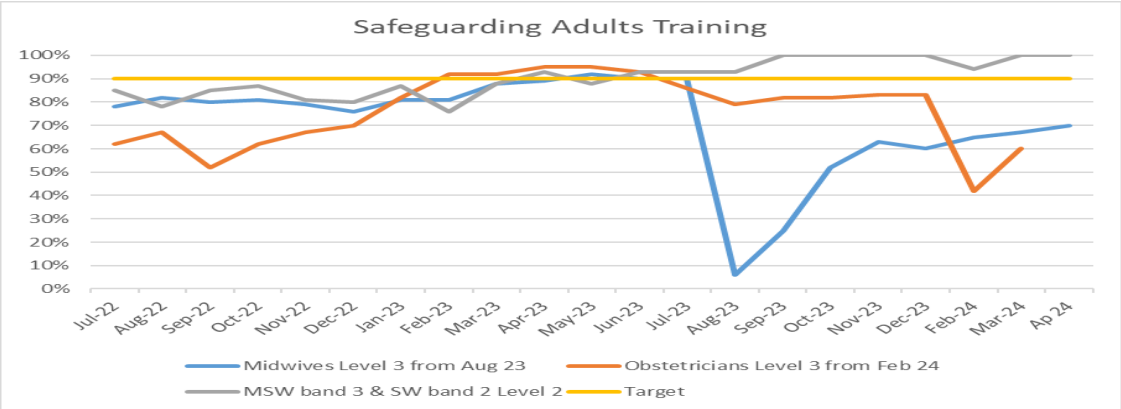
8.0 Training Compliance For All Staff Groups in Maternity Related to Core Competency Framework And Wider Job Essential Training

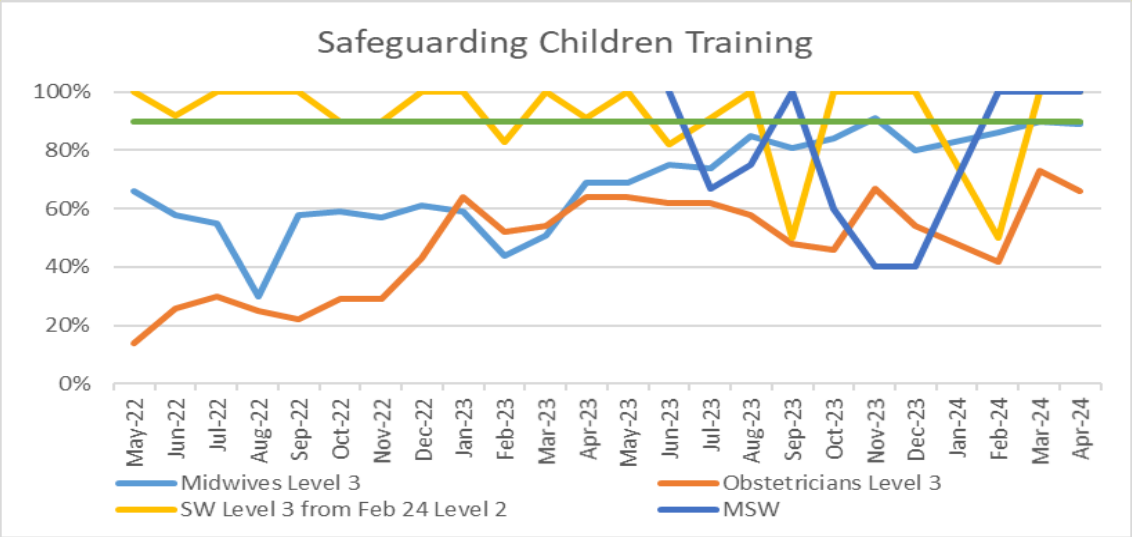
8.1 Mandatory training (as at 13/05/24)



8.2 Maternity Incentive Scheme and Core Competency version 2 Training Compliance

Apr-24	Obs cons	Obs other	Midwives	MSW	Anaes cons	Anaes other	SCBU nurses	Paediatric Consultant	Paediatric other
Adult Basic Life Support with paediatric modifications	100%	72%	97%		N/A	N/A	77%	n/a	n/a
Harrogate Newborn Advanced Life Support (HNALS)	N/A	N/A	90%	N/A	N/A	N/A	88%	63%	65%
Harrogate Newborn Intermediate Life Support (HNILS)	N/A	N/A	99%		N/A	N/A	0%	n/a	n/a
MAT - Growth Assessment Protocol (GAP)	88%	75%	93%	N/A	N/A	N/A	n/a	n/a	n/a
MAT – K2 CTG	100%	86%	87%	N/A	N/A	N/A	n/a	n/a	n/a
MAT – Maternity Training Day 2	100%	100%	100%	N/A	N/A	N/A	n/a	n/a	n/a
MAT - Prompt	100%	64%	96%	100 %	92%	89%	n/a	n/a	n/a
MAT - Saving Babies Lives	88%	62%	69%	N/A	N/A	N/A	n/a	n/a	n/a





8.3 Additional requirements

Birthing pool evacuation training 91% compliance.
Safeguarding supervision community midwifery = 80%, acute midwifery data not available.

9.0 Risk and Safety

9.1 Maternity unit divert

There has been two events of divert of the unit in April 2024. Three women were transferred to another unit for care during these closures.

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 April only 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 is a reduction from previous months.

9.3 Maternity Risk register summary

The Risk Register was last formally reviewed on 21/3/24. Risks have now been transitioned to DCIQ.
There are seven current risks

- **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 Oct/Nov. Pressure on lists remain but being managed as required. No change at present.
- **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.
- **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 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.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 6).** Joint work continuing to support administrative team. Staffing fully established now. Ongoing support plans in place. Risk downgraded.
- **Risk to reputation and patient satisfaction for failing to meet national target and provide evidence based care in relation to Continuity of Carer (Score 4).** Building blocks being established and plans in place. 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 April 2024 there were 60 total incidents reported through DCIQ since go-live on 2nd April 2024.

One incident was reported as Moderate Harm relating to extradural haematoma and skull fracture identified in neonate. A 48h review has been completed.

There are no outstanding PSII investigations.

Additional incidents of note include:

- Six incidents of Low Apgar score (all cases have been reviewed by the MDT)
- Three antenatal and newborn screening related
- Three readmissions of Mother of Baby (one mother admitted with raised BP, one baby readmitted with jaundice, one baby with weight loss)
- Three PPH≥1500ml
- Three incidents of missed antenatal or postnatal care
- Three incidents related to Customised Growth Charts
- Two third degree tears
- Two shoulder dystocia
- Severe pre-eclampsia on magnesium sulphate regime
- One baby born at <32 weeks at HDFT
- Two Unexpected Term Admissions to SCBU
- Lack of bed availability on MAC
- Breach of MAC triage timescales
- Additional theatre list not staff appropriately

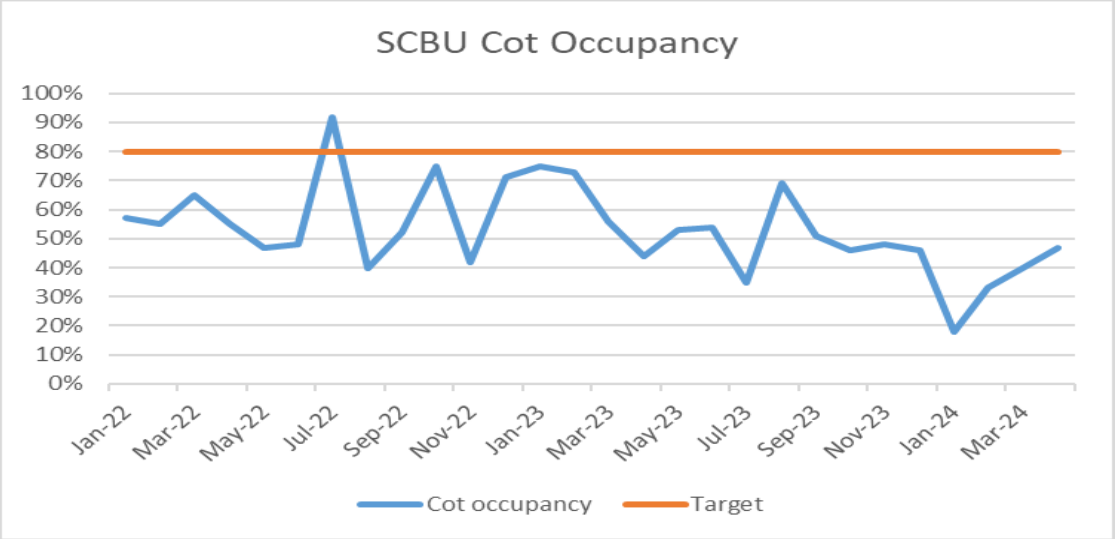
9.5 SCBU Incidents

No moderate harm incidents.

9.6 SCBU Risk Register

No new risks.

9.7 Cot occupancy and babies transferred out



Four babies were transferred out during April. One baby was transferred out due to extreme prematurity, one baby for surgical review and two babies for more complex care. All transfers out were appropriate.

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

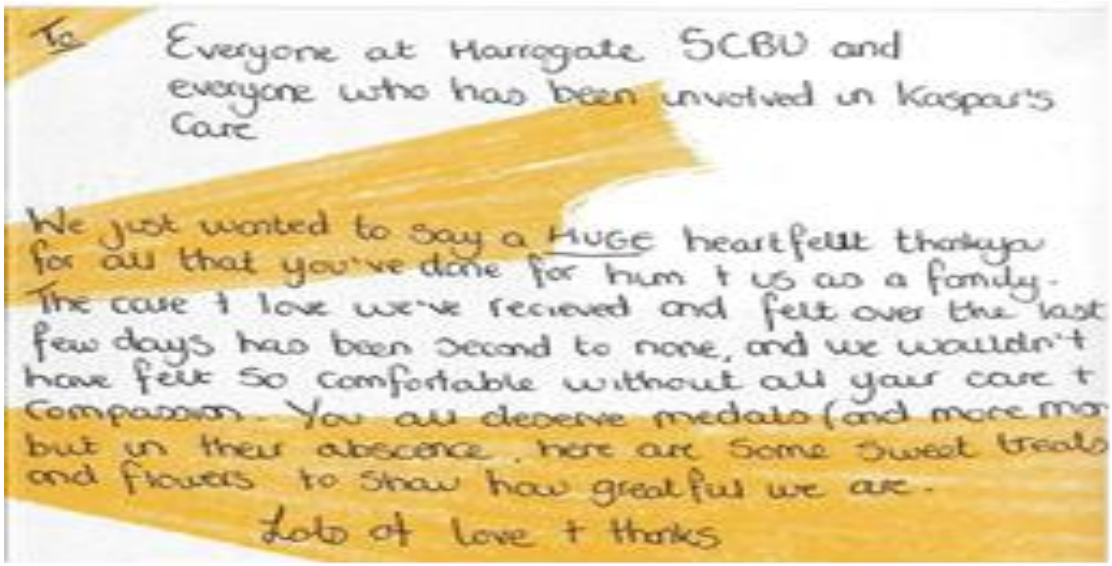
There are no outstanding PMRT reports in progress as at the end of April 2024.

11.1 Maternity service user feedback

What was good - Midwives themselves were all lovely people and made me feel safe and welcome at all appointments. Breastfeeding support group was FANTASTIC. Jo is great! Birthing mechanics workshop was great.

What would you have liked to have been different - Wait times during scans/appointments – communication if running behind etc. Continuity of consultant/doctor care as and when possible. More communication postnatally in Pannal Ward.

11.2 SCBU feedback –



11.0 Staff feedback

Staff feedback on the Inpulse survey appears to have deteriorated this quarter with staff feeling stressed, frustrated and unappreciated however the response rate has also deteriorated from around 50 responses per survey to only 21. The reduced response rate may be related to survey fatigued as between Inpulse surveys there has also been the SCORE culture survey completed. Work is ongoing to improve staff wellbeing, wellbeing walks have recommenced now the weather is better, there is plans for daily communications during Mental Wellbeing week and time out days have been arranged for the summer.

12.0 Complaints

There has been one new concern raised relating to Pannal Ward staffing and hygiene, and one new complaint raised directed at general surgery/obstetric services relating to the management and communication surrounding a postnatal hernia.

All previous complaints received in March have been responded to.

13.0 Coroner 28 made directly to Trust

No Regulation 28 notifications have been received.

14.0 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.

15.0 Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents have been reported in April 2024. There are no open cases. A MNSI Quarterly review meeting last occurred in January 2024 and is next planned for 13th May 2024.

16.0 Maternity Incentive Scheme – year six (NHS Resolution)

The requirements for Year Six of the Maternity Incentive Scheme were released in April 2024. NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. The compliance period for MIS will end 30 November 2024. The deadline for submission of a completed Board declaration form documenting achieving all ten maternity safety actions will be 12:00 midday on 3 March 2025.

Overview of Progress on Safety Action Requirements:

The below demonstrates the requirements of Trust Board oversight for Maternity Incentive Scheme. Assurance will be provided as required to progress compliance with these elements.

	Requirement		Completed	Date
SA1	A quarterly report should be received by the Trust Executive Board each quarter from 2 April 2024 that includes details of the deaths reviewed from 8 December 2023, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	By 30/11/24	No	
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/24	Yes	
	Trust positions with compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' should be shared with Trust Boards	By 30/11/24	No	

	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	By 30/11/24	No	
	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.	By 30/11/24	No	
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	Yes	
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	By 30/11/24	No	
SA6	Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/24	No	
SA9	Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)	By 30/11/24	Yes	
	Evidence that a monthly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set. This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	By 30/11/24	Yes	
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	

	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/24	No	
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Q1	No	
		Q2	No	
		Q3	No	
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/24	Yes	
	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/24	No	
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/24	No	

Current areas of concern are related to the following –

- Meeting compliance with Safety Action 8 requirement for 90% of neonatal and paediatric medical staff who attend neonatal resuscitations to have a valid resuscitation council NLS certification. This years' ask is for there to be an action plan to achieve this for year 7 so it will be possible to meet the requirements this year however next year may be more challenging. It is under consideration across the Regional Operational Delivery Network that there are not enough external RCUK NLS sessions held to accommodate all paediatric staff who attend newborn deliveries.
- Training for Saving Babies lives is to be in-house and MDT in line with Core Competency Framework from 2025. Again this should not affect this year's compliance but will be challenging for next year with the number of doctors available to attend all role specific training face to face. The business case in relation to Core Competency Framework v2 remains under review.

17.0 National priorities

17.1 Three Year Delivery Plan For Maternity And Neonatal Services

NHS England published a three-year delivery plan for maternity and neonatal services on 30th March 2023. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. The Plan aims to deliver change rather than set out new policy and combines a number of existing maternity and neonatal requirements including original Better Births (2016), Long Term Plan (2019), Ockenden (2020 and 2022), East Kent (2022), Saving Babies Lives Care Bundle v2, CSNT requirements, MBRRACE reports, BAPM7 neonatal ambitions and equity/race related guidance. For the next three years, services are asked to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care.

Theme and Objective	RAG Status and narrative (if not green)
Theme 1: Listening to and working with women and families with compassion **Objective 1 - Care that is personalised**	Continuity of carer not in place but 'building blocks' continue to be developed – see 17.3

Theme 1: Listening to and working with women and families with compassion **Objective 2 - Improve equity for mothers and babies**	Ongoing and on track – Audit of experience and outcome of women from different backgrounds required.
Theme 1: Listening to and working with women and families with compassion **Objective 3 - Work with service users to improve care**	
Theme 2: Growing, retaining and supporting our workforce **Objective 4 - Grow our workforce**	
Theme 2: Growing, retaining and supporting our workforce **Objective 5 - Value and retain our workforce**	
Theme 2: Growing, retaining and supporting our workforce **Objective 6 - Invest in skills**	
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 7 - Develop a positive safety culture**	
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 8 - Learn and improve**	
Theme 3: Developing and sustaining a culture of safety, learning and support **Objective 9 - Support and Oversight**	
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 10 - Standards to ensure best practice**	Ongoing – Work on going to fully implement Saving Babies Lives Version three.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Objective 11 - Data to inform learning**	
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.

NHS England provide a Three Delivery Plan Oversight Tool which demonstrates that Harrogate is a negative outlier on only one metric – Awareness of Medical History during Antenatal check-ups. The data for this metric is taken from the CQC survey which was conducted prior to the implementation of Badgernet. It is hoped that the introduction of Badgernet will have improved the response to this metric on the next survey. It should be noted that Harrogate maternity and neonatal services are the only area in the North East and

Yorkshire Region which has Baby Friendly Initiative accreditation for both maternity and neonatal. Please see 17.2 for further information in relation to this.

17.2 UNICEF Baby Friendly Initiative (BFI)

The maternity department and SCBU received the Baby Friendly Initiative Gold Award for achieving sustainability standards in 2017 and 2020 respectively. This award comes with a commitment to ensure current standards are maintained, robust monitoring processes are in place and the service is responsive to change and can demonstrate continued improvement in outcomes. The report attached in Appendix A demonstrates that rates for initiation and duration of breastfeeding appear to be improving across maternity and neonatal. The focus will now be on increasing rates in areas where women are least likely to breastfeed.

17.3 Ockenden – No update this month

17.4 Continuity of Carer – No update this month

17.5 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

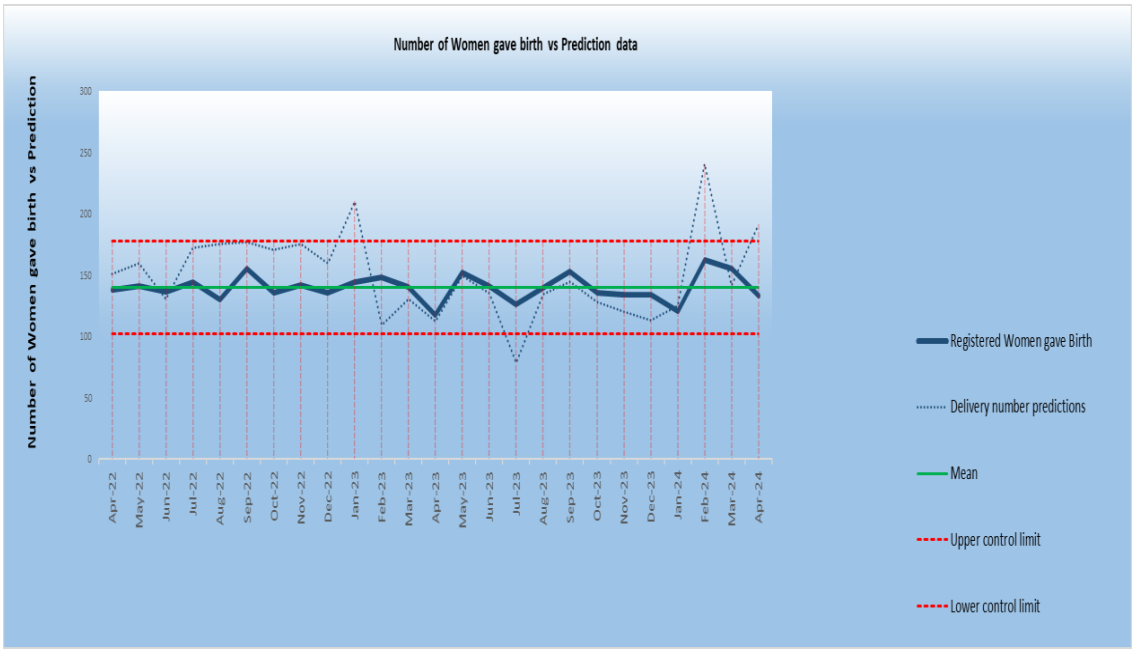
Scheme Year 5. The programme included a series of workshops and action learning sets which commenced in October 2023 and provided dedicated time to the quadrumvirate to work and learn together, accompanied by individual time to focus on personal development. The final component of this is the SCORE Culture 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 now been completed and Listening sessions are planned for May 2024.

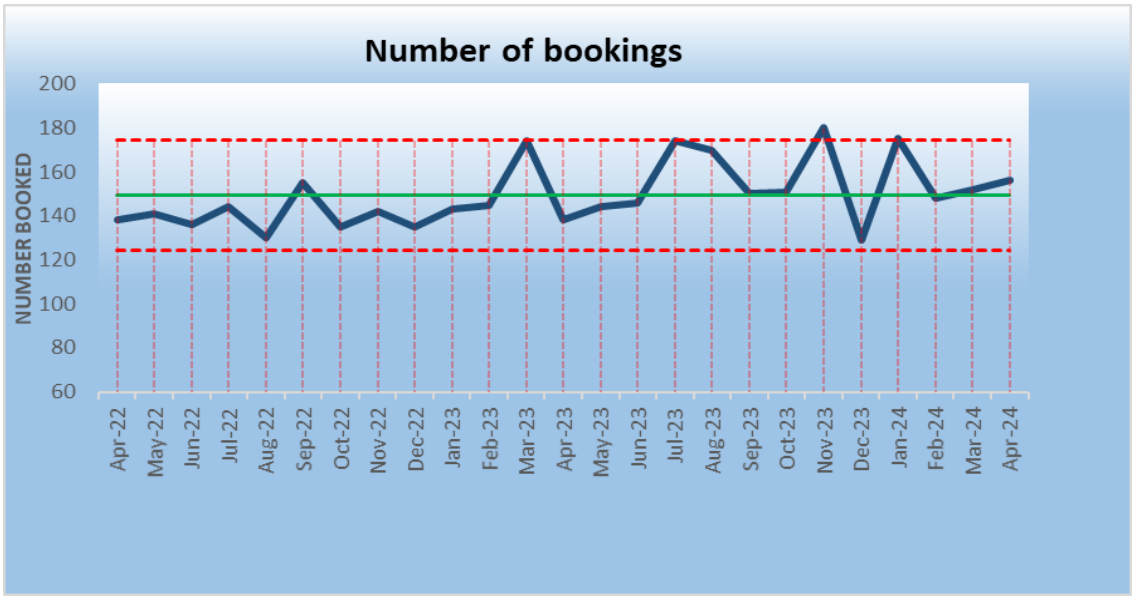
18.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

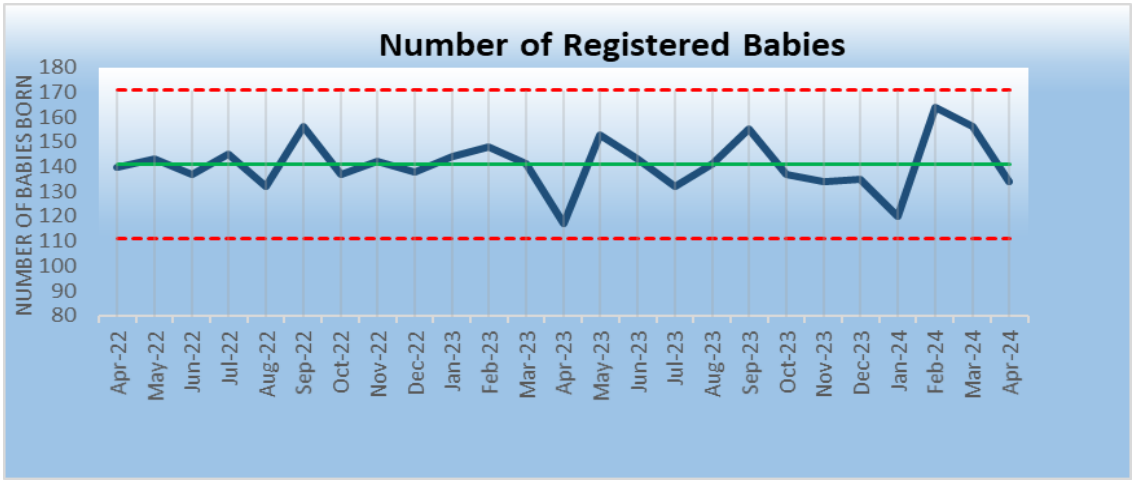
The next Quarterly Dashboard update is due to be submitted in June 2024.

19.0 Local HDFT Maternity Services Dashboard

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






Number of Registered Babies
NUMBER OF BABIES BORN
180
170
160
150
140
130
120
110
100
90
80
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
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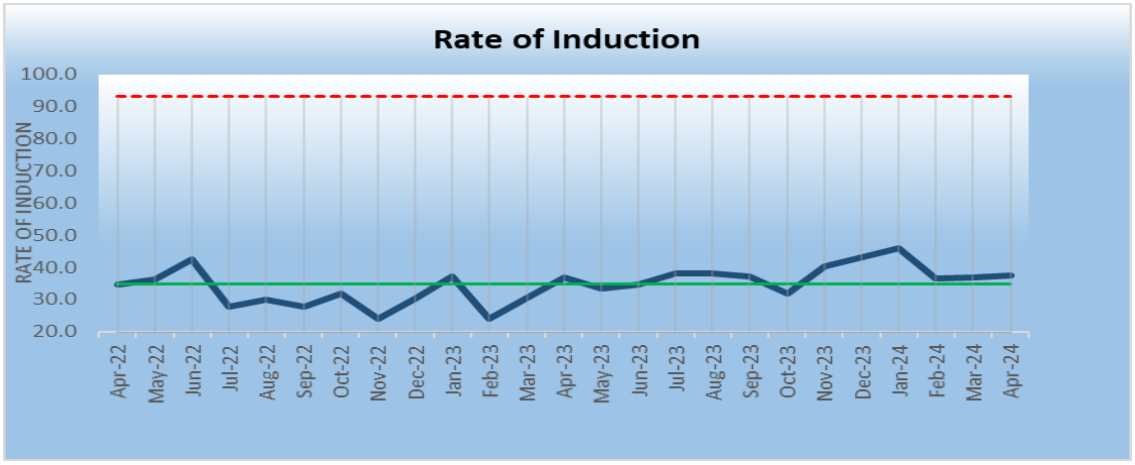
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Rate of Induction
RATE OF INDUCTION
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
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
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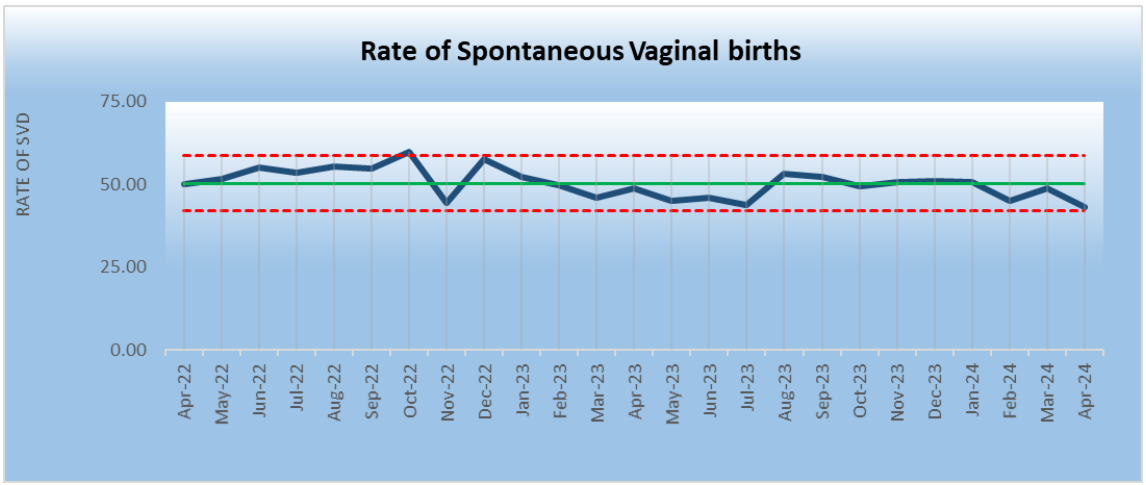
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Rate of Spontaneous Vaginal births
RATE OF SVD
75.00
50.00
25.00
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
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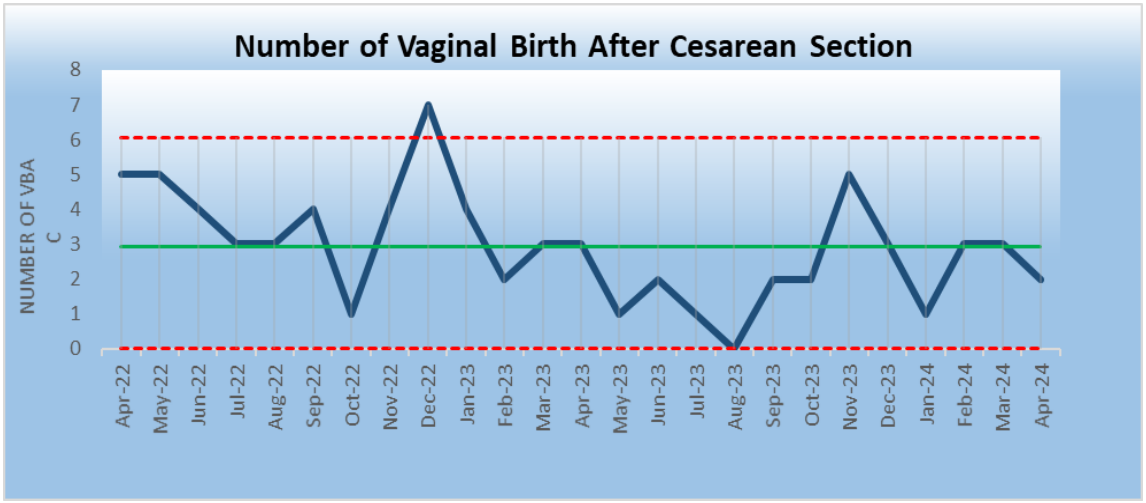
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


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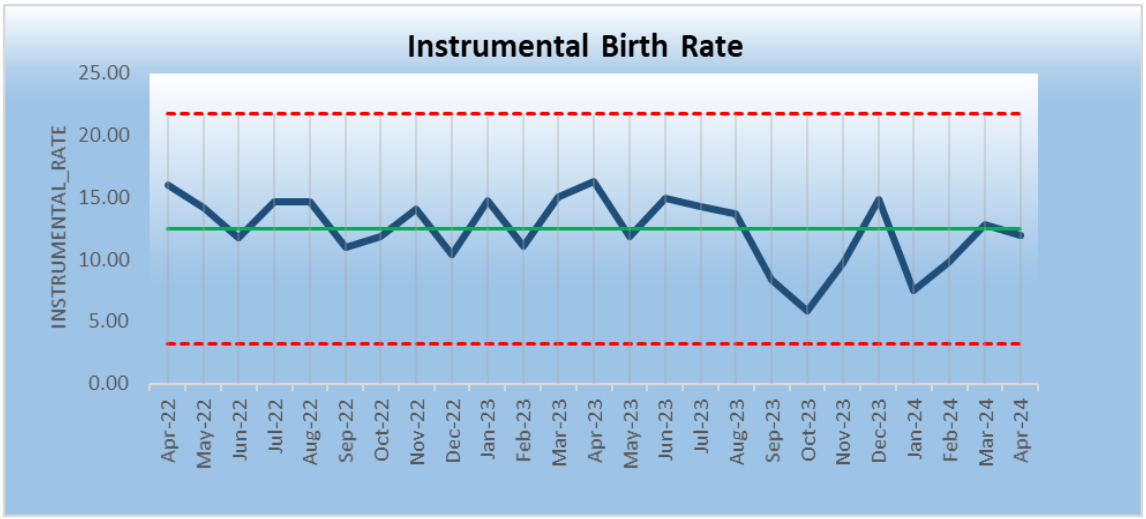
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Instrumental Birth Rate
INSTRUMENTAL_RATE
0.00
5.00
10.00
15.00
20.00
25.00
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
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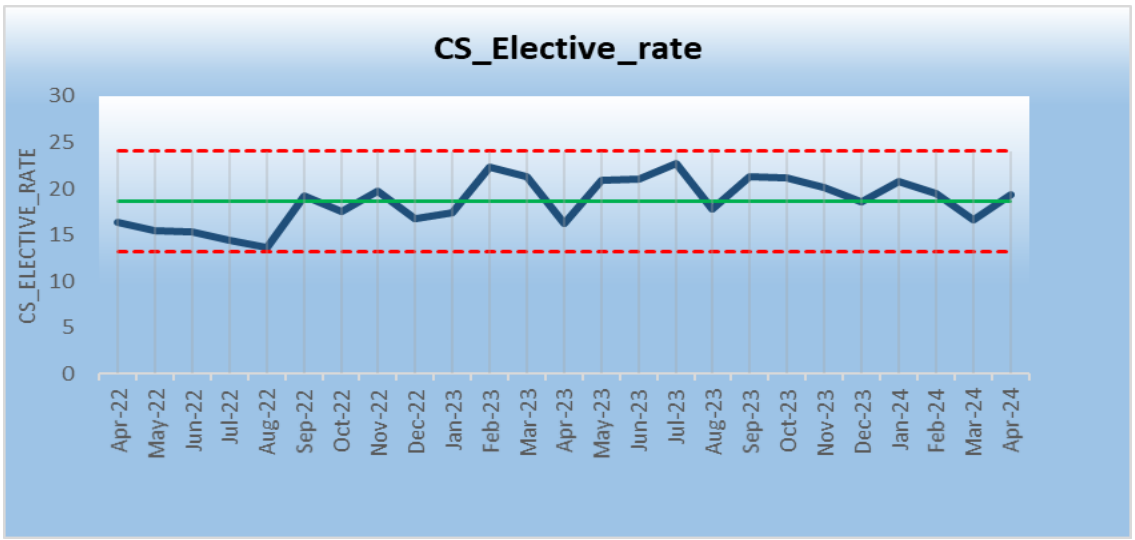
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


