**Board of Directors Meeting Held in Public**

**To be held on Wednesday, 29th January 2025 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 27th November 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 |
| **2.2** | **Visitors' Charter** | Director of Nursing, Midwifery and AHPs | **Approve** | Attached |
| **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 |

| Item No. | Item | Lead | Action | Paper |
|---|---|---|---|---|
| **3.2a** | **Strengthening Maternity and Neo-Natal Safety** | Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery | Note | Attached |
| **3.2b** | **Maternity Incentive Scheme** | Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery | **Approve** | 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 |
| **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 | Deputy Director of Strategy & Improvement, & Resources Committee Chair | **Approve** | Attached |
| **SECTION 7: Escalation from Committees** | | | | |
| **7.1** | **Escalation from Sub-Committees of the Board** | All Executive and Non-Executive Directors | Discuss | Verbal |
| **SECTION 8: Governance Arrangements** | | | | |
| **8.1** | **Audit Committee Update** | Committee Chair | Note | Verbal |
| **8.2** | **Use of Trust Seal** | Company Secretary | **Approve** | Attached |
| **9.0** | **Any Other Business** *By permission of the Chair* | Chair | Discuss/ Note/ Approve | Verbal |
| **10.0** | **Board Evaluation** | Chair | Discuss | Verbal |

| Item No. | Item | Lead | Action | Paper |
|---|---|---|---|---|
| **11.0** | **Date and Time of next Board Meeting to be held in public:**<br>Wednesday 26th March 2025 at 1.00 – 3.45pm<br><br>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 22 January 2025

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Jacqueline Andrews | Executive Medical Director | June 2020<br><br>June 2020<br><br>December 2023<br>April 2024<br><br>May 2024 | April 2024<br><br>Current<br><br>Current<br>Current<br><br>Current | 1. Familial relationship with managing partner of Priory Medical Group, York<br>2. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board<br>3. Member, Leeds Hospitals Charity Scientific Advisory Board<br>4. Familial relationship with Director of GPMx Ltd (healthcare consultancy)<br>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<br>Chair from 1 April 2022 | October 2018<br><br><br><br><br><br>September 2024 | Date<br><br><br><br><br><br>Date | 1. Company director for the flat management company of current residence<br>2. Chief Executive, The Ewing Foundation, Ovingdean Hall Foundation and Burwood Park Foundation<br>3. Director of Coffee Porter (family business)<br>4. Member of West Yorkshire Chairs & Leaders Forum<br>5. Member HNY Provider Chairs<br>6. Member HNY CAP Board<br>7. Member Trustee – NHS Charities Together |
| Azlina Bulmer | Associate<br>Non-executive Director | November 2022<br>November 2022<br>February 2024 | February 2024<br>Date<br>Date | 1. Executive Director, Chartered Insurance Institute<br>2. Familial relationship, Health Education England<br>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)<br>2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023) |
| Jonathan Coulter | Finance Director<br>Chief Executive from March 2022 | March 2022 | | No interests declared |
| Jeremy Cross | Non-executive Director | January 2020 | Date | 1. Chairman, Tipton Building Society<br>3. Director and Shareholder, Cross Consulting Ltd (dormant)<br>4. Chairman, Forget Me Not Children's hospice, Huddersfield |

| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| | | | | 5. Governor, Grammar School at Leeds<br>6. Director, GSAL Transport Ltd<br>7. Member, Kirby Overblow Parish Council<br>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<br>November 2022<br>May 2024 | May 2024<br>Date<br>Date | 1. Director of Support and Influencing, Prostate Cancer UK<br>2. Clinical Trustee, Candlelighters (Children's Cancer Charity)<br>3. Director of Health Services, Equity & Improvement, Prostate Cancer UK |
| Matt Graham | Director of Strategy | September 2021<br><br>April 2022 | Date<br><br>Date | 1. Member: Local Governing Body, Malton School (part of Pathfinder Multi-Academy Trust)<br>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<br>2. Bencher, The Honourable Society of the Middle Temple<br>3. Director and Deputy Head of Chambers, Park Square Barristers<br>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<br>2. Ambassador for Action for Sport |
| Laura Robson | Non-executive Director | No interests declared | | |

