Board of Directors Meeting Held in Public

To be held on Wednesday, 25th September 2024 at 13.00 – 3.45pm

Venue: Boardroom, HDFT, Strayside Wing, Harrogate District Hospital Lancaster Park Road, Harrogate, HG2 7SX.

AGENDA

All items listed in blue text (throughout the agenda), are to be received for information/ assurance and no discussion time has been allocated within the agenda. These papers can be found in the supplementary pack.

Item No.	Item	Lead	Action	Paper
SECTION 1: Opening Remarks and Matters Arising				
1.1	**Welcome and Apologies for Absence**	Chair	Note	Verbal
1.2	**Patient Story**	Director of Nursing, Midwifery and AHPs/ Medical Director	Discuss	Verbal
1.3	**Register of Interests and Declarations of Conflicts of Interest**	Chair	Note	Attached
1.4	**Minutes of the meeting held on 31st July 2024**	Chair	Approve	Attached
1.5	**Matters Arising and Action Log**	Chair	Note	Attached
1.6	**Overview by the Chair**	Chair	Note	Verbal
1.7	**Chief Executive's Report**	Chief Executive	Note	Attached
1.8	**Board Assurance Framework:** Summary	Chief Executive	Approve	Attached
1.9	Corporate Risk Register	-	Note	Supp. Pack
SECTION 2: Ambition: Best Quality, Safest Care				
2.1	**Board Assurance Framework:** Best Quality, Safest Care	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	Approve	Attached
2.2a	**Workforce Safeguards Report**	Director of Nursing, Midwifery and AHPs	Note	Attached
2.2b	Safe Staffing – SNCT for Adults Safe Staffing – SNCT for Children & Young People	-	Note	Supp. Pack
2.3	Safeguarding Annual Report	-	Note	Supp. Pack

Item No.	Item	Lead	Action	Paper
SECTION 3: Ambition: Great Start in Life				
3.1	**Board Assurance Framework:** Great Start in Life	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	Approve	Attached
3.2	**Strengthening Maternity and Neo-Natal Safety**	Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework:** Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer / Resource Committee Chair	Approve	Attached
4.2	**Board Assurance Framework:** Finance	Finance Director / Resource Committee Chair	Approve	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	**Board Assurance Framework:** At Our Best: Making HDFT the Best Place to Work	Director of People & Culture / People & Culture Committee Chair	Approve	Attached
5.2	Workforce Race Equality Standards Report (WRES)	-	Note	Supp. Pack
5.3	Workforce Disability Equality Standards Report (WDES)	-	Note	Supp. Pack
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	Approve	Attached
6.2	**Board Assurance Framework:** Healthcare Innovation to Improve Quality and Safety	Medical Director & Innovation Committee Chair	Approve	Attached
6.3	**Board Assurance Framework:** An Environment that Promotes Wellbeing	Director of Strategy & People & Culture Committee Chair	Approve	Attached
SECTION 7: Escalation from Committees				
7.1	**Escalation from Sub-Committees of the Board**	All Executive and Non-Executive Directors	Discussion	Verbal
SECTION 8: Governance Arrangements				
8.1	**Audit Committee Update**	Committee Chair	Note	Verbal

Item No.	Item	Lead	Action	Paper
8.2	**Medical Revalidation Assurance Report**	Medical Director / Director of People & Culture	Approve	Attached
8.3	WYAAT Programme Executive minutes	-	Note	Supp. Pack
8.4	WYAAT Memorandum of Understanding Review	-	Note	Supp. Pack
8.5	Collaboration of Acute Providers minutes	-	Note	Supp. Pack
9.0	**Any Other Business** *By permission of the Chair*	Chair	Discuss/ Note/ Approve	Verbal
10.0	**Board Evaluation**	Chair	Discuss	Verbal
11.0	**Date and Time of next Board Meeting to be held in public:** Wednesday 27 November 2024 at 12.45 – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

Confidential Motion – the Chair to move:
Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.

NOTE: The agenda and papers for this meeting will be made available our website. Minutes of this meeting will also be published in due course on our website.

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Board of Directors – Register of Interests

As at 19 September 2024

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Executive Medical Director	June 2020 June 2020 December 2023 April 2024 May 2024	April 2024 Current Current Current Current	1. Familial relationship with managing partner of Priory Medical Group, York 2. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board 3. Member, Leeds Hospitals Charity Scientific Advisory Board 4. Familial relationship with Director of GPMx Ltd (healthcare consultancy) 5. Member, Independent Advisory Group for the National Medical and Surgical Clinical Outcomes Review Programme (hosted by HQIP on behalf of NHSE)
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	Date	1. Company director for the flat management company of current residence 2. Chief Executive, The Ewing Foundation, Ovingdean Hall Foundation and Burwood Park Foundation 3. Director of Coffee Porter (family business) 4. Member of West Yorkshire Chairs & Leaders Forum 5. Member HNY Provider Chairs 6. Member HNY CAP Board
Azlina Bulmer	Associate Non-executive Director	November 2022 November 2022 February 2024	February 2024 Date Date	1. Executive Director, Chartered Insurance Institute 2. Familial relationship, Health Education England 3. Chief Operating Officer, Institute of the Motor Industry
Denise Chong	Insight Programme: Non-executive Director	January 2024	Date	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022		No interests declared
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Tipton Building Society 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman, Forget Me Not Children's hospice, Huddersfield 5. Governor, Grammar School at Leeds

Board Member	Position	Relevant Dates From	To	Declaration Details
				6. Director, GSAL Transport Ltd 7. Member, Kirby Overblow Parish Council 8. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Chiara De Biase	Non-executive Director	November 2022 November 2022 May 2024	May 2024 Date Date	1. Director of Support and Influencing, Prostate Cancer UK 2. Clinical Trustee, Candlelighters (Children's Cancer Charity) 3. Director of Health Services, Equity & Improvement, Prostate Cancer UK
Matt Graham	Director of Strategy	September 2021 April 2022	Date Date	1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust) 2. Stakeholder Non-executive Director, Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jordan McKie	Director of Finance (from July 2023)	August 2022	Date	1. Chair, Internal Audit Provider Audit Yorkshire
Kama Melly	Associate Non-executive Director	November 2022	Date	1. Kings Counsel, Park Square Barristers 2. Bencher, The Honourable Society of the Middle Temple 3. Director and Deputy Head of Chambers, Park Square Barristers 4. Governor, Inns of Court College of Advocacy
Russell Nightingale	Chief Operating Officer	April 2021	Date	1. Director of ILS and IPS Pathology Joint Venture
Emma Nunez	Director of Nursing Deputy Chief Executive from March 2022	No interests declared.		
Andrew Papworth	Non-executive Director	March 2020	Date	1. Chief Finance Officer, Insight222 2. Ambassador for Action for Sport
Laura Robson	Non-executive Director	No interests declared		
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023	Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd.

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Board Member	Position	Relevant Dates From	To	Declaration Details
		August 2023 September 2023 October 2023 August 2024		3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Julia Weldon	Non-executive Director	November 2022 May 2024	Date	1. Director of Public Health / Deputy Chief Executive, Hull City Council 2. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board 3. Voluntary role as Honorary Board Member of the National ADPH.
Angela Wilkinson	Director of People & Culture	October 2019	Date	1. Director of ILS and IPS Pathology Joint Venture

Harrogate and District NHS Foundation Trust

Clinical Directors, Deputy Directors and Others Attendees (providing advice and support to the Board)

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director, Earlmed Ltd, provider of private anaesthetic services 2. Treasurer, Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Emma Edgar	Clinical Director (Long term & Unscheduled Care)	No interests declared
Dr Katherine Johnson	Clinical Director (Planned and Surgical Care)	No interests declared
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)	1. Member, North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair, Safeguarding Practice Review Group. 3. Chair, North Yorkshire and York Looked After Children Health Professionals Network. 4. Member, North Yorkshire and York Safeguarding Health Professionals Network. 5. Member, national network of Designated Health Professionals. 6. Member, Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR 7. Familial relationship within Harrogate & District NHS Foundation Trust 8. Member, NHS Safeguarding Strategic Community of Practice for ICBs (Regional).
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care) Deputy COO	1. Director, Shepherd Property Ltd (March 2019-March 2022)
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Kate Southgate	Associate Director, Quality & Corporate Affairs	1. Familial relationship with Director in NHS England

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Directors and Attendees
Previously recorded Interests – For the 12 months period pre July 2024

Board Member	Position	Relevant Dates From	To	Declaration Details
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018	31 March 2022	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jonathan Coulter	Finance Director Chief Executive from March 2022	November 2017	31 March 2022	1. (Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Richard Stiff	Non-Executive Director (resigned July 2023)		December 2021 February 2022 February 2022 July 2023	1. Director and Trustee of TCV (The Conservation Volunteers) – ceased December 2021 2. Local Government Information Unit (Scotland) Associate – LGIU has now fully merged with LGIU listed as current interest 3. Chair of the Corporation of Selby College – dissolved 28 February 2022 when it became part of the Heart of Yorkshire Group. 4. Director (and 50% owner), Richard Stiff Consulting Limited 5. Director, NCER CIC (Chair of the Board from April 2019) 6. Member, Association of Directors of Children's Services 7. Member, Society of Local Authority Chief Executives 8. Local Government Information Unit Associate 9. Fellow, Royal Society of Arts 10. Member of the Corporation of the Heart of Yorkshire Education Group 11. Stakeholder Non-Executive Director, of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Wallace Sampson OBE	Non-executive Director	March 2020	31 March 2023	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board

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Board Member	Position	Relevant Dates From	To	Declaration Details
		November 2021	March 2023	4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. 7. Member of Challenge Board for Northumberland County Council. 8. Trustee for the Harrogate District Climate Change Coalition CIO (effective November 2021)

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)
Wednesday, 31st July 2024
Held at Trust HQ, Harrogate District Hospital, Harrogate, HS2 7SA

Present:	
Sarah Armstrong	Trust Chair
Jonathan Coulter	Chief Executive
Chiara DeBiase (CD)	Non-executive Director
Jeremy Cross (JC)	Non-executive Director
Laura Robson (LR)	Non-executive Director
Wallace Sampson OBE (WS)	Non-executive Director
Azlina Bulmer (AB)	Associate Non-executive Director
Denise Chong (DC)	Non-executive Director (Insight Programme)
Jacqueline Andrews	Executive Medical Director
Jordan McKie	Director of Finance
Emma Nunez	Executive Director of Nursing, Midwifery and Allied Health Professionals and Deputy Chief Executive
Angela Wilkinson	Director of People & Culture
Matt Shepherd	Deputy Chief Operating Officer (*formally deputising for the Chief Operating Officer)*

In Attendance:	
Emma Edgar (EE)	Clinical Director for Long Term and Unscheduled Care Directorate (LTUC)
Kat Johnson (KJ)	Clinical Director for Planned and Surgical Care Directorate (PSC)
Emma Anderson (EA)	Interim Clinical Director for Children's Directorate (CC)
Leanne Likaj	Associate Director of Midwifery
Kate Southgate	Associate Director of Quality and Corporate Affairs

Apologies:	
Andy Papworth (AP)	Non-executive Director
Julia Weldon (JW)	Non-executive Director
Matthew Graham	Director of Strategy
Russell Nightingale	Chief Operating Officer
Kama Melly (KM)	Associate Non-executive Director

Observers:	
Governors	2 governors
Member of the public / press	5 members of the public / press

Item No.	**Item**
BD/7/31/1 **1.1** **1.2**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.
BD/7/31/2 **2.1** **2.2**	Patient Story The Chair welcomed Ethan and Tracey (Ethan's mum) and his Step-Mum, supported by colleagues in HDFT including Joanne Crowne from the Youth Justice Service to the Board to share their story. The Youth Justice Service (YJS) prevents offending and re-offending, identifying the needs of each young person utilising the skills of each health professional within the team. This allows identification of specific risk factors that contribute to the young person re-offending again. They offer interventions and restorative justice and specialist

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	support referrals. The health team consists of a Youth Justice Consultant, the specialist Youth Justice Service public health nurse, speech and language specialist, drug and alcohol specialist workers, mental health specialist nurse, clinical psychologist and 2 well-being workers.
2.3	Tracey explained to the Board that Ethan's physical health had played a part in to how he was emotionally affected after sustaining a significant injury requiring surgery after been assaulted in school. Ethan was initially referred to the specialist nurse from the YJS. Tracey highlighted that there had been a number of mental health issues which had resulted in Ethan attempting to take his own life.
2.4	It was noted that school had been difficult for Ethan since the assault and he had spent time in isolation which had contributed to his difficulties.
2.5	Tracey described the YJS (Joanne's) holistic assessment of physical and emotional health and how she had been able to identify multiple health needs for Ethan. Ethan's voice was heard throughout the work which was carried out and he was given time to talk about his health both physically and emotionally. He was listened to whilst he shared his thoughts and feelings. Tracey described how Joanne's support had helped Ethan and Tracey in a very difficult situation.
2.6	Ethan wanted the Board to know how grateful he was for Joanne's support.
2.7	Board members asked a wide range of questions to Ethan, his family and HDFT staff. The Board expressed their thanks to Ethan and his family for sharing his story. The Board discussed the learning from the story and how HDFT can support and influence all partners.
2.8	**Resolved:** The patient story was noted.
BD/7/31/3 **3.1**	**Declarations of Interest and Register of Interests** The register of interests was received and noted.
3.2	**Resolved:** The declarations were noted.
BD/7/31/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 29 May 2024** **Resolved:** The minutes of the meeting on the 29 May 2024 were approved as an accurate record of the meeting.
BD/7/31/5 **5.1**	**Matters Arising and Action Log** The actions were noted as follows: • BD/3/29/36.2 – Board Effectiveness Survey – Linked to the review of governance arrangements in relation to HDFT Impact – remains ongoing. • BD/5/29/35.1 – Great Start in Life – Closed.
5.2	The Non-executive Director (WS) queried if equality, diversity and inclusion would be included in the Non-executive and Executive Directors appraisals. The Director of People and Culture confirmed that the appraisal process was being revised as part of HDFT Impact and objectives for all senior managers would include EDI elements. Confirmation was provided that this would link back into the People Plan.
5.3	**Resolved:** All actions were agreed as above.
BD/7/31/6 **6.1**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board.

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6.2	The Chair highlighted the following points: • Highlighted the revised Board Assurance Framework and the ongoing developments. • Noted significant changes since the last meeting of the Board in Public such as a new government, a proposal for junior doctors pay rise, changes in governors, and further development of HDFT Impact. • Thanks were expressed to Clare Illingworth, Lead Governor who had stepped down. • Noted the key responsibility of the Board was the delivery of the Trust Strategy.
6.3	**Resolved:** The Chair's report was noted.
BD/7/31/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read.
7.2	It was noted that the outcome of the General Election had resulted in a number of national statements about the NHS and a number of initial pieces of work being announced by the new government. A review of the state of the NHS had been launched, led by Lord Darzi, and this would report back at the end of September. The outcome of this stocktake will inform short terms plans for 2025/26, but will also inform the plan for the next 10 years. The 10 year plan is scheduled to be produced by the end of March 2025. It was also noted that externally the new Secretary of State had described the NHS as "being broken". As an organisation and as a wider NHS we continue to strive for better however, staff continue to deliver care and support the population despite some of the constraints in which they work.
7.3	A significant national focus has remained upon finalising financial plans for 2024/25 and concern in respect of delivery against these plans. In Humber and North Yorkshire (HNY) Integrated Care Board (ICB), the aggregate deficit at the end of Q1 is £47m, against a plan of £40m. The Board were reminded that the year-end deficit plan agreed is £50m, with improvement phased later in the year.
7.4	It was noted that there was also concern in respect of urgent care delivery, with HNY performing significantly worse than the rest of the region and is a poor performer nationally. A HNY Urgent and Emergency Care (UEC) summit was due to take place in July and a further clinical summit in August. HDFT remain a positive outlier in the system in respect of performance in this area, and continue to support other organisations in the system.
7.5	As part of reviewing the performance of various parts of the system, NHS England, through the Regional Office, has moved HDFT from segment two to segment three as part of the national oversight framework (segment one is low risk, through to segment four being very high risk). This would then mean that HDFT were in the same segment as the ICB and other acute providers in HNY. This is solely based on the risk in relation to finance with all remaining four domains performing well.
7.6	Work across HNY on "Design for the Future" continues with further discussions due to take place over the coming months.
7.7	The Non-executive Director (WS) queried what practical arrangements / requirements were in place now HDFT had moved to Segment 3 of the National Oversight Framework. It was confirmed that previously, in Segment 3 organisations would receive enhanced regional support. The Trust awaited further details in this regard. The Non-executive Director (LR) queried if maternity services would be able to use the theatre at Wharfedale for additional capacity as noted in the report. It was confirmed

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7.8	that there would be increased theatre capacity over the next 18 months which would allow the maternity service to more easily access theatres on the HDH site.
7.9	**Resolved:** The Chief Executive's Report was noted.
BD/7/31/8 **8.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/7/31/9 **9.1**	**Board Assurance Framework – Best Quality, Safest Care** The Executive Director of Nursing, Midwifery and AHPs provided the Board with an overall update on the ambition and goals for this area of the BAF. This element of the BAF remained within our risk appetite. No Corporate Risks were open in relation to this element of the BAF.
9.2	**Resolved:** The update on the BAF: Strategic Ambition - Best Quality, Safest Care was noted.
BD/7/31/10 **10.1**	**Quality Committee Chair's Report** The Chair of the Committee noted that the meeting in June 2024 had focused on the approval of the Quality Account prior to submission to the Trust Board. Internal audit reports were also discussed and noted the Nutrition and Hydration report had gained Significant Assurance. The Committee had discussed the Discharge Policy and it was noted that this was an HDFT Impact Corporate Project. Maternity and Neonatal Safety were discussed in detail.
10.2	In July 2024, the Committee had discussed the relevant True North objectives as well as the approach to Gemba. The Committee had also received the Infection, Prevention & Control Annual Report. Thanks were expressed by the Committee for the team's hard work. Maternity and Neonatal Safety were discussed in detail.
10.3	**Resolved:** The update from the Quality Committee Chair was noted.
BD/7/31/11 **11.1**	**Integrated Board Report – Indicators from Safe, Caring and Effective domains** The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
11.2	**Resolved:** The Board noted the content of the report.
BD/7/31/12 **12.1**	**Executive Director of Nursing, Midwifery and AHPs Report** The Executive Director of Nursing, Midwifery and AHPs' report was received and taken as read.
12.2	Super-intermediate care September would be taking place to look at ensuring appropriate support to support patients in appropriately returning to their original residence prior to admission.
12.3	**Resolved:** The Board noted the content of the report.
BD/7/31/13 **13.1**	**Executive Medical Director' Report** The Executive Medical Director took the report as read.
13.2	A risk to escalate to Board was highlighted in relation to the primary care ballot for collective action. Further details were awaited.
13.3	A kaizen event was being held to commence the development of our Clinical Services Strategy. It was noted that this was an HDFT Impact Strategic Programme.

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13.4	**Resolved:** The Board noted the content of the report.
BD/7/31/14 **14.1**	**Infection Prevention and Control Annual Report** The Infection, Prevention and Control Annual Report was accepted through the supplementary papers
14.2	**Resolved:** The Infection, Prevention and Control Annual Report was noted.
BD/7/31/15 **15.1**	**Board Assurance Framework – Great Start in Life** The Director of Nursing, Midwifery and AHPs provided the Board with an update on this element of the BAF. The workstreams were highlighted to the Board for information.
15.2	A corporate risk associated with this element of the BAF was noted in relation to autism assessments. Mitigation remains in place and ongoing discussions continue with commissioners.
15.3	The Non-executive Director (WS) queried if there were clear metrics that would be include in this and other elements of the BAF. It was confirmed that metrics would be used and these would be included once they have been selected.
15.4	**Resolved:** The update on the BAF: Strategic Ambition - Great Start in Life was noted.
BD/7/31/16 **16.1**	**Strengthening Maternity and Neonatal Safety** The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery presented the February Strengthening Maternity and Neonatal Safety Report to the Board.
16.2	The report provided a summary and update on the board level safety measures for the month of June 2024 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020).
16.3	Whilst staffing levels were generally good, it was highlighted that risks remain in relation to a few staffing gaps. Mitigation was in place and recruitment was ongoing.
16.4	The Breast Feeding Incentive Gold Accreditation had now been awarded for both maternity and neonatal services.
16.5	**Resolved:** The Strengthening Maternity and Neonatal Safety report was reviewed and approved.
BD/7/31/17 **17.1**	**Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** The Deputy Chief Operating Officer provided the Board with an overall update on the ambition and goals for this area of the BAF and noted the highlights in relation to performance and corporate risks. Each of the four workstreams were highlighted. Initially the breakthrough objective for ED 4 hour performance was focused on improving the time to the first clinical assessment. Following a review of the data this had been amended to admission to a medical bed in 2 hours.
17.2	The Corporate Risk that had been linked to RTT, given the achievements in relation to RTT, had now reduced in rating and would no longer be managed through the corporate risk register. The ED performance risk remains as a corporate risk.

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17.3	The Non-executive Director (WS) noted that trending performance would be useful.
17.4	The Non-executive Director (LR) noted the no criteria to reside was an area of concern for HDFT. It was queried if this was being measured in this element of the BAF. It was confirmed that it was captured as part of the length of stay data. The focus for this work was to ensure the right support and assessments were available at the front end of the pathway. This links to the super September work highlighted by the Executive Director of Nursing, Midwifery and AHPs earlier in the meeting.
17.5	**Resolved:** The update on the BAF: Strategic Ambition - person centred, integrated care, strong partnerships was noted.
BD/7/31/18 **18.1**	**Resources Committee Chair Report** The Chair of the Committee noted that a wide range of agenda items had been discussed at the Committee.
18.2	The £8.2m deficit at the end of the first quarter was highlighted as an additional unplanned deficit of £xxx (CHECK WITH JORDAN ABOUT VARIANCE). Work was ongoing in relation to ensuring this position was improved. In addition, discussions took place around enhanced theatre capacity, patients with no criteria to reside, control measures for financial management and the support across the region being provided.
18.3	The key performance operational targets had been discussed in depth.
18.4	The Committee had also received the Block C development business case which was recommended to private board. The Committee had also received an update on business development activities.
18.5	**Resolved:** The Board noted the content of the report.
BD/7/31/19 **19.1**	**Premises Assurance Model – Delegation** The Director of Finance introduced the report and noted the request for delegated authority from the Trust Board.
19.2	Non-executive Director (WS) queried if it was suitable rather than sustainably environment. It was confirmed it was suitable.
19.3	**Resolved:** The Board agreed to delegate authority to the Resources Committee to consider and approve the Premises Assurance Model on an annual basis.
19.4	**Action:** The Premises Assurance Model to be included in the supplementary pack when appropriate.
BD/7/31/20 **20.1**	**Integrated Board Report -** Indicators from Responsive, Efficiency, Finance and Activity Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised.
20.2	**Resolved:** The Board noted the content of the report.
BD/7/31/21 **21.1**	**Chief Operating Officers Report** The Deputy Chief Operating Officer presented the report which was taken as read.
21.2	The Non-executive Director (LR) queried the robotic processes and what this included. The robot was an automated computer process which helped support repetitive tasks to be undertaken.

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21.3	**Resolved:** The Board noted the content of the report.
BD/7/31/22 **22.1**	**Director of Finance Report** The Director of Finance presented his report which was taken as read.
22.2	It was highlighted that resources were required to deliver the level of performance required, the risks and mitigations that were associated with this and the plans in place to ensure a balance of quality of care and financial sustainability. HDFT would be clear regarding the productivity gains and the balance against the support required to be provided within the system.
22.3	The Non-executive Director (LR) queried the claw back in relation to Wakefield Council services and if this was in relation to this year. It was confirmed that discussions were ongoing with commissioners regarding commissioning and delivery of services against agreed contracts.
22.4	**Resolved:** The Board noted the content of the report.
BD/7/31/23	**Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work**
23.1	The Director of People and Culture updated the Board on this element of the BAF. The True North metrics were highlighted and the workstreams associated with them. The level of risk associated with delivery of the BAF remains in a positive position and below the risk appetite. No corporate risks were associated with this element of the BAF.
23.2	**Resolved:** The update on the BAF: Strategic Ambition - At Our Best, making HDFT the best place to work was noted.
BD/7/31/24	**People and Culture Committee Chair's Report**
24.1	The Non-executive Director (LR) had chaired the Committee in the absence of the Non-executive Director (AP). An overview of the discussions held at the People and Culture Committee was given including a discussion regarding rostering practices and measles vaccinations.
24.2	The True North and Breakthrough Objectives had been discussed in detail.
24.3	The Guardian of Safe Working report had been received and discussed in detail. This included the fines that had been issued to the organisations, themes and trends. This was noted as a risk that was being escalated to the Board. The Clinical Director for PSC provided the context in relation to a fine that had been received in relation to a junior doctor working excessive hours. Assurance was provided regarding the wide range of actions that had been implemented since the event had occurred.
24.4	The Freedom to Speak Up Guardian report had also been received and discussed.
24.5	The Chief Executive confirmed that the actions taken following the fine for a junior doctor working excessive hours needed to be confirmed with the Guardian of Safe Working to provide assurance that actions were being taken.
24.6	**Action:** The Clinical Director for PSC to share the findings of the investigation regarding the junior doctor working excessive hours with the Guardian of Safe Working.
24.7	**Resolved:** The Chair's update was noted.

Item No.	Item
BD/7/31/25 **25.1** **25.2**	**Integrated Board Report -** Indicators from Workforce Domains The Integrated Board Report was in the supplementary pack for reference. The Chair asked the board for any comments. None were raised. **Resolved:** The Board noted the content of the report.
BD/7/31/26 **26.1** **26.2**	**People and Culture Director Report** The Director of People & Culture presented their report which was taken as read. **Resolved:** The Board noted the content of the report.
BD/7/31/27 **27.1** **27.2** **27.3**	**Board Assurance Framework – Enabling Ambition: Digital Transformation** The Executive Medical Director provided the Board with an overall update on the ambition and goals for this area of the BAF. EPR was currently rated as Amber due to the risks associated with the workstream that were outside of HDFT's control. **Resolved:** The update on the BAF: Enabling Ambition: Digital Transformation was noted.
BD/7/31/28 **28.1** **28.2**	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation** The Executive Medical Director provided the Board with an overall update on the ambition and goals for this area of the BAF. The Innovation Hub was highlighted with further work ongoing towards the opening and launch. **Resolved:** The update on the BAF: Enabling Ambition: Healthcare Innovation was noted.
BD/7/31/29 **29.1** **29.2** **29.3** **29.4**	**Innovation Committee Chair's Report** The Chair of the Committee noted that the Committee had a wide ranging discussion. The following were highlighted: • A Gemba to Wensleydale Ward had taken place. The improved physical environment and digital enhancement were noted. • EPR programme is on track and progressing well. • LIMS system has a clear go live schedule and programme in place. • The single sign on programme was noted as being completed. • The Committee had discussed the tracking of benefit realisation following conclusion of major projects or programmes of work. A trial of receiving a benefits realisation plan linked to digital schemes would take place over the next 6 months, reported through the Committee. • Progress against clinical trials had been discussed and it was noted that HDFT was ranked 8th out of 23 in the region for progress. • HDFT Impact roll out was reported against. **Resolved:** The Chair's update was noted. *The Associate Non-executive Director, Azlina Bulmer left the meeting.*
BD/7/31/30 **30.1**	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing** The Director of Finance updated the Board on the environment enabling ambition. The range of workstreams that made up this element of the BAF were highlighted. This included the work ongoing with RAAC. The Health and Safety risks that remain on the Corporate Risk Register have mitigation in place and are monitored through the Environment Board.

Item No.	Item
30.2	The Non-executive Director (WS) queried where sustainability fits within this element of the BAF. The Non-executive Director (JC) confirmed that a discussion had been held at the HIF Board regarding the Green Plan. A request was made for the Green Plan to be more visible to the HDFT Board.
30.3	**Action:** The Green Plan to be included on the Board agenda.
30.4	**Action:** Metrics to be included for this element of the BAF for September.
30.5	**Resolved:** The update on the BAF: Enabling Ambition: An Environment that Promotes Wellbeing was noted.
BD/7/31/31 **31.1**	**Director of Strategy Report** In the absence of the Director of Strategy, the Director of Finance presented the report which was taken as read. The HDFT Impact programme was highlighted.
31.2	**Resolved:** The Director of Strategy Report was noted.
BD/7/31/32 **32.1**	**Audit Committee Update** The Chair of the Audit Committee provided an overview of the discussions held at the Audit Committee.
32.2	It was noted that the Annual Report and Accounts were submitted to timescales and the Annual Report was laid before parliament as required.
32.3	The Internal Audit programme for 2023-24 remains ongoing with a backlog of reports being received by the Committee periodically. The Director of Finance noted that a debrief had been held with regards to the processes for production and auditing of the annual accounts.
32.4	Counter fraud plans continue to progress well and a report had been received on the impact of AI on fraud.
32.5	The Trust awaited the External Audit final annual report, in particular value for money assessment. It was noted that this would be submitted to the next meeting of the Committee.
32.6	**Resolved:** The Chair's update was noted.
BD/7/31/33 **33.1**	**Use of Trust Seal** The Company Secretary (Associate Director of Quality & Corporate Affairs) presented the report which was taken as read.
33.2	**Resolved:** The details of the use of the Trust Seal were approved by the Board.
BD/7/31/34 **34.1**	**Any Other Business** No further business was received.
BD/7/31/35 **35.1**	**Board Evaluation** Thanks were expressed to observers.
BD/7/31/36 **36.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 25 September 2024.
BD/7/31/37	**Confidential Motion**

Item No.	Item
37.1	**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E), (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Signed: ----------

Dated: ----------

Board of Directors (held in Public) Action Log
for September 2024 Board Meeting (updated after July 2024 Board meeting)

Minute Number	Date of Meeting	Subject	Action Description	Responsible Officer	Due Date	Comments	Status - completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BD/3/29/36.2	29 March 2023	Board Effectiveness Survey	Discussions to be held at the August 2023 Board workshop regarding further developments as a result of the survey.	Associate Director of Quality and Corporate Affairs	31st August 2023	A survey is being circulated to Board members in January and February with Non-executive individual discussions and Executive forum being held in February 2024 with the support of an independent lead (Mark Chamberlain) March: Survey circulated for completion mid to late March 2024. Action to remain open until results reviewed at Board	Ongoing
BD/5/29/35.1	29 May 2024	Board Assurance Framework (BAF)	Include the ambition for "Great Place to Work" in the 2024-25 BAF.	Associate Director of Quality and Corporate Affairs	July 2024	Action complete.	Closed
BD/7/31/19.4	31 July 2024	Premises Assurance Model - Delegation	The Premises Assurance Model to be included in the supplementary pack when appropriate	Director of Strategy	November 2024		Ongoing
BD/7/31/24.6	31 July 2024	People & Culture Committee Chair's Report - Review of Guardian of Safe Working report	The findings of the investigation regarding the junior doctor working excessive hours to be shared with the Guardian of Safe Working.	Clinical Director for PSC	September 2024		Ongoing
BD/7/31/30.3	31 July 2024	BAF Enabling Ambition: An Environment that Promotes Wellbeing	Green Plan to be included on the Board Agenda	Associate Director of Quality and Corporate Affairs	September 2024		Ongoing
BD/7/31/30.4	31 July 2024	BAF Enabling Ambition: An Environment that Promotes Wellbeing	Metrics to be included for this element of the BAF	Director of Strategy	September 2024		Ongoing

BOARD OF DIRECTORS (PUBLIC)
25th September 2024

Title:	Chief Executive's report
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	x
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
BOARD OF DIRECTORS (PUBLIC)
SEPTEMBER 2024

CHIEF EXECUTIVE'S REPORT

National and system issues

1. The Independent Investigation of the NHS in England undertaken by Lord Darzi (the Darzi Review) was published last week. This report spells out the state of the NHS and diagnoses the problems that we are facing. It also sets out how we can approach improving the service.

2. In terms of the key messages, the report clearly outlines that health outcomes have been declining, quality is mixed, money is being spent in the wrong areas of the NHS, capital investment has been insufficient, we were under-prepared for the CoVid pandemic, and the constant and significant restructures of the architecture of the NHS have been at best a distraction. The report also references that some of the recent moves towards larger organisations and group models have as yet no evidence of improved care.

3. The report is also keen to say that management within the NHS has been focused on keeping the show on the road in and amongst the external challenges, and that there is a greater need to value and invest in our leadership and management across the service.

4. From my discussions with colleagues internally and across the wider NHS, the report is an eloquent and relatable statement of the current state of the NHS, and is viewed positively as a point from which we can now improve and take the NHS forward.

5. The report outlines the key things that should be thought about as part of future plans to recover the NHS; these include engaging better with patients and staff, hard-wiring financial flows into out of hospital services, leaning into technology, improving hospital productivity, reducing waiting lists as a contributor to the nation's prosperity, and integrating services at neighbourhood level in a way that helps the local population.

6. The next step is the development of a 10 year plan which will set out how the NHS will recover and improve. The three themes that have already been identified are to move from hospital care to community care, to shift from treatment to prevention, and to move from analogue to digital. Again, there is support for all of these themes, with the challenge being to ensure that that these become a reality rather than an aspiration.

7. There will be supporting information from NHSE shortly which will aim to engage and involve many people and organisations in the creation of the 10 year plan, and we will have an opportunity as a Board to discuss this in more detail over coming months and ensure that are future plans are aligned. My reflection is that we are well-placed as an organisation to respond to and deliver the improvements necessary for the population we serve.

8. We have received communication this week from NHSE in relation to winter planning. There is nothing significantly new in the letter which is reassuring and expected; we are well-versed in the requirements to ensure we manage periods of pressure and peak

demand on the service. The letter reinforces the fact that we should not be normalising care in settings that aren't appropriate, for example in corridors, and is also silent on any additional resource being available. Again this is not unexpected, as the clear messages have been that there is no extra funding for winter beyond what we already have in our plans for the year.

9. Finally in terms of external communications, organisations have been asked to undertake a self-assessment of our workforce planning and controls. This is a request to be coordinated through the Regional Office of NHSE and reflects the ongoing concern in respect of the financial pressure within the NHS.

10. As the Board will be aware, an offer was made by the government to Junior Doctors in respect of their pay dispute that has been ongoing for 18 months. I am pleased to report that this offer has been accepted. Separately, we continue to monitor any impact in relation to GP action. At present there has been no material impact but we are aware that as we move into the winter period that this could become a bigger risk, depending upon negotiations and discussions nationally.

11. In relation to our local systems of Humber and North Yorkshire (HNY) and West Yorkshire (WY), I and executive colleagues have been increasingly engaged in a number of issues.

12. Work continues in HNY in respect of developing a 'Design for the Future'. The aim is to engage stakeholders and the public about the future for health services in HNY over the next six months. This can now be aligned with the national exercise to engage people in the NHS 10 year plan development, which is helpful. There are different views understandably expressed across HNY, but importantly, we have reinforced our approach to integrating care for our local population and ensuring pathways for our patients best reflect their needs.

13. As part of this work, we met with the York Executive Team this week as part of our approach to collaborating in a more organised way through a Joint Collaborative Board. It was a helpful initial discussion, we have agreed some actions to explore in relation to existing clinical alliances and digital services in particular. We also agreed to set out a governance framework for our collaboration before we meet again in three months.

14. We have a Collaborative of Acute Providers (CAP) timeout on Monday 23rd September, where we will discuss our contribution to the Design for the Future and also review the initial findings of a piece of work that we collectively commissioned in respect of our hospital services. This work explores by key specialty the current service provision and any service fragility through a number of lenses such as workforce, clinical standards, and productivity. It is recognised that for ourselves, a lot of the solutions for any service resilience issues will be through our networks into West Yorkshire and WYAAT.

15. A second Grant Thornton review is concluding across HNY, with a focus on reviewing financial controls and ability to deliver the efficiency gains needed in this financial year. There is a summit for all organisations at the end of next week to discuss and go through the findings. Initial feedback is that there isn't anything material that we aren't already aware of and taking action about, which is reassuring. The system-wide financial challenge is still significant though.

16. In relation to WYAAT, we are working through discussions about our clinical services in the light of the Darzi review and the WYAAT strategy that we already have established. This will be a part of the Committee in Common meeting in October.

17. The Wharfedale Hospital theatre capital scheme is complete and we will start undertaking theatre lists in October, which will benefit our patients and also contribute to elective recovery and elective recovery funding. We also hosted a WYAAT children's ENT list in August where children from WY were seen and had their operation in Harrogate, which was undertaken by colleagues from other WYAAT organisations. Again, this is beneficial to the children involved, has reduced the waiting list, and contributed ERF to the system.

18. In relation to our North Yorkshire Council partners, we met recently to jointly go through the performance indicators that we had drafted for HARA. This was a positive session and the aim is to use a further iteration of this information to inform the future discussions about the HARA s75 and where we should be focused going forward. We are also picking up a conversation with senior leaders in NYC in relation to the North Yorkshire Place and our understanding of developments across the HNY ICB that I have already described.

19. We continue to engage well with our Local Authority partners across all of our 0-19 service footprint.

20. Since the last meeting, we have received official communication from the Regional Office that our segmentation for regulatory purposes has moved from segment two to three as a result of having a deficit financial plan for the year. There has been an initial meeting to discuss the process of review and support, and routine meetings with the Regional Team and the ICB are being organised to help deliver the appropriate improvements.

HDFT issues

Introduction

21. As I have referenced earlier, there is a lot of focus on the NHS at the moment and a lot of challenges have been highlighted through the Darzi report. It is important to note that our strategy and approach is consistent with the suggested ways in which the NHS can recover and improve. We know that there are areas we absolutely want to improve, but we also need to recognise the care and support delivered every day to thousands of people in many communities, by our hard-working colleagues.

22. I also continue to emphasise that *how* we do things is as important as *what* we do, as we will only succeed in delivering better services if we are consistently operating in line with our values. There will always be discussion and potentially disagreements about how we do things in HDFT, but the important thing is to be open and have the discussions that are needed to ensure that we get the optimal outcomes for our patients and population. This is the right approach, and collectively as a Board and through our senior leadership, we need to remain confident that this is the right approach.

Our people

23. We continue to have good staffing levels across most parts of the Trust. In particular, our ward staffing levels remain positive, and this continues to translate into a reduction in the use of agency staff. There are some challenges in respect of our maternity staffing but this is more as a result of the complexity and change in service expectation and subsequent impact on capacity rather than an inability to recruit to our establishment, which remains something that we do well. We remain focused on staff availability as a key indicator within the HDFT Impact programme.

24. As reported previously, we are refreshing our programme of staff wellbeing. We have had feedback from colleagues about the small-scale environmental improvements that would improve their working life, and are working on prioritising a programme to be delivered through HIF.

25. The latest quarterly inpulse survey reported strong engagement from staff across the trust. As always, there are areas where the responses were not as favourable, and we will be using this intelligence to guide some of our Gemba activity going forward.

26. The pay award for colleagues has now been agreed nationally which is positive, and we will be paying the new award and relevant back pay next month. Hopefully, we will get an earlier pay agreement next year, so that staff don't suffer any financial hardship from not being paid what is agreed in a timely way.

Our Quality

27. As I have mentioned earlier, we received a letter in respect of planning for winter this week. We are developing our winter plan which we will share with the Board next month, and the focus as always will be on ensuring that we can manage all patients safely, either in or outside of the hospital. There will be some positive changes from last winter that will help to manage the expected pressure on demand. These include moving our surgical ward and surgical assessment unit to a better and bigger environment which will protect service provision, implementing the Directorate service changes that will help manage the urgent care pathway in an integrated way in hospital and the community, further roll out of the discharge programme, the new HELPSS service to better provide End of Life Care, and taking any learning from our ongoing 'super September' pilot. We have discussed further ward moves, but having assessed the risk and undertaken a QIA, we will not be implementing any further changes. I have no doubt that there will be challenges through winter, and patient safety will be our overriding driver of action as we work through our escalation processes, but we will have robust arrangements in place to manage risk.

28. As I have reported before, we continue to have occasions when our maternity unit has to divert patients to other units and also has to receive patients diverted from elsewhere in the local network. This has occurred 16 times in four months. There remain pressures in the system, but it is also a symptom of the standards and levels of staffing required in all maternity units. Our staffing levels our strong, but there are fluctuations in pressure which we have to manage across the system at times. We have included the number of maternity diverts as a metric as part of the Impact programme of improvement.

29. We had a Never Event this month that we have reported in relation to a retained swab. The process of review and further investigation of this is in train to ensure that we learn from this incident. I can report that there has been no immediate harm to the patient involved.

Our Services

30. Our 0-19 services continue to deliver strong performance across the majority of our geographic footprint and across the vast majority of the KPIs that we measure ourselves against. This is very positive and we are now focusing on developing and monitoring new outcome indicators as part of our Impact programme of improvement.

31. Our urgent care pathway remains an area of concern in terms of delivering the quality of service we would like to our population, but it is positive to report the position for August where our ED 4 hour performance was just under 80%. We are keen to improve this further but realistic to know that over the winter period there will be fluctuations and challenges. We need to stay focussed on the improvement plan in place.

32. In relation to cancer, this is an improving picture. Positively, we delivered the FDS in August and in relation to the 62 day standard, we currently have less than 50 people waiting over 62 days (our target).

33. We continue to deliver our elective recovery plan, and we continue to be on track to eliminate over 52 week waits by the end of the year. The elective care programme of the ICB performs strongly and is much improved when compared to other ICB areas.

34. I referred to needing to progress a number of commissioning issues with our Place/ICB in my last two reports. Whilst we have shared information with the ICB, this is still the position and is becoming more relevant for our services in the current financial situation and the segmentation change that has been confirmed. We will update the Board as these discussions occur.

Our money

35. Our month 5 financial position is in line with the deficit position that we had planned at this point in the year. There is still a significant challenge to meet which will become more difficult in the second half of the year. However, our runrate, our WRAP delivery, and our ERF position have improved through the hard work of colleagues, supported by the finance team.