CS_Elective_rate
CS_ELECTIVE_RATE
0
5
10
15
20
25
30
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
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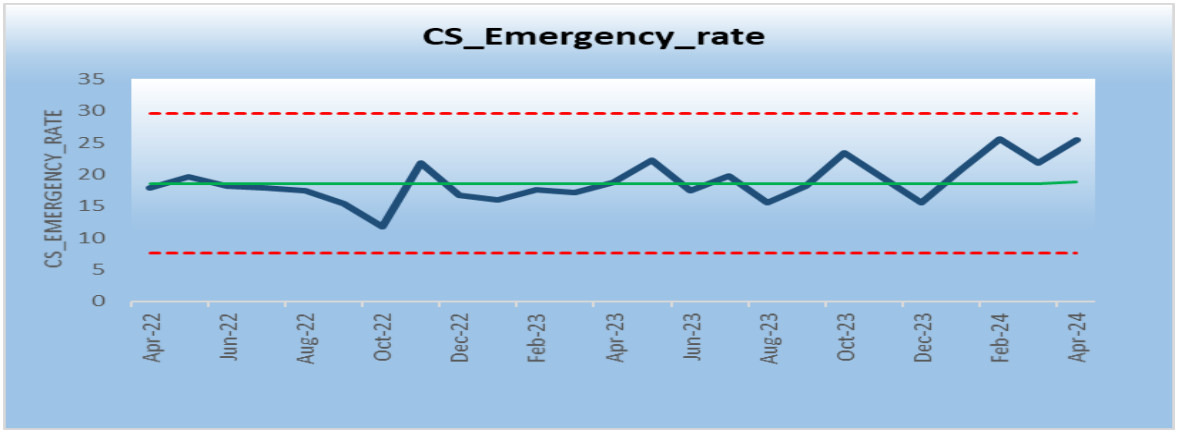
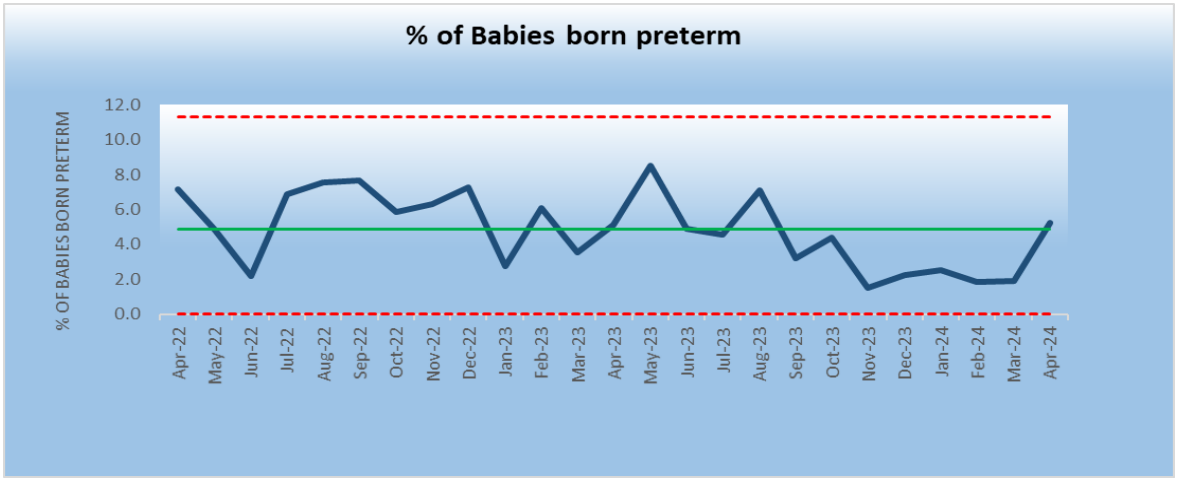
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


CS_Emergency_rate
CS_EMERGENCY_RATE
35
30
25
20
15
10
5
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24


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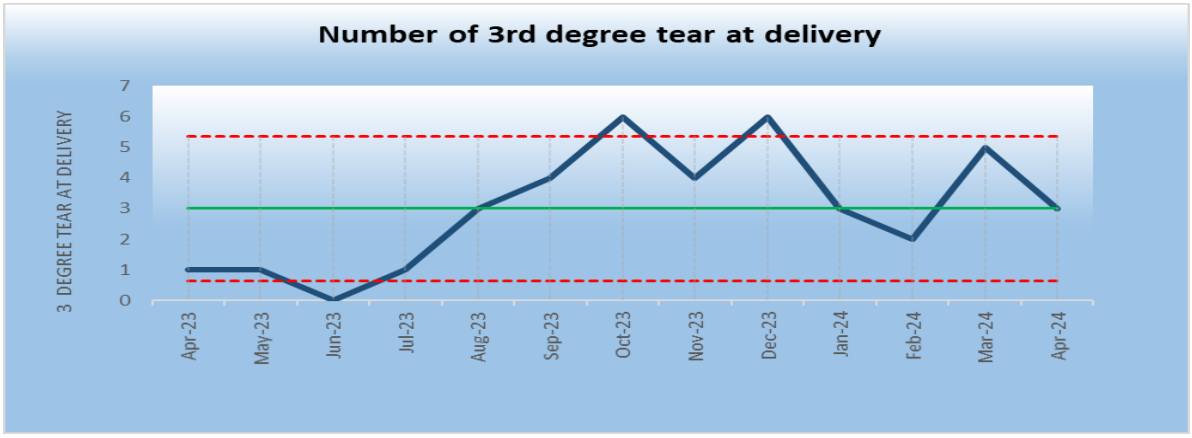
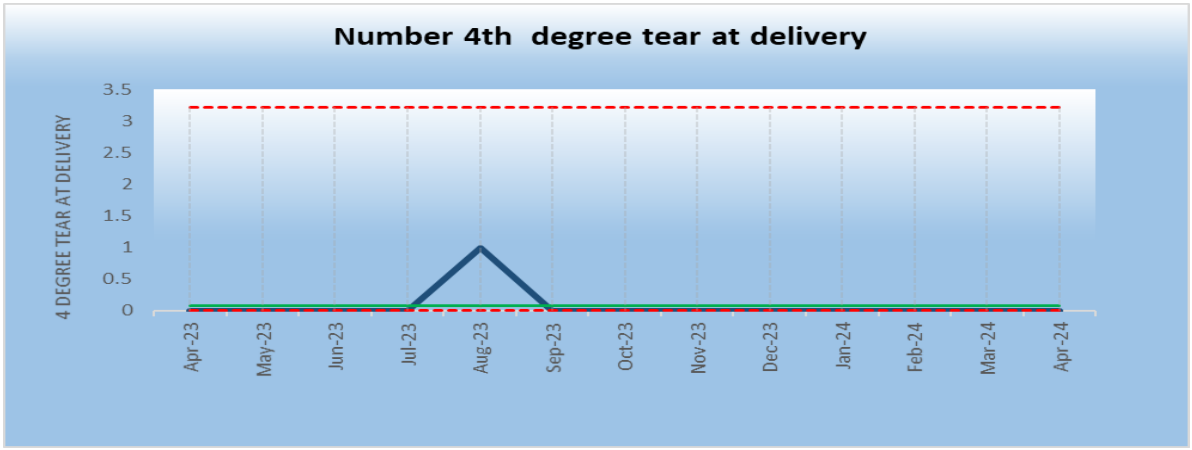
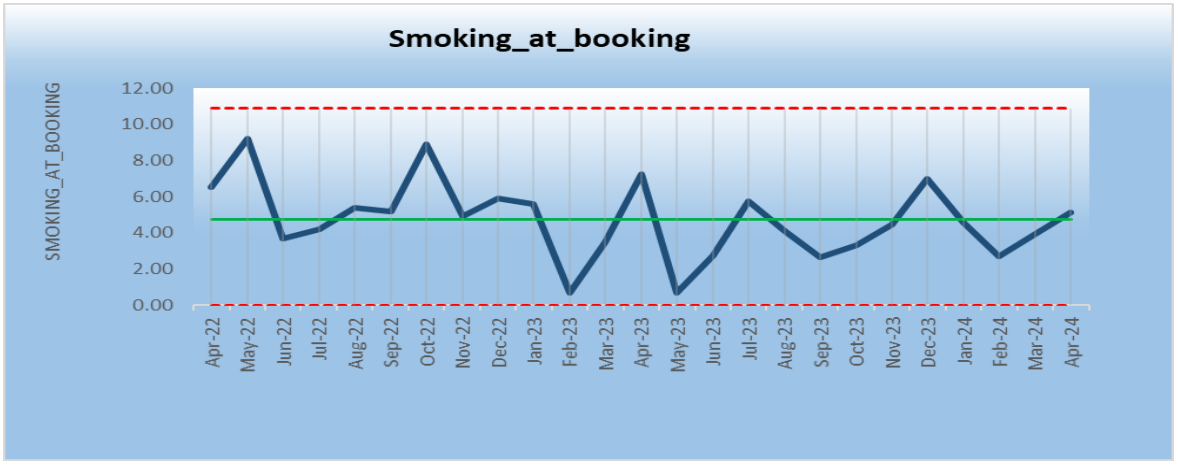
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Number of 3rd degree tear at delivery
3 DEGREE TEAR AT DELIVERY
7
6
5
4
3
2
1
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Number 4th degree tear at delivery
4 DEGREE TEAR AT DELIVERY
3.5
3
2.5
2
1.5
1
0.5
0
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Smoking_at_booking
SMOKING_AT_BOOKING
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
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Aug-23
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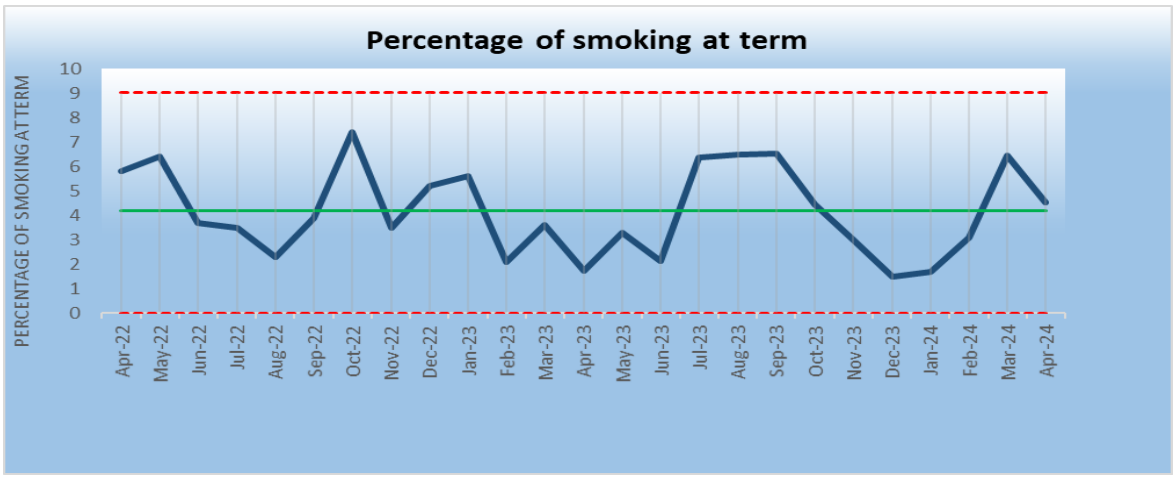
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


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
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Aug-23
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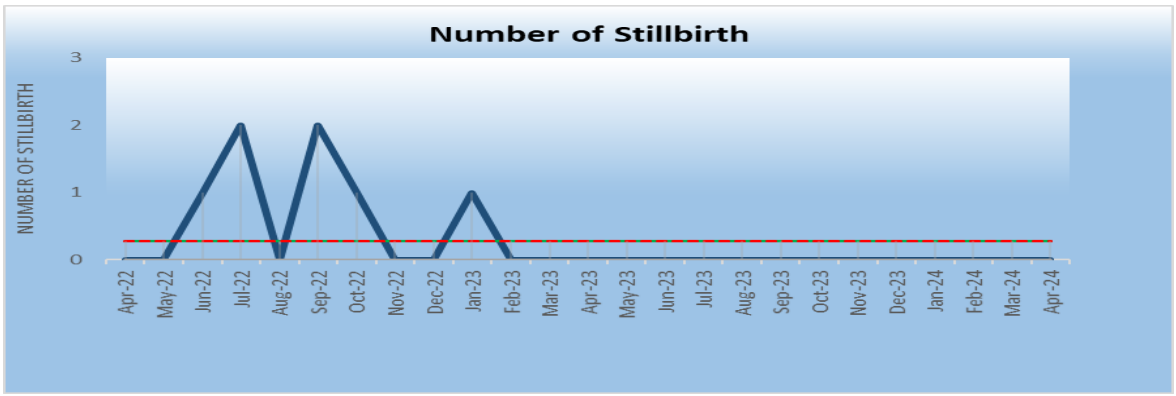
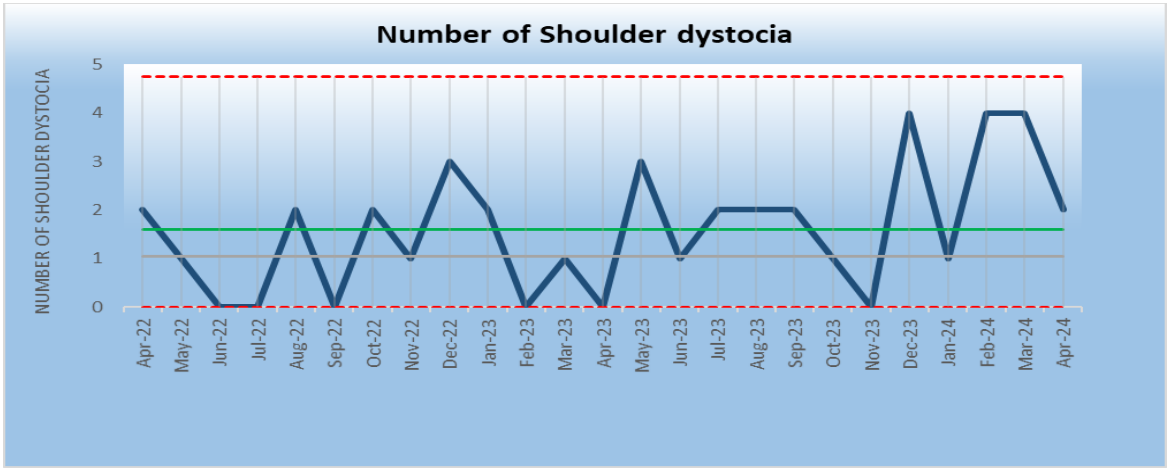
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Number of Stillbirth
NUMBER OF STILLBIRTH
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
Mar-24
Apr-24


Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
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
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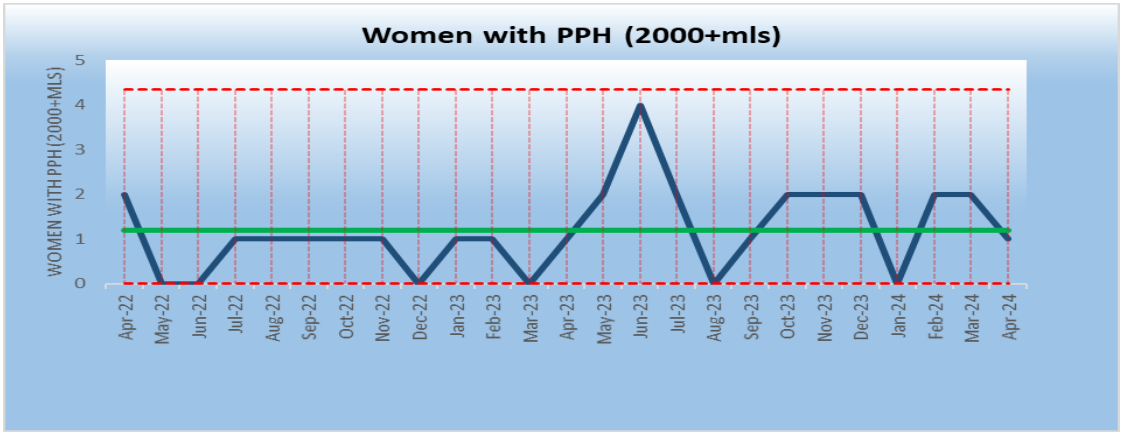
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24

5


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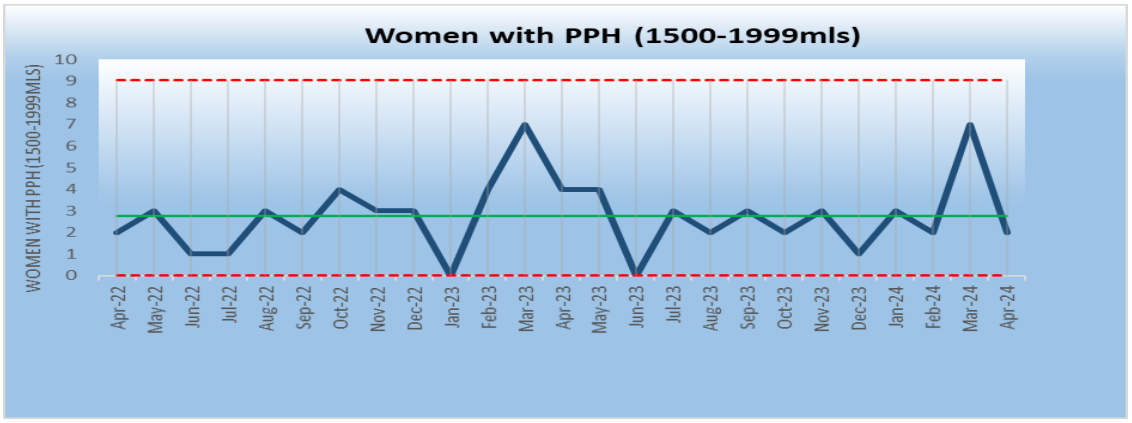
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Women with PPH (1500-1999mls)
WOMEN WITH PPH (1500-1999MLS)
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
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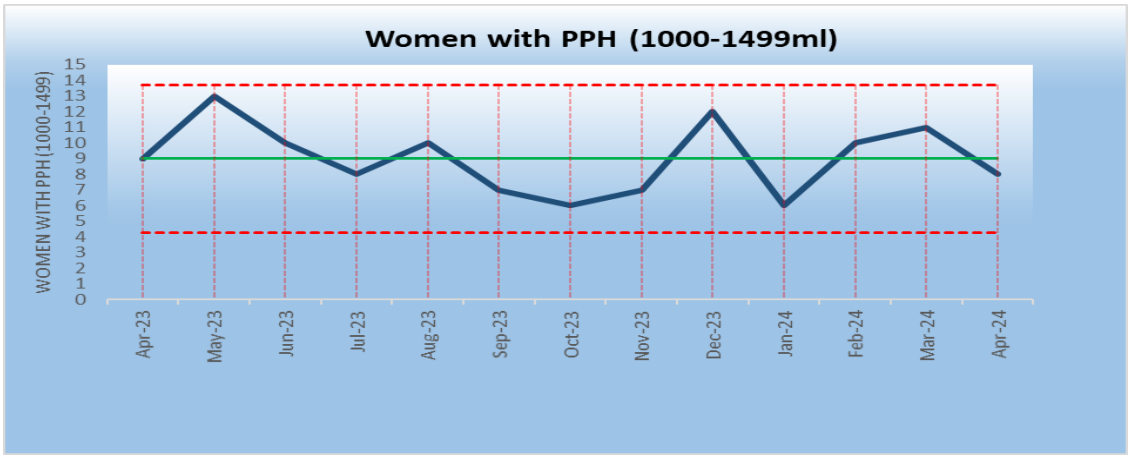
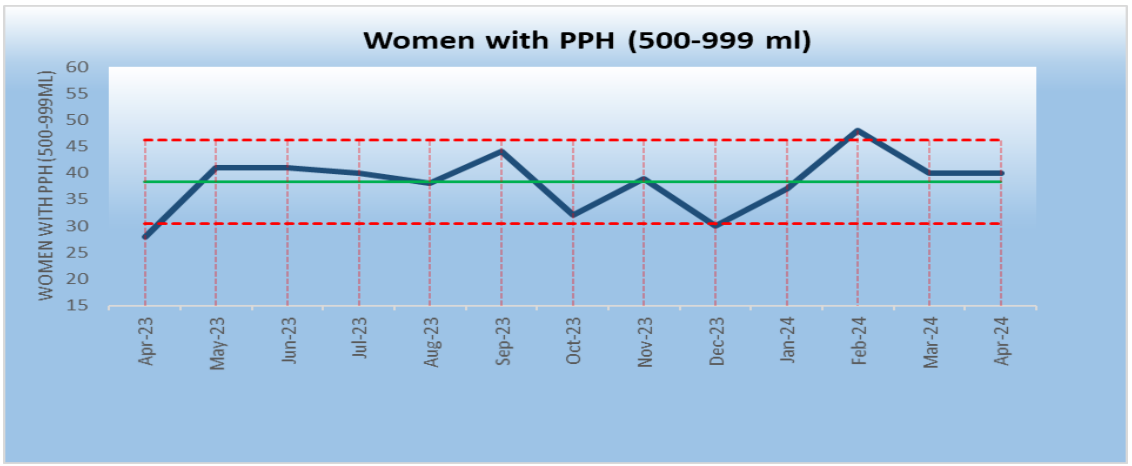
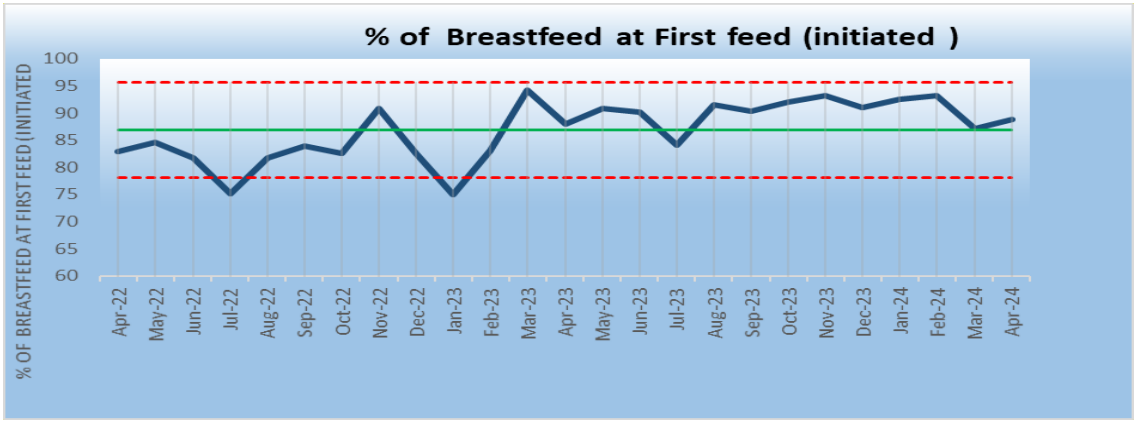
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Women with PPH (1000-1499ml)
WOMEN WITH PPH (1000-1499)
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24


Women with PPH (500-999 ml)
WOMEN WITH PPH (500-999ML)
15
20
25
30
35
40
45
50
55
60
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24



20.0 Avoiding Term Admissions in Neonatal Units (ATAIN)

There is overwhelming evidence that separation of mother and baby at or soon after birth can affect the positive development of the mother–child attachment process. Mothers may find it harder to establish and maintain breastfeeding and it may affect their mental health. Preventing separation, except for compelling medical indications, is an essential part of providing safe maternity services and an ethical responsibility for healthcare professionals. There are five main reasons for admitting babies to SCBU and thereby separating mother and baby; infection, respiratory problems, observation, hypoglycaemia and jaundice. There is a lot of cross over between all of the reasons for admission. An ATAIN Audit tool is completed for every baby admitted to SCBU with a birth gestation over 37 weeks to review if the reason for separation was appropriate and if there is any learning to prevent future incidences of separation. The Quarterly report for ATAIN is included at Appendix B.

20.1 Term Admissions to SCBU

There were two Unexpected Term Admissions to SCBU in April. One was a baby requiring admission for oxygen support following maternal placental abruption; one was admitted due to an ongoing respiratory issue.

20.2 ATAIN actions

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

Issue	Action	Due and Update
Lack of adherence to hypoglycaemia policy	For clarification and education of Medical Staff	30/4/24 - Guidance being reviewed alongside national guidance as guidance not clear. New due date 30/06/24
Should formula via NGT be 1st line treatment for hypoglycaemia (unless <1.0) on SCBU, instead of IV fluids		
Delay in transfer of patients to theatre once decision made for operative delivery	For audit of time between decision and entry into theatre	30/04/24 – Audit scheduled to be completed however timings available via Badgernet. Actions implemented include having theatre grab box in Delivery rooms with necessary items inc scrubs for dad to speed up transfer,

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	Investigated but not possible therefore action closed.
Neonatal collapse in skin to skin contact	Implementation of mandatory discussion with mothers about safe skin to skin on PNW & SCBU	30/4/24 – Information card to support conversation when initiating skin-skin drafted and discussed at LMNS task & finish group. Needs finalising. Additional resources including temporary poster was completed and are in delivery rooms, but need proper photos of safe skin-skin positioning to be taken and can then create some more official posters. New completion date – 30/06/24
Lack of neonatal resuscitation equipment in PACU	To consider bringing second resuscitaire from SCBU, or new platform area	30/6/24 – Conversations commenced and possible actions being considered.

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

The Saving Babies' Lives Care Bundle (SBLCBv3) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

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

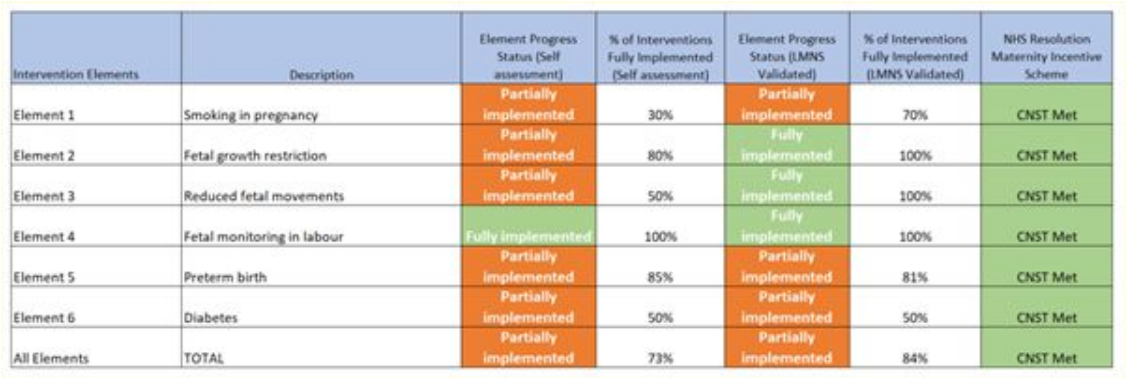
1. Reducing Smoking in Pregnancy
2. Fetal Growth: Risk Assessment, Surveillance and Management
3. Raising Awareness of Reduced Fetal Movement
4. Effective Fetal Monitoring During Labour
5. Reducing Preterm Birth
6. Management of Pre-existing Diabetes in Pregnancy

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

Small-for-gestational age/Fetal growth restriction detection rates	Q1 (calendar): 32.7% detection (<10th centile; 17 cases) (National average 42.9%) Q1 (calendar): 21.4% detection (<3rd centile; 3 cases) (National average 36.6%)	
	Jan-March 2024	April 2024
Percentage of babies <3rd centile >37+6 weeks' gestation	2.48% (11/444)	2.2% (3/135)
Percentage of babies <10th centile >39+6 weeks' gestation	5.4% (24/444)	2.97% (4/135)

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)	3 fetal loss born 16-24 weeks 1 neonatal death at 20 weeks (0.9%, 4/440)	No babies born 16-23^{+6} weeks (0%, 0/133)
• Preterm (24^{+0}-36^{+6} weeks)	1.8% (live, 8/440)	5.3% (live, 7/133)

The current position of compliance with the requirements of SBLCBv3 remains unchanged. The LMNS will attend Maternity Risk Management Group in July to verify the position. An action plan is in place, work is on-going and compliance is reassessed by the LMNS quarterly.



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

5

22.0 Maternity Safety Champions

Bi-monthly walk around and meetings continue. Executive and Non-executive Safety Champions walk around occurred in community (Leon Smallwood) on 18th March and was followed by a Safety Champions meeting. The next walk-around/staff engagement and meeting will be held on the 20th May 2024.

23.0 Conclusion and recommendation

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

Appendix A – Baby Friendly Initiative annual report 2024

The purpose of this report is to provide assurance that work to support Baby Friendly accreditation within the Maternity department and Special Care Baby Unit is effective and achieving the required outcomes and impact. The report is based around the sustainability standards; Leadership, Culture, Monitoring and Progress.

Background

The maternity department and SCBU received the Baby Friendly Initiative Gold Award for achieving sustainability standards in 2017 and 2020 respectively. This award comes with a commitment to ensure current standards are maintained, robust monitoring processes are in place and the service is responsive to change and can demonstrate continued improvement in outcomes.

Overview of the UNICEF UK Baby Friendly Initiative Standards

Stage 1: Building a firm foundation

1. Have written policies and guidelines to support the standards.
2. Plan an education programme that will allow staff to implement the standards according to their role.
3. Have processes for implementing, auditing and evaluating the standards
4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

Stage 2: An educated workforce

Educate staff to implement the standards according to their role and the service provided.

Stage 3: Parents' experiences of **maternity** services

1. Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and wellbeing of their baby.
2. Support all mothers and babies to initiate a close relationship and feeding soon after birth.
3. Enable mothers to get breastfeeding off to a good start.
4. Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
5. Support parents to have a close and loving relationship with their baby.

Stage 3: Parents' experiences of **neonatal** units

1. Support parents to have a close and loving relationship with their baby.
2. Enable babies to receive breastmilk and to breastfeed when possible.
3. Value parents as partners in care.

Re-accreditation

Embed all the standards to support excellent practice for mothers, babies and their families.

Achieving Sustainability (Gold)

Provide the leadership, culture and monitoring needed to maintain and progress the standards over time.

Code compliance

All services accredited as 'Baby Friendly' are expected to adhere to The International Code of Marketing of Breastmilk Substitutes (the Code) and subsequent resolutions. The Code prohibits all promotion of milks and equipment related to bottle feeding and sets out requirements for labelling and

information on infant feeding. Any activity that undermines breastfeeding also violates the aim and spirit of the Code.

- There have been no Code compliance issues since the last report.

Maternity

Revalidation process for maternity

Future submissions required to maintain gold accreditation	
April 2024	**Annual audit due to be submitted to the Baby Friendly Initiative**
April 2025	Revalidation assessment to ensure standards are being maintained. Includes interviews with the leadership team, a presentation on progress since the last assessment and submission of a portfolio of evidence.

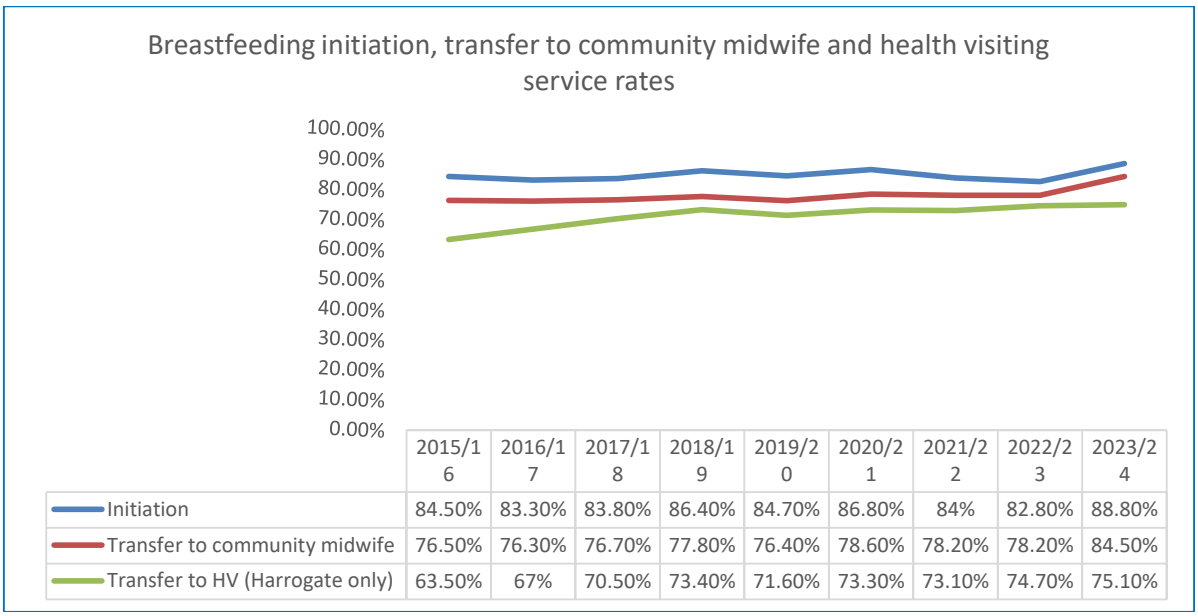
Training and leadership

- Two maternity managers require sustainability training, dates are booked in May
- 100% of staff have competed their initial Breastfeeding and Relationship Building training
- All staff now repeat the Breastfeeding and Relationship Building training every 3 years.
- Yearly mandatory updates for infant feeding are part of Mat 3 'Personalised Care and Care in Labour' education day for midwives. The infant feeding session this year is based on the complexities of infant feeding decisions and personalising feeding care plans.

Data and monitoring

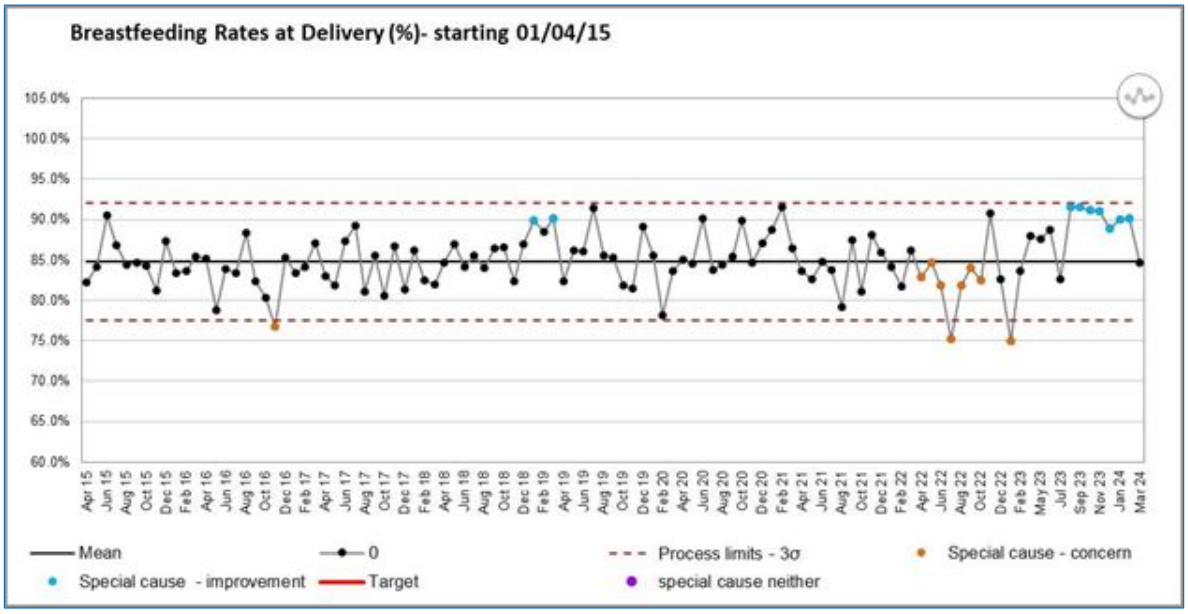
- Several mandatory fields have been added to BadgerNet this year to capture initiation rates. This data collection is now complete and accurate for 2023/24.
- Breastfeeding on transfer to the community midwife data entry points now have a data quality link applied so we can assure accuracy for this time frame.

Graph 1



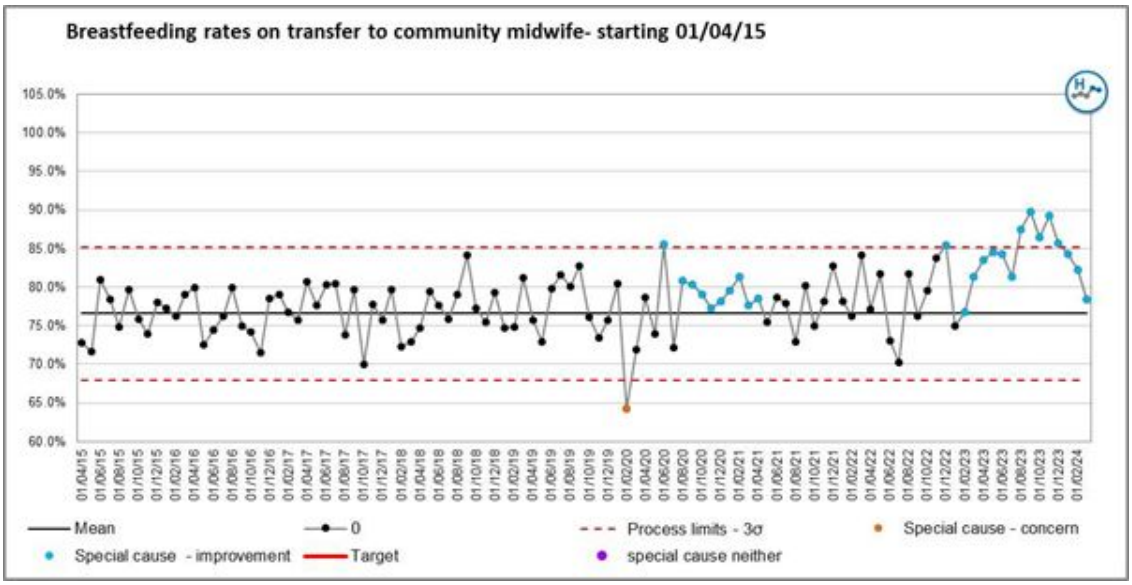
	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Initiation	84.50%	83.30%	83.80%	86.40%	84.70%	86.80%	84%	82.80%	88.80%
Transfer to community midwife	76.50%	76.30%	76.70%	77.80%	76.40%	78.60%	78.20%	78.20%	84.50%
Transfer to HV (Harrogate only)	63.50%	67%	70.50%	73.40%	71.60%	73.30%	73.10%	74.70%	75.10%

Graph 2 Statistical Process Control chart (SPC) for breastfeeding initiation



There has been an improvement in breastfeeding initiation rates for seven consecutive months during the latter part of the year. Breastfeeding rates fluctuate in a small unit however with the reintroduction of parent education classes and staff training on effective communication around feeding choices in the antenatal period it is hoped increases will continue to be sustained. Future plans include providing targeted information to support feeding decisions in pregnancy and inclusion of infant feeding on the 'Maternity and More' evenings for parents.

Graph 3 Statistical Process Control chart (SPC) for breastfeeding rates on transfer to the community midwives



Breastfeeding at discharge from hospital average is 77%. The last 14 consecutive months have an increased trend over the average (special cause variation) with 6 consecutive months above 3 standard deviations which is a statistically significantly improvement (Graph 3).

Improving breastfeeding duration continues to be a priority. This year the frenulotomy clinic and breastfeeding support group opened (see details below). Future plans include producing bite size information for mothers and their families on common feeding topics and concerns, with the aim of supporting effective feeding and allaying concerns in the early days and weeks following birth.

Supplementation rates

Supplementation of breastfed babies with formula milk has been shown to shorten the length of time a mother continues to breastfeed (1) and may have an impact on the long term health of their baby. Our aim is ensure supplements are given only for medical indication or following fully informed decision making by the mother.

Percentage of breastfed babies given formula in hospital before transfer to community. (This percentage includes mothers choosing to mix feed from birth):

2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
12.2%	10%	9.6%	10.5%	11.1%	10.3%	15.7%	11.5%	8.9% *

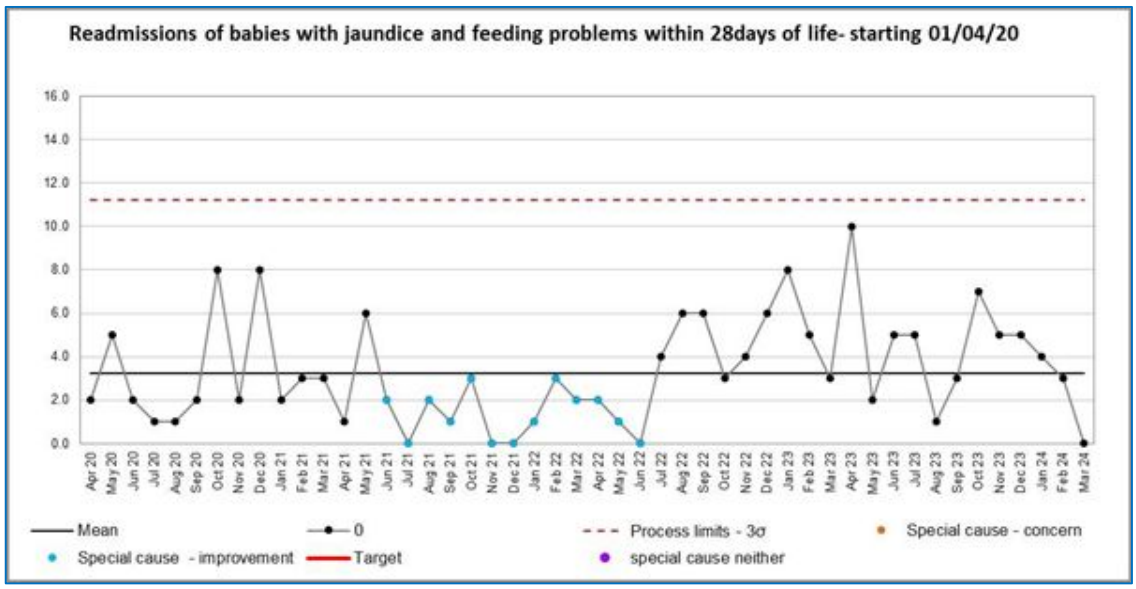
Supplementation rates increased in 2021/22. During this period a significant number of new staff started in maternity, many with differing experiences from other Trusts. Training during 2022 was online following the Covid 19 pandemic. Since this increase we have recommenced the infant feeding study day and mandatory sessions face to face.

*Data collection for supplementation has changed since moving to BadgerNet. The supplementation rate above for 2023/24 is based on numbers of mothers who started breastfeeding and are now also using formula. This includes mothers who chose to mix feed from birth but does not include any individual supplements given during the mothers stay when the mother then went on to fully breastfeed. The last audit of supplements for maternal request and medical indication (Dec 2023) showed a 4.7% rate with an improvement in care, with mothers being offered extra support and alternatives such as expressing. This year we will continue auditing quarterly. A request to separate numbers of supplements in hospital and at home has been sent to BadgerNet.

Readmission rates

Readmission of a baby to hospital causes stress and anxiety for parents and families. Review of cases aim to find modifiable predictors and develop interventions to reduce the risk of readmissions when possible. Presently the highest reason for readmission to maternity is jaundice with prematurity being a significant risk factor. (For further information see 'Hospital readmissions of babies within 30 days of life' quarterly reports)

Graph 4



Frenulotomy (tongue-tie division) clinic

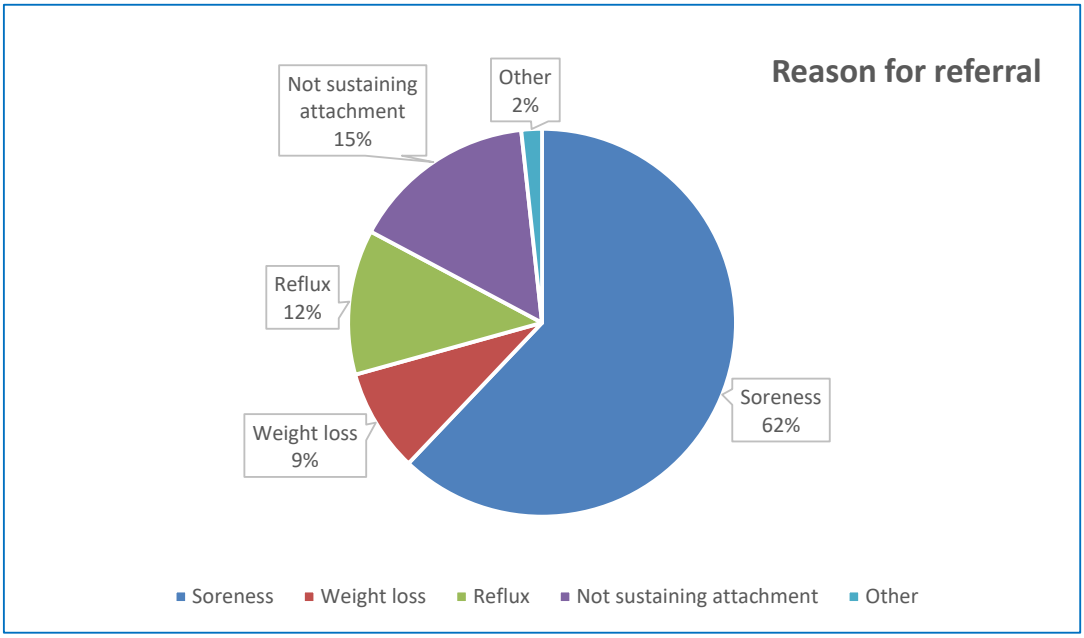
As part of the infant feeding service for more complex feeding issues a local frenulotomy service is essential. Historically this service was run by maxillofacial surgery in Harrogate, but clinics discontinued when surgeons trained in the procedure moved to other Trusts. For several years, mothers and babies were referred by their general practitioners to Leeds Ear Nose and Throat (ENT) services. The waiting time for an appointment has increased over the years due to demand and we have received several complaints on the impact this has had on individual mothers breastfeeding journeys.

Following the training of two midwives at Hull University a midwife led frenulotomy clinic was set up in Harrogate in November 2023.

Year (April – March)	2023/24 (Nov-March only)
Referrals received	92
Completed frenulotomies	58
Number declined by the midwife	27
Normal frenulum present	7

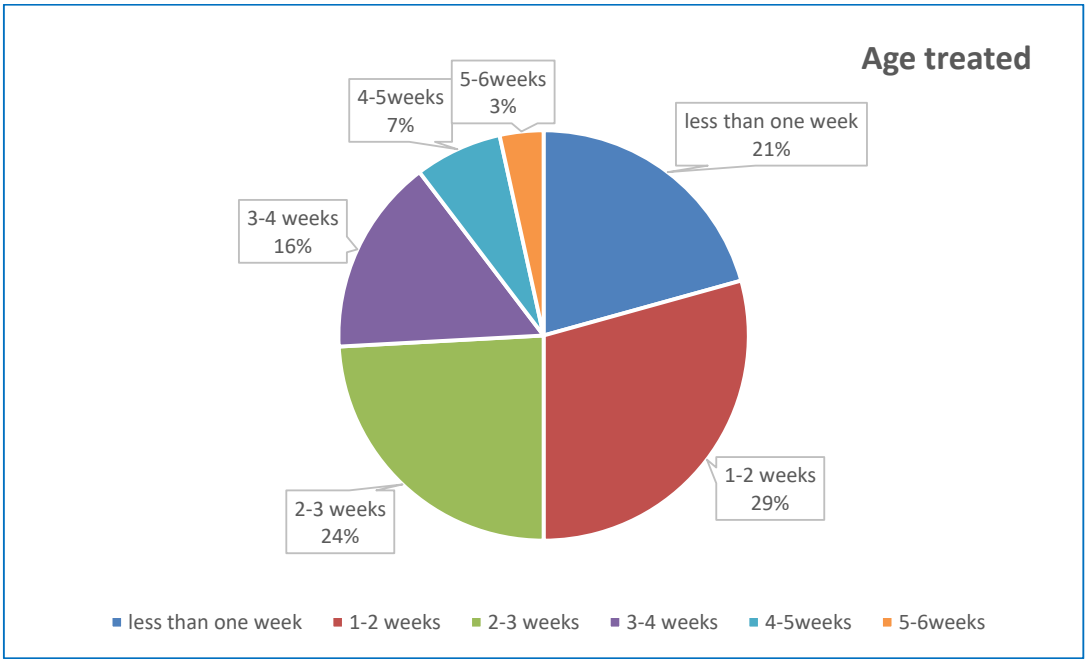
Of the 58 babies that had tongue tie division, 36 were exclusively breastfeeding, 5 were giving expressed breastmilk only, 16 were mixed feeding and 1 was formula feeding. The formula feeding baby was referred by the General practitioner due to significant feeding difficulties.

Graph 5



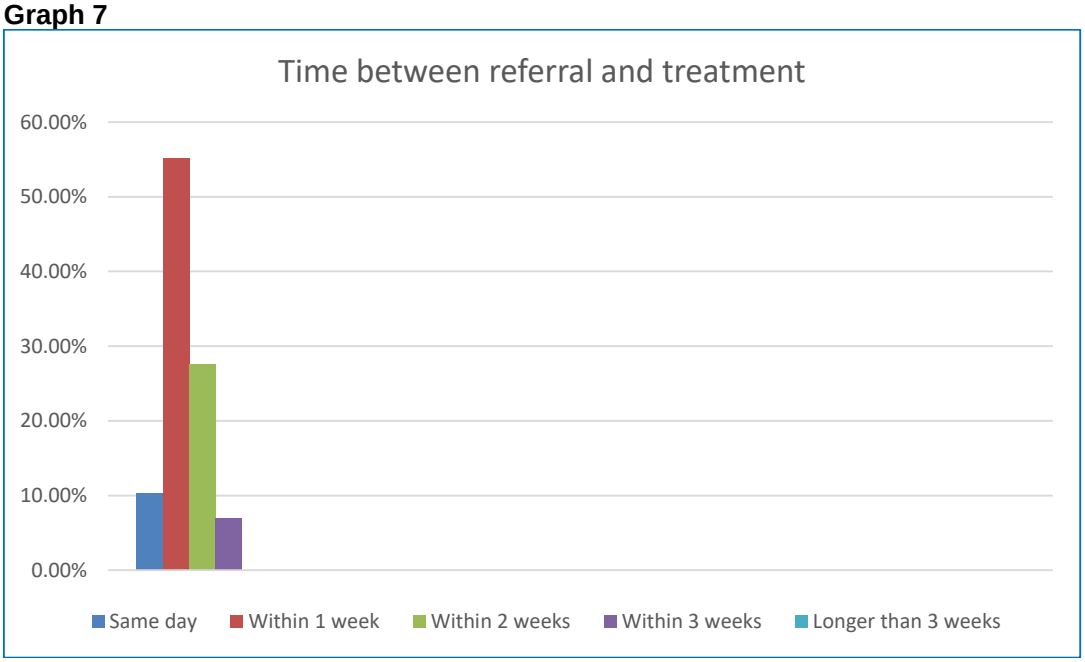
Graph 5 shows the majority of babies referred have problems with attachment and soreness that is not improving with appropriate support.

Graph 6



Graph 6 shows the majority of babies were between 1-2 weeks old. 10% of babies were between 4-6weeks however most of these babies were in the early weeks of opening the clinic so we accepted babies already on a waiting list elsewhere.

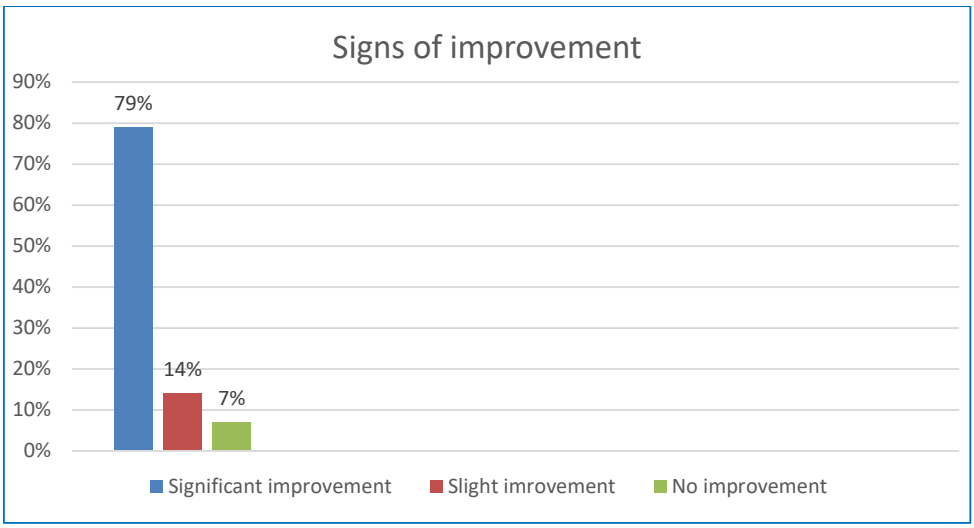
Graph 7



- Graph 7 shows six babies were treated on the ward, two were over 24 hours old and had not attached to breastfeed since birth. Two were readmissions for weight loss and one for jaundice. The longest wait was fifteen days. One baby waited seventeen days however the mother declined an earlier appointment.
- Two mothers declined an appointment as they had received private care. One was offered an appointment three days after referral and one at seven days after being referred.

No babies required any additional treatment for bleeding or infection.

Graph 8



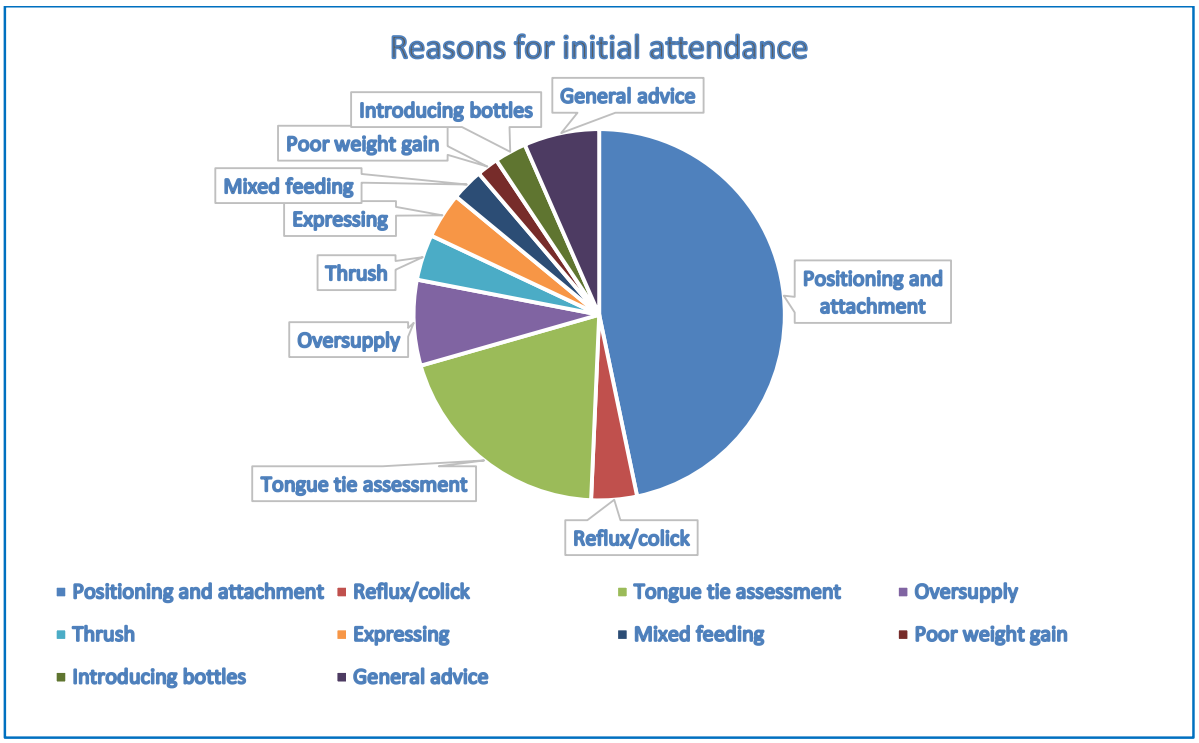
Graph 8 - of the 58 babies treated, 44 were audited. Initially audits were completed 2-3 weeks following the procedure but due to low responses, this now takes place after one week.

Culture

Breastfeeding club

A breastfeeding club was opened in Harrogate Library in March 2023 to offer both general breastfeeding support and offer a specialist service for mothers with more complex lactation needs. Since opening, 145 mothers have attended with a total of 280 attendances. Approximately one third of mothers attended once only. The other two thirds visited between 2 and10 times with an average of 4 visits. Numbers attending each clinic was between 2 and 16, with an average of 7 mothers attending each week.

Graph 9



108 mothers were audited on reasons for initial attendance (graph 9). Requiring help with positioning and attachment was the major reason, with mothers coming along to seek help or being referred by their community midwife for additional support. Babies with potential tongue tie (referred when the midwife was unsure) were seen in the breastfeeding club to prevent appointment slots being used unnecessarily in the frenulotomy clinic. Attendance for peer support alone is not included but will be audited in this year.

Special Care Baby Unit (SCBU)

Revalidation process Special Care Baby Unit

Future submissions required to maintain gold accreditation	
April 2024	**Revalidation assessment to ensure standards are being maintained. Includes interviews with the leadership team, PowerPoint presentation and submission of a portfolio of evidence.**
April 2025	Annual audit due to be submitted to the Baby Friendly Initiative

Training and leadership

- All managers have attended sustainability training
- 100% of staff have competed their initial Breastfeeding and relationship building training
- All staff will now repeat the infant feeding and relationship-building course, 88% have completed this so far this year
- New doctors continue to receive infant feeding training as part of their induction programme

Data and monitoring

Note: These numbers are very small and therefore fluctuation in rates is to be expected. Initiation includes term babies initiating breastfeeding when admitted to SCBU. Babies who initiated on delivery suite are not included. Discharge rates include transfers in from other units following initial care.

Year (Jan – Dec) Data collected for financial year from 2023/4	2018	2019	2020	2021	2022	2023	2023/24
Initiation	82.9%	88.7%	87.9%	91.5%	84.3%	91.7%	92.9%
Any breastmilk / breastfeeding at discharge	77.2%	79.2%	82.9%	80.7%	88.5%	91.5%	92.9%
Exclusive breastmilk / breastfeeding at discharge	63.2%	65.3%	77.5%	69.7%	68.8%	72.3%	75%
Formula feeding at discharge	22.8%	20.8%	17%	19.3%	11.5%	8.5%	7.1%

- Although there has been an increase in breastfeeding/receiving breastmilk at discharge, exclusively breastfeeding without extra breastmilk has declined. In the majority of cases this is

one feed of expressed milk per day. The fall in the number of babies being exclusively breastfed is a concern and further data analysis will enable us to better understand whether this is medically indicated or a truly informed maternal decision.

- Staff now ask mothers already formula feeding on admission whether they would be prepared to express some breastmilk for their baby to support them while are on the unit. This conversation is now becoming embedded in practice. We have had a number of successes from this approach with some mothers expressing and or breastfeeding longer term.

Culture

- The staff on SCBU continue to value parents as partners in care. Audits show extremely positive feedback from parents that have been on the unit. Detailed information is available in the yearly reports to the Baby Friendly Initiative.
- Plans are now underway to have BFI champions on the unit to monitor standards on a daily basis. The aim is for staff to be autonomous, making required changes and planning individualised care.

SCBU support group

SCBU coffee mornings are run by staff from the unit every two months. The days and times are changed each meeting following parent feedback. Approximately ten families attend each event. Families with older babies / young children still attend on occasion and support families recently discharged from the ward.

The group also provides a way to capture feedback once parents are back in their own environment and parents opinions on changes and potential improvements on the unit are also sought.

More recently our small team of allied health professionals (dieticians, physiotherapists, speech and language) held a drop in to support parents with any issues and answer any concerns they may have. This is a positive way to give advice and refer when appropriate.

Overall Conclusion

Rates for initiation and duration of breastfeeding appear to be improving across maternity and neonatal. The focus will now be on increasing rates in areas where women are least likely to breastfeed.

More detailed information is available in the Baby Friendly action plans for Maternity and SCBU.

References

1. Evidence for the 10 Steps to Successful Breastfeeding. Geneva, World Health Organization 1998.

Appendix B – ATAIN Quarterly Report

ATAIN and Transitional Care provision report Quarter 4 (Jan- Mar 2024)

Report Overview

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

The National Ambition

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

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

Why is it important?

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

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

ATAIN data: Quarter 4 2023/24:

During quarter 4 there were a total of 439 babies of all gestations born in Harrogate, 428 of these were >37/40 weeks gestation and there for admissible for ATAIN audit. Of the 428, 12 babies of >37/40 gestation were admitted to the neonatal unit. Special Care Baby Unit (SCBU) admissions for this quarter were lower than the previous quarter at 3% compared to the 6% of the previous quarter and in line with 3% that has been consistently reported in all other quarters of the year. All 14 of the cases have been reviewed at the multi-disciplinary ATAIN forum, two had been rejected due to being duplicates. Of the cases reviewed all were deemed to have had appropriate care with one being noted as potentially avoidable.

Following review of the term neonatal admissions and recognising an increase in Respiratory Distress Syndrome (RDS) cases over the previous quarters, a 'Management of Term Babies with Respiratory distress in the first hour of life' flow chart has been attached to all resuscitaires. This flow chart allows for safe assessment and placement of the term infant showing symptoms of respiratory distress, whilst aiming to reduce inappropriate separation of mother and baby. This information has been disseminated to both midwifery and medical staff for immediate implementation.

Potentially Avoidable Admissions:

Following review at the ATAIN forum 30th April 2024 one baby could have potentially avoided admission to SCBU. Baby was born in good condition and transferred with mother to the postnatal ward. A Transcutaneous Biliflash was performed as baby appeared jaundiced which plotted above treatment level on the individualised chart. A formal bilirubin blood sample was sent which was nearing the threshold for exchange transfusion. Baby required multiple surface phototherapy, and nasogastric tube feeding was indicated to ensure optimal exposure to treatment lights. This was appropriate management of the care and appropriate admission to SCBU, however evidence suggests that if there was a dedicated transitional care ward the baby could have been cared for whilst remaining with parents.

Evaluation of Data:

The most common condition for admission in this quarter was Respiratory Distress Syndrome (RDS) with seven of the twelve cases listing RDS as admission reason. This remains consistent with previous quarters as being the leading cause of unexpected admission to SCBU. Of the twelve cases reviewed, only one case was deemed potentially avoidable.

Condition	Number of Admissions	Number of Avoidable Admissions
Hypothermia	0	0
Jaundice	1	1
Respiratory Distress Syndrome	7	0
Hypoglycaemia	1	0
Other Clinical Conditions	2	0

Transitional Care Provision and Standards:

Introducing Transitional Care (TC)

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

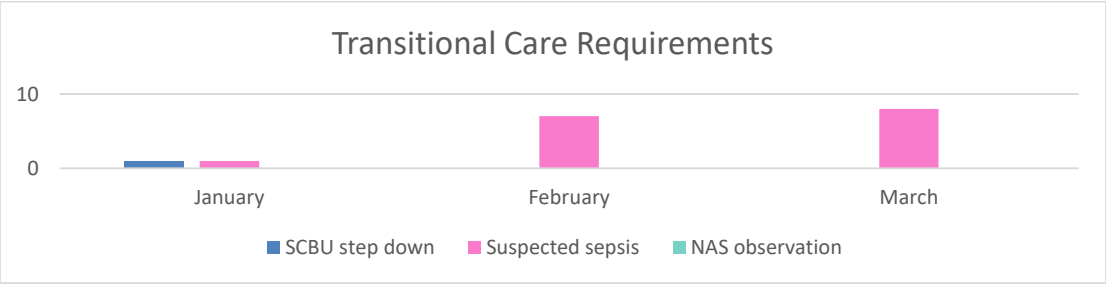
One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Thus, reducing the risk of maternal and neonatal separation and increasing the chance that neonates remain well. This also ensures that care is cost effective. It is important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

At HDFT, a review of TC babies occurs daily during dedicated rounds, where assessment takes place and plans of care are made. This review takes place using the jointly approved neonatal/maternity document. There is an escalation policy for any babies who are unwell which is well known by the team and followed should the need arise.

Transitional Care Provision 2023/24: The table below shows a breakdown of TC activity delivered within Harrogate over the previous year.

Date	Number of admissions	Electronic method used to record data
April 2023	4	Badgernet
May 2023	3	Badgernet
June 2023	4	Badgernet
July 2023	3	Badgernet
August 2023	5	Badgernet
September 2023	5	Badgernet
October 2023	4	Badgernet
November 2023	7	Badgernet
December 2023	6	Badgernet
January 2024	2	Badgernet
February 2024	7	Badgernet
March 2024	8	Badgernet

Quarter 4 Transitional Care Data:



During quarter 4 there were a total of 17 babies requiring transitional care provision. 16 of these admissions were due to suspected sepsis and completed Intravenous Antibiotic treatment, one was stepped down from special care and reunited with parents on Pannal ward and all babies have documented reasons for requiring transitional care.

All 17 are noted to have Badgernet documentation, which has been the case since quarter 1 of the past financial year, transitional care documentation has commenced under the dedicated tab in Badgernet. 16 of the 17 babies had documentation under the designated transitional care round and the other listed as a daily review.

During this quarter an improvement in the number of baby notes being produced for those requiring TC has been noted. Following transitioning to electronic records, reporting consistent documentation within badger has improved. The ongoing action to increase the number of transitional care booklets as a record of care can now be completed. In aims to continuously improve the completion of Badgernet ward rounds this has been included in the induction package for junior doctors rotating into paediatrics. This will continue to be audited and the action log amended to reflect this.

Recommendations:

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

Transitional Care Action Log:

Recommendation From Case Review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date
MDT transitional care ward round to occur at set time each day.	Discuss with department leads and arrange trial pilot period.	Amy Howard Lesley Copeland	**30/06/2024**

Appendix 1: Cumulative ATAIN Action Log:

Add to proforma for Trisomy 21	Jo Orgles	**30/06/2024**	Discussed with Jo 22/6 - looking into adding to a current guideline. Ensure formal observations completed in accordance with guideline and add to proforma. Awaiting implementation of NEWTTS2
Disseminate to nursing & medical staff	Lisa & Pat	**Completed**	Pat to share with medical team. Slack message sent to nursing team.
Contact ODN	Lisa Nesbitt	**Completed**	Normal saturation limits of 90-95% apply
Educate midwifery staff & share with SCBU	Jo Orgles	**Completed**	Emailed Jo 15/11/23, Re-emailed 4/2/24
Educate midwifery staff & share with SCBU	Jo Orgles	**Completed**	
Educate medical staff & share with SCBU	Pat Gilbertson	**30/04/2024**	26/3 To add additional box onto current hypo policy, to d/w Jo Orgles
Medical & nursing feedback to admitting Dr/Nurse	Amy Howard & Pat Gilbertson	**Completed**	
Print RDS flowchart and add to nursing handover folder	Lisa Nesbitt	**Completed**	
Include a baby 'transitioning' to ex utero environment as an example for a neonatal 'resus' simulation	Amy Howard	**Completed**	Emailed Amy 1/12
Audit last 3 months of Vapotherm use in term babies on SCBU to see if there was clinical jusitification for use	Lisa Nesbitt & Amy Howard	**Closed to continue monitoring**	Audit in process

Include insertion of i-gel as part of neonatal simulations	Amy Howard	**Completed**	
Audit previous transfers to determine potential causes of delay	Paula Olsen	**30/04/2024**	Not yet commenced but d/w Andy Brown 26/3 that improvements are in place to speed up the transfer
Midwifery leads to disseminate to staff	Laila, Jo & Lesley	**Completed**	Emailed 4/2/24
Disseminate to medical team	Pat Gilbertson	**Completed**	Emailed 4/2/24
Discuss with resuscitation team	Lisa Nesbitt	**31/05/2024**	Lisa emailed main theatres for advice 26/3
Disseminate to medical team	Pat Gilbertson	**Completed**	Amy to share at Governance on 28/3
Midwifery team to document in free text on Badger net that discussion has been had. SCBU to incorporate tick box into admission paperwork	Hazel/Jo (PNW) & Lisa (SCBU)	**31/05/2024**	To discuss with Jo Orgles re: wording of skin of skin advice

Operational Update

May 2024

Russell Nightingale
Chief Operating Officer

Children's and Community

Metrics	Q1	Q2	Q3	Q4	YTD 2023/24	Apr-24
% of antenatal contacts						
Darlington	95.5%	94.6%	98.8%	96.9%	**96.5%**	98.1%
Durham	88.4%	85.6%	85.0%	88.1%	86.8%	88.5%
Gateshead	93.5%	96.5%	96.9%	94.4%	**95.3%**	98.4%
Middlesbrough	90.5%	96.8%	94.2%	96.0%	**94.4%**	93.7%
North Yorkshire	89.1%	96.3%	95.9%	96.5%	**94.4%**	97.1%
Northumberland	86.0%	87.3%	85.4%	93.0%	**87.7%**	95.8%
Stockton	96.2%	96.6%	97.6%	96.4%	**96.2%**	92.6%
Sunderland	94.9%	130.1%	93.9%	95.5%	**103.6%**	96.4%
Wakefield	96.5%	89.6%	86.1%	84.5%	**89.1%**	85.3%
% New Birth Visits completed by 14 days						
Darlington	98.8%	98.6%	99.3%	99.3%	99.0%	97.1%
Durham	96.1%	96.4%	86.5%	87.6%	91.6%	90.5%
Gateshead	96.5%	98.6%	92.4%	96.4%	95.8%	98.0%
Middlesbrough	96.7%	98.7%	96.2%	96.4%	97.0%	94.7%
North Yorkshire	93.3%	96.3%	90.2%	91.1%	92.7%	89.9%
Northumberland	91.5%	92.4%	88.5%	97.0%	92.9%	96.7%
Stockton	94.8%	95.1%	93.3%	96.9%	95.0%	87.2%
Sunderland	98.8%	98.7%	98.3%	99.3%	99.0%	99.5%
Wakefield	83.7%	70.5%	97.7%	94.0%	86.2%	88.3%
% Infants Breastfeeding at 10-14 days						
Darlington	51.6%	55.7%	57.1%	57.4%	55.4%	61.4%
Durham	43.7%	43.0%	44.4%	45.3%	44.1%	45.9%
Gateshead	53.6%	56.0%	55.5%	60.4%	57.3%	58.5%
Middlesbrough	50.6%	56.5%	55.3%	60.6%	57.5%	53.0%
North Yorkshire	67.4%	69.4%	67.3%	65.8%	67.3%	67.2%
Northumberland	54.5%	52.6%	53.9%	54.1%	54.5%	57.3%
Stockton	50.3%	50.9%	47.9%	53.8%	50.3%	48.6%
Sunderland	47.4%	49.5%	46.1%	48.2%	47.4%	48.0%
Wakefield	53.6%	52.1%	52.6%	54.1%	53.6%	51.5%
% infants breastfeeding at 6-8 weeks						
Darlington	40.6%	42.8%	39.3%	43.4%	41.0%	44.8%
Durham	31.6%	29.3%	33.9%	31.5%	31.6%	36.6%
Gateshead	46.1%	47.6%	43.8%	48.2%	46.1%	48.3%
Middlesbrough	45.6%	47.0%	44.5%	45.8%	46.1%	54.3%
North Yorkshire	55.3%	55.8%	55.6%	55.5%	55.3%	55.4%
Northumberland	42.5%	41.0%	42.9%	45.5%	42.5%	44.1%
Stockton	36.2%	39.5%	38.2%	39.8%	38.3%	39.6%
Sunderland	31.5%	36.1%	36.9%	35.0%	34.4%	37.9%
Wakefield	36.5%	38.1%	40.1%	37.6%	37.8%	41.7%

Metrics	Q1	Q2	Q3	Q4	YTD 2023/24	Apr-24
% of 6-8 week reviews completed by the time the infant is 8 weeks old						
Darlington	95.9%	98.6%	98.9%	97.5%	97.8%	99.0%
Durham	93.1%	92.3%	82.3%	79.6%	86.8%	85.6%
Gateshead	96.4%	97.6%	92.4%	94.5%	95.6%	94.5%
Middlesbrough	92.9%	93.2%	90.1%	94.7%	92.7%	94.8%
North Yorkshire	89.0%	95.0%	94.1%	94.8%	93.2%	95.2%
Northumberland	87.1%	89.4%	84.2%	92.0%	88.2%	94.7%
Stockton	96.0%	96.2%	94.4%	97.4%	96.0%	94.9%
Sunderland	97.9%	96.9%	98.6%	97.9%	97.9%	97.9%
Wakefield	93.9%	91.4%	96.4%	95.5%	93.9%	91.5%
% of 12 month reviews completed by the time the child is 15 months old						
Darlington	99.2%	99.6%	99.1%	99.6%	**99.4%**	97.7%
Durham	94.6%	94.7%	93.5%	94.5%	**94.3%**	93.2%
Gateshead	98.8%	98.3%	98.6%	98.9%	**98.6%**	100.0%
Middlesbrough	98.2%	96.6%	99.0%	99.0%	**98.2%**	100.0%
North Yorkshire	96.8%	99.2%	98.7%	99.5%	**98.5%**	99.7%
Northumberland	93.2%	93.2%	97.0%	97.8%	**94.5%**	98.6%
Stockton	97.7%	99.4%	98.8%	98.7%	**98.6%**	98.7%
Sunderland	97.1%	97.5%	96.8%	97.4%	**97.1%**	98.5%
Wakefield	96.3%	97.3%	97.7%	97.6%	**96.3%**	97.5%
% of 2-2.5 year reviews completed by the time the child is 2.5 years old						
Darlington	96.9%	96.0%	99.2%	99.5%	**98.3%**	98.8%
Durham	93.1%	92.9%	84.3%	84.7%	**88.7%**	88.5%
Gateshead	95.1%	97.1%	92.1%	94.5%	**95.4%**	94.7%
Middlesbrough	96.8%	97.4%	90.0%	90.3%	**93.6%**	89.9%
North Yorkshire	95.7%	97.9%	97.9%	98.3%	**97.3%**	84.4%
Northumberland	91.1%	91.8%	80.0%	92.96%	**88.8%**	86.1%
Stockton	95.6%	96.9%	93.8%	96.1%	**95.6%**	95.9%
Sunderland	94.8%	95.7%	94.7%	94.3%	**94.8%**	95.5%
Wakefield	95.2%	96.9%	94.1%	98.4%	**95.2%**	97.0%
% of 2 to 2.5 year reviews completed in the month with a completed ASQ3						
Darlington	100.0%	99.6%	99.6%	99.0%	**99.6%**	100.0%
Durham	92.9%	92.9%	96.0%	96.2%	**94.5%**	96.5%
Gateshead	95.9%	97.1%	92.3%	97.8%	**96.4%**	98.7%
Middlesbrough	99.5%	100.0%	99.8%	99.6%	**99.7%**	100.0%
North Yorkshire	99.5%	99.8%	99.4%	99.4%	**99.5%**	98.8%
Northumberland	96.9%	96.6%	99.0%	97.6%	**97.6%**	98.3%
Stockton	97.4%	94.9%	94.9%	94.2%	**95.4%**	95.1%
Sunderland	95.6%	95.6%	96.6%	95.1%	**95.6%**	94.9%
Wakefield	99.5%	99.7%	99.8%	99.3%	**99.5%**	99.8%

% Antenatal contacts

- Durham - Main issue non notifications and late notification which is being picked up with Maternity – improving picture
- Wakefield – Targeted antenatal offer as agreed with commissioners.

% new Birth Visits by 14 days

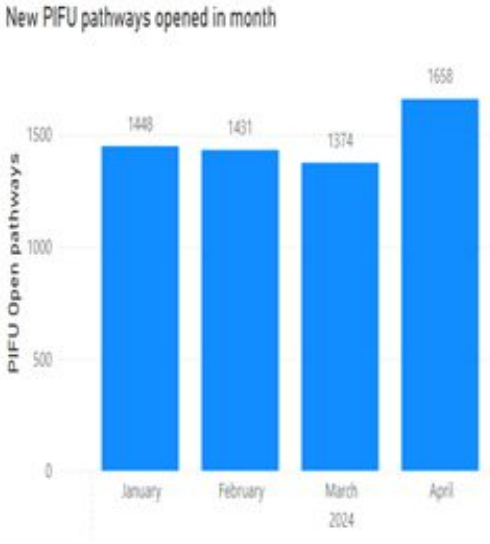
- Wakefield – Due to high health visitor vacancies. Service at OPEL 3 so timescales flexed to 10 to 20 days. Improving picture

% Infants Breast Feeding

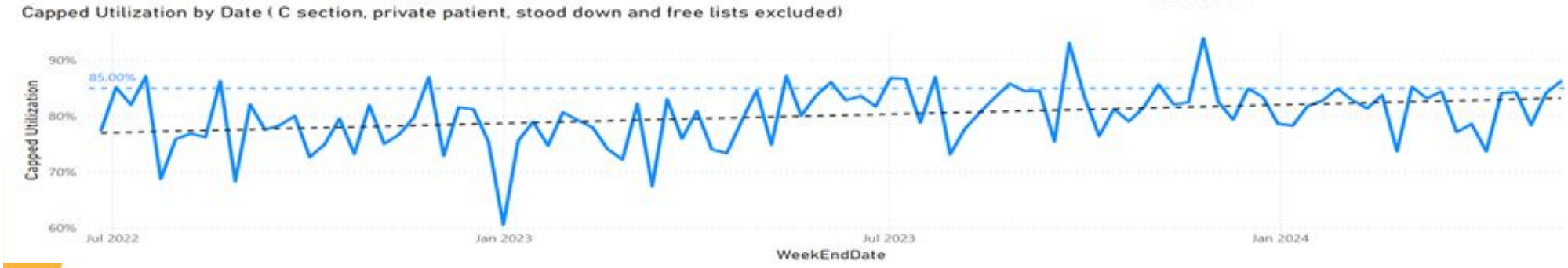
- Durham – Increased focus on antenatal care including family hub developments and insights work commissioned by LA. Currently reviewing at locality level the issues. Small improvement

Planned Care Recovery & RTT

MonthYear Description	Apr 2024 YTD activity	PYTD activity
Elective Daycases	2417	3200
Elective Endoscopy Daycases	811	604
Elective Inpatients	230	157
Follow-up Consultant Led Outpatients	8846	8510
Follow-up Consultant Led Outpatients Procedure	1532	470
Follow-up Nurse Led Outpatients	6520	6277
Follow-up Nurse Led Outpatients Procedure	1206	784
New Consultant Led Outpatients	4020	3644
New Consultant Led Outpatients Procedure	669	393
New Nurse Led Outpatients	2779	2409
New Nurse Led Outpatients Procedure	490	401
Non-Elective Inpatients	2191	1906
Primary Care Referrals	5665	4690

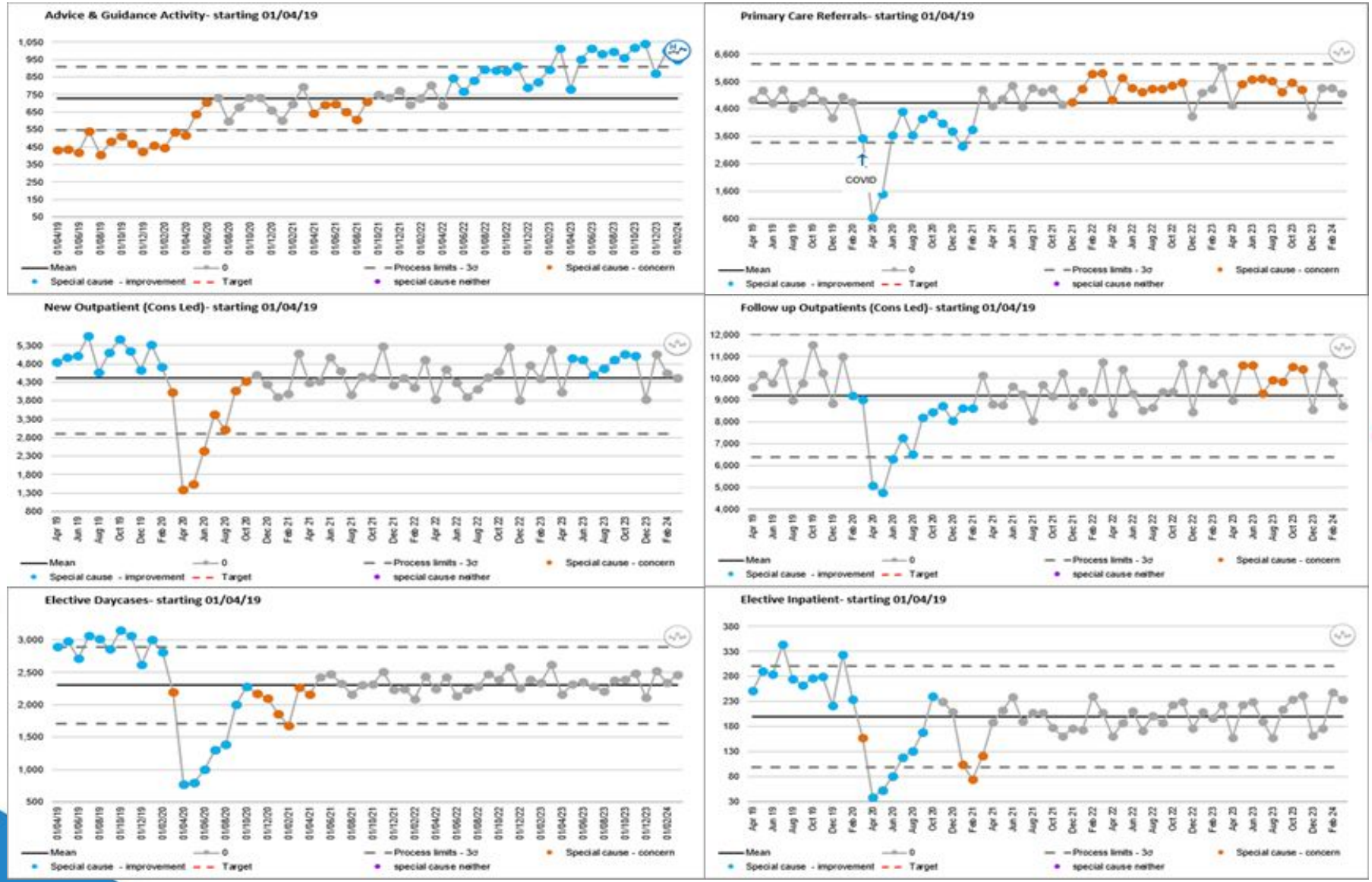


Year	Month	Dashboard Clock Stop	Dashboard Clock Start	Dashboard Live PTL end of month	Open pathways over 52 weeks	Open pathways over 65 weeks	Open pathways over 78 weeks
2023	June	5891	6879	25879	758	156	7
2023	July	5353	6952	25856	760	175	2
2023	August	5515	6643	25823	767	173	1
2023	September	5873	6690	25810	837	218	3
2023	October	5094	6044	22956	443	114	
2023	November	5403	6166	22791	473	123	
2023	December	4884	5931	22541	421	123	
2024	January	5110	5280	22488	421	109	
2024	February	4796	5768	22376	386	113	
2024	March	5499	6138	22167	380	69	
2024	April	5186	6039	22450	414		



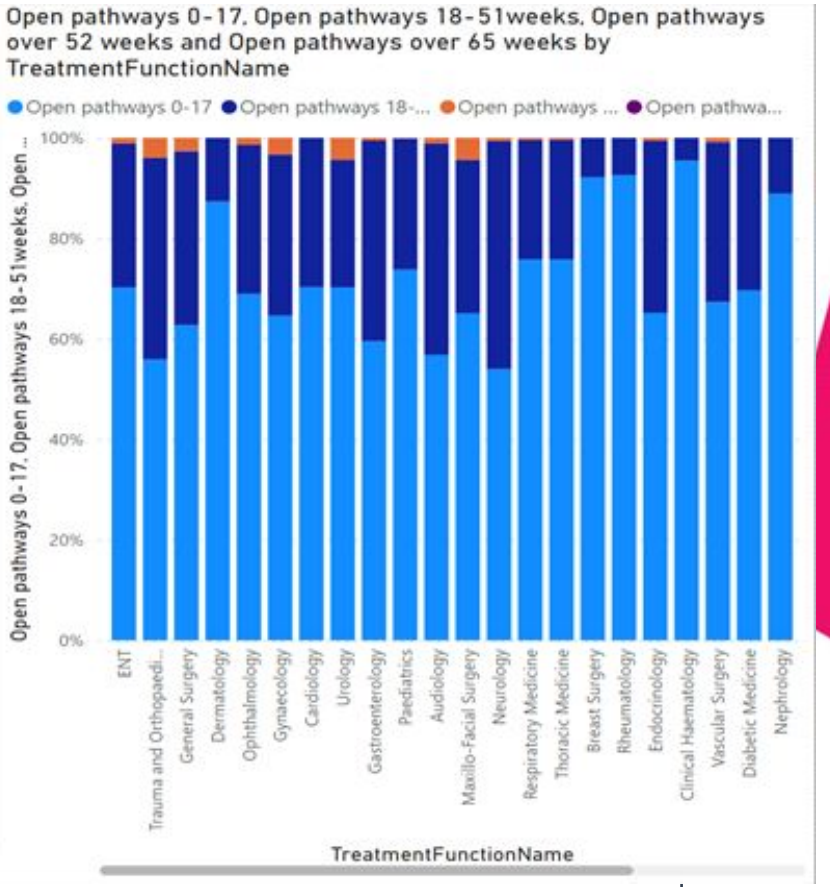
Over delivery against comparable month of last year across all points of delivery
Utilisation of PIFU instead of follow ups continues to increase
Theatre utilization showing upward trajectory

Elective Recovery



Referral to Treatment (RTT)

TreatmentFunctionName	Open pathways 0-17	Open pathways 18-51weeks	Open pathways over 52 weeks
ENT	1849	753	30
Trauma and Orthopaedics	1845	1320	132
General Surgery	1364	751	59
Dermatology	1344	195	
Ophthalmology	1228	529	24
Gynaecology	1221	606	63
Cardiology	888	375	
Urology	885	320	55
Gastroenterology	562	377	5
Paediatrics	549	194	1
Audiology	522	387	10
Maxillo-Facial Surgery	475	223	32
Neurology	446	375	5
Respiratory Medicine	382	120	2
Thoracic Medicine	382	120	2
Breast Surgery	328	28	
Rheumatology	311	25	
Endocrinology	234	123	2
Clinical Haematology	232	11	
Vascular Surgery	231	109	3
Diabetic Medicine	101	44	
Nephrology	56	7	
Medical Oncology	47		
Orthodontics	32	2	
Geriatric Medicine	30	12	
General Medicine	28	3	
Hepatology	28	54	
Paediatric Surgery	24	2	
Paediatric Trauma and Orthopaedics	22	4	
Total	**15264**	**6949**	**423**

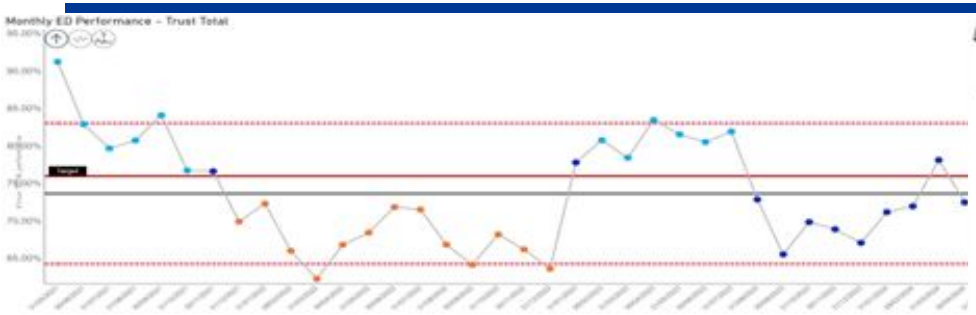


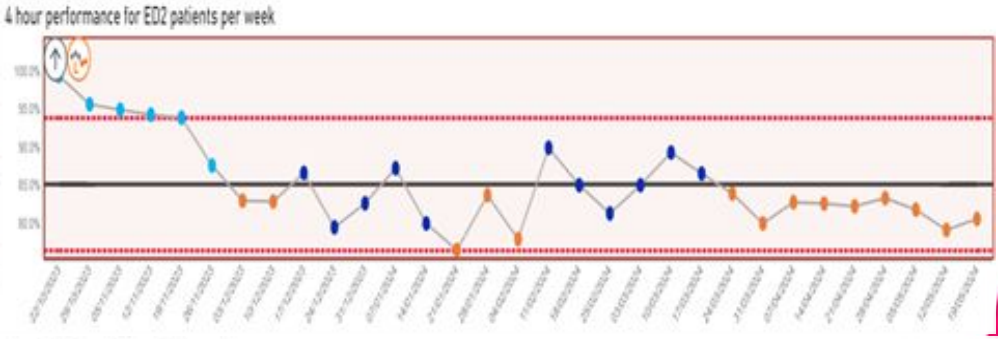
RTT – The provisional April position was 22,450 patients waiting with no current patients waiting over 65 weeks.

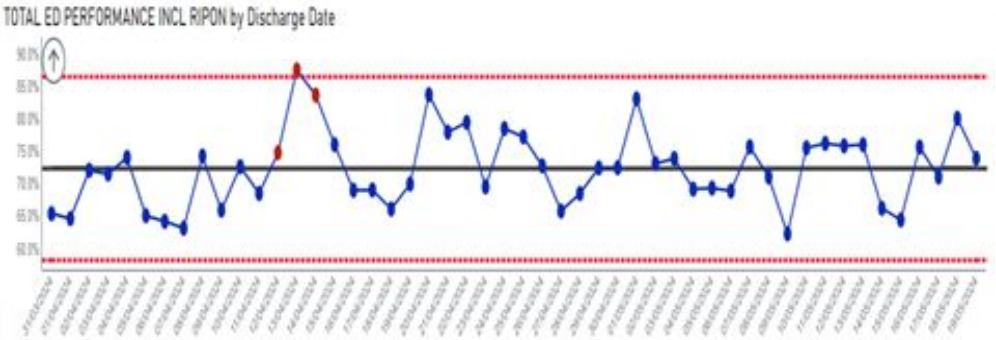
Provisional April figures suggest 22,982 patients waiting at the end of April – is subject top further reduction as validation continues prior to submission to NHSE (by 20th May). We continue to aim for elimination of 52 week waits by the end of 2024/5

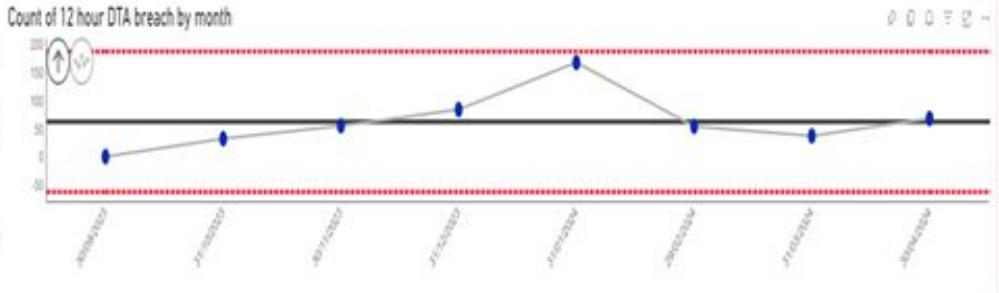
Of the patients waiting for a procedure on our waiting list, 40% are Orthopaedics and 14% are Ophthalmology.

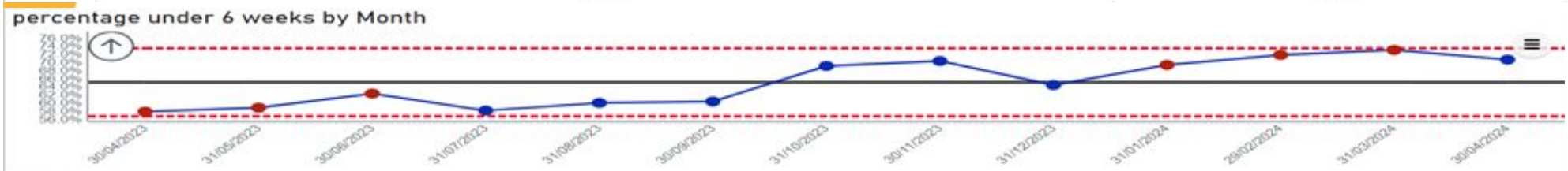
Urgent Care and Diagnostics





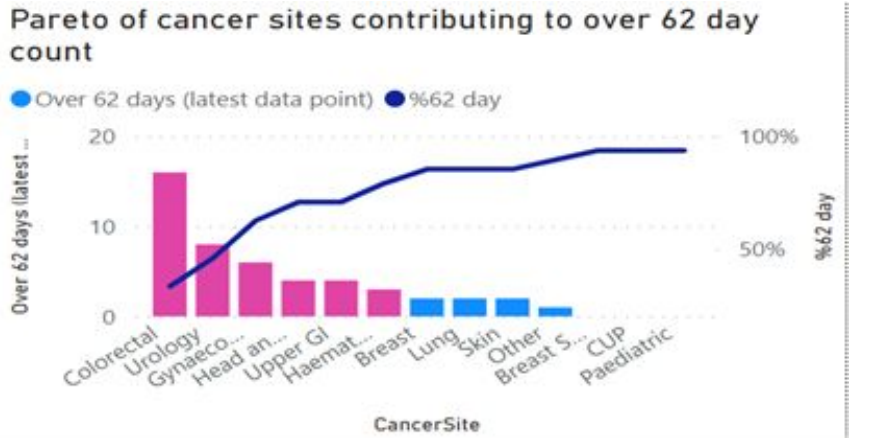


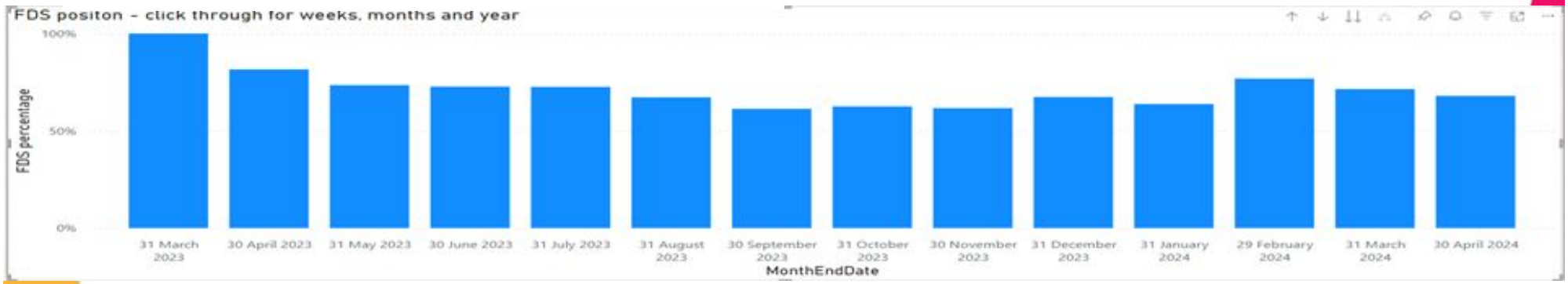




- Performance against the A&E 4-hour standard was at 72% in April, below performance standard of 76%.
- ED2 performance is also shown- it is consistently over 80% however the target is achieving over 90% consistently in this stream
- There were 66 over 12-hour trolley wait breach in April (35 in March).
- There were 3 over 30-minute ambulance handover breaches in April (4 in March) and none (1 in March) over 60 minutes.
- ED attendances are now back in line with 2019/20 levels.
- For diagnostics. the percentage under 6 weeks has decreased to 66% in April (67% in March).

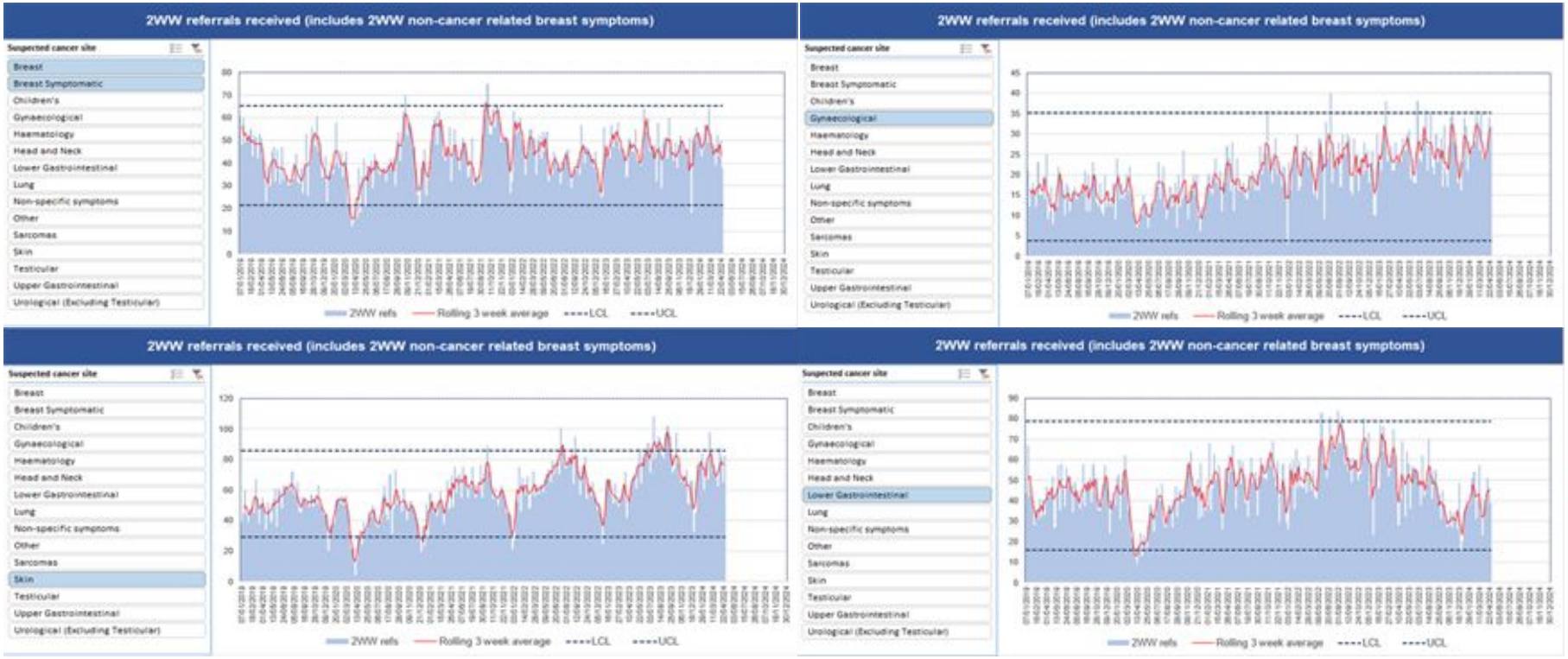
Cancer Performance





- Cancer performance now reported against the combined standards for 31-day and 62-day standards – in line with national change.
- The 62-day standard was not met in April with a performance of 70.6% against the 85% standard but in line with annual planning ambition of 70%
- The 2-week wait standard was at 76.4%, an improvement on March but remaining below the 93% standard, again in line with the annual planning ambition
- The number of patients remaining on the PTL over 62 days (i.e. treatment no complete) was 45.
- The Faster Diagnosis Standard (FDS) was not achieved in April with performance at 68.8% against the 75% standard.

Cancer Performance



- Performance against the 2WW Cancer standard was at 76.4% in April, an improvement on March but remaining below the 93% standard..

Finance Report Month 1
March – 2024/25

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

24/25 Finance summary as at April

teamHDFT At our best

£-1.8M

DEFICIT

WASTE REDUCTION DELIVERED

(WASTE REDUCTION AND PRODUCTIVITY)

23%

£15.9M TARGET + £6.2M STRETCH

£0M

ERF RISK UNDER PERFORMED (Elective Activity Recovery)

CASH IN THE BANK

£4M

(APR 2024)

£4.7M

AGED DEBT

(OUTSTANDING OVER 30 DAYS)

AGENCY SPEND

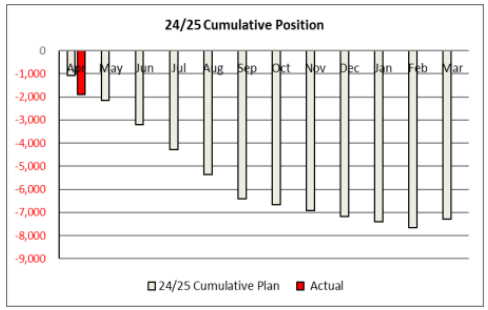
£382k

1.6%

24/25 Plan £7.2m Deficit, 100% CIP, 100%+ ERF, Agency below 3.2% of Substantive Pay Spend

YTD Summary

£1.8M
DEFICIT YTD



As at the end of April, the Trust has a £1.8m deficit against a £1m planned deficit. The trust plan has been phased to match the delivery of the WRAP programme.

One of the main risks in delivering the 24/25 plan is the delivery of the WRAP programme, £15.9m target increased by a stretched ask £6.2m during planning. As at M1 £624k undelivered WRAP is included in the position. Additional WRAP sessions have been delivered across all Directorates to support understanding and delivery.

Cash continues to be monitored closely, 5 Council Contracts did not make any payment in April, £2.4m in total, which is being actively chased due to ongoing discussions around revised baselines factoring in pay award uplifts. This has also contributed to the aged debt increasing to £4.7m in month.

There has been a further improvement in agency spend, the trust are well below the national threshold of 3.2%.

There are three significant capital schemes being delivered in 24/25 these include, TIF2,RAAC and EPR all of the schemes are supported with external funding. Resulting in a capital programme £26m. £729k has been spent in M1.

High Level Analysis	Annual Plan £000's	Mth Budget £000's	Mth Actual £000's	Variance £000's
Commissioner Income	**301,567**	**25,129**	**25,417**	**288**
Directorate Income	**49,881**	**4,159**	**3,997**	**-162**
Pay Costs	-257,058	-21,074	-21,663	-589
Non Pay Costs	-94,391	-8,722	-9,697	-976
Expenditure	**-351,448**	**-29,795**	**-31,360**	**-1,565**
Surplus / (Deficit)	**0**	**-508**	**-1,947**	**-1,439**
Budget Phasing		**-564**		
Donated Assets/Depreciation			**50**	
Revised Surplus/(Deficit)	**0**	**-1,072**	**-1,897**	**-825**

Directorate Summary

LTUC – As at April LTUC is £564k overspent, spend has reduced by £361k in comparison to the previous month.
Key drivers in month include

- £471k Ward Pay spend, largest pressures in Farndale and Jervaulx
- £167k undelivered WRAP
- £123k Medical Staffing, this includes £56k pay award which funding will be drawn down in May.
- £71k ED Pay spend, £95k of agency RN spend

Key areas of focus for 24/25

- £4.3m CIP to deliver
- £1.1m Doctors in Training pressure
- £1m ED medical staffing pressures (vacancies/sickness)
- Ward enhanced care

LTUC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**7,576**	**640**	**575**	**-65**
Pay Costs	-72,044	-6,005	-6,369	-363
Non Pay Costs	-29,946	-2,519	-2,655	-136
Expenditure	**-101,990**	**-8,524**	**-9,024**	**-500**
Total	**-94,414**	**-7,884**	**-8,448**	**-564**

PSC – As at April PSC is £738k overspent, there is still work to do in delivery of WRAP and ensuring activity is captured and coded correctly at source to maximize ERF opportunities.
Key Drivers in month include

- £237k Locum Consultant pay spend, this is across multiple specialties but most significant in General Surgery, £68k and Radiology, £40k.
- £224k undelivered WRAP
- £100k Non Pay spend, the biggest contributor relating to Clinical Supplies, £52k

Key areas of focus for 24/25

- £3.9m CIP to deliver
- £0.6m WLI Pressure - Ensuring income covers additional sessions)
- Imaging Service staffing pressures

PSC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**780**	**68**	**95**	**27**
Pay Costs	-65,372	-5,406	-5,736	-330
Non Pay Costs	-14,651	-1,238	-1,672	-435
Expenditure	**-80,022**	**-6,643**	**-7,408**	**-765**
Total	**-79,242**	**-6,575**	**-7,313**	**-738**

Directorate Summary

CC – As at April CC is underspent by £86k, spend has increased generally in comparison to 23/24 as vacancies are filled.
Key Drivers in month include

- £159k Undelivered WRAP
- £70k Income not delivered, Dom Care and NMET targets contribute to this
- £18k Travel

£273k underspend in pay mainly contributed to by the following 4 contracts, Durham, Stockton, N Yorkshire and Sunderland.
Conversations continue with councils to establish contract increases for the anticipated pay award this year.

Community &Childrens	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**3,118**	**260**	**190**	**-70**
Pay Costs	-80,153	-6,677	-6,404	273
Non Pay Costs	-4,225	-365	-482	-118
Expenditure	**-84,378**	**-7,041**	**-6,886**	**155**
Total	**-81,260**	**-6,781**	**-6,696**	**86**

CORP –As at April Corporate is overspent by £53k, although Corporate is generally managing with budget there a few divisions that require further investigation.
Key Areas of Focus

- £60k under recovery of Private Patient income
- £58k Undelivered WRAP

Corporate	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**8,818**	**735**	**707**	**-28**
Pay Costs	-24,054	-2,020	-2,142	-122
Non Pay Costs	-39,643	-3,311	-3,214	97
Expenditure	**-63,697**	**-5,331**	**-5,357**	**-26**
Total	**-54,879**	**-4,596**	**-4,649**	**-53**

HIF – As at April HIF is £32k underspent.
Focused Finance training has been delivered and there has been a noticeable increase in budget holders accessing REACH.

HIF	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**25,956**	**2,154**	**2,143**	**-11**
Pay Costs	-11,865	-966	-984	-18
Non Pay Costs	-14,091	-1,188	-1,126	61
Expenditure	**-25,956**	**-2,154**	**-2,111**	**43**
Total	**0**	**0**	**32**	**32**

Elective Recovery Funding

2023/24	2024/25
£1.6M	£0M
OVER DELIVERY	RISK UNDER DELIVERY

103%
PERFORMANCE

£7M
OPTIMISATION

NHSE have not confirmed baselines for 2024/25 yet. Future under/Over performance will be reported in Directorate positions.

Assumed Baselines summarised below

Baseline Activity	PSC	LTUC	CC
Daycase	16,664	13,558	360
Elective Inpatient	2,696	172	25
Outpatient Firsts	46,171	23,710	3,940
Outpatient Procedures	32,609	13,064	0

As at M1 the main area of under delivery was Day cases,800 below expected levels there is ongoing work to establish how this can be mitigated.

Key areas of focus for 24/25

- Technical Classification and Coding scoping work
- Income opportunities
- Reporting structure

ERF Activity Priced £'000 By Directorates	2023/24 Baseline	2023/24 Actuals	Uncoded Estimate	*Optimisation Estimate	Revised 2033/234 Actuals	Achievement Actual	Performance
Childrens and County Wide Community Care	£1,234	£975	£25		£1,000	-£235	81%
Long Term and Unscheduled Care	£12,516	£12,325	£873		£13,198	£683	105%
Planned and Surgical Care	£42,460	£37,708	£4,082	£1,760	£43,550	£1,090	103%
Trust level	**£56,211**	**£51,024**	**£4,980**	**£1,760**	**£57,764**	**£1,554**	**103%**

*Optimisation Estimate - remaining for transaction/transformation

Waste Reduction and Productivity

23%
DELIVERED
£15.9M +
£6.2M
STRETCH
TARGET

23% of the current WRAP target has been achieved as at M1. Movement in months will be monitored in upcoming reports.

	Target per Schedule	Actioned at M1	% identified
CC	2,502,700	701,200	28%
Corporate	1,307,000	78,800	6%
LTUC	5,396,300	1,836,200	34%
PSC	3,719,900	107,600	3%
Central	9,213,100	2,331,500	25%
Total	**22,139,000**	**5,055,300**	

Target	Actioned	Low	Medium	High	Unidentified
22,139	5,055	2,382	426	5,257	9,019
Cost Reduction	814				
% of target	**23%**	**11%**	**2%**	**24%**	**41%**

WRAP sessions have been carried out with all Directorates highlighting opportunities around

- Waste Reduction
- Activity productivity
- Procurement

WRAP conversations have been prioritised in all budget holder meetings.

Agency

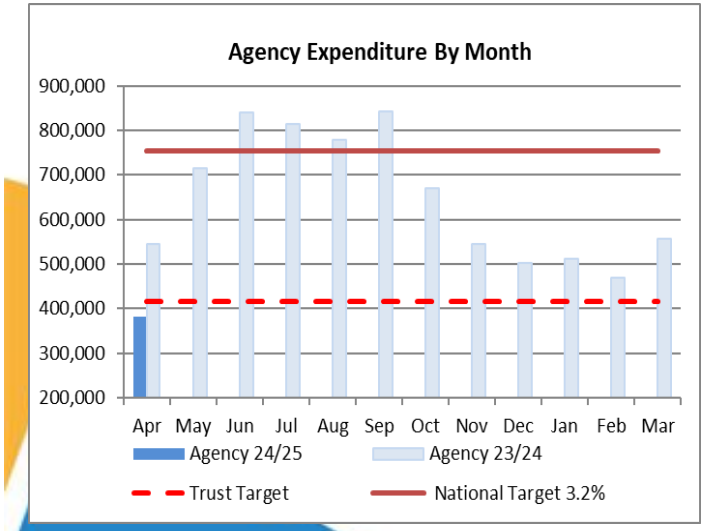
£382K
SPEND YTD

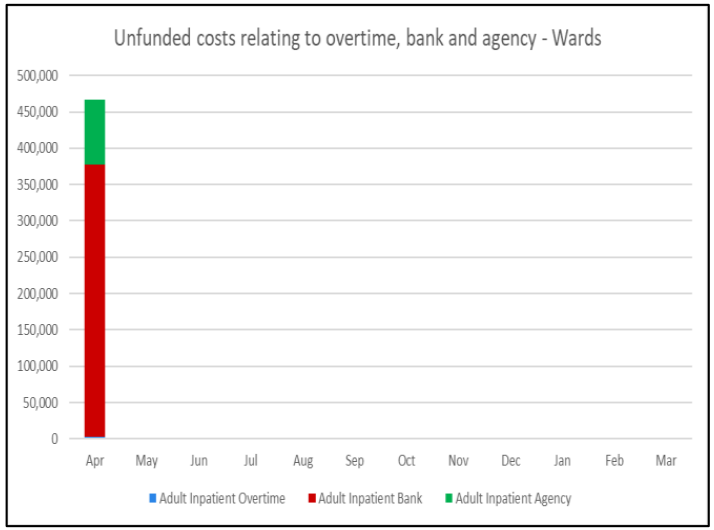
£382k agency in month, a reduction of £174k in comparison to M12.

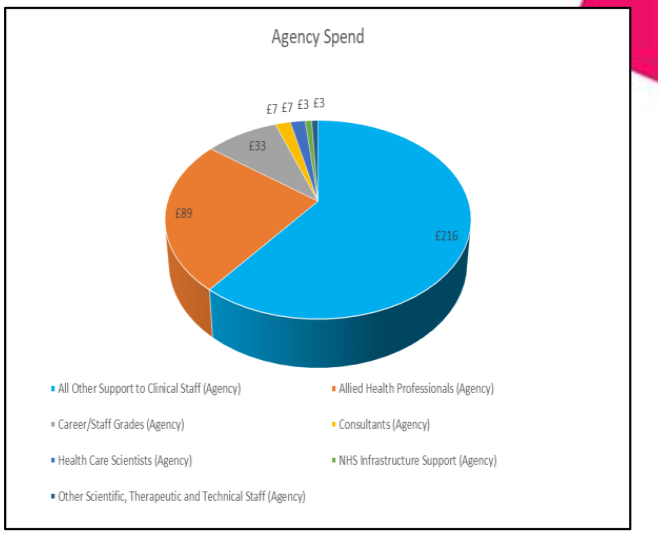
The agency target set nationally is 3.2% of substantive staffing budgets, M1 actuals are well within this target. As a Trust we are still aiming for agency spend to return back to 19/20 levels.

Main areas of agency spend include

- ED, £104k Agency Nursing
- Wards, £79k Agency Nursing (No CSW agency spend)
- Cardiology, £36k Agency Consultant
- SDEC, £20k Agency Consultant







Capital

£730k
SPEND YTD
EXCL IFRS16

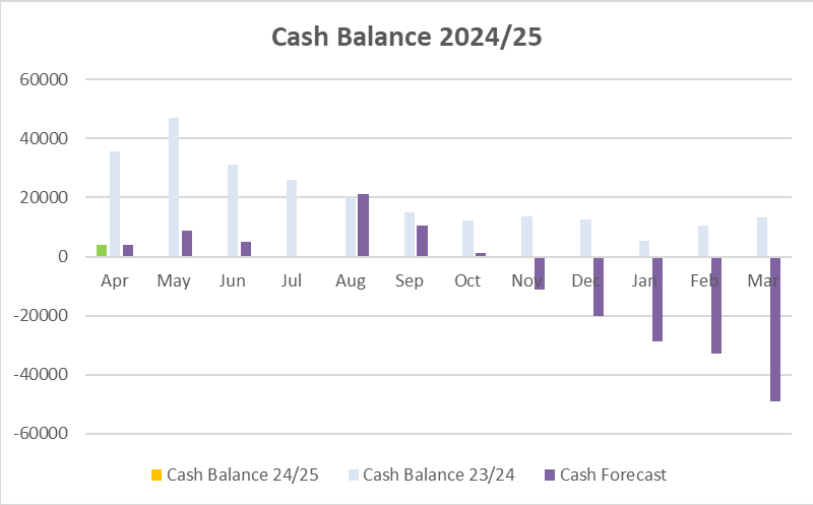
There are three significant capital schemes being delivered in 24/25 these include, TIF2, RAAC and EPR all of the schemes are supported with external funding which has resulted in a capital programme of £26m.

£730k has been spent in M1.

CDEL Assumption	Description	Scheme ID	Plan	Actual
	IT	IT	500	7
	Community Estate Maintenance	COMM ESTATE	250	0
	Contingency	CONT	500	0
	E Diagnostic Roll Over	EDIAGNOSTIC	0	0
	Schemes Carry Forward from 2023/24	PRIOR YEAR	930	113
	Schemes Carry Forward from 2023/24	HIF PRIOR YEAR		11
	Backlog Maintenance	BACKLOG 24/25	1,300	0
	Backlog Maintenance	BACKLOG 23/24		0
	Imaging relocation	IMAGING 24	2,100	0
	HIF Depreciation	DEPN 24/25	400	0
	HIF Depreciation	DEPN 23/24		15
	Corridors	CORRIDORS	500	0
	Trust Overheads (Staffing)	T OH		5
	HIF Overheads (Staffing)	H OH		0
	Salix	SALIX		0
	Costs to be allocated out	UNKNOWN		3
Sub Total Plans against CDEL			**6,480**	**154**
Grant Schemes				
Sub Total Grant Schemes			0	0
Total Plans against CDEL			**6,480**	**154**
PDC Schemes (Non CDEL)				
	Trustwide EPR	EPR	6,239	177
	TIF2	TIF2	10,290	301
	RAAC	RAAC	3,000	99
Total Non CDEL Schemes			**19,529**	**576**
Sub Total			**26,009**	**730**

Cash

£4M
(APR 2024)



Amount Due Remaining		
31-60 Days Past Invoice Due Date	61-90 Days Past Invoice Due Date	Over 90 Days Past Invoice Due Date
2,869,095.65	491,419.16	1,384,739.54

Cash continues to be monitored closely, 5 Council Contracts did not make any payment in April, £2.4m in total, which is being actively chased due to ongoing discussions around revised baselines factoring in pay award uplifts. This has also contributed to the aged debt increasing to £4.7m in month.

The chart to the right highlights the cash pressure if the income and expenditure run rate continues as is.

Debt continues to be monitored, but the over 90days has reduced by £478k in comparison to the previous month.

Ongoing Issues over 90 Days
£180k St Michaels Hospice, Consultant recharge query
£98k Overseas patient
£178k Council

Controls

PAYROLL OVERPAYMENTS
(APR 24)

£12k IN TOTAL

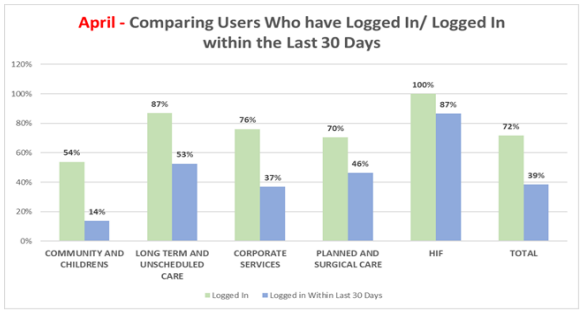
11 OCCASSIONS

HEALTH ROSTER
HOURS OVER PLAN IN MTH

WARDS CSW 939 HRS (OFFSET WITH RN)

ADULT COMMUNITY 235 HRS

REACH REPORTING
BUDGET REPORTS



No PO & INVOICE R/C
(MARCH)

NUMBER 130

VALUE £1.7m

DISCRETIONARY SPEND

£269K SPEND SAVED

OCT 23-APR 24

BUDGET HOLDER ENGAGEMENT
(REVIEWED QTRLY –MAR 24)

CC 50% ⬇

CORP 75% ⬆

PSC 70% ⬇

LTUC 67% ⬇

24/25 Controls

- Continue with Vacancy Panels (Need to ensure OD's or equivalent is part of the review).
- Weekly review by Finance of all TRAC requests.
- Requisitions are in place before any spend is committed.
- Discretionary spend controls remain in place.
- All spend over £10k is authorised by the Finance Director.
- EASY expenses is restricted for specific spend requests including Travel/Eye Test/Course Fees/Vaccination/Blue Light Card/Telephone Calls.

GAPS identified

- Agency requests

Public Sector Equality Duty Report

April 2023 – March 2024

Title:	Public Sector Equality Duty Report 2023 - 2024
Responsible Director:	Director of People and Culture
Author:	Head of Education, Learning and Development Equality, Diversity and Inclusion Manager

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance of compliance with the Public Sector Equality Duty (PSED) for the period of March 2023 – April 2024. The Trust is required to comply with both the general duties and the specific duties of the PSED and is mandated to publish the results of activities in relation to the Equality Delivery System (EDS) 22, Workforce Equality Standards and Gender Pay Gap (GPG) Report. This report is an aggregation of all Equality, Diversity and Inclusion (EDI) work to provide assurance that Harrogate District NHS Foundation Trust (HDFT) is compliant with PSED. Key themes include: - Improvements in staff engagement and diversity - Notable increases in BAME representation - Notable increases in disclosures of disability and sexual orientation. The National Staff Survey (NSS) results indicate that HDFT falls below the national average concerning discrimination across various protected characteristics: - Gender - Sexual Orientation - Disability

<table>
<tr><td></td><td colspan="2">- Age
- Other

Efforts to address disparities in career progression and harassment are highlighted, along with initiatives such as BAME leadership programs and reasonable adjustment support. Recommendations include implementing action plans derived from Workforce Equality Standards to inform future diversity and inclusion strategies.

The report is for noting prior to its publication.</td></tr>
<tr><td rowspan="9">BAF Risk:</td><td colspan="2">The Patient and Child First
Improving the health and wellbeing of our patients, children and communities</td></tr>
<tr><td>Best Quality, Safest Care</td><td></td></tr>
<tr><td>Person Centred, Integrated Care; Strong Partnerships</td><td></td></tr>
<tr><td>Great Start in Life</td><td></td></tr>
<tr><td>At Our Best: Making HDFT the best place to work</td><td>√</td></tr>
<tr><td>An environment that promotes wellbeing</td><td>√</td></tr>
<tr><td>Digital transformation to integrate care and improve patient, child and staff experience</td><td></td></tr>
<tr><td>Healthcare innovation to improve quality</td><td></td></tr>
<tr><td>Corporate Risks</td><td colspan="2">None</td></tr>
<tr><td>Report History:</td><td colspan="2">The report has not been discussed or presented elsewhere.</td></tr>
<tr><td>Recommendation:</td><td colspan="2">It is recommended that this report is noted prior to publication on the Trusts external website.</td></tr>
</table>

Contents Page

1. Purpose

The Equality Act 2010, sets out the Public Sector Equality Duty (PSED) in three key areas of compliance of which the general duty requires the Trust to exercise their functions, to have due regard to the need to:

- Advance equality of opportunity between people who share and people who do not share a relevant protected characteristic.
- Foster good relations between people who share and people who do not share a relevant protected characteristic.
- Eliminate unlawful discrimination, harassment, victimisation and any other unlawful conduct prohibited by The Act.

The purpose of the report is to provide assurance of Harrogate District NHS Foundation Trusts (HDFT) compliance with the Public Sector Equality Duty (PSED) under the Equality Act 2010, focusing on advancing equality of opportunity, fostering good relations and eliminating unlawful discrimination.

2. Background

The first two aims of the PSED (advancing equality and fostering good relations) applies to the first 8 of the 9 protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation and marriage or civil partnership status). Although marriage and civil partnership is a protected characteristic, it is not relevant to the first two aims; it only needs to be considered in relation to eliminating unlawful behaviour, which applies to all 9 protected characteristics.

HDFT strives to create a culture of inclusivity through the People Plan 2024 and beyond. The delivery of this of this is through a governance structure which includes the Belonging governance group. This group facilitates the organisations EDI ambitions:

- Everyone will demonstrate HDFT KITE (Kindness, Integrity, Teamwork and Equality) behaviours to care for our patients, children and communities
- HDFT will build strong teams who support each other
- HDFT will promote equality and diversity
- HDFT will increase diversity in leaders and decision makers

Alongside the use of the PSED, HDFT also work in line with the NHS's first National EDI improvement plan, published on June 8th 2023. This improvement plan sets out targeted actions to address the prejudice and discrimination – direct and indirect – that exist through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The NHS EDI improvement plan includes 6 high impact actions (HIA):

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, on boarding and development programme for internationally-recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Success metrics for the National Improvement Plan include NSS results, WRES and WDES, National Education and Training Survey (NETS) and Board Assurance Framework. Metrics for diversity in shortlisted candidates will be developed in 2025. The implementation of the national EDI improvement plan will strengthen the progress of the PSED within HDFT, leading to better outcomes for patients and a more inclusive work environment for staff. The success metrics for the NHS Improvement Plan are largely encompassed within this PSED.

This report will now set out HDFT data under the three key areas of the PSED for the period of April 2023 to March 2024. Please be aware that there may be variations in headcount figures between the 2022 – 2023 and 2023 – 2024 periods throughout the report, as the data is sourced from multiple channels at different points in time.

3. To advance equality of opportunity

3.1 Staff Survey Results

HDFT saw a rise in the NSS response rate, with 288 more colleagues participating in 2023 compared to 2022, marking a 15% increase in participation. The overall response rate was 2,203 which is a response rate of 46%.

The National Staff Survey was undertaken by IQVIA between September and November 2023 for 126 organisations, including HDFT. 63 of these Organisations are Acute and Acute & Community Trusts which make up the comparator group displayed as a comparison across the HDFT NSS results.

Two questions from the NSS can demonstrate improvements in the advancement of opportunity:

1. Staff who agree or strongly agree that the organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc.).

There is a 4.1% improvement in respondents agreeing that the organisation respects individual difference, as illustrated below.

HDFT 2022	HDFT 2023	Difference	Comparator
71.3% (1,363 staff)	75.6% (1,647 staff)	+4.1%	69.6%%

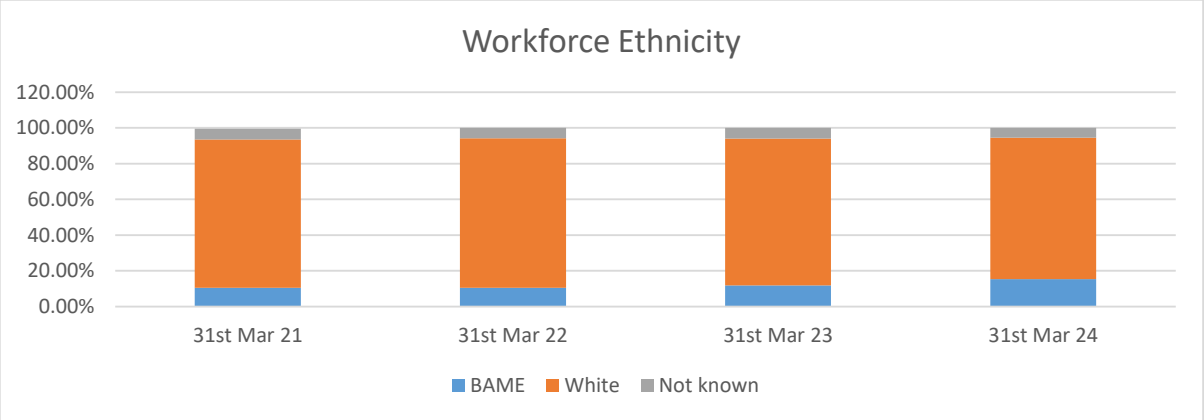
2. Staff who agree the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

There is a 5.6% improvement in respondents agreeing that the organisation acts fairly concerning career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age, as illustrated below.

HDFT 2022	HDFT 2023	Difference	Comparator
55.3% (1,055 staff)	60.9% (1,324 staff)	+5.6%	55%

3.2 Workforce Ethnicity

The proportion of Black and Minority Ethnic Staff (BAME) has year on year increased, as illustrated below.



The table below shows the total number of BAME staff on 31 March 2024.

Out of the 807 employees who disclosed their racial identity under the umbrella category of "BAME," the following ethnic identities were included:

BAME Ethnic Origin	Headcount
Mixed - White & Black Caribbean	5
Mixed - White & Black African	16
Mixed - White & Asian	19
Mixed - Any other mixed background	13
Mixed - Black & Asian	1
Mixed - Chinese & White	3
Mixed - Asian & Chinese	1
Mixed - Other/Unspecified	4
Asian or Asian British - Indian	273
Asian or Asian British - Pakistani	68
Asian or Asian British - Bangladeshi	9
Asian or Asian British - Any other Asian background	42
Asian Mixed	1
Asian Sri Lankan	10
Asian Sinhalese	2
Asian British	10
Asian Unspecified	10
Black or Black British - Caribbean	11
Black or Black British - African	144
Black or Black British - Any other Black background	6
Black Somali	1
Black Mixed	2
Black Nigerian	44
Black British	5
Black Unspecified	1
Chinese	16
Any Other Ethnic Group	45
Filipino	36
Malaysian	3
Other Specified	6
TOTAL	**807**

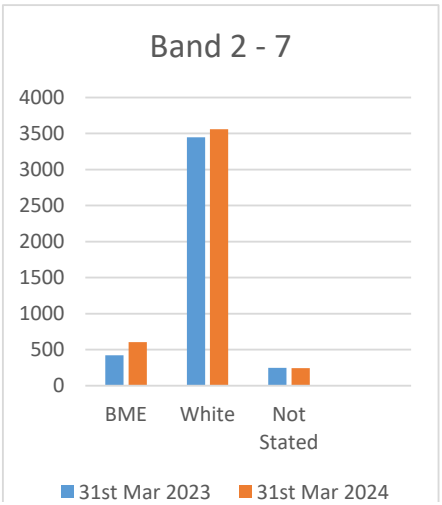
3.3 Seniority and Ethnicity

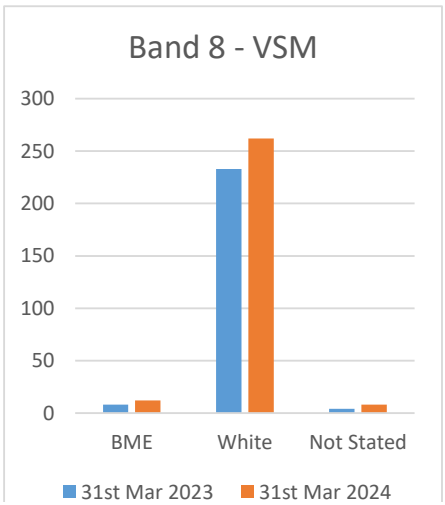
Using three broad pay bandings, it is evident that there is an increase in the number of staff disclosing their ethnicity from 2023 to 2024 across all staff groups. The overall growth increase of the BAME workforce is more significant than the white workforce, largely driven by the increase of BAME staff and reduction of white staff within Medical and Dental.

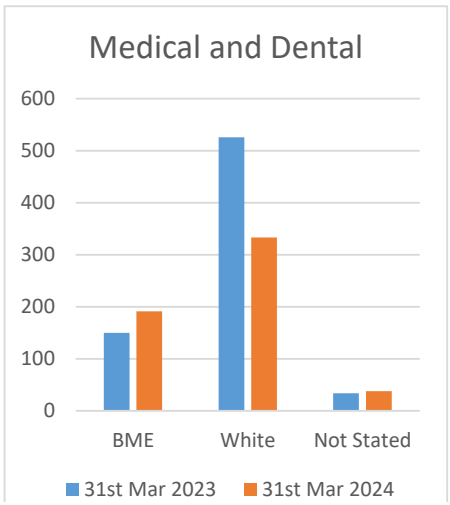
HDFT remains committed to taking positive action to address underrepresentation or disadvantage faced by certain groups and over this reporting cycle has:

- Encouraged disclosure of protected characteristics on employment records
- Implemented cohort 2 of a Reciprocal Mentoring programme
- Maintained the BAME and Ally Staff Network (now known as REACH network)
- Implemented a BAME Leadership Programme

31st Mar 2024				
Banding	**BAME**	**White**	**Not Stated**	**TOTAL**
Bands 2 -7	604	3,562	242	**4,408**
	14%	81%	5%	
Bands 8 - VSM	12	262	8	**282**
	4%	93%	3%	
Medical and Dental	191	333	38	**562**
	34%	59%	7%	
TOTAL	**807**	**4,157**	**288**	**5,252**
31st Mar 2023				
Banding	**BAME**	**White**	**Not Stated**	**Total**
Bands 2 -7	421	3,447	249	**4,117**
	10%	84%	6%	
Bands 8 - VSM	11	240	4	**245**
	4%	94%	2%	
Medical and Dental	150	526	34	**710**
	21%	74%	5%	
TOTAL	**579**	**4,206**	**287**	**4,824**







3.4 Workforce Race Equality Standard (WRES) Data

HDFT can demonstrate improvements in the advancement of equality of opportunity, through WRES data (reporting period to 31 March 2023):

- Metric 1: The total percentage of BAME employees in HDFT (excluding Board members) has increased by 1.2% since 2022.
- Metric 5: 2.3% reduction in staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. 0.5% lower experience than the National average.
- Metric 6: 2.6% reduction in staff experiencing harassment, bullying or abuse from staff in last 12 months.
- Metric 8: 7.5% reduction in staff experiencing harassment, bullying or abuse from their manager, team leader or other colleague.
- Metric 9: An 8.5% improvement in overall Board of Directors representation, from 1.9% in 2022 to 10.4% in 2023, which puts HDFT in the top 2% for representation at this level.

The Trust regularly holds its REACH (Race, Ethnicity and Cultural Heritage) staff network group (previously known as BAME and Allies network), a well-established network with approximately 111 members. Activities undertaken during this reporting cycle include:

- Workforce celebrations and awareness raising, i.e., ethnicity, religious festivals such as Ramadan, Eid and the Festival of Light, health inequalities, and Black History Month.
- Information through X (previously known as Twitter), Facebook pages and Team Talk – our Chief Executive leads live MS Teams Trust-wide communication sessions each week including invited speakers to raise awareness of EDI, health and long-term conditions and many other topics.
- The Executive sponsor, Russel Nightingale, and Non-Executive Director Wallace Sampson have attended some of the network meetings providing high-level support and commitment to its members.

See Appendix 1 WRES Data 2023 for more information

3.5 Gender

The workforce remains predominantly female with little movement in percentage terms (85% in March 2021, 86% in March 2022, 85% in March 2023 and 83% in March 2024). The Trust can demonstrate a steady increase in female staff at higher bands and in Medical and Dental.

	31 Mar 2021			31 Mar 2022			31 Mar 2023			31 March 2024		
	Employees	**Female**	**Male**	**Employees**	**Female**	**Male**	**Employees**	**Female**	**Male**	**Employees**	**Female**	**Male**
Bands 2-7	3,618	3215	403	3,791	3,412	379	3,983	3,545	438	4,408	3,887	521
Band 8 to VSM	200	155	45	219	175	44	242	190	52	282	219	63
Medical and Dental	433	226	207	433	235	198	470	244	226	562	277	285

The data tells us:

3. There are disproportionately more women in roles band 2 – 7: 88% Female, 12% Male
4. There are disproportionately more women in roles band 8 – VSM: 78% Female, 22% Male
5. There is equal representation between men and women within Medical and Dental: 49% Female, 51% Male

Across the whole of the NHS women make up 77% of the NHS workforce but are under-represented at senior level.

3.6 Gender Pay Gap

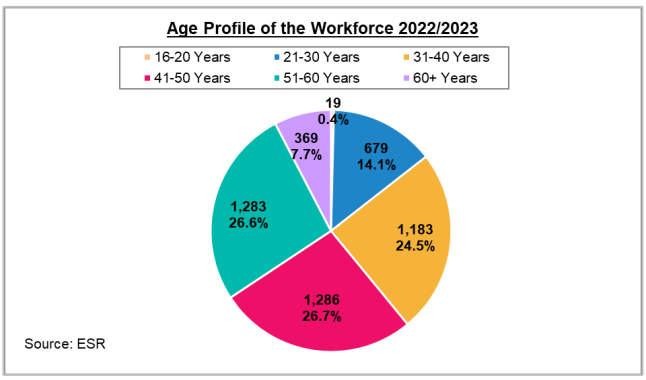
In 2018, it became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap (GPG) information. The GPG is a measure of the percentage difference in pay between all male and female workers. Closing the gender pay gap is about more than just the numbers, it's about increasing support for female staff.

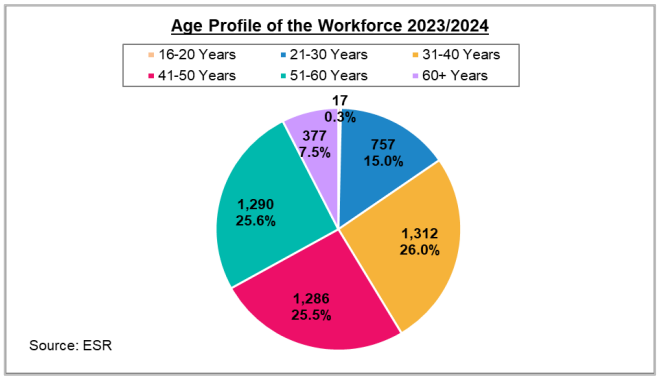
At HDFT, females earn on average £18.82 hour compared to £25.43 for males. This means that females earn £6.61 less per hour which equates to a 26% gender pay difference or 'gap'. Last year this was 28%, which means that the gap has marginally reduced (by 2%) since the previous year.

3.7 Age

The majority of Trust staff are aged between 31 and 60. More than 33% of staff are aged over 51, highlighting the importance age inclusion. The Organisation has seen a rise in the headcount, but not percentage of staff aged 51 and over. NHS Employers anticipates an increase in the older workforce primarily attributed to the rising cost of living.

	2022/2023		2023/2024	
Age Band	**Headcount**	**% of Workforce**	**Headcount**	**% of Workforce**
16-20 Years	19	0.4%	17	0.3%
21-30 Years	679	14.1%	757	15.0%
31-40 Years	1,183	24.5%	1,312	26.0%
41-50 Years	1,286	26.7%	1,286	25.5%
51-60 Years	1,283	26.6%	1,290	25.6%
60+ Years	369	7.7%	377	7.5%
TOTAL	**4,819**		**5,039**	





3.8 Disability

The number of staff who have disclosed their disability on the Electronic Staff Record (ESR) has risen by 33 but remains as 1% of the workforce. There is a 2% reduction in colleagues choosing not to declare their disability or long-term condition.

The ability to report on who has or has not verified their information has only been reportable from March 2023. Most ESR data is provided at the start of employment; however, it should be considered that the majority of disabilities are acquired during employment, and therefore not reported.

The National Staff Survey for 2023, shows 588 employees disclosing a disability or long-term condition, which is 27% or respondents or approximately 11% of the workforce. Data collection on ESR continues to be improved in several ways, including regular communications in our all-staff weekly bulletin, promoting step-by-step guides to complete ESR, and highlighting what the data is used for on the Intranet.

Disability Status	Headcount 31 March 2023	Headcount 31 March 2024
Yes	282	315
No	4134	4,402
Not Declared	605	525
Prefer not to answer	9	10
TOTAL	**5,030**	**5,252**

Significant amounts of work continue to take place in the organisation regarding disability and long-term conditions, including:

- Within the Disability and Long –Term Condition Staff network:
  - The membership has more than doubled to approximately 70 people.
  - Examples of discussion topics include WDES data, staff policies and specific conditions to raise awareness.
  - The development of a reasonable adjustments passport.
  - The Executive Sponsors; the Director of strategy and a Non-Executive Director both attend network meetings to offer support.
  - A hub of resources can be found on the Intranet relating to the staff network.

- Within the Neurodiversity Staff network:
    - The membership increased to over 30 people.
    - Topics of discussion are usually based on people's lived experiences.
    - Colleagues who are neurodivergent, or parents to neurodivergent children attend to gain understanding and learn from others.
    - Communication including E-updates, and intranet articles.
    - Equality, Diversity and Inclusion training is delivered during Corporate Induction.
    - 'Understanding Bias's training is being delivered to over 250 HDFT Acute and Community registered staff.

Furthermore the Trust is recognised under the Disability Confident scheme (level II). The scheme is a best practice standard to ensure that those people who identify as being disabled or having a long-term condition can be offered an interview where they can demonstrate they meet the minimum requirements of the role. Work continues to embed the scheme into the recruitment and selection process ensuring that people who identify as having a disability are not disadvantaged. The annual review of the level 2 programme is scheduled for quarter 1 2024/2025.

The Trust has several initiatives or points of contact in place to prevent the development of long-term mental health conditions, including burnout:

- Mental Health First Aiders
- Workforce Psychologist
- Health and Wellbeing Manager
- Referral links between Vivup, the Employee Assistance Programme and Occupational Health Department.
- Annual health and wellbeing events
- Health promotions using the Blue Light Card
- Staff rest areas within the hospital.

3.9 Reasonable Adjustments

Significant work has been carried out since last year to enable colleagues to feel more empowered to request reasonable adjustments from their manager. The annual national staff survey asks the question, "Has your employer made adequate adjustment(s) to enable you to carry out your work?"

44.7% (259 staff) of NSS respondents do not need a reasonable adjustment. Of the 55.3% who declared requiring a reasonable adjustment, 75.9% received their reasonable adjustment and 24.1% did not. Compared to 2022, there is an 8.1% increase in staff accessing required reasonable adjustments, simultaneous to a decrease in those not receiving or not requiring them as illustrated below.

	HDFT 2022		HDFT 2023	
Yes	173	67.8%	243	75.9%
No	82	32.2%	77	24.1%
No adjustment required	239	48.4%	259	44.7%

3.10 Workforce Disability Equality Standard (WDES) Data

Harrogate District Hospital Foundation Trust can demonstrate improvements in the advancement of equality of opportunity at the Trust, through WDES data (reporting period to 31 March 2023):

- Metric 1: There continues to be year on year increases of staff declaring their disability or long-term condition. HDFT had more staff declaring this protected characteristic than the national average.
- Metric 3: No employees with a disability or long-term condition entered the capability process in 2022 or 2023.
- Metric 4a – d: Fewer incidents of bullying and harassment have occurred to disabled staff since the last WDES from managers, colleagues and patients/service users. For the incidents that did occur, more were reported in 2022 in comparison to the previous year. HDFT disabled staff experience bullying and harassment less than the national average.
    - Metric 4a: Harassment, bullying or abuse from patients, relatives or the public in last 12 months reduced from 30.7% to 29.7% and is 3.5% lower than the national average.
    - Metric 4b: Harassment, bullying or abuse from line managers in last 12 months reduced from 20.6% to 29.7% and is 1.6% lower than the national average.
    - Metric 4c: Harassment, bullying or abuse from other colleagues in last 12 months reduced from 26.7% to 21.2% and is 3.6% lower than the national average.

- Metric 4d: Reporting last incident of harassment, bullying or abuse increased from 48.2% to 49.3% but is less than the national average of 51.3%.

Please see Appendix 2 WDES data for more information

3.11 Sexual Orientation

The table below shows the number of LGBT+ people who have disclosed their sexuality on ESR.

Sexual Orientation	2023		2024	
	Headcount	%	Headcount	%
Bisexual	33	0.7%	43	0.8%
Gay or Lesbian	51	1.1%	71	1.4%
Heterosexual or straight	3,677	76.2%	4,107	78.2%
Not stated (person asked but declined to respond)	1,040	21.6%	1,024	19.5%
Other sexual orientation not listed	3	0.1%	4	0.1%
Undecided	3	0.1%	3	0.1%
TOTAL	**4,824**		**5,252**	

The number of staff who have disclosed their sexual orientation has increased since by 12% 2023. The number of people on ESR who identify within the umbrella of “LGBTQ+” (Lesbian, Gay, Bisexual, Transgender, Questioning and the plus stands for non-cisgender and non-heterosexual identities not captured within the acronym) has increased from 90 employees to 121 employees. This figure includes only sexual orientation within LGBTQ+ as gender is referred to in other sections the report (2.6 and 2.13).

The number of people who have ‘not stated’ their sexual orientation remains high at 19.5%; however, it is 2.1% lower than last year.

The Executive Director of Nursing, Midwifery and Allied Health Professionals, and Deputy Chief Executive is the sponsor of the LGBTQ+ staff network who supports the network by attending meetings and being part of various events implemented by the network. The network membership stands at 48 colleagues.

3.12 Gender Reassignment and Transgender

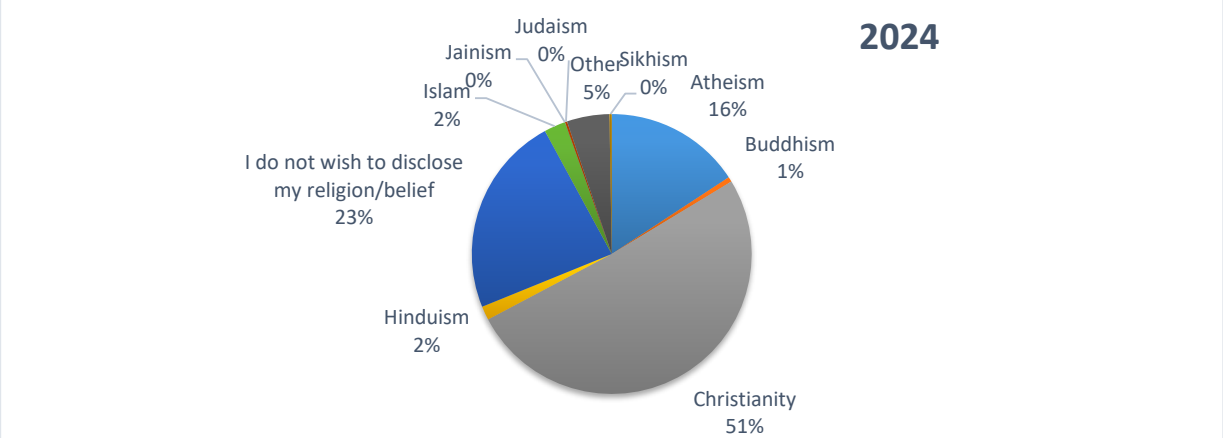
Records of non-binary colleagues are limited as currently the ESR system is programmed to only record male or female. The way for colleagues to disclose themselves as non-binary or transgender is to identify as “Mx” (gender-neutral title) in the title category.

Staff are encouraged to have their ID badge updated, use their pronouns and use them on their email signature, alongside their name. (Examples include: “he, him, his”, “she, her, hers” or “they, them, theirs”).

3.13 Religion

Compared to 2023, the proportional split of religious groups is similar to 2024 in that over 50% of employees disclose Christianity as their religious belief. 23.2% of the workforce have not disclosed their religion on ESR, which is less than last year.

Religious Belief	2023		2024	
	Headcount	%	Headcount	%
Atheism	690	14.3%	828	15.8%
Buddhism	24	0.5%	30	0.6%
Christianity	2491	51.6%	2,674	50.9%
Hinduism	56	1.2%	84	1.6%
I do not wish to disclose my religion/belief	1183	24.5%	1,220	23.2%
Islam	99	2.1%	130	2.5%
Jainism	-	-	1	0.0%
Judaism	10	0.2%	13	0.2%
Other	238	4.9%	258	4.9%
Sikhism	11	0.2%	14	0.3%
Unspecified	22	0.5%	-	-
TOTAL	**4,824**		**5,252**	



ear' with visibility for staff and patients at the ward level. The Chaplains are also available for prayers, communion and confession for patients and employees. The Chaplain Service collaborates closely with the Wellbeing Manager, Freedom to Speak Up, and the Equality, Diversity, and Inclusion Manager to exchange strategies and identify areas where the workforce would benefit from enhanced awareness of their collective pastoral efforts.

3.14 Pregnancy & Maternity and Part-Time Working

The number of pregnant employees totalled 235 in the period to 31 March 2024. This figure excludes employees who TUPE transferred during their maternity leave. The Trust does not have the ability to collate data on TUPE staff transfers.

Metric	2022/23 Headcount	2023/24 Headcount
Number of staff who went off on maternity leave between Apr 23 and Mar 24	222	235
How many returned during this period	129	107
How many left the Trust during this period	23	17
How many returned part-time	72	76
How many returned full-time	35	31

Of the 235 colleagues who had maternity leave in 2023/24, 107 returned within the period. This equates to 15.9% leaving, which is 3.9% higher than the 2023/24 turnover rate of 11.99%. Although this is an improvement on 2022/23 in which the percentage of leavers following maternity was 17.8% against a Trust turnover rate of 15.4%, the gap between maternity and turnover has increased from 2.4% in 2022/23 to 3.9% in 2023/24.

Of the colleagues who returned from maternity leave and stayed with the organisation, 71% returned part-time and 29% returned full-time.

All pregnant staff have a risk assessment, which may involve an Occupational Health referral if required and considers the pregnant worker's physical and mental health.

4. Fostering good relations between those who share protected characteristics and those who do not

There are regular events run by all of the staff networks to improve all colleagues understanding of underrepresented groups. The Trust uses the network to inform

which NHS Employers inclusion calendar says should be recognised across the Trust. The Trust uses the staff networks to inform which NHS Employers inclusion calendar says should be recognised across the Trust, some of which include the Lunar New Year, Ramadan, Eid, Christmas, Transgender Awareness Week and Black History Month. Examples of initiatives to recognise these events include Trustwide communication, social media posts, guest speakers, charity funded snack bags to break fast, amongst others.

Education and training to support fostering good relations include the commencement of Cohort 2, Reciprocal Mentoring, targeted at for BAME colleagues and pairing them with senior leaders in the organisation which helps influence policy change, improve opportunities for career progression, further inclusion and provide increased understanding by non-BAME colleagues of the daily 'lived experience' of being a person of colour. Candidates who attended cohort one of Reciprocal Mentoring were invited to participate in a BAME Leadership and Development Programme in this reporting cycle. In total, 20 BAME colleagues have accessed Reciprocal Mentoring and 12 followed onto BAME Leadership. According to the Trusts WRES report, people of colour are more likely to access continuing professional development that their white peers.

5. To eliminate unlawful discrimination, harassment and victimisation

5.1 National Staff Survey

The NSS asks questions regarding discrimination at work. HDFT data for the 2023 survey shows that some staff with protected characteristics are experiencing more discrimination than the national average. This is evident across the following protected characteristics:

- Gender
- Sexual Orientation
- Disability
- Age
- Other

There is only one protected characteristic group experiencing less discrimination than the national average, which is Religion.

The work carried out by the Trust to eliminate unlawful discrimination, harassment and victimisation includes appropriate policies, processes and networks to support staff where discrimination is raised:

- Campaigns to demonstrate the Trusts response to racism and abuse.
- More positive imagery has been used to advertise the diversity of staff; members of the LGBTQ+, BAME, and disabilities networks are using headshots and blogs to highlight the diversity and inclusion in the organisation.
- An equality, diversity and inclusion portal is now available on the Trust website which includes information about the staff networks and vlogs from the EDI Non-Executive Director, and from other colleagues.
- The Trust remains a Disability Confident Employer level II.
- The Trust was awarded Bronze for the Stonewall Rainbow Badge Accreditation Scheme in April 2023 and is working towards its silver award.
- The Trusts Equality Delivery System 22 (EDS22) improved across all domains and the overall rating has improved from ‘Developing’ to ‘Achieving’ demonstrating progress made since the last reporting cycle.

5.2 Equality Delivery System 22

The Equality Delivery System (EDS) is designed to assist NHS organisations in enhancing the quality of services offered to their communities and fostering discrimination-free work environments for NHS employees, all in accordance with the Equality Act 2010. The implementation of EDS22 is a mandatory assessment for all NHS services, excluding primary care.

EDS 22 is the newest iteration of EDS aligned to NHS England’s Long Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. This iteration was introduced in 2023 and is the version HDFT’s latest assessment was made against.

It is important to stress that EDS2022 is not a self-assessment tool. Performance must be assessed and graded by NHS organisations in discussions with local people and their workforce. It is therefore driven by both evidence and insight. In 2023, the scoring system was updated by NHS England to include a peer review process for domain three. This domain was reviewed independently by staff from York and

Scarborough Teaching Hospitals NHS Foundation Trust using evidence provided by HDFT in support of the marking criteria. The remaining two domains were evidenced by HDFT colleagues and scored by the Equality Reference Group.

The results for the February 2024 assessment rated HDFT overall as “Achieving” which is an improvement on the 2023 rating of “Developing”. A detailed breakdown of the ratings are illustrated below.

Outcome	Description	2023 Rating/Score	2024 Rating/Score
1A	Patients (service users) have required levels of access to the service	Developing (1)	Achieving (2)
1B	Individual patients (service user’s) health needs are met	Developing (1)	Developing (1)
1C	When patients (service users) use the service, they are free from harm	Achieving (2)	Excelling (3)
1D	Patients (service users) report positive experiences of the service	Developing (1)	Achieving (2)
2A	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Developing (1)	Achieving (2)
2B	When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Achieving (2)	Achieving (2)
2C	Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source	Achieving (2)	Excelling (3)
2D	Staff recommend the organisation as a place to work and receive treatment	Developing (1)	Developing (1)
3A	Board members, system leaders (Band 9 and VSM) and those in line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Developing (1)	Achieving (2)
3B	Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Developing (1)	Achieving (2)
3C	Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	Developing (1)	Achieving (2)

6. Conclusions

The National EDI Improvement Plan articulates that where there is diversity across the whole workforce underpinned by inclusion, staff engagement, retention, innovation and productivity improvement. Inclusive environments create psychological safety and release the benefits of diversity – for individuals and teams, and in turn efficient, productive and safe patient care.

Staff survey and workforce data reflecting the lived experience of NHS staff demonstrates that HDFT, much like the whole of the NHS, have more to do regarding inclusivity in the workplace. For example, women make up 88% of the HDFT workforce but are under-represented at senior level.

The results shown in this report demonstrates some improvements across the objectives compared to 2022, and some areas of decline. It is therefore proposed

that the Trust fully implements the EDS22 action plan and uses the NHS EDI Improvement Plan alongside the WRES and WDES to inform the Trust's future equality, diversity and inclusion agenda. This will help the Trust in benchmarking, measuring, monitoring and developing future activity and plans.

7. Recommendations

The Board of Directors are asked to:

- Review the enclosed paper and note how the Trust is meeting the Public Sector Equality Duty requirements.
- Approve the report for publication on the Trust's website.

8. Appendices

Appendix 1: Workforce Race Equality Standard 2023

Points to note:

- **Point 2** - A figure below 1.00 indicates that BAME staff are more likely than White staff to be appointed from shortlisting.
- **Point 3** - It is 0.00 for 2023 as no BAME colleagues entered the formal disciplinary process in 2022/23, whereas white colleagues did.
- **Point 4** - A figure below 1.00 indicates that BAME staff are more likely than White staff to access non-mandatory training and CPD.

			March 2022	March 2023		Comment
1	Percentage of BAME staff	Overall	10.6%	11.8%	↑	
		VSM	14.3%	14.3%	↔	Does not include NED's/Chairman
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants		1.29	2.19	↑	
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff		0.49	0.00	↓	
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff		6.42	0.63	↓	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	BAME	30.4%	29.4%	↓	Close to equal (BAME + White)
		White	26.3%	28.1%	↑	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BAME	27.7%	23.6%	↓	Close to equal (BAME + White)

		White	23.2%	23.4%	↔	
7	Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	BAME	43.9%	50.3%	↑	Much improved but still room for improvement
		White	60.1%	58.0%	↓	
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BAME	14.2%	14.2%	↔	
		White	5.3%	6.9%	↑	
9	BAME board membership	BAME	12.5%	22.2%	↑	
		White	87.5%	77.8%	↓	

Appendix 2: Workforce Disability Equality Standard 2023

WDES Data 2021/22
(Workforce Disability Equality Standard)

*The March 2022 WDES submission included bank staff and therefore data is not entirely comparable

		March 2022			March 2023		
1	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members, but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce.	Disabled (number)	Disabled (%)		Disabled (number)	Disabled (%)	
	Cluster 1 (up to Band 4)	77	4.90%		89	5.65%	↑
	Cluster 2 (Bands 5-7)	114	4.62%		142	5.58%	↑
	Cluster 3 (Bands 8a-8b)	14	6.97%		15	6.88%	↓
	Cluster 4 (Bands 8c-9 and VSM)	1	4.00%		1	3.70%	↓
	Cluster 5 (Medical/dental consultants)	2	1.28%		4	2.47%	↑

		March 2022			March 2023		
	Cluster 6 (Medical/dental, non-consultants)	0	0.00%		0	0.00%	↔
	Cluster 7 (Medical/dental, trainees)	10	5.75%		6	4.03%	↓
		218	**4.56%**		**257**	**5.34%**	↑
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	1.04			1.09		↑
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.00			0.00		↔
		Disabled	Non-Disabled		Disabled	Non-Disabled	
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients or other members of the public	33.1%	26.9%		32.3%	27.8%	↓
4b	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	24.3%	11.7%		18.5%	9.6%	↓
4c	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues	24.9%	17.4%		26.0%	18.4%	↑
4d	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	45.8%	43.9%		50.0%	46.1%	↑
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	47.4%	54.4%		48.2%	55.8%	↑
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	31.8%	21.5%		29.6%	22.7%	↓
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	34.7%	50.8%		35.0%	45.5%	↑
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	67.5%	69.6%		n/a	n/a	↑

		March 2022			March 2023		
9a	The staff engagement score for Disabled staff, compared to non-disabled staff.	6.4	7.0		6.3	6.9	↓
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes			Yes		↔
10a	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (voting membership of the Board)	-5%			-5%		↔
10b	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (Executive membership of the Board)	-5%			-5%		↔

Code:

	The score has worsened
	The score has remained at the same or similar level as the previous year
	The score has improved

Harrogate and District NHS Foundation Trust

Public Board
May 2024

Title:	Gender Pay Gap Report
Responsible Director:	Angela Wilkinson, Director of People and Culture
Author:	Becki Maree, Business Information Manager Richard Dunston Brady, Equality Diversity and Inclusion Manager

Purpose of the report and summary of key issues:	Harrogate and District NHS Foundation Trust (the Trust) employs more than 5,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds and children's services stretching from Berwick upon Tweed in the North to Wakefield in the South, and across the whole of North Yorkshire, from Settle in the West to Scarborough in the East. The total number of staff eligible for inclusion in this report was 4,697. The proportion of female to male staff is much higher in lower bands when compared to senior bandings, Medical and Dental and VSM, which would explain why there is a gender pay gap. As shown the Trust is reporting a 26% gender pay gap, meaning that based on an average hourly rate men are paid 26% more than women. The figures also demonstrate that the Trust has a 12.65% median gender pay gap, which is a decrease of 2022's figure of 14.53%. Included within this report are 76 male Consultants and 81 female Consultants. As the Trust employees fewer men overall, the number of male Consultants as a proportion of the overall male workforce at 10.06% is higher than that of female Consultants 2% of the female workforce.

9

BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	√
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	√
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	**There are no corporate risks**	
Report History:	**The report to be considered at the People and Culture Programme Board**	
Recommendation:	**The Boards are recommended to accept this report and enable it to be published by the end of March 2024.**	

Gender Pay Gap Report
As at 31 March 2023

1. Gender pay gap reporting

Legislation has made it statutory for organisations with 250 or more employees to report annually on their gender pay gap. Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31 March 2017. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap data annually, including:

- Mean gender pay gap in hourly pay.
- Median gender pay gap in hourly pay.
- Mean bonus gender pay gap.
- Median bonus gender pay gap.
- Proportion of men and women receiving a bonus payment.
- Proportion of men and women in each pay quartile.

The gender pay gap is different to equal pay. Equal pay means that men and women in the same employment who are performing equal work must receive equal pay, as set out in the Equality Act 2010. It is unlawful to pay people unequally because they are a man or a woman.

While the Electronic Staff Record (ESR) facility does not enable the Trust to include non-binary staff as part of the data, the Trust is committed to including staff who have transitioned and is proud to have established our Policy for supporting Transgender patients, services users and staff.

The Trust pays most employees, excluding medical and dental staff, on the Agenda for Change pay system and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the Band 5 scale with the same level of qualifications and experience would be paid the same irrespective of gender; they would then have the opportunity to progress up the pay scale annually.

2. Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust (the Trust) employs more than 5,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds and children's services stretching from Berwick upon Tweed in the North to Wakefield in the South, and across the whole of North Yorkshire, from Settle in the West to Scarborough in the East.

The total number of staff eligible for inclusion in this report was 4,697.

	31 March 2023		**31 March 2022**	
	Headcount	**%**	**Headcount**	**%**
Female	3,979	85%	3,822	86%
Male	718	15%	623	14%
TOTAL	**4,697**		**4,445**	

Figure 1 illustrates the gender distribution within the Trust at 31 March 2023

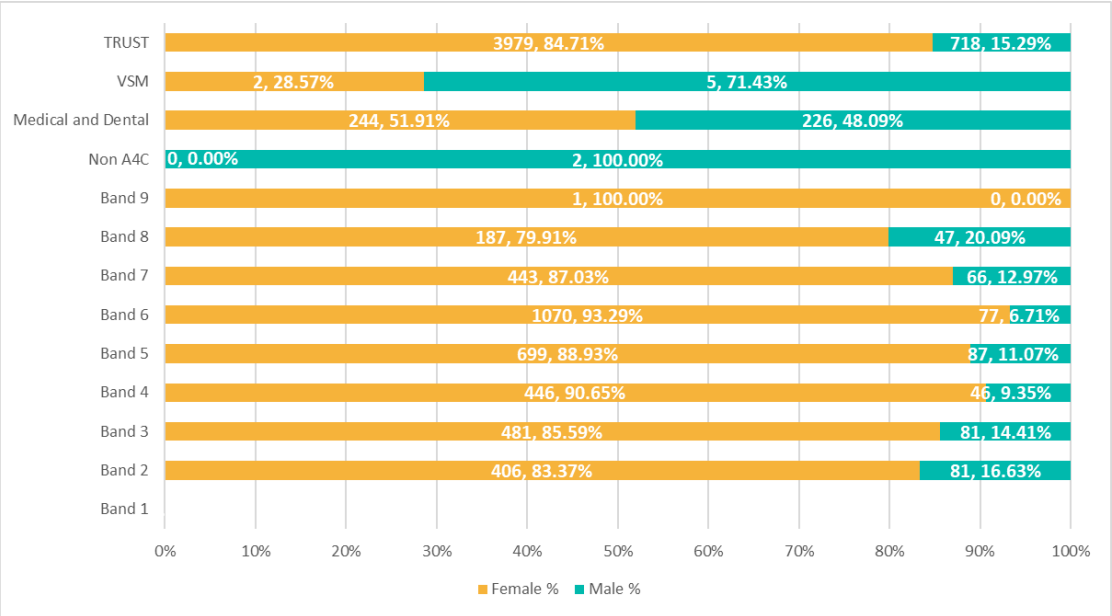
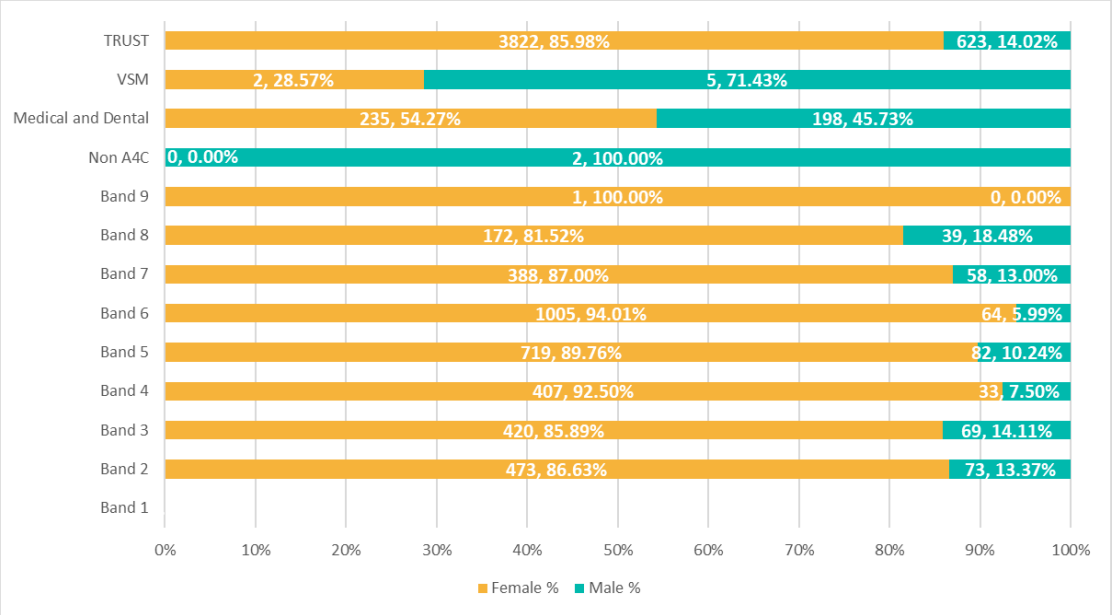


Figure 2 illustrates the gender distribution within the Trust at 31 March 2022



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and all existing staff on a Band 1 contract at the Trust transitioned over to Band 2 from April 2019.

Definitions and scope

The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation.

The gender pay gap is described in two different terms. Firstly, the difference between the mean of hourly rates of men and the hourly rates of women, and secondly as the difference between the median of hourly rate (men) and hourly rate (women).

Mean and Median

• The "mean" is an average of all hourly rates of pay.
• The "median" is the middle value in a complete list of all hourly rates of pay.

The report is based on rates of pay for the financial year 2022/23. It includes all workers in scope at 31 March 2023. A positive figure indicates a gender pay gap disadvantageous to women; a negative figure indicates the gender pay gap disadvantageous to men:

4. Mean and median gender pay gap in hourly pay

Gender	Mean Hourly Rate 2023	Median Hourly Rate 2023	Mean Hourly Rate 2022	Median Hourly Rate 2022
Male (£)	25.43	19.73	24.88	19.33
Female (£)	18.82	17.24	18.00	16.52
Difference (£)	6.61	2.50	6.88	2.81
Pay Gap %	26.00	12.65	27.66	14.53

* rounded up to 2 d.p.

- As highlighted in Figure 1, the proportion of female to male staff is much higher in lower bands when compared to senior bandings, Medical and Dental and VSM, which would explain why there is a gender pay gap.
- As shown, the Trust is reporting a 26.00% gender pay gap, meaning that based on an average hourly rate men are paid 26.00% more than women.
- The figures also demonstrate that the Trust has a 12.65% median gender pay gap, which is a decrease of 2022's figure of 14.53%.

The Influence of Medical and Dental Staff

Medical and Dental staff have a substantial impact on the Trust's gender pay gap, as individuals in this staff group tend to be paid higher wages than other Trust employees.

Included within this report are 76 male Consultants and 81 female Consultants. As the Trust employs fewer men overall, the number of male Consultants as a proportion of the overall male workforce at 10.6% is higher than that of female Consultants, which is 2.0% of the female workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that taking out all medical and dental staff from the calculations, the pay gap percentage for the average mean hourly rate in 2023 is reduced from 26.00% to 3.48%. The median hourly rate pay gap percentage is favourable to females when you take out the medical and dental staff as the median rate changes from 12.65% to -3.01%.

The data shows a small decrease in the gender pay gap percentage for the mean hourly rate of non-medical staff in 2023 compared to 2022, from 4.68% to 3.48%.

Gender	Mean Hourly Rate 2023	Median Hourly Rate 2023	Mean Hourly Rate 2022	Median Hourly Rate 2022
Male (£)	17.94	16.38	17.36	16.13
Female (£)	17.32	16.87	16.55	16.13
Difference (£)	0.62	-0.49	0.81	0.00
Pay Gap %	3.48	-3.01	4.68	-0.01

5. Mean and median bonus gender pay gap

The Trust pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards. The latter takes the shape of a £40 bonus paid to both males and females in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out at an equal level to all employees it has no influence on the figures.

The Long Service Awards were postponed in 2021/22 due to Covid and were awarded to employees in November 2022, along with the Long Service Awards for 2022/23. The two consecutive years are therefore reported in the 31 March 2023 Gender Pay Gap report.

In 2022/2023 there were two types of CEA's that were awarded to the Trust's Consultants. One of these CEA's was a lifetime CEA Award and that was paid to 81 Consultants. The other type of CEA paid was a non-pensionable, non-consolidated award.
The below figures reflect the CEA payments for Consultant medical staff. The Trust currently employs 157 Consultants of whom 76 are male and 81 are female (as at 31.03.23 and are eligible for inclusion in this report). Of the 76 male Consultants, 66 Consultants received a CEA payment in 2022/23 (86.8% of male Consultants), which is 9.2% of the total male workforce. Of the 81 female Consultants, 73 Consultants received a CEA payment in 2022/23 (90.1% of female Consultants), which is 1.8% of the total female workforce.

Gender	Mean Bonus 2023 (£)	Median Bonus 2023 (£)	Mean Bonus 2022 (£)	Median Bonus 2022 (£)
Male	10,049.22	6,781.47	10,651.97	7,246.00
Female	9,024.28	6,781.47	9,979.67	7,246.00
Difference	1,024.93	0.00	672.30	0.00
Pay Gap %	10.20	0.00	6.31	0.00

- The data shows a decrease in the mean gender bonus gap differential by 3.89% from 2022 to 2023, with the gap increase being more favourable to males.
- The median gender bonus gap displays that the median bonus is equal for both genders and remains the same compared to the previous year.

6. Proportion of men and women receiving a bonus payment

In addition to the above, the Trust issues Long Service Awards. Long Service Awards include a £40 bonus paid to both men and women in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out equally to both men and women it would have no influence on the figures.

229 Long Service Awards were issued to staff still employed as at 31st March 2023. 91.3% were issued to females with the remaining 8.7% being issued to males. All long service awards carry the same financial value of £40 meaning that the gender bonus gap would be zero.

Taking both Clinical Excellence Awards and Long Service Awards into account, as a proportion 7.1% of females received a bonus compared to 12.0% of males. This is again influenced by the ratio of males in receipt of bonus to the overall number of males.

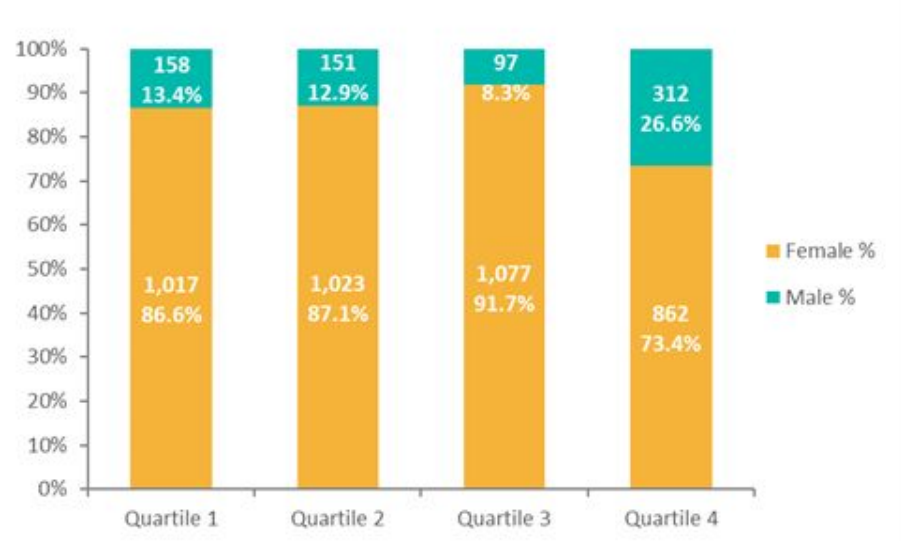
7. Proportion of men and women in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

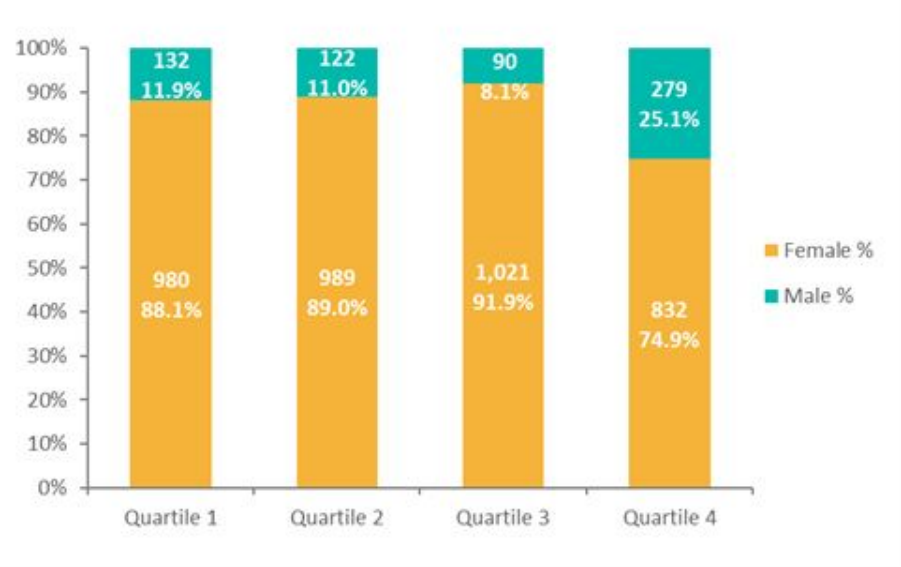
- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph below shows that the highest proportion of males is found in the upper quartile. In contrast, the lowest proportion of females is found in the upper quartile compared with other quartiles. This is influenced by the large proportion of male doctors and dentists within the Trust. The percentage of females in the upper middle and upper quartiles has decreased from the 2022 figures.

2023



2022



8. Summary and next steps in reducing the gender pay gap

Based on the data at 31 March 2023, women working in HDFT earn 87p for every £1 that men earn when comparing median hourly wages. Their median hourly wage is 12.65% lower than men's.

When comparing mean hourly wages, women's mean hourly wage is 26.00% lower than men's.

Women occupy 73.4% of the highest paid jobs and 86.6% of the lowest paid jobs. Women account for 84.7% of the total workforce.

In the 'Medical and Dental' category, the number of female Consultants (of whom were eligible to be included in this report) increased slightly from 80 in 2022 to 81 in 2023 and male Consultants increased from 70 in 2022 to 76 in 2023.

When comparing mean bonus pay, women's bonus pay is 10.20% lower than men's, however the median bonus pay is equal for both genders.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations, the pay gap percentage for the average mean hourly rate in 2023 is reduced from 26.00% to 3.48%. The median hourly rate pay gap percentage is 3.01% greater for females when you take out the medical and dental staff meaning men earn 96p for every £1 that women earn when comparing median hourly wages.

The gender pay gap report has been shared with the Trust Board to make informed decisions on actions that are required to improve the gender pay gap.

Harrogate and District NHS Foundation Trust

Public Board
May 2024

Title:	HDFT Ethnicity Pay Gap Report
Responsible Director:	Angela Wilkinson, Director of People and Culture
Author:	Becki Maree, Business Information Manager Richard Dunston Brady, Equality, Diversity and Inclusion Manager

Purpose of the report and summary of key issues:	Research shows that organisations with diverse workforces and inclusive cultures perform better because they benefit from having a range of lived experiences and deeper understanding and viewpoints in the room. This in turn promotes diverse, creative and innovative decision-making. The culture of an organisation also depends on these values; a place where people are proud to work, where they feel valued, recognised and supported to develop their true potential. While there is currently no legal requirement to publish ethnicity pay gap data in the UK, we are reviewing this data alongside our mandated Gender Pay Gap data as good practice and in line with our commitment on closing gaps in workplace inequalities between our Black, Asian and Minority Ethnic (BME) staff and White staff. The Ethnicity Pay Gap is a measure that shows the difference in average earnings between BME colleagues and White colleagues across an organisation. The data in the report shows that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations, the pay gap percentage for the average mean hourly rate and median rate in 2023 changes in favour of White staff, providing a reflection of the larger proportion of the workforce. In total, 12.5% of colleagues who have shared their data identify as BME, based on a 94.5% disclosure rate from colleagues across HDFT.

10

BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	√
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	√
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	**There are no corporate risks**	
Report History:	**The report has been approved at the People and Culture Programme Board.**	
Recommendation:	**The Boards are recommended to accept this report and enable it to be published by the end of March 2024.**	

10

Ethnicity Pay Gap Report

As at 31 March 2023

1. Ethnicity pay gap reporting

Diversity and inclusion are fundamental to the success of an organisation; in the service it provides and in creating a fair, diverse and inclusive environment for its workforce.

Research shows that organisations with diverse workforces and inclusive cultures perform better because they benefit from having a range of lived experiences and deeper understanding and viewpoints in the room. This in turn promotes diverse, creative and innovative decision-making.

The culture of an organisation also depends on these values; a place where people are proud to work, where they feel valued, recognised and supported to develop their true potential.

While there is currently no legal requirement to publish ethnicity pay gap data in the UK, we are reviewing this data alongside our mandated Gender Pay Gap data as good practice and in line with our commitment on closing gaps in workplace inequalities between our Black, Asian and Minority Ethnic (BME) staff and White staff.

The disclosure of diversity data, such as ethnicity, is optional for staff. The data used in this report is based on a snapshot of data from 31 March 2023 for colleagues who have chosen to disclose their ethnicity. While this is the first time we are reporting on this information, we will continue in the future to track our progress.

Our mean ethnicity pay gap, shows the difference in average pay between BME colleagues and White colleagues and takes into account all roles at all levels within Harrogate and District NHS Foundation Trust (HDFT). This is different to the concept of equal pay i.e. the comparison in pay received by BME and White colleagues performing the same roles at the same grade.

HDFT pays most employees, excepting some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the band 5 scale with the same level of qualifications and experience would be paid the same irrespective of ethnicity; they would then have the opportunity to progress up the pay scale annually

The report will provide a breakdown of:

- Mean ethnicity pay gap in hourly pay.
- Median ethnicity pay gap in hourly pay.
- Mean bonus ethnicity pay gap.
- Median bonus ethnicity pay gap.
- Proportion of White and BME colleagues receiving a bonus payment.
- Proportion of White and BME colleagues in each pay quartile.

2. Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust (the Trust) employs more than 5,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds and children's services stretching from Berwick upon Tweed in the North to Wakefield in the South, and across the whole of North Yorkshire, from Settle in the West to Scarborough in the East.

The total number of staff eligible for inclusion in this report was 4,439 from a workforce of 4,697. The data in this report is based on those who have chosen to disclose their ethnicity which accounts for 94.5% of the workforce.

	31 March 2023		31 March 2022	
	Headcount	**%**	**Headcount**	**%**
BME	555	12.5%	466	11.1%
White	3,884	87.5%	3,733	88.9%
TOTAL	**4,439**		**4,199**	

We must continue to encourage staff to declare their ethnicity. The disclosure rate is important as it reflects how comfortable, or not, people are about sharing these details with us and more broadly whether we are creating an environment where people can truly be themselves.

Figure 1 illustrates the ethnicity distribution within HDFT at 31 March 2023

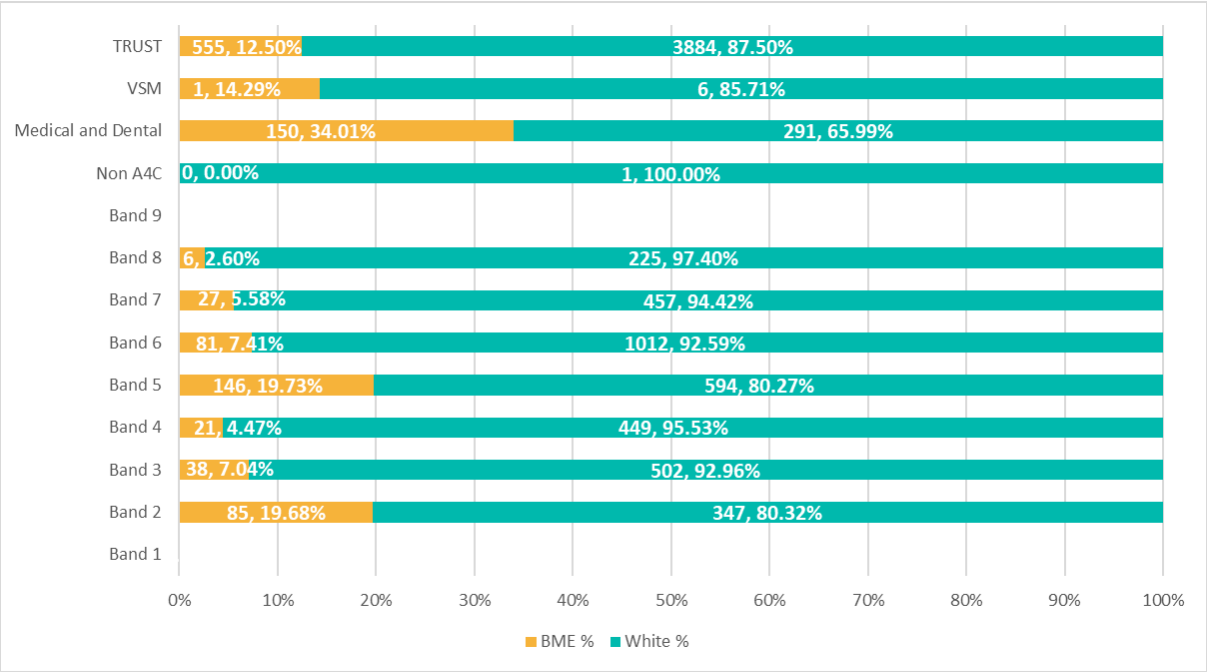


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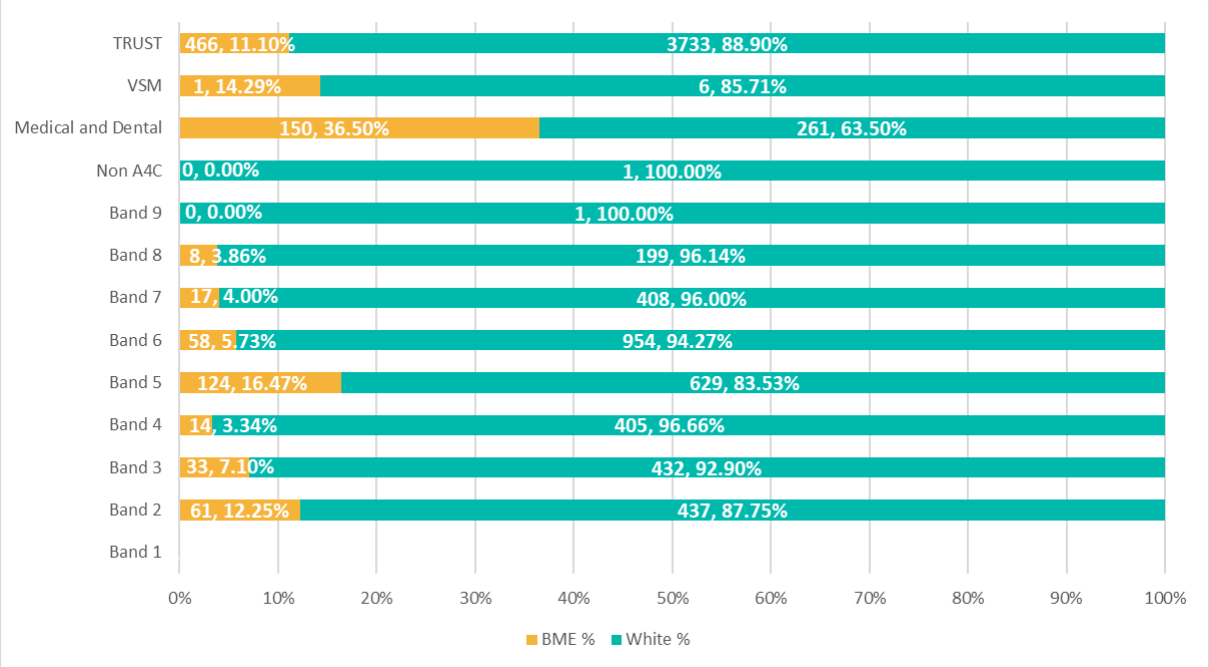
Figure 2 illustrates the ethnicity distribution within HDFT at 31 March 2022



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and all existing staff on a Band 1 contract at HDFT transitioned over to Band 2 from April 2019.

3. Definitions and scope

The Ethnicity Pay Gap is a measure that shows the difference in average earnings between BME colleagues and White colleagues across an organisation

The report is based on rates of pay for the financial year 2022/23. It includes all workers in scope at 31 March 2023. A figure above zero indicates an Ethnicity Pay Gap disadvantageous to BME colleagues; a minus figure indicates the ethnicity pay gap disadvantageous to White colleagues.

The Ethnicity Pay Gap is described in two different terms. Firstly, the difference between the mean of hourly rates of White colleagues and the hourly rates of BME colleagues and secondly as the difference between the median of hourly rates of White colleagues and the median hourly rates of BME colleagues.

Mean and Median

- The "mean" is an average of all hourly rates of pay.
- The "median" is the middle value in a complete list of all hourly rates of pay.

4. Mean and median ethnicity pay gap in hourly pay

Ethnicity	Mean Hourly Rate 2023	Median Hourly Rate 2023	Mean Hourly Rate 2022	Median Hourly Rate 2022
White (£)	19.54	17.24	18.62	16.52
BME (£)	22.44	18.19	22.55	17.92
Difference (£)	-2.91	-0.95	-3.93	-1.40
Pay Gap %	-14.87	-5.54	-21.13	-8.49

- As highlighted in Figure 1, the proportion of BME staff is much higher in the medical and dental staff group than in any other pay band.
- As shown above, HDFT is reporting a minus ethnicity pay gap of -14.87%, meaning that based on an average hourly rate, BME employees are paid 14.87% more than White employees. This is a decrease of 2022's figure of -21.13%.
- The figures also demonstrates that HDFT has a minus median ethnicity pay gap of -5.54%, a decrease of 2022's figure of -8.49%.

The Influence of Medical and Dental Staff

Medical and Dental staff have a substantial impact on HDFT's Ethnicity Pay Gap, as individuals in this staff group tend to be paid higher wages than other HDFT employees.

Included within this report are 119 White Consultants and 36 BME Consultants. As the Trust employs fewer BME colleagues overall, the number of BME Consultants as a proportion of the overall BME workforce at 6.49% is higher than that of White Consultants 3.06% of the overall White workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that taking out the medical and dental staff from the calculations, the Ethnicity Pay Gap percentage for the average mean hourly rate in 2023 increases from -14.87% to 4.95% and becomes favourable to White colleagues. The median hourly rate pay gap percentage increases from -5.54% to 0.66% when you take out the medical and dental staff.

Ethnicity	Mean Hourly Rate 2023	Median Hourly Rate 2023	Mean Hourly Rate 2022	Median Hourly Rate 2022
White (£)	17.52	16.87	16.73	16.13
BME (£)	16.66	16.75	16.41	16.13
Difference (£)	0.87	0.11	0.32	0.00
Pay Gap %	4.95	0.66	1.92	0.01

5. Mean and median bonus ethnicity pay gap

The Trust pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards. The latter takes the shape of a £40 bonus paid to both white and BME colleagues in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out at an equal level to all employees it has no influence on the figures.

The Long Service Awards were postponed in 2021/22 due to Covid and were awarded to employees in November 2022, along with the Long Service Awards for 2022/23. The two consecutive years are therefore reported in the 31 March 2023 Ethnicity Pay Gap report.

In 2022/2023 there were two types of CEA's that were awarded to the Trust's Consultants. One of these CEA's was a lifetime CEA Award and that was paid to 80 Consultants included within this report with a stated ethnicity. The other type of CEA paid was a non-pensionable, non-consolidated award.

The below figures reflect the CEA payments for Consultant medical staff. The Trust currently employs 155 Consultants of whom 119 are white and 36 are BME (as at 31.03.23 and are eligible for inclusion in this report). Of the 119 white Consultants, 109 Consultants received a CEA payment in 2022/23 (91.6% of white Consultants), which is 2.8% of the total white workforce. Of the 36 BME Consultants, 27 Consultants received a CEA payment in 2022/23 (75.0% of BME Consultants), which is 4.9% of the total BME workforce.

Ethnicity	Mean Bonus 2023 (£)	Median Bonus 2023 (£)	Mean Bonus 2022 (£)	Median Bonus 2022 (£)
White	10,462.73	6,781.47	11,569.66	7,246.00
BME	6,195.19	3,765.47	6,662.26	4,230.00
Difference	4,267.54	3,016.00	4,907.40	3,016.00
Pay Gap %	40.79	44.47	42.42	41.62

- This shows a decrease in the mean ethnicity bonus gap differential by 1.63% and an increase in the median bonus gap differential by 2.85% respectively from 2022 to 2023.
- The mean pay gap remains significantly high in the favour of White consultants.

6. Proportion of White and BME colleagues receiving a bonus payment

In addition to the above, the Trust issues Long Service Awards. Long Service Awards include a £40 bonus paid to both white and BME colleagues in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out equally to all ethnicities it would have no influence on the figures.

222 Long Service Awards were issued to staff still employed as at 31st March 2023 who had a recorded ethnicity and are included within this report. 98.2% were issued to white colleagues with the remaining 1.8% being issued to BME colleagues. All long service awards carry the same financial value of £40 meaning that the ethnicity bonus gap would be zero.

Taking both Clinical Excellence Awards and Long Service Awards into account, as a proportion 8.4% of white colleagues received a bonus compared to 5.6% of BME colleagues.

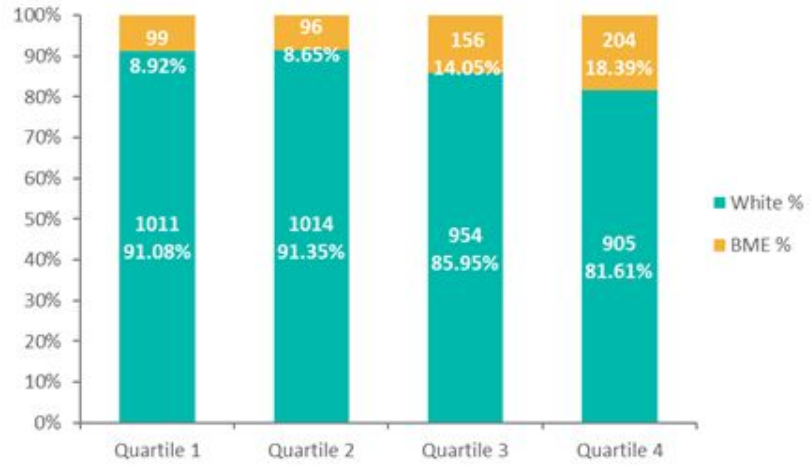
7. Proportion of White and BME colleagues in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph below shows that the highest proportion of white colleagues is found in the lower middle quartile and lowest quartile. The highest proportion of BME colleagues is found in the two upper quartiles compared with the lower quartiles. This is influenced by the large proportion of BME doctors and dentists within HDFT. The percentage of BME in the upper quartiles has increased compared to the 2022 figures.

2023



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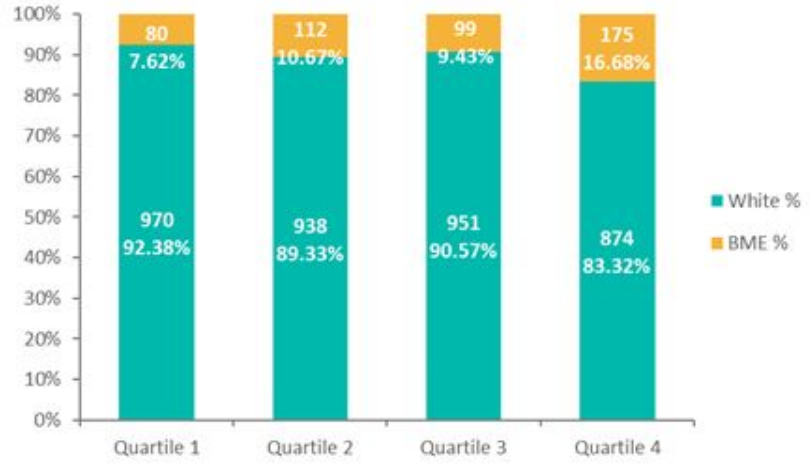
2022



8. Summary and next steps in reducing the ethnicity pay gap

The data in this report is based on those who have chosen to disclose their ethnicity.

The report demonstrates the impact of medical and dental staff as driving the percentage gap. Removing medical and dental staff from the calculations (10% of the overall workforce), the pay gap percentage for the average mean hourly rate and median rate in 2020 changes in favour of White staff, providing a reflection of the larger proportion of the workforce.

Work to eradicate inequity will continue to be monitored through annual reporting of the Workforce Race Equality Standard (WRES).

10

HARROGATE & DISTRICT NHS FOUNDATION TRUST

BOARD ASSURANCE FRAMEWORK

30 November 2022

AMBITION: BEST QUALITY, SAFEST CARE

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. Through continuous learning and improvement we will make our processes and systems ever safer – we will never stop seeking improvement. We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. We want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to continuously improve.

GOALS:

- **Safety: Ever safer care through continuous learning and improvement**
- **Effectiveness: Excellent outcomes through effective, best practice care**
- **Patient Experience: A positive experience for every patient by listening and acting on their feedback**

Governance:

- **Board Assurance:** Quality Committee
- **Programme Board:** Quality Governance Management Group
- **SRO:** Director of Nursing, Midwifery and AHPs, Medical Director

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

Goal	Metrics		
Safety			
Effectiveness			
Patient Experience			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR5	Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	4x4=16	4x2=8 (Dec 23)	Clinical Workforce	Averse
CRR73	Insufficient Staffing for Special Care Baby Unit (SCBU)	Risk to continuity of SCBU service, with consequent risk to provision of maternity service, due to inability to provide one “Qualified in Specialty” staff member on every shift due to high vacancy rate.	4x3=12	4x2=8 (Mar 23)	Clinical Workforce	Averse

GOAL: BEST QUALITY, SAFEST CARE: Ever safer care through continuous learning and improvement

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Theatres Safety To improve the safety culture in theatres	Reduction in SIs in theatres		• Cultural review in Theatres (B3Sixty) • Implementation of the revised WHO Checklist • Cleanliness: revised IPC and Cleaning audits implemented • Safety Dashboard implemented • Implementation of revised Stop Before you Block SOP • Implementation of revised Swab Count SOP	• Completed – Action Plan in progress • Completed – Implemented, embedding ongoing • Partially Completed – embedding required • Partially Completed – trial in place • Partially Completed – action plan outstanding • Partially Completed – audit to be undertaken	
Falls To reduce the number of falls in the acute setting rated moderate and above.	Reduction in Falls rated moderate and above per 1,000 bed days		• Older people routinely risk assessed at all appointments • Those at risk of falls have an individualised multifactorial intervention • Older people who fall during admission are checked for injury • Older people in the community with a known history of recurrent falls are referred for strength and balance training • Older people who are admitted after a fall in the community offered a home assessment and safety interventions	• Partially completed – documentation in place in the community, further work required in Acute • Partially completed – available on WebV, compliance to be assessed • Partially completed – post fall initial assessment available, compliance to be assessed • Not completed – gap analysis to be undertaken and referral process developed • Partially completed – environmental assessments available, however process needs to be created for referral	
Pressure Ulcers To reduce the number of pressure ulcers in the acute setting rated moderate and above.	Reduction in pressure ulcers rated moderate and above per 1,000 bed days		• Pressure Ulcer Improvement Plan developed • PURPOSE T risk assessment tool used on all patients • Reassessment of patients as per revised SOP • All at risk patients to have a pressure ulcer management plan in place • Patients with MASD to have joint assessment with continence nurse and TVN • Clinical staff to have Preventing Pressure Ulcer training • Patients who develop Cat 3, 4 and Unstable pressure ulcer, DTI and device related pressure damage to be reviewed by a TVN	• Completed • Partially completed – assessment tool available, training continuing, compliance to be confirmed • Partially completed – reassessment tool available, compliance to be confirmed • Partially completed – tool in place, compliance to be confirmed • Not completed – review and relaunch of MASD pathway to be undertaken • Partially completed – training in place, compliance needs to be improved • Completed	

GOAL: BEST QUALITY, SAFEST CARE: Excellent outcomes through effective, best practice care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Missed Results To reduce diagnostic results not acted upon	Reduction in number of diagnostics results not acted upon		• Digital workstream to be considered • Trust wide policy on requesting clinical investigations	• Non compliant – further work required to scope • Non compliant – on hold until a digital solution explored	
Medication Errors To reduce medication errors and provide assurance against CQC, RPS and HTM standards	Reduction in missed doses Reduction in safety incidents rated moderate and above		• Lead Pharmacist – Medicines Quality and Safety in post • Develop Medicines Quality and Safety Group work plan • Update all medicine safety policies • Develop and implement insulin safety initiatives • Develop and implement oxygen prescribing initiatives • Embed high risk medicines and allergy status dashboards • Complete fridge temperature monitoring actions • Develop e-learning/e-assessment for medicines management	• Completed • Completed • Partially completed – Medicine Policy Updated • Not Complete – Action Plan to be developed • Partially completed – further work to embed • Partially completed – further work to embed • Partially completed – further work to ensure full compliance • Partially completed – tool developed, compliance to be assessed	

GOAL: BEST QUALITY, SAFEST CARE: A positive experience for every patient by listening and acting on their feedback

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Patient Experience To improve patient experience by using patient feedback to drive quality improvement and learning. This will be achieved by full compliance with the 6 principles of patient experience.	Reduction in the number of complaints when compared to the previous year Improved completion time of complaint response		• Principle 1: Leadership – Patient experience manager in post. • Principle 2: Organisation Culture: revised complaints process implemented • Principle 3: Capacity and Capability to effectively collect feedback: patient experience surveys piloted in acute paediatrics • Principle 4: Analysis and Triangulation: quality analyst in post • Principle 5: Using patient feedback to drive quality improvement and learning: Learning Summit implemented • Principle 6: Reporting and Publication: PE section of the Quality Report to move beyond complaints and PALs	• Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance) • Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance) • Partially completed – current rating 3 (out of 5 with 5 being full compliance) • Partially completed – current rating 2 (out of 5 with 5 being full compliance)	

AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS

For Harrogate and District, our ambition is to support person centred, integrated care through strong local partnerships. Our goal is for Harrogate and District to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail. By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

GOALS:

- **The best place for person centred, integrated care**
- **An exemplar system for the care of the elderly and people living with frailty**
- **Equitable, timely access to best quality planned care**

Governance:

- **Board Assurance:** Resources Committee
- **Programme Board:** Elective Programme Board, Urgent & Emergency Care Programme Board
- **SRO:** Chief Operating Officer

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

Goal	Indicators		
Person Centred, Integrated Care			
Care of the Elderly			
Planned Care			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR41	Referral To Treatment (RTT)	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19	3x4=12	3x2=6 (Mar 24)	Clinical Operational	Cautious
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4 hour standard.	3x5=15	3x2=6 (Aug 23)	Clinical Operational	Cautious

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: The best place for person centred, integrated care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Streaming	Improved ED 4 Hour Performance Improved flow through ED Improved patient experience		• Staff Recruitment – Sep 22 • Staff in post – Oct 22 • E-streaming in place – Oct 22 • Staff training complete – Jan 23	• Complete • Complete • Missed (dependency on E-Streaming tablets) • On track (delayed from original plan of Oct)	
ED Reconfiguration: Fit to Sit, Majors Area	Improved ED 4 Hour Performance Improved flow through ED		See "Enabling Ambition: An environment that promotes wellbeing" for details		
ED/Acute Flow – Acute Referral Triage	Reduction in ED attendances Improved satisfaction from referrers Patients referred to the right service first time		• Workforce & data review – Sep 22 • User feedback analysed – Sep 22 • Pathways written – Nov 22 • Single point of access for acute and community services in place - TBC	• Complete • Complete • Complete • Decision required on whether to progress with single point of access for acute and community	
ED/Acute Flow – Consultant Allocation	Reduce delays in medical review Reduce number of outliers Improved clinical experience Improved consultant working		• Centralised ward clerk management – Nov 22 • Standard ward clerk training programme – Nov 22 • Future ward reconfiguration agreed – Nov 22 • SOP agreed – Dec 22 • Future ward reconfiguration implemented – Dec 22	• On Track • On Track • On Track • On Track • On Track	
ED/Acute Flow – Acute Medicine Model	Reduced LoS for acute medicine patients Compliant with 14hr senior review standard Extended SDEC opening hours, increased SDEC capacity		• Acute Assessment Team & SDEC specification – Jul 22 • Acute Medicine staffing review – Aug 22 • Acute Medicine matron in post – Aug 22 • Training programme in place – Dec 22 • Staff investment (business case) – Mar 23 • Increased consultant team in place – Aug 23	• Complete • Complete • Complete • On track • To be considered as part of 22/23 planning • Dependent on 22/23 planning outcome	
ED/Acute Flow – Internal Referrals	Reduced time to request inpatient specialty review Standardising process Improving patient flow Reduce 24 hr maximum time to accept inpatient specialty review		• Design SDEC and Elderly Med referral forms – Oct 22 • SDEC & Elderly Med referral forms in WebV – Dec 22 • Train users – TBC • WebV referral forms testing – TBC • Go Live - TBC	• Complete • On Track • TBC • TBC • TBC	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Urgent Care Response (UCR)	Admission avoidance Reduced delayed discharges		• UCR pathways approved – Sep 22 • UCR clinical gov agreed with Pri Care – Oct 22 • UCR practitioners recruited – Oct 22 • Systm1 updated with pathways – Oct 22 • UCR team completed training – Oct 22 • All UCR pathways live – Oct 22 • Update DoS with UCR service – Oct 22 • Additional support workers recruited – Dec 22	• Complete • Complete • Complete • At Risk (2 pathways to complete) • Complete • Complete (2 pathways not yet on Systm1) • Overdue (needs ability to update capacity on DoS) • On Track	
Virtual Ward (VW)	Increased virtual ward capacity for a larger cohort of patients Reduced delayed discharges		• Elderly medicine consultant capacity in place – Nov 22 • Night staff recruitment – Dec 22 • IT solution to manage VW in place – Dec 22 • Identify first cohort of VW patients – Dec 22 • VW beds implemented on Systm1 – Dec 22 • Initial Hospital at Home capacity live – Dec 22 • Full additional Virtual Ward capacity live – Dec 23	• Complete • At Risk (Nursing recruited; HCA re-advertised) • At Risk (ICB solution not delivered; Trust solution now requested leading to delay) • On Track • On Track • On Track (small numbers of patients) • On Track	

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: An exemplar system for the care of the elderly and people living with frailty

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
No strategic objectives for 22/23 identified for this goal – focus in 22/23 on urgent and emergency care flow through ED, hospital and community services.					

GOAL: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS: Equitable, timely access to best quality planned care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Wharfedale Theatres (TIF1)	• Additional activity (estimated 282 General Surgery Day Case, 1017 Urology Day Case, 535 Gynaecology Day Case per annum) • Improved waiting time performance		• NHSE Business Case (BC) approval – Nov 22 • Internal BC approval – Jan 23 • MOU signed – Feb 23 • Proposal operationalised - Nov 23 • Contract signed – Feb 24 • Recruitment complete – Feb 24 • Construction complete – Mar 24 • Go Live – May 24	• On Track • On Track • On Track • On Track • On Track • On Track • On Track • On Track	
HDH Additional Theatres (TIF2)	• Additional activity (General Surgery 750 day case/inpatient, Urology 1300 day case/inpatient, Gynaecology 60 day case/inpatient, Breast 250 day case/inpatient per annum) • Improved waiting time performance		• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Planning permission awarded – Jan 23 • Complete tender, appoint contractor – Jun 23 • Recruitment complete – May 24 • Construction complete – Jul 24 • Go Live – Aug 24	• Complete • On Track • On Track • On Track • On Track • On Track • On Track • On Track	

Outpatient Transformation	• Reduce Follow Ups by 25% (compared to 19/20)
	• Expand uptake of Patient Initiated Follow Up (PIFU) to all major outpatient specialties
	• 2% of all outpatient attendances to PIFU pathway
	• Deliver 16 speciality advice requests, including A&G, per 100 outpatient 1st attendances
	• At least 25% of outpatient appointments to take place via telephone or video
	• Improved waiting time performance
			• PIFU rolled out to Rheumatology, Orthopaedics, Ophthalmology, Gastro
			• PIFU rolled out in:
			  ○ Gastro, Neurology, ENT, Physiotherapy – Dec 22
			  ○ Dermatology , Cancer – Jan 23
			• Waiting List validation – Jan 23
			• Orthopaedic Pathway Re-design complete (Hip and Knee 12mth FU) – Apr 23
				• Complete
				• On Track
				• On Track
				• On Track
				• On Track	

Theatres Productivity	• Increased activity through theatres • More specific metrics to be agreed through RPIW		• Priority specialties agreed - TBC • Improvement events delivered – TBC • Further actions dependent on outcome of improvement events.	• At risk • At risk	

AMBITION: GREAT START IN LIFE

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life. We have the opportunity to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the 'Hopes for Healthcare' principles co-designed with our Youth Forum. Providing high quality, safe care and a great patient experience for mothers and their babies, and ensuring they and their families have confidence in that care, is the beginning of a great start in life.

GOALS:

- **The national leader for children and young people's public health services.**
- **Hopes for Healthcare: services which meet the needs of children and young people.**
- **High quality maternity services with the confidence of women and families**

Governance:

- **Board Assurance:** Resources Committee; Quality Committee
- **Programme Board:** Great Start in Life Programme Board; Quality Governance Management Group
- **SRO:** Director of Strategy; Director of Nursing, Midwifery and AHPs

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

Goal	Indicators		
C&YP PH Services			
Hopes for Healthcare			
Maternity Services			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	3x4=12	3x2=6 (Mar 26)	Clinical Operational	Cautious

GOAL: GREAT START IN LIFE: The national leader for children and young people's public health services

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Children's Public Health (PH) Services Growth Strategy	More integrated services for children Securing long-term partnerships		• Children's PH Strategy Workshop – Oct 22 • Draft Growth Strategy supported by Children's PH Services Board Working Group (WG) – Jan 23 • Growth Strategy approved by Trust Board – Mar 23	• Complete • On Track • On Track	
Increasing the profile and influence of our Children's PH Services	Sharing evidence and learning for Children's PH Services Influencing regional/national policy Increased staff engagement		• Children's PH Strategy Workshop – Oct 22 • Draft Engagement Plan supported by Children's PH Services Board WG – Jan 23 • Children's PH Services Conference – TBC	• Complete • On Track • TBC	
Improving strategic relationship management with system partners	Improved outcomes for children Securing long-term partnerships		• Children's PH Strategy Workshop – Oct 22 • Review existing strategic relationships – Dec 22 • Stakeholder Management Plan supported by Children's PH Services Board WG – Jan 22	• Complete • On Track • On Track	
An operating model to support & enable services outside Harrogate	Improved outcomes for children Improved service delivery Increased staff engagement		• Children's PH Strategy Workshop – Oct 22 • Review of corporate support – Jan 23 • Review of community estate and processes – Mar 23 • Proposal for "Northern Hub" – Mar 23 • Draft Operating Model supported by Children's PH Services Board – Apr 23	• Complete • On Track • On Track • On Track • On Track	

GOAL: GREAT START IN LIFE: Hopes for Healthcare – services which meet the needs of children and young people

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To embed the "Hopes for Healthcare" principles in all HDFT services	Better patient experience for children Improved safety for children		• Establish Great Start in Life Programme Board – Jan 23 • Further actions to be determined through programme board – TBC	• On Track • TBC	

GOAL: GREAT START IN LIFE: High quality maternity services with the confidence of women and families

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Ockenden Safety Action 1 – Enhanced Safety	Robust governance of maternity services at service and trust board level Improved safety and outcomes through learning from incidents		• Maternity dashboard on LMNS agenda quarterly • Maternity Triumvirate working in place • Ockenden Action Plan discussed at Board • Triangulation of incidents/complaints, claims • External clinical specialist opinion for mandated incidents • Maternity SI reports and key issues summary to Trust Board and LMNS quarterly • PMRT cases reviewed to required standard • Data submitted to the Maternity Services Dataset • All HSIB cases reported • Perinatal clinical quality surveillance model implemented	• Compliant • Compliant • Compliant • Partially compliant • Compliant • Compliant • Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 2 – Listening to women and families	Improved patient experience for women and families Improved safety and outcomes through learning from incidents		• Non-Executive lead for maternity, collaborative working with Exec lead and maternity team safety champions • Involvement of women and families in using PMRT tool to review perinatal deaths • Robust mechanism for service user feedback through Maternity Voices Partnership • Maternity team safety champions meet bimonthly with board safety champions	• Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 3 – Staff training and working together	Improved teamworking in general and, particularly, in response to maternity emergencies		• Maternity multi-disciplinary team (MDT) training • Day and night consultant led ward round on labour ward • Dedicated obstetric governance lead • External training funding ringfenced for maternity • 90% attendance at multi-professional maternity emergencies training since Dec 19 • Schedule for MDT training in place	• Compliant • Compliant • Compliant • Partially compliant • Compliant • Compliant	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Ockenden Safety Action 4 – Managing complex pregnancy	Improved safety and outcomes for women with complex pregnancies and their babies		• Agreement on criteria for referral to tertiary maternal medicine centre • Named consultant lead for women with complex pregnancies, and mechanism to audit compliance • Early intervention for women with complex pregnancies • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • Agreed maternal medicine centre	• Compliant • Compliant • Compliant • Compliant • Compliant	
Ockenden Safety Action 5 – Risk assessment through pregnancy	Improved safety and outcomes for women and their babies		• Ongoing review of place of birth as part of antenatal risk assessment and developing clinical picture • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • Risk assessment review and place of birth discussion recorded at every contact with Personalised Care Plan	• Partially compliant • Compliant • Partially compliant	
Ockenden Safety Action 6 – Monitoring fetal wellbeing	Improved safety and outcomes for women and their babies		• Lead midwife and obstetrician for fetal wellbeing, with sufficient seniority and expertise, appointed • Compliance with all 5 elements of "Saving Babies Lives" care bundle version 2 • 90% attendance at multi-professional maternity emergencies training since Dec 19	• Compliant • Compliant • Compliant	
Ockenden Safety Action 7 – Informed Consent	Improved patient experience for women		• Accessible information available to enable informed choice of place and mode of birth • Accessible, evidence based information on antenatal, intrapartum and postnatal care • Equal participation and informed choices by women in decision making processes • Respect for women's choices following informed discussion and decision making • Robust mechanism for service user feedback through Maternity Voices Partnership • Clear, written information on care pathways, compliant with NHS policy, available on trust website	• Compliant • Compliant • Partially compliant • Partially compliant • Compliant • Compliant	

AMBITION: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. We will offer everyone opportunities to develop their career at HDFT through training and education. We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

GOALS:

- **Looking after our people: physical and emotional support to be "At Our Best"**
- **Belonging: teamHDFT – teams with excellent leadership, where everyone is valued and recognised; where we are proud to work**
- **New ways of working: education, training and career development for everyone**
- **Growing for the future: the right people, with the right skills, in the right roles**

Governance:

- **Board Assurance:** People and Culture Committee
- **Programme Board:** People & Culture Programme Board
- **SRO:** Director of Human Resources and Organisational Development

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

Goal	Metrics		
Looking after our people			
Belonging			
New ways of working			
Growing for the future			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR6	The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of both short and long term mental health impacts on staff	4x4=16	3x4=12 (Apr 23)	Clinical Workforce	Minimal

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Looking after our people: physical and emotional support to be "At Our Best"

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Belonging: teamHDFT – teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: New ways of working: education, training and career development for everyone

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

GOAL: AT OUT BEST – MAKING HDFT THE BEST PLACE TO WORK: Growing for the future: the right people, with the right skills, in the right roles

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Objectives to be confirmed following first People & Culture Programme Board in Dec 22			•		
			•		
			•		

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

GOALS:

- **A patient and staff environment that promotes wellbeing.**
- **An environment and equipment that promotes best quality, safest care.**
- **Minimise our impact on the environment.**

Governance:

- **Board Assurance:** Resources Committee
- **Programme Board:** Environment Board
- **SRO:** Director of Strategy

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

Goal	Metrics		
Environment that promotes wellbeing			
Environment that promotes best quality, safest care			
Minimise our impact on the environment			

Related Corporate Risks

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

GOAL: AN ENVIRONMENT THAT PROMOTES WELLBEING: A patient and staff environment that promotes wellbeing.

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Wellbeing Improvements	To improve the working environment for staff		• Minor refurbishments and redecoration • Complex schemes project briefs and designs – Oct 22 • Complex schemes costing and detailed design – Nov 22 • Complex schemes prioritisation – Dec 22 • Prioritised complex schemes completed – Mar 23	• Complete • Complete • On Track • On Track • On Track	

GOAL: AN ENVIRONMENT THAT PROMOTES WELLBEING: An environment and equipment that promotes best quality, safest care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
ED Reconfiguration: Fit to Sit, Majors Area	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete - Jul 22 • Contract award - Aug 22 • Fit to Sit Phase 1 start - Sep 22 • Fit to Sit Phase 1 complete - Dec 22 • Majors Area Phase 2A start - Jan 23 • Majors Area Phase 2A complete - Mar 23 • Majors Area Phase 2B start - Mar 23 • Works complete - Apr 23	• Complete • Complete • Complete • On Track • On Track • On Track • On Track • On Track	
Aseptics	• To meet standards for aseptic production for medicines safety and staff safety		• Design complete – Aug 22 • Tender & Contract award – Mar 23 • Build complete – Jun 23 • Commissioning complete – Aug 23 • In service – Sep 23	• Complete • On Track • On Track • On Track • On Track	
Radiology Reconfiguration Phase 1-2 – XRay & CT	• To improve reliability and capacity of imaging services		• Feasibility study, including phasing – Sep 22 • Initial costs – Oct 22 • Design concept – Jan 23 • Tender & Contract award - TBC • Build complete - TBC • Commissioning complete – TBC • In service – TBC	• Complete • Complete • On Track • Further milestones dependent on phasing of overall capital programme for 23/24)	
ED2 (UTC) Reconfiguration	• Improved ED 4 Hour Performance • Improved flow through ED		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build start – Mar 23 • • Build complete – Aug 23 • Commissioning complete – Sep 23 • In service – Sep 23	• On Track • On Track • On Track • At risk (may be delayed by ED Majors completion) • At risk • At risk • At risk	
Wensleydale Ward Refurbishment	• Dedicated cardiology and respiratory ward, including High Observation/Non-invasive Ventilation Beds		• Design complete – Nov 22 • Tender issued – Nov 22 • Contract award – Mar 23 • Build Start – Apr 23 • Build complete – Oct 23 • Commissioning complete – Nov 23 • In service – Dec 23	• On Track • On Track • On Track • At risk (needs coordination with window replacement completion) • At risk • At risk • At risk	

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
HDH Additional Theatres (TIF2)	• Additional activity (General Surgery 750 day case/inpatient, Urology 1300 day case/inpatient, Gynaecology 60 day case/inpatient, Breast 250 day case/inpatient per annum) • Improved waiting time performance		• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Planning permission awarded – Jan 23 • Complete tender, appoint contractor – Jun 23 • Recruitment complete – May 24 • Construction complete – Jul 24 • Go Live – Aug 24	• Complete • On Track • On Track • On Track • On Track • On Track • On Track • On Track	

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Development of the Trust "Green" Plan	A longterm plan and governance structure for the reduction of the Trust's carbon emissions		• Green Plan approved by HDFT and HIF Boards • Governance structure, Sustainability Board, in place reporting to HIF Board	• Complete • Complete	
SALIX Carbon Reduction Programme	To improve the estates infrastructure at Harrogate District Hospital in order to reduce carbon emissions		• Solar panels • Air and ground source heat pumps • Window replacement	• Behind original programme • Current completion planned for Aug 23	
Travel Plan	To develop sustainable models of transport for patients, staff and visitors		• Patient, staff, stakeholder engagement • Travel Plan drafted • Discussed with Environment Board and SMT – Dec 22 • Further actions TBC	• Complete • Complete • On Track	

ENABLING AMBTION: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE

Digital technology is an essential part of delivering high quality healthcare, but it is also important to remember that it is a tool, not an end in itself. Our ambition at HDFT is provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience. Through digitisation we can also collect huge amounts of data about our services – we will increase our ability to create useful information which enables us to learn and continuously improve our services. Over the next few years, we intend to implement a new electronic health record which will revolutionise how we provide care.

GOALS:

- **Systems which enable staff to improve the quality of care**
- **Timely, accurate information to enable continuous learning and improvement**
- **An electronic health record to enable effective collaboration across all care pathways**

Governance:

- **Board Assurance:** Innovation Committee
- **Programme Board:** Digital Board, EPR Programme Board
- **SRO:** Medical Director

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

Goal	Metrics		
Systems which enable staff to improve the quality of care			
Timely, accurate information to enable continuous learning and improvement			
An electronic health record to enable effective collaboration across all care pathways			

Related Corporate Risks

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

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: Systems which enable staff to improve the quality of care

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Luna (RTT Tracking)	To improve the quality of waiting list data in order to support timely treatment of patients		• Business Case approved – Jun 22 • Contract signed – Jun 22 • Initial Go Live – Dec 22	• Complete • Complete • On Track	
eRostering	To improve how staff are rostered for shifts in order to provide a better staff experience (better planning and management of shifts) and more efficient and effective utilisation of staff		• Business Case approved – Dec 20 • Contract signed – Dec 20 • Initial Go Live – Jun 21 • Project complete – Dec 22	• Complete • Complete • Complete • On Track	
Datix Cloud	To provide a robust clinical governance and risk management platform for the Trust to underpin our quality learning and improvement system		• Business case approved – Apr 22 • Initial Go Live – Apr 23 • Project complete – Dec 23	• Complete • On Track • On Track	
ASCOM Nurse Call (linked to Wensleydale Digital Exemplar Ward)	To improve quality and staff experience by enabling more effective and efficient response to patient calls		• Business Case approved – Mar 22 • Wensleydale refurbishment starts – Apr 23 • Wensleydale back in service – Dec 23 • Basic nurse call solution live – Dec 23 • Task management live – Mar 24 • Medical device integration – Jun 24	• Complete (implementation delayed due to timescales for Wensleydale refurbishment) • On Track • On Track • On Track • On Track • On Track	

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: Timely, accurate information to enable continuous learning and improvement

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Implement Microsoft Azure/Power BI	To improve decision making by providing more accurate, timely information to clinicians and managers		• Business Case – Oct 22 • Contract signed – Dec 22 • Go Live – Mar 23	• Complete • On Track • On Track	

GOAL: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE: An electronic health record to enable effective collaboration across all care pathways

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
New Electronic Patient Record	To improve the quality of maternity services		• Strategic Outline Case – Aug 22 • Outline Business Case – Jun 23 • Full Business Case – Jan 24 • Contract signed – Jan 24 • EPR delivery project starts – Mar 24 • Initial Go Live – TBC, likely Q2/3 25/26	• Complete • On Track • On Track • On Track • On Track • TBC	
Maternity Electronic Patient Record	To improve quality of maternity services and staff experience through better clinical information, more efficient and effective ways of working.		• Business Case approved – Mar 22 • Contract signed – Mar 22 • Go Live – Mar 23	• Complete • Complete • On Track	
Single Sign On	To improve the security of Trust IT systems, save staff time and implement an enabler for the EPR		• Business Case – Nov 22 • Contract signed – Dec 22 • Initial Go Live – Jun 23	• Complete • On Track • On Track	
Laboratory Information Management System (LIMS)	To provide a single LIMS across all WYAAT pathology services to enable system working and information sharing		• WYAAT Business Case approved – Jan 21 • Contract signed – Jan 21 • Go Live – Dec 23	• Complete • Complete • On Track	
Scan4Safety Medicines Management (Omnicell) (Link to Medicines Safety Quality Priority)	Reduction in medicines safety incidents		• Business Case approved – Jul 21 • Contract signed – May 22 • Initial Go Live – Oct 22 • Project complete – Mar 23	• Complete • Complete • Complete • On Track	
Somerset (Cancer Tracking)	To enable the timely management of cancer referrals and meet mandated cancer reporting requirements		• Business Case approved – Aug 21 • Contract signed – Feb 22 • Initial Go Live – Oct 22	• Complete • Complete • Complete	
Outpatient Flow and eOutcomes	To improve outpatient outcomes data and outpatient productivity by capturing of outcomes at point of care and supporting flow		• Business Case approved – Apr 22 • Contract signed – Dec 22 • Initial Go Live – Sep 23	• Complete • On Track • On Track	
Robotic Process Automation	To release staff time, reduce delays and improve data processing accuracy by using automating information processes		• Business Case approved – Dec 22 • Contract signed – Mar 23 • Initial Go Live – Jun 23	• On Track • On Track • On Track	
Yorkshire & Humber Care Record	To enable sharing of patient information across systems and organisations		• Regional Business Case approved – Jun 20 • Regional contract signed – Jun 20 • Initial Go Live – May 22	• Complete • Complete • Complete	

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY

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

GOALS:

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

Governance:

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

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

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

Related Corporate Risks

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

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
Establish Harrogate Innovation Hub	Facilitate and accelerate the growth of innovative healthcare solutions by building partnerships with industry, academia, government and voluntary sector and offering a real world testbed for healthtech and digital innovations		• Harrogate Innovation Hub Launch event – Oct 22 • Identify Innovation Hub location – Oct 22 • Recruit Innovation Manager – Jan 23 • Appoint Clinical Lead for Innovation – Jan 23 • Further actions to be developed	• Complete • Complete • On Track • On Track	
Research, Audit, Innovation and Service Evaluation (RAISE) group	To build collaboration with innovation partners		• Scoping the potential for RAISE with partners such as Academic Health Science Network, Research Design Service – Mar 23 • Further actions TBC following scoping	• On Track	

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

Strategic Objective	Outcome	Metric RAG	Plan	Position	Delivery RAG
To understand Children's PH research and identify how we can contribute	Build the evidence base for Children's PH Services Improved outcomes for children		• Children's PH Services Strategy Workshop – Oct 22 • Paper on Children's PH research for Children's PH Services Board WG – Jan 22 • Further actions to be developed	• Complete • On Track • TBC	
To provide opportunities for Children's PH services, and the children and families they support, to be involved in research studies	Build the evidence base for Children's PH Services Improved outcomes for children		• Identify and open research studies into children's public health – Mar 23	• On Track – 3 studies opening	

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

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

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2024-2025

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience. Through continuous learning and improvement we will make our processes and systems ever safer – we will never stop seeking improvement. We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. We want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to continuously improve.

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

A positive experience for every patient by listening and acting on their feedback

GOVERNANCE:

Quality Framework

- Board Assurance: Quality Committe
- Programme Board: Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Executive Medical Director
- Operational Lead: Associate Director of Quality & Corporate Affairs

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. • **Eliminating Moderate & Above Harm**
2. • **Patient Experience Positive Response Rates**

Breakthrough Objective:	Pressure Ulcers
Corporate Project:	Patient Experience
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**								
	Excellent Outcomes										
	A positive experience	**Patient Experience**	**Clinical: Minimal**								

True North Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care  Excellent Outcomes 	Eliminate Moderate & Above Harm **Breakthrough Objective**	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 170 per annum (approx. 14 per month) Year 1: 136 Year 2: 109 Year 3: 87	December 2023 and January 2024 saw an increase in moderate and above harm safety events. Mitigation is in place to reduce this number. The target for Year 1 is 136 or less moderate and above incidents (approximately 11 per month). This will be tracked from April 2024. Falls Improvement Plan Pressure Ulcers Improvement Plan Missed Results Improvement Plan Medication Errors Improvement Plan	**Break through Objective: Pressure Ulcers – noted below** Falls Improvement Plan on track for delivery. 19% of moderate and above harms are linked to Falls. Slight increase in falls overall in December 2023 and January 2024. 3 moderate harms occurred. This remains within control limits. Missed results improvement plan continues to progress with enhanced reporting and escalation impacting on the number of missed results. No moderate and above incidents declared in December 2023 and January 2024. Medication errors improvement plan continues, however, enhanced risks have been identified in relation to electronic monitoring. A deep dive is currently ongoing. No patient harm has been identified to date in relation to this.		
A Positive Experience 	Patient Experience Response Rates **Corporate Project**	For every patient to recommend our services	Long term: Development of a real time engagement tool Short term: Increase the % of positive response to FFT by 20% each year for 3 years	Corporate Project in development In January 2024, the trust received 447 inpatient FFT responses (out of 2619 eligible) – on average, 94% of all patients rated their care good or very good. • In January 2024, the trust received 3074 outpatient FFT responses (out of 9998 eligible) – on average, 94% of all patients rated their care good or very good.	Corporate Project In development Level of Risk for Progressing Actions: Amber due to project being in development		

Breakthrough Objective: Pressure Ulcers

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm	No Category 3 or 4 Pressure Ulcers	Pressure Ulcers Improvement Plan	Progress March 2024: • Data collection for Q3 CQUIN CCG 12 – compliance *76.1% (from 79.2%), overall compliance 75% YTD* • Revised Quality Oversight process in place and providing increased assurance to ICB • Learning gleaned from investigation process actioned in timely and meaningful way • Daily TVN teaching for areas of concern have improved risk assessment compliance • Slide sheet drop in sessions complete with excellent feedback • Training compliance 82% Actions delivery by end of Quarter 4 2023-2024 • Revised TVN training programme launched to include workshop style sessions with hands on exercises and tasks • TVN link nurse role relaunched to provide opportunity for professional development and encourage specialist interests • Ongoing training with the fundamentals of care nurses focusing on preventing medical device related pressure ulcers • TVN Tendable audits to be tailored further based on results of Q3 of CQUIN CCG12 • Training compliance to increase to 85% • Q4 CQUIN CCG12 compliance 85%		

Corporate Project: Patient Experience

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates	Development of real time engagement tool	Corporate Project Currently in development. Continuing to monitor FFT rates and response whilst project in development	Development of clear project plan to including: options for potential engagement tools, review of other Trusts and private business to understand potential for gathering information, lead appointed to oversee project, governance including task and finish groups established, roll out plan for embedding. Currently rated amber for delivery as the project plan remains in development.		

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

STRATEGIC AMBITION: GREAT START IN LIFE 2024-2025

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life. We have the opportunity to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally. As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the 'Hopes for Healthcare' principles co-designed with our Youth Forum. Providing high quality, safe care and a great patient experience for mothers and their babies, and ensuring they and their families have confidence in that care, is the beginning of a great start in life.

GOALS:

Public Health

The national leader for children & young people's public health services

Hopes for Healthcare

Services which meet the needs of children & young people

Maternity Services

High quality maternity services with teh confidence of women and families

GOVERNANCE:

Great Start in Life

- Board Assurance: Quality Committe & Resource Committee
- Programme Board: Great Start in Life Programme Board & Quality Governance Management Group (QGMG)
- SRO: Executive Director of Nursing, Midiwfery & AHPs and Director of Strategy
- Operational Lead:Clinical Director for Children & Community & the Associate Director of Midwifery

True Metrics (Executive Lead: 10-15 Year deliverable)

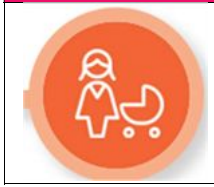
1. Early Intervention & Prevention
2. Child Patient Experience
3. Maternity Harm Events

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Clinical - Minimal

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Great Start in Life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal								
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal								
	High Quality Maternity Services	Maternity Harm Events	Clinical: Minimal								

True North Metrics Summary:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
Public Health 	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	As an organisation we wish to recognise all children at risk of vulnerabilities in the ante natal period so that by the age of 30 months the child can be graduated into universal services	1st Goal : to configure SystmOne to enable representative performance reporting across the geographies. 2nd Goal: to be able to measure the impact of early intervention and prevention by 1st June 2024	Increasing the profile and influence of our Children's PH Services Improving strategic relationship management with system partners An operating model to support & enable services outside Harrogate To Increase the percentage of children identified as at risk of vulnerabilities at birth who are in universal services by 30 months			
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Engage with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare. Develop an HDFT CYP Patient Experience Test which will provide outputs that will translate into themes, trends and areas for improvement. This data set will be visible and accessible across Trust governance frameworks. Develop a CYP Shadow Board with representation from HDFTs geography who will provide consultancy to HDFT Board and Services	To embed the "Hopes for Healthcare" principles in all HDFT services			
Maternity Services	Maternity Services – Maternity Harm Events	In order to give people the best start in life,	Reduce the number of readmissions to Pannal and term admissions to	Embedded immediate and essential actions from Ockenden Report (2020 & 2022)			

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
		maternity services must be of good quality.	Special Care Baby Unit by 25%	Progress actions towards the Three Year Delivery Plan for Maternity and Neonatal Services (2023)			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. 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)	4 x 4 = 16	4 x 2 = 8	Clinical: Patient Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

STRATEGIC AMBITION: PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS 2024-2025

For Harrogate and District, our ambition is to support person centred, integrated care through strong local partnerships. Our goal is for Harrogate and District to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place. With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and frail. By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

GOALS:

Best Place

The best place for person centred, integrated care

Exemplar System

An exemplar system for the care of the elderly and people living with frailty

Equitable & Timely

Equitable, timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

- Board Assurance: Resource Committe
- Programme Board: Elective Programme Board, UEC Programme Board
- SRO: Chief Operating Officer
- Operational Lead: Deputy Chief Operating Officer

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. **Meet the 4 Hour ED wait time**
2. **Emergency Admission of Patients with Frailty**
3. **Elective Recovery RTT - No Patients 18 weeks**
4. **No patient waiting longer than 62 days for cancer treatment**

Breakthrough Objective:	Time to first Clinical Assessment
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred , integrated care**	**4 hour ED standard**	**Operational: Cautious**	
	An exemplar system for the care of the elderly	**Admissions of People with frailty**	**Operational: Cautious**	
	Equitable, Timely Access to Best Quality Planned Care	**18 Week RTT**	**Operational: Cautious**	
		Cancer – 62 day Treatment Standard	**Operational: Cautious**	

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	4 Hour Waits	100% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 100% of admitted patients to be moved to required department within 30 minutes of medical decision.	In 12 months we want to be at 85% of patients having their care completed within 4 hours. In 24 months we want to be at 95% of patients having their care completed within 4 hours.	December 2023 performance 67% ED Reconfiguration: Fit to Sit, Majors Area ED/Acute Flow – Acute Referral Triage Urgent Care Response (UCR) Virtual Ward (VW)	Breakthrough Objective: Time to 1st Clinical Assessment		
Care of the elderly 	Emergency Admission of Patients with Frailty	To improve the health and wellbeing of our eldest and most frail patients by supporting care closer to home through the reduction in unnecessary emergency inpatient admissions and, for those who are admitted, ensure their length of stay is only as long as medically required.	1st Goal: To identify all patients with frailty by developing a suitable platform for recording and accessing Clinical Frailty Scores, and undertake more detailed evaluation of assessment admission pathways based on CFS data 2nd Goal: to reduce the overall number of patients with frailty who are admitted by improving access for all appropriate patients to early specialist review and intervention 3rd Goal: For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention	Implement clear process for accurate digital recording of CFS at first point of acute assessment. Explore digital means of obtaining this data Explore the CFS being a trigger for specific interventions and admission pathways eg therapist or Frailty expert attendance/contact Transformation of admission processes for patients with frailty including exploring specialist Geriatric and MDT rostering. Develop pathway for geriatrician-led MDT review of all surgical patients identified >65 of CFS >5 (NELA standard)			
Equitable & Timely 	Elective Recovery RTT	No patients waiting 18 weeks.	1st Goal : Specialties with 52 week waits to continue focus (T/O, Gynae, Gastroenterology) 2nd Goal: 18-51 weeks pathway breaches reduced to 7000 within 6 months (April 2024)	Wharfedale Theatres (TIF1) HDH Additional Theatres (TIF2) Outpatient Transformation Theatres Productivity			
	62 Day Cancer	Vision: No patient would wait longer than 62 days and 90% of	TBC	Develop workforce capability and expertise to better guide analyst time in creation of	April 2024 – 37 of 80 patients over 62 days		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
		our patients would commence treatment within 55 days.		stratified data dashboard for cancer waiting times Develop process for access for Power BI alignment to cancer data in Data Warehouse			

Breakthrough Objective: Time to first Clinical Assessment

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred Care	4 hour ED Wait Time	TBC				

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4 hour standard.	4 x 4 = 16	4 x 2 = 8	Clinical: Patient Safety	Cautious
CRR87	Community Dental	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.	3 x 4 =12	3 x 2 = 6	Clinical: Patient Safety	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

STRATEGIC AMBITION: MAKING HDFT THE BEST PLACE TO WORK 2024-2025

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture. Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'. We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT. We will offer everyone opportunities to develop their career at HDFT through training and education. We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

Teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

New ways of working

The right people, with the right skills, in the right roles

Growing for the future

Education, training and career development for everyone

GOVERNANCE:

People & Culture Framework

- Board Assurance: People & Culture Committee
- Programme Board: People & Culture Programme Board
- SRO: Director of People & Culture
- Operational Lead: Deputy Director of People & Culture

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. Staff Engagement Index
2. Staff Availability

Breakthrough Objective:	Vacancy Whole Time Equivalent (WTE)
Corporate Project:	N/A
Overarching Risk Appetite:	Workforce - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
At Our Best – Making HDFT the Best Place to Work	Looking After our people	Staff Engagement	Workforce: Cautious								
	Belonging										
	Growing for the future	Staff Availability	Workforce: Cautious								
	New ways of working										

Strategic Metrics Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Looking after our people  Belonging 	Staff Engagement Index	To continually improve out Employment Engagement score against the Pulse survey benchmark by having a framework for leaders and line managers which supports colleagues to bring their whole selves to work and that they belong, that they feel they can influence their role and suggest improvements and that hey feel their Health & Wellbeing is a key priority in the Trust	1. Increase quarterly survey response rate by 3% within 6 months and by 6% within 12 months 2. Increase positive responses to the survey questions feeding the overall engagement questions by 2% within 6 months and by 3% within 12 months 3, Validate the improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2023 survey results.	To have strong focus on all aspects of health and wellbeing to retain colleagues. To continue to develop employment practices and policies, which support colleague work life balance. To develop our leaders to ensure at compassionate and inclusive leadership is the accepted and expected leadership culture, in line with our KITE values. To be an organisation where everyone demonstrates KITE behaviours (Kindness, Integrity, Teamwork and Equality), to care for patients, children and communities who are the focus of everything we do. To build strong teams who support each other, work collaboratively and with collective goal of delivering excellent care to our patients. To promote equality and diversity so everyone is valued and recognised through the embedding of Equality Impact Assessments as expected practice, the continued development of our Staff Support networks, leadership development and training of all colleagues.			
Growing for the future 	Staff Availability	A vacancy gap which does not exceed **?** Class leading deployment (rostering) (need to define an aim). Sickness levels throughout HDFT to not exceed 2% Staff Turnover doesn't exceed a level of 5% All staff within HDFT feel valued, supported and happy with their work	Within 6 months reduce vacancy levels by 1.5% (preference for numerical rather than %) Within 12 months reduce vacancy levels by 3% (preference for numerical rather than %) 50% of wards deploying best practice workforce KPIs within 6 months 75% of wards deploying best practice workforce KPIs within 12 months	To plan and design our workforce as creatively as possible, to have the right number of skilled colleagues in the right roles. To recruit great colleagues by building a strong employer brand and implementing effective recruitment practices, making the best use of digital solutions. To continue with the implementation of e-rostering to ensure that safe staffing levels can be allocated and managed with maximum efficiency.	Breakthrough Objective: Vacancy WTE		

Workstream	True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
New Ways of Working 		Innovative roles developed and available and efficient routes to existing roles in place.	Within 6 months reduce sickness levels by 1% Within 12 months reduce sickness levels by 2% Within 6 months reduce staff turnover by 1.5% Within 12 months reduce staff turnover by 3%				

Breakthrough Objective: Vacancy Whole Time Equivalent (WTE)

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Growing for the Future	Staff Availability					

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR93	Risk to patient safety due to low staffing levels Risk to colleague health and wellbeing due to sustained work pressures	CRR93 emphasizes the risk to patient safety and colleague wellbeing due to low staffing levels, particularly in North Yorkshire's 0-19 Service. Challenges include high turnover, sickness rates, and difficulty recruiting Band 6 roles. Mitigation efforts include recruitment strategies, support for SCPHN students, and consultation for virtual team implementation.	4 x 3 = 12	4 x 1 = 4	Workforce	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

ENABLING AMBITION: DIGITAL TRANSFORMATION TO INTEGRATE CARE AND IMPROVE PATIENT, CHILD AND STAFF EXPERIENCE 2024-25

Digital technology is an essential part of delivering high quality healthcare, but it is also important to remember that it is a tool, not an end in itself. Our ambition at HDFT is provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience. Through digitisation we can also collect huge amounts of data about our services – we will increase our ability to create useful information which enables us to learn and continuously improve our services. Over the next few years, we intend to implement a new electronic health record which will revolutionise how we provide care.

GOALS:

Quality & Safety

Systems which enable staff to improve the quality and safety of care

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

An Electronic Health Record to enable effective collaboration across all care pathways

GOVERNANCE:

Digital Framework

- Board Assurance: Innovation Committee
- Programme Board: Digital Board / EPR Programme Board
- SRO: Executive Medical Director
- Operational Lead: Digital Information Officer

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. • Quality & Safety - TBC
2. • Information- TBC
3. • Electronic Health Record- TBC

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Digital Transformation	Quality & Safety	TBC	Operational: Cautious								
	Information	TBC	Operational: Cautious								
	Electronic Health Record	TBC	Operational: Cautious								

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
Quality & Safety 	Systems which enable staff to improve the quality and safety of care		Luna (RTT Tracking) eRostering Datix Cloud ASCOM Nurse Call (linked to Wensleydale Digital Exemplar Ward)			
Information 	Timely, Accurate Information to enable continuous improvement					
Electronic Health Record 	An Electronic Health Record to enable effective collaboration across all care pathways		New Electronic Patient Record Maternity Electronic Patient Record Single Sign On Laboratory Information Management System (LIMS) Scan4Safety Medicines Management (Omnicell) Somerset (Cancer Tracking) Outpatient Flow and eOutcomes Robotic Process Automation Yorkshire & Humber Care Record			

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

ENABLING AMBTION: HEALTHCARE INNOVATION TO IMPROVE QUALITY AND SAFETY 2024-25

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

GOALS:

Healthcare Innovation

To be a leading trust for the Testing, Adoption and Spread of Healthcare Innovation

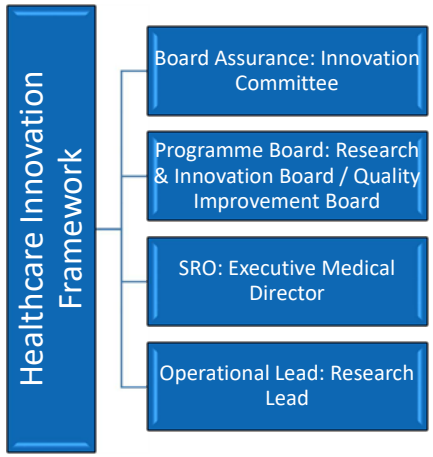
Children's Public Health

To be a leading trust for the Children's Public Health Services Research

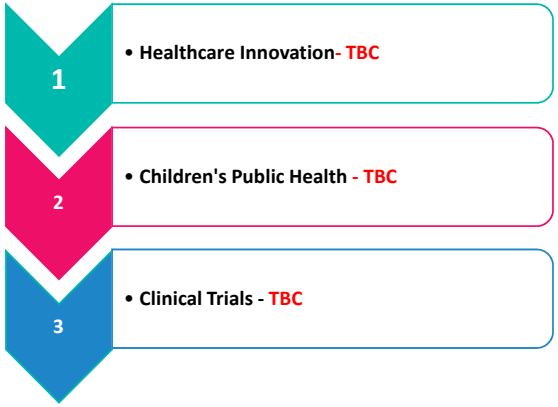
Clinical Trials

To increase access for patients to clinical trials through growth and partnerships

GOVERNANCE:



True North Metrics (Executive Lead: 10-15 Year deliverable)



Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Healthcare Innovation	Healthcare Innovation	TBC	Operational: Cautious			●	▬	▬			
	Children's Public Health	TBC	Operational: Cautious		●		▬	▬			
	Clinical Trials	TBC	Operational Cautious		●		▬	▬			

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
Healthcare Innovation 	To be a leading trust for the testing, Adoption and Spread of Healthcare Innovation	Establish HDFT Innovation Hub Develop robust innovation governance processes and pathway Develop workforce and create a culture of innovation Secure sponsorship and funding to support infrastructure Build key innovation partnerships Identify areas of unmet clinical need	To facilitate and accelerate the growth of innovative healthcare solutions in HDFT by: • establishing HDFT Innovation Hub; • building partnerships with industry; academia, government and voluntary sector; • developing robust innovation governance processes; • raising profile of innovation and developing workforce; • Generating income through sponsorship and grant applications	<u>Establish HDFT Innovation Hub</u> • Move into new hub – June 24 • HDFT Innovation Hub Launch event – Autumn 24 • Organise networking event with HNY-ICB IRIS – Oct 24 <u>Develop innovation governance procedures</u> • Test adoption process on innovative device – Oct 23 • Devise new adoption process for medical device – May 24 <u>Workforce development</u> • Deliver regular introductory innovation training events • Deliver innovation training programme – Feb 24 • Plan for 2nd cohort of training programme – Sept 24 <u>Secure sponsorship and funding to support infrastructure</u> • Secure sponsorship from industry – June 24 • Apply for funding from UK Share Prosperity Fund – Aug 24 <u>Build key partnerships</u> • WYAAT collaboration • IRIS <u>Identify areas of unmet clinical need</u> • Work with Health Innovation to proactively identify key priority areas and unmet needs		
Children's Public Health 	To be a leading trust for the Children's Public Health Services Research	Build the evidence base for Children's PH Services Improve outcomes for children Utilise extensive data from BaBi Harrogate	To understand Children's PH research and identify how we can contribute To provide opportunities for Children's PH services, and the children and families they support, to be involved in research studies	Identify and open research studies into children's public health Work with ICB to identify opportunities for data sharing and collaborative projects.		

True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
		study to further inform research children's PH research				
Clinical Trials 	To increase access for patients to clinical trials through growth and partnerships	To increase commercial research by 10% Develop academic partnerships Sustain Research Delivery Network (RDN) income Develop clinical leadership and comms strategy	To establish a clinical research facility (CRF) at HDFT To increase research workforce capacity To generate income through increase in commercial research Align with the strategy of the newly formed Research Delivery Network (RDN)	Develop plans for CRF Work with Skin Research Centre to develop further partnerships within University of York. Deliver HLO as outlined by RDN Appoint Clinical Lead for Research Work with hospital charity to support pilot studies Develop patient research ambassador scheme		

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2024-25

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing. At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality. As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

- Board Assurance: Resource Committee
- Programme Board: Environment Board
- SRO: Director of Strategy
- Operational Lead:XXxx

True North Metrics (Executive Lead: 10-15 Year deliverable)

1. • Wellbeing - TBC
2. • Quality & Safety - TBC
3. • Impact on the environment - TBC

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
An Environment that promotes wellbeing	Wellbeing	TBC	Operational: Cautious	
	Quality & Safety	TBC	Operational: Cautious	
	Environmental Impact	TBC	Operational: Cautious	

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Wellbeing 	A patient environment that promotes wellbeing		To improve the working environment for staff			
Quality & Safety 	An environment and equipment that promotes best quality, safest care		Aseptics ED2 (UTC) Reconfiguration Wensleydale Ward Refurbishment RAAC – Block C, Therapies HDH New Theatres, Treatment Rooms and Ward (TIF2) Imaging Reconfiguration CT Business Continuity			
Environmental Impact 	Minimise our impact on the environment		Delivery of the Trust "Green" Plan SALIX Carbon Reduction Programme Travel Plan			

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR75	CHS1 – Health & Safety: Identification & Management of risk.	There is a risk of incidents arising and a risk of failure of compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health & safety of employees, patients and others.	4 x 3 = 12	4 x 2 = 8	Operational: Health & Safety	Minimal
	CHS2 – Health & Safety: HDH Goods Yard	Risk of major injuries, fatality or permanent disability to employees, patients and others due to a failure to comply with legislative requirements.	4 x 3 = 12	4 x 1 = 4	Operational: Health & Safety	Minimal
	CHS3 – Health & Safety: Managing the risk of injury from fire.	Risk of major injuries, fatality or permanent disability to employees, patients and others due to a failure to comply with legislative requirements.	5 x 3 = 15	5 x 2 = 10	Operational: Health & Safety	Minimal

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	CHS5 – Health & Safety: Violence & Aggression against Staff	Risk of major injuries, fatality or permanent disability to employees, patients and others due to a failure to comply with legislative requirements including a lack of suitable control measures and training.	4 x 4 = 16	4 x 2 =8	Operational: Health & Safety	Minimal
	CHS8 – Health & Safety: RAAC Roofing	Risk of major injuries, fatality or permanent disability to employees, patients and others due to a failure to comply with legislative requirements.	4 x 5 = 20	4 x 2 = 8	Operational: Health & Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					

STRATEGIC AMBITION: OVERARCHING FINANCE 2024-2025

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:

Financial Framework

- Board Assurance: Resource Committee
- Programme Board: XXXX
- SRO: Director of Finance
- Operational Lead: Deputy Director of Finance

True North Metrics (Executive Lead: 10-15 Year deliverable)

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- **Financial Sustainability**

Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Financial - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Finance	**Financial Sustainability**	**Financial Sustainability**	**Financial: Cautious**								

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	A positive reserve balance to allow investment. Achievable CIP program. Acute contract offer covers inflationary pressures (including pay award uplifts).				

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR71	Agency Usage	If the Trust continues to incur premium costs for staffing where vacancies exist, there is a risk it will exceed the agency price cap for the financial year. The consequence of this will be a breach of regulations and a negative impact on overall financial position.	3 x 4 = 12	3 x 3 = 9	Financial: revenue, funding & liquidity	Cautious
CRR76	Underlying Financial Position	If the current in year performance continues as is, the Trust will continue to increase its year to date deficit and therefore not reach its projected breakeven position. Over the longer term, this will result in the overall financial position of the Trist being effected which will affect the financial standing of the Trust.	3 x 5 = 15	1 x 5 = 5	Financial: revenue, funding and liquidity	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
ICB	TBC					