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	July 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. Target date adjusted in July 24 in line with backlog maintenance work.

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 and reduced to 10 in June 24.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS2: HDH Goods yard	Appetite	Initial Rating	June Rating	July 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	March 25

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 Outline costs and plans were included in paper to Environment Board 28/5/24 as part of plans for Backlog Maintenance work in 24/25	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 Programme outline being developed with Contractor to allow ongoing use of the Goods Yard during construction activity.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS3: Managing the risk of injury from fire	Appetite	Initial Rating	June Rating	July 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. Fire Manager position is being recruited to, recruitment process ongoing. Oakleaf is carrying out risk assessment process; this will continue to be monitored by Fire Safety Group and reported to H&S Committee. Fire Safety Group to review current position (next meeting 10/7/24) and advise on actions needed.	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. Evacuation procedures to be escalated, training to clinical teams, including simulated exercise at extended SMT workshop – workshop taking place at extended SMT in July New Monthly Acute and Community Fire Checklist being produced to completed by all teams / departments / community location Recommendations of the Fire Authority being actioned Meetings to be held with clinical teams to progress the creation of suitable evacuation plans Backlog Maintenance paper for 24/25 to Environment Board to include the following fire related works: Basement compartmentation, Fire damper remedial, Main entrance remedial, upgrades to fire doors included in mini theatre refurbs. Outline proposal has been agreed, detailed costs and programme plan being developed, expected by early July

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS5: Violence and aggression against staff	Appetite	Initial Rating	June Rating	July 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	12	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 • Compliance with training is being monitored and reported to exec risk review • August H&S committee will review this risk to and introduce a separate security entry • Security policies and procedures / physical security presence on site / Lockdown procedures / Bomb Alert / Community Support / Theft are to be reviewed	• H&S led task and finish group • Changes to mental health triage work in ED being made – to be reflected in new Managing Patients who may self-harm / those suffering with mental health issues Policy • Ligature assessments and training to be reviewed • Development new course content for Conflict Resolution Training – with Provider (GoodSense) • Plan to have 3 levels of training available to staff based on level of risk: Conflict Resolution Level 1 (e-learning), CR Breakaway Skills, and CR Physical Restraint with content to be brought in line with CQC supported Restraint Reduction Network. • Domestic Abuse and Sexual Violence, and Sexual safety in the workplace – view to include this as part of the Violence Prevention and Reduction Strategy • Review of Lockdown Policy and Bomb Alert Policies • New Trust wide risk assessment developed, now being used to inform team/department risk assessments as part of new risk assessment process being implemented across the Trust – Work continues on Risk assessments within all directorates

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	June Rating	July Rating	Target Rating	Target Date
CRR93: Health Visitor workload and staffing levels	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 Procedure for management of Universal caseloads written, will be presented to 0- 19 Learning and Best Practice Group 10/7/24 Action and recovery plan in place • Ongoing recruitment and retention work as part of the Workforce workstream and recruitment strategy • Ongoing transformation re Virtual Delivery Team, mobilisation plan for team implementation 1/9/24 is underway • Consideration of roll out of Optima to whole servi

	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	July 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**

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CRR34**: Autism Assessment	Appetite	Initial Rating	June Rating	July 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	March 25

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	June Rating	July 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 new national target for 24-25 is 78%. Whilst we delivered 78% in March, performance deteriorated in April to 72.47% and has sustained that performance level in May and June (with fluctuations of less than 1%)

	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	Mar 24	April 24	May 24	June
Type 1 & 3	63%	72%	81%	78%	83%	81%	80%	82%	73%	65%	70%	68.7%	66.9%	71.1%	71.8%	78%	72%	73%	72%

12 hour DTA rates have comtinued to fall in June as have ambulance handover delays > 30 mins

12 hour waits

	12 Hour DTA	12 Hour total wait
September 23	1	119
October 23	14	167
November 23	46	226
December 23	71	332
January 24	124	344
February 24	42	202
March 24	35	138
April 24	66	238
May 24	54	282
June 24	31	237

We now record ambulance delays using YAS data and ambulance delays are a care group driver metric. The ED Tri management team are measuring the % patients arriving by Ambulance where handover is complete within 30 minutes. The data source is YAS.

Month	Arrivals	30 Min HO	60+ Min HO
February 24	1173	215	70
March 24	1243	190	54
April 24	1139	208	80
May 24	1262	198	68
June 24	1124	193	49

Controls and Plans to implemented

ED 4 hour standard = Trust True north objective.

Focussed HDFT Impact work at directorate, care group and ED front line level

Internal professional standards to be relaunched to support more timely specialty review;

Focussed work to ensure all patients receive an initial triage within 15 minutes of arrival

More focussed support to stream more effectively to SDEC and ED2.

EPIC internal training re standardised working planned for June

Proposal to support additional admission beds and SAU ring fence

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

Summary in Month:
This area of the Corporate Risk Register is linked to the Use of Resources Domain.
Delivery of financial plan 24-25 was raised to the register in June 24

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	June Rating	July Rating	Target Rating	Target Date
CRR94 Delivery of financial plan	Overarching Finance	Financial	The Trust achieved a breakeven plan in 23/24 however for the Trust to deliver the 24/25 plan, £5.2m deficit, it will require a reduction to current run rate and delivery of the waste reduction and productivity program	**Cautious**	9	12	12	6	**March 25**

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Monthly financial reporting **2. NHSE productivity analysis** **3. Agency Expenditure** **4. Cash position**	The Trust has reviewed and established the underlying pressure moving into 24/25, £20.1m. Following further scrutiny across the wider system, the system agreed to a higher efficiency % target and an allocation of further funding. This has resulted in a £5.2m deficit plan for 24/25 which includes a 6% efficiency target. There are a number of risks contained within this plan including • Continued ED boundary divert • Inflation above the levels included in planning • Recurrent delivery of the efficiency programme • ERF Funding is achieved/over delivered The Directorate highlighted a number of issues when signing budget plans for 24/25. A number of mitigations are being reviewed to manage these. **The current run rate is having a detrimental impact on the cash balance. Cash support will be required throughout the year if the reduction in run rate is not delivered. Current cash forecast highlights that this will be required in Qtr 3 (Oct-Dec)**	1. Continued discussions with ICB. 2. Efficiency becoming a Corporate programme. Targeted Directorate training and support have been delivered to all Directorates. 3. WRAP Champions to be developed across the Trust.

Harrogate and District NHS Foundation Trust Corporate Risk Register

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	June Rating	July Rating	Target Rating	Target Date
CRR95 NHS Pay awards	Overarching Finance	Financial	Ability of Local Authorities to fund the impact of NHS pay award could result in a cost pressure for HDFT. The Public Health Grant for 2024/25 varies by Local Authority. While NHS national guidance suggests that the Public Health Grant has been uplifted to cover both the ICB non recurrently funded 2.9% from the 2023/24 pay award and the 2.1% proposed pay award for 2024/25 this appears not to be the case for all the Local Authorities we have contract with. Where there is a gap between LA public health grant and the cost of pay award there is a risk HDFT could be left with a financial pressure	**Cautious**	**12**	**12**	**12**	**4**	**March 25**

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Written confirmation of funding for pay awards received from LA. Revised workforce model agreed and signed off by LA and HDFT	Written to all LA making them aware of the 2.9% pay award that now needs to be funded by them and also the proposed 2.1% in the planning guidance for 24/25. Finance have provided them with the cost and meetings are ongoing to discuss funding. Meetings being held with LA's to work through Public Health Grant allocations and cost of NHS pay awards. Monthly meeting with Directorate, Contracting and Finance set up to agree next steps based on feedback from LA's. Position being tracked with update as below A breakdown of non-recurrent 23/24 and planning guidance 24/25 that has been agreed by service has been provided to Exec risk review.	Where it has already been confirmed that the LA cannot afford any 24/25 pay award we will need to revise the model to mitigate any cost pressure. This will be done in partnership between HDFT and the relevant LA. Once the 24/25 pay award confirmed need to calculate any impact and share with LA Where this results in LA being unable to fund the 24/25 pay award we will need to meet. Where the LA cannot afford the additional cost we will need to revise the model. This will be done in partnership between HDFT and the relevant LA

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	July 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	June Rating	July 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 No of overdue continuing care patients. **Current position – 2230 patients overdue. Longest waiter - 4 years overdue.**	. 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. 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. Key actions for July are the continued focus on recruitment for clinical lead following resignation, the continued input into the IT procurement and recruitment process for additional dental leavers. To support the CDS team, we have recommended that they go forward with HDFT Impact work in phase 4 as we recognised the low staff engagement score in the service is a key risk to service delivery.	ICB liaison Waiting list initiative (WLI) clinic sessions for the financial year ongoing – 2 GA sessions ran in April and 1 a month is planned from July to March. Progression of the SOEL Health dental IT system replacement – procurement has commenced. SOEL is not supported from April 2024 onwards. Delays to procurement process, following no provider meeting essential criteria from procurement process. Capital kit replacement progressed – dental chairs and X-ray kit etc. 2023/24 capital replacement kit ordered and due to be delivered/installed. Recruitment of additional staffing. Good progress with dentist and dental nurse appointments however majority of contract start dates agreed until now are for September 24.

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	**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.
Executive Committee	Senior Management Committee (SMT)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	March 24	

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**

HDFT Trust IBR – static view for June 2024

Live view:

INTEGRATED BOARD REPORT - Power BI

Integrated Board Report – Breakthrough Objectives – In Breach

- None to report

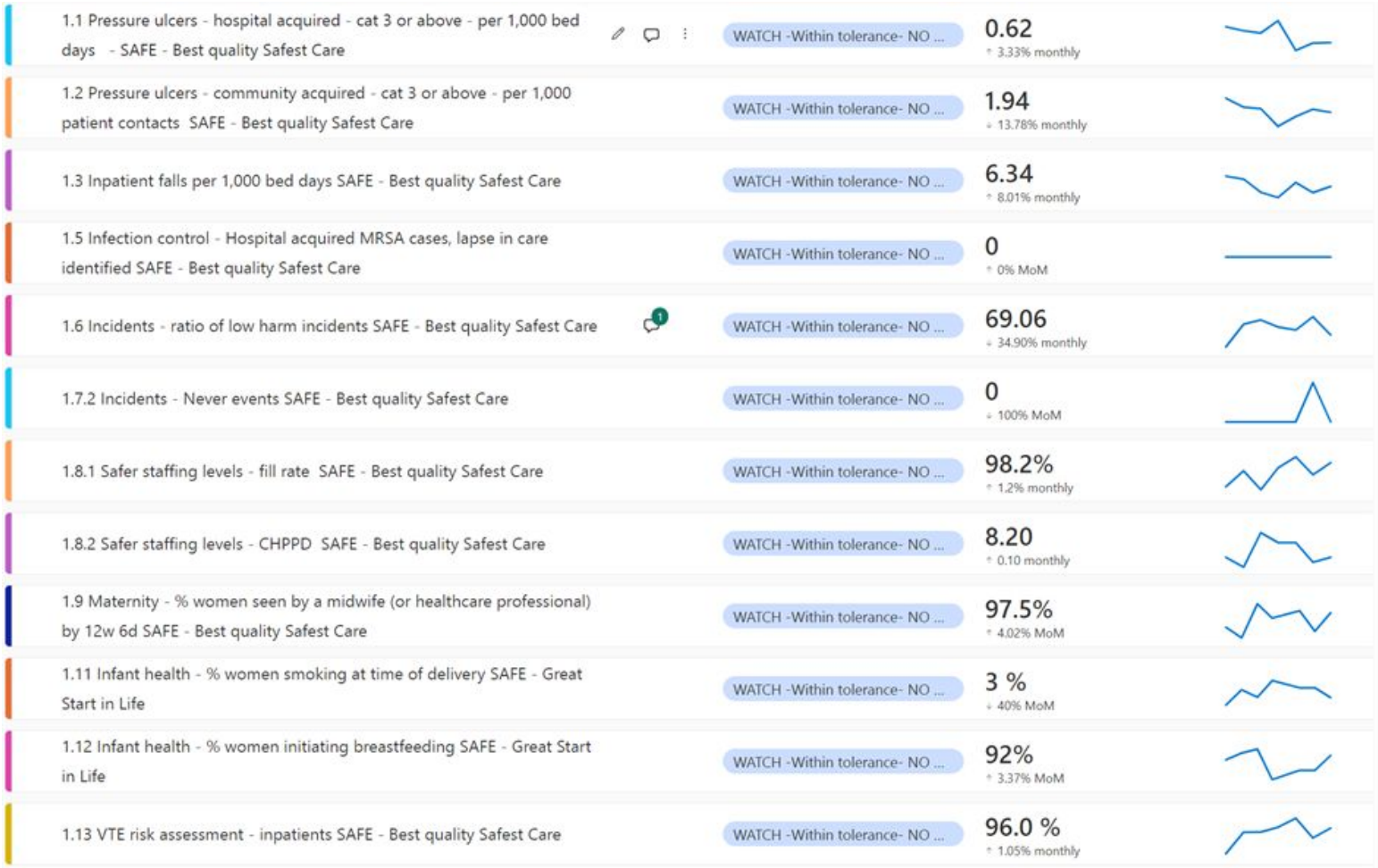
Integrated Board Report – Breakthrough Objectives – Stable

62 day wait for first treatment from urgent GP referral to treatment RESPONSIVE - Breakthrough Obj- Best Quality and Safest Care	BO DRIVER - Stable or Improving	51 ↓ -15 monthly	
Staff Availability - Breakthrough Obj - Person Centred, Integrated Care; Strong Partnerships	BO DRIVER - Stable or Improving	96% ↑ 0.29% MoM	
Moderate Harm and above - Breakthrough Obj - Best Quality and Safest Care	BO DRIVER - Stable or Improving	18 ↑ 63.64% monthly	
Improved ED Waiting Times - Number of patients waiting longer than 90 mins for clinical assessment by a clinical decision maker - Breakthrough Obj - Best	BO DRIVER - Stable or Improving	324 ↓ -39 monthly	
RTT - percentage of patients on an RTT pathway under 18 weeks - Breakthrough Obj - Best Quality and Safest Care	BO DRIVER - Stable or Improving	64% ↓ -1.6% monthly	

Integrated Board Report – Watch Metrics – In Breach

1.4 Infection control - Hospital acquired C.difficile cases, lapse in care identified SAFE - Best quality Safest Care	WATCH -SPC Breach - refer to b...	5	↑ 150% MoM
1.7.1 Incidents - comprehensive serious incidents (SI) SAFE - Best quality Safest Care	WATCH -SPC Breach - refer to b...	1	↑ 0% MoM
2.2.2 Complaints - % responded to within time CARING - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	76%	↑ 94.87% MoM
3.4 Returns to theatre EFFECTIVE - Best Quality Safest Care	WATCH -SPC Breach - refer to b...	13	↑ 333.33% MoM
4.1 Appraisal rate - Non Medical and Medical Staff WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	81 %	↓ 1.22% MoM
5.6 A&E 4 hour standard RESPONSIVE -Best Quality Safest Care	WATCH -SPC Breach - refer to b...	72.6 %	↑ 1.71% MoM
6.1 Agency spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	£374.00K	↓ 17.07% MoM
6.2 Surplus/ Defecit and variance to plan EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	-£ 3.92M	↓ 77.64% MoM
6.4 Cash balance EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	4.54M	↓ 60.81% MoM
7.1 GP Referrals against 2019/20 baseline ACTIVITY - Person Centred, Integrated Care; Strong Partnerships	WATCH -SPC Breach - refer to b...	111%	↑ 5.71% MoM

Integrated Board Report – Watch Metrics – Within Tolerance (1)

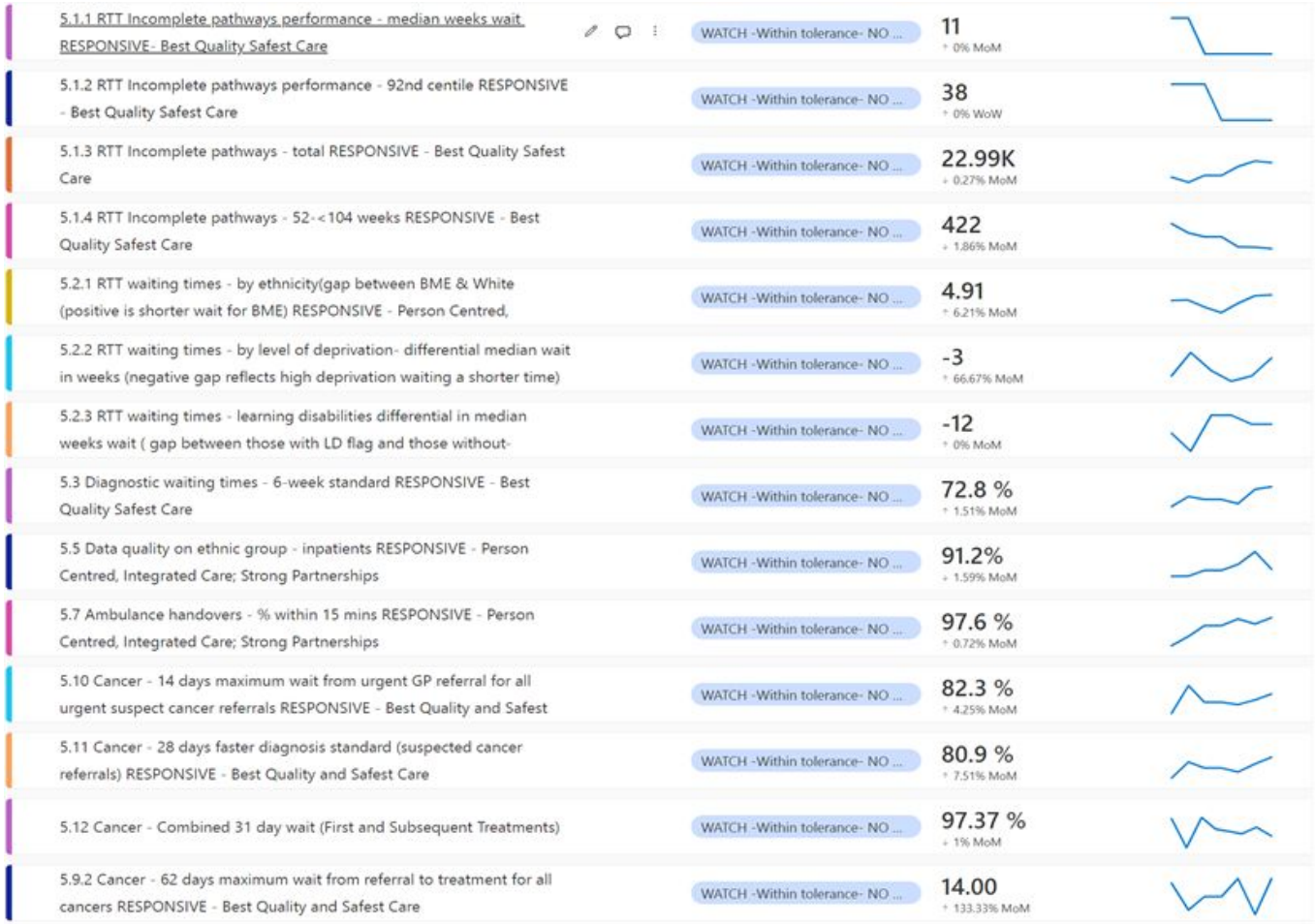


1.1 Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days - SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	0.62	↑ 3.33% monthly
1.2 Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	1.94	↓ 13.78% monthly
1.3 Inpatient falls per 1,000 bed days SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	6.34	↑ 8.01% monthly
1.5 Infection control - Hospital acquired MRSA cases, lapse in care identified SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	0	↑ 0% MoM
1.6 Incidents - ratio of low harm incidents SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	69.06	↓ 34.90% monthly
1.7.2 Incidents - Never events SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	0	↓ 100% MoM
1.8.1 Safer staffing levels - fill rate SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	98.2%	↑ 1.2% monthly
1.8.2 Safer staffing levels - CHPPD SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	8.20	↑ 0.10 monthly
1.9 Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	97.5%	↑ 4.02% MoM
1.11 Infant health - % women smoking at time of delivery SAFE - Great Start in Life	WATCH -Within tolerance- NO ...	3 %	↓ 40% MoM
1.12 Infant health - % women initiating breastfeeding SAFE - Great Start in Life	WATCH -Within tolerance- NO ...	92%	↑ 3.37% MoM
1.13 VTE risk assessment - inpatients SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	96.0 %	↑ 1.05% monthly

Integrated Board Report – Watch Metrics – Within Tolerance (2)

1.14 Sepsis screening - inpatient wards SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	96%	+ 1.05% MoM
1.15 Sepsis screening - Emergency department SAFE - Best quality Safest Care	WATCH -Within tolerance- NO ...	92%	+ 1.08% MoM
2.1.1Friends & Family Test (FFT) - All Patients CARING - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	93%	+ 1.09% MoM
2.1.2 Friends & Family Test (FFT) - Adult Community Services CARING - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	94%	+ 2.17% MoM
2.2.1 Complaints - numbers received CARING - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	23	+ 21.05% MoM
3.2 Mortality - SHMI EFFECTIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	0.990	+ 0.30% MoM
3.3.1 Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions EFFECTIVE - Best	WATCH -Within tolerance- NO ...	3.7%	+ 12.12% MoM
3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions EFFECTIVE- Best	WATCH -Within tolerance- NO ...	7.2%	+ 16.28% MoM
3.5 Delayed Transfer of Care - % inpatients not meeting the criteria to reside EFFECTIVE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	19%	+ 9.52% MoM
4.2 Mandatory and Essential Skills Training rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	91 %	+ 0% MoM
4.3 Staff sickness rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	5 %	+ 0% MoM
4.4 Staff turnover rate WORKFORCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	0.12	+ 0% MoM
4.5 Vacancies WORKFORCE -Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	5 %	+ 25% MoM

Integrated Board Report – Watch Metrics – Within Tolerance (3)

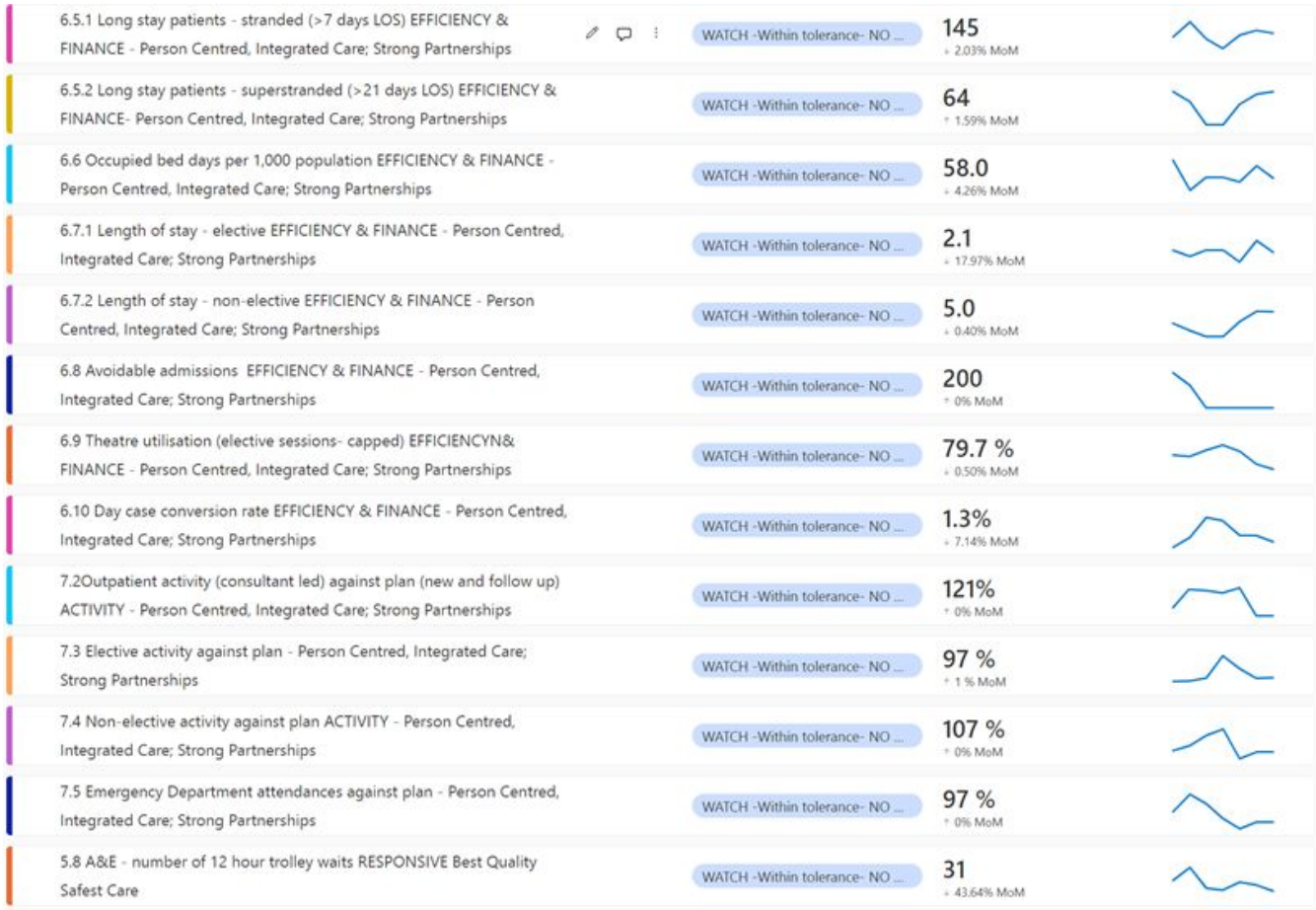


5.1.1 RTT Incomplete pathways performance - median weeks wait RESPONSIVE- Best Quality Safest Care	WATCH -Within tolerance- NO ...	11	0% MoM
5.1.2 RTT Incomplete pathways performance - 92nd centile RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	38	0% WoW
5.1.3 RTT Incomplete pathways - total RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	22.99K	0.27% MoM
5.1.4 RTT Incomplete pathways - 52-<104 weeks RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	422	1.86% MoM
5.2.1 RTT waiting times - by ethnicity(gap between BME & White (positive is shorter wait for BME) RESPONSIVE - Person Centred,	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)	WATCH -Within tolerance- NO ...	-3	66.67% MoM
5.2.3 RTT waiting times - learning disabilities differential in median weeks wait (gap between those with LD flag and those without-	WATCH -Within tolerance- NO ...	-12	0% MoM
5.3 Diagnostic waiting times - 6-week standard RESPONSIVE - Best Quality Safest Care	WATCH -Within tolerance- NO ...	72.8 %	1.51% MoM
5.5 Data quality on ethnic group - inpatients RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	91.2%	1.59% MoM
5.7 Ambulance handovers - % within 15 mins RESPONSIVE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	97.6 %	0.72% MoM
5.10 Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals RESPONSIVE - Best Quality and Safest	WATCH -Within tolerance- NO ...	82.3 %	4.25% MoM
5.11 Cancer - 28 days faster diagnosis standard (suspected cancer referrals) RESPONSIVE - Best Quality and Safest Care	WATCH -Within tolerance- NO ...	80.9 %	7.51% MoM
5.12 Cancer - Combined 31 day wait (First and Subsequent Treatments)	WATCH -Within tolerance- NO ...	97.37 %	1% MoM
5.9.2 Cancer - 62 days maximum wait from referral to treatment for all cancers RESPONSIVE - Best Quality and Safest Care	WATCH -Within tolerance- NO ...	14.00	133.33% MoM

Integrated Board Report – Watch Metrics – Within Tolerance (4)

5.13.1 Children's Services - 0-12 months caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	1.92K	↑ 5.15% MoM
5.13.2 Children's Services - 2-3 years caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	2.04K	↓ 5.11% MoM
5.14 Children's Services - Safeguarding caseload RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	1.21K	↓ 12.41% MoM
5.15 Children's Services - Ante-natal visits RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	92.8%	↑ 2.57% MoM
5.16 Children's Services - 10-14 day new birth visit RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	89.2%	↓ 2.19% MoM
5.17 Children's Services - 6-8 week visit RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	93.4%	↓ 0.32% MoM
5.18 Children's Services - 12 month review RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	99%	↑ 1.23% MoM
5.19 Children's Services - 2.5 year review RESPONSIVE - Great Start in Life	WATCH -Within tolerance- NO ...	95.7%	↑ 1.70% MoM
5.23 Community Care Adult Teams - performance against new timeliness standards RESPONSIVE- Person Centred, Integrated Care;	WATCH -Within tolerance- NO ...	86%	↓ 6.52% MoM
5.27 Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation RESPONSIVE- Best Quality Safest	WATCH -Within tolerance- NO ...	30 %	↑ 7.14% MoM
5.28 Home visit: Face to face consultations started for URGENT cases within 2 hrs RESPONSIVE Best Quality Safest Care	WATCH -Within tolerance- NO ...	84.6 %	↓ 7.74% MoM
6.3 Capital spend EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	£1.86M	↑ 89.53% MoM

Integrated Board Report – Watch Metrics – Within Tolerance (5)



6.5.1 Long stay patients - stranded (>7 days LOS) EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	145	+ 2.03% MoM
6.5.2 Long stay patients - superstranded (>21 days LOS) EFFICIENCY & FINANCE- Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	64	+ 1.59% MoM
6.6 Occupied bed days per 1,000 population EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	58.0	+ 4.26% MoM
6.7.1 Length of stay - elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	2.1	+ 17.97% MoM
6.7.2 Length of stay - non-elective EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	5.0	+ 0.40% MoM
6.8 Avoidable admissions EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	200	+ 0% MoM
6.9 Theatre utilisation (elective sessions- capped) EFFICIENCYN& FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	79.7 %	+ 0.50% MoM
6.10 Day case conversion rate EFFICIENCY & FINANCE - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	1.3%	+ 7.14% MoM
7.2Outpatient activity (consultant led) against plan (new and follow up) ACTIVITY - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	121%	+ 0% MoM
7.3 Elective activity against plan - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	97 %	+ 1 % MoM
7.4 Non-elective activity against plan ACTIVITY - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	107 %	+ 0% MoM
7.5 Emergency Department attendances against plan - Person Centred, Integrated Care; Strong Partnerships	WATCH -Within tolerance- NO ...	97 %	+ 0% MoM
5.8 A&E - number of 12 hour trolley waits RESPONSIVE Best Quality Safest Care	WATCH -Within tolerance- NO ...	31	+ 43.64% MoM

3

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2023/24

Contents

Abbreviations

HCAI	Healthcare associate infection
IPCT	Infection Prevention and Control Team
ICD	Infection Control Doctor
DIPC	Director Infection Prevention Control
IPCC	Infection Prevention Control Committee
QGMG	Quality Governance Management Group
QC	Quality Committee
SMT	Senior Management Team
IBR	Integrated Board Report
APSG	Antimicrobial Prescribing Sub-Group
APC	Area Prescribing Committee
CEF	Clinical Effectiveness Forum
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
UKSHA	UK Security Heath Agency
NHSE	National Health Service Executive
LTUC	Long Term Unscheduled Care
HiF	Harrogate Integrated Facilities
CC	Children and County Wide
PSC	Planned and Surgical Care

1.0 Introduction

Harrogate and District NHS Foundation Trust recognises that effective prevention of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients.

This annual report covers the period 1st April 2023 to 31st March 2024 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

The ten criteria of the Health Act are below and will be discussed in more detail in the next section of this report.

Criterion	Detail
1	There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance
4	Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individuals care and provider organisations that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.0 Criterion 1

There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them

Hospital Infection Prevention and Control Team

The Hospital Infection Prevention and Control Team (IPCT) provide advice and training on all aspects of infection prevention and control (IPC) to the Trust Directorates, wards, departments and Harrogate Integrated Facilities (HIF).

The members of the Hospital Infection Prevention and Control Team are as follows:

Role	Role holder	Responsibility
Director of Infection Prevention and Control (DIPC)	Dr Jaqueline Andrews (Executive Medical Director)	Executive authority and responsibility for the development and delivery of the Trust's IPC strategy
Deputy DIPC	Jenny Nolan (Deputy Chief Nurse)	Supports and deputises for the DIPC
IPC Matron	Sonya Ashworth	Manages the IPC team
Infection Control Doctor (ICD)	Dr Lauren Heath	Clinical IPC support and leadership
Consultant Medical Microbiologists	Dr Katharine Scott Dr Richard Hobson (retired Feb 24) Dr Sarah Drake Dr Alison Muir (starts Sept 24)	Deputises for the ICD
IPC Team Lead	Amanda Gooch	Operational management of the IPC team
IPC Specialist Nurses (3.2 WTE)	Iona Goodwin Jane Cozens Leisa Mark Sheeba Sojan	Provide specialist advice on all aspects of IPC
IPC Support Nurse (0.4 WTE)	Gillian Mitchell	Routine review of patients with transmissible infection
IPC Clinical Support Worker (0.6 WTE)	Post starting September 2024	IPC audit programme, delivering IPC education to non-registered staff
IPC Admin and Surveillance Officers (2.0 WTE)	Chris Richardson Karina Hess	Data collection, mandatory external data reporting & surveillance of transmissible infection.
Ward Hygienists	James Wightman Rafal Gasiorowski	Carry out specialist cleaning of patient equipment and environment

Changes to the team 2023-24:

Dr Richard Hobson (Consultant Microbiologist and former ICD) retired at the end of February 2024. Dr Alison Muir has been successfully appointed as his replacement and will be joining us from September 2024.

Christine Brown (IPC educator) and Anne Hampton (IPC admin support) have both left this team this year. A new Band 3 role has been created which will be centred on providing support with IPC audit activities and delivering education to non-registered staff.

External Reviews

- Invited Review: Surgical Site Infection Prevention in elective hip and knee replacement and fracture. Professor Mike Reed - July 2023 (see Section 6.0)

Infection Prevention and Control Committee

The Trust Infection Prevention and Control Committee (IPCC) is held monthly and is chaired by the DIPC. (Appendix 1 – Terms of Reference for IPCC, Appendix 2 - meeting record for 2023/24).

The IPCC is responsible for maintaining the IPC Board Assurance Framework and the IPC risk register. The IPCC is responsible for the monthly review of IPC performance across the Trust. (Appendix 3 – IPC Board Assurance Framework)

The IPCC reports to Quality Committee (QC), which is chaired by a Non-Executive Director (NED). Infection Prevention and Control is a standing agenda item at this committee and IPC are represented by the DIPC. QC has responsibility for obtaining assurance that the Trusts IPC service is meeting the Standards set out in the Code of Practice. Assurance is provided through the monthly IPC report and Trust Integrated Board Report (IBR).

IPCC is also directly linked into the Quality Governance Management Group (QGMG). The monthly IPC report is presented at this meeting.

In addition to the routine work carried out by the IPC team there is an annual plan of work, which describes the quality improvement objectives for the year. The plan of work for 2023-24 can be viewed in Appendix 4.

The work plan consisted of 26 separate pieces of work. 22 (84%) have been completed and 4 items have been rolled over to next year's plan. This is a great achievement, especially as the team also took part in the National HCAI & AMS Point Prevalence Survey in the autumn of 2023.

Trust Board

The Code of Practice requires that the Trust Board have a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at the Trust. The Trust has a designated DIPC and this role is undertaken by the Medical Director who attends Trust Board meetings with detailed updates on IPC performance and matters.

Antimicrobial Prescribing Sub-Group (APSG)

The Antimicrobial Prescribing Sub-Group (APSG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The group meets bi-monthly and is chaired by the Trust Lead for Antimicrobial Stewardship. The Antimicrobial Medicines Code describes the Trusts policy for antimicrobial stewardship. APSG is responsible for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews. To realign the antimicrobial stewardship work more closely with IPC, APSG now reports directly to IPCC. APSG produces a biannual report to the IPCC demonstrating compliance with the Code of Practice.

Decontamination Committee

The Trusts Decontamination Lead is the Chief Operating Officer. The management of Decontamination and compliance is overseen by the Decontamination Committee, which also now reports directly to IPCC. The Chair of the Decontamination Committee produces a quarterly assurance report for IPCC.

Water and Ventilation Safety Group

The Trust has a multi-disciplinary Water and Ventilation Safety Group. It is chaired by the Deputy Director of Estates and meets bi-monthly. The ICD represents the IPCT on this group. This group produces a quarterly assurance report for IPCC.

Harrogate Integrated Facilities (HIF): Cleanliness and Estate Services

Harrogate Integrated Facilities is a wholly owned subsidiary of Harrogate and District NHS Foundation Trust (HDFT). Cleaning and maintenance of the patient environment is the responsibility of HIF. The Trust has implemented the National Standards for Cleanliness.

Infection Prevention and Control Assurance

To demonstrate compliance with the Trust IPC Policies there is an IPC programme of audit in place. The audits are undertaken by both the clinical and IPC teams and are summarised in the table below.

Compliance with completion of the monthly General IPC audit has improved this year with an average compliance figure of 90.1% over 12 months.

Table 1.0

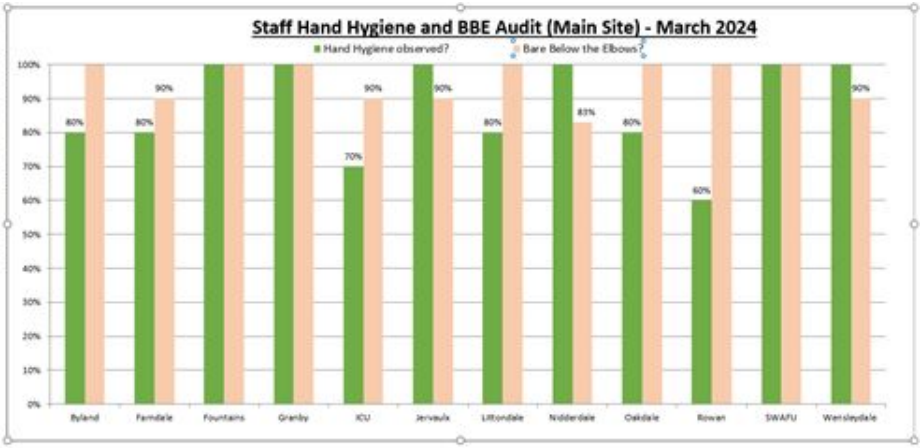
Audit	**Completed**	**Average Overall score April 2023 –March 2024 (all directorates)**
General IPC Inspection (including hand hygiene)	Monthly	95.7%
Commode	Monthly	98.7%
Cannula Insertion	Monthly	84.4%

Audit results are reviewed at the monthly IPC team meeting. Where issues are identified, an action plan is devised by the IPCT and fed-back to the Matron and Ward/Department Manager. Wards/Departments of concern are escalated to the IPCC.

Hand Hygiene Audits

Hand hygiene audits are included in the monthly general IPC inspection, which includes staff and patient hand hygiene. The IPC team undertook an independent Hand Hygiene and Bare Below the Elbows (BBE) Audit in March 2024. Overall, the results demonstrated a high level of compliance especially with BBE. Results were shared with Directorates. The IPC team have decided to make Hand Hygiene and "Gloves off" their leading educational campaign for 2024-25.

Ward	Hand Hygiene observed?	Bare Below the Elbows?
Byland	80%	100%
Farndale	80%	90%
Fountains	100%	100%
Granby	100%	100%
ICU	70%	90%
Jervaulx	100%	90%
Littondale	80%	100%
Nidderdale	100%	83%
Oakdale	80%	100%
Rowan	60%	100%
SWAFU	100%	100%
Wensleydale	100%	90%



Healthcare Associated Infection Surveillance (including mandatory reporting)

The IPC team continues to monitor all alert organisms (defined as organisms of IPC significance). A business case for an automated surveillance system has been written. A meeting was held between IPC and the Trust Digital team. The project will be given a priority score and presented at the Digital Strategy Board. It is expected this will not be a high priority project for the Trust at present.

Clostridioides difficile

Clostridioides difficile (*C.difficile)* is a bacterium found in the gut, which can cause diarrhoea after receiving antibiotics, particularly broad-spectrum antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. The bacterium is capable of forming spores, which are very resistant and can survive in the environment for prolonged periods. The spores require effective (sporicidal) cleaning products to remove them from the environment and prevent transmission to others.

The Trust reports all cases of *C.difficile* diagnosed in the laboratory to Public Health England via the national Data Capture System (DCS). Every Trust is given a threshold level, which it should not exceed over the course of one year. The Harrogate threshold level for *C.difficile* in 2023/24 was 26.

At the end of March 2024, there were 32 cases of *C.difficile* apportioned to the Trust. This means we exceeded our threshold by 6 cases, however following post-infection review (PIR) the vast majority of cases (91%) were deemed unavoidable. PIR's are subject to external scrutiny by the ICB at the monthly HCAI review meeting.

It is the role of the ICB to determine if there have been any lapses in care. There are two types of lapses in care, 1. Contributory lapse in care, this is where as a result of inappropriate action (usually inappropriate antimicrobial prescribing or patient placement) the patient has acquired *C.difficile*. 2. Non-contributory lapse in care, this is where our action has not directly resulted in the acquisition of *C.difficile* infection but it did not represent "best" care.

In 2023-24 we have maintained a very low number of avoidable cases, antibiotic prescribing errors are unchanged but remain uncommon. It is very positive to see that we have significantly reduced the delay in isolation despite sustained high bed occupancy levels across much of the year. This year we have not had any patients experience a delay in starting C.difficile treatment, which is testimony to our Pharmacy colleagues who have ensured C.difficile treatment is readily accessible out of hours.

Table 2.0

ICB Decision	Number (%) 2023-24	Number (%) 2022-2023	Number (%) 2021-2022
Avoidable	3 (9%)	2 (7.4%)	4 (11%)
Unavoidable	29 (91%)	25 (92.6%)	33 (89%)

Table 3.0

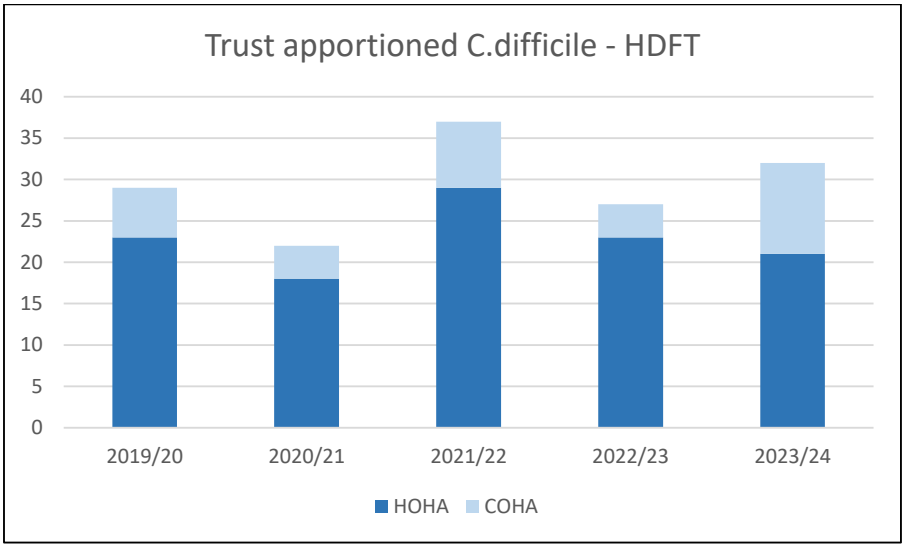
Lapse in care (avoidable cases)	Number (%) 2023-24	Number (%) 2022-2023	Number (%) 2021-2022
Inappropriate antibiotic prescribing	2 (67%)	2 (100%)	4 (100%)

Table 4.0

Lapse in care (unavoidable cases)	Number (%) 2023-24	Number (%) 2022-2023	Number (%) 2021-2022
Delay in stool sampling	10 (31%)	9 (36%)	13 (38%)
Delay in isolation	3 (9%)	7(28%)	10 (29%)
Delay in starting C.diffiicle treatment	0	4 (16%)	2 (6%)

*some cases have more than one type of lapse in care.

Figure 1.0



There is continuous work by the IPC team to reduce the cases *of C.difficile*. This relies on the prompt identification, sampling and isolation of patients with loose stools and the appropriate use of antimicrobials. *C.difficile* diagnosis continues to be a major focus of the IPC education programme.

There have been no instances of known patient-to-patient transmission of *C.difficile* or outbreaks of *C.difficile* this year.

MRSA bacteraemia

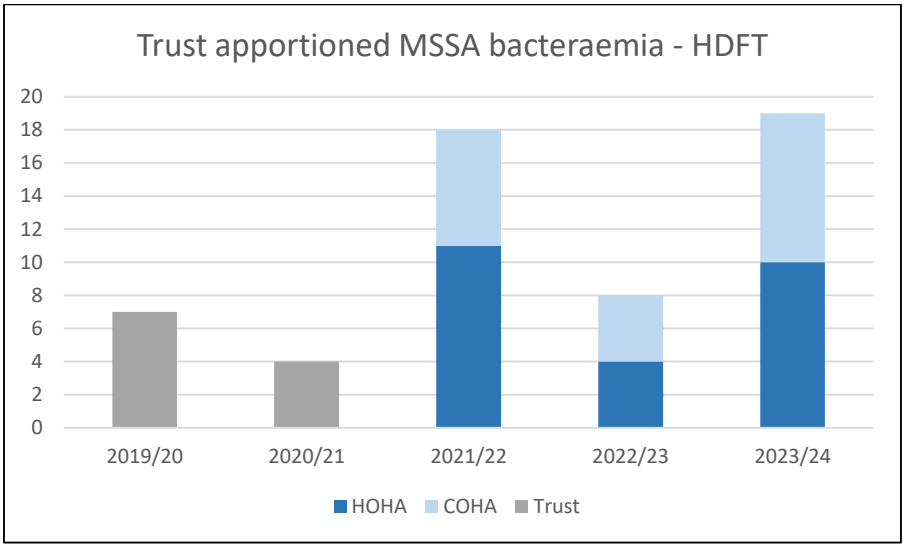
In 2023/24 there have been no trust apportioned MRSA bacteraemia.

MSSA bacteraemia

MSSA (methicillin sensitive *Staphylococcus aureus*) is the much more common and antibiotic sensitive version of Staphylococcus aureus. 19 MSSA bacteraemia's were apportioned to the Trust in 2023/24, this is a significant increase on the previous year but in keeping with the 2021/22 numbers.

The increase in MSSA bacteraemia's has been seen nationwide and the reasons are not fully understood. One possibility is the number of hospital admissions has increased (at HDH by ~20%). All of our HOHA MSSA bacteraemia's have a detailed post infection review and significant lapses in care have not been found. See Table 5 for the trend analysis of our HOHA bacteraemia's.

Figure 2.0



Gram negative bloodstream infections

There are three Gram negative organisms that are monitored. *E.coli, Klebsiella sp* and *Pseudomonas aeruginosa*. In keeping with the rise in MSSA bacteraemia, a rise has been seen in all trust-apportioned Gram negative bacteraemia's. Post-infection reviews have not identified significant lapses in care resulting in the bacteraemia and no one particular source of infection dominates. (See table 5.0)

Figure 3.0

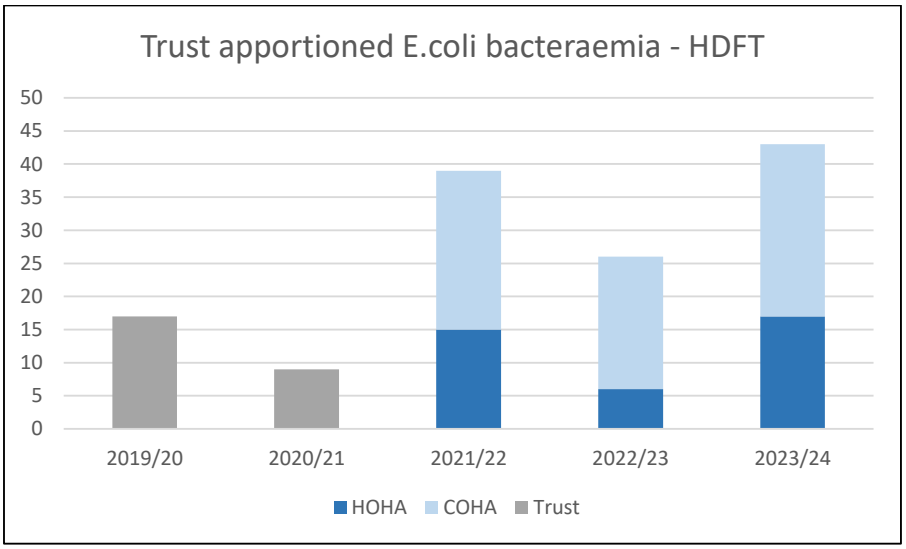


Figure 4.0

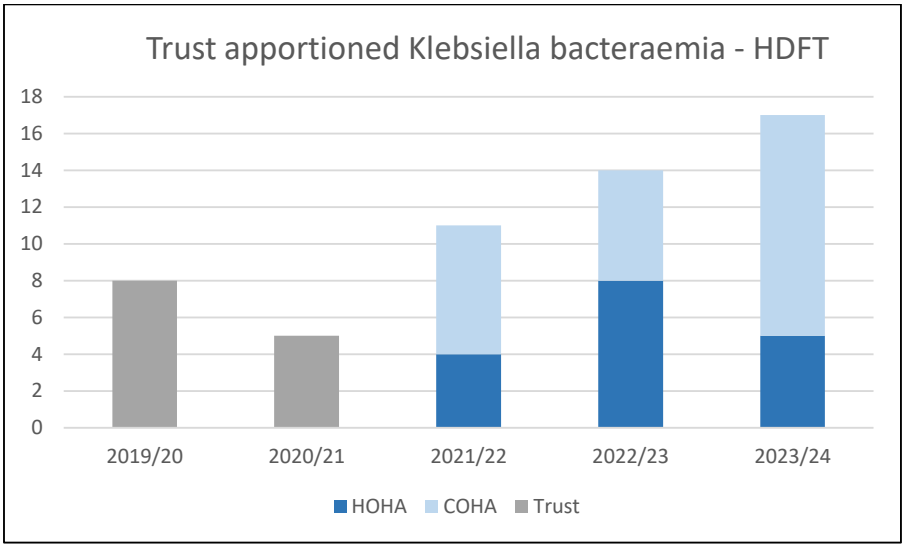


Figure 5.0

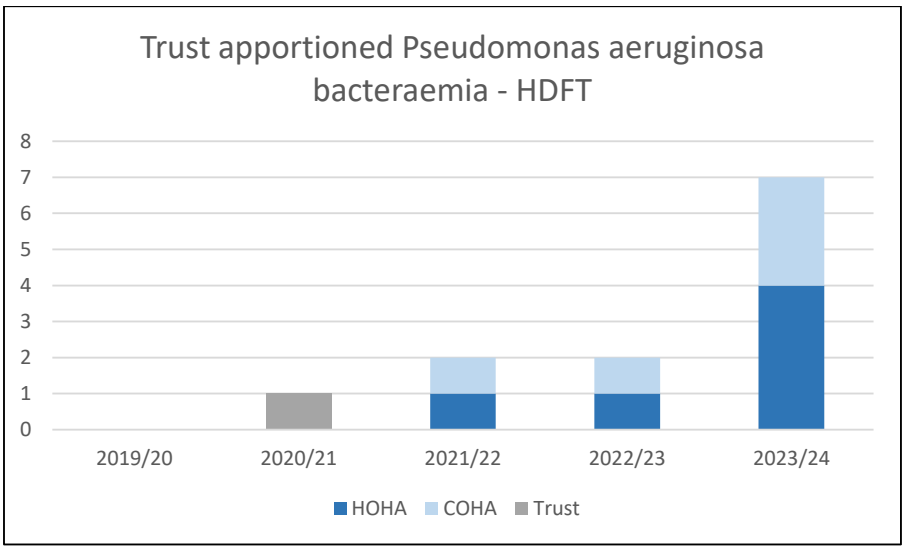


Table 5.0

Infection		MSSA	*E.coli*	*Klebsiella sp.*	*Pseudomonas aeruginosa*
HOHA 23-24		10	17	4	4
Trend	2022-23	4	6	8	1
	2021-22	11	15	4	1
Proportion of all HA's (2023-24)		*53%*	*40%*	*24%*	*57%*
Gender		Male 70% Female 30%	Male 47% Female 53%	Male 50% Female 50%	Male 50% Female 50%
Age (mean)		72 years	73 years	84 years	74 years
Source		CA-UTI-1 LRTI – 2 SSTI – 2 Device -2 Unknown – 3	CA-UTI-2 UTI – 9 IA – 2 SSTI – 1 Unknown-3	CA-UTI-1 UTI-1 IA-1 SSTI-1	CA-UTI – 1 SSTI – 1 Unknown - 2

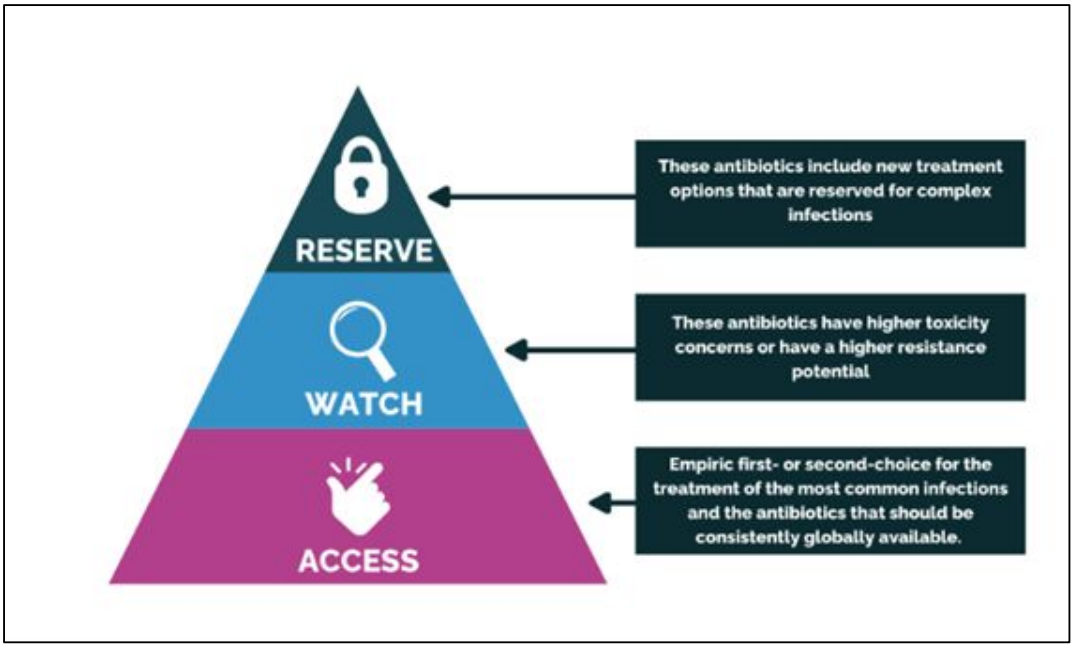
National HCAI and Antimicrobial use Point Prevalence Survey 2023

On behalf of the Trust, the IPC team participated in the National Point Prevalence Survey on Healthcare Associated Infections, Antimicrobial Use and Antimicrobial Stewardship in England.

The aim of this survey is to estimate the total burden of HCAI and antimicrobial use in acute care hospitals, community Trust sites and mental health sites.

The IPC team entered data for 310 patients who met the inclusion criteria. Our total HCAI prevalence rate was 8.7%. 108 patients (34.8%) were receiving an antibiotic are the time of the survey. National Statistics for HCAI prevalence and antimicrobial use have not yet been released and are in the final stages of verification. Provisional data suggest HDFT has performed favourably in comparison to the National picture.

One aspect of the survey in which HDFT performed very well was the distribution of antibiotic use across the AWaRe categories. The WHO introduced the AWaRE categorisation in 2017. The principle being that the majority of your antibiotic prescriptions should be with agents, which fall in the "Access" category. Use of agents in the " Watch" and "Reserve" category should be restricted.



HDFT antibiotic use by AWaRe category:

	Surgery	Medicine
Access	51.2%	46.5%
Watch	27.9%	31.4%
Reserve	7%	4.7%

Carbapenemase producing Enterobacteriaceae (CPE) cases

CPE are Gram-negative bacteria, which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics are ineffective. It is therefore extremely important to detect patients carrying these bacteria and prevent spread through isolation and cleaning. The Trust has a policy on the screening and management of patients with CPE, which reflects the guidance produced by UKHSA. HDFT has a very low incidence of CPE with only 1 new case detected in 2023/24. No patient-to-patient transmission has been identified.

3.0 Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The Trust cleaning strategy is based around the National Standards for Cleanliness and all areas are assigned a Functional Risk (FR) category of 1-4. Senior members of the IPC are involved in the categorisation of areas.

The cleaning provided at HDFT for all clinical and non-clinical areas is the responsibility of Harrogate Integrated Facilities (HIF) and completed by the in-house Domestic Services team. Domestics are responsible for ensuring that cleaning is performed in accordance with standard operating procedures. All Domestic staff play an essential role in ensuring the Trust reduces hospital-acquired infections. The Deputy Director of Estates and Facilities presents cleaning audit results at the monthly IPCC.

Cleanliness assurance

Role of the Domestic Supervisor –The Domestic Supervisors undertake weekly quality monitoring of the hospital wards and departments.

Deep Cleans

The Trust has an agreed list of circumstances / infections where a deep clean is required of a bed space or bay. A process is in place for Ward Managers (appropriate deputies) to request a deep clean by the Domestic Services Team 24 hours/day.

4.0 Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance

Antimicrobial Prescribing Sub-Group (APSG)

This group includes representation from pharmacy, microbiology, nursing and medical staff in both primary and secondary care. Its remit is to oversee the use of antimicrobial agents within the trust and promote prudent, safe and cost-effective prescribing of these drugs.

Assurance reports are received by IPCC on a biannual basis and are mapped to the code of practice criteria. APSG also produce an annual report.

Annual Report of the Antimicrobial Prescribing Subgroup 2023-24

Annual Report of the Antimicrobial Prescribing Subgroup 2023-24

The purpose of this annual report is to provide assurance that this group is working effectively within its terms of reference and achieving the required outcomes and impact.

Remit of the Group

To oversee the use of antimicrobial agents within the Trust and promote prudent, safe and cost-effective prescribing of these drugs.

Meetings held, membership and attendance

Title	May 2023	July 2023	Sept 2023	Nov 2023	Jan 2024	Mar 2024
Consultant Microbiologist (Chair)	✓	✓	✓	✓	✓	✓
Director of Pharmacy (Deputy Chair)	Apologies	✓	✓	✓	✓	✓
Director of Infection Prevention & Control						

Antimicrobial Pharmacist	✓	✓	✓	✓	✓	✓
CCG Pharmacist	✓	✓	✓	✓	✓	✓
CCG Lead General Practitioner	Unable to attend					
Lay Representative	✓	Apologies	Apologies	✓	✓	✓
Directorate Antimicrobial Link Physicians	Apologies (HM)			Apologies (MS)		
Junior Doctor(s)	Apologies			Apologies	✓	
Nursing Representative			✓	Apologies	Apologies	
Lead Pharmacist - Medicines Quality & Safety			✓	✓		✓

Terms of Reference

Reviewed in September 2022; next due for review September 2024.

Key Areas of Responsibility

1. Development and implementation of evidence-based guidelines for antimicrobial use.
2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.
3. Development of education and training resources for antimicrobial stewardship (AMS) and the means to deliver them.
4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.
5. Review of root cause analyses following cases of *Clostridioides difficile* infection.
6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.
7. Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.
8. Align local practice with UK AMR National Action Plan goals using AMR tools and resources, such as AMR local indicators produced by UKHSA.

The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.

Summary of Work during 2023/24

1. <u>Development and implementation of evidence-based guidelines for antimicrobial use.</u>

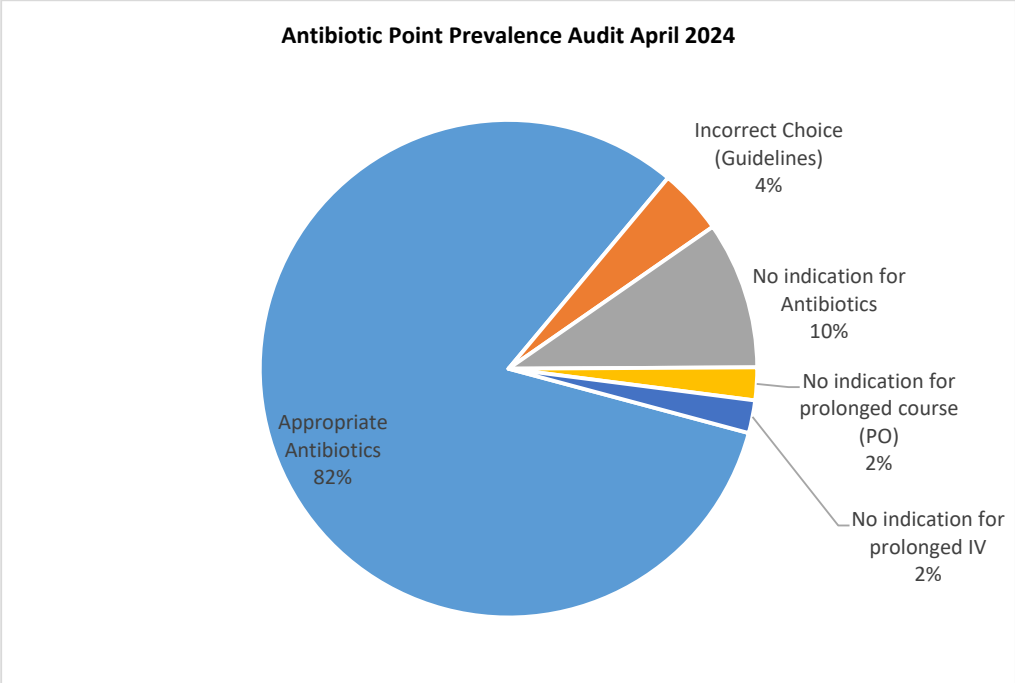
Revisions to antimicrobial guidelines:

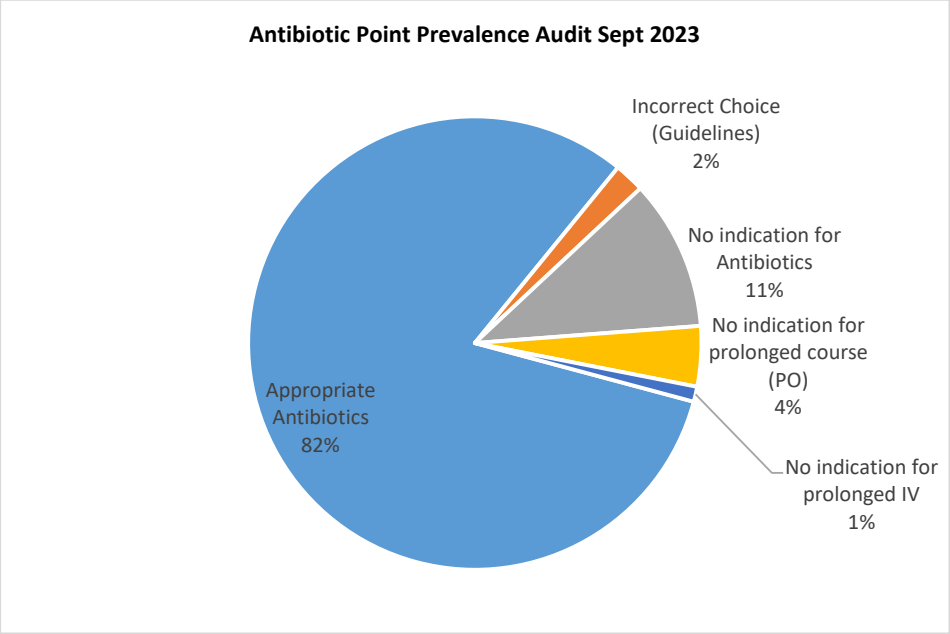
- Additional warnings added to nitrofurantoin in light of MHRA alert April 2023
- NICE QS90 incorporated into guidance for uncomplicated lower UTI in non-pregnant women
- Recommendation for sputum culture in severe CAP added as per NICE NG138Addition of advice regarding use of topical antimicrobial agents for surgical wounds that are healing by primary attention as per NG125Addition of antimicrobial susceptibility testing update
- Minor amendments to severe cellulitis guideline to bring into line with NG141
- Addition of guideline for MRSA decolonisation
- Minor additions to cellulitis and erysipelas guidelines in line with NG141
- New leg ulcer infection guideline
- Changes to recommended dosing for teicoplanin and gentamicin in orthopaedic surgical prophylaxis
- Change to recommended antibiotic prophylaxis for closed fracture repairs at all sites other than hips
- Removal of ciprofloxacin from guidance for oral step-down for intra-abdominal sepsis of unknown origin, acute diverticulitis, biliary tract sepsis and anorectal abscess, on the basis of new MHRA advice
- Addition of required blood culture volume: 8-10mls per bottle

2. <u>Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.</u>

Trust-wide antibiotic point prevalence audit, April and September 2023, and April 2024 (Antimicrobial Stewardship Team)

All inpatient antibiotic prescriptions were reviewed on a given day. The results demonstrate appropriate prescribing in over 80% of cases; similar to previous audits.


Antibiotic Point Prevalence Audit April 2024
Incorrect Choice (Guidelines) 4%
No indication for Antibiotics 10%
No indication for prolonged course (PO) 2%
No indication for prolonged IV 2%
Appropriate Antibiotics 82%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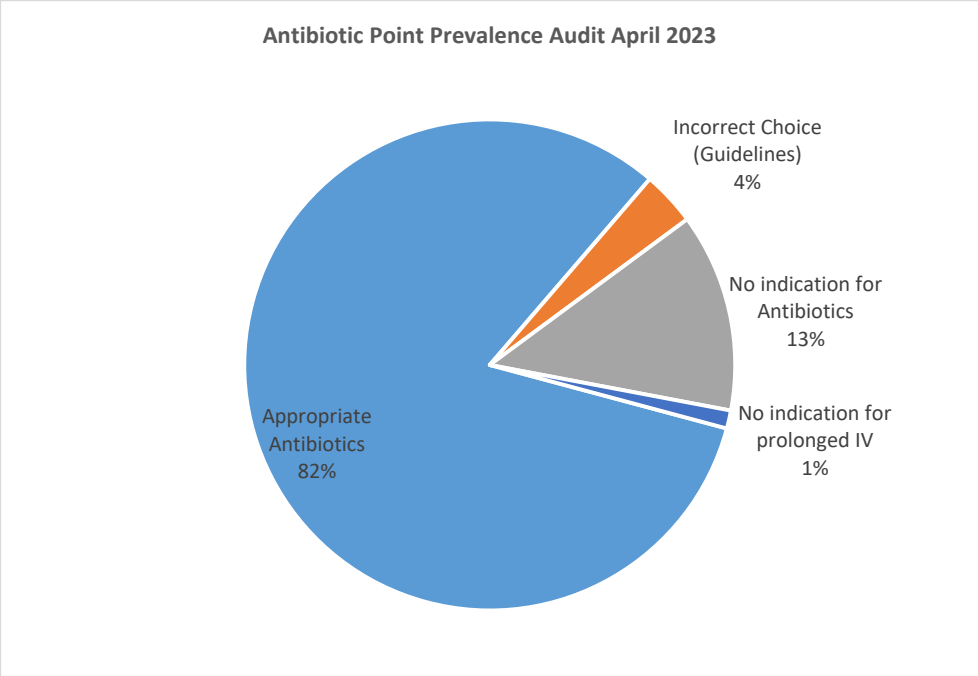


Key successes

- Daily antibiotic review is happening in most cases (over 90%), around 85% of which were good quality
- 87% of prescriptions in April 2024 included a stop date, which is an improvement from previous audit
- Most of the use of IV antibiotics is justified

Key Concerns

- There is a stubborn proportion of prescriptions (around 10%) in successive audits where the reviewers judge antibiotic therapy is not indicated, either because of lack of evidence of bacterial infection or inappropriately long course length

Recommendations

- AMS teaching for ED middle grades and juniors
- Modify aspiration pneumonia antibiotic guidelines to discourage early initiation of antibiotics following an aspiration event
- Explore addition of an antibiotic prescribing decision outcome to the WebV ward round template

National HCAI AMS Point Prevalence Survey

This was the third national point prevalence survey on antimicrobial use. Data collection took place over several days in autumn 2023. Prevalence of antimicrobial use at HDFT was 34.8%

Key successes

- Only single dose surgical prophylaxis was prescribed at HDFT, whereas nationally surgical prophylaxis >1 day was more common
- Use of narrow spectrum antimicrobial agents was more common at HDFT than nationally (co-amoxiclav was the most commonly prescribed antibiotic nationally, but did not feature in the top 10 antibiotics at HDFT)

Orthopaedic antibiotic prophylaxis audit, August 2023 (F2 Doctor)

Retrospective review of notes of patients who had surgery in a 2 week period in April 2023. 100% of prophylactic antibiotics prescribed according to guidelines. 18% were prescribed on ePMA; the remainder were prescribed on the paper anaesthetic chart.

Key successes

- Antibiotic prophylaxis was administered appropriately on all occasions i.e. correct indication, antibiotic, and dose.

Key Concerns

- Antibiotic prophylaxis was prescribed on ePMA for very few patients. This is consistent with other specialties and previous cycles of the audit.

Recommendations

- Results to be discussed in anaesthetics and orthopaedics clinical governance meetings

CQUIN 2023-24 IV to Oral Switch (IVOS)

There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broad spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections.

This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

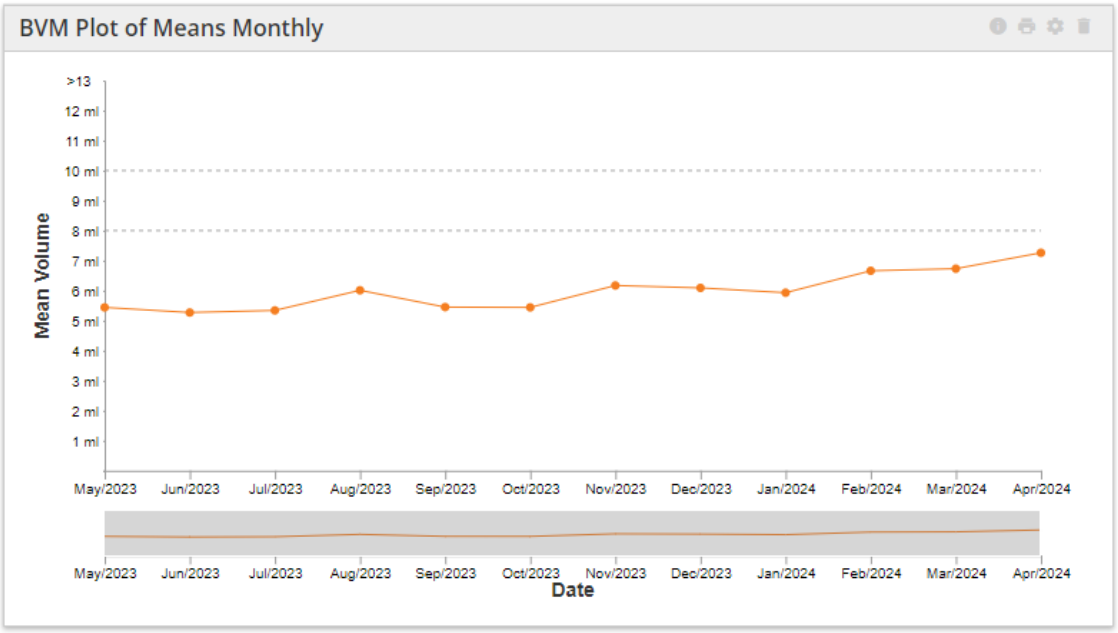
The CQUIN audited what percentage of adult inpatients were still receiving IV antibiotics past the point at which they meet the switching criteria, with a target of <40%.

HDFT achieved the following results for quarter 1-4 respectively: 8%, 6%, 6%, 3%. These results were well below the national average of 20.4%.

Improving the Blood Culture Pathway

The volume of blood cultured is key to the detection of bloodstream infection. There is a direct relationship between blood volume and yield, with approximately a 3% increase in yield per mL of blood cultured. NHS England and NHS Improvement recommend the collection of two sets of blood cultures (two aerobic and two anaerobic bottles) from patients with suspected sepsis. At HDFT these bottles should be filled with 8-10mL of blood.

Graph to show average blood culture volume previous 12 months – all wards and departments



Average blood culture volume per bottle falls below the recommended 8-10mL in nearly all wards/departments. Over the 12 months April 2023 – March 2024, there has been a steady increase overall in mean blood culture volume from 5.4mL to 7.3mL.

Two blood culture sets were collected in only 10% of septic episodes.

The consensus of WYAAT Consultant Microbiologists is to focus on achieving one adequately filled blood culture set in the first instance. It is acknowledged that the existing blood culture analysers will soon run out of capacity if the number of bottles received almost doubles.

3. Development of education and training resources for antimicrobial stewardship and the means to deliver them

Alongside the antimicrobial stewardship training already provided for F1 doctors, enhanced training in prescribing and monitoring of gentamicin continues to be provided. An interactive teaching session was given to final year medical students on the Post Finals Assistantship (PFA) programme in May 2023 and this was repeated for all F1s in December 2023.

Antimicrobial stewardship teaching was given to ED doctors in August 2023.

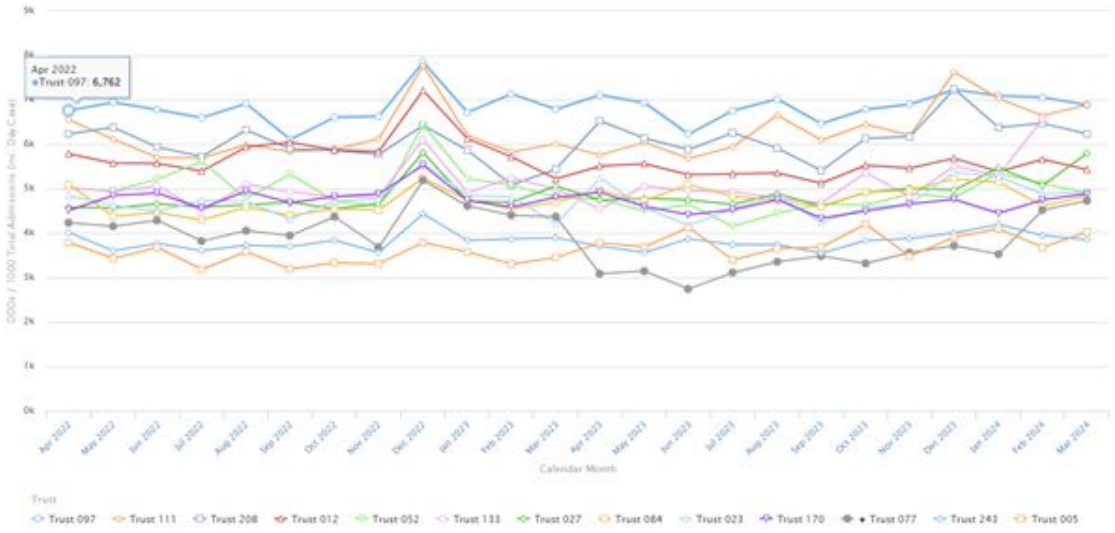
Weekly antimicrobial stewardship ward rounds were introduced with the surgical junior doctors in September 2022. These focus on duration of antibiotics, timing of iv to oral switch, restriction of gentamicin course length to 5 days, review of microbiology culture results and discussion of complex cases. These offer a further opportunity to provide education, as well as discussing patient cases.

4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.

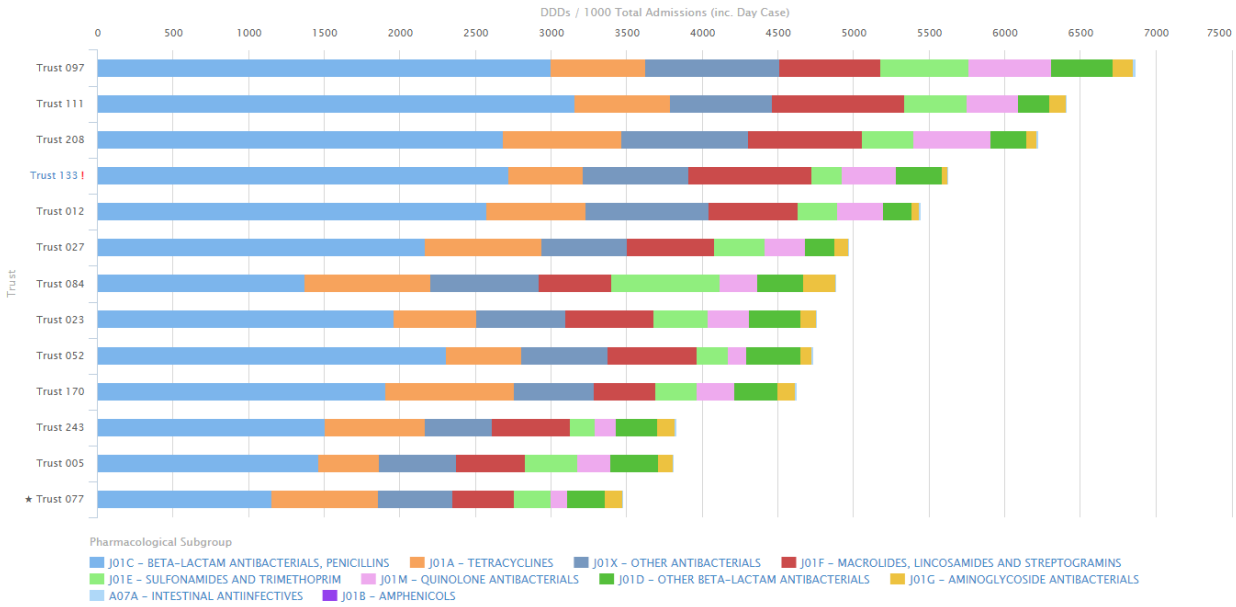
The following charts compare antibiotic consumption at HDFT with other Trusts in the region. HDFT is Trust 077.

HDFT continues to compare favourably to other Trusts in the region in terms of antibiotic use, particularly with regards to low use of broad spectrum agents (e.g. meropenem and piperacillin/tazobactam).

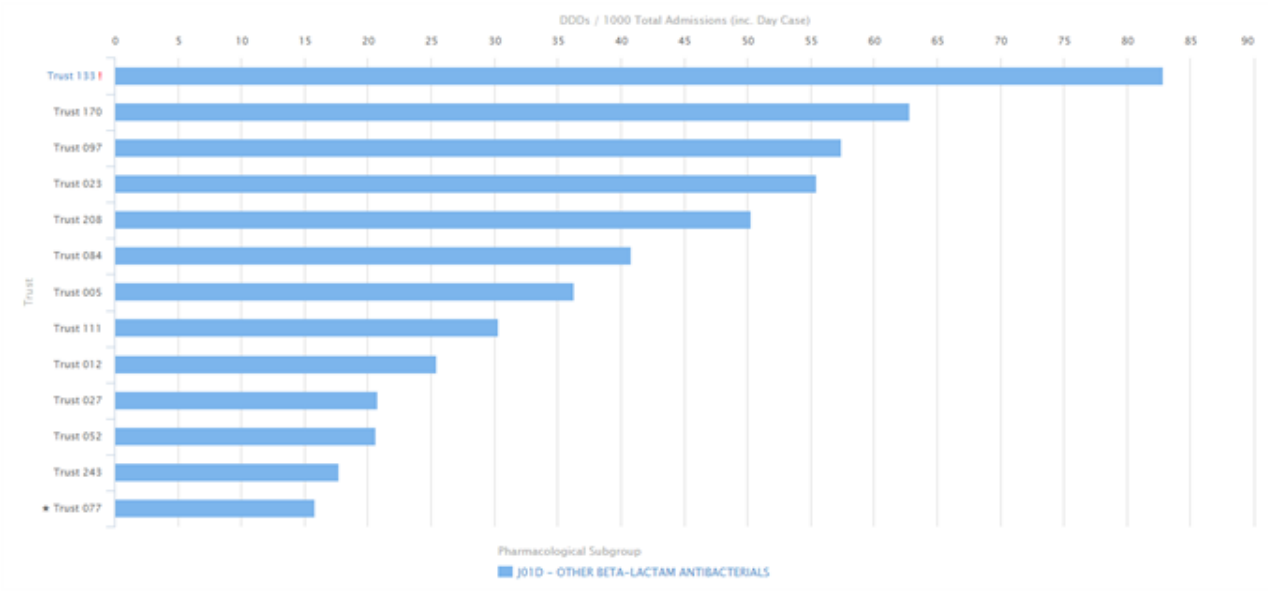
Total Antimicrobial Use in DDD/1000 Admissions



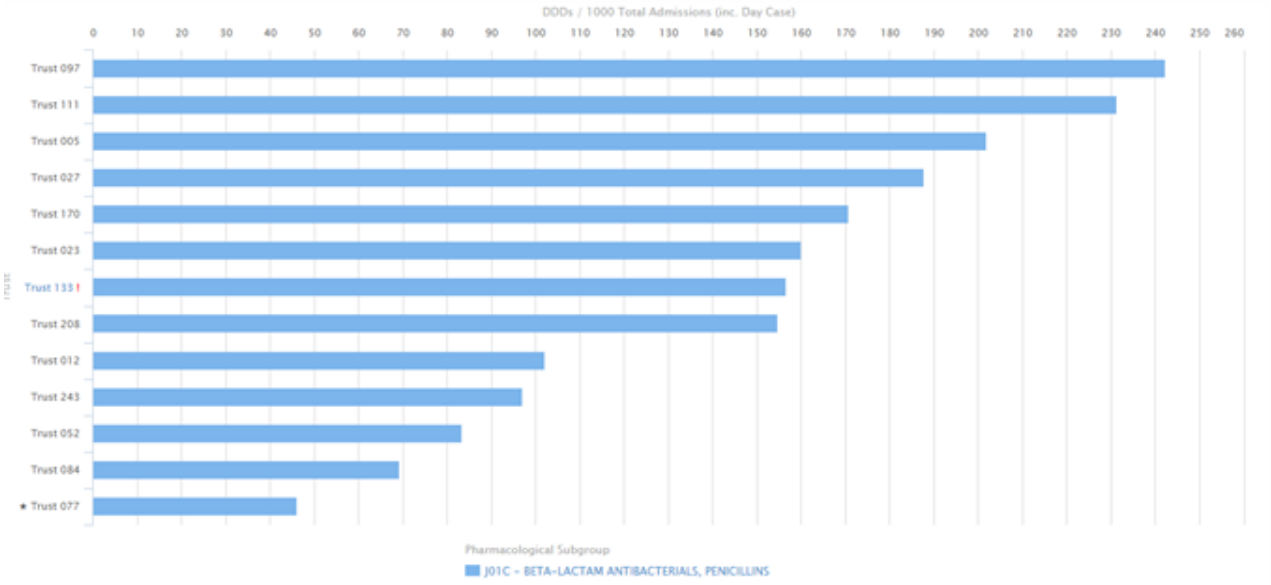
Breakdown of Antimicrobial Consumption into Antimicrobial Classes



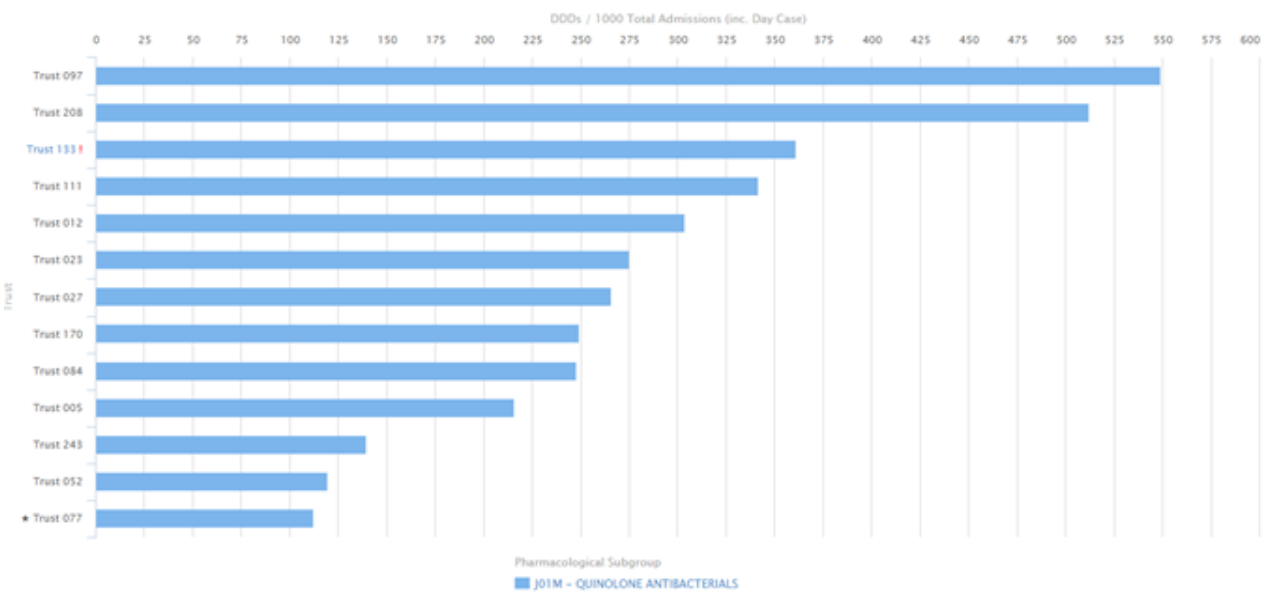
Meropenem



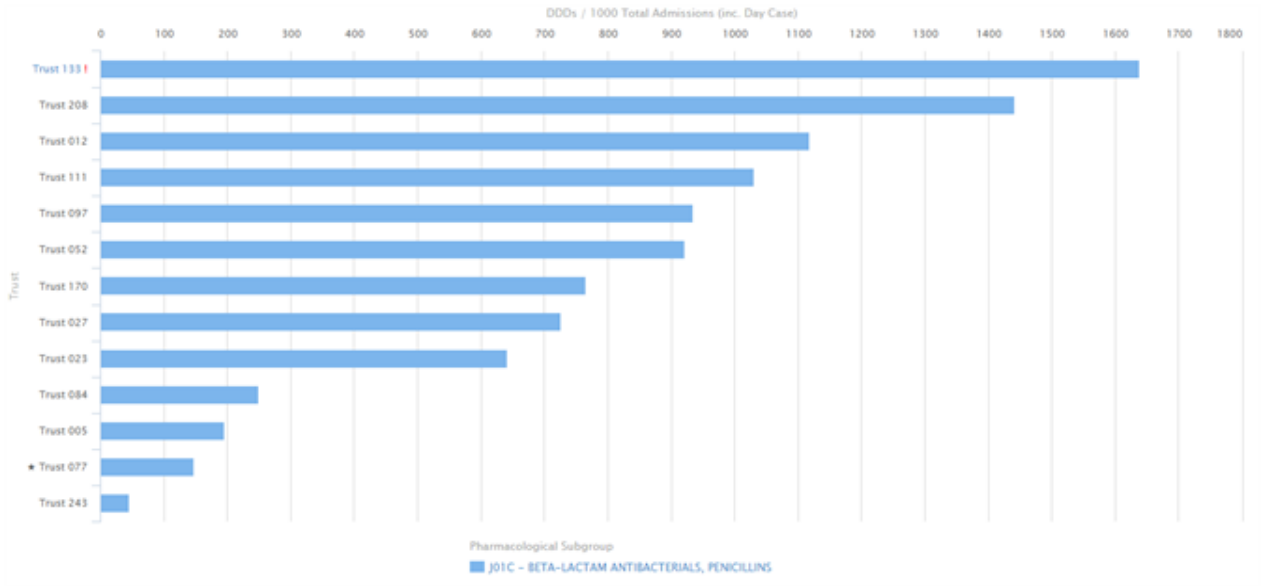
Piperacillin/tazobactam



Fluoroquinolones



Co-amoxiclav



AWaRe Categories

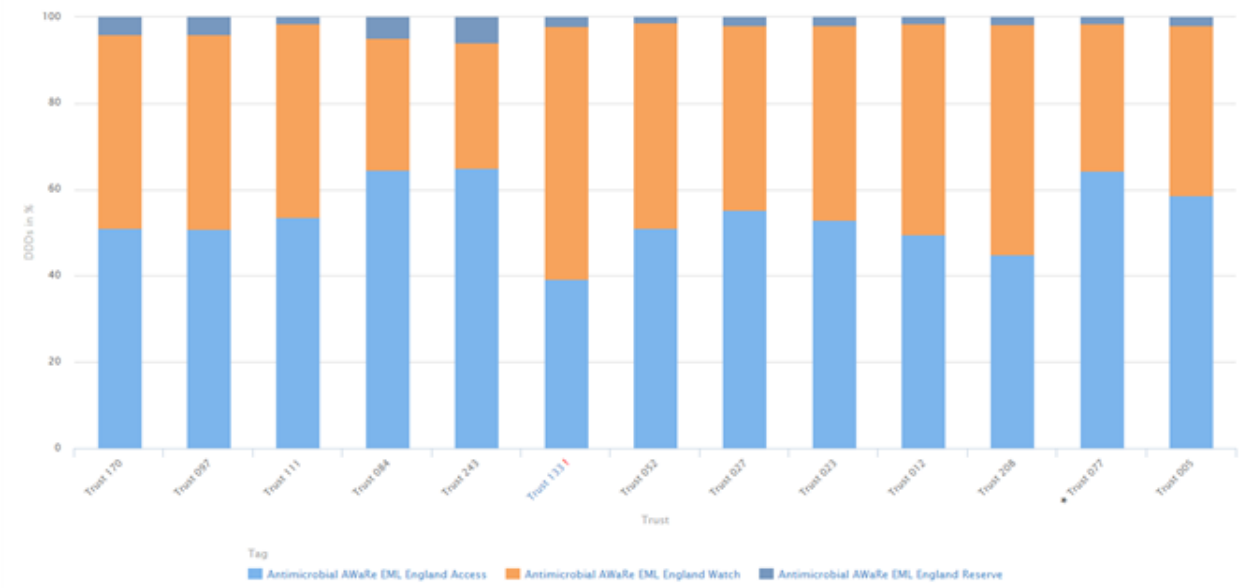
The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, taking into account the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use.

Access – first and second choice antibiotics for the empiric treatment of most common infectious syndromes;

Watch – antibiotics with higher resistance potential whose use as first and second choice treatment should be limited to a small number of syndromes or patient groups

Reserve – antibiotics to be used mainly as 'last resort' treatment options.

The following chart shows that HDFT is amongst the highest user of 'access' antimicrobials, and the lowest user of 'reserve' antimicrobials in the region.



5. <u>Review of cases of *Clostridioides difficile* infection where inappropriate antibiotic prescribing has been highlighted during post-infection review.</u>

Since January 2022, antimicrobial prescribing lessons learnt from the CDI post-infection reviews have been formally fed back to the AMS team for discussion at APSG. Inappropriate antibiotic prescribing was implicated in only 2 of 32 Trust-apportioned cases.

6. <u>Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.</u>

This is reported annually and uploaded to the HDFT intranet under 'Antibiograms' at:

https://nww.hdft.nhs.uk/long-term-and-unscheduled-care/infection-prevention-control-tb-service/hospital-and-hdft-community-staff-resources/antibiograms/

7. <u>Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.</u>

National antibiotic prescribing data shows that the North Yorkshire Sub Integrated Care Board Level (SICBL) performs well against national antimicrobial prescribing targets, and is one of the lowest prescribers in the region. It should be noted that this is a much larger geographical area than the Harrogate and Rural District CCG for which data was previously reported.

The North Yorkshire Antibiotic Prescribing Guideline for Primary Care is overdue review (expired September 2019) and is currently archived. Review was delayed because of redeployment of key authors during the COVID pandemic. With the introduction of ICSs, the guidelines will apply to a much wider geographical area than before. With the recent establishment of the Humber and North Yorkshire ICS Antimicrobial Stewardship Steering Group, plans are currently underway to set up a working group involving all stakeholders to review the guidelines. Primary Care are directed to use the NICE guidelines in the meantime.

The Outpatient Parenteral Antimicrobial Therapy (OPAT) MDT meets every week. There is continued representation from Bionical, who provide the nursing service in the community. This has vastly improved communication between the hospital and community and therefore positively impacted on patient care.

8. Align local practice with UK AMR National Action Plan goals using AMR tools and resources, such as AMR local indicators produced by UKHSA.

HDFT performance compared with peers is reviewed at APSG. This includes antimicrobial resistance for key pathogens, antibiotic prescribing, healthcare-associated infection and antimicrobial stewardship.

Progress Towards Proposed Objectives for 2023/24

Objective	Progress
Add requirement for automatic stop dates for antimicrobial prescriptions on ePMA	Introduced November 2023
Continue weekly targeted antimicrobial stewardship ward round with junior doctors in general surgery/urology	Introduced September 2022 - ongoing
Address antibiotic prescribing in ED, including access to MicroGuide™ and use of broad-spectrum agents such as piperacillin/tazobactam and co-amoxiclav outside of guidelines	AMS teaching session given to ED junior doctors, middle grades and ACP August 2023
Support of antimicrobial audit in clinical specialties	Ongoing (see report)
Support penicillin allergy delabelling pilot for patients undergoing elective orthopaedic surgery	Five patients were successfully de-labelled during a 6-week feasibility study. A further nine patients were consented. Funding has not yet been agreed to set up a permanent service.
Promote and support Trust adherence to Improving the Blood Culture Pathway	Blood cultures now loaded on to the analyser overnight Blood cultures can now be sent in the pneumatic tube system, which should improve compliance with the 4 hour target from collection to incubation
Participate in 2023/24 CQUIN Prompt switching of intravenous antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	Completed with excellent results (see report)
Provide guidance on the use of antimicrobials for the Hospital at Home service	Deferred until Autumn 2024 - little usage to date

Dr Katharine Scott, Consultant Microbiologist, June 2024

5.0 Criterion 4

Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Communication

Advice leaflets have been produced for patients on a number of organisms / infections e.g. MRSA, CPE, *C. difficile* which are available to download from the website. This provides useful information to the patient and their family on the precautions required whilst they are in hospital and when they are discharged home. Notification of a patient's infectious status is documented in the discharge letter. A patient's infectious status is documented as an IR Flag on their electronic notes.

IPC Guidance is available via PolicyStat providing a single policy and procedure reference point.

6.0 Criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Alert organism system

The Infection Prevention and Control team are alerted on a daily basis by the laboratory when an alert organism is isolated on an inpatient. The notes are then electronically tagged with an IR Flag, which alerts ward staff that the patient has an infection. The notes are labelled by the Team with a coloured sticker on the inside of the front cover with the type of infection e.g. MRSA.

Surgical Site Infection Surveillance (SSIS)

The Trust's mandatory Orthopaedic SSI for 2024 was carried out on repair of fractured neck of femur fractures. There were a total number of 78 operations performed during the surveillance period (1/10/23-31/12/23), 3 SSI's were identified which is an infection rate of 4%.

In July 2023, the Orthopaedic Department invited Professor Mike Reed, Chair of the UK Bone and Joint Infection Registry to undertake an external review. This was in response to concerns of elevated infection rates in both elective hip and knee replacements and hip trauma operations.

Following the review a comprehensive Orthopaedic Action Plan has been developed. IPC have contributed with the implementation of *Staphylococcus aureus* suppression protocols and changes to antibiotic surgical prophylaxis.

QGMG are the group responsible for overseeing the implementation of the action plan by the Planned and Surgical Care Directorate.

Outbreak Management

The IPC team are involved in the identification and management of outbreaks and periods of increased incidence. The IPC team monitors (via the HCAI tracker) alert organisms to identify trends and potential links between cases based on their location. This is a manual task and is completed without the aid of an automated surveillance system. If links are identified then an investigation is undertaken to ascertain if the outbreak threshold has been reached. Outbreaks are managed in accordance with the IPC Outbreak policy.

In 2023/24 we had no *C.difficile* transmission events.

COVID-19 outbreaks have continued to be our most frequent outbreak organism throughout 2023/24. A total of 15 outbreaks affecting inpatient wards, which is reduced from 22 last year, the

vast majority were confined to a single bay rather than whole ward closures. No outbreaks of Influenza A, B or RSV. A total of 3 outbreaks of viral gastroenteritis.

One "period of increased incidence" event during 2023-2024.

In December 2023 we diagnosed two patients with hospital acquired Salmonella gastroenteritis. The patients had been in adjacent beds within the same bay for a period. Genetic typing of the Salmonella isolates revealed they were the same strain confirming either patient-to-patient transmission or a common infection source. A multi-disciplinary Outbreak Control Group led the investigation. The original source of the infection could not be identified. It was proposed that the close proximity of the patients to each other supported patient-to-patient transmission but it could not be determined which patient was the index case. Thankfully, both patients recovered and no further cases were identified.

Measles

In the final quarter of the HCAI year, the IPC team have been working hard to ensure the Trust is prepared for an increased number of patients presenting with Measles. From October 2023, there has been an increased incidence of Measles in the UK. A large outbreak in the West Midlands, predominantly in young children accounted for a large proportion of the cases but increased numbers have been confirmed across England including Yorkshire and the Humber.

The IPC team have worked with our high-risk departments, ED, Paediatrics and Maternity providing them with education and easy to follow "guidance on a page" so that suspected cases are recognised early and exposure to staff and other patients is kept to a minimum.

The Occupational Health Team in collaboration with colleagues from the People and Culture Directorate have carried out a large piece of work to ensure any gaps in staff vaccination records (including Measles) have been addressed.

7.0 Criterion 6

Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection

At the Trust, Infection Prevention responsibilities are included in all job descriptions.

In relation to contractors, documented IPC advice is provided to the person managing the contractors, which covers current guidance on COVID-19 and other general IPC issues.

Staff Induction

All clinical staff receive IPC training on induction to the Trust. This year we have been successful in our attempt to obtain a face-to-face IPC session at the Trust Induction Day. This is a huge step forward for the team and allows us to convey that IPC is everyone's responsibility no matter their role in the organisation.

Staff Training and Education

All staff are required to complete a Mandatory Training session on Infection Prevention and Control, which includes Hand Hygiene. Level 1 is for non-clinical staff and is required every 3 years. Level 2 is for clinical staff and is required annually. Compliance with mandatory training has been a focus for the Directorate teams this year and this is reflected in the improvements seen across the year.

Table 5.0 – figures as of 31/3/24.

	Level 1	Level 2
Corporate	97	89
HiF	96	81
LTUC	98	88
PSC	96	85
CC	98	93
Total Average Compliance	97%	87.2%

This year the team have re-started in-person IPC half day study events, each event is themed towards a particular staff group. Four events were held targeting Care Support Workers, Registered Nurses, Preceptorship nurses and IPC Champions. The focus being on 'back to basics'. All the events were well attended with excellent feedback given.

The Team worked with SC Johnson delivering hand hygiene training to wards and departments on several occasions using their Semmelweis interactive hand hygiene machine.

As well as the above, we participated in the annual WHO World Health Hand Hygiene day and International IPC Week with an educational stand in the hospital.

One of the more specialist areas of IPC knowledge is Water and Ventilation Safety. Amanda Gooch (Team Lead for IPC) has delivered a bespoke training session to all Ward Managers explaining their role in the prevention of waterborne infections. Lauren Heath (ICD) delivered a training session for IPCC members on the basics of Water and Ventilation Safety.

Water Safety for Ward Managers APR

Water Safety session for IPCC MA

Ventilation Safety session for IPCC JUL

8.0 Criterion 7

Provide or secure adequate isolation facilities

At HDFT, all inpatient wards have single room (isolation) facilities. The proportion of single rooms available across our inpatient beds is 26% of these single rooms 60% are en-suite.

This can, at times of high demand, significantly impact the ability to isolate all patients who should be isolated according to national guidance. When demand exceeds single room occupancy, a risk assessment is carried out to ensure the most appropriate patient is allocated a single room. The IPC Team work closely with the Clinical Site Team to support the risk assessment and decision-making. A priority isolation list is available to help the Clinical Site Team out of hours and ensure that practice is consistent.

Specialist isolation rooms are available in the Emergency Department and the Intensive Care unit. The Emergency Department has three single resus rooms, which can be put into negative pressure mode. (*This is the mode you want when caring for a patient with a suspected/confirmed infection, which spreads via the airborne route*). Intensive Care has two single rooms, which can be put into negative pressure mode.

9.0 Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for HDFT are located on-site. The Microbiology Laboratory has full UKAS ISO 15189 accreditation.

The IPC nurses work closely with the Consultant Microbiologists and the Senior Biomedical Scientists. One of the Consultant Microbiologists has the additional role (awarded 3PA's) of being the Infection Control Doctor and is the primary link between the IPC team and the laboratory service.

The Laboratory department have continued to work flexibly with the Trust and have maintained an extended working hour's rota to provide on-site COVID and respiratory virus testing until 9pm seven days per week. This has been key to maximising safe patient flow.

10.0 Criterion 9

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

The IPC Team has this year successfully transferred the IPC Policy and Procedure documents to PolicyStat. This now allows centralised monitoring of review dates. Reminders are sent out via email to document owners alerting them a document is due for review. The IPC team is committed to the continuous updating of IPC procedures, the IPC Matron has been given special permission to enable us to update policies in between the formal review dates when appropriate.

11.0 Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The Trust has an Occupational Health Department who have responsibility for carrying out pre-employment health assessments and immunisation needs. Staff are able to self-refer to the Occupational Health service at any time for additional advice and support.

The Occupational Health Manager is now a core member of the IPCC. A major review of the following policies is underway by the Occupational Health Team with support from IPC.

- Blood Borne Virus and Needle stick Policy
- Staff Pre-Placement Policy

The Occupational Health department have undertaken a huge piece of work this year to address legacy issues with the recording of staff immunisation status and transfer this information to a digital system.

All HDFT staff continue to be offered seasonal vaccinations as per NHSE guidance.

12.0 IPC Work Plan for 2023/24

The HIPCT Work Plan describes the IPC improvement work to be undertaken in 2024-2025. The plan is ratified at the Infection Prevention and Control Committee (IPCC). The IPCC review progress against the plan on a quarterly basis.

Item	Task	Task Lead	Target Date	Progress
Policy and Guidelines				
1	Section 003: Procedure for individual diseases – **redraft**	LH	31/3/25	
2	Section 017: Communicable diseases in staff and exclusion policy - **redraft**	IG	31/3/25	
3	Section 031: Principles of asepsis – **redraft**	IG	31/3/25	
4	Section 027: Procedure for Hospital Outbreak – routine review	LH	30/06/24	
5	Section 002: Procedure for Isolation- routine review	SA	31/07/24	
6	Section 009: Procedure for C.difficile- routine review	SA	30/09/24	
7	Section 012: Procedure for MRSA - **redraft**	LH	31/3/25	
8	Section 029: Handling bodies after death – routine review	SA	31/08/24	
Quality Improvement and Audit				
9	Embed the quarterly IPC and Hand Hygiene audit of High risk areas	SA	31/10/24	
10	Embed the annual IPC and Hand Hygiene audit of Low risk areas	SA	31/3/25	
11	Review of Staph aureus (MSSA/MRSA) infection prevention strategy	LH	31/3/25	
Education and Training				
12	"Gloves off" campaign	SA/AG	30/09/25	

13.0 Conclusion

The IPC team continue to provide a dynamic and responsive service. This has been particularly demonstrated by the teams' ability to partake in large national surveys and respond to changing local and national epidemiology. The team have embraced new digital ways of working with their advice documented in the electronic patient record and are expanding their expertise in the IPC aspects of the built environment by being involved in capital projects right from the start of the design phase.

The IPCC continues to be a well-attended and productive committee. Members of IPCC continue to develop their expertise in the very wide remit of infection prevention. The committee offers robust challenge and scrutiny to the work of the Trust, which has IPC implications.

The IPC team are committed to continuing the journey of improvement in order to deliver high quality care to the patients we serve.

14.0 Reference

Department of Health: The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance.

http://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

13.0 Appendices

1.0 Terms of reference IPCC
2.0 IPCC meeting attendance record 2023/24
3.0 IPC Board Assurance Framework
4.0 IPC annual plan of work 2023/24

Appendix 1 – IPCC Terms of Reference:

Terms of Reference

Infection Prevention and Control Committee (IPCC)

1. Accountable to:

- Quality Committee (QC)
- Board of Directors

2. Purpose of the group

The purpose of the IPCC is to provide strategic leadership and direction on infection prevention and control activities across the trust to ensure that the risks posed by transmission of avoidable infection is minimised.

Specifically to include the following:

- To ensure compliance with the Health and Social Care Act 2008 Code of Practice (CoP) on the prevention and control of infections and related guidance by having appropriate monitoring and management systems in place to identify risk of infection to susceptible service users and any risk that their environment may pose to them.
- To approve and monitor the IPC Board Assurance Framework (BAF) to ensure CQC registration compliance with the Code's criteria.
- To approve and monitor the IPC Annual Plan of Work (APW) and any incidents arising which would impact upon compliance with the code of practice.

3. Responsibilities

The key responsibilities of the group are *to lead and monitor the work of its subgroups and* to:

- Set annual objectives and a plan of work.
- Report effectiveness against objectives and terms of reference at year-end.
- Produce and annual report for the Trust Board.
- *Approve annual objectives, work plan and terms of reference of subgroups.*
- Show leadership in setting a culture of continuous improvement in delivering high quality care.
- *Lead work to ensure compliance with the following CQC fundamental standards*.
- Set relevant strategy, policies and processes to support the objectives of the Trust, and ensure that these are reviewed and updated appropriately.
- Support the delivery of the Trusts annual quality improvement priorities.
- Promote high reliability processes to deliver consistent high quality care by using standard operating procedures, pathways, checklists etc.
- Employ performance and outcome measures through dashboards to triangulate quality information and benchmark against other organisations, and share with relevant staff and stakeholders.
- Promote actions to reduce risk.
- Identify and escalate risks that present a threat to Trust objectives, including from audit results.
- Identify and disseminate learning to relevant staff.
- Address substandard performance.
- Empower staff to make changes to improve quality.
- Ensure participation in national and local audits, patient surveys and quality improvement projects.
- Identify audits for the clinical audit plan.
- Track performance against standards by reviewing audit reports and ensuring the development and progression of action plans.
- Provide information and assurance to the Quality Committee as required.

The key standards for this group are:

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (UKHSA 2015)

Mandatory enhanced MRSA, MSSA, and Gram negative bacteraemia, and Clostridium difficile infection surveillance. (PHE 2016)

HM Government (2019): Tackling antimicrobial resistance 2019-2904: The UK's 5 years National Action Plan

4. Membership

The core membership comprises:

Title	**Deputy**
Director of Infection Prevention and Control (DIPC)(Chair)	Deputy DIPC (Deputy Chair)
Executive Director of Nursing, Midwifery and Allied Health Professionals (Deputy Chair)	Deputy Director of Nursing, Midwifery and Allied Health Professionals
Matron for IPC and TB services	Infection Control Doctor (ICD)
Infection Control Doctor	Matron for IPC and TB services
Head of Nursing (LTUC)	LTUC Matron
Head of Nursing (PSC)	PSC Matron / Associate Director of Midwifery
Head of Nursing (CC)	Matron for Paediatric Services
Matron for Paediatric services (CC)	Head of Nursing (CC)
Deputy Director of Estates and Facilities	Head of Estates / Head of Facilities
Head of Health and Safety	Health and Safety Advisor
Deputy Chief Operating Officer	Clinical Operations Manager

Secretary to the Consultant Microbiologist's	N/A

Ad hoc attendance may be by invitation of the Chair.

5. **Quorum**
   To be decided by the Chair according to representation present and agenda content

6. **Administrative support**
   Secretary to the Consultant Microbiologist's

7. **Subgroups**
   Hospital Infection Prevention and Control Team

   - Group responsible for implementation of the IPC APW and acute IPC service

   Antimicrobial Prescribing Sub-Group (APSG)

   - Group responsible for developing and implementing the Trusts antimicrobial stewardship strategy

   Water and Ventilation Safety Group

   - Group responsible for the provision of safe water and air by the management of water/ventilation related risks

   Decontamination Committee

   - Group responsible for ensuring the reusable medical devices undergo effective decontamination

8. **External relationships**
   ICB

   North East and Yorkshire IPC Team

9. **Frequency of meetings**
   Monthly

10. **Communication**
    Minutes and action log to be produced for each meeting by the administration support. Escalation of issues to Quality Committee.

11. **Review**
    Annually (April)

12. **Date**
    April 2023

Appendix 2 – IPCC Meeting Record 2023/24

Meeting	1	2	3	4	5	6	7	8	9	10	11	12
Date	2/5	22/5	26/6	24/7	4/9	25/9	OCT	27/11	18/12	22/1	26/2	25/3
DIPC			R									
Executive Director of Nursing, Midwifery and AHP's		R		R		A		R				
Matron IPC	R				R				R			
ICD									R			
Deputy Chief Operating Officer						A		A	A		A	
LTUC HoN												
PSC HoN										R	R	
CC HoN								R			A	
Matron for Paediatric Services		R	R	R				A				A
Deputy Director of Estates and Facilities (HiF)	R	R	R	R				R	R	R		
Head of Health and Safety								A	A			

Key:

R – Representative sent

A – Apologies received

Appendix 3: IPC Board Assurance Framework:

Infection Prevention and Control Board Assurance Framework – 2023-2024

The Infection Prevention and Control (IPC) Board Assurance Framework(BAF) has been developed to support HDFT self-assess compliance with the 10 criteria set out in the Health and Social Care Act (2008) Code of Practice on the prevention and control of infection.

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

NIPC BAF - HDH 2023-24 (31.3.24).xls:

Appendix 4: IPC Annual Work Plan 2023-24

The HIPCT Work Plan describes the IPC improvement work to be undertaken in 2023-2024. The plan is ratified at the Infection Prevention and Control Committee (IPCC). The IPCC review progress against the plan on a quarterly basis.

Item	Task	Task Lead	Target Date	Progress
	Policy and Guidelines			
1	Section 003: Procedure for individual diseases – redraft	LH	31-3-24	In progress
2	Section 004: Blood borne virus and inoculation incident policy – transfer to Occupational Health	JB	30-9-23	O/H – Accepted policy. IPC have reviewed the O/H draft. IPC work complete.
3	Section 009: C.difficile – routine review	AG	31-7-23	**Complete**
4	Section 017: Communicable diseases in staff and exclusion policy – amalgamate with Occupational Health policy – Infectious diseases in Staff.	JB	30-11-23	Not started – next priority after BBV policy and staff clearance policy.
5	Section 024: Carbapenemase producing Enterobacteriaceae (CPE) – routine review	LH	30-09-23	**Complete**
6	Section 025: Pest control – routine review	SA	31-07-23	**Complete**
7	Section 027: Hospital Outbreak Policy – routine review	LH	30-08-23	**Complete**
8	Section 029: Handling bodies after death – routine review	SA	31-08-23	**Complete**
9	Section 030: Infection Control and Legionellosis – routine review	LH	31-07-23	**Complete**
10	Section 031: Principles of asepsis – routine review	LH/SA	31-3-24	Not started
11	Section 032: Prevention of Infection for Visitors, Visiting staff, Volunteers and work experience student – routine review	SA	30-09-23	**Complete**
12	Section 037: Prevention of surgical site infection	LH	31-10-23	**Complete**
13	Section 044: Prevention of infection in the mortuary and post-mortem room	SA	30-10-23	**Complete**
	Quality Improvement and Audit			
14	Embed the new departmental IPC monthly audit	SA	30-09-23	**Complete**
15	Reduce the rate of Blood culture contamination to <1%	LH	31-03-24	**Phase 1 – Complete** Data collection
16	Review and refine the ward IPC monthly audit tool on Tendable	LH/SA	30-10-22	**Complete**
17	Develop and embed a new process for asepsis training and competency assurance	LH/SA	31-03-24	**Not started**
18	Prepare a business case for ICNet (to be submitted when new LIMS system has been installed at HDH)	RH	31-03-24	**Complete**
19	Create an appendix for the IPC Policy describing the IPC audit cycle	AG	31-07-23	**Complete**
20	Occupational health - establish collaborative working relationship and agree assurance reporting process	LH/SA	30-09-23	**Complete**
21	Complete annual mandatory SSI surveillance audit	IG	31-03-24	**Complete**
22	Review and improve the PIR process for community onset cases of C.difficile	LH/SA	30-06-23	**Complete**
23	Review guidance for sampling patients with loose stools	SA/AG	31-07-23	**Complete**
24	Start to document IPC (patient specific) advice in WebV. To start with patient placement decisions	SA	30-10-23	**Complete**
	Education and Training			
25	Develop and embed an annual IPC training program	SA	31-03-24	**Complete**
26	Provide all ward managers with Water Safety training	AG	30-09-23	**Complete**

Harrogate and District NHS Foundation Trust

Strengthening Maternity and Neonatal Safety Report

SMT

June 2024

4

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 June 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 June 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 Two new risks –

- Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8).

- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8).

6.0 Recommendation

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

Maternity – July 2024 (June's data)

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Midwifery staffing issues – incentive rate implemented • Increase in number of caesarean sections taking place in Strayside theatre	• 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 – delayed due to image transfer issue • Perinatal Culture action plan developed • Birthrate Plus establishment setting review on-going • Plans to move Daycare activity from MAC to ANC from September • MAC call monitoring project commencing • Web V implementation on-going • AQUA Induction of Labour QI project with HNY • HNY OPEL and mutual aid pilot • PSII following cardiac arrest • Discussions regarding ROTEM ongoing • 2nd Maternity and More Carousel in July • RSV vaccination to be launched in September • Maternity Strategy being finalised • Make Birth Better training and time out days planned for July and September • Maternity Assessment Centre action plan
Positive news & assurance	**Decisions made & decisions required of the Board**
• No new MNSI cases reported • Video tour of maternity unit with MVP created • All midwifery groups mandatory training over 90% compliance • SCBU reaccredited WHO Baby Friendly Initiative Gold Award	PMRT quarterly report submitted to Board for assurance

Narrative in support of the Provider Board Level Measures – June 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 a middle grade gap which has been covered internally by other middle grades doing extra shifts. 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 May 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 72.18 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 –
3.22 WTE sickness absence Main cause - Stress
5.8 WTE maternity leave
2.08 WTE study
1.14 WTE other leave (carers/compassionate/phased return)
10.43 WTE Annual Leave

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

3.2 Vacancy position

Currently there is 2.8 WTE Band 6 midwifery vacancy due to maternity leave which is out to advert and 1.31 maternity support work vacancies. 4.6WTE student midwives due to qualify in autumn have been recruited to Band 5 roles.

3.3 Turnover

March twelve month rolling rates –
Midwives 10.26%
Maternity support workers 20.3%

3.4 International Midwifery Recruitment

Both internationally recruited midwives have received their NMC PIN number and continue working supernumerary. One midwife will complete her supernumerary period at the end of July.

3.5 NHSP provision

Midwives -
4.09 WTE NHSP midwifery staffing used in June 2024

Support workers –
2.76 WTE NHSP maternity support worker staffing has been used across maternity in June 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.

Six homebirths were booked for the month of June 2024. One woman birth at home. Two women birthed in the hospital for medical reasons, one woman lived in York and hdft supported the initial stages of labour until relieved by York and two women are still pregnant.

In the period 01/06/24 – 30/06/24, the home birth provision was suspended on two occasions due to unexpected sickness and no volunteers to cover.

Work on-going with Human Resources and Occupational Health to review how best to provide cover for homebirths. Staffing homebirths from Delivery Suite being considered.

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.
0.23 WTE nurse short term sickness absence

4.2 Neonatal Vacancy

1 WTE non-QIS nurse vacancy July.

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. June QIS compliance was 68.8% therefore added to risk register.

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

Data entry throughout June 2024 found an 81.6% confidence level, a decrease of 1.6% from the May report.

64% of the time staffing factors were recorded as follows –

SF1	Short term sickness	**43**	**28%**
SF2	Lack of beds	**3**	**2%**
SF3	Unable to fill vacant shifts	**76**	**49%**
SF4	Staff redeployed to another area	**10**	**6%**
SF5	No maternity support worker	**22**	**14%**
	Total	**154**	

49% (85 occasions) of the time no clinical actions were required. 51% (89) of the occasions clinical actions were required, these included:

CA1	Delay in commencing IOL (Inpatient)	**17**	**14%**
CA2	Delay in continuing IOL	**78**	**66%**
CA3	Delay in EL LSCS (delivery suite)	**6**	**5%**
CA4	Postponed IOL (at home)	**13**	**11%**
CA5	Delivery Suite coordinator not supernumerary	**4**	**3%**
	Total	**118**	

Delivery Suite Coordinator was not supernumerary on four occasions over the course of the month. Of the entries noted the reasons were varying, one episode was a woman presented in advanced labour and quickly delivered, the other was a number of periods when the coordinator was working with the supernumerary midwives and overseeing them with a woman in labour. This was quickly escalated and management actions occurred as described in 6.2 to ensure the co-ordinator could return to being supernumerary as soon as possible.

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.
98.8 % of women received one to one care when labour within the unit.

5.2 Pannal Ward Staffing

The Birthrate Plus Ward Acuity App had a 74.2% 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 and the compliance has improved this month. Data entry analysis is now available in the Birthrate plus system. For the month of June 44 staffing factors were recorded, the top three reasons being vacant shifts, midwife absence and midwife redeployed to Delivery Suite/Theatre. The following clinical actions were taken to mitigate the risk.

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in IOL > 24hrs	**8**	**62%**
CA2	No beds	**2**	**15%**
CA3	Delay in continuing IOL > 24hrs	**3**	**23%**
CA4	Delay in Elective LSCS - cancelled on the day of planned surgery	**0**	**0%**
CA5	Delay in discharge > 2hrs	**0**	**0%**
CA6	Delay in ward attender being reviewed > 30 mins	**0**	**0%**
TOTAL		**13**	**100%**

The main reasons for delaying inductions of labour recorded were staffing shortages and delays in bringing woman in for the process, and Pannal also being bed blocked. During this time one woman was diverted for artificial rupture of membranes elsewhere following receiving a hormonal pessary in Harrogate.

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 on Birthrate Plus during June 2024 which relate to a midwife being unable to provide one to one high dependency care for an antenatal or postnatal patient.

The following management actions were taken to manage the staffing situation described in 5.1

MA1	Redeploy staff from Pannal	**30**	**41%**
MA2	Staff unable to take breaks	**10**	**14%**
MA3	Review of staff on management time	**4**	**5%**
MA4	Use of Specialist Midwife	**8**	**11%**
MA5	Use of staff on training days	**0**	**0%**
MA6	Use of ward/department managers	**5**	**7%**
MA7	Staff sourced from wider Trust (theatre & CSW's)	**1**	**1%**
MA8	Use of hospital MW on call	**2**	**3%**
MA9	Use of community MW	**0**	**0%**
MA10	Unit on Divert	**12**	**16%**
MA11	Patient diverted	**1**	**1%**
	Total	**73**	

6.3 Pannal Ward Red Flags

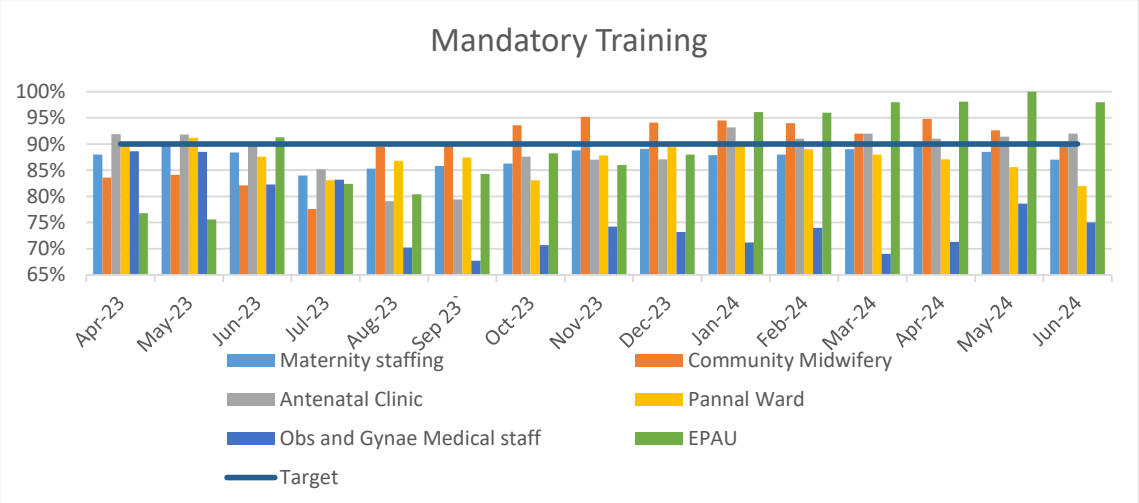
During June there were twenty delays in induction of labour over 24 hours, fifteen were accommodated one day later than planned and five were delayed for 48 hours due to unit activity. See 5.2.

7.0 Appraisals

Department	Assignments Appraised	Assignment Count	Percentage Compliant
Obs & Gynae - Medical Staffing	8	15	53%
Ante Natal Clinic	6	13	46%
Community Midwifery	17	21	81%
Maternity Staffing	39	52	75%
Pannal Ward	15	19	79%
Early Pregnancy Assessment Unit	5	5	100%
Total	90	125	72%

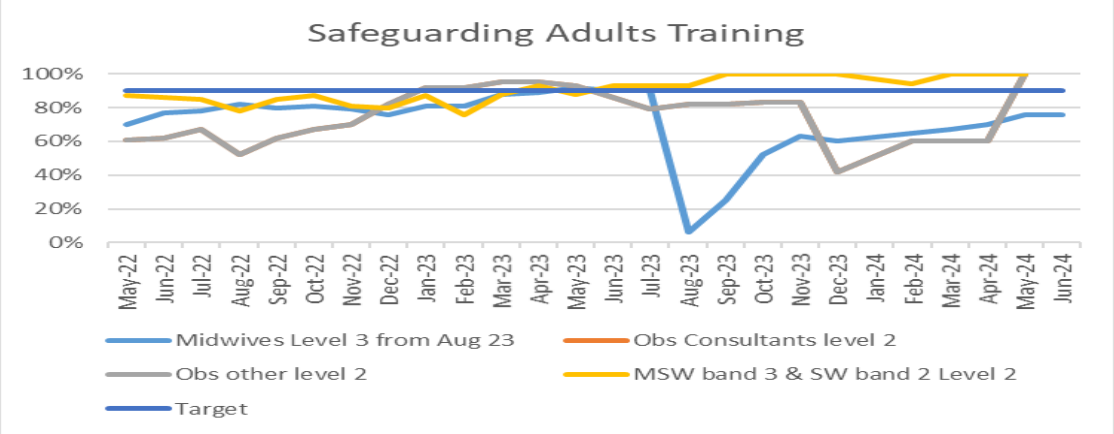
8.0 Training Compliance For All Staff Groups in Maternity Related to Core Competency Framework And Wider Job Essential Training

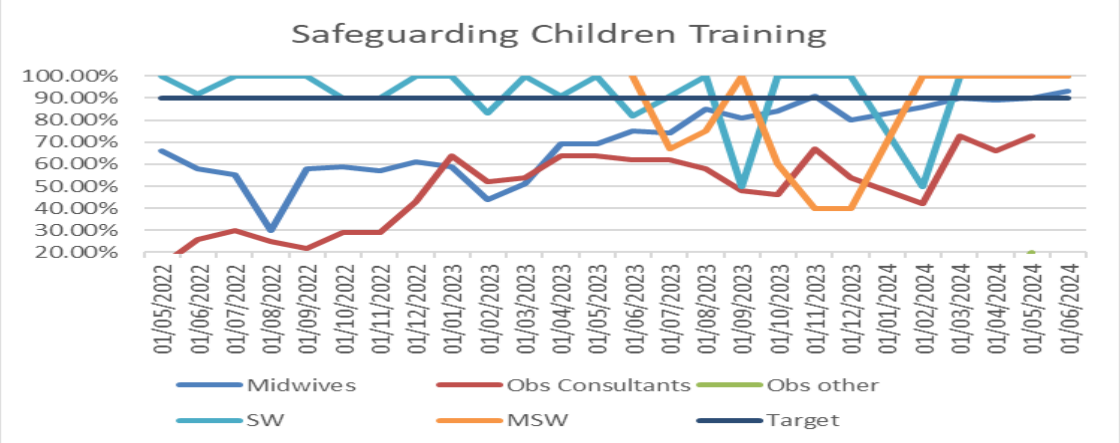
8.1 Mandatory training (as at 01/07/24)



8.2 Maternity Incentive Scheme and Core Competency version 2 Training Compliance

June 2024	Midwives	Obs cons	Obs other	Anaes cons	Anaes other	MSW
Adult Basic Life Support with paediatric modifications	85/86 – 99%	6/7 – 86%	7/8 – 75%	N/A	N/A	
Harrogate Newborn Advanced Life Support (HNALS)	8/13 – 62%	N/A	N/A	N/A	N/A	N/A
Harrogate Newborn Intermediate Life Support (HNILS)	82/86 – 95%	N/A	N/A	N/A	N/A	
MAT - Growth Assessment Protocol (GAP)	79/86 – 92%	7/7 – 100%	6/8 – 75%	N/A	N/A	N/A
MAT – K2 CTG	68/84 – 81%	5/7 - 71%	5/8 – 63%	N/A	N/A	N/A
MAT – Maternity Training Day 2	83/84 – 99%	7/7 – 100%	7/8 – 88%	N/A	N/A	N/A
MAT - Prompt	83/86 – 97%	7/7 – 100%	14/15 – 93%	9/11 82%	8/10 – 80%	15/15 100%
MAT - Saving Babies Lives	78/86 – 91%	6/7 – 86%	6/8 - 86%	N/A	N/A	N/A





8.3 Additional requirements

Safeguarding supervision-
Community midwifery = 87%,
Acute midwifery = 64% compliant
Anticipated increase in compliance, the projection is to reach more than 90 per cent by autumn 24.

RCUK NLS - 2 x Professional Development Midwives, 4 x coordinators completed RCUK NLS within last 4 years.
4 people booked on to training dates in August and September 2024 (total 13 to complete). Difficulty obtaining spaces on the external course. HDFT do not run the RCUK NLS course. Discussions with Bradford and Calderdale about the allocation of a further four spaces.

9.0 Risk and Safety

9.1 Maternity unit divert

There has been three events of divert of the unit in June 2024. Five 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 June four women were 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 or labour care.

9.3 Maternity Risk register summary

Risk Register reviewed 13/6/24. There are eight currently active risks

- **Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 9).** Situation unchanged at present. Scheduled theatre plans still on track with November timescale. Risk score remains the same
- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8)**. Risk unchanged. Requires audit to evidence from patient feedback that informed consent being undertaken correctly. Some work ongoing within LMNS about audit requirements and how to evidence. Local MVP also involved to seek patient perspective, but additional guidance required on how to elicit feedback regarding whether informed consent was taken without leading to patient trauma. Additional regional videos being developed to support informed consent about induction of labour. Work in progress but likely to be long term plan to evidence.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8).** Significant staff shortages of 8 WTE vacancies at present. Shortages leading to increased risk of needing to close the Maternity Unit with potential need for diversion of patients to other regional maternity units in attempt to preserve patient safety. Associated risk to patient safety due to lack of timely and effective care with possible remedial delays in planned procedures
- **Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8).** Over last 3 years, MAC

attendances have increased from average 150 attendances per month to 320 attendances per month. Midwifery staffing levels have not increased to compensate leading to increased pressure on the service. Risks that patients may breach required triage assessment timescales leading to possible safety consequences and delays causing poor patient experience. Additional staff stress and risk of burnout.

- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 6).** Standard Operating Procedure for checking Trust-wide systems including WebV/SystmOne/CPIS produced by Named Midwife for Safeguarding. Staffing requiring to completed training video prior to receiving WebV login. Risk currently to remain the same until implementation.
- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 4).** Issues improved. To monitor situation. Risk level 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).** Situation unchanged. Some ringfenced funding within LMNS budget to support Continuity of Carer. Expression of Interest request circulated amongst community staff but limited engagement. Currently not meeting continuity pathway requirements. Risk score remains the same
- **Risk to ability to diagnose preterm labour due to national shortage of Hologic fetal fibronectin (FFN) cassettes (Score 4).** Some supply on ward but restricting use. Advised that FFN test production will cease and qualitative Actim Partus will be test of choice. Risk to be reconsidered.

Planned addition of additional risk relating to inability to complete orthopaedic follow up and management of newborn hip concerns within required KPI timescales. Typically relates to disagreement with timescales by Leeds Orthopaedic Consultant. Risk level to be defined.

9.4 Maternity Incidents

In June 2024 there were 60 total incidents reported through DCIQ.

Two incident of Moderate Harm or above.

- One relating to a Maternal Cardiac arrest in response to a total spinal following migration of epidural catheter. 48h report completed and PSII investigation initiated. Duty of Candour (DoC) letter completed. No suspected lapse in care at this time and all appropriate safety checks were completed. Logged as Severe Harm.
- One return to theatre with intra-abdominal bleeding. 3.4L blood loss. Moderate Harm but appropriate management. For DoC letter.

Additional incidents of note include:

- Six incidents of Incorrect treatment/test/procedure (no theme)
- Five incidents of Readmission of Mother/Baby (3 maternal readmissions, 2 neonatal readmissions)
- Four PPH≥1500ml
- Four Shoulder dystocia (all occurring at instrumental delivery in theatre)
- Four incidents of Suspension of maternity services, including one suspension of home birth service
- Three Screening Related incidents

- Seven elective LSCSs completed in Delivery Suite Theatre

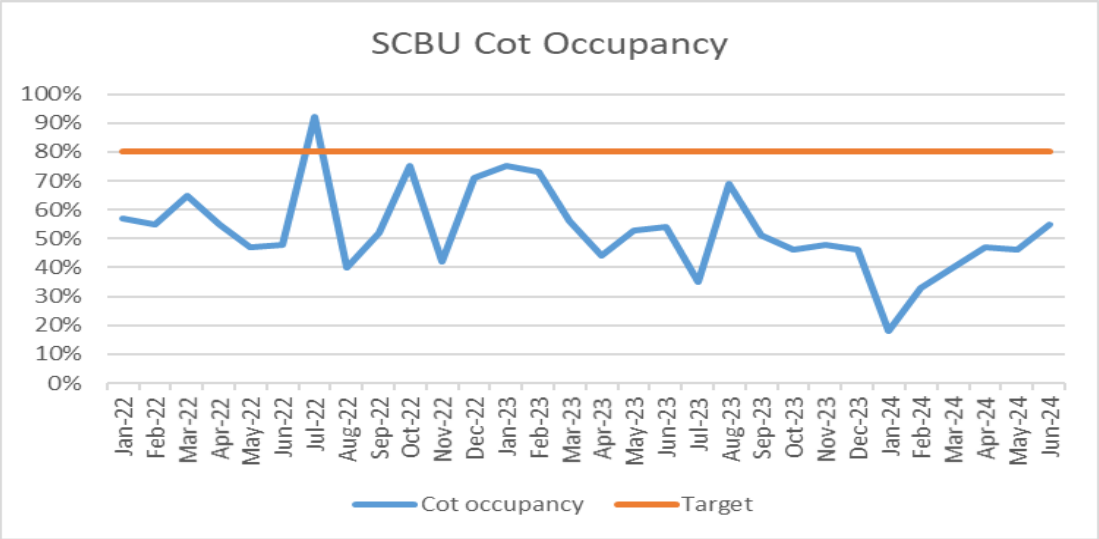
9.5 SCBU Incidents

No moderate harm incidents.

9.6 SCBU Risk Register

Vacancy of QIS staff added to risk register due to drop in % and anticipated maternity leave in September.

9.7 Cot occupancy and babies transferred out



One baby was transferred out during June due to prematurity.

10.0 Perinatal Mortality Review Tool (PMRT)

10.1 Principles for the conduct of local perinatal mortality reviews:

- There should be comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight <500g if the gestation at birth is not known;
- Such reviews should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- A multidisciplinary group should review each case at a meeting where time is set aside for doing the work
- There should be scope for parental input into the process from the beginning
- An action plan should be generated from each review, implemented and monitored
- The review should result in a written report that should be shared with families in a sensitive and timely manner
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6;
- All antepartum and intrapartum stillbirths;
- All neonatal deaths from birth at 22+0 to 28 days after birth;
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation;
- Babies who die in the community 28 days after birth or later who have not received neonatal care;
- Babies with brain injury who survive.

10.2 HDFT PMRT Information

One case requiring PMRT to be completed. See the quarterly report at Appendix A for further details.

11.0 Feedback

11.1 Maternity service user feedback

“Had baby in March 24. Everything was good. It seems like there is less staff problem however the care and treatment I receive was good during my stay in maternity ward. I feel well looked after and my baby during pregnancy, giving birth and early parenthood. The support during early parenthood is really appreciable. Harrogate’s maternity services is excellent. Everything they are doing is great apart from less staff in maternity ward which results in delay care but were amazing.”

12.0 Complaints

- One previously submitted complaint relating to forceps injury still waiting formal consent.
- One concern received relating to elective LSCS date
- Three complaint responses completed in June relating to previously submitted complaints
- One previous complaint still ongoing. Associated concern received from Birthrights about delayed response.

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 June 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.

Work is on-going to ensure all Safety Action requirements are met.

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.

17.2 UNICEF Baby Friendly Initiative (BFI)

Reaccreditation of WHO BFI Gold status confirmed for Special Care Baby Unit.
Quarterly readmission report included at Appendix A.

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 took place in May 2024. A feedback session with the Culture Coach is planned for July and an action plan will be developed.

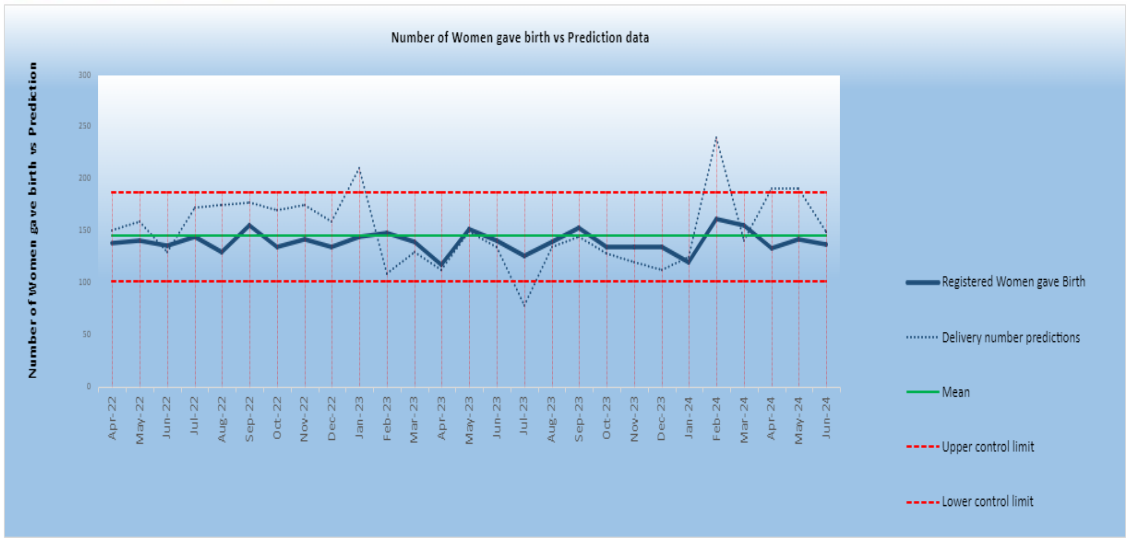
18.0 Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

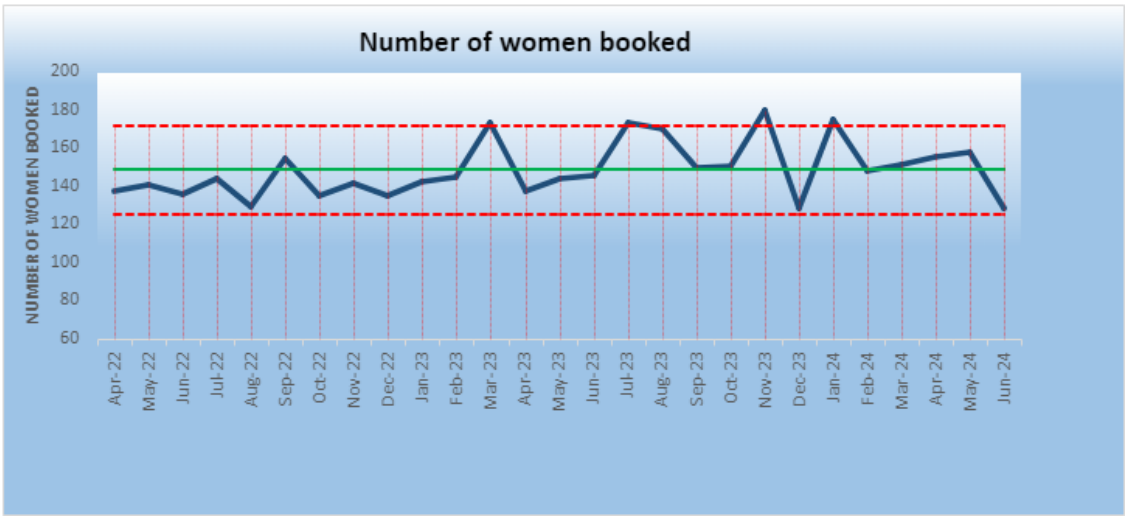
In summary for Quarter 4:

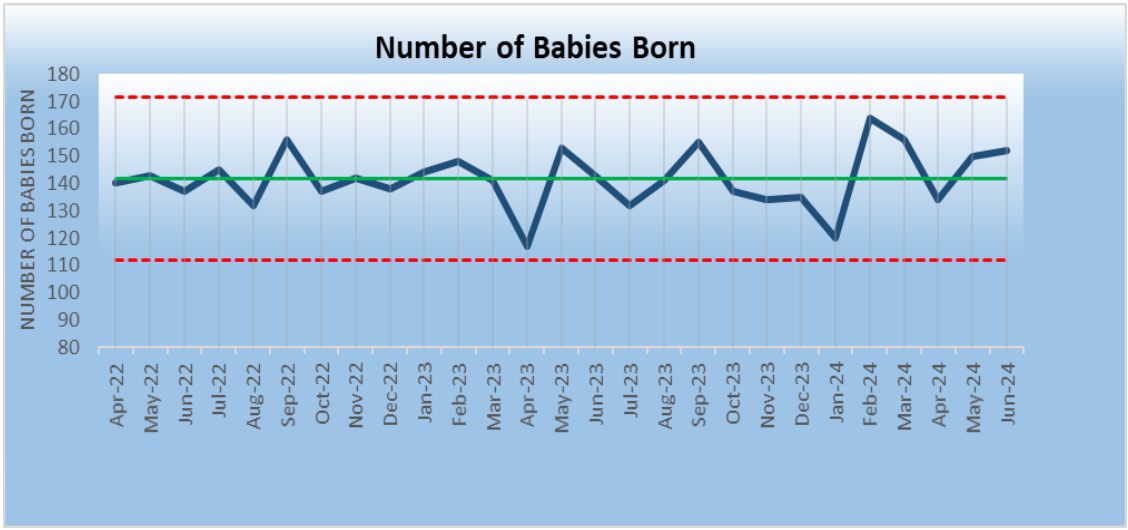
- Bookings less than 10 weeks are 68.9%. Y&H average 68.8%. No Y&H Trust has yet met the 90% target.
- 1:1 care in labour for HDFT was 94.9% in Q3. Y&H average 99.1%
- BBA rate 0.5% is comparable to the Y&H average of 0.9%.
- Homebirth rate currently 1.8%, against Y&H average of 0.7%
- Normal delivery rate was 48.1% in this quarter, against the regional average of 50.8%.
- Total Caesarean section rate was 41.6% in this quarter (compared to the regional average of 39.0%). Of these, there were 18.5% elective Caesarean sections (higher than the 15.8% regional average).
- Induction rate in this quarter was 40.7%, and this is above the Y&H average (37.8%), with the highest induction rate in the region being 46.3%.
- Significant PPH rate in this quarter (3.7%) is comparable with the regional average (3.5%).
- Preterm birth rate <37 weeks in this quarter (2.5%), was lower than the regional average (7.7%).
- There were no stillbirths at HDFT in Q4. Annual antenatal stillbirth rate is currently 0 per 1000 births compared with the Y&H average of 3.3 per 1000.
- Breastfeeding initiation rates remain high at 86.3% compared with the regional average of 70.2%.
- Smoking rates at booking and time of birth are 3.9% and 3.9% respectively. This remains low, compared with Y&H average of 9.9% and 7.1%.

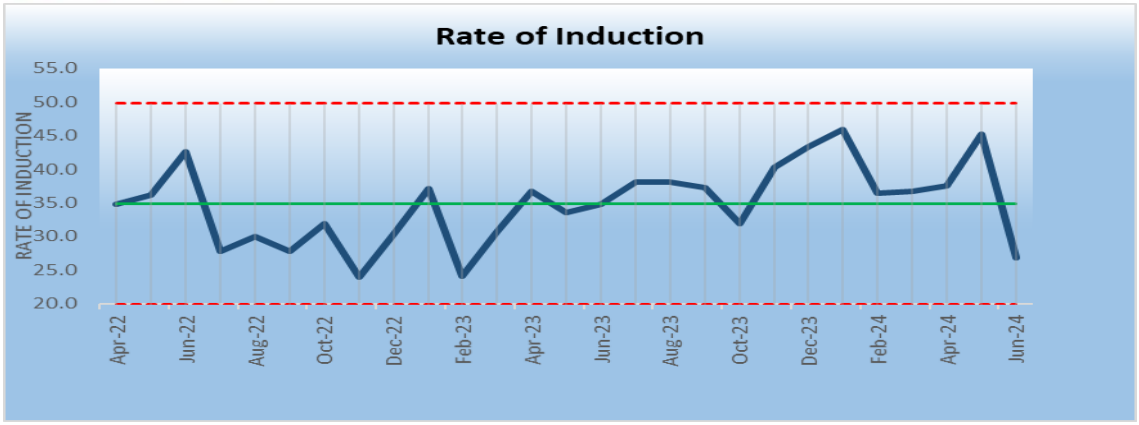
19.0 Local HDFT Maternity Services Dashboard

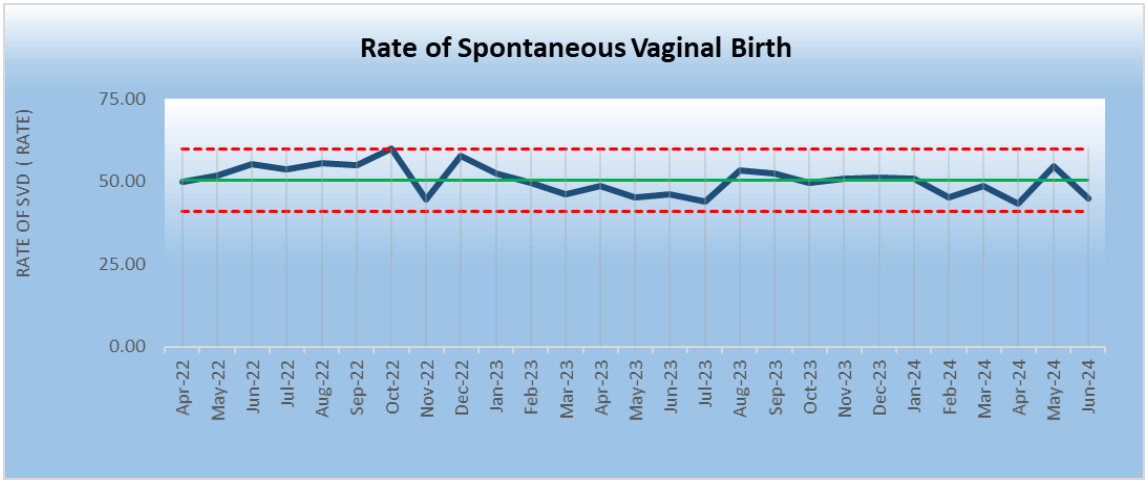
The metrics available demonstrate that there are no statistically significant outlying metrics this month.


Number of Women gave birth vs Prediction data
Number of Women gave birth vs Prediction
Registered Women gave Birth
Delivery number predictions
Mean
Upper control limit
Lower control limit


Number of women booked
NUMBER OF WOMEN BOOKED


Number of Babies Born
NUMBER OF BABIES BORN


Rate of Induction
RATE OF INDUCTION
55.0
50.0
45.0
40.0
35.0
30.0
25.0
20.0
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
Jun-24


Rate of Spontaneous Vaginal Birth
RATE OF SVD (RATE)
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
Jun-23
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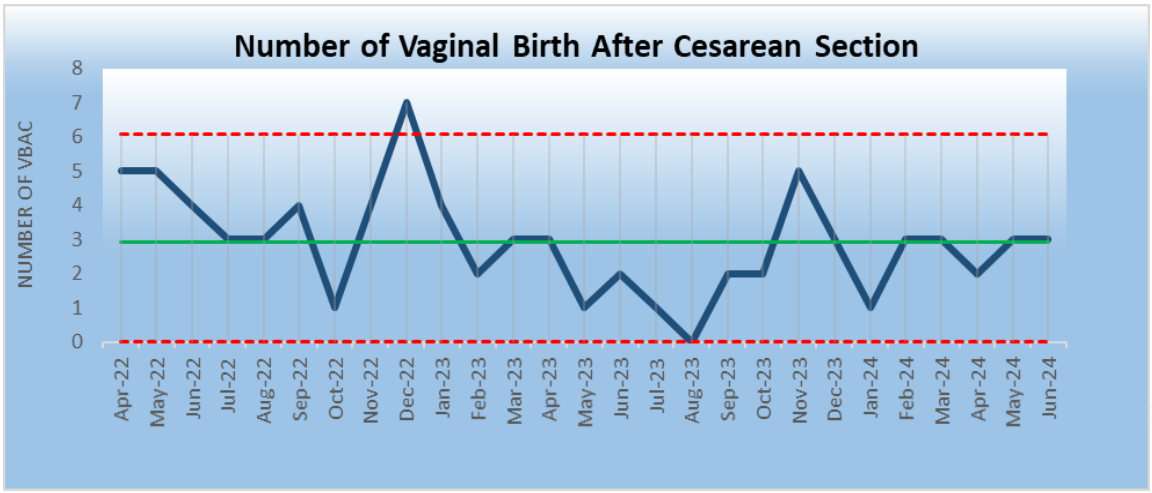
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24


Number of Vaginal Birth After Cesarean Section
NUMBER OF VBAC
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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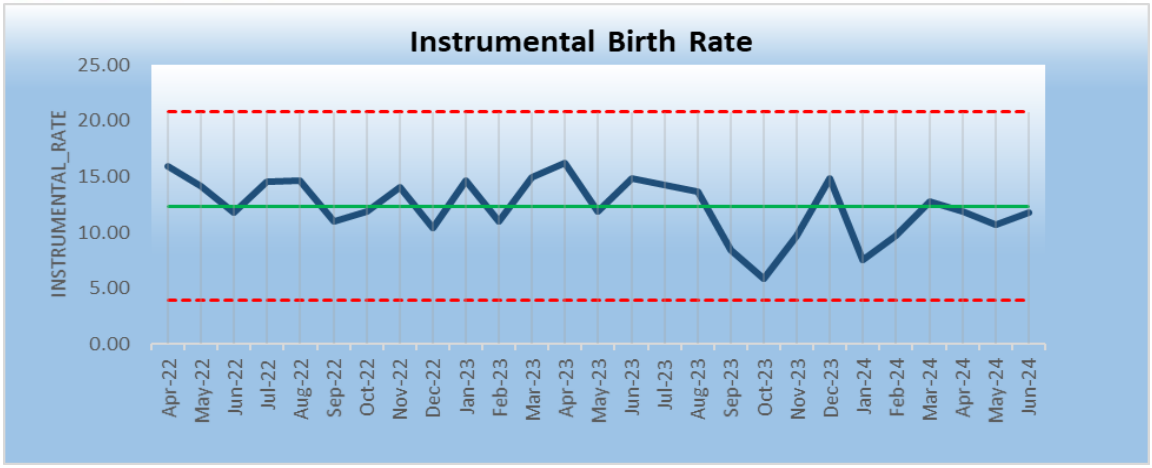
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24


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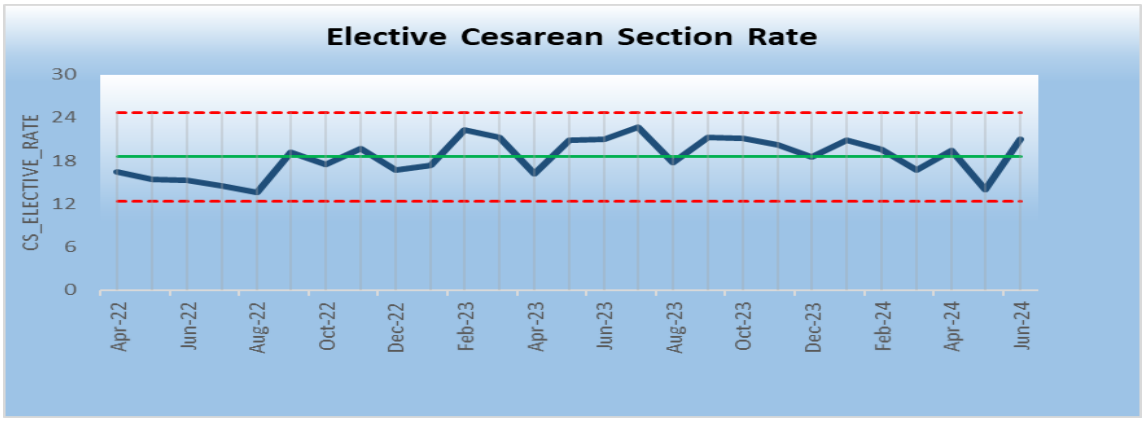
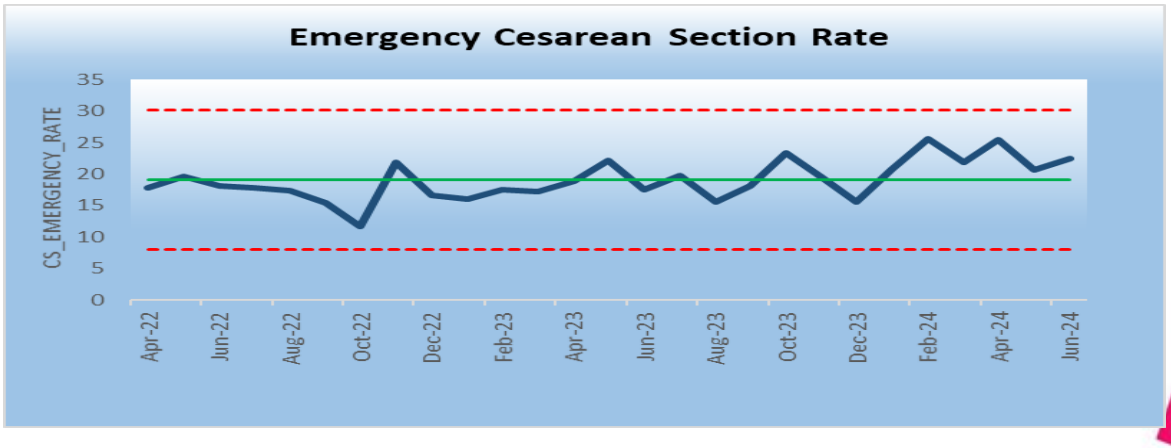
Feb-24
Mar-24
Apr-24
May-24
Jun-24


Elective Cesarean Section Rate
CS_ELECTIVE_RATE
30
24
18
12
6
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
Jun-24


Emergency Cesarean Section Rate
CS_EMERGENCY_RATE
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30
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20
15
10
5
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
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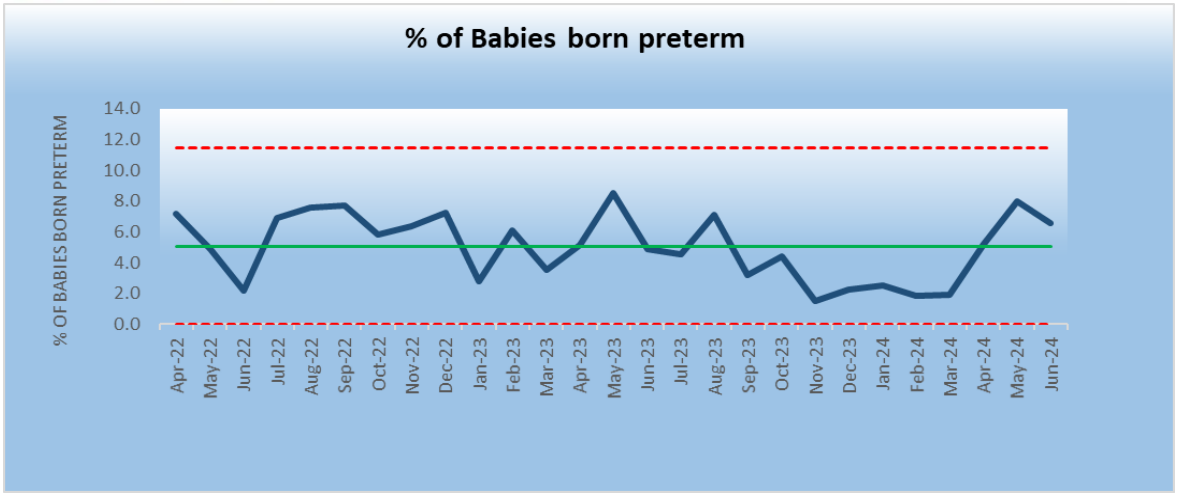
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24


% of Babies born preterm
% OF BABIES BORN PRETERM
14.0
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
Jun-23
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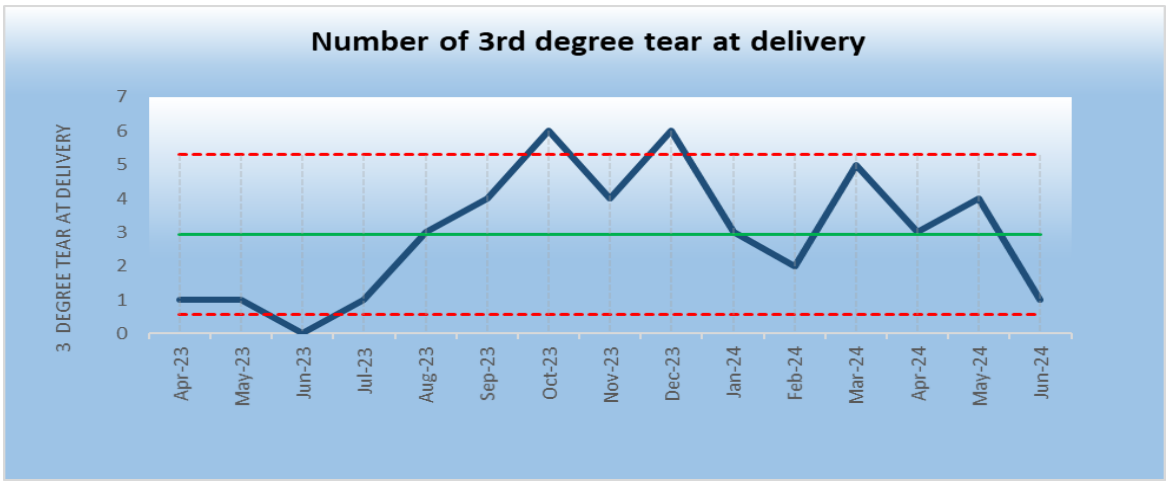
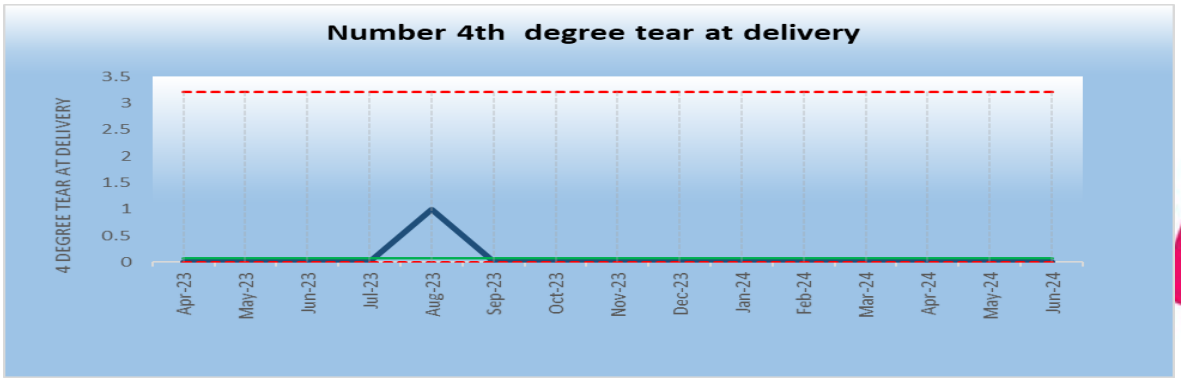
May-24
Jun-24


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
May-24
Jun-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
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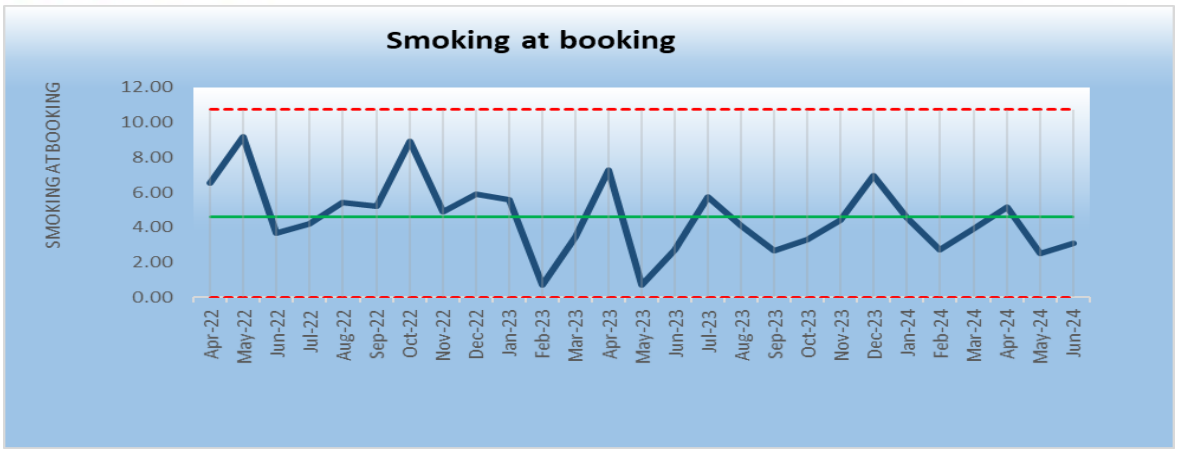
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24


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
May-23
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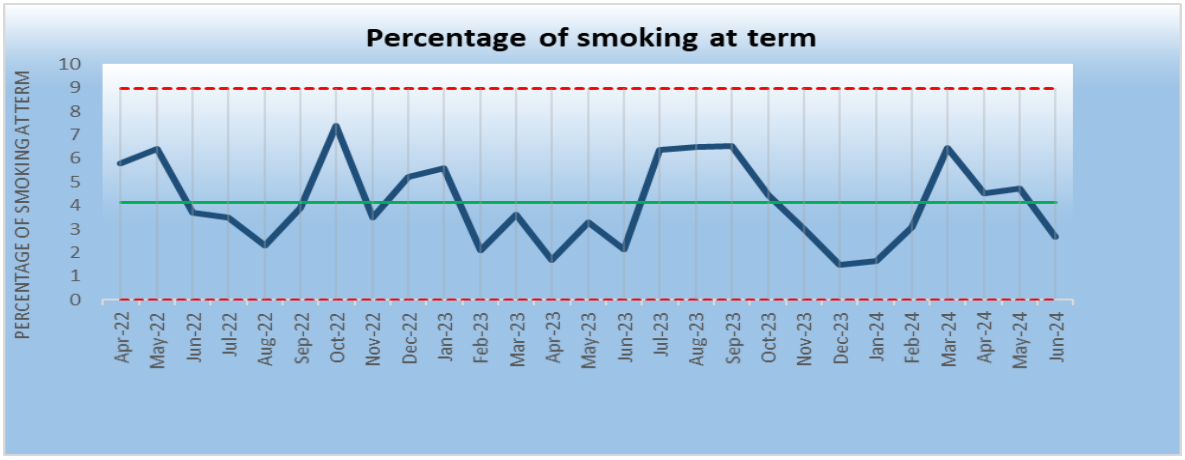
Jun-24


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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Mar-24
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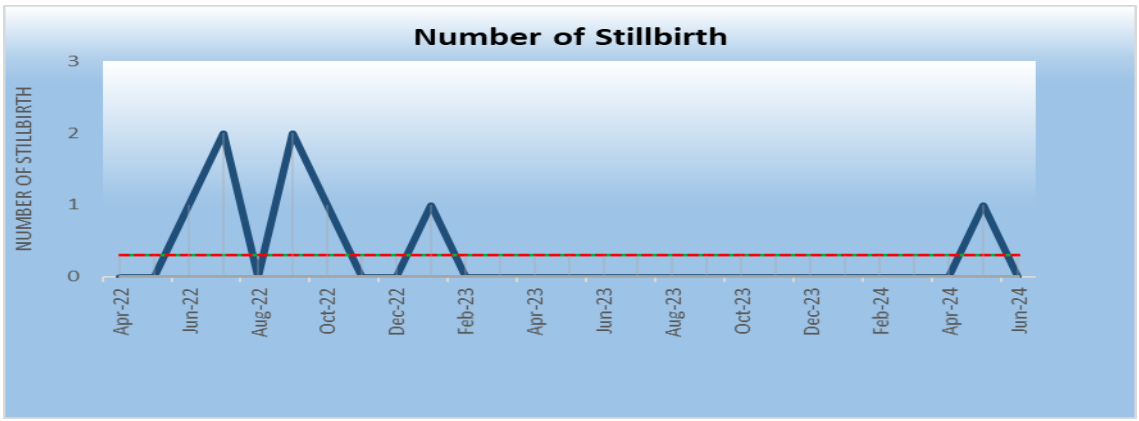
May-24
Jun-24


Number of Stillbirth
NUMBER OF STILLBIRTH
3
2
1
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
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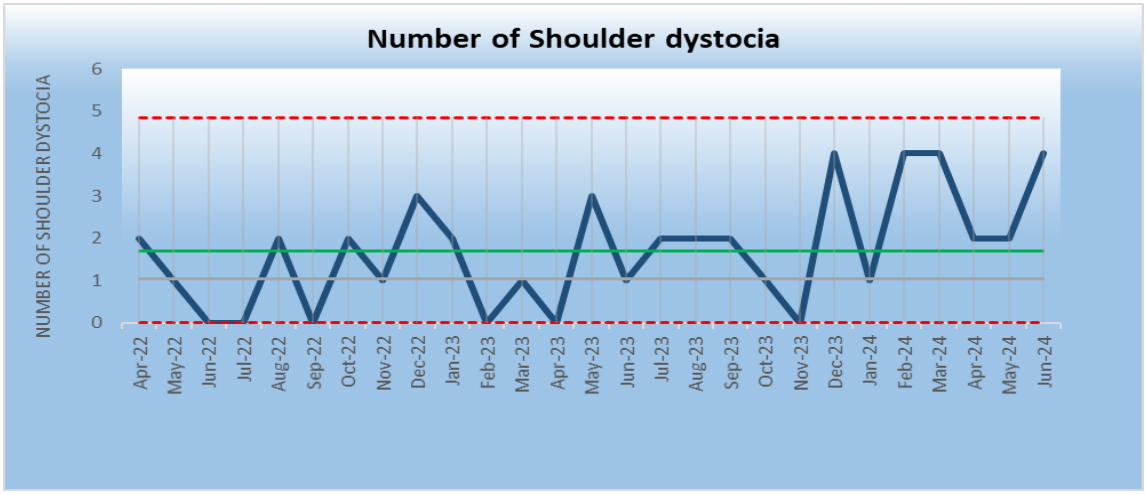
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24


Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
0
1
2
3
4
5
6
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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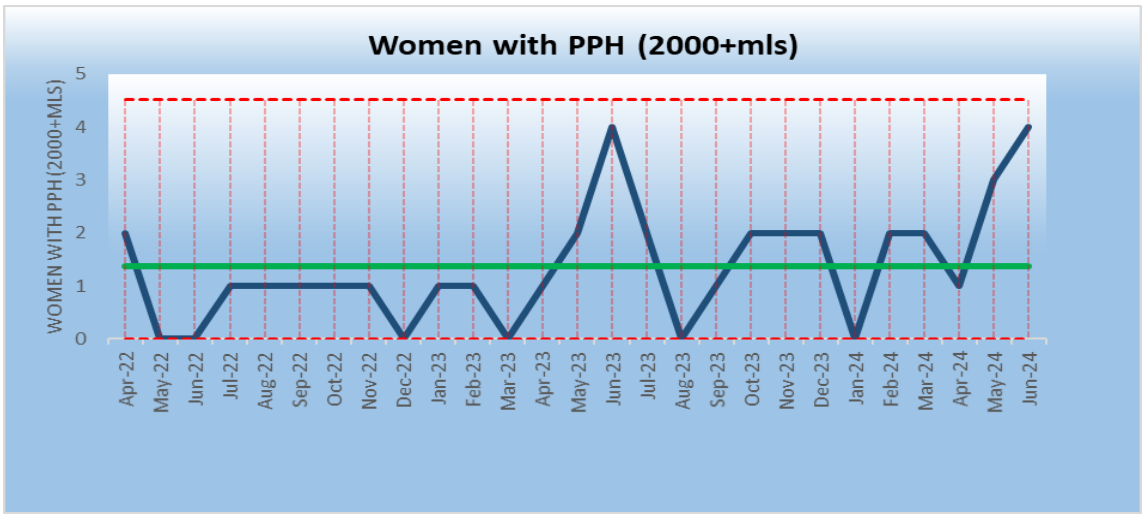
Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)
0
1
2
3
4
5
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
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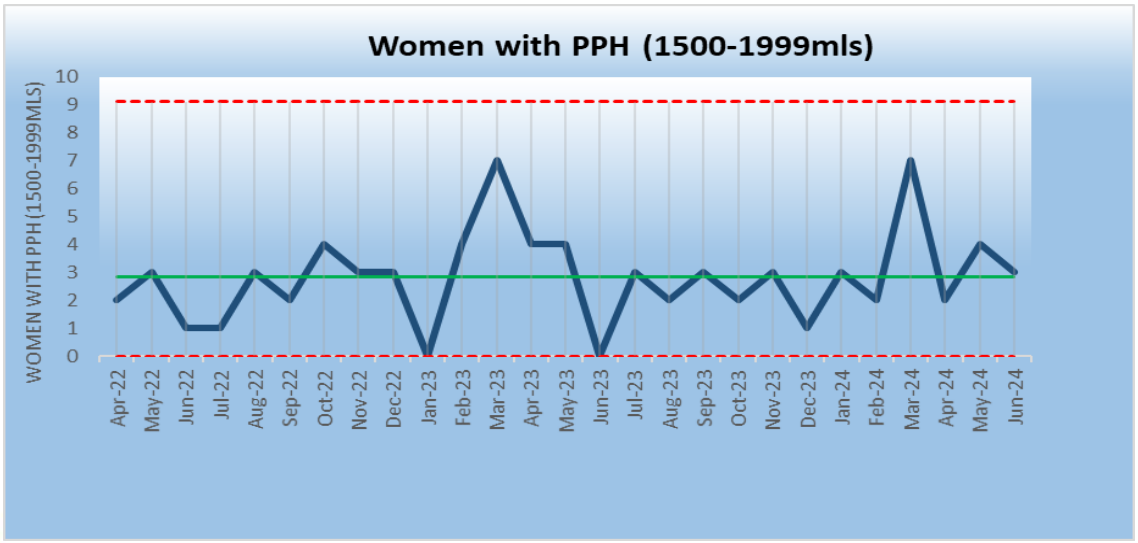
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24


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
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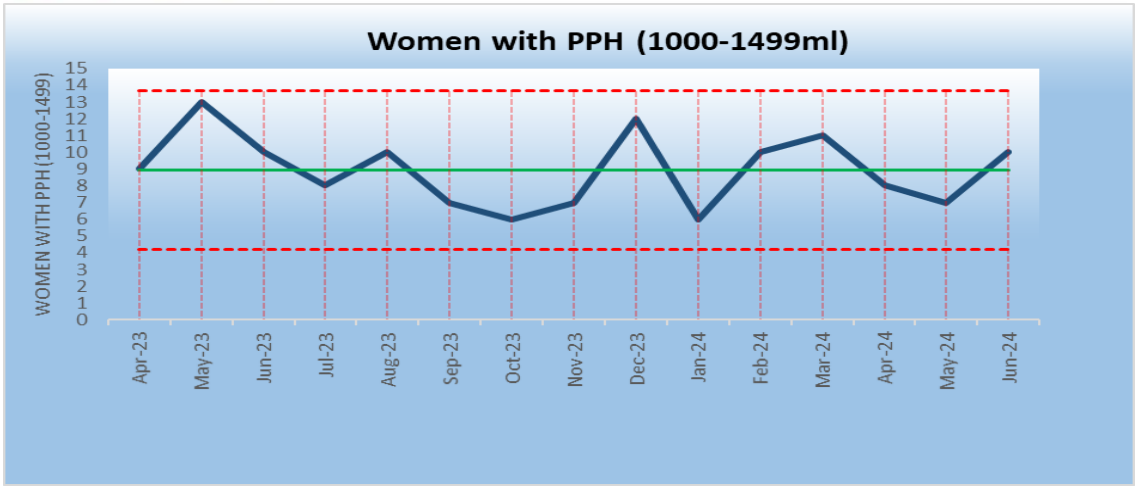
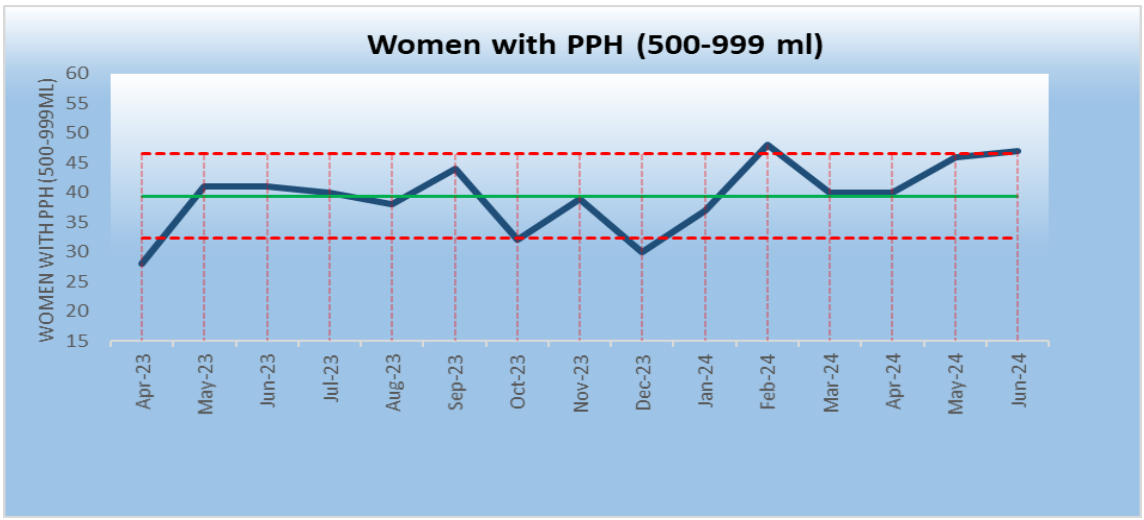
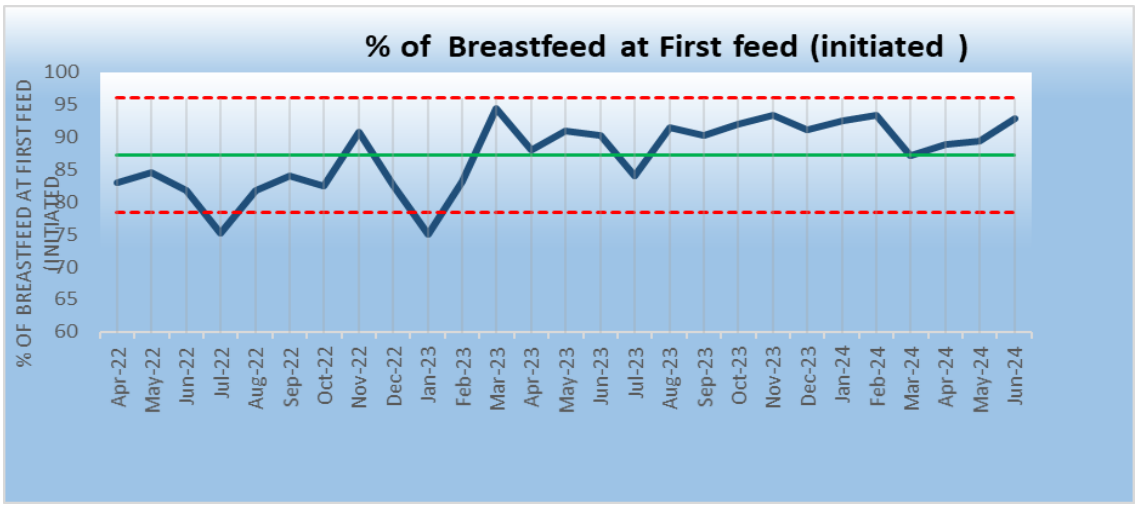






20.0 Avoiding Term Admissions in Neonatal Units (ATAIN)

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. See Appendix C for quarterly report.

20.1 Term Admissions to SCBU

One Unexpected Term Admissions to SCBU (ATAIN) in June 2024 due to low oxygen saturation following emergency LSCS.

20.2 ATAIN actions

See Appendix C

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%)	
	April-June 2024	June 2024
Percentage of babies <3rd centile >37+6 weeks' gestation	3.4% (15/440)	3.29% (5/152)
Percentage of babies <10th centile >39+6 weeks' gestation	3.4% (15/440)	4.6% (7/152)
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)	2 fetal loss born 16-23+6 weeks (0.46%, 2/428)	1 fetal loss 16-23+6 weeks (0.6%, 1/147)
• Preterm (24+0-36+6 weeks)	4.2% (live, 18/428) 0.23% (stillborn, 1/428)	2.7% (live, 4/147)

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

22.0 Maternity Safety Champions

Bi-monthly walk around and meetings continue. The next walk around and meeting is planned for 15th July 2024

23.0 Conclusion and recommendation

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

Appendix A

Compliance of completion of Perinatal Mortality Review Tool, Quarter 1, April-June 2024

This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the second quarter, April-June 2024.

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

Requirements of the Maternity Incentive Scheme Safety Action 1:

1. **Notify all deaths:** All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.
2. **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023.
3. **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.
4. **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

Table 1: Eligible perinatal death against MIS requirements

Compliance of eligible perinatal deaths with MIS requirements

MBRRACE-UK Case ID	Date of death	Date of birth	Reported to MBRRACE (within 7 working days)	Review started (within 2 months)	Report published (within 6 months)	Parents informed of review and questions/concerns sought
93563	30.5.24	30.5.24	30.5.24	17.6.24	In progress	Yes
Overall Compliance against targets of Safety Action 1			100% - Compliant (target 100%)	100% - Compliant (target ≥95%)	100% - Compliant (target ≥60%)	100% - Compliant (target ≥95%)

During Quarter 1, one perinatal death was eligible to be reported to MBRRACE-UK and receive a panel review as part of PMRT. The PMRT report is currently in progress and a panel review is due to be scheduled in line with the MIS requirements.

Ongoing Action Plan following PMRT review

Root cause/Contributory Factor	*Action*	*Risk at review*	*Evidence of Progress/Completion*	*Target completion date*
Lack of compassionate communication and care	Ongoing work into provision of compassionate care, including culture survey work with MVP around language. Complete SCORE (culture survey). Continue to provide staff with case studies and parental feedback to work on culture.		SCORE (culture survey) completed and closed 18.3.24. Ongoing culture conversations and awaiting results from culture survey due in July 2024.	31.7.24

Appendix B

Hospital readmissions of babies within 30 days of life

Quarter 1 *April – June 2024*

1.1 Report Overview

Potentially preventable readmissions, such as for jaundice or feeding problems, make up the majority of early neonatal readmissions across the UK. Theoretically, such admissions could be reduced either through additional support during the newborn hospital stay, or increased levels of follow-up after discharge. Evidence on safe early discharge is conflicting as most of the evidence comes from the United States where postnatal care in the community is very different. UK studies have demonstrated that decreasing the length of postpartum stay does not increase readmission rates, given adequate postnatal care outside of hospital.

There should be cautious interpretation of data between Trusts across the UK due to differing admission criteria, breastfeeding rates and levels of supplementation of breastfed babies in the community. Although lower readmissions is often measured as a positive marker this may be at the detriment of exclusive breastfeeding. Breastfeeding initiation in Harrogate is currently 88.8% and supplementation rates continue to be within World Health Organisation and Unicef UK parameters (2023/24).

1.2 Process for data collection

A datix report is completed for all babies readmitted within 28 days with Jaundice and /or feeding issues (weight loss). Datix reports are then investigated by the infant feeding co-ordinator to determine if care was appropriate in the days before admission. Individual feedback is given to staff when appropriate and general themes and trends are examined in more detail and discussed at the Maternity Risk Management group (MRMG).

1.3 External reporting

Health Care Evaluation data (HED) is an external reporting system used by HDFT which compares *all* readmissions of babies in the first month of life. The aim is to enable healthcare organisations to drive clinical performance in order to improve patient care and deliver financial savings

1.4 National guidance

Both maternity and paediatrics follow NICE guidance on recognising, measuring, monitoring and treating jaundice in the newborn. Maternity and paediatrics also use UK-WHO information and growth charts for monitoring weight loss and growth in babies and children.

1.5 Local guidance and preventative measures

- Unicef UK Baby Friendly weight loss guidance has been adapted locally to ensure plans of care are introduced early and are supportive of long term breastfeeding.
- A breastpump loan scheme supports mothers to implement plans of care.

1.6 Individual readmission data of babies with jaundice / feeding issues in the first month of life - Quarter 1

Jaundice	Age when readmitted	Gestation at birth	Treatment	Length of stay
Baby 1	3 days	39+2	Phototherapy	24 hours
Baby 2*	2 days	37+5	Phototherapy	24 hours
Baby 3	3 days	39+6	Phototherapy	48 hours
Baby 4	2 days	37+2	Phototherapy	48 hours
Baby 5*	4 days	35+5	Phototherapy	48 hours

Feeding issues	Age when readmitted	Gestation At birth	Weight loss	Treatment	Length of stay
Baby 6	9 days	39+3	12.7%	Feeding plan	48 hours
Baby 7*	3 days	39+6	12.6%	Feeding plan	48 hours
Baby 8*	9 days	40	13%	Feeding plan	5 days
Baby 9*	4 days	41+4	15.6%	Feeding plan	24 hours
Baby 10	3 days	40+2	14.9%	Feeding plan	24 hours

Comments *

Baby 2 – Baby admitted with jaundice within exchange transfusion levels, direct Coombs positive. Treated initially on Pannal ward with multi-surface phototherapy but transferred to SCBU after 4 hours as serum bilirubin levels not responding.

- *Following recent review of the jaundice guideline it is now agreed that babies requiring multi-surface phototherapy will be cared for in SCBU.*

Baby 5 – Baby treated with phototherapy on the ward before discharge, then readmitted again at 4 days and 8 days of age requiring further treatment. Remained under the care of paediatrics for investigations including genetic screening.

Baby 7 – Admitted with weight loss. No other concerns noted by community midwife, stooling and urine output appropriate for age. On admission baby found to have low blood glucose and was treated with glucose gel, no risk factors to trigger hypoglycaemia policy post birth, baby remained asymptomatic.

Baby 8 – Admitted for weight loss day 9, feeding plan implemented at home however vomiting after feeds. 'Floppy episodes' in hospital. Metabolic screening sent, antibiotics commenced. Feeding plan introduced and gaviscon for possible reflux. Blood cultures negative.

Baby 9 – Admitted for 15.6% weight loss on day 4, however baby had lost 13.5% on day 3. At this point it was agreed by the paediatrician and midwife to keep the baby at home with a feeding plan.

- *Plan of care did not follow guidance. Feedback given to staff involved.*

Chart 1 Statistical process control chart (SPC) for readmissions with feeding issues /weight loss since April 2020

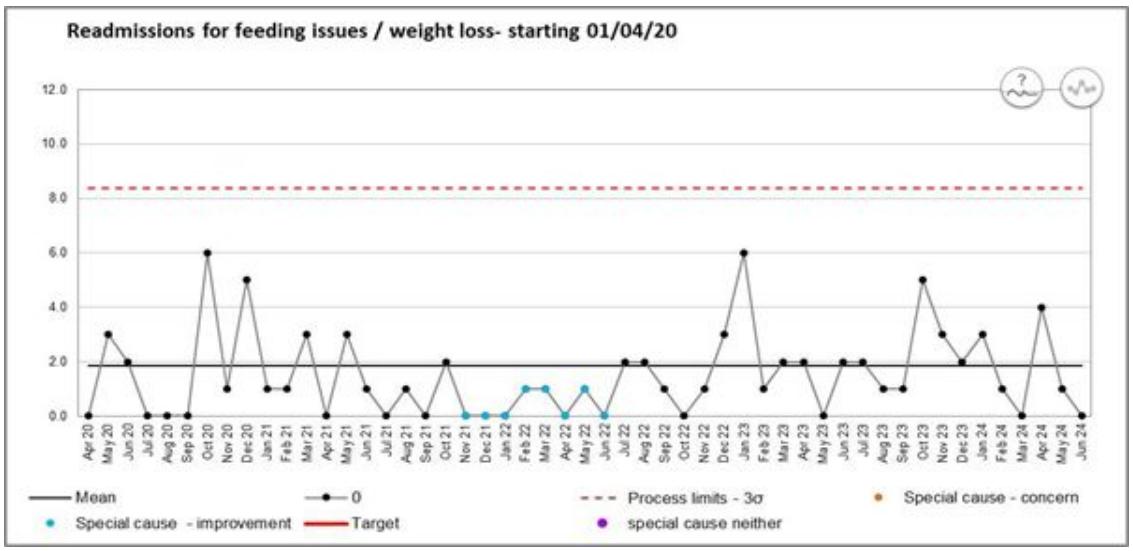


Chart 2 SPC chart for readmissions with jaundice since April 2020

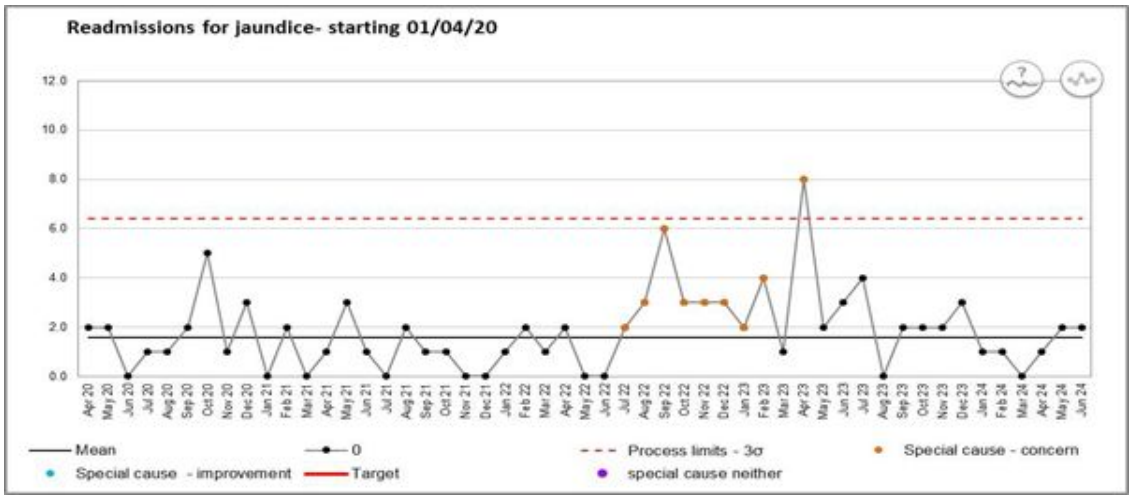
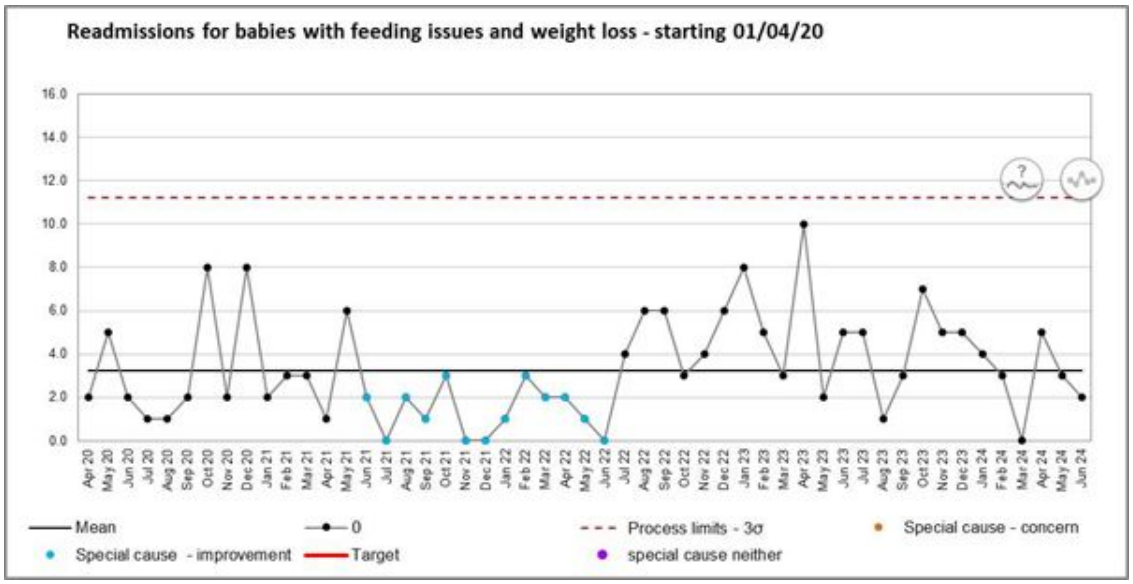


Chart 3 SPC chart including *all* babies' readmitted for jaundice and/or feeding problems since 2020



1.7 Recommendations

Action plan

Recommendations from datix review	Action To Achieve Compliance with Recommendation (SMART)	Lead Responsible	Expected Completion Date	Comments
Ensure accurate weighing and recording of babies weights in hospital and community	Ensure staff: • Check weight with another person, except where not possible in exceptional circumstances • Take a photograph for evidence. • Enter the weight on BadgerNet immediately. • Take care not to transpose digits. • Make sure equipment is set to zero prior to placing baby on the surface. • Baby's to be weighed naked.	Andy Brown	**Completed**	'Learning from incidents' news letter sent to all staff
When possible avoid overnight stays for babies	1. Explore cost of purchasing a hospital grade double breastpump to loan to	Jo Orgles	**July 2024**	June 24:

with weight loss that have normal blood test results	parents overnight to help with feeding plan. 2. Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on the postnatal ward in 24 hours.			
Ensure feeding plans are consistent for babies readmitted with weight loss.	1. Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to supplement and when to repeat weight and bloods. 2. Update guideline to reflect outcomes of decisions made at meeting. 3. Communicate updated guideline to staff. 4. Ensure training includes updated guidance.	Pat Gilbertson Jo Orgles	**July 2024**	June 24: In progress
Ensure moderately preterm babies on the postnatal ward receive the same level of care as babies on SCBU	1. Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care. 2. Develop an information package for parents. 3. Ensure any changes to care are included in appropriate guidelines	Jo Orgles Amy Howard	**August 2024**	June 24: In progress
Share learning with the community team to improve care and consistency	1. Arrange dates to meet with community midwives 2. Share good practice and discuss individual	Jo Orgles Ellie Kay	**October 2024**	

	cases where care could possibly be improved 3. Develop plans of care for static weight / weight loss following introduction of a feeding plan			

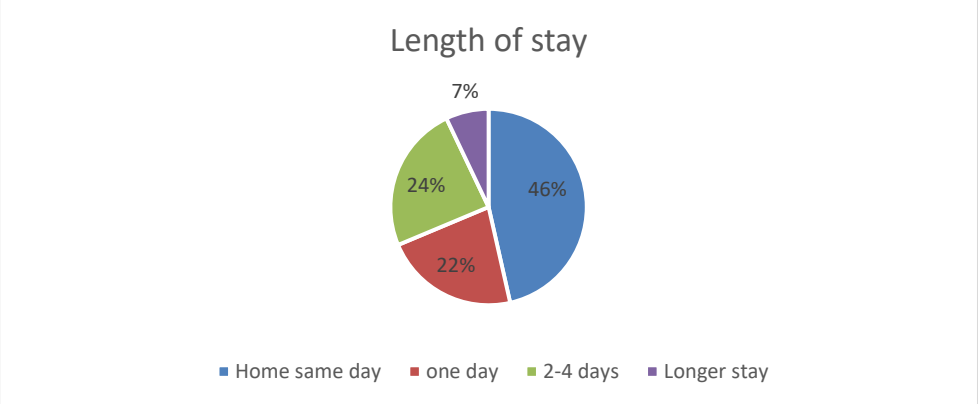
1.8 Increased readmissions to paediatrics

In July 2022 /2023 HDFT received alerts from HED due to higher than expected readmissions of babies under a month of age. In March 2023 the process for triaging babies on Woodlands was changed and now all babies with no concerns other than jaundice and/or feeding are seen directly on Pannal ward. This new pathway ensures a suitable environment for the needs of mothers and babies, supports breastfeeding and reduces the risk of hospital acquired infections. However neonatal admissions for other causes remain high – see 1.9 for further details.

1.9 Paediatric readmission data – Quarter 1

A total of 44 babies, with an age range between 2 and 30 days, had 53 readmissions for a variety of reasons. Three of the babies were admitted to SCBU as no beds were available on Pannal ward.

Chart 4 Length of stay of babies admitted to paediatrics in the first month of life.



1.10 Conclusion

Readmission of a baby to hospital causes stress and anxiety for parents and families and the aim is to avoid this whenever possible. For some babies' there are no alternatives to admission and care in a hospital setting is essential. However, there are a small number of babies where, for differing reasons, admission is preventable and for some, care could potentially be improved in the community.

We continue to assess individual cases and learn from each event to prevent recurrence. We also aim to find modifiable predictors and develop interventions to reduce risk in certain categories. Presently the highest reason for readmission to maternity is jaundice with prematurity being a significant risk factor. All actions will be implemented (see action plan 1.7) and evaluated. Progress will be monitored via Maternity Risk Management Group.

Appendix C

ATAIN and Transitional Care provision report Quarter 1

(April- Jun 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 1 2024/25:

During quarter 1 there were a total of 435 babies of all gestations born in Harrogate, 407 of these were >37/40 weeks gestation and there for admissible for ATAIN audit. Of the 407, 5 babies of >37/40 gestation were admitted to the neonatal unit. Special Care Baby Unit (SCBU) admissions for this quarter were 1% which is lower than the previous quarter at 3% and lower than the 3% that has been consistently reported in all other quarters of the year. Four cases have been reviewed at the multi-disciplinary ATAIN forum. Of the cases reviewed at the forum one was rejected as did not meet ATAIN criteria. Three of the cases had been reviewed and were deemed to have had appropriate care with none being noted as potentially avoidable. Information on cases taken from datix. One case remains listed as under review on datix and had no review information added.

Case 1:

Baby born at 0423, IOL due to gestational diabetes. Apgar 8/1,9/5, noted to have only 2 vessels in cord. Baby commenced hypoglycaemia pathway began grunting at 4 hours of age. Continued to intermittently grunt and became intermittently tachapnoeic. Baby was reviewed multiple times over the day and night shift. Scored 4 on a routine NEWS midwives requested further review. X ray performed and cannula and IV's sited and commenced. X-ray report was abnormal, baby was transferred to SCBU for oxygen therapy. Appropriate admission.

Case 2:

Baby born in main theatre at ELCS, set of twins, single twin admitted following 2222 emergency resuscitation call. Admitted to SCBU deemed appropriate care.

Case 3:

Baby admitted to SCBU following placental abruption at birth. Delivered in good condition but required PEEP to maintain optimal oxygen saturations. Transferred to SCBU for ongoing respiratory support.

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:

None of the cases reviewed for this quarter were deemed potentially avoidable.

Evaluation of Data:

The most common condition for admission was Respiratory Distress Syndrome (RDS) with admissions in the quarter with four of four cases listing RDS as admission reason – this remains consistent with previous quarters as being the leading cause of unexpected admission to SCBU.

Condition	Number of Admissions	Number of Avoidable Admissions
Hypothermia	0	0
Jaundice	0	0
Respiratory Distress Syndrome	4	0
Hypoglycaemia	0	0
Other Clinical Conditions	0	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 which are unwell which is well known by the team and followed should the need arise. We are continuing to within our MDT to ensure these occur at a set time every day and increase representation from both services.

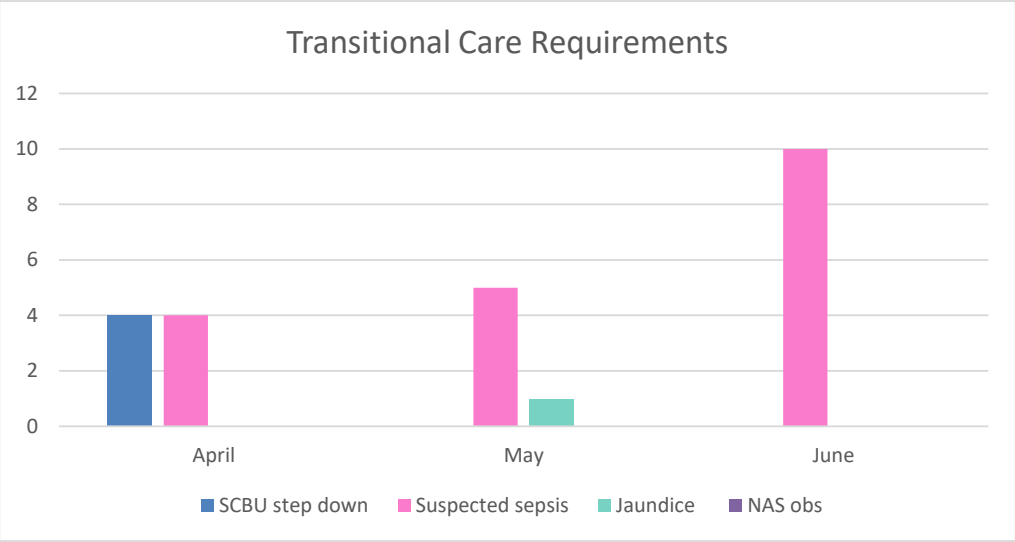
Transitional Care Provision 2023/24:

The table below shows a breakdown of TC activity delivered within Harrogate during 2023.

Date	Number of admissions	Electronic method used to record data
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
April 2024	8	Badgernet
May 2024	6	Badgernet
June 2024	12	Badgernet

Quarter 4 Transitional Care Data:



During quarter 1 there were a total of 26 babies requiring transitional care provision. 19 of these admissions were due to suspected sepsis and completed Intravenous Antibiotic treatment, four were stepped down from special care and reunited with parents on Pannal ward and 26 babies have documented reasons for requiring transitional care. Two babies (a set of twins) were included in the audit but in addition to TCU care were admitted to SCBU on day 5 due to weight loss. Their care episode was completed on SCBU.

There are 23 noted to have Badgernet documentation, there are two episodes of no badgernet documentation being recorded but written documentation being completed. There is one incident of no documentation being recorded. Since q1 2023 transitional care documentation has commenced under the dedicated tab in Badgernet. It is noted that 23 of the 26 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, compliance with reporting consistent documentation within badger has been consistent until this quarter where we have noted a drop. In aims to continuously improve the completion of Badgernet ward rounds we have included this 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
Increased documentation in TC booklets/ Badgernet	Introduced at junior doctors induction, badgernet training Continued meetings with digital midwife to assess possibility for inputting on badgernet. Will be included in induction.	Nina Kapur, Rachael Waddington	**Completed 30/09/23**
Transitional Care inclusion at Obstetric/ Neonatal Meeting	Transitional care added to agenda as a standing discussion item	Lesley Copeland	**Completed 30/11/23**
Requirement of TC booklets	Discussion to examine need of using booklets alongside badgernet	Lesley Copeland Nina Kapur Rachel Robson	**Completed 01/09/23**
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	**31/07/24**

Appendix 1: Cumulative HDFT ATAIN Action Plan:

Add to proforma for Trisomy 21	Jo Orgles	**Completed**	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 medical staff & share with SCBU	Pat Gilbertson	**Completed**	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 justification 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	**Completed**	Audit not undertaken however improvements are in place to speed up the transfer
Midwifery leads to disseminate to staff	Laila, Jo & Lesley	**Completed**	Emailed 4/2/24

Do not passively cool on delivery suite to ensure drugs would be effective if required	Lisa and Pat	**Completed**	Disseminate to nursing & medical staff
Determine acceptable saturations for babies with a pneumothorax receiving oxygen, to guide oxygen delivery	Lisa Nesbitt	**Completed**	Contact ODN
Follow hypoglycemia policy correctly -	Jo Orgles/Amy Howard	**Completed**	
Check base excess after resuscitation to determine if baby needs to be put on hypoglycemia policy	Jo Orgles	**Completed**	Educate midwifery staff & share with SCBU
Do not check blood sugar if 'jitters' are baby's only symptom	Jo Orgles	**Completed**	Educate midwifery staff & share with SCBU
Formula via NGT should be 1st line treatment for hypoglycemia (unless <1.0) on SCBU, instead of IV fluids (unless baby has signs of RDS)	Jo Orgles	**30/07/24**	Educate medical staff & share with SCBU
Stay longer with stable babies on D/S with borderline observations, whilst they transition to ex utero environment	Amy Howard/ Pat Gilbertson	**Completed**	Medical & nursing feedback to admitting Dr/Nurse
	Lisa Nesbitt	**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
	Lisa Nesbitt	**Close to continue monitoring**	Audit last 3 months of Vapotherm use in term babies on SCBU to see if there was clinical jusitification for use
Improve management of neonatal airways using the i-gel	Amy Howard	**Completed**	Include insertion of i-gel as part of neonatal simulations

Reduce the time taken to transfer antenatal women to theatre once the decision has been made to caesarean section	Paula Olsen	**Completed**	Audit previous transfers to determine potential causes of delay
Do not use adult bladder scanner on babies on postnatal ward	Laila, Jo & Lesley	**Completed**	Midwifery leads to disseminate to staff
Prior to considering catheterisation, for medical team to discuss with Consultant.	Pat Gilbertson	**Completed**	Disseminate to medical team
Explore can an 'Air' port be installed in main theatres recovery for NEONATAL USE ONLY, in order to observe babies without having to use resuscitaire cylinder	Lisa Nesbitt	**30/07/2024**	Discuss with resuscitation team
Registrar or higher must review baby prior to admitting patient.	Pat GIlbertson	**Completed**	Disseminate to medical team
Mandatory discussion must take place with mothers about safe skin to skin on PNW & SCBU	Jo Orgles/ Lisa Nesbitt	**30/70/24**	Midwifery team to document in free text on Badger net that discussion has been had. SCBU to incorporate tick box into admission paperwork
Discussion about resuscitaire in recovery areas - using SCBU resuscitaire or new platform	LC/LB	**30/07/2024**	For agreement with theatre manager
For a baby on PNW with low oxygen saturations on handheld monitor, recheck sats with resuscitaire probe	Lisa Nesbitt	**Completed**	Disseminate to midwifery staff
Babies who are jaundiced and require 'intensified phototherapy' must be admitted to SCBU. 2surfaces must not be delivered on PNW	Lisa Nesbitt	**Completed**	Disseminate to midwifery, medical and nursing staff
Following a minimum of 1hour skin to skin post birth, if a baby has a temperature of < 36.5 degrees, then place baby on	Lisa Nesbitt	**Completed**	Disseminate to midwifery and medical staff

the resuscitaire under the overhead heater instead of keeping in skin to skin.			

Operational Update

July 2024

Russell Nightingale
Chief Operating Officer

Children's and Community

Metrics	Q1	Q2	Q3	Q4	YTD
% of antenatal contacts					
Darlington	97.6%				97.6%
Durham	87.8%				87.8%
Gateshead	98.2%				98.2%
Middlesbrough	94.5%				94.5%
North Yorkshire	96.6%				96.6%
Northumberland	96.5%				96.5%
Stockton	91.2%				91.2%
Sunderland	93.1%				93.1%
Wakefield	82.9%				82.9%
% New Birth Visits completed by 14 days					
Darlington	98.6%				98.6%
Durham	90.0%				90.0%
Gateshead	97.7%				97.7%
Middlesbrough	95.2%				95.2%
North Yorkshire	92.8%				92.8%
Northumberland	95.5%				95.5%
Stockton	90.7%				90.7%
Sunderland	99.4%				99.4%
Wakefield	91.7%				91.7%
% Infants Breastfeeding at 10-14 days					
Darlington	58.1%				58.1%
Durham	47.0%				47.0%
Gateshead	53.6%				53.6%
Middlesbrough	50.6%				50.6%
North Yorkshire	67.9%				67.9%
Northumberland	51.9%				51.9%
Stockton	52.3%				52.3%
Sunderland	49.8%				49.8%
Wakefield	52.4%				52.4%
% infants breastfeeding at 6-8 weeks					
Darlington	42.4%				42.4%
Durham	33.5%				33.5%
Gateshead	48.5%				48.5%
Middlesbrough	49.2%				49.2%
North Yorkshire	57.3%				57.3%
Northumberland	41.9%				41.9%
Stockton	38.4%				38.4%
Sunderland	37.8%				37.8%
Wakefield	40.5%				40.5%

Metrics	Q1	Q2	Q3	Q4	YTD
% of 6-8 week reviews completed by the time the infant is 8 weeks old					
Darlington	98.8%				98.8%
Durham	83.5%				83.5%
Gateshead	96.4%				96.4%
Middlesbrough	92.6%				92.6%
North Yorkshire	96.1%				96.1%
Northumberland	94.8%				94.8%
Stockton	92.5%				92.5%
Sunderland	97.7%				97.7%
Wakefield	95.5%				95.5%
% of 12 month reviews completed by the time the child is 15 months old					
Darlington	99.2%				99.2%
Durham	95.0%				95.0%
Gateshead	98.8%				98.8%
Middlesbrough	98.2%				98.2%
North Yorkshire	99.6%				99.6%
Northumberland	98.6%				98.6%
Stockton	97.9%				97.9%
Sunderland	98.7%				98.7%
Wakefield	98.3%				98.3%
% of 2-2.5 year reviews completed by the time the child is 2.5 years old					
Darlington	99.2%				99.2%
Durham	89.5%				89.5%
Gateshead	95.1%				95.1%
Middlesbrough	93.3%				93.3%
North Yorkshire	93.9%				93.9%
Northumberland	87.4%				87.4%
Stockton	94.3%				94.3%
Sunderland	94.1%				94.1%
Wakefield	97.8%				97.8%
% of 2 to 2.5 year reviews completed in the month with a completed ASQ3					
Darlington	100.0%				100.0%
Durham	97.0%				97.0%
Gateshead	95.9%				95.9%
Middlesbrough	100.0%				100.0%
North Yorkshire	99.3%				99.3%
Northumberland	99.1%				99.1%
Stockton	96.3%				96.3%
Sunderland	93.0%				93.0%
Wakefield	99.7%				99.7%

% Antenatal contacts

- Durham - Main issue non notifications and late notification which is being picked up with Maternity
- Wakefield – Targeted antenatal offer agreed with commissioners linked to staffing gaps. Recovery plan being progressed linked to recruitment.

2.5 year review

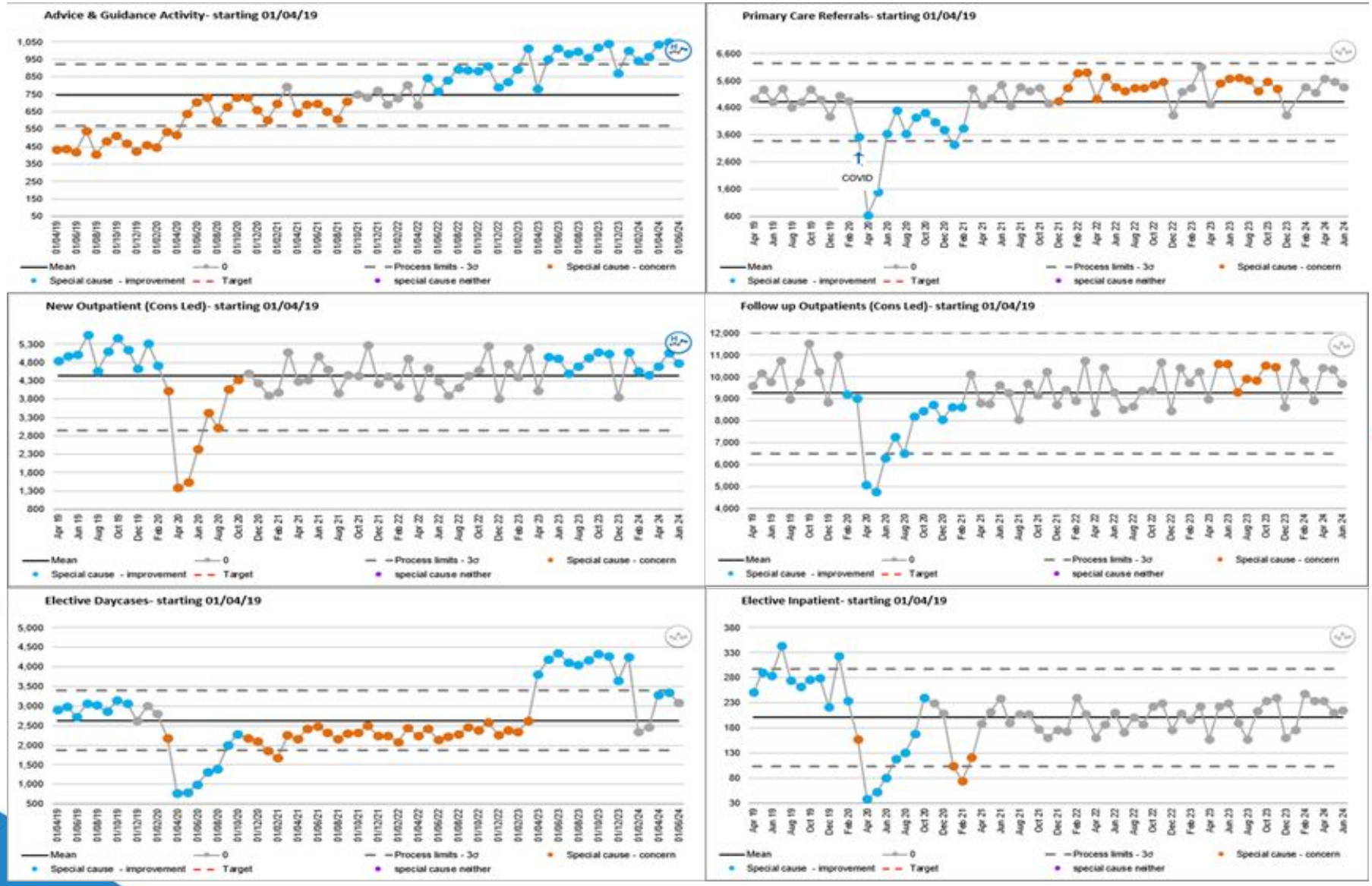
- Northumberland – Issue with validations not being reflected in performance. Now resolved with the data team and performance will improve in the coming months.

Planned Care Recovery

Outpatients	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of episodes moved or discharged to a patient initiated follow up plan (PIFU) - Plan	960	960	960	960	960	960	960	960	960	960	960	960
Actual	1,612	1,546	1,433									
Consultant-led first outpatient attendances (Spec acute) - Plan	3,786	3,854	3,957	5,330	4,332	4,960	5,532	5,219	4,688	5,403	4,799	4,146
Consultant-led first outpatient attendances (Spec acute) - Actual	4,702	5,052	4,782									
Consultant-led follow up outpatient attendances (Spec acute) - Plan	7,216	7,813	7,353	10,309	8,687	9,416	11,228	10,137	8,908	10,730	9,176	9,034
Consultant-led follow up outpatient attendances (Spec acute) - Actual	10,437	10,358	9,716									
Elective Admissions												
Total number of specific acute elective spells in period -Plan	3,152	3,712	3,390	4,425	4,306	4,054	4,545	4,420	3,745	4,380	4,036	3,089
Total number of specific acute elective spells in period -Actual	3,513	3,554	3,304									
Total number of specific acute elective day case spells in period -Plan	2,999	3,523	3,204	4,146	4,081	3,843	4,314	4,183	3,560	4,110	3,837	2,957
Total number of specific acute elective day case spells in period -Actual	3,279	3,343	3,089									
Total number of specific acute elective ordinary spells in period -Plan	153	189	186	279	225	211	231	237	185	270	199	132
Total number of specific acute elective ordinary spells in period -Actual	234	211	215									
RTT												
Number of completed admitted RTT pathways - Plan	824	968	881	1,139	1,122	1,056	1,185	1,150	978	1,130	1,054	813
Number of completed admitted RTT pathways - Actual	1,001	1,044	1,017									
Number of completed non-admitted RTT pathways - Plan	3,625	3,757	3,817	5,220	4,575	4,846	5,535	5,144	4,587	5,312	4,719	3,862
Number of completed non-admitted RTT pathways - Actual	4,499	4,462	4,328									
Number of New RTT pathways (clock starts) - Plan	4,911	5,090	5,171	7,071	6,197	6,564	7,498	6,968	6,214	7,196	6,392	5,231
Number of New RTT pathways (clock starts) - Actual	6,583	6,432	5,995									
Number of RTT incomplete pathways waiting +52 weeks - Plan	500	500	500	500	500	500	400	300	200	150	75	0
Number of RTT incomplete pathways waiting +52 weeks - Actual	432	430	422									
Number of RTT incomplete pathways waiting +65 weeks - Plan	0	0	0	0	0	0	0	0	0	0	0	0
Number of RTT incomplete pathways waiting +65 weeks - Actual	1	0	1									
Total number of RTT incomplete pathways - Plan	22,500	22,400	22,300	22,200	22,100	22,000	21,800	21,600	21,500	21,400	21,200	21,000
Total number of RTT incomplete pathways - Actual	22,829	23,056	22,993									
Cancer												
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Plan												
Number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral - Actual	49	53	54									

- Increasing elective capacity to 2019/20 levels continues to be the key focus
- Weekend working is continuing to support the EL IP increase of activity from 23/24
- The number of open RTT pathways remains stable overall but pressures remain in specialties matching the regional picture
- Follow up activity continues to over deliver despite region topping percentage of PIFU

Elective Recovery

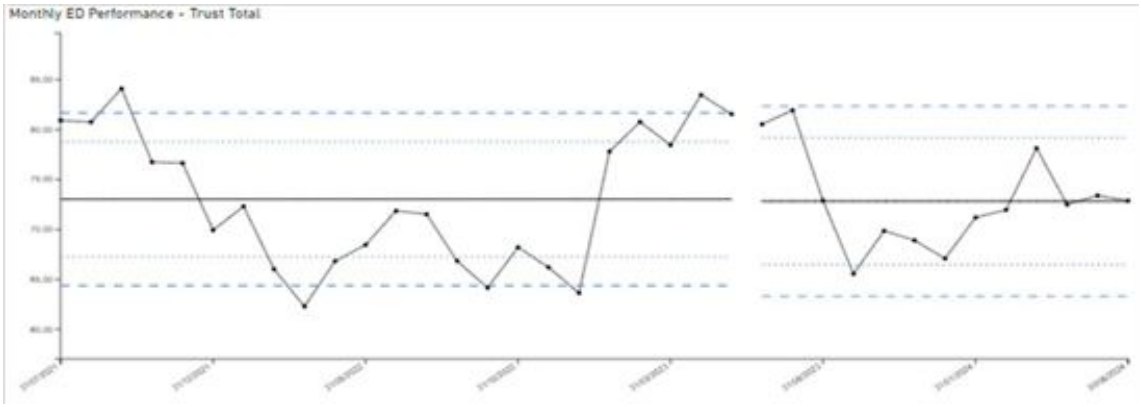


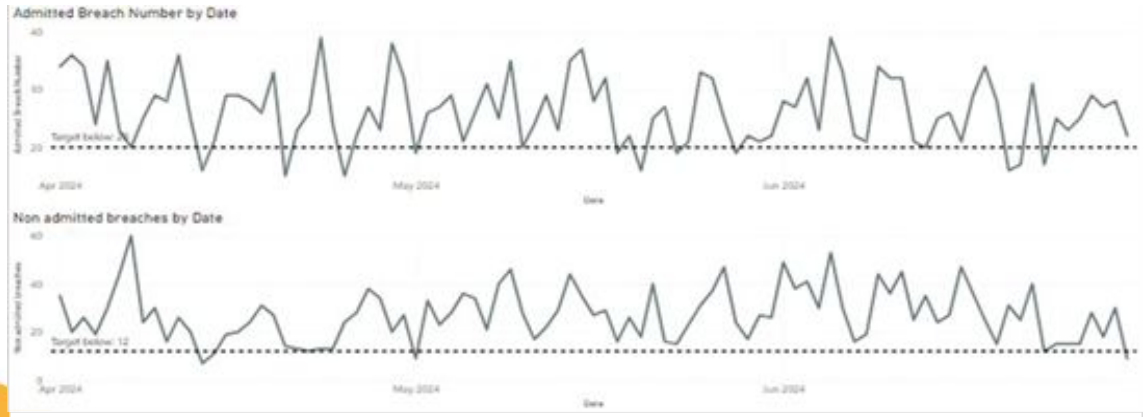
Referral to Treatment (RTT)

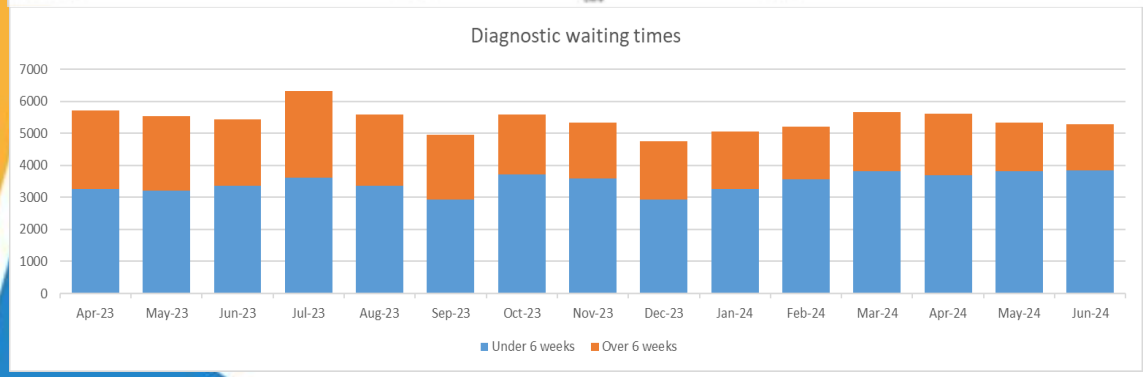
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total incomplete RTT pathways	22,829	23,056	22,993			
0<18 weeks	15,205	15,389	15,058			
18-<39 weeks	5,777	5,799	6,171			
39-<52 weeks	1,415	1,438	1,342			
> 52 weeks	432	430	422			
> 65 weeks	1	0	1			
> 78 weeks	0	0	0			
> 104 weeks	0	0	0			

- The confirmed June position was 22,993 patients waiting with 1 patient waiting over 65 weeks.
- We remain ahead of plan for over 52 week waits.
- Of the patients waiting for a procedure on our waiting list, 41% are on an Orthopaedic pathway and 16% are on a Ophthalmology pathway.

Urgent Care and Diagnostics

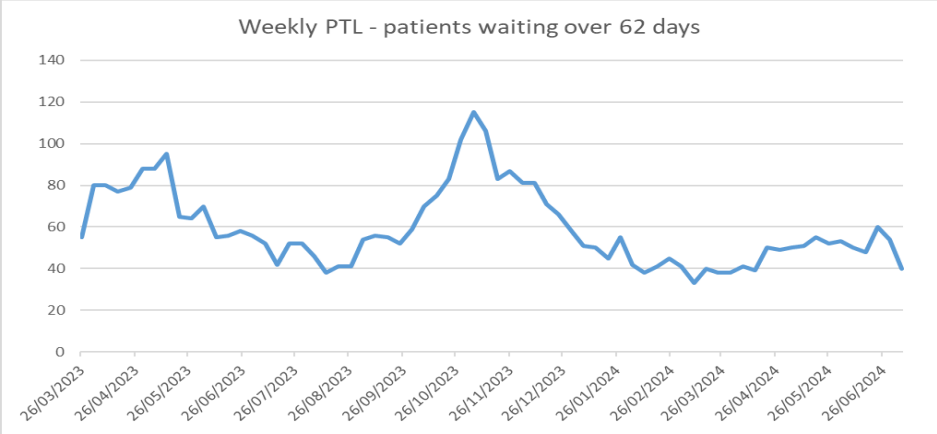


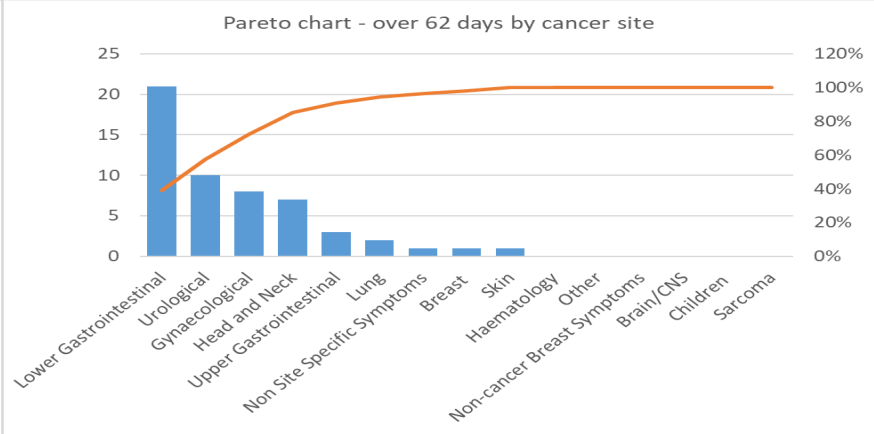


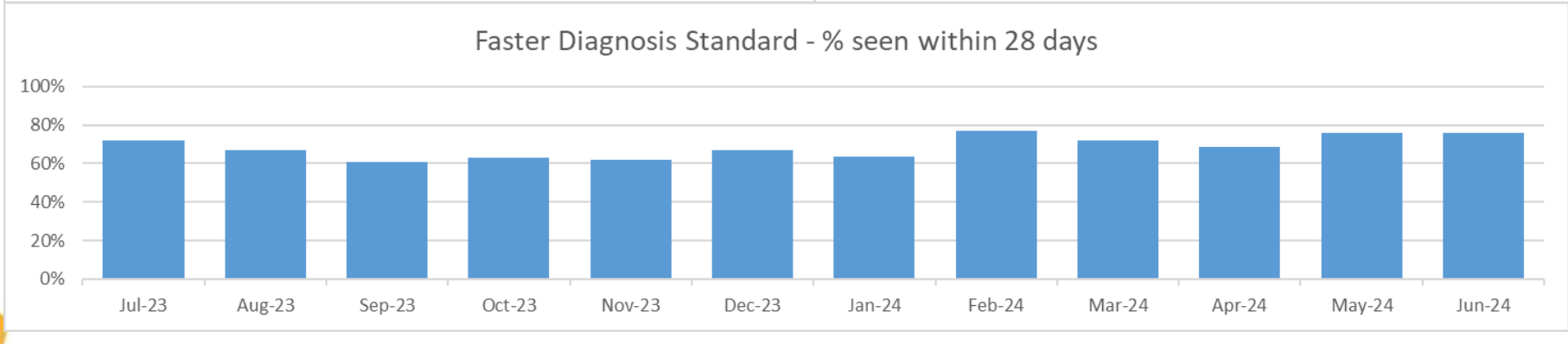


- Performance against the A&E 4-hour standard was at 73% in June, an increase on last month (71%) but remains below performance standard of 76%.
- There were 33 over 12-hour trolley wait breach in June (55 in May).
- There were 214 over 30-minute ambulance handover breaches in June (198 in May) and 53 (68 in May) over 60 minutes.
- For diagnostics, the percentage under 6 weeks has increased to 73% in June (72% in May).

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 June with a performance of 70% against the 85% standard.
- The number of patients remaining on the PTL over 62 days (i.e. treatment no complete) was 54 (target 50).
- The Faster Diagnosis Standard (FDS) was achieved in June with performance at 80.9% against the 75% standard.

Finance Report Month 3
June – 2024/25

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

24/25 Finance summary as at June

teamHDFT At our best

£-8.2M

YTD DEFICIT

£2.8M AWAY FROM PLAN

WASTE REDUCTION AND PRODUCTIVITY DELIVERED

(WRAP)

30%

£15.9M TARGET + £6.2M STRETCH

£-0.2M

97%

ERF UNDER PERFORMED

(Elective Recovery Funding – related to activity)

DECREASING CASH IN THE BANK

£4.5M ⬇

(JUNE 2024)

£11.6M

(MAY 2024)

£3.6M ⬆

INCREASING AGED DEBT

(OUTSTANDING OVER 30 DAYS)

AGENCY SPEND

£373k

1.6%

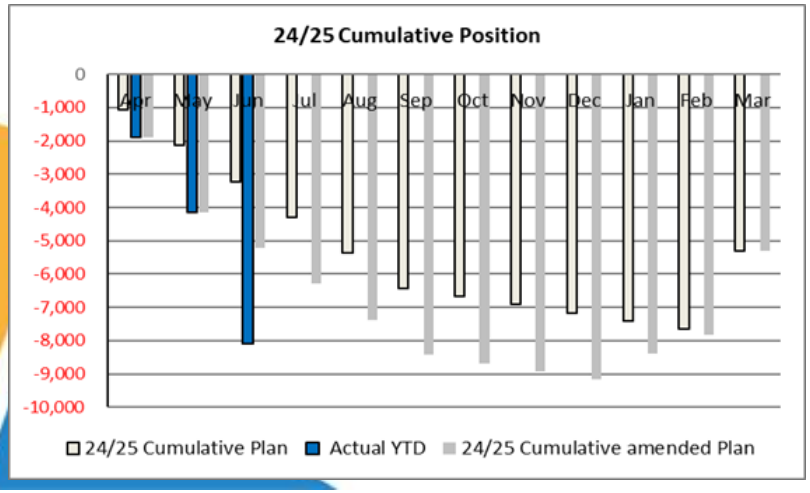
24/25 plan £-5.3m deficit, 100% WRAP, 103%+ ERF, Agency below 3.2% of Substantive Pay Spend

YTD Summary

£-8.1M
DEFICIT YTD
£-2.8M
AWAY FROM PLAN

As at the end of June, the Trust has a £8.1 deficit position, which is £2.8m behind plan. This month includes strike costs of £150k.

Undelivered WRAP contributes £2m to the YTD position. This continues to be one of the main risks in delivering the 24/25 plan. £15.9m target increased by a stretched ask £6.2m during planning. A further 5% has been actioned in month, there is ongoing work to encourage further schemes.
ERF reporting has been developed and Directorate positions will now include any financial impact of any under/over performance. The delay in activity being coded is affecting the activity being accurately accounted for. In M3 an under recovery of £200k has been reported. There are a number of actions which need to be undertaken which will be monitored weekly.
Cash continues to be monitored closely, no cash support will be required in Qtr 2 however will be needed in Qtr 3 as per the current forecast.
Agency spend is still well below the NHS target expectation, £373k spend reported in June which is mainly in relation to medical staffing. Further monitoring on pay spend has been instigated including off framework and overtime.



High Level Analysis	Annual Plan £000's	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's
Commissioner Income	**247,844**	**20,650**	**20,467**	**-182**	**61,455**	**62,028**	**574**
Directorate Income	**105,526**	**8,761**	**8,575**	**-186**	**26,236**	**26,700**	**465**
Pay Costs	-257,948	-21,458	-21,755	-297	-63,860	-65,058	-1,197
Non Pay Costs	-95,423	-9,415	-11,261	-1,846	-27,073	-31,921	-4,848
Expenditure	**-353,371**	**-30,873**	**-33,016**	**-2,143**	**-90,933**	**-96,978**	**-6,045**
Surplus / (Deficit)	**0**	**-1,462**	**-3,974**	**-2,511**	**-3,243**	**-8,250**	**-5,007**
Budget Phasing		**-1,754**			**-1,981**		
Donated Assets/Depreciation			**50**			**150**	
Revised Surplus/(Deficit)	**0**	**-3,216**	**-3,924**	**-707**	**-5,224**	**-8,100**	**-2,876**

Directorate Summary

LTUC – As at June LTUC is £1.8m overspent, the run rate has maintained at the prior month levels.
Key drivers YTD include

- £526k Ward Pay spend, Agency spend continues to reduce and move across to bank.
- £526k undelivered WRAP
- £276k Medical Staffing, Doctors in Training the main contributing factor.
- ERF Income has over recovered £408k, Haematology being the biggest contributor £301k.

ED nursing pay is improving, £20k reduction in overspend in comparison to the prior months.
Key areas of focus for 24/25

- £4.3m CIP to deliver
- £1.1m Doctors in Training pressure
- £1m ED pay pressures (vacancies/sickness)
- Ward enhanced care, £53k YTD
- Diabetic Pumps
- Pathology charges from JV, including Covid/Flu tests, £200k overspend YTD.

LTUC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**19,531**	**4,766**	**5,192**	**425**
Pay Costs	-72,339	-18,083	-19,093	-1,009
Non Pay Costs	-30,318	-7,649	-8,903	-1,254
Expenditure	**-102,657**	**-25,733**	**-27,995**	**-2,263**
Total	**-83,126**	**-20,966**	**-22,804**	**-1,837**

PSC – As at June PSC is £2.3m overspent, there has been a significant deterioration in comparison to the prior month due to the ERF position. It is important to note there is a high level of activity uncoded for April and May so this position may improve.
Key Drivers YTD include

- £887k Locum Consultant pay spend, this is across multiple specialties but most significant in General Surgery and Radiology
- £716k undelivered WRAP, ERF was going to be a main contributor to achieving the target.
- £286k Non Pay Clinical Supplies spend, the biggest contributor is Main Theatres

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
- ERF Opportunities

PSC	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**40,686**	**10,702**	**10,428**	**-274**
Pay Costs	-65,881	-16,385	-17,160	-775
Non Pay Costs	-14,893	-3,735	-5,079	-1,344
Expenditure	**-80,774**	**-20,120**	**-22,239**	**-2,119**
Total	**-40,088**	**-9,418**	**-11,811**	**-2,393**

Directorate Summary

CC – As at June CC is underspent by £275k, run rate is being maintained.
Key Drivers YTD include

- £476k Undelivered WRAP
- £57k Travel, paper agreed to extend the mileage rate
- £1m underspend in pay mainly contributed to by the following 2 council contracts, Wakefield, Northumberland and Adult Community. Wakefield have started conversations around potential clawback as per their contract arrangement.
- Paediatric diabetic pumps is an area to review as currently £91k overspent YTD.

Community & Childrens	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**3,927**	**991**	**974**	**-17**
Pay Costs	-80,685	-20,163	-19,123	1,040
Non Pay Costs	-4,305	-1,114	-1,862	-748
Expenditure	**-84,990**	**-21,277**	**-20,984**	**292**
Total	**-81,063**	**-20,285**	**-20,010**	**275**

CORP –As at June Corporate is overspent by £115k, although Corporate is generally managing with budget there a few divisions that require further investigation.
Key Areas of focus

- £84k under recovery of Private Patient income
- £206k Undelivered WRAP, this remains the biggest risk to Corporate, Finance is the only area to have achieved their target.
- Income is due from Cancer Alliance to fund specific Corporate posts (still to be resolved)

Corporate	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**8,806**	**2,152**	**2,437**	**286**
Pay Costs	-25,131	-6,329	-6,614	-285
Non Pay Costs	-40,691	-10,233	-10,348	-116
Expenditure	**-65,822**	**-16,562**	**-16,962**	**-401**
Total	**-57,016**	**-14,410**	**-14,525**	**-115**

HIF – As at June HIF is £25k overspent.
Focused Finance training has been delivered and there has been a continued increase in budget holders accessing REACH.
Key Areas of focus

- £56k, Hotel Services Pay and potential opportunity to reduce agency spend as rostering templates have been reviewed and revised.
- £11k, undelivered WRAP

HIF	Annual Plan £000's	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**26,958**	**6,716**	**6,721**	**5**
Pay Costs	-11,874	-2,900	-2,956	-56
Non Pay Costs	-15,085	-3,759	-3,733	26
Expenditure	**-26,958**	**-6,659**	**-6,689**	**-30**
Total	**0**	**58**	**33**	**-25**
Plan Surplus	**200**	**58**	**33**	**-25**

2024/25 Elective Recovery (ERF) Performance summary Month 2 (AP03)

teamHDFT
At our best

-£0.2M

TRUST ACHIEVEMENT

97%

PERFORMANCE DELIVERY

£

ERF OPTIMISATION & TRANSFORMATION

ERF £performance by Directorate & Cost Centre	2024/25 Baseline*	2024/25 Actuals	Uncoded Estimate	Optimisation Estimate		Revised 24/25 Actuals	Achievement Actual	Performance
Childrens&Community Directorate	**£240,063**	**£163,703**	**£9,463**	**£0**	**£0**	**£173,166**	**-£66,896**	**72%**
Central	£37,927	£1,028				£1,028	-£36,899	3%
253062_HNY ICB	£153,096	£142,513	£7,850			£150,363	-£2,733	98%
253069_WYAT ICB	£49,040	£20,162	£1,614			£21,776	-£27,264	44%
Planned/Surgical care Directorate	**£7,292,767**	**£3,487,837**	**£3,216,343**	**£0**	**£0**	**£6,704,180**	**-£588,587**	**92%**
Central	£353,837	£62,695	£23,121			£85,816	-£268,020	24%
253064_HNY ICB	£5,076,830	£2,820,694	£2,635,543			£5,456,237	£379,407	107%
253067_WYAT ICB	£1,862,101	£604,449	£557,679			£1,162,127	-£699,973	62%
LT & Unscheduled Care Directorate	**£2,051,287**	**£1,914,368**	**£542,181**	**£0**	**£0**	**£2,456,549**	**£405,262**	**120%**
Central	£42,309	£41,986	£323			£42,309	£0	100%
253063_HNY ICB	£1,619,591	£1,584,630	£474,693			£2,059,323	£439,732	127%
253068_WYAT ICB	£389,386	£287,751	£67,165			£354,916	-£34,470	91%
Grand Total	**£9,584,116**	**£5,565,908**	**£3,767,987**	**£0**	**£0**	**£9,333,895**	**-£250,221**	**97%**

*2024/25 Baseline not yet confirmed/released

Waste Reduction and Productivity

30%
DELIVERED
£15.9M +
£6.2M
STRETCH
TARGET

28% of the current WRAP target has been achieved as at June, there is ongoing work to encourage further development of schemes.

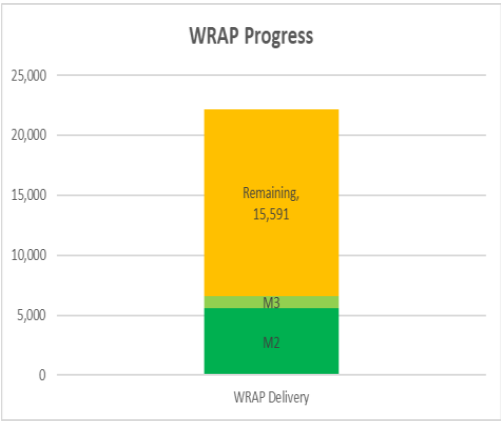
Following the WRAP sessions, Finance will be promoting a WRAP champion initiative across the Trust.

HNY have also identified three areas for HDFT to explore to assist with identifying all of the £22.1m.

- Theatre utilisation 80-85%
- No criteria to reside/Bed reductions
- Reduction in outpatient follow ups

These have now been incorporated into achieving the £22.1m however we need to ensure these are not already accounted for in ERF assumptions.

		CIP Plans					
	Target	Actioned at M2	Actioned at M3	MOM move	% identified	Actioned	Gap (unactioned)
CC	2,502,700	701,200	1,215,700	514,500	105%	1,215,700	1,287,000
Corporate	1,307,000	78,800	157,100	78,300	55%	157,100	1,149,900
LTUC	5,396,300	1,836,200	1,818,800	-17,400	118%	1,818,800	3,577,500
PSC	3,719,900	107,600	521,600	414,000	134%	521,600	3,198,300
HIF		503,400	503,400	0	0%	521,600	-521,600
Central	9,213,100	2,331,500	2,331,500	0	6%	503,400	8,709,700
Total	**22,139,000**	**5,558,700**	**6,548,100**	**989,400**	**31%**	**4,738,200**	**17,400,800**



Agency

£373K
SPEND YTD
1.6%

£373k agency in month, a reduction of £74k in comparison to M2.

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.

The main areas include

Nursing

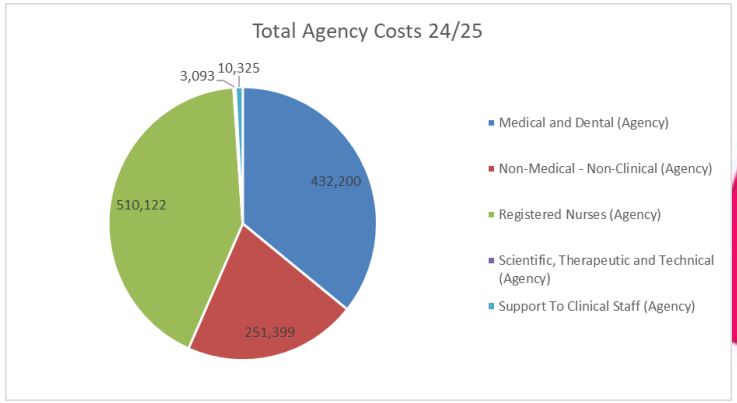
Emergency Department, In Mth £78k, £281k YTD

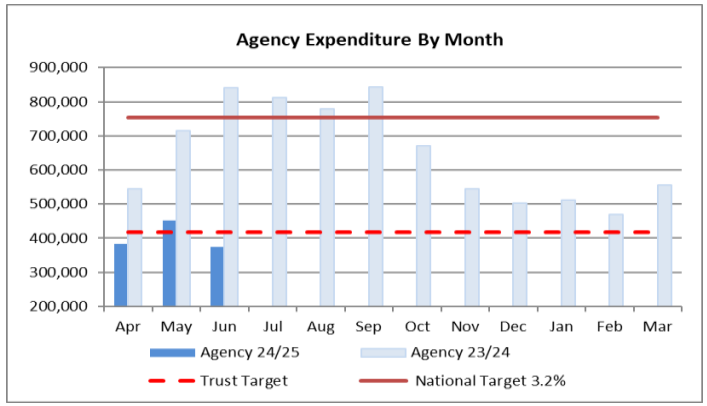
Medical Staffing

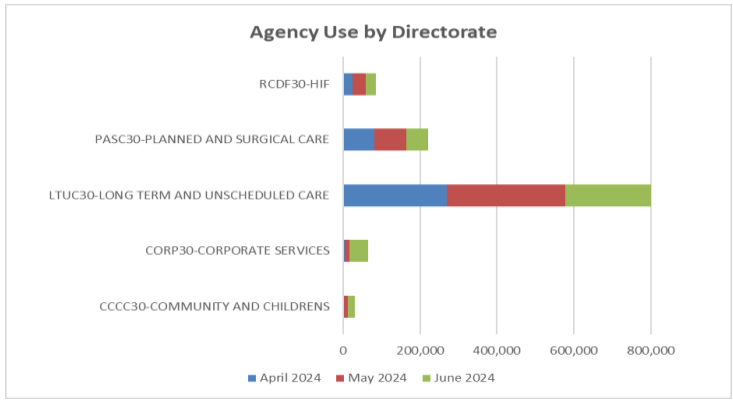
Haematology Med Staff, In Mth £33k, £108k YTD
Elderly Medicine, In Mth £24k, 77k YTD
SDEC Med Staff, In Mth £24k, £73k YTD

Non Clinical

Estates, In Mth £23k, £35k YTD







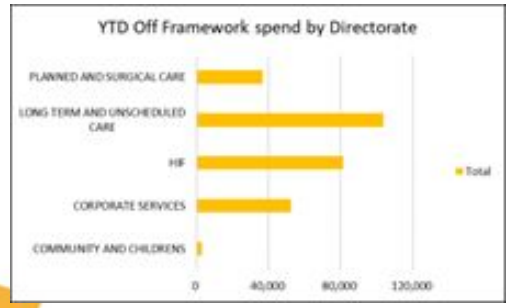
Off Framework and Overtime

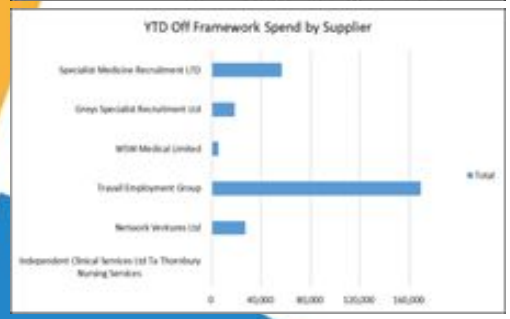
£373K

OFF FRAMEWORK SPEND YTD

From July we will also be focusing on areas which are using off framework agencies, there is a national deadline to remove all off framework agency use by July. Weekly reporting will commence with NHSE from 8th July.

Below summarises the off framework use since April 24.



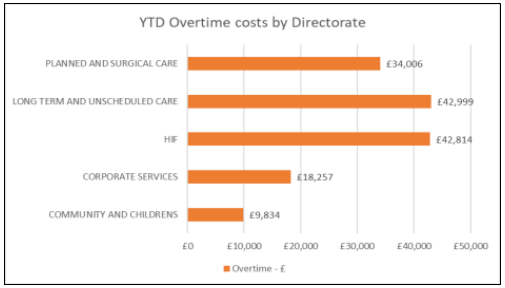


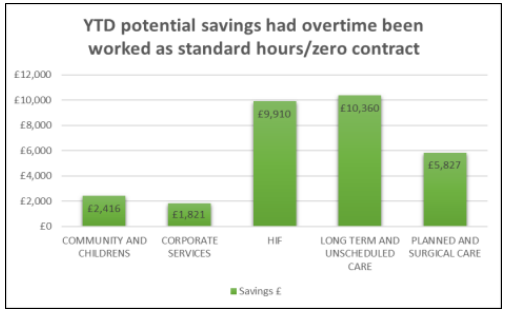
Off Framework Staffing Group	Total
Admin	169,194
Medical	89,265
Nursing	18,420
Grand Total	**276,879**

£147.9k - 6,430hours

OVERTIME YTD

Below summarises the overtime use since April 24.
Top 5 areas for overtime worked includes
Domestics - £17k
Patient Meals - £8.7k
Transport - £5k
Portering - £5.6k
Emergency Department £4.8k





Staff group	Overtime - hours	Overtime - £
Administrative and Clerical Staff	1,509	£33,114
Asset Under Construction	0	£0
Dietitians	15	£309
Executive Board and Senior Managem	0	£0
Healthcare Assistants	177	£3,409
Maintenance Staff	74	£1,866
Occupational Therapist	91	£3,139
Orthoptists	22	£835
Other AHPS	3	£118
Other Employees	0	£0
Other Scientific Staff	211	£2,694
Other Support Staff (Ancillary Staff)	2,196	£39,361
Pharmacy	78	£1,755
Physiotherapy	301	£8,605
Podiatrist	0	£0
Psychology	0	£0
Qualified Bank Nurses	0	£0
Qualified Nurses / Nurse Managers	1,148	£35,920
Radiography	217	£6,796
Speech Therapy	0	£0
Technical Officers	359	£9,397
Unqualified Bank Nurses	0	£0
Unqualified Nurses	28	£592
Grand Total	**6,430**	**£147,909**

Capital

£3.6M 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.

Following a plan resubmission there has been some minor changes to allocated CDEL and further CDEL allocated which is now resulting in a total capital plan of £33m.

Spend is currently on track however there are additional capital requests emerging including

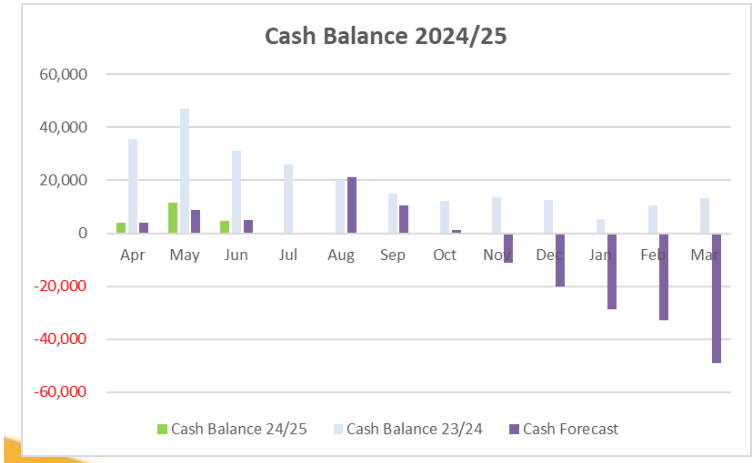
- Pharmacy Robot
- Cat 111 room
- Replacement Defibrillator

Internal audit have reviewed and approved revised capital processes for Digital, Equipment and Estates. These will be circulated with Directorates.

		£000	£000	£000
Description	**Scheme ID**	**Plan**	**Amended Plan - 12th June**	**Actual**
IT	IT	500	500	116
Community Estate Maintenance	COMM ESTATE	250	250	0
Contingency	CONT	500	1,484	0
E Diagnostic Roll Over	EDIAGNOSTIC	0		0
Schemes Carry Forward from 2023/24	PRIOR YEAR	930	930	424
Schemes Carry Forward from 2023/24	HIF PRIOR YEAR			19
Backlog Maintenance	BACKLOG 24/25	1,300	800	0
Backlog Maintenance	BACKLOG 23/24			-0
Imaging relocation	IMAGING 24	2,100	3,300	0
HIF Depreciation	DEPN 24/25	400	400	8
HIF Depreciation	DEPN 23/24			24
Corridors	CORRIDORS	500	0	0
Trust Overheads (Staffing)	T OH			17
HIF Overheads (Staffing)	H OH			6
Salix	SALIX			0
Costs to be allocated out	UNKNOWN			6
st CDEL		**6,480**	**7,664**	**622**
mes		0	0	0
DEL		**6,480**	**7,664**	**622**
DEL)				
Trustwide EPR	EPR	6,239	6,239	520
ED - (Dependant on 23/24 performance)	ED			0
TIF2	TIF2	10,290	9,200	648
RAAC	RAAC	3,000	10,290	1,782
mes		**19,529**	**25,729**	**2,951**
		26,009	**33,393**	**3,572**

Cash

£4.5M
(JUNE 2024)



Cash continues to be monitored closely, Council payments have now been forthcoming but there a number which are not up to date. (Sunderland/Northumberland)

The chart to the right highlights the cash pressure if the income and expenditure run rate continues as is. The forecast assumes all contract income is received and any known expenditure including capital.

Debt continues to be monitored, over 90days has increased by £0.2m in comparison to the previous month.

Ongoing Issues over 90 Days
£221k Integrated Lab Solutions, discussions with the accounts team and payment expected.
£204k St Michaels Hospice, Consultant recharge query, SLA now being reviewed.
£107k BMI, part payment has been received and further payment expected.
£98k Overseas patient, unlikely payment will be received, original payment arrangement has ceased.

June	31-60 Days Past Invoice Due Date	61-90 Days Past Invoice Due Date	Over 90 Days Past Invoice Due Date
Total Trust	1,364,365	393,172	1,916,289
Movement from prior month	**1,363,978**	**-118,790**	**173,171**

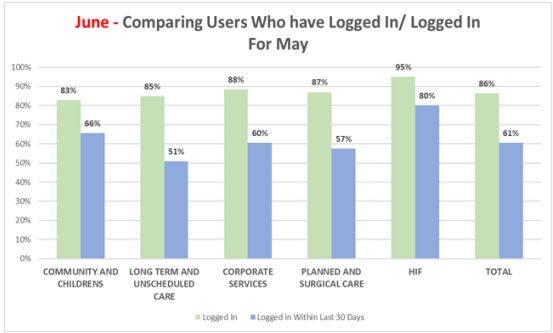
Controls

PAYROLL OVERPAYMENTS
(MAY 24)
£7k IN TOTAL
10 OCCASSIONS

HEALTH ROSTER
HOURS OVER PLAN IN MTH

ENDOSCOPY 579 HRS
EMERGENCY DEPT 357 HRS

REACH REPORTING
BUDGET REPORTS



No PO & INVOICE R/C
(JUNE)
NUMBER 132
VALUE £2.6m
(INCL HIF)

DISCRETIONARY SPEND
£305K SPEND SAVED
OCT 23-JUN 24

BUDGET HOLDER ENGAGEMENT
(REVIEWED QTRLY –JUNE 24)
CC 74% ⇩
CORP 68% ⇩
PSC 75% ⇧
LTUC 60% ⇩

24/25 Controls

CURRENT 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.
- NHS Supply Chain restrictions 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.
- Weekly Workforce Performance Meetings have been introduced.
- Non clinical overtime being monitored and escalated to mangers to review arrangements and approval.
- Off Framework agency monitoring

ESCALATIONS TO CONSIDER

- TRAC panel
- Discretionary spend panel
- Cease all Non Clinical overtime
- Vacancy freezes