36. The focus continues to be on our delivering our financial plans for the year, with a need to deliver the productivity improvements and waste reduction that will ensure we achieve our financial plan whilst delivering our expected quality and performance standards.

37. There is a path through to achieving our financial plan for this year, and we are focused on the key drivers and actions to ensure that we deliver this. This is in part dependent upon the resolution of a number of service commissioning issues that I have referred to earlier.

38. As a result of our (planned) financial deficit, delays in receiving the cash due to us in respect of last year's ERF funding, and a lack of certainty in respect of the cash funding to support the payment of the pay award and associated arrears next month, we have submitted a cash support request to NHSE. Should we not need it (i.e. if these issues are resolved) then we will not utilise the support request, but it is prudent to have an arrangement in place.

Other

39. Our RAAC elimination programme and TIF2 schemes continue, with Block C now empty and in the process of being demolished. We are working through the timing and quantum of capital resource needed over the life of the project and will be updating the Resources Committee.

40. It was a pleasure to attend and present at our recent Annual Members' Meeting. It was an opportunity to reflect on how we have performed for our patients and population over the last year and what our ambitions are for the future. I summed up my reflections as being that we had delivered well for our patients, and that we were a good provider of health and care – but that we wanted to be better. We should absolutely celebrate what we do and the fantastic achievements delivered by our colleagues every day, often in the face of difficult challenges, but combine this with a relentless impatience to want to be even better. We know that healthcare is the most important thing of all for everyone across the country, and therefore we should embrace the opportunity of improvement in a very positive way. I will certainly continue to do, I know that my colleagues will also do so, and between us we need to continue to try and create the right environment for all people in HDFT to deliver of their best, as this will be how we achieve the success that we all want for our patients and population.

Jonathan Coulter
Chief Executive
September 2024

HDFT – BOARD ASSURANCE FRAMEWORK 2024-25

HDFT has set its Strategy with an overall purpose of improving the health and wellbeing of our patients, children and communities. To do this we have set our True North Ambitions: to deliver the best quality, safest care; to provide person centred, integrated services through strong partnerships; to give our children and young people a great start in life and to be a great place to work with the right people with the right skills, in the right roles. These will be supported by a strong financial foundation and by our three enabling ambitions to provide care and working environment that promotes wellbeing; to use digital transformation to integrate care and improve patient, children and staff experience; and to be innovative to improve quality and safety.

To support our Strategy, HDFT have set our risk appetite within 6 domains:

Domain	Appetite	
Clinical	Minimal *Threshold – 12*	Appetite for taking **very limited clinical risks** if essential to patient care and outcomes. Such risks are properly assessed with mitigating controls in place
Operational	Cautious *Threshold - 16*	Risk Management capabilities in place to **meet regulatory standards** to deliver safe and effective patient services. Robust oversight processes in place

Domain	Appetite	
Financial	Cautious *Threshold - 16*	**Limited financial impacts or losses** are accepted if they yield upside opportunities elsewhere in HDFT. **Minimum cash balance retained for a trust our size**
Workforce	Cautious *Threshold - 16*	Seek options to deliver safe and effective patient care and outcomes **with limited workforce risks** only if it could yield patient care opportunities elsewhere in the Trust

Domain	Appetite	
Reputational	Minimal *Threshold - 12*	Only prepared to accept the possibility of **minor adverse publicity** if related to actions that are essential to the safe and effect patient care and outcomes
Regulation	Averse *Threshold – 8*	**Zero appetite** for any decisions that present risks to the Trust maintaining its CQC registration and complying with the law

Summary of Risk

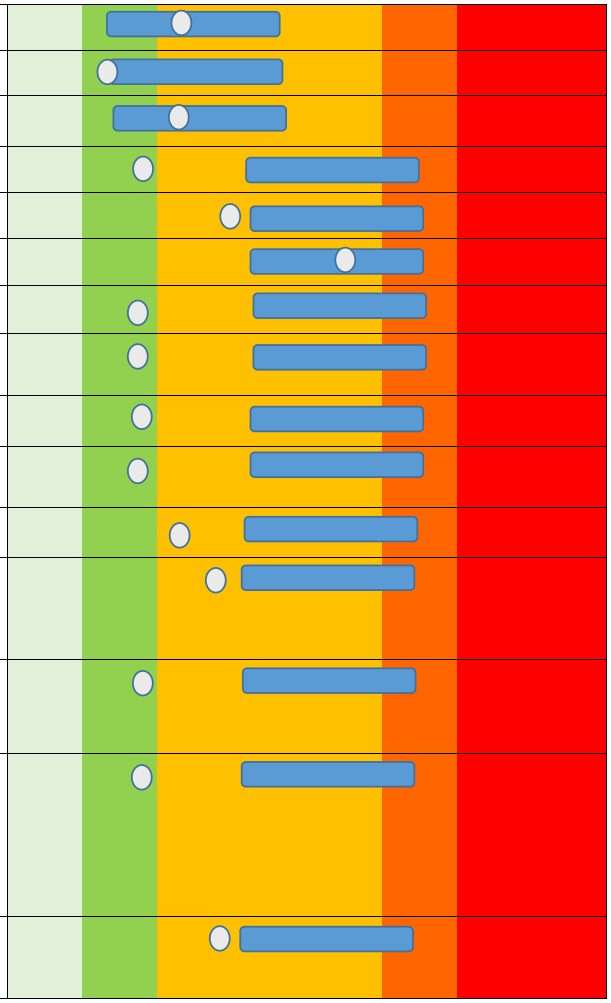
Summary of Activity since last report:

The report was last reviewed at the Trust Board in Public in July 2024. The report contains information in relation to the risk of non-delivery of our True North ambitions. The report provides details of the current level or risk and if the status of delivery is in line with our risk appetite. There are two True North Metrics currently above our HDFT's risk appetite: 4 hour ED standard and Cancer – 62 day treatment standard.. Plans are in place to mitigate these risks and bring in line with our risk appetite. All other True North metrics remain within or below our HDFT Risk Appetite Tolerance.

Of note since the last report:

- Person Centred, Integrated Care, Strong Partnerships: 18 Week Referral to Treatment (RTT) has reduce in level of risk to an 8 in line with improved performance.
- Great Start in Life: Hopes for Healthcare has reduced in level of risk to a 4 following the implementation of countermeasures.

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

Great Start In life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal	
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal	
	High Quality Maternity Services	Maternity Harm Events	Clinical: Minimal	
At Our Best – Making HDFT the Best Place to Work	Looking After our people	Staff Engagement	Workforce: Cautious	
	Belonging			
	Growing for the future	Staff Availability	Workforce: Cautious	
	New ways of working			
Finance	Financial Sustainability	Financial Sustainability	Financial: Cautious	
An Environment that promotes wellbeing	Wellbeing	Wellbeing Works Capital Spend vs Budget	Operational: Cautious	
	Quality & Safety	Major Projects Capital Spend vs Budget; High Risk Backlog Maintenance Cost	Operational: Cautious	
	Environmental Impact	Natural Gas Consumption	Operational: Cautious	
Digital Transformation	Quality & Safety	100% Completion of the countermeasures	Operational: Cautious	
	Electronic Health Record	Programme Performance	Operational: Cautious	
Healthcare Innovation	Healthcare Innovation	Support at least 2 external innovations, at least 2 internal innovations and establish at least 1 strategic partnership with industry.	Operational: Cautious	
	HDFT Impact	Development and implementation of a behaviors model and improvement academy	Operational: Cautious	
	Children's Public Health	Identify the key priority research needs for children and PH before end March 2025 . Sponsor at least one research study in the children and public health based around the trust needs identified .	Operational: Cautious	
	Clinical Trials	2001 patients recruited into research studies by end March 2025. 80% of studies delivered to time and target.	Operational Cautious	

Key:
Risk Appetite threshold

Current Risk Level

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2024-2025

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

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

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

GOVERNANCE:

Quality Framework

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

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

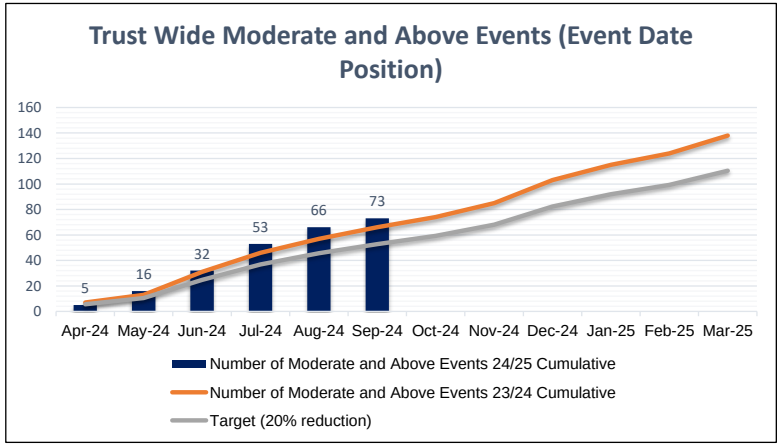
1. **Eliminating Moderate & Above Harm**
2. **Patient Experience Positive Response Rates**

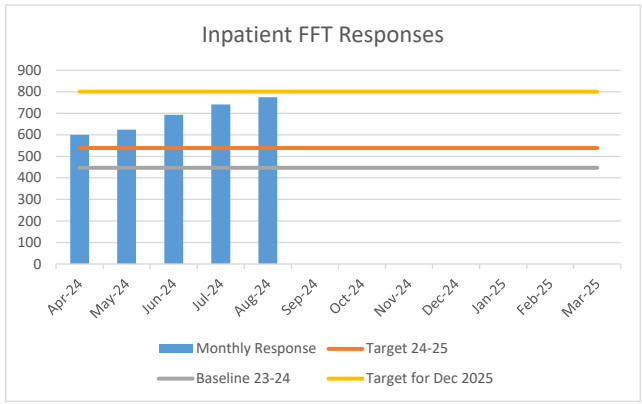
Breakthrough Objective:	Pressure Ulcers
Corporate Project:	Patient Experience
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

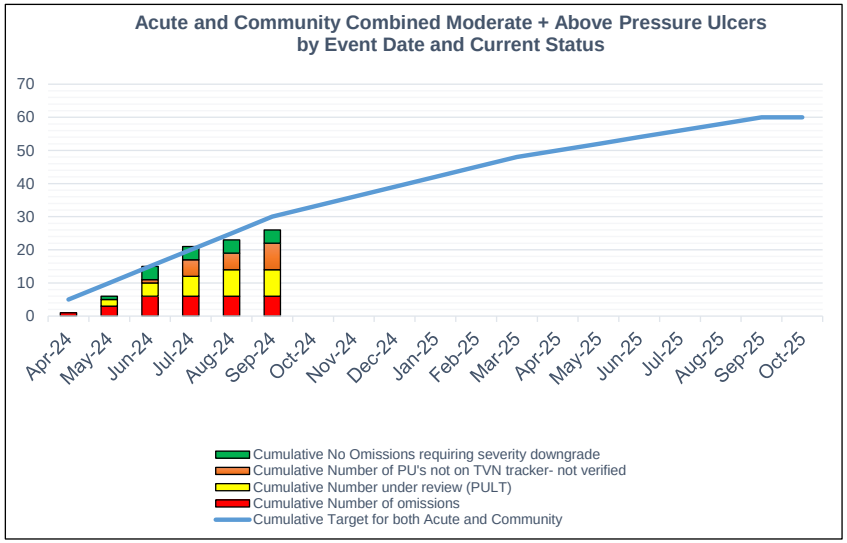
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Best Quality, Safest Care	**Ever Safer Care**	**Moderate & Above Harm**	**Clinical: Minimal**								
	Excellent Outcomes										
	A positive experience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

True North Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care  Excellent Outcomes 	Eliminate Moderate & Above Harm **Breakthrough Objective**	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 170 per annum Year 1: 136 now 110 Year 2: 109 Year 3: 87	The target for Year 1 (2024-25) is 110 or less moderate and above incidents (approximately 9 per month). This will be tracked from April 2024. Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Implementation Plan	**Break through Objective: Pressure Ulcers – noted below** April 2024 – 6 Moderate and above Safety Events May 2024 – 11 Moderate and above Safety Events June 2024 – 16 Moderate and above Safety Events (data being validated) July 2024 – 21 Moderate and above Safety Events (data being validated) August 2024 – 13 Moderate and above Safety Events (data being validated) Stratified data used for 2022-23 indicated that Pressure Ulcers was the top reported moderate and above harm, followed by Falls and Diagnostics. Pressure Ulcer improvement plan and breakthrough objective detailed below. A period of validation of data took place in July 2024 to ensure accuracy of data. This included ensuring that all levels of harm following 48 hour reviews, were updated on the Datix reporting system. In addition, it is noted that the moderate and above events for June – August may reduce following validation and review of both acute and community acquired pressure ulcers.  Moderate and above incidents are currently above trajectory for year 1. 66 events up to the end of August 24 (data awaiting final validation). Trajectory would have been 47 events to end of August.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
A Positive Experience 	Patient Experience Response Rates **Corporate Project**	For every patient to recommend our services	Long term: Development of a real time engagement tool Short term: Increase the response to FFT by 20% over the next 12 months for inpatient (baseline 447) By March 2025: 539 responses per month By December 2025: 801 responses per month	Corporate Project on social value in development Project on increasing engagement led by the Quality Team in development	Corporate Project on social value in development In August 2024 the Trust received 775 inpatient FFT responses. With an average of 96% of patients rating their care good or very good. Currently above trajectory (positive trend) with responses above baseline (2023-24 data) and above target for 2024-25. Steady pace being maintained to achieve the stretch target in December 2025.  Plan in development of increased engagement in development with a focus on: • Public engagement events • Review of feedback systems (Datix, FFT, Surveys etc) Watch Metrics: Complaints compliance at 96% for August 2024		

Breakthrough Objective: Pressure Ulcers

Workstream	True North Metric	Vision	Countermeasures	Current State	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm	No Category 3 or 4 Pressure Ulcers	Pressure Ulcers Improvement Plan	April 2024 – 6 Moderate and above Safety Events, 1 related to an acute acquired pressure damage (omissions noted) May 2024 – 11 Moderate and above Safety Events, 2 related to an acute acquired pressure damage (omissions noted), 2 related to a community acquire pressure damage (both currently in the PULT process) June 2024 – 16 Moderate and above Safety Events (data being validated), 3 related to acute acquired pressure damage (2 with omissions, 1 being verified), 3 related to community acquired pressure damage (1 had omissions noted, 2 in the PULT process) July 2024 – 21 Moderate and above Safety Events (data being validated), 0 related to acute acquired pressure damage, 6 related to community acquired pressure damage (2 in the PULT process, 4 awaiting verification) August 2024 – 13 Moderate and above Safety Events (data being validated), 1 related to acute acquire pressure damage (in the PULT process), 0 related to community acquired pressure damage.  Each directorate has used stratified data to determine the locations where pressure ulcers are reported in the highest number. Currently above trajectory overall. Red indicates PU with confirmed omissions, Yellow are under PULT review and Orange are awaiting TVN verification. Green are where following review no omissions were identified and harm downgraded. Acute acquired pressure damage is currently below trajectory (positive trend) with community trending above trajectory (negative trend – ie above threashold).		

Corporate Project: Patient Experience

Workstream	True North Metric	Vision	Countermeasures	Actions	Level of Risk To Achieving in Year Goal	Level of Risk for progressing actions
A Positive Experience	Patient Experience Response Rates	Development of real time engagement tool	Corporate Project Currently in development. Continuing to monitor FFT rates and response whilst project in development	Scoping meeting took place in June 2024. Discussions held on wide range of social value initiatives. Project Plan in development. Discussions held on using Patient Experience at different levels to support decision making from ward to board: strategic planning, operational excellence and day to day improvement. Plans moving forward include: • Strategic Planning: improved FFT return rates by giving multiple channel options (telephone, card, online survey) & automated analysis and reporting of FFT • Operational Excellence: tracking of Patient Reported Experience Measures (PREMs) and tracking Patient Reported Outcome Measures (PROMs), mapping out patient experience of pathways to understand experience by stage / process • Day to Day: improved lessons learned and sharing of day to day process improvement Further review of stratified data to take place linked to wider public health impacts and programmes of work. Consideration being given to areas of focus linked to the Trust Strategy: Children and Young People and Frailty being considered. Currently rated amber due to project plan being in development phase.		

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related External Risks impacted on the above ambition currently.					

Trust Board held in Publc

25th September 2024

Title:	Adult and Children and Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review
Responsible Director:	Emma Nunez
Author:	Brenda Mckenzie

Purpose of the report and summary of key issues:	The purpose of this paper is to provide the Board of Directors with an overview of outcomes of the April 2024 Safer Nursing Care Tool (SNCT) for the Adult and Children and Young People (C&YP) Inpatient Nurse staffing levels at Harrogate District NHS Foundation Trust, as recommended by the Developing Workforce Safeguards (NHSI 2018) which builds on the National Quality Board (NQB) standards (2016). The Developing Workforce Safeguards, reinforces the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing. Compliance with the principles outlined in the document is to be assessed bi-annually	
Trust Strategy and Strategic Ambitions:	**SNCT Safer Staffing**	
	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:	Safer Staffing Levels; triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing.	
Report History:	SNCT Review Meetings June 2024 Establishment Review Panel July 2024	
Recommendation:	The Board / Committee is asked to agree the SNCT review of the Adult and C&YP inpatient ward safer staffing review. **Adult Inpatient Wards**	

	The recommendations within this report were presented at Establishment Review Panel on Friday 19th July 2024. The SNCT review has given us assurance that the Adult inpatient wards, establishment and skill mix, achieve optimal safe staffing requirements. There is ongoing work being undertaken to identify the most appropriate way to manage our Enhanced Care requirements and further SNCT data required to validate a potential establishment change within the PSC wards. **C&YP (Woodlands Ward)** The recommendations within this report were presented at Establishment Review Panel on Friday 19th July 2024. There was acknowledgement that the SNCT demonstrates a slight establishment change for the Woodlands Ward. However, the Children's Assessment Unit (CAU) service review and redesign may influence additional changes. Therefore, no changes to be made until the CAU service review and establishment modelling has been completed. This should then come back through Establishment review panel.

Freedom of Information:	

STRATEGIC AMBITION: GREAT START IN LIFE 2024-2025

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

GOALS:

Public Health

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

Hopes for Healthcare

Services which meet the needs of children & young people

Maternity Services

High quality maternity services with teh confidence of women and families

GOVERNANCE:

Great Start in Life

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

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

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

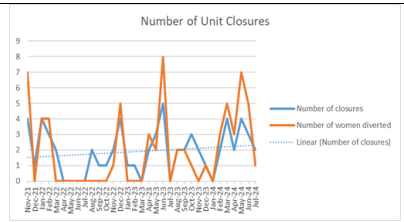
Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Clinical - Minimal

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

True North Metrics Summary:

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Satus	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
Public Health 	Great Start in Life: Early intervention & prevention – Children at Risk of Vulnerability	As an organisation we wish to recognise all children at risk of vulnerabilities in the ante natal period so that by the age of 30 months the child can be graduated into universal services	1st Goal : to configure SystmOne to enable representative performance reporting across the geographies. 2nd Goal: to be able to measure the impact of early intervention and prevention by 1st June 2024	HDFT Learning and Best Practice 'Early Intervention' workstream to: Define a minimum offer / GSIL care pathway to children identified at risk of vulnerability in the antenatal period. The workstream will report into the Learning and Best Practice Group. Establish a corresponding performance framework to measure the impact of early intervention and prevention and subsequent reporting enablers. HDFT Learning and Best Practice 'Early Intervention' workstream to: Define a minimum offer / GSIL care pathway to children identified at risk of vulnerability in the antenatal period. The workstream will report into the Learning and Best Practice Group. Establish a corresponding performance framework to measure the impact of early intervention and prevention and subsequent reporting enablers.	Annual HDFT run 0-19 Conference set up to promote the Trust as a provider of services. Set up Great Start if Life Foundation to support a charitable offer for 0-19 Services based outside Harrogate and District. First one took place April 24 with a plan to undertake a second in 2025. Representation at local system meetings along with catch up meetings now established with all LA leads. Attended by mix of 0-19 General Managers, CC Triumvirate and Director of Strategy and Planning. Sessions held in 2023/24 to help corporate services understand size, challenges of CC Directorate and contribution 0-19 contracts make to corporate services. Working with corporate services to offer consistent offer to staff based outside Harrogate and District. Significant improvements made in IT & Occ Health Offer (local vaccination offer and Wellbeing session in Durham with plans for more in the North East). Working on logistics and movement of equipment etc with HIF. Draft contract for transport of drugs being set up with HIF to support 0-19 service where medicines are part of the contract (Durham, Sunderland and Northumberland). S1 Power BI reports developed to give data on % of patients identified at risk of vulnerabilities at birth who are in universal services by 30 months. Audit being undertaken by services to understand drivers now data available and target Contract areas to pilot the GSIL Pathway which will launch September 24.	4 x 2= 8	

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Satus	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
					Research opportunity identified for HDFT to lead on a comparative study of Early Intervention prescribed pathways. This research will allow us to retrospectively examine any differences in outcomes between contract areas and to analyse what effect, if any, the differing pathways have had. Additionally, we now have an opportunity to standardise the HDFT Great Start in Life Pathway across all contract areas and therefore to prospectively compare experiences and outcomes for Children and Young People who receive this pathway versus those who received the Enhanced Parenting Pathway or traditional Health Visitor lead delivery.		
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Engage with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare. Develop an HDFT CYP Patient Experience Test which will provide outputs that will translate into themes, trends and areas for improvement. This data set will be visible and accessible across Trust governance frameworks. Develop a CYP Shadow Board with representation from HDFTs geography who will provide consultancy to HDFT Board and Services	To embed the "Hopes for Healthcare" principles in all HDFT services	Ten Focus groups have now been delivered across all HDFT Local Authority Contract areas and the Acute setting with over 100 Children and Young People. Steering Group held the 16th July 2024 where Patient Experience leads presented the outcome and video feedback by the Children and Young People. A proposal is now being developed for Board to summarise feedback involving our Great Start in Life Young Advisors and narration. Great Start in Life Young Advisors from Focus Groups across the footprint and Acute setting have directed, produced, and filmed the outcome of sessions held. The video is their proposal and feedback to Board. GSIL Young Advisor Feed back Film presented to Board with considerations for future engagement.	2 x 2 = 4	

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Satus	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
					CYP Patient Experience Tool ratified and Standard Work process / Central Reporting in progress.		
Maternity Services 	Maternity Services – Maternity Harm Events	In order to give people the best start in life, maternity services must be of good quality.	Improve the safety and quality of maternity and neonatal services with a focus on personalised care, and equity and equality.	Embedded immediate and essential actions from Ockenden Report (2020 & 2022) Progress actions towards the Three Year Delivery Plan for Maternity and Neonatal Services (2023)	All actions from the Ockenden report have been completed. Work is ongoing regarding personalised care and informed consent. Work is on-going to fully implement the recommendations of Saving Babies Lives Version 3 – specific outstanding actions relate to the embedding of the new in-house tobacco dependency service and improving care provision to people with diabetes in pregnancy and postnatal.		
Maternity Services	Maternity Services	The aim of our maternity services is to work in partnership to provide a safe, friendly and effective service, aiming to deliver the highest standard of care throughout pregnancy, birth and postnatal period.	To ensure the service is available for service users at all times, reducing diverts to zero	• Review staffing establishment including midwifery and QIS nurse numbers at night • Review on call processes for hospital and homebirth. • Review culture and practice of people returning from maternity leave and nights • Review flexible working contracts • Consider self-rostering	 • Flexible working agreements have been reviewed. • Birthrate plus report received and undergoing review and application of professional judgement in relation to skill mix • SOP being developed for process returning from maternity leave. • QIS nurses being uplifted to Band 6 and advertising at Band 6 going forward to increase recruitment and retention.		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR34	Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	3 x 5 = 15	3 x 3 = 9	Clinical: Patient Safety	Minimal

Related External Risks

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

Harrogate and District NHS Foundation Trust

3.2

Strengthening Maternity and Neonatal Safety Report

SMT

August 2024

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Leanne Likaj (Associate Director of Midwifery), Andy Brown (Lead Midwife for Safety, Quality & Clinical Governance)

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 August 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 August 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

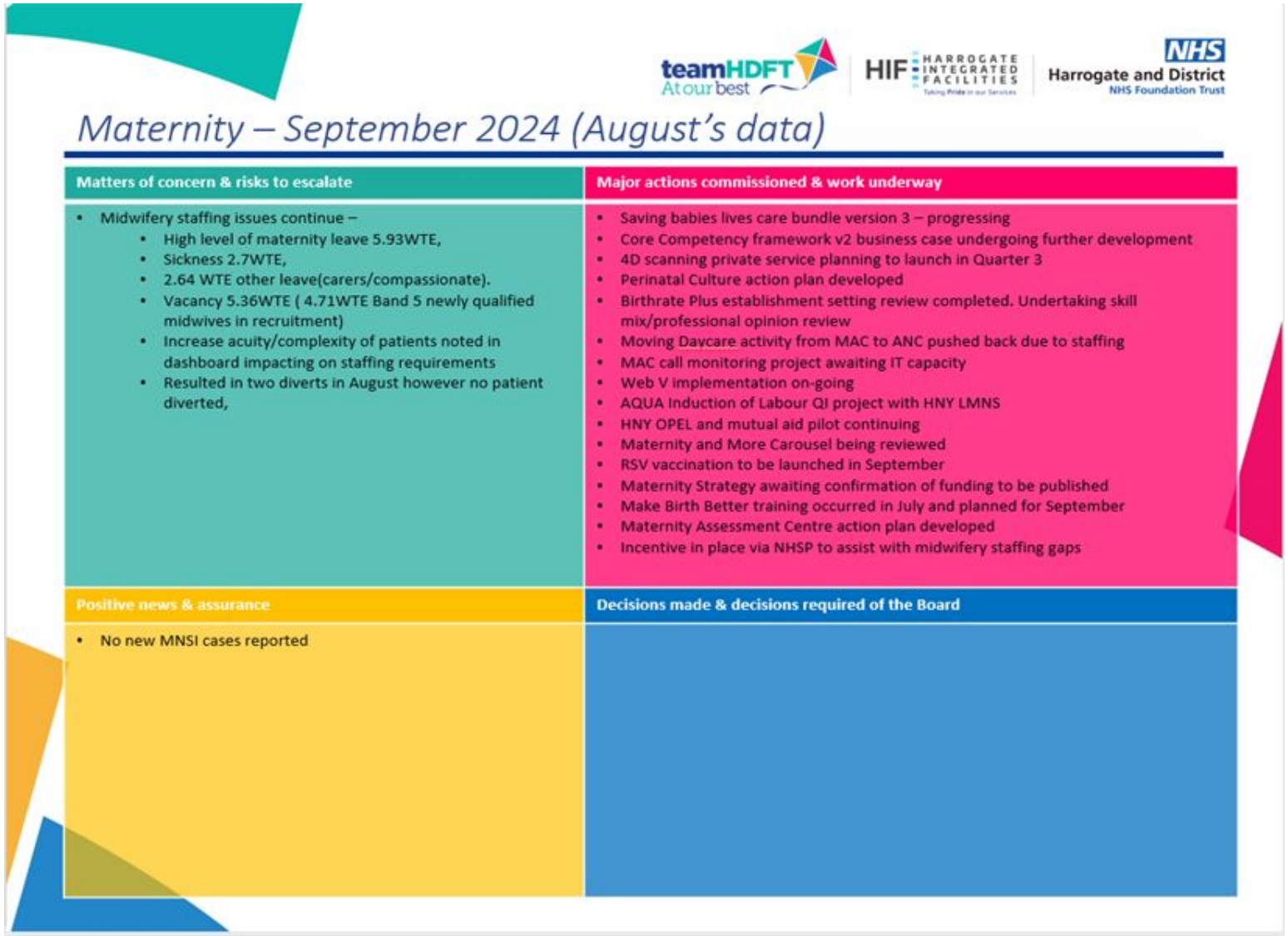
5.0 Risks and Mitigating Actions

5.1 Four new risks under consideration:

- 5.1.1 Response to a SHOT report safety concern relating to ability to manually enter blood results into BadgerNet and risk of transcription errors
- 5.1.2 Risk relating to extensive documentation requirements and potential for staff to fail to meet gold standard level
- 5.1.3 Clinical risk of completing elective caesarean sections in Delivery Suite [related to existing risk of increased elective caesarean section requirement]
- 5.1.4 Risk of poor patient experience due to current process for booking elective caesarean sections

6.0 Recommendation

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



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Maternity – September 2024 (August's data)

Matters of concern & risks to escalate	Major actions commissioned & work underway

• Midwifery staffing issues continue –
  • High level of maternity leave 5.93WTE,
  • Sickness 2.7WTE,
  • 2.64 WTE other leave(carers/compassionate).
  • Vacancy 5.36WTE (4.71WTE Band 5 newly qualified midwives in recruitment)
  • Increase acuity/complexity of patients noted in dashboard impacting on staffing requirements
  • Resulted in two diverts in August however no patient diverted,
	• Saving babies lives care bundle version 3 – progressing
	• Core Competency framework v2 business case undergoing further development
	• 4D scanning private service planning to launch in Quarter 3
	• Perinatal Culture action plan developed
	• Birthrate Plus establishment setting review completed. Undertaking skill mix/professional opinion review
	• Moving Daycare activity from MAC to ANC pushed back due to staffing
	• MAC call monitoring project awaiting IT capacity
	• Web V implementation on-going
	• AQUA Induction of Labour QI project with HNY LMNS
	• HNY OPEL and mutual aid pilot continuing
	• Maternity and More Carousel being reviewed
	• RSV vaccination to be launched in September
	• Maternity Strategy awaiting confirmation of funding to be published
	• Make Birth Better training occurred in July and planned for September
	• Maternity Assessment Centre action plan developed
	• Incentive in place via NHSP to assist with midwifery staffing gaps

Positive news & assurance	**Decisions made & decisions required of the Board**
• No new MNSI cases reported	

Narrative in support of the Provider Board Level Measures – August 2024 data

1. 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. Obstetric cover on Delivery Suite, gaps in rota

Appropriate cover has been provided to Delivery Suite during the month of August 2024.

3. 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 has been completed and the process of review is underway. Headroom uplift is currently set at 20.78 across the acute service.

a. Absence position

Unavailability of midwifery staff hours –
2.7 WTE sickness absence Main cause – Stress
5.93 WTE maternity leave
0.3 WTE study
2.64 WTE other leave (carers/compassionate/phased return)
12.87 WTE Annual Leave

Total midwifery absence 24.44WTE

Unavailability of Maternity support worker hours –
0.61 WTE sickness absence

1.08 WTE Maternity leave
0.23 WTE study leave
0.63 WTE other leave
2.74 WTE Annual leave

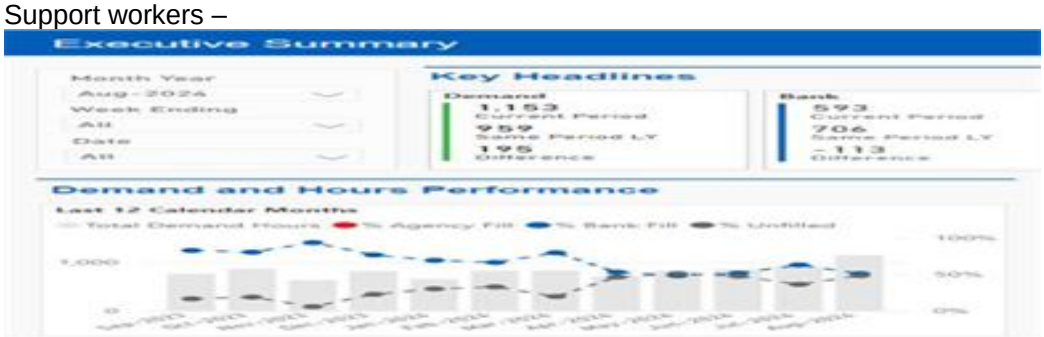
Total MSW absence 5.29 WTE

b. NHSP provision

Midwives -

Demand for NHSP midwives has increased over the last three months following increased midwifery absence as stated above. The cost of NHSP has also increased due to the addition of an incentive rate. Agency midwives have also been utilised to help fill staffing gaps.

Support workers –



4. Homebirth provision

Home birth provision is covered by community midwives working clinically in the day and a first and second on-call midwife every night between 17:00 – 08:00.

Five homebirths were booked for the month of August 2024. Two women birthed at home and one transferred to hospital during labour. One woman birthed in the hospital for medical reasons, and one woman didn't birth in August.

In the period 01/07/24 – 31/07/24, 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.

5. 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)

a. Delivery Suite Staffing

Data entry throughout August 2024 found an 77.42% confidence level.

52% of the time staffing factors were recorded as follows –

SF1	Short term sickness	31	24%
SF2	Lack of beds	0	0%
SF3	Unable to fill vacant shifts	37	29%
SF4	Staff redeployed to another area	27	21%
SF5	No maternity support worker	34	26%
	Total	129	

87% (148 occasions) of the time no clinical actions were required. 13% (23) of the occasions clinical actions were required, these included:

CA1	Delay in commencing IOL (Inpatient)	3	11%
CA2	Delay in continuing IOL	18	64%
CA3	Delay in EL LSCS (delivery suite)	0	0%
CA4	Postponed IOL (at home)	2	7%
CA5	Delivery Suite coordinator not supernumerary	5	18%
	Total	35	

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

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

100% of women received one to one care when labouring within the unit.

b. Pannal Ward Staffing

The Birthrate Plus Ward Acuity App had a 74% 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. For the month of August staffing factors were recorded, the top reasons related to being unable to fill midwifery and support worker shifts. The following clinical actions were taken to mitigate the risk;

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in IOL > 24hrs	**2**	**50%**
CA2	No beds	**1**	**25%**
CA3	Delay in continuing IOL > 24hrs	**1**	**25%**
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		**4**	**100%**

Management actions take include the following;

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	**7**	**78%**
MA2	Staff unable to take allocated breaks	**1**	**11%**
MA3	Redeploy staff from training	**0**	**0%**
MA4	Specialist MW working clinically	**0**	**0%**
MA5	Manager/Matron working clinically	**0**	**0%**
MA6	Utilise on call MW	**0**	**0%**
MA7	Redeploy from community	**0**	**0%**
MA8	Maternity Unit on Divert	**0**	**0%**
MA9	Staff sourced from bank/agency	**0**	**0%**
MA10	Staff stayed beyond rostered hours	**1**	**11%**
MA11	Escalate to manager on call	**0**	**0%**
TOTAL		**9**	**100%**

6. Red Flag Events Recorded on Birthrate Plus

a. 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.*

b. 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 August 2024, both related to being unable to provide one to one care for a high dependency patient.

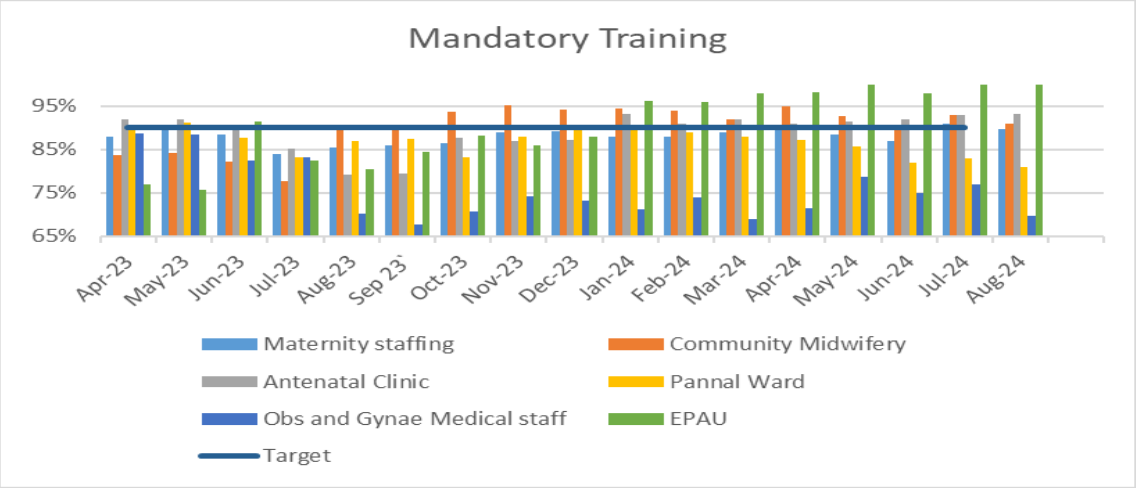
c. Pannal Ward Red Flags

There was three occasions where a Red Flag was identified from the Birth Rate Plus Data;

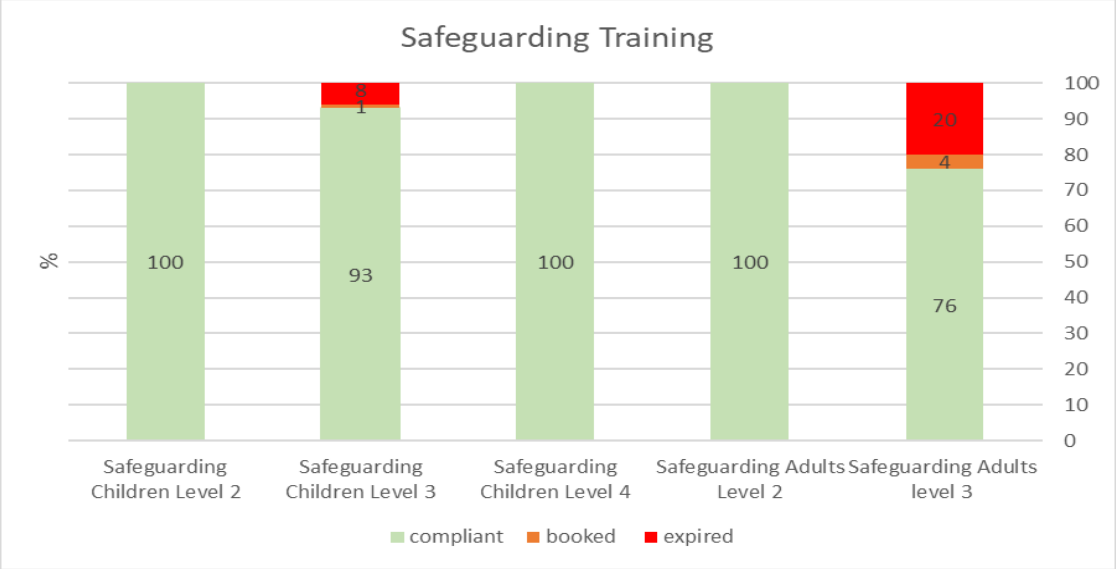
Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	**0**	**0%**
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	**0**	**0%**
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	**0**	**0%**
RF4	Delay in providing pain relief	**2**	**67%**
RF5	Delay between presentation and triage	**0**	**0%**
RF6	Full clinical examination not carried out when presenting in labour	**0**	**0%**
RF7	Delay between admission for induction and beginning of process	**1**	**33%**
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	**0**	**0%**
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	**0**	**0%**
TOTAL		**3**	**100%**

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

a. Mandatory training (as at 01/09/24)



b. Maternity Incentive Scheme and Core Competency version 2 Training Compliance



Safeguarding Adults Level 2	Consultants	Obs Reg	Rm	MSW
	100%	100%	N/A	100%
Safeguarding Adults Level 3	Consultants	Obs Reg	Rm	MSW
	N/A	N/A	76%	N/A
Safeguarding Children Level 2	Consultants	Obs Reg	Rm	MSW
	N/A	N/A	N/A	100%
Safeguarding Children Level 3	Consultants	Obs Reg	Rm	MSW
	95%	100%	99%	95%
Safeguarding Children Level 4	Consultants	Obs Reg	Rm	MSW
	N/A	N/A	100%	N/A

Courses to include:	Midwives	Obs cons	Obs other	Anaes cons	Anaes other	MSW
Adult Basic Life Support with paediatric modifications	95%	86%	88%	N/A	N/A	86%
Harrogate Intermediate Life Support (HILS)	77%	N/A	N/A	N/A	N/A	N/A
RCUK Newborn Life Support (RCUK NLS)	62%	N/A	N/A	N/A	N/A	N/A
Harrogate Newborn Intermediate Life Support (HNILS)	95%	N/A	N/A	N/A	N/A	100%
MAT - Growth Assessment Protocol (GAP)	96%	100%	75%	N/A	N/A	N/A
MAT – K2 CTG	91%	86%	71%	N/A	N/A	N/A
MAT – Maternity Training Day 2	97%	100%	100%	N/A	N/A	N/A
MAT - Prompt	96%	100%	93%	82%	80%	93%
MAT - Saving Babies Lives	95%	86%	75%	N/A	N/A	N/A

NOTE – RCUK NLS – Two Professional Development Midwives, six delivery suite coordinators completed RCUK NLS within last 4 years. Three are booked for September 24 (total 13 to complete). There is difficulty obtaining spaces as HDFT do not run the RCUK NLS course. Discussions with Bradford + Calderdale regarding an allocation of a further two spaces.

HILS – 3 out of date, no current availability for future dates. To await further dates.

No PROMPT in July/August therefore PROMPT figures unable to improve until September. All have dates booked. ABLS also on this date, adhoc sessions in process of being organised.

Continuous monthly email reminders in line with the HDFT Non Compliance SOP.

c. Additional requirements

Safeguarding supervision-
Acute midwifery = 75% compliant

8. Risk and Safety

a. Maternity unit divert

There has been two events of divert of the unit in August 2024.

b. Maternity Risk register summary

Risk Register formally reviewed 13th June 2024. Next review due 13th Sept 2024.

Four new risks under consideration:

- Response to a SHOT report safety concern relating to ability to manually enter blood results into BadgerNet and risk of transcription errors
- Risk relating to extensive documentation requirements and potential for staff to fail to meet gold standard level

- Clinical risk of completing elective caesarean sections in Delivery Suite [related to existing risk of increased elective caesarean section requirement]
- Risk of poor patient experience due to current process for booking elective caesarean sections

Nine 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). 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 of breaching NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6). Requirement of National Screening Committee that babies with screen positive hip result (on clinical examination or hip risk factors) for developmental dysplasia of the hips should be either discharged or attend for clinical assessment by orthopaedic specialist by 6 weeks of age (for babies born ≥34+0 weeks). Current situation that Leeds Orthopaedic specialist may require further reassurance ultrasound scan before treatment commenced leading to missing the required KPI window.
- 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. Some 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.

c. Maternity Incidents

In August 2024 there were 59 total incidents reported through DCIQ.

One incident of Moderate Harm or above relating to the sustaining of extensive skin staining following iron infusion. 48hour report has been completed. Complaint response in progress but likely successful claim.

Additional incidents of note include:

- 10 PPH≥1500ml (2 at elective LSCS including one set of twins with return to theatre; 6 at emergency LSCS [issues include adherent placenta, adhesions, poorly formed lower segment]; 2 at NB forceps). No PPH occurring at normal delivery. A deep dive for increased PPH rate is being initiated
- 4 incidents of Missed Diagnosis (include two incidents of abnormal GTT filed as 'no action required'; undiagnosed placenta praevia and FGR; one missed GTT)
- 4 incidents of Unexpected Term Admission to SCBU (including 3 babies with persistent low oxygen saturations; one with hypoglycaemia and poor swallow)
- 3 incidents of Low Apgar score (one following emergency LSCS for abnormal antenatal CTG; one following ventouse delivery and APH; one unexpected)
- 3 incidents of Readmission of Mother/Baby (one baby with jaundice; two babies with weight loss)
- 3 incidents of 3rd degree tear (including one instrumental delivery completed without episiotomy. Duty of Candour has been completed)
- 2 incidents of Suspension of maternity services, with:
  - 1 additional incident of Insufficient Staff for Workload on MAC
  - 1 additional incident of Escalation to on-call midwifery staff

9. Perinatal Mortality Review Tool (PMRT)

a. 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.

b. HDFT PMRT Information

One PMRT completed 14/8/24. Post-mortem confirms true knot in umbilical cord. Positive patient feedback relating to bereavement care. No open cases

10. Feedback

a) Maternity service user feedback

'The care that I received during my pregnancy, during labour and post birth was outstanding. My mental health declined rapidly during pregnancy and I received the most incredible care from the team. I felt so heard and seen, and as though the nurses, GPs and midwives genuinely cared about me, my wellbeing and the baby. Thank you for helping me, I don't think I would have made it through the other side without your support. Forever grateful.

It's hard to put into words how lucky I feel to have had such incredible care throughout my pregnancy and after my son was born. From the start I felt supported and was treated with care and compassion. I always speak to highly when talking about the care I received from Harrogate hospital and every single person I came into contact with whilst there. I was made me feel like I was the only person they were looking after, even though that wasn't the case. I had concerns over a vaginal delivery and this was taken very seriously. My section was the best experience of my life, thank you to the amazing maternity dept

I was really worried about giving birth as I had seen some horror stories online about midwives being unkind during labour and birth, and not listening to the patient. However, I was so impressed with the care I received, the whole way through I felt listened to and cared for, I had the most incredible experience thanks to all of the midwives and doctors on the ward that day. Every single person I spoke to was lovely and put me at ease. I'm so grateful to the hospital staff for making my first labour and birth experience such a special one, thank you.'

11. Complaints

Two submitted complaints in August

1. One relating to skin staining following iron infusion
2. One related to management of hyperemesis

Six concerns have also been received this month. No themes noted.

12. Coroner 28 made directly to Trust

No Regulation 28 notifications have been received.

13. 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.

14. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents have been reported in August 2024.

15. 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.

16. National priorities

a) 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.

a) Ockenden

No update this month

b) Continuity of Carer

No update this month

c) **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

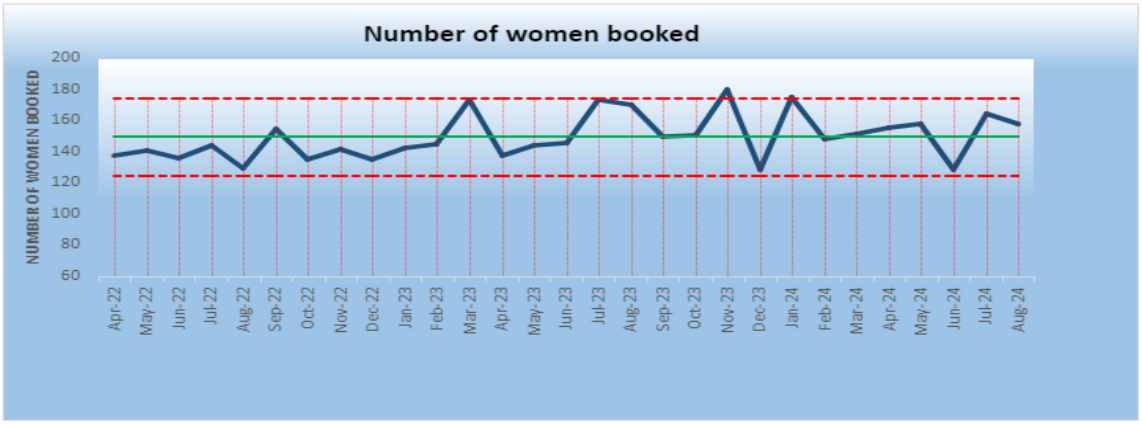
psychologically safe working environments and building compassionate leadership to make work a better place to be and was included in the requirements for Maternity Incentive Scheme Year 5. The programme included a series of workshops and action learning sets which commenced in October 2023 and provided 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 and July 2024. An action plan has been developed.

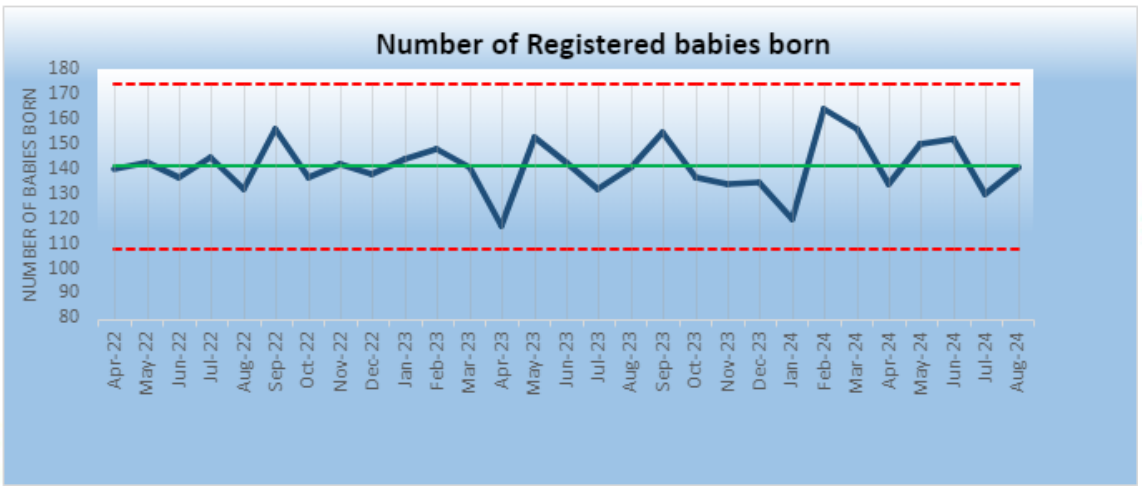
17. Clinical Indicators – Yorkshire and Humber (Y&H) Regional Dashboard

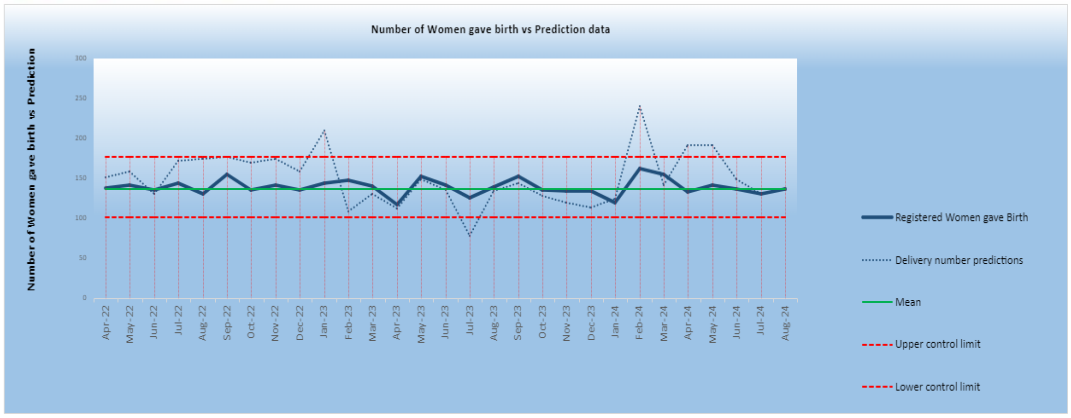
Next update due for Quarter One in October.

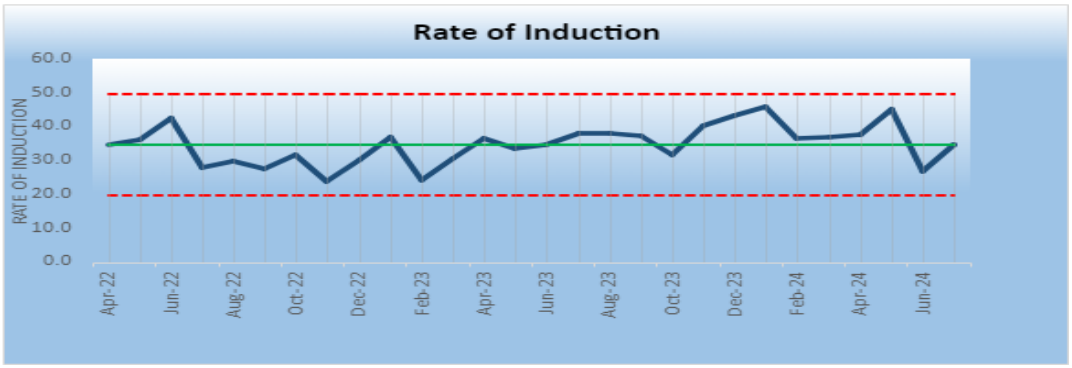
18. Local HDFT Maternity Services Dashboard

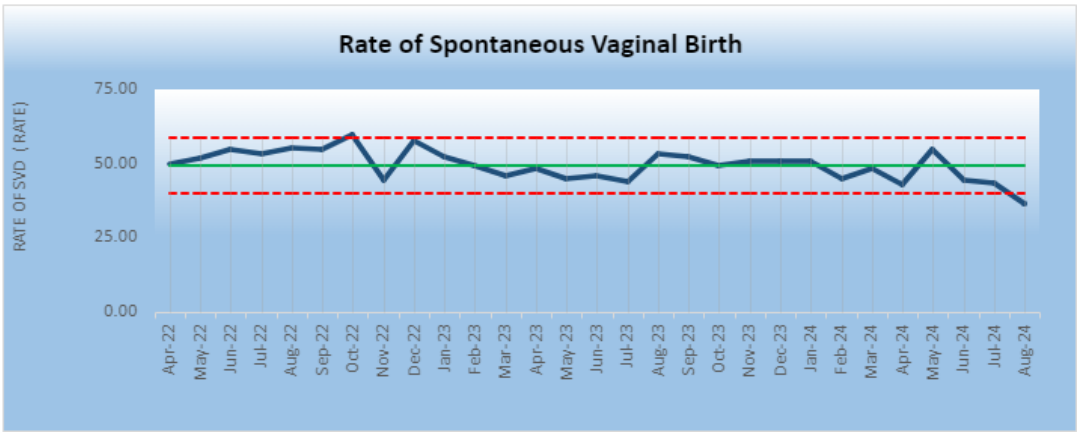
The metrics available demonstrate that there has been a significant increase in the number of women experiencing a postpartum haemorrhage. This is under review to understand what may be causing this and any actions that can be taken.

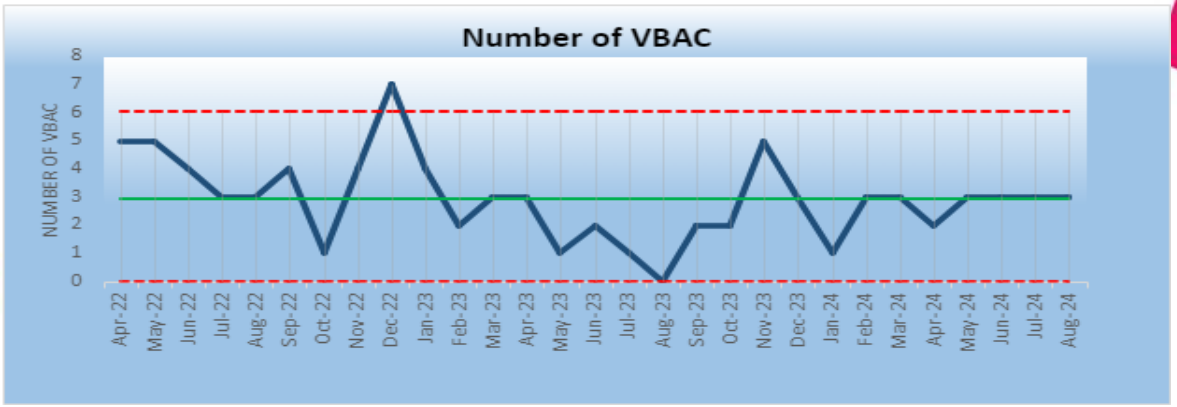


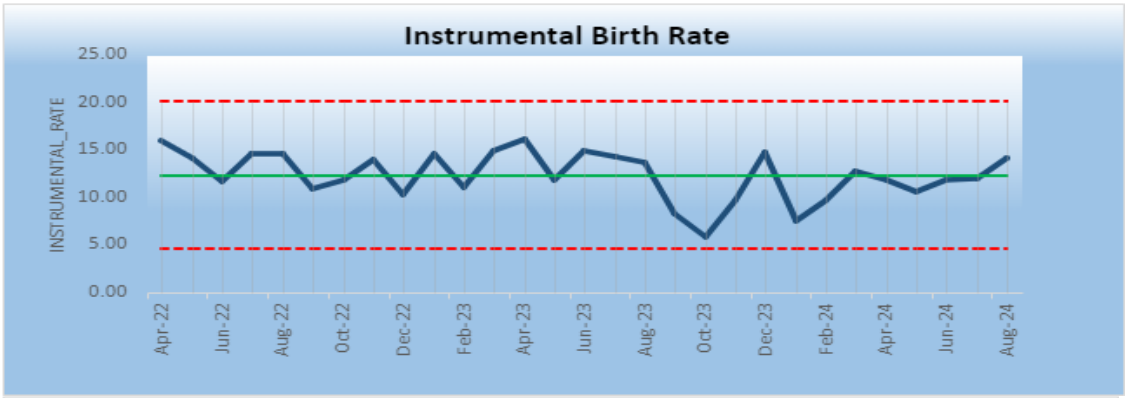



Number of Women gave birth vs Prediction data
Number of Women gave birth vs Prediction
Registered Women gave Birth
Delivery number predictions
Mean
Upper control limit
Lower control limit


Rate of Induction
RATE OF INDUCTION


Rate of Spontaneous Vaginal Birth
RATE OF SVD (RATE)


Number of VBAC
NUMBER OF VBAC


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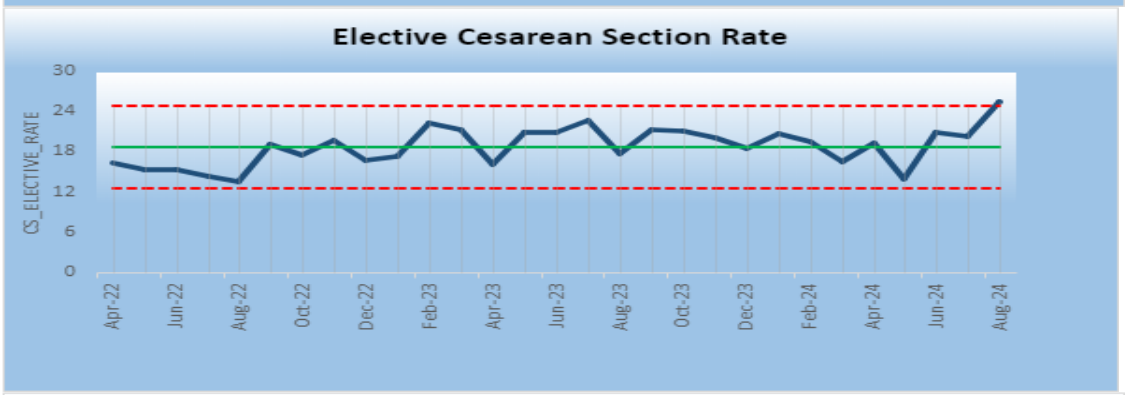
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24


Elective Cesarean Section Rate
CS_ELECTIVE_RATE
30
24
18
12
6
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
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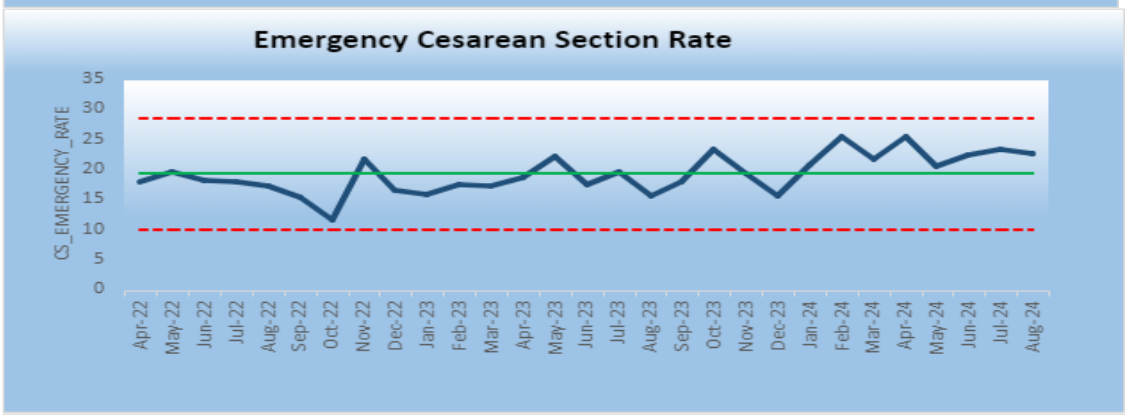
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24


Emergency Cesarean Section Rate
CS_EMERGENCY_RATE
35
30
25
20
15
10
5
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
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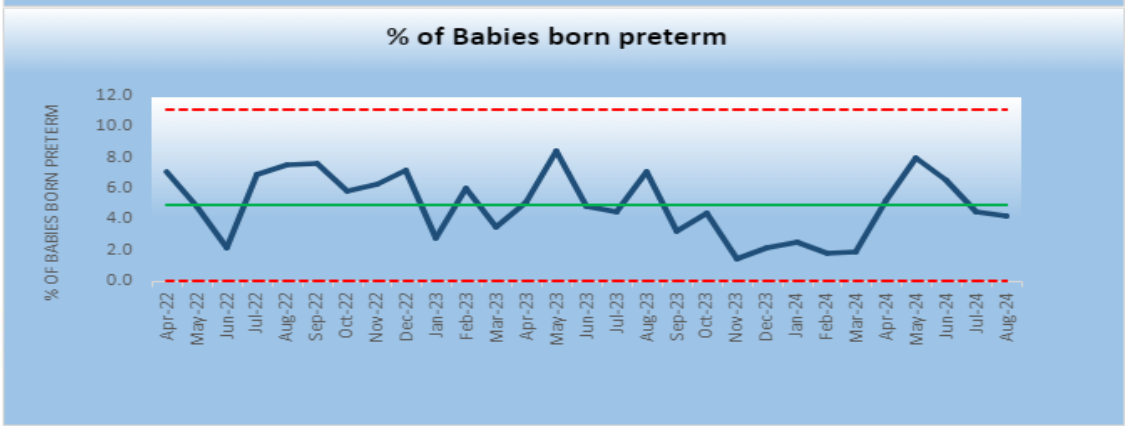
% of Babies born preterm
% OF BABIES BORN PRETERM
12.0
10.0
8.0
6.0
4.0
2.0
0.0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
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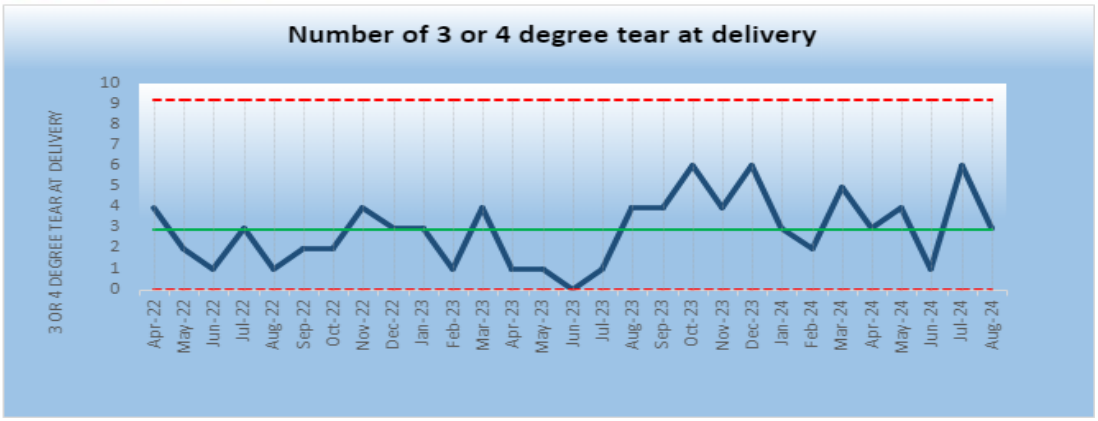
Aug-24


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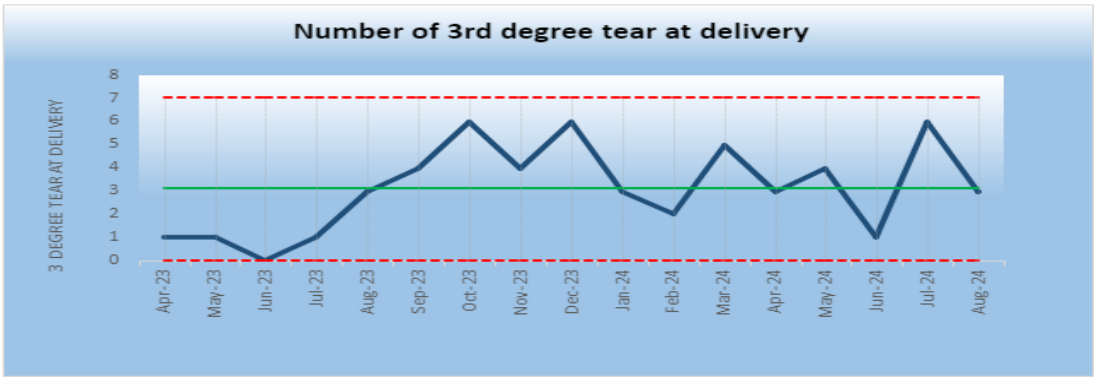
Jul-24
Aug-24


Number of 3rd degree tear at delivery
3 DEGREE TEAR AT DELIVERY
0
1
2
3
4
5
6
7
8
Apr-23
May-23
Jun-23
Jul-23
Aug-23
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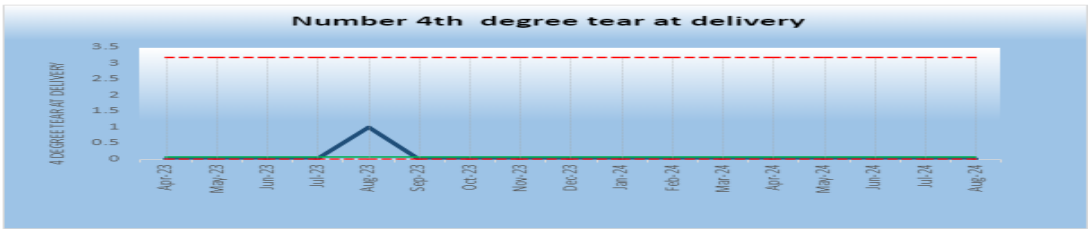
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24


Number 4th degree tear at delivery
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
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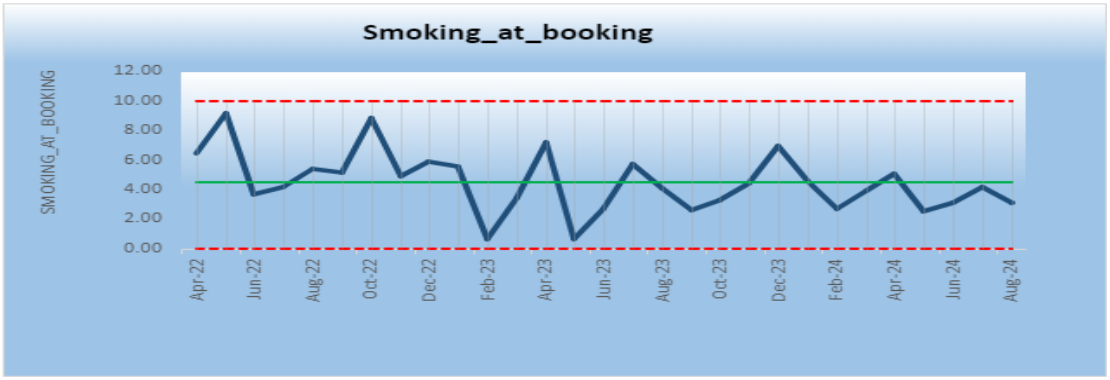
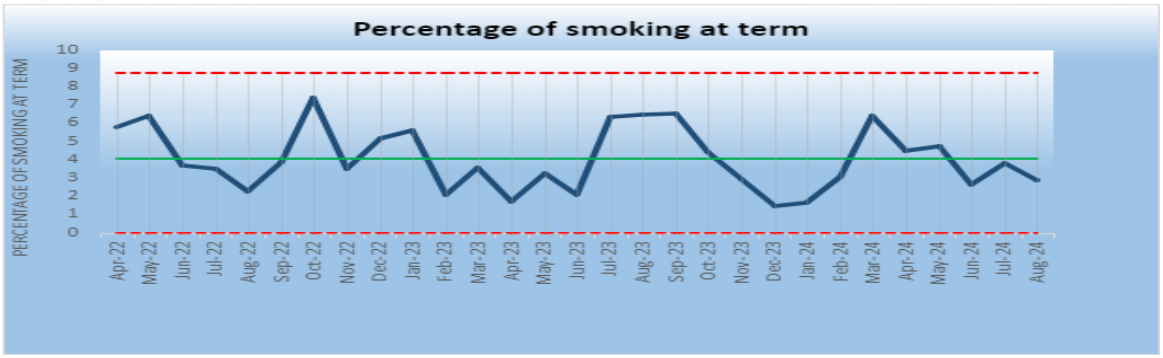
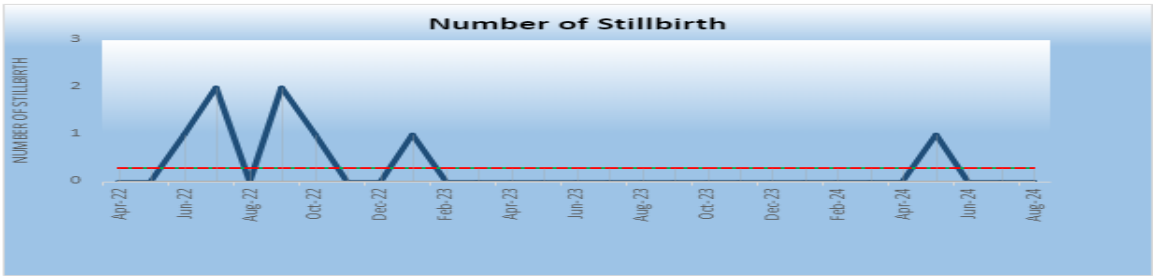
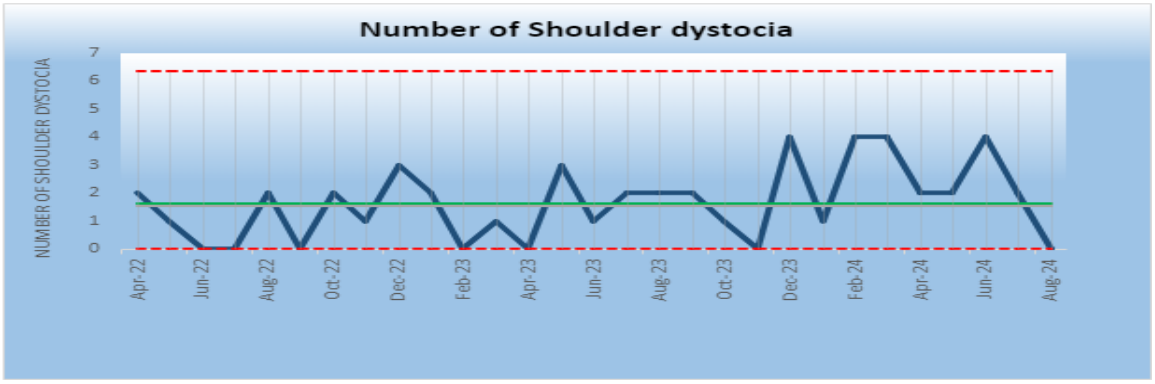
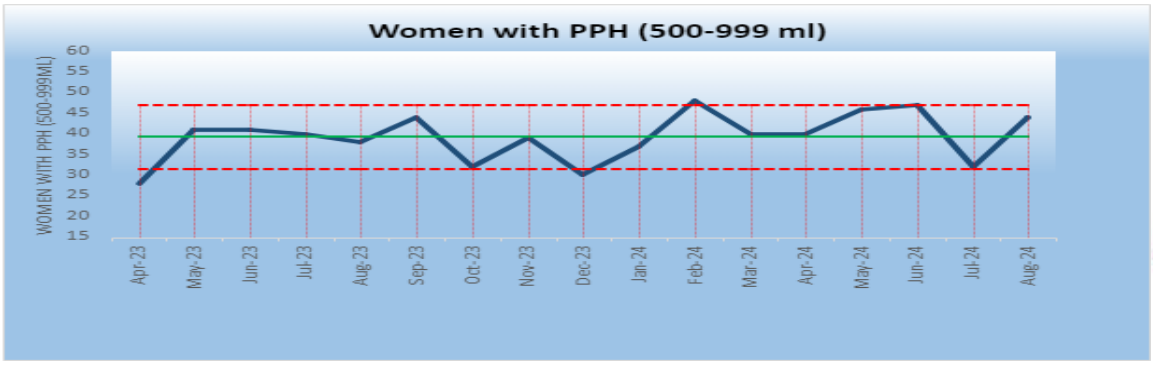
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24

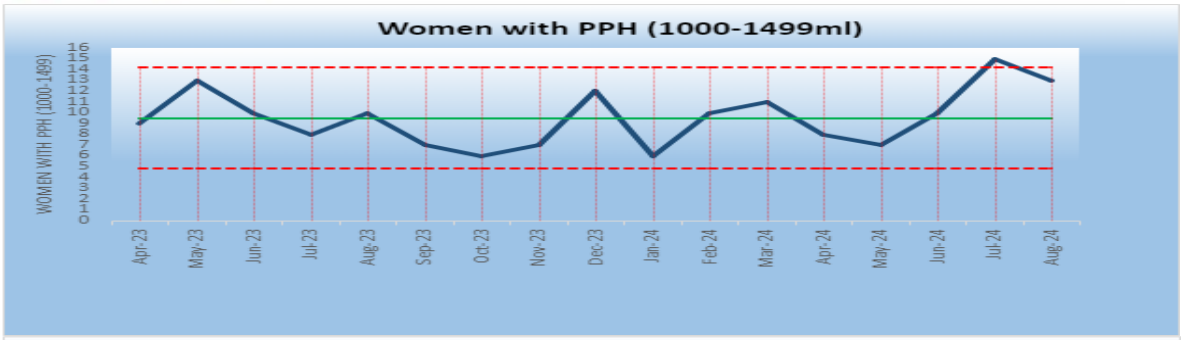

Smoking_at_booking
SMOKING_AT_BOOKING
0.00
2.00
4.00
6.00
8.00
10.00
12.00
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24

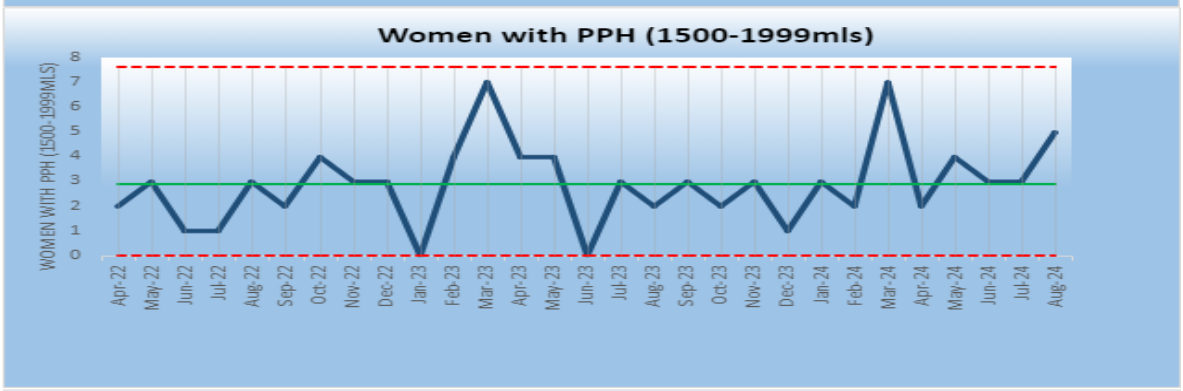

Percentage of smoking at term
PERCENTAGE OF SMOKING AT TERM
0 1 2 3 4 5 6 7 8 9 10
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

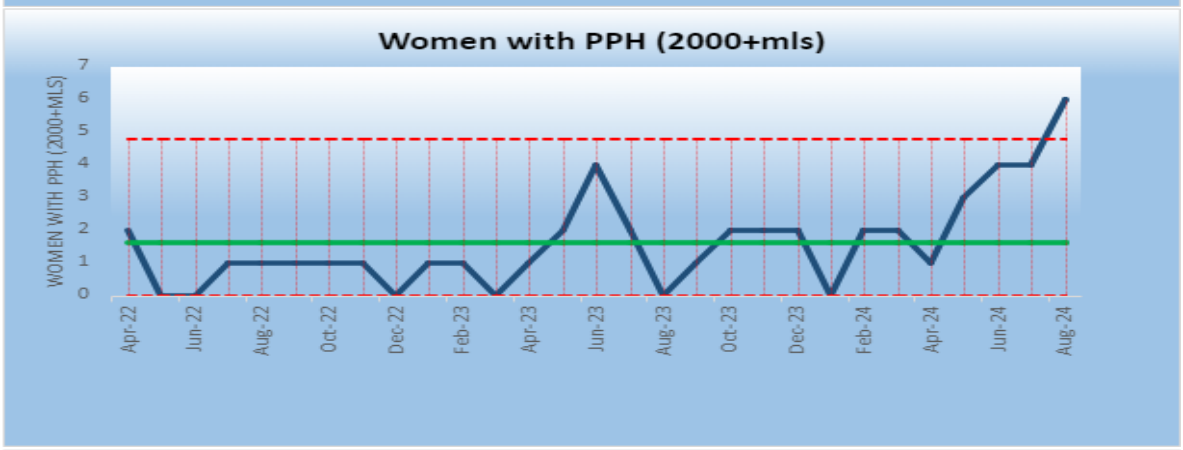

Number of Stillbirth
NUMBER OF STILLBIRTH
0 1 2 3
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24

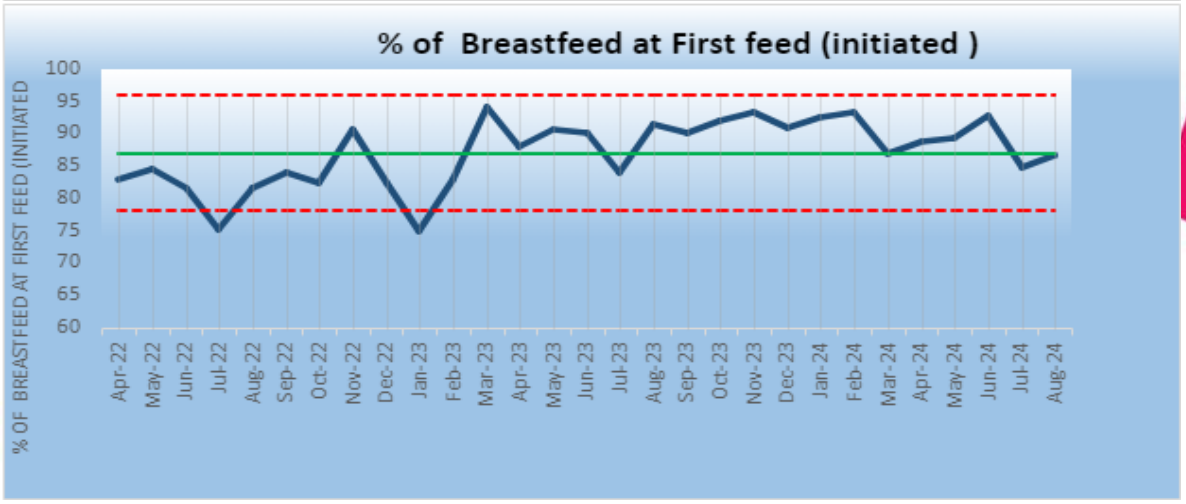

Number of Shoulder dystocia
NUMBER OF SHOULDER DYSTOCIA
0 1 2 3 4 5 6 7
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24


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


Women with PPH (1000-1499ml)
WOMEN WITH PPH (1000-1499)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
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 Jul-24 Aug-24


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


Women with PPH (2000+mls)
WOMEN WITH PPH (2000+MLS)
0 1 2 3 4 5 6 7
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 Aug-24


% of Breastfeed at First feed (initiated)
% OF BREASTFEED AT FIRST FEED (INITIATED
60 65 70 75 80 85 90 95 100
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24

19. 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.

a. Term Admissions to SCBU

There were four Unexpected Term Admissions to SCBU (ATAIN) in August 2024 noted from BadgerNet Neonatal. Here babies had persistent low oxygen saturations and one baby had hypoglycaemia.

b. ATAIN actions

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

Issue	Action	Due and Update
Delay in transfer of patients to theatre once decision made for operative delivery	For audit of time between decision and entry into theatre	Timings available via Badgernet.
Neonatal collapse in skin to skin contact	Implementation of mandatory discussion with mothers about safe skin to skin on PNW & SCBU	30/9/24 Photographic images taken and draft poster completed. Draft information card developed
Lack of neonatal resuscitation equipment in PACU	To consider bringing second resuscitaire from SCBU, or new platform area	30/6/24 Closed Agreement at Neonatal Obstetric meeting that resuscitaire not required in PACU
To keep babies warm whilst receiving delayed cord clamping during caesarean sections	For additional training of obstetric staff in relation to DCC, or consideration of midwives scrubbing up to dry/stimulate baby	24/9/24 Additional requirement to monitor theatre environmental temperature
Continue to monitor babies for longer on Delivery Suite with borderline saturations/respiratory symptoms before admitting (where safe to do so)	Modify and promote management of respiratory distress flow chart to include staying with the baby when appropriate	24/9/24 Governance Lead for SCBU discussing with Neonatal Lead. Good improvement in practice

20.0 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 detection rate [AN detection of SGA user reported or EFW <10th: Proportion of babies SGA (<10th) at birth that were reported by users to be suspected antenatally as SGA <10th or detected by EFW <10th] Fetal growth restriction detection rate [AN detection of SGA <3rd by EFW <3rd: Proportion of babies with birthweight<3rd centile who were detected as <3rd centile from one or more AN EFW]	SGA - Q2 (calendar): 40.9% detection (<10th centile; 18 cases) (National average 46.9%) FGR - Q2 (calendar): 23.5% detection (<3rd centile; 4 cases) (National average 32.7%)	
	April-June 2024	August 2024
Percentage of babies <3rd centile >37+6 weeks' gestation	3.4% (15/440)	2.7% (4/142)
Percentage of babies <10th centile >39+6 weeks' gestation	3.4% (15/440)	6.3% (9/142)
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 (0.7%, 1/134)
• Preterm (24+0-36+6 weeks)	4.2% (live, 18/428) 0.23% (stillborn, 1/428)	4.48% (live, 6/134)

The current position of compliance with the requirements of SBLCBv3 remains unchanged. The LMNS attended 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

21.0 Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The next walk around and meeting of the Safety Champions is due on 16th September.

22.0 Conclusion and recommendation

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

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

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

GOALS:

Best Place

The best place for person centred, integrated care

Exemplar System

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

Equitable & Timely

Equitable, timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

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

True North Metrics

1. **ED 4hr Standard - 95% of patients admitted or dishcharged within 4 hours**
2. **Length of Stay - Top quartile nationally for patients with frailty**
3. **Elective Recovery RTT - 92% of patients waiting under 18 weeks for treatment**
4. **Cancer 62 Day Standard - 90% of patients seen adn treated within 55 days on a cancer pathway**

Breakthrough Objective:	Time to first Clinical Assessment
Corporate Project:	Discharge, Bed Configuration
Overarching Risk Appetite:	Operational - Cautious

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

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ED 4-hour standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	In 12 months, we want to be at 85% of patients having their care completed within 4 hours. In 24 months, we want to be at 95% of patients having their care completed within 4 hours.	Refresh of root cause analysis – revealed wait for medical bed as highest driver of 4-hour breach. Agreed (at PRM) switch of breakthrough objective to allow focus on this – switched to admission to inpatient bed within 120mins of decision to admit Root cause analysis of bed delays to be undertaken to develop directorate countermeasures	Breakthrough Objective: Time to medical bed less than 120mins from DTA Median time to PSC, LTUC or Paediatric bed ED performance breaches and LOS - Power BI LTUC – 208.36mins *(314 mins)* PSC –261.82mins *(288 mins)* Paeds –121.36mins *(108 mins)* *( ) previous month*	4 x 4 = 16	3 x 2 = 6
Care of the elderly 	Length of Stay with frailty	To improve the health and wellbeing of our eldest and most frail patients by supporting care closer to home through the reduction in unnecessary emergency inpatient admissions and, for those who are admitted, ensure their length of stay is only as long as medically required. Top quartile LOS nationally for patients with frailty	1st Goal: To identify all patients with frailty by developing a suitable platform for recording and accessing Clinical Frailty Scores, and undertake more detailed evaluation of assessment admission pathways based on CFS data 2nd Goal: to reduce the overall number of patients with frailty who are admitted by improving access for all appropriate patients to early specialist review and intervention 3rd Goal: For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention	Implement clear process for accurate digital recording of CFS at first point of acute assessment. - linked to implementation of 'new' EPR over next 12-18 months Explore digital means of obtaining this data - linked to implementation of 'new' EPR over next 12-18 months Explore the CFS being a trigger for specific interventions and admission pathways e.g. therapist or Frailty expert attendance/contact - *further detail/focused countermeasures on this will come out of the 'Super September' focus on frailty admissions and attendances in ED.* Transformation of admission processes for patients with frailty including exploring specialist Geriatric and MDT rostering. Develop pathway for geriatrician-led MDT review of all surgical patients identified >65 of CFS >5 (NELA standard)	Delay due to timescales for EPR. Bed capacity issues have made it difficult to progress the Transformation of the admission process at present. Super September underway – learning and then data/metrics to be developed by End October	4 x 3 = 12	4 x 4 =16
Equitable & Timely 	Elective Recovery (RTT) standard	No patients waiting 18 weeks.	In 12 months, no patients waiting over 52 weeks for treatment In 12 months, 18-52 weeks pathways reduced to 6,000 In 24 months, back to RTT 92% standard	Wharfedale Theatres (TIF1) going live September 2024, staffing in place HDH Additional Theatres (TIF2) build on track for 2025 delivery Outpatient Transformation, rollout of further faster programme and track 6 key metrics Theatres Productivity	On trajectory for clearance of 52 weeks. Over 52-week pathways end of year breaches active: 10,823 (13847) down from 23,217(1st April 2024) Current pathways over 18 weeks = 7383 (7209)	2 x 4 = 8	3 x 2 = 6
	62 Day Cancer standard	No patient would wait longer	Never greater than 60 patients over 62 days.	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times	August 2024 – 41 patients over 62 days (58-July)	4 x 4 = 16	3 x 2 = 6

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
		than 62 days and 90% of our patients will commence treatment within 55 days of referral	Less than 40 patients over 62 days by 1st April 2025 Never lower than 70% of patients have their treatment commenced by 62 days 80% of patients have their treatment commenced in under 62 days by 1st April 2025	Ensure capacity to deliver first appointments within 19 Days Stratify impact of complex imaging waits on cancer performance - data now available (August 2024)	CANCER(FDS&62DAY) - Power BI August 2024 80% patients treated by 62 days (July 2024- 76.5%) Cancer Dashboard v2(unvalidated) - Power BI		

Breakthrough Objective: Time to move to medical bed from decision to admit in Emergency Department

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred Care	4-hour ED Wait Time	All patients will move to a ward within 120mins of the decision to admit being made Goal:10% Reduction in number of medical bed delays by November 2024	• Support from corporate project - Discharge • Pilot of flow matron • Launch and functionality of Optica • Directorate restructure - Adult Community team and discharge team • Discharge lounge • Extension of non-headed bed space SOP to include to confirmed and predicted discharges • Redesign of patient board on Farndale, to be replicated on AFU**C** • Support Acute team with weekly Driver meeting specifically relating to bed availability delays on Farndale • Exec support with inpatient bed proposal to maximise medical admission capacity. • Pilot of Flow Matron	Time to medical bed less than 120mins from DTA Median time to PSC, LTUC or Paediatric bed ED performance breaches and LOS - Power BI LTUC – 208.36mins *(314 mins)* PSC –261.82mins *(288 mins)* Paeds –121.36mins *(108 mins)* *( ) previous month*	4 x 4 = 16	2 x 4 = 8

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR41	RTT	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020). On track for 52 week breach elimination, 65 week zero reached on track.	3 x 3 = 9	3 x 2 = 6	Clinical: Patient Safety	Cautious
CRR61	Emergency Department (ED) 4 Hour Standard	Risk of increased morbidity/ mortality for patients due to a failure to meet the 4 hour standard. See the A3 & Breakthrough Objectives pertaining to this.	4 x 4 = 16	4 x 2 = 8	Clinical: Patient Safety	Cautious

Related External Risks

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

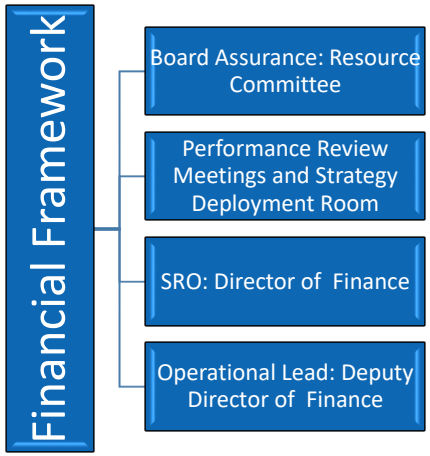
STRATEGIC AMBITION: OVERARCHING FINANCE 2024-2025

GOALS:

Financial Sustainability

HDFT To be a financial sustainably organisation

GOVERNANCE:



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

1

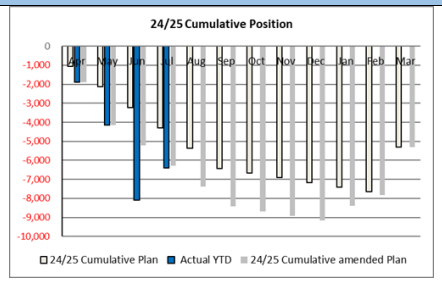
- **Financial Sustainability**

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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2024/25 the Trust, and therefore directorates, should live within the financial resources available to us. Where this is not possible there is a need	In relation to the operational position the current countermeasures are in place – 1. Delivery of coding optimisation schemes 2. Activity delivery schemes 3. Wider Waste Reduction and Productivity (WRAP) Schemes 4. Review of "unfunded" posts	As at month 5 the Trust is reporting a deficit of £7.4m against the system plan of £7.4m deficit.	4 x 3 = 12	

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		to develop wider mitigating actions. The Trust will return to segment 2 of the National Oversight Framework.	5. Controls and actions regarding Medical and Dental/Agency 6. Approach to Clinical Supplies and Services 7. PRM focus – move from budget change to run rate impact To support delivery there is also wider Monthly Financial reporting, REACH reporting (financial reporting system) has been rolled out to increase visibility and accessibility of spend information. Discretionary Spend controls and monitoring in place. Additional approval for spend over £10k introduced. NHS Supply Chain restrictions. Introduction WRAP Champions being developed. There is a formal plan in relation to the Price Waterhouse Cooper review commissioned by the West Yorkshire Association of Acute Trusts for the Trust, however, a number of countermeasures are responding to the findings. The Trust is currently participating in the Grant Thornton review of the financial grip and control in Humber and North Yorkshire Integrated Care System. Following the change in Trust segmentation work is being undertaken to establish the exit criteria associated with finance.	 Costs related to strike action are deemed to be acceptable variances. The cost of strike action equates to £326k, therefore adjusting results in a £326k favourable position. The graph to the below outlines the various forecast scenarios for 2024/25 outturn.  The “best” forecast represents a variance associated with strikes, as mentioned above. Risk adjusted achievement currently reflects the challenges with achieving cash releasing efficiencies from the WRAP programme. This reflects the operational challenge at month 4. Further detail is contained within the finance A3 and regular finance report shared at Resource Committee.		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR94	Delivery of Financial Plan	If the current in year performance continues as is, the Trust will continue to increase its year to date deficit and therefore not reach its projected deficit position. Over the longer term, this will result in the overall financial position of the Trust being affected which will affect the financial standing of the Trust. This will also cause significant cash pressures which could result in delayed payments to Suppliers.	3 x 4 = 12	2 x 4 = 8 March 2025	Financial: revenue, funding and liquidity	Cautious
CRR95	Local Authority funding for the impact of NHS pay award	Complexity with the approach to funding and competing guidance result in pay award funding for 2023/24 and 2024/25 pay awards being slow to agree. Potential for revenue pressure, as well as cashflow whilst discussions are ongoing.	4 x 3 = 12	4 x 1 = 8 March 2025	Financial: revenue, funding and liquidity	Cautious

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Demand for services, as well as service change to meet this demand prevents cashable savings and exceeds system resource	There are a number of pressures as a result of demand that are exceeding the planned levels of funding, in particular from decisions made at a system level. This is also impacting the WRAP delivery.	5 x 2 = 10	5 x 1 = 5 March 2025	Financial: revenue, funding and liquidity	Cautious
	Pressures emerging outside of planning position	There are some issues which the Resource Committee is briefed on which will impact the current forecast position	4 x 3 = 12	4 x 1 = 4 November 2024	Financial: revenue, funding and liquidity	Cautious

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

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

GOALS:

Looking after our people

Physical and emotional support to be "At Our Best"

Belonging

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

New ways of working

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

Growing for the future

Education, training and career development for everyone

GOVERNANCE:

People & Culture Framework

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

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

1. Staff Engagement Index
2. Staff Availability

Breakthrough Objective:	Vacancy Whole Time Equivalent (WTE)
Corporate Project:	Medical Rostering
Overarching Risk Appetite:	Workforce - Cautious

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

Strategic Metrics Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Looking after our people  Belonging 	Staff Engagement Index	Central to HDFT's strategic vision is that it should create a great place to work with the right people, with the right skills in the right roles. This includes providing a caring working environment that promotes wellbeing and innovation whilst improving quality and safety. The ambition is to understand how colleagues are feeling towards HDFT as a place to work and as an employer using a range of emotional indicators. The twin ambitions are to: 1. Continuously improve the level of survey response rates. 2. Improve the overall Staff Engagement Score	To continually improve our Employee Engagement Score against Pulse survey benchmark by having a framework for leaders and line managers which supports colleagues to bring their whole selves to work and that they belong, that they feel they can influence their role and suggest improvements and that they feel their Health & Wellbeing is a key priority in the Trust **Goals:** 1. Continuously improving trend regarding Inpulse survey response rate. 2. Continuously tracking above our benchmark group engagement score. 3. Validate the improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2024 survey results.	Incorporating the NHSE "Expectations of Line Managers" into HDFT people management infrastructure and developing appraisal and diagnostic tool to reflect IMPACT behaviours. Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on age and disability discrimination. (Also implementing the Workforce Race Equality Standard action plan.) HDFT IMPACT programme (Transformation and Continuous Improvement): methodology implementation across the Trust will enable staff to influence how their role is carried out.	Teamwork survey, which closed 31.7.24 response rate was 30%. Engagement score for July 2024 is 7.15 against a benchmark score of 6.55. This is an increase on the previous engagement score in April 2024 of 6.79. Executive Director Appraisal process up-dated to incorporate HFDT IMPACT Leadership Behaviours and methodology and NHSE Competency Framework for Board Level Leaders.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Growing for the future  New Ways of Working 	Staff Availability (Staff unavailability = vacancies WTE + WTE lost to sickness + Career Break WTE + Maternity WTE + Secondment WTE + Turnover WTE + Inefficient rostering practice + time to hire) .	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to enable those staff to have a good experience and do their best. The combination of vacancies against the budgeted establishment or service line versus the number of staff that can be deployed from it at any given time determines how many staff are available for work. The budgeted establishment figures in August were 4,528.34 WTE for the whole of HDFT with an overall 4,179.37 WTE in post (this equates to 349 WTE vacancies). However, there are a further 392 WTE unavailable for work for a variety of reasons including sick leave, turnover, maternity/paternity leave and careers breaks and time to hire that expand the vacancy position by creating a "workforce deployment gap". Therefore, the total gap in establishments of vacancy plus deployment gap equates to 764 WTE that were unavailable in August**.**	To reduce the establishment gap we will focus on vacancy rates and on increasing workforce deployment. Where we know a vacancy cannot be filled through recruitment advertising (e.g. National or Local shortage occupations) we will ensure there is a plan to cover this gap longer term through apprenticeships, training programmes or the development of new roles. **Goals:** 1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not exceed 12% (HNY is 12.2%) 3. Staff leaving within their first year of employment to not exceed 15% 4. 100% of rosters signed off and issued 8 weeks before. 5. Sickness levels throughout HDFT to not exceed 4.5% (HNY is 4.8%) 6. Apprenticeship or training plan/development of new role in the medium to longer term for shortage occupations	(Only ones still in train/to do listed, completed countermeasures not listed) The sickness absence process and Managing Attendance Policy has been reviewed and is going to SMT for final sign off.	Staff unavailability continues to be below the average value from August 2023. The Trust vacancy rate is 4.19% at the end of August 2024 (A3 target met) -Trust turnover is 11.69% (A3 target met) -Sickness is 4.49% (0.59% above target) -Staff leaving within 1st year is 16.35% (1.35% above the A3 target) - 67.7% of rosters are signed off and issued 8 weeks before they run. (32.3% gap to A3 target)		

Breakthrough Objective: Vacancy Whole Time Equivalent (WTE)

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
New Ways of Working	Staff Availability	To improve the vacancy rate at Directorate level and for Directorates to be below the Trust target of 7%.	(Only ones still in train/to do listed, completed countermeasures not listed) The sickness absence process and Managing Attendance Policy has been reviewed and is going to SMT for final sign off.	The overall Trust vacancy rate is currently 4.19% at the end of August 2024. At the end of August 2024, CC has a vacancy rate of 4.97%. LTUC has a rate of 6.53% and PSC has a rate of 5.60%.		

Related Corporate Risks

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

Related External Risks

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

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

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

GOALS:

Quality & Safety

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

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

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

GOVERNANCE:

Digital Framework

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

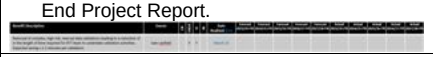
True North Metrics (Executive Lead: 10-15 Year deliverable)

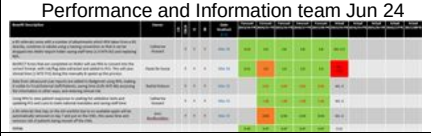
1. Quality & Safety - 100% Completion of the countermeasures
2. Electronic Health Record - Programme Performance

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

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Digital Transformation	Quality & Safety	100% Completion of the countermeasures	Operational: Cautious	
	Electronic Health Record	Programme Performance	Operational: Cautious	

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures (Start Date)	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Quality & Safety 	Systems which enable staff to improve the quality and safety of care	Removal of complex, high risk, manual data validations leading to a reduction in the length of time required for RTT team to undertake validation activities. Expected saving c.1-2 minutes per validation.	• Luna RTT Tracking (May 22)	• To Be Complete Sep 24 – Now formally being closed • Solution live – The benefits anticipated have not been realised. This will be detailed in the End Project Report. 		
		% Reduction in temporary staffing spend measured by comparing agency/bank spend against WTE establishment, vacancy and unavailability rates with 'expected' 24/25 - £150k saving 25/26 - £300k saving…..	• Medic Rostering (Jul 23)	• To Be Complete Mar 25 • Solution live and being rolled out – KPI performance to start to be realised in Mar 25 		
		Introduction of real time reporting will reduce the administration overhead and release staff time to repurpose to other tasks with the information being captured at source, without the need to investigate back through events later to find the information.	• Datix Cloud (Mar 23)	• Complete Jun 24 • Project closed – Any ongoing benefits management to be picked up by Kate Southgate		
		Improved patient safety, experience and more prompt care resulting from more efficient patient call management, and better sleep through reduction in call noises	• ASCOM Nurse Call (Sep 23)	• Live Feb 24 - • Moving into closure – End Project Report to follow • Reports for KPIs/Benefits being developed by Simon Brazier and Martin Huntley		
Electronic Health Record 	An Electronic Health Record to enable effective collaboration across all care pathways	Deliver cash, quality, non-cash efficiencies and societal benefits through the reduction of paper and inefficient processes, new digital functionality, enabled by the EPR system and transformation of working processes.	• New Electronic Patient Record (Apr 22)	• Complete Business Case Sep 24 • Sign Contract Oct 24 • Initiate Programme Delivery Nov 24 • Go Live Q3/Q4 24/25 • KPI's/Benefits include in the FBC – These will not be realised until after go live, some much further on		
		Reduce the time to access clinical applications by 50%, as well as improving the clinician's usability experience, IG and Cyber Security. The conservative estimated annual impact would be in the region of 9 extra FTE productivity realised.	• Single Sign On (Jan 23)	• Completed (Mar 24) – Now BAU • KPI/Benefits being reviewed by the digital benefits manager		
		More resilient systems, improved patient outcomes through earlier diagnosis and staff time saved through harmonisation of working practices in Pathology for trusts and a consolidation of work in the region.	• Laboratory Information Management System (LIMS) (Jan 22)	• BT Live Jun 24 • Remaining specialities to be complete Nov 24 • KPIs/Benefits will be picked up by the JV post go live – This project is seen as an enabler – Transformation to take place post project		

True North Metric	Vision	Goal	Countermeasures (Start Date)	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
		Assists specialists to schedule and review surveillance tests for patients who have completed treatments without the need for face to face appointments. RMS supports individuals who are suitable to be on a self managed pathway. This will enable clinicians to work more efficiently, and patients can access their own records digitally.	• Somerset Remote Monitoring System (Dec 22)	• To be complete Sep 24 – Project closure activities started • KPI/Benefits being reviewed by the digital benefits manager 		
		Introduction of check-in kiosks for patients, a patient app, call screens to call patients to clinic rooms and give Clinicians the ability to record patient outcomes electronically along with a system for Room Booking. This will lead to a reduction in paper, improved data quality and patient experience, reduction in lost outcomes and quicker appointment booking.	• Outpatient Flow and eOutcomes (Sep 23)	• Project Closed Aug 24 • KPI/Benefits being reviewed by the digital benefits manager 		
		RPA bots to automate repetitive, digital activities usually performed by human workers. Deploying RPA reduces the amount of WTE's required to perform day to days tasks and in turn support our Trust in delivering staff time efficiencies, cash and quality benefits.	• Robotic Process Automation (Apr 23)	• ERS automation live Jan 24 • ReSPECT automation live Feb 24 • Multiple further automations planned during 24/25 • KPIs/Benefits report being managed by the PM – Available on request • Project handed over from digital to Performance and Information team Jun 24 		
		The YHCR will enable staff to share with and view data from other providers including GPs, Mental Health, Social Care and other Trusts that currently can be only be shared via paper, email and phone. This will help improve clinical decision making and save staff time,	• Yorkshire & Humber Care Record (Sep 20)	• GP Connect live via WebV Jul 22 • PAS data sent to YHCR Jul 22 • YHCR via S1 Apr 24 • Further delivery plans being developed • KPI/Benefits being reviewed by the digital benefits manager 		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	None					

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
523	Political changes and instability	There is a risk that political changes/government instability will give rise to changes in policy and EPR funding priorities that leave the trust without sufficient budget to complete the programme.	4 x 3 = 12	4 x 1 = 4	Operational / Information Technology	Averse

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

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

GOALS:

Healthcare Innovation

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

Children's Public Health

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

Clinical Trials

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

GOVERNANCE:

Healthcare Innovation Framework

- Board Assurance: Innovation Committee
- Programme Board: Research & Innovation Board / Quality Improvement Board
- SRO: Executive Medical Director
- Operational Lead: Research Lead

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

1. Healthcare Innovation - Support of External and internal innovations and Strategic partnership with industry.
2. Children's Public Health - Development and implementation of a behaviours model and improvement academy.
3. Clinical Trials - Recruitment of patients into reseach studies. Studies to be delivered within target timeframe.

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

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Healthcare Innovation	Healthcare Innovation	Support at least 2 external innovations, at least 2 internal innovations and establish at least 1 strategic partnership with industry.	Operational: Cautious	
	HDFT Impact	Development and implementation of a behaviors model and improvement academy.	Operational: Cautious	
	Children's Public Health	Identify the key priority research needs for children and PH before end March 2025. Sponsor at least one research study in the children and public health based around the trust needs identified.	Operational: Cautious	
	Clinical Trials	2001 patients recruited into research studies by end March 2025. 80% of studies delivered to time and target.	Operational Cautious	

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (C x L)	Level of Risk for progressing actions
Healthcare Innovation 	To be a leading trust for the testing, adoption and spread of Healthcare Innovation and to facilitate and accelerate the growth of innovative healthcare solutions in HDFT.	**Establish a regional Innovation Hub** led by HDFT, building partnerships with industry; academia, government and voluntary sector by: 1. moving into new dedicated estate by end of 2024; 2. Holding launch event/opening by end of 2024; 3. holding at least twice-yearly regional networking events.	1.Working with planning department and HIF to complete lease and redecorate for move in date –Sept/Oct 24. 2. Plan for local opening event Autumn/Winter 24 and larger launch event early 2024. 3. Planning IRIS Innovation Community of Practice networking event for Nov 24.	1. Lease complete, move in date – 1st Oct. 2. Planning on track to new deadline. 3. Planning on track to new deadline.		
		Develop workforce and create a culture of innovation by: 1. providing introductory innovation training at least twice yearly; 2. providing in-depth innovation training at least yearly; 3. establishing unique Clinical Entrepreneur Fellow programme for at least 3 trainee doctors.	1. Work with Medipex to deliver regular intro innovation training events; Present at nurse preceptorship programme. 2. Deliver innovation training programme in partnership with LTHT, BTHFT Medipex, HI Y&H – Autumn/Winter 2024. 3. Develop and run 2-year unique Clinical Entrepreneur Fellows – beginning August 2024; Identifying opportunity to employ 3 Innovation fellows with funding through NHSE for training / mentorship.	1. Presented at 2 x preceptorship sessions to >50 nurses. 2. Planned 2nd cohort of training Oct 2024. 3.i Fellows agreed - June 24. ii. Mentors appointed – July 2024. iii. 3 industrial partnerships established for placements – BT, B Braun and Visfo.		
		Develop robust innovation governance processes by: 1. Developing and implementing new processes for approving and adopting medical devices through a New Interventional Procedure form. 2. Developing new Intellectual Property Policy. 3. Develop system for prioritising projects.	1. Work with Deputy MD (CO&WD) to develop novel governance processes for innovation. 2. Work with Medipex and other Trusts on IP and contractual aspects – ongoing. 3. Adapt Impact Strategic filter to fit in with innovation key priorities.	1. Complete - May 24; seeking approval - July 24. 2. New IP Policy written - seeking approval and adoption - Autumn 2024. 3. Complete		
		Develop innovation infrastructure by: 1. Securing at least 1 industrial sponsorship by March 25. 2. Identifying, applying for and securing at least 1 grant to support infrastructure by March 25.	1. Develop partnerships with industry. 2. Apply for funding from UK Share Prosperity Fund and/or Mayoral Investment Fund – Nov 24; Continue to identify other funding opportunities – ongoing.	1. Applied for funding from B Braun – Dec 23, awaiting outcome. 2. Discussing Mayoral funding bid plan with NY Combined authority. Potential access to early fund.		

		Build key innovation partnerships by collaborating with regional NHS partners, academia, industry, local council.	1. WYAAT collaboration – ongoing with bi-monthly meetings. 2. Close collaborative working with IRIS = Networking event with HNY-ICB IRIS being organised – Nov 24. 3. Developing relationships with the University of York to identify synergies – working with Associate Dean of Partnerships for the UoY, the Skin Research Centre and data analytics company. 4. Working with the NY Combined Authority – bimonthly meetings. 5. Working with external 3rd party (BT) to develop POC and minimal viable product for an area of unmet need in radiology using remote sonography.	1. On track, identifying areas of shared work. 2. Planning on track for event in Nov 24. 3. Met July & Aug 2024 and supporting an innovation strategy. 4. Jointly working on funding bid to Mayoral Investment fund. Supporting visit by delegation of Polish biotech companies. 5. Collaboration agreement and MOU signed.		
		Identify areas of unmet need to improve health care through innovation.	1. Continuing to scope areas of unmet need and care pathways where innovation would improve health care inc. novel approaches and practices. 2. Integration of AI into radiology reporting pathways for fracture detection.	1. Working with HIYH to proactively identify key priority areas and unmet needs. 2. AI processes being audited currently.		
HDFT Impact	To develop our capacity and capability and to embed the culture for continuous improvement through the Implementation of the Impact Improvement Operating Model. To align and enable everyone in the Trust to make improvement in line with our Strategy as part of their daily work so that local improvements reinforce and amplify each other to deliver significant improvement in our True North Ambitions (as measured by our True North Metrics) at Trust level.	**Strategy Deployment**: Establish True North metrics and cascade throughout the Trust to set deliberate priorities and areas of focus for improvement.	Establish Breakthrough Objectives and Directorate Driver Metrics.	Complete		
			Identify and deliver Strategic Programmes and Corporate Projects.	Strategic Programmes and Corporate Projects agreed; scope and milestones to be developed.		
			Establish Strategy Deployment Room and Performance Review systems to maintain focus on identified improvement priorities.	Directorate PRMs in place; SDR established and now transitioning into SMT and Board routines.		
		Leadership Development: Create a framework of behaviours that will reinforce the culture of continuous improvement throughout HDFT.	Integrated Leadership Behaviours framework defined and signed off (Jul 2024). Roadmap for 2025 agreed (Jul 2024). LB framework in appraisals for Senior Leadership Team (Sep 2024).	On track Late. On track for new early Sep deadline. On track		
		Impact Improvement Operating Model: 70% of teams trained by June 26 (% TBC – needs confirmation of total teams and required capacity).	Wave 3, July 2024 Wave 4, Oct 2024 Wave 5, Jan 2025 Wave 6, Apr 2025	On track		
			Roadmap implementation for waves 1 and 2, Jan 2024.	On track		

		All trained teams rated as "Level 3 – Maturing" across all tools and processes by Mar 2025.	Process Confirmation – 90% green tickets by Apr 2025.	On track – 60% green tickets		
		Improvement Academy: Build capacity and capability to support high quality training, coaching and facilitation.	Whole team baseline assessment.	Complete		
		Communications: 67% "strongly agree" or "agree" with Impact Inpulse survey question by Mar 25.	Design and deliver a communications and engagement strategy that will support the IOM roll-out, generate awareness and understanding of Impact**.**	On track		
Children's Public Health 	To be a leading trust for the Children's Public Health Services Research.	Build the evidence base for Children's PH Services to improve outcomes for children. Identify some key Children's public health needs and research priorities by January 25.	Scoping Children's PH research and identifying how we can contribute, to provide opportunities for children and families they support, to be involved in research studies. Create strategic plan for this area by end March 2025. Scoping the workforce within Children's Public Health Services to establish training needs to expand the opportunities to engage with research. Scoping to be completed by December 2024. Utilise extensive data from BaBi Harrogate study to further inform Children's PH research. Identify some key public health needs and research priorities by January 25.	Identified National validated 'SORT tool' to be used in scoping the training needs of workforce. Developing plan to implement in trust by March 25. Continue to recruit into BaBi Harrogate: target for 2024-2025 = 172; current recruitment since March 24 397 Research prioritisation workshop planned for late November, plan in progress. Continued work with the ICB to identify opportunities for data sharing and collaborative projects.		
Clinical Trials 	To increase access for patients to clinical trials through growth and partnerships.	To continue to deliver the contractual agreement with the RDN as a partner organisation to provided research opportunities and to sustain Research Delivery Network (RDN) income through delivery of HLOs. a) trust recruitment target of 2001 annually b) 80% of studies recruiting to time and target c) Patient experience survey annual target 52	Align HDFT strategy with the strategy of the newly formed Research Delivery Network (RDN). Create new Trust research strategy by March 2025. Working to deliver agreed HLOs as outlined by RDN. Regular performance mapping / reporting for RDN.	Current recruitment at 1268 which is on target for this financial year. Currently 8th Position in region for number of patients in research. Studies on time and target 95%. PRES (Patient Research Evaluation Survey) 11 returned - active campaign to		

			Aligning with strategic working of the regional non- surgical oncology (NSO) research group. Increasing research workforce capacity through training and education: -Increase awareness and workforce capacity through training and education; -Continue delivery of Nursing preceptorship course; -Research included in medical induction; -Awareness sessions for SAS staff, 0-19 service managers and AHP professionals on-going; - Develop research fundamentals course to pilot and then produce learning hub version By March 25; - Develop research internship programme in collaboration with local l university;.	improve this with new monthly reviews in place. Research clinical lead representing trust on the NSO from June 2024. National vaccine cancer platform trust accepted this month. 2 Nurse preceptorship courses completed this month both evaluated extremely well. Input on doctors in training induction continues. Research fundamentals course key elements of content developed.		
		To increase commercial research by 10% this year and to generate income to maintain and increase research staffing.	**Increase commercial research** Establishing a clinical research facility (CRF) at HDFT by Dec 24. Increasing research workforce capacity for commercial research. Find funding and recruit new team by June 25. Developing commercial research partnerships. "new partnership by March 25. Working with RDN and IQVIA to identify new commercial partners and opportunities.	Plans for a dedicated CRF underway, charitable funding secured – plan to open Q4 2024 delayed due to new plan development and costing delays. Now estimated March 2025. Scoping possible funding - sources for staff funding. New commercial partnership with INCYTE formed. (Oncology and Dermatology trials). Two new commercial dermatology studies open in November 24.	Amber	
		Develop 2 new academic partnerships by end March 2025.	Applying for funding to deliver studies – aim to secure 2 grants.	Working with the Skin Research Centre at the University of York a) Supporting 2 HYMS academic clinical fellows appointed June 2024 and September 2024.		

				b) developing further clinical studies and translational research projects. c) one small grant awarded in collaboration with the UoY, further grant application in development.		
		Develop clinical leadership.	Providing leadership to further develop oncology and commercial research. Scope / identify clinical academics working in trust who we could potentially develop research in their clinical areas. By end of March 2024.	Clinical Lead for Research appointed June 2024 – leading a strategy developing oncology and commercial research. Representing HDFT on new regional NOS research group. Work with hospital charity to identify resource to support potential pilot studies through a process of open competition – by end of 2024.		
		Increase Patient engagement in research. Develop 4 patients ambassadors and one speciality patient research group by end March 25.	Develop patient research ambassador scheme. Encourage development of speciality patient research groups via social media and research engagement days. Continue to have lay people involved in research key meetings. Improve our profile to encourage public involvement on social media and through and active publicity campaign.	On-going - delays to start of work because of significantly reduced staff numbers in last 2 months. Further delays due to continued staffing resource issues but still on track to achieve goals by March.		

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No related external risks					

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

ENABLING AMBTION: AN ENVIRONMENT THAT PROMOTES WELLBEING 2024-25

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

GOALS:

Wellbeing

A patient and staff environment that promotes wellbeing

Quality & Safety

An environment and equipment that promotes best quality, safest care

Environmental Impact

Minimise our impact on the environment

GOVERNANCE:

Environment Framework

- Board Assurance: Resource Committee
- Programme Board: Environment Board
- SRO: Director of Strategy
- Operational: Assistant Director of Strategy & Planning

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

1. **Wellbeing - Wellbeing Works Capital Spend vs Budget**
2. **Quality & Safety - Major Projects Capital Spend vs Budget; High Risk Backlog Maintenance Cost**
3. **Impact on the environment - Natural Gas Consumption**

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

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
An Environment that promotes wellbeing	Wellbeing	Wellbeing Works Capital Spend vs Budget	Operational: Cautious								
	Quality & Safety	Major Projects Capital Spend vs Budget; High Risk Backlog Maintenance Cost	Operational: Cautious								
	Environmental Impact	Natural Gas Consumption	Operational: Cautious								

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Wellbeing 	A patient environment that promotes wellbeing	To improve the working environment of staff	• 24/25 Staff Wellbeing Works - minor refurbishments and redecoration – March 2025	• On target		
Quality & Safety 	An environment and equipment that promotes best quality, safest care	**Aseptics** To meet standards for aseptic production for medicines safety and staff safety	• Initial Design complete – Aug 22 • Tender & Contract award and Design – Mar 23 • Build complete – November 23 • Commissioning complete – Due Dec 23 • In service – Due Dec 23	• Complete • Complete • Complete (delayed to Feb 24 due to Drainage issues, AHU, Design sign off, supply chain issues) • Delayed to October 24 • Delayed to October 24		
		RAAC – Block C, Therapies To eradicate RAAC from Block C, Therapies by demolishing and rebuilding the block	• Relocation of services to new locations – end of Mar 24 • Pre-construction for demolition complete – Mar 24 • Demolition starts – Apr 24 • Demolition complete – Sep 24 • Pre-construction for new block (shell) – Sep 24 • New block (shell) construction starts – Oct 24	• Complete - June 2024 • Complete - complete June 2024 • Complete – commenced June 2024 • On Track • On Track • On Track		
		HDH New Theatres, Treatment Rooms and Ward (TIF2) To increase elective operating capacity and improve waiting time performance.	• NHSE BC approval Sep 22 • HDFT capital to support enabling schemes agreed – Dec 22 • Internal BC approval – Jan 23 • Complete tender, appoint contractor – Jun 23 • Decision to revise project from a standalone block on the Briary Wing carpark to fitting out the first floor of the new block replacing Block C – Oct 23 • Pre-construction phase complete – Sep 24 • Fit-out complete – Dec 25 • Go Live – Dec 25	• Complete • Complete • Complete • Complete • Complete • On Track • On Track – financial risk • On Track		
		Imaging Department	• Feasibility study, including phasing – Sep 22	• Complete		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		To improve reliability and capacity of imaging services	• Initial costs – Oct 22 • Design concept – Jan 23 • Decision to revise project from reconfiguration of the existing imaging department to fitting out the ground floor of the new block replacing Block C – Oct 23 • Pre-construction phase complete – Sep 24 • Fit out complete – TBC • Go Live – TBC	• Complete • Complete • Complete • On Track • TBC – financial risk • TBC		
		CT Business Continuity To ensure HDFT has a reliable CT service to support emergency care	• Canon Dismountable on site: 26 May 23 • Canon dismountable operational 10 Jun 23 • Portakabin on site 22 Jun 23 • Siemens CT in Portakabin operational 24 Jul 23 • Additional works to Portakabin needed for CT installation – August 24 • Go Live – Planned September 24	• Complete • Complete • Complete • Delayed to July 24 due to delays in completing the environment to accommodate the Siemens CT Scanner delivery. Delayed to October 24 due to contractor availability. • Delayed to October 24 due to contractor availability.		
Environmental Impact 	Minimise our impact on the environment	**Delivery of the Trust "Green" Plan** A long term plan and governance structure for the reduction of the Trust's carbon emissions	• Green sub groups for each of the work streams to deliver the programme of work with Governance structure, Sustainability Board, in place reporting to HIF Board • Each work group delivering this year's objectives and reporting to the Sustainability Board. Including N20 waste and Food waste projects • Develop the website with more content to engage with our staff	• On Track • On Track • On Track		
		SALIX Carbon Reduction Programme To improve the estates infrastructure at Harrogate District Hospital in order to reduce carbon emissions	Revised programme (second extension): • Window replacement – Apr 23 • Air and ground source heat pumps – Jun 23 • Air Handling Units – Sep 23 • Solar panels – Aug 23	• Significantly behind original programme which was due to complete in Apr 22 • Complete • Complete • X Ray Basement pump replacement – Complete April 24 • Additional work needed. PV Array – Solar panels require a new power logger as		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
			• Roof Top Plant Rooms – Aug 23	requested by the national grid / DNO. Requires a power shut down. TBC. • New plant rooms complete • Kitchen Plant Room – RAAC funding approved to replace RAAC roof		
		Travel Plan To develop sustainable models of transport for patients, staff and visitors	• Work with local and national cycle retailers to obtain a discount code for staff – promote this through newsletters and a Travel Information Leaflet. • Investigate the possibility of holding cycle maintenance training at Harrogate and Ripon hospitals. This should include the provision of a permanent cycle maintenance kit to be placed at both sites. • Deliver cycle training to staff who are interested in cycling commuting. • Investigate a renewed partnership with Liftshare or internal equivalent to encourage car sharing both for commuting and business trips. • Sign up to Modeshift STARS. • Reintroduction of parking permits. Revenue raised to be used to support active and sustainable transport initiatives.	• Discount now obtained , this will be promoted via the sustainability section on our website by end of October – on Track • Local provider found but at a cost, enquiries with two local bike shops who are considering supporting free of charge if they can also promote their services Summer 2023 – now end of Oct – on track • Free of charge provider now found, action to promote to all staff Summer 2023 – now end of Oct via new section on website -on Track • Summer 2023 - complete • Complete • September 2023 part of the Car Parking Project – Complete		

Related Corporate Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
CRR75	CHS2 – Health & Safety: HDH Goods Yard	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	4 x 3 = 12	4 x 2 = 8 Mar 25	Operational: Health & Safety	Minimal
	CHS3 – Health & Safety: Managing the risk of injury from fire.	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place.	5 x 3 = 15	5 x 2 = 10 Sep 24	Operational: Health & Safety	Minimal

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
		H&S Managing the risk of injury from fire				
	CHS5 – Violence and aggression against staff	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training. Appetite Initial Rating July Rating Aug Rating Target Rating Target Date CRR75: CHS5 Health and Safety An Environment that promotes wellbeing Operational ; Health & Safety	4 x 3 = 12	4 x 2 = 12 Sept 24	Operational: Health & Safety	Minimal
CRR98	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	4 x 3 = 12	4 x 2 = 8 March 25	Operational: Health & Safety	Minimal

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	No Related External Risks					

People and Culture Committee

25th September 2024

Title:	Framework of quality assurance for responsible officers and revalidation
Responsible Director:	Director of People and Culture and Executive Medical Director
Author:	Lee-anne Hutchison – Head of Resourcing and Workforce Information Dr David Lavalette – Consultant in T&O and Responsible Officer

Purpose of the report and summary of key issues:	Revalidation is the process by which licensed doctors demonstrate to the General Medical Council (GMC) that they are up-to-date and fit to practice. The cornerstone of the revalidation process is that doctors participate in a regular annual medical appraisal as well as colleague and patient feedback at least once every 5 years. In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded a slimmed down version of the AOA and a revised Board Report template, which is accompanied, is required for annual submission to NHS England in October of each year. The purpose of this completed Board Report template is to guide our Trust by setting out the key requirements for compliance with regulations and national guidance, to enable us to measure Trust compliance and demonstrate continued improvement. Good progress has been made on last years' action plans, particularly with regard to embedding a more robust system of monitoring annual medical appraisal. This is now clearly embedded within Trust governance process and provides a robust approach to ensuring appraisal compliance continues to improve. Progress has been made on appraiser recruitment, and the number of trained appraisers have increased significantly. There is also further interest from Consultants and SAS colleagues to be trained as appraisers. A peer review is currently underway with a neighbouring Trust within WYAAT (West Yorkshire Association of Acute Trusts). The results of the peer review will be available within Q4 of 24/25 and will be scrutinised by the People and Culture Committee.
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: √

8.2

	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	√
Corporate Risks	There are currently no issues of risk to be updated on the Corporate risk register related to this report.	
Report History:	The annual board report and statement of compliance has been to the People and Culture Programme Board for review.	
Recommendation:	Our recommendation of the Board is to approve the annual board report and statement of compliance for submission to NHS England in October 2024.	

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes – The Responsible Officer (RO) and Revalidation Team actively review the processes in line with the policy. The Trust's appraisal policy was reviewed and updated during the 22/23 revalidation year. The Trust's internal audit department review and monitor our policies through the audit program.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

We are currently working with Calderdale and Huddersfield NHS Foundation Trust to perform a reciprocal peer review of our processes. The peer review findings will be published during Q4 24/25.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes Comments: Locum doctors are expected to follow the same process as our permanent doctors with reference to their continuing professional development, appraisal, revalidation, and governance. Locums are able to access resources within this organisation during their period of employment.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

The organisation has a well embedded process to support colleagues in completing an appraisal every 12 months. The Trust continues to engage with the appraisal 2020 model (most current version of medical appraisal) with our colleagues across the Trust.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continueing to monitor and work towards improved compliance figures.

Comments: We have embedded our new 3-step process of escalation, which is working well. The Trust actively monitors colleagues who are not compliant and supports these colleagues with any difficulties, which may compromise their ability to complete their appraisal within the mandated timeframe.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Yes

Comments: The organisation has increased the number of appraisals and will continue to ensure we have a number of sufficient appraisers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Bi-annual appraiser forums take place and the RO continually shares relevant correspondence with all our appraisers.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2024	313
Total number of appraisals undertaken between 1 April 2023 and 31 March 2024	206
Total number of appraisals not undertaken between 1 April 2023 and 31 March 2024	17
Total number of agreed exceptions	6

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Yes

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Yes – the Trust uses MPIT forms.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

Good progress has been made on last years' action plans, particularly which regards to embedding a more robust system of monitoring annual medical appraisal. This is now clearly embedded and provides a robust approach to ensuring appraisal compliance continues to improve.

Progress has been made on appraiser recruitment, and the number of trained appraisers have increased significantly. There is also further interest from consultants and SAS colleagues to be trained as appraisers.

A peer review is currently underway with a neighbouring Trust within WYAAT (West Yorkshire Association of Acute Trusts). The results of the peer review will be available within Q4 of 24/25 and will be scrutinised by the People and Culture Committee.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

_____

Signed on behalf of the designated body

Jonathan Coulter – Chief Executive Officer

Official name of designated body: **Harrogate and District NHS Foundation Trust**

Name: David Lavalette

Role: Responsible Officer

Signed: _____

Date:

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This publication can be made available in a number of other formats on request.

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