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| Board Member | Position | Relevant Dates From | To | Declaration Details |
|---|---|---|---|---|
| Wallace Sampson OBE | Non-executive Director | March 2020<br>July 2023<br>August 2023<br><br>September 2023<br><br>October 2023<br><br>August 2024 | Current | 1. Member of Society of Local Authority Chief Executives<br>2. Advisory Board Consultant – Commercial Service Kent Ltd.<br>3. Commissioner – Local Government Boundary Commission for England<br>4. Chair – Middlesbrough Independent Improvement Advisory Board.<br>5. Director and Shareholder – Sampson Management Services Ltd.<br>6. Member – Council of Governors, Leeds University |
| Julia Weldon | Non-executive Director | November 2022<br><br><br>May 2024 | Date | 1. Director of Public Health / Deputy Chief Executive, Hull City Council<br>2. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board<br>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 |
|---|---|---|
| Emma Anderson | Interim Clinical Director (Children and Young People's Public Health) | No interests declared |
| Dr Dave Earl | Deputy Medical Director | 1. Director, Earlmed Ltd, provider of private anaesthetic services<br>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.<br>2. Chair, Safeguarding Practice Review Group.<br>3. Chair, North Yorkshire and York Looked After Children Health Professionals Network.<br>4. Member, North Yorkshire and York Safeguarding Health Professionals Network.<br>5. Member, national network of Designated Health Professionals.<br>6. Member, Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR<br>7. Familial relationship within Harrogate & District NHS Foundation Trust<br>8. Member, NHS Safeguarding Strategic Community of Practice for ICBs (Regional). |
| Dr Matthew Shepherd | Clinical Director (Long Term & Unscheduled Care)<br>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 |

Harrogate and District NHS Foundation Trust

## 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<br>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<br>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<br><br>February 2022<br><br>February 2022<br><br><br><br><br><br><br><br><br>July 2023 | 1. Director and Trustee of TCV (The Conservation Volunteers) – ceased December 2021<br>2. Local Government Information Unit (Scotland) Associate – LGIU has now fully merged with LGIU listed as current interest<br>3. Chair of the Corporation of Selby College – dissolved 28 February 2022 when it became part of the Heart of Yorkshire Group.<br>4. Director (and 50% owner), Richard Stiff Consulting Limited<br>5. Director, NCER CIC (Chair of the Board from April 2019)<br>6. Member, Association of Directors of Children's Services<br>7. Member, Society of Local Authority Chief Executives<br>8. Local Government Information Unit Associate<br>9. Fellow, Royal Society of Arts<br>10. Member of the Corporation of the Heart of Yorkshire Education Group<br>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<br>2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company.<br>3. Chair of Harrogate Public Services Leadership Board |

Harrogate and District NHS Foundation Trust

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

# BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

**Wednesday, 27 November 2024**

**Held at Trust HQ, Harrogate District Hospital, Harrogate, HS2 7SA**

| **Present:** | |
|---|---|
| Sarah Armstrong | Trust Chair |
| Jonathan Coulter | Chief Executive |
| Jeremy Cross (JC) | Non-executive Director (Chair of Resource Committee) |
| Chiara DeBiase (CDB) | Non-executive Director (Chair of Audit Committee) |
| Andy Papworth (AP) | Non-executive Director (Chair of People & Culture Committee) |
| Laura Robson (LR) | Non-executive Director (Chair of Quality Committee) |
| Wallace Sampson OBE (WS) | Non-executive Director (Chair of Innovation Committee) |
| Sarah Shaw (SS) | Non-executive Director (Insight Programme) |
| Jacqueline Andrews | Executive Medical Director |
| Matthew Graham | Director of Strategy |
| Jordan McKie | Director of Finance |
| Russell Nightingale | Chief Operating Officer |
| Emma Nunez | Executive Director of Nursing, Midwifery & Allied Health Professionals (AHPs) and Deputy Chief Executive |
| Angela Wilkinson | Director of People & Culture |

| **In Attendance:** | |
|---|---|
| Leanne Likaj | Associate Director of Midwifery (*for Item 11-14 only)* |
| Charly Gill | Associate Director of Nursing, LTUCC (*for Item 1 only*) |
| Sue Grahamslaw | Assistant Company Secretary |

| **Apologies:** | |
|---|---|
| Azlina Bulmer (AB) | Associate Non-executive Director |
| Julia Weldon (JW) | Non-executive Director |
| Kama Melly (KM) | Associate Non-executive Director |
| Kate Southgate | Associate Director of Quality and Corporate Affairs |

| **Observers:** | |
|---|---|
| Governors | 7 governors:<br>Public Governors: Jackie Lincoln; Rachel Carter; Tony Doveston; John Hindle; Kevin Parry.<br>Staff Governors: Jonathan Allen; Emily Legge. |
| Members of the public / press | 2 members of the public / press |
| Members of staff | 3 new staff members |

| Item No. | Item |
|---|---|
| **BD/11/27/1**<br>**1.1**<br><br>**1.2**<br><br><br>**1.3** | **Welcome and Apologies for Absence**<br>The Chair welcomed everyone to the meeting.<br><br>It was noted that the meeting would be Tony Doveston's, Public Governor, last session as he had come to the end of his final term as Governor.<br><br>Apologies for absence were noted as above. |
| **BD/11/27/2**<br>**2.1** | **Patient Story**<br>The Chair introduced the Patient Story, advising that the patient, Paul, was unwell and so unable to attend. However, the Associate Director of Nursing, Long Term, Urgent and Community Care advised that he had consented to his story being presented on his behalf. |

| Item No. | Item |
|---|---|
| **2.2** | Paul's conditions were outlined and his hospital stay explained. |
| **2.3** | It was explained that Paul's independence was very important to him and how he had struggled with some elements of the hospital environment and facilities. It was also discussed that he would have preferred his sister to be included in some of the conversations relating to his care, such as DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation). |
| **2.4** | The learning from the patient story had contributed to a number of ongoing programmes of work, such as:<br>• "Hello my name is" project;<br>• Learning disability appropriate environments;<br>• Oliver McGowan training (listening to people with lived experience);<br>• Disability improvement plan (through the Making Experiences Count forum); |
| **2.5** | The Board members were grateful for the experiences being shared and discussed the learning from the story. |
| **2.6** | The Non-executive Director (JC) raised the length of time Paul was in the hospital. It was explained that this was due to his medical condition. |
| **2.7** | The Non-executive Director (LR) suggested a patient should be asked if they wanted someone present for Do Not Resuscitate (DNR) and similar conversations. The Associate Director of Nursing, LTUCC, advised this was part of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) discussions. |
| **2.8** | The Non-executive Director (AP) was grateful for the experience being shared and questioned if there was a personal care plan recorded. The Associate Director of Nursing, LTUCC, advised the patient had an individualised care plan but handovers between staff from different wards could be improved, including electronic personal care plans. |
| **2.9** | The Non-executive Director (LR) noted that the Quality Committee had completed a Gemba visit to the Oakdale Ward, where Paul had received some of his care, and noted the considerable improvements that had been made. |
| **2.10** | The Non-executive Director (SS) questioned if there was a team of Learning Disability Liaison Nurses or just one person. It was noted that it was a specialist role and that their knowledge was being embedded in all teams. |
| **2.11** | The Associate Director of Nursing, LTUCC, was thanked for her time. |
| **2.12** | *The Associate Director of Nursing, LTUCC, left the meeting.* |
| **2.13** | **Resolved:** The patient story was noted. |
| **BD/11/27/3**<br>**3.1** | **Declarations of Conflicts of Interest and Register of Interests**<br>The register of interests was received and noted. |
| **3.2** | **Resolved:** The declarations were noted. |
| **BD/11/27/4** | **Minutes of the Previous Board of Directors meeting held on 25 September 2024** |
| **4.1** | **Resolved:** The minutes of the meeting on the 25 September 2024 were approved as an accurate record of the meeting. |

| Item No. | Item |
|---|---|
| **BD/11/27/5**<br>**5.1** | **Matters Arising and Action Log**<br>The actions were noted as follows:<br>• **BD/3/29/36.2 – Board Effectiveness Survey** – this item would be reviewed again once the new Board and Committee meeting format had been embedded. *Action to remain ongoing.*<br>• **BD/9/25/19.3 – Workforce Disability Equality Standards** – The Director of People and Culture clarified the WRES metric 4 principles noting that BAME staff were more likely to access non-mandatory training than other staff. *Action to be closed.* |
| **5.2** | No further matters arising were raised which were not already noted on the agenda. |
| **5.3** | **Resolved:** All actions were agreed as above. |
| **BD/11/27/6**<br>**6.1** | **Overview by the Chair**<br>The Chair noted a range of activities had taken place since the last meeting of the Board and highlighted the following points:<br>• A number of regional and national meetings had been held announcing future plans for the NHS.<br>• At the NHS Providers Conference, the Secretary of State for Health and Social Care outlined the 10-year plan.<br>• The Chair had visited a GP Practice with two Governors as part of a programme of work in relation to better understanding GP services locally. |
| **6.2** | **Resolved:** The Chair's report was noted. |
| **BD/11/27/7**<br>**7.1** | **Chief Executive's Report**<br>The Chief Executive presented his report as read. The following points were highlighted:<br>• A number of announcements from the Secretary of State and the NHSE Chief Executive had been made since the last meeting of the Board. It was noted that the consultation on the NHS 10 year plan was ongoing and the plan was due to be published in May 2025.<br>• The new NHS Operating Model was discussed.<br>• Humber & North Yorkshire (HNY) Integrated Care Board (ICB) were noted as being in Tier 2 for Urgent Care.<br>• There were two new risks entered onto the Corporate Risk Register since the last meeting of the Board - the fragility of the cardiology service, and the risk to stroke patients of a treatment delay. |
| **7.2** | The Non-executive Director (LR) advised the Board that at the NEDs ICS meetings, there were discussions regarding the 10 year plan. |
| **7.3** | **Resolved:** The Chief Executive's Report was noted. |
| **BD/11/27/8**<br>**8.1** | **Board Assurance Framework – Summary**<br>The Chief Executive provided an overview on the Board Assurance Framework (BAF). It was confirmed that the BAF focused on assurance regarding the delivery of the Trust Strategy. |

| Item No. | Item |
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| **8.2** | The Non-executive Director (WS) queried where the risk appetite for digital transformation and innovation should be set. The Chief Executive advised that risk appetite thresholds would be reviewed at a future workshop. |
| **8.3** | The Non-executive Director (WS) noted that he felt that the Electronic Patient Record (EPR) risk was not "cautious". A discussion was held on the level of risk and mitigation in place for the EPR Strategic Programme and noted that this would be reviewed via the Innovation Committee. |
| **8.4** | **Resolved:** The Board Assurance Framework Summary was approved. |
| **BD/11/27/9** | **Corporate Risk Register** |
| **9.1** | **Resolved:** The Corporate Risk Register was noted. |
| **BD/11/27/10** | **Board Assurance Framework – Best Quality, Safest Care** |
| **10.1** | The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Best Quality, Safest Care. |
| **10.2** | This Strategic Ambition had two True North metrics. The first metric was a reduction in moderate and above harm, which had a breakthrough objective linked to it: Pressure Ulcers. The second metric was an improved positive patient experience, which had a corporate project linked to it: A Positive Patient Experience. |
| **10.3** | Both True North metrics were within the Trust's risk appetite (tolerance). |
| **10.4** | The Chair of the Quality Committee confirmed that this element of the BAF had been discussed in detail at the Quality Committee. It was noted that the risk appetite was minimal. |
| **10.5** | It was noted that the October data for reduction in moderate harm was still in the process of being validated. |
| **10.6** | The Friends & Family test (FFT) responses were currently above trajectory and the November 2024 complaint response rate was 100%. |
| **10.7** | There were no Corporate Risks linked to this element of the BAF at this time. |
| **10.8** | The Non-executive Director (AP) questioned if the FFT response rate should be a percentage or ratio rather than a volume. It was agreed that this would be considered further. |
| **10.9** | The Non-executive Director (LR) questioned that as the FFT was a national test, where would HDFT fall within a "league table". It was confirmed that this information was not available at the present time. |
| **10.10** | The Quality Committee Chair noted that the Learning from Deaths report had been received. |
| **10.11** | The Non-executive Director (AP) took assurance from the Learning from Deaths Report but questioned the assessments on avoidability of deaths stating that avoidable deaths should be investigated. The Executive Medical Director noted that it was likely to correlate with the Patient Safety Incident Investigation (PSII). |

| Item No. | Item |
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| **10.12** | The Non-executive Director (LR) questioned if GPs were community medical examiners. It was explained that medical examiners scrutinised all deaths and that a number of primary care GPs were involved in SJRs. |
| **10.13** | The high level of safeguarding demands on staff were noted, together with a delivery plan and actions. It was noted that the safeguarding action plan encompassed both the acute and community services. |
| **10.14** | **Resolved:** The update on the BAF: Strategic Ambition - Best Quality, Safest Care was approved. |
| **10.15** | *The Associate Director of Midwifery joined the meeting.* |
| **BD/11/27/11**<br>**11.1** | **Workforce Safeguards Report (Safer Staffing Tool)**<br>The Executive Director of Nursing, Midwifery and AHPs took the report as read. The purpose of the report was to provide the Board of Directors with an overview of outcomes of the July 2024 Safer Nursing Care Tool (SNCT) assessment for the Adult and Children and Young People (C&YP) Inpatient areas 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). |
| **11.2** | The Non-executive Director (CDB) noted staffing in the Emergency Department had a number of peaks and troughs in the achievement of the standard. The Chief Operating Officer noted that agency staff were no longer used within the Emergency Department and senior nursing managers were coordinating staffing successfully. However, the numbers of patients attending the Emergency Department would always fluctuate. |
| **11.3** | **Resolved:** The Workforce Safeguards Report was noted. |
| **BD/11/27/12** | **Learning from Deaths Quarterly Report (Q2; 2024-25)** |
| **12.1** | The Learning from Deaths Quarterly Report was received and accepted through the supplementary papers. |
| **12.2** | **Resolved:** The Learning From Deaths Quarterly Report was noted. |
| **BD/11/27/13**<br>**13.1** | **Board Assurance Framework – Great Start in Life**<br>The Executive Director of Nursing, Midwifery and AHPs provided the Board with an update on the Strategic Ambition: Great Start in Life. |
| **13.2** | This Strategic Ambition had three True North metrics. The first metric was children at risk of vulnerabilities. The second metric was an improved positive patient experience. The third metric was maternity harm events. There were no corporate projects or breakthrough objectives linked to this area. It was noted however, that the corporate project on patient experience for Best Quality, Safest Care ambition would impact on this element of the BAF. |
| **13.3** | All True North metrics were within the Trust's risk tolerance. |
| **13.4** | It was explained that the children's patient experience metric had been completed. A Children and Young People' Strategy was in the process of being developed. |

| Item No. | Item |
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| **13.5** | The Board noted that the Early Intervention metric had been discussed at the Quality Committee where there was a focus on children's health outcomes. It was confirmed that the Great Start in Life pathway would launch in January 2025. |
| **13.6** | The Chair of the Quality Committee also advised that in-depth discussions had taken place at the Quality Committee in relation to:<br>• Maternity.<br>• Autism Risk (with options for next steps).<br>• Maternity diverts metric (with the challenges of predicting required staffing levels). |
| **13.7** | The Non-executive Director (WS) questioned where assurances were gained on safeguarding for children and young people. The Executive Director of Nursing, Midwifery & AHPs advised that this was not currently a key metric on HDFT Impact but would be reviewed. |
| **13.8** | **Action:** Further information to be reviewed at the Quality Committee on Section 11 of the Children Act 2004. |
| **13.9** | **Resolved:** The update on the BAF: Strategic Ambition – Great Start in Life was approved. |
| **BD/11/27/14**<br>**14.1** | **Strengthening Maternity and Neonatal Safety**<br>The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery presented the October 2024 Strengthening Maternity and Neonatal Safety Report to the Board. |
| **14.2** | The report provided a summary and update on the board level safety measures for the month of October 2024 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020). |
| **14.3** | The Associate Director of Midwifery outlined the major actions commissioned and work underway, as well as the matters of concern and risks to escalate. The deadline of 3 December 2024 for the Maternity Incentive Scheme (MIS) was noted. |
| **14.4** | The Chair of the Quality Committee confirmed that an in-depth discussion had taken place at the Quality Committee on the report. |
| **14.5** | The Non-executive Director (CDB) noted the drop in training compliance. It was confirmed that this linked to recent recruitment who had yet to fully complete their training. |
| **14.6** | The Non-executive Director (AP) took assurance from the volume of data presented. He noted the risk around neonates and highlighted that this had been discussed with the ICB. He confirmed that the issue had also been discussed with the maternity champions. |
| **14.7** | **Resolved:** The Strengthening Maternity and Neonatal Safety report was noted. |
| **14.8** | *The Associate Director of Midwifery left the meeting.* |
| **BD/11/27/15** | **Board Assurance Framework – Person Centred, Integrated Care, Strong Partnerships** |
| **15.1** | The Chief Operating Officer provided the Board with an update on the Strategic Ambition: Person Centred, Integrated Care, Strong Partnerships. |

| Item No. | Item |
|---|---|
| **15.2** | This Strategic Ambition had four True North metrics. |
| **15.3** | Metric 1: 4 Hour ED standard – this remained outside of risk appetite. The target of 85% of patients having their care completed within 4 hours had a trajectory compliance date of March 2025. It was noted that the key areas of breach was due to availability of a medical bed. |
| **15.4** | Metric 2: Length of stay for frailty patients – It was noted that there had been a significant improvement in this metric, with an 8% reduction in length of stay. |
| **15.5** | Metric 3: 18 week RTT (elective recovery standard) – the trajectory was on track to deliver no patients waiting over 52 weeks. The goal to reach target by March 2026 of 18-52 week pathways reduced to 6,000 was also on track. It was noted that the metric was slightly below risk appetite. |
| **15.6** | Metric 4: Cancer 62 day treatment standard – The Board were advised that the Trust was on track to achieve the target by March 2025. |
| **15.7** | There were two Corporate Risks that remained linked to this element of the BAF. the BAF: CRR41: RTT and CRR61: ED 4 Hour standard. In addition, two new risks had been confirmed onto the Corporate Risk Register – Cardiology and Stroke provision. The Board were advised that a trial had been agreed with York and Scarborough Trust for the stroke pathway. |
| **15.8** | The Chair of the Resource Committee noted that the BAF had been scrutinised and discussed in detail at the Committee highlighting that Children's Services had progressed well. |
| **15.9** | **Resolved:** The update on the BAF: Strategic Ambition - person centred, integrated care, strong partnerships was approved. |
| **BD/11/27/16**<br>**16.1** | **Board Assurance Framework – Finance**<br>The Director of Finance provided the Board with an update on the Enabling Ambition: Finance. |
| **16.2** | This Ambition had one True North Metric: Financial Sustainability. There were no breakthrough objectives linked to this area. There were a wide range of corporate projects in place which had direct and indirect positive implications for the financial position. |
| **16.3** | The metric remained within the Trust's risk tolerance. |
| **16.4** | The Board were advised that the BAF had been discussed in detail at the Resources Committee earlier in the day and a typographical error on the BAF (the deficit reported should have read £4.3m rather than just £4.3) was noted. The following points were noted:<br>• Financial pressures linked to the pay award.<br>• A number of WRAP projects awaiting confirmation of savings realisation.<br>• Elective Recovery Funding was performing above trajectory.<br>• Agency spend remains low. |
| **16.5** | Assurance had been received from the Price Waterhouse Coopers (PWC) and Grant Thornton exercises. |

| Item No. | Item |
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| **16.6** | There were two Corporate Risks linked to this element of the BAF. CRR94: Delivery of the Financial Plan and CRR95: local authority funding and the impact of the NHS pay award. |
| **16.7** | The Chair of the Resource Committee noted in depth discussions had taken place at the Committee. Until funding was clarified, there were challenges to identify exact financial position. The assurances from PWC and Grant Thornton were welcomed. |
| **16.8** | **Resolved:** The update on the BAF: Strategic Ambition – Finance was approved. |
| **BD/11/27/17** | **Board Assurance Framework – At Our Best: Making HDFT the Best Place to Work** |
| **17.1** | The Director of People and Culture provided the Board with an update on the Strategic Ambition: At Our Best: Making HDFT the Best Place to Work. |
| **17.2** | This Strategic Ambition had two True North metrics. |
| **17.3** | Metric 1: Staff Engagement with a focus on continually improving the Employee Engagement Score – The Board were advised that, owing to the timing of the National Surveys, there had been no new data to review. The response rate to the National Staff Survey had improved compared to 2023. |
| **17.4** | Metric 2: Staff Availability – The Board were advised that the availability of staff was linked to those who were unavailable to work for a variety of reasons, including vacancy and sickness absence. |
| **17.5** | It was noted that the composite metric had improved with fewer staff being unavailable now. The vacancies metric had reduced sufficiently. It was confirmed that Vacancy Rates was no longer a breakthrough objective. |
| **17.6** | **Resolved:** Breakthrough Objective: Vacancy rate was formally closed. |
| **17.7** | The Non-executive Director (WS) sought clarification on staff engagement. In addition, the question of Equality, Diversity & Inclusion (EDI) objectives forming part of executive director appraisals was raised. The Director of People & Culture confirmed that every director now had an EDI objective as did all senior managers throughout the Trust. |
| **17.8** | The People & Culture Committee Chair commented on the positive staff survey response rate and noted the use of Gemba walks to help increase responses. He noted the need to focus on sickness rates to improve staff availability and emphasised that this was being reviewed at the People & Culture Committee. It was also noted that the actions from the Guardian of Safe Working were followed up at the Committee. |
| **17.9** | The Committee Chair also advised that the Freedom To Speak Up (FTSU) Report had been scrutinised at the Committee, as well as consideration of a second FTSU Guardian to cover any absences. The Committee was supportive of the recruitment but acknowledged the challenges of confidentiality in a shared role. |
| **17.10** | Both True North metrics were below the Trust's risk tolerance. |
| **17.11** | There were no Corporate Risks linked to this element of the BAF at this time. |

| Item No. | Item |
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| **17.12** | **Resolved:** The update on the BAF: Strategic Ambition – At Our Best, making HDFT the best place to work was approved. |
| **BD/11/27/18** | **Freedom to Speak Up Annual Report** |
| **18.1** | The Freedom to Speak Up Annual Report was received and accepted through the supplementary papers. |
| **18.2** | **Resolved**: The Freedom to Speak Up Annual Report was noted. |
| **BD/11/27/19** | **Board Assurance Framework – Enabling Ambition: Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience** |
| **19.1** | The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation. |
| **19.2** | The Enabling Ambition had two true north metrics: Metric 1: Quality & Safety – systems which enable staff to improve quality and safety of care. Metric 2: Electronic Patient Record (EPR). |
| **19.3** | There were no breakthrough objectives or corporate projects linked to this element of the BAF. There was however, a Strategic Programme: EPR linked to this Ambition. |
| **19.4** | The Executive Medical Director noted the metrics were below the Trust's risk tolerance as a number of projects had been completed or were within timeframes. |
| **19.5** | The Non-executive Director (AP) raised the issue of medical rostering. It was explained that this was a Corporate Project about job planning but that implementation and planning had been delayed. |
| **19.6** | There were no Corporate Risks linked to this element of the BAF at this time. |
| **19.7** | The Innovation Committee Chair noted that this had been discussed in detail at the Committee. A Gemba visit to the Committee by the Research Team provided the opportunity for in-depth discussions on the breadth of research activity, reasons for proceeding or not with projects, and the link to the Trust's strategic objectives. The Board were reminded that Laboratory Information Management Systems (LIMS) had now gone live. |
| **19.8** | The Board were further advised on the mobilisation of the Electronic Patient Record (EPR) and the work with York & Scarborough NHS Trust. Owing to the other EPR projects around the country, effective project management by the Trust would be required. The benefits realisation would be monitored throughout the project. |
| **19.9** | The Executive Medical Director confirmed to the Non-executive Director (SS) that the Trust was linked to knowledge networks and other trusts to share EPR experiences. |
| **19.10** | **Resolved:** The update on the BAF: Enabling Ambition: Digital Transformation was approved. |
| **BD/11/27/20** | **Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety** |
| **20.1** | The Executive Medical Director and the Director of Strategy provided the Board with an update on the Enabling Ambition: Healthcare Innovation. |

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| **20.2** | This Enabling Ambition had two True North metrics: Healthcare Innovation and Clinical Trials. All workstreams were on track and remained below the Trust's risk appetite. |
| **20.3** | There are no Breakthrough Objectives or Corporate Projects linked to this Ambition. There was however, a Strategic Programme: HDFT Impact linked. |
| **20.4** | The Executive Medical Director noted the goals that had been achieved and, in some cases, targets exceeded. |
| **20.5** | The Chair of Innovation Committee noted that this had been scrutinised within the Committee. |
| **20.6** | **Resolved:** The update on the BAF: Enabling Ambition: Healthcare Innovation was approved. |
| **BD/11/27/21**<br>**21.1** | **Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**<br>The Director of Strategy provided the Board with an update on the Enabling Ambition: Environment. |
| **21.2** | The Enabling Ambition had three True North Metrics: A patient environment that promotes wellbeing; An environment and equipment that promotes best quality, safest care; Minimise our impact on the environment. |
| **21.3** | All True North metrics remained below the Trust's risk appetite. |
| **21.4** | There were no Breakthrough Objectives or Corporate Projects linked to this ambition. |
| **21.5** | The Director of Strategy noted the range of workstreams within this element of the BAF. |
| **21.6** | The Non-executive Director (LR) raised a concern in relation to nitrous oxide canisters. It was explained that the majority of this greenhouse gas was lost through the pipe system. It was confirmed that clinicians were in agreement that the move to canisters was safe. |
| **21.7** | The People & Culture Committee Chair confirmed that this element of the BAF had been discussed in detail at the Committee. |
| **21.8** | **Resolved:** The update on the BAF: Enabling Ambition: An Environment that Promotes Wellbeing was approved. |
| **BD/11/27/22**<br>**22.1** | **Premises Assurance Model**<br>The Premises Assurance Model was received and accepted through the supplementary papers. The Chair of Resource Committee noted that this had been discussed within the Committee. |
| **22.2** | **Resolved**: The content of the Premises Assurance Model was noted. |
| **BD/11/27/23**<br>**23.1** | **Escalations from Sub-Committees of the Board**<br>The Chair invited Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day. |

| Item No. | Item |
|---|---|
| **23.2** | The Non-executive Director (JC) noted he had raised questions as they occurred during the meeting. |
| **23.3** | The Non-executive Director (LR) reminded the Board of the progress that had been made around theatre capacity. |
| **23.4** | The Non-executive Director (AP) escalated the dental and autism assessment risks but noted these had been discussed earlier in the meeting. |
| **23.5** | **Resolved:** The escalations were noted. |
| **BD/11/27/24**<br>**24.1** | **Emergency Preparedness & Resilience Report (EPRR) & Statement**<br>The Chief Operating Officer presented the report which was taken as read. An overview of the processes and self-assessments undertaken against the domains and core standards to determine the compliance rates were highlighted. |
| **24.2** | The Chair of Resource Committee noted that the report had been scrutinised in the Committee. |
| **24.3** | It was explained that NHSE had introduced the EPRR and statement process in 2023. At that time HDFT self-assessed at 10% compliance. The improvements made were outlined and the Trust now assessed at 45% compliant against the EPRR Core Standards. |
| **24.4** | For those areas where the Trust was not compliant, an action plan had been developed which would form the basis for the 2025-26 EPRR work programme. |
| **24.5** | It noted that there was a trajectory to be 76% compliant by the end of 2025. The Board were advised that out of the 11 trusts in the HNY ICB, one had achieved 76% compliance and the lowest had achieved 30% compliance. |
| **24.6** | The Non-executive Director (LR) questioned if it was just the hospital that was included in the EPRR or if the 0-19 and Community Services were also included. The Chief Operating Officer confirmed that there were Business Continuity Plans in 0-19 services but they did not form part of the EPRR Statement. |
| **24.7** | **Resolved:** The Board:<br>(i) considered the compliance self-assessment, rating and associated guidance;<br>(ii) approved the overall compliance rating and associated action plan for the 2024-25 work programme. |
| **BD/11/27/25**<br>**25.1** | **Any Other Business**<br>No further business was received. |
| **BD/11/27/26**<br>**26.1** | **Board Evaluation**<br>The Non-executive Director (CDB) and the Chief Executive noted that the scrutiny and questioning by those with relevant expertise was done at the Committees, with reassurance then being provided to board. |
| **26.2** | The Executive Director of Nursing, Midwifery & AHPs noted the usefulness of the Gemba walks and the ability to triangulate the information which provided an improved level of assurance. It was noted that further work was required to ensure 0-19 and Community Services were included in the programme. |
| **BD/11/27/27**<br>**27.1** | **Date and Time of the Next Meeting**<br>The next meeting will be held on Wednesday, 29 January 2025. |

| Item No. | Item |
|---|---|
| BD/11/27/28<br>28.1 | **Confidential Motion**<br>**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 January 2025 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 | Ongoing | Noted that significant work has been completed with regards to the Corporate Framework. Revised agendas, membership and timings are being put in place in Autumn 2024 for Sub-Committees and the Trust Board in Public. This item will remain open as part of the ongoing review. | Ongoing |
| BD/9/25/19.3 | 25 September 2024 | Workforce Disability Equality Standards (WRES) | A review of Metric 4 to take place and further clarity circulated to Board members | Director of People and Culture | November 2024 | Director of People & Culture clarified the WRES metric 4 principles noting that BAME staff were more likely to access non-mandatory training than other staff. | Closed |
| BD/11/27/7.2 | 27 November 2024 | Chief Executive's Report | From WYAAT CiC, review services being provided (incl access to and cost of services, such as Wharfedale) at Feb 2025 Workshop | Associate Director of Quality and Corporate Affairs | February 2025 | WYAAT attending February 2025 Workshop to provide an update. | Closed |
| BD/11/27/13.8 | 27 November 2024 | Board Assurance Framework - Great Start in Life | Review assurances gained for Section 11 of the Children's Act 2004. | Executive Director of Nursing Midwifery & AHPs | March 2025 | Section 11 action plan updated at Quality Committee in November 2024. Safeguarding Watch Metrics being developed as part of review of Trust-wide suite of watch metrics. | Propose to close |

# BOARD OF DIRECTORS (PUBLIC)
## 29th January 2025

| | |
|---|---|
| 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**<br>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)**
**JANUARY 2025**

# CHIEF EXECUTIVE'S REPORT

## National and system issues

1. Following the publication of the Darzi report and the autumn budget in the last quarter of 2024, the focus nationally has been on developing the planning guidance for 2025/26. This needs to be cogniscent of the development of the 10 year plan which is due to be published in May, where the framework will be the shift from care in hospital to the community, the shift from treatment to prevention, and the shift from analogue to digital. As I have reflected before, we are very well placed with our strategy to respond positively to this.

2. Alongside development of the planning guidance, we have received the elective care recovery plan and there is continuing discussions about the operating framework of the NHS, and the role of ICB's as strategic commissioners.

3. The planning guidance is now due to be published on 28th January. We do know though the principles upon which this will be built. There will be a greater focus on high quality, honest conversations rather than iterating plans through multiple submissions to NHSE; there will be greater recognition of individual Boards in owning, assuring and being accountable for the delivery of plans; there will be a shift in NHSE resources from plan assurance to providing better support to systems; and there will be an emphasis on efficiency and productivity opportunities.

4. These principles are to be welcomed, as is the timetable for this year that will see plans being signed off by Boards by the end of March, rather than have a process that lasts into the summer, as was the case for 2024/25.

5. Clearly, one of the significant national challenges is the level of funding to meet all that the NHS would want to deliver, and there is an emphasis on developing plans based upon the financial resources available rather than starting from what level of service needs to be delivered and working out the cost. This will sharpen some of the discussions that will be needed in systems about the transparency of which services are commissioned and resourced as priorities to be delivered.

6. In terms of the elective recovery plan, there is an expectation (that will be confirmed within the planning guidance) that the NHS returns to the referral to treatment (RTT) constitutional standard of 92% of patients being seen within 18 weeks. This standard is targeted to be delivered by 2029, with stepped improvement each year. Within the recovery plan, there is an emphasis on patient experience whilst waiting, and we will review the expectation and ensure that we respond appropriately.

7. We are currently working through our internal planning process, and our Board workshop in February will be focussed on 2025/26 plans, so that we can sign off our plan at the Board at the end of March. There is a lot of work to do over the next two months, particularly through discussions with our system partners in both HNY and West Yorkshire.

8. Away from the planning process, nationally there has been an understandable focus on the here and now challenges across the country in relation to urgent care, where a combination of seasonal pressures, flu, and the weather has led to a number of critical incidents. We have experienced significant winter pressures over the last month, and we have enacted our winter plans, including the opening of additional bed capacity earlier than anticipated. Colleagues across the Trust have responded really well, as you would expect, and we have managed the situation well and continued to provide support to others in the system despite the pressure we've experienced.

9. In terms of our local systems, focus continues across HNY to improve urgent care and to manage the financial risk of the system. In terms of impact upon HDFT, the key discussions relate to the financial risk across the system. The current financial risk is significant, with a forecast outturn for the system of a deficit of £45m - £48m. As we discussed before Christmas, we have prepared (as have others across HNY) information in relation to the protocol that signals this risk to NHSE nationally. We are working with partners to continue to manage this process consistently, and as such the protocol has not yet been triggered. This will be reviewed at Month 10.

10. As part of the financial assurance process, there have been sessions with the ICB and the Regional Office of NHSE, which have been challenging. As we have discussed on a number of occasions, HDFT remains a very productive organisation, has strong financial controls as validated by external reviews this year, and has extremely low agency spend. The financial pressure is largely as a result of factors such as funding for pay awards and commissioning issues that we need to resolve with the system. It is important to regularly reinforce the data driven narrative, particularly as we enter into negotiations in respect of 2025/26 plans.

11. In West Yorkshire, we are in the process of our service review across WYAAT trusts, with the aim of strengthening our delivery of high quality care through our WY collaborative. In particular, this will strengthen our partnership working with LTHT, as we seek to maximise the value in what we do together for the benefit of both trusts and importantly the wider population of Leeds and Harrogate. For a part of our Board workshop in February we will be joined by the WYAAT Director for a more in depth discussion about this work.

12. I attended the official opening of the Elective Care hub at Wharfedale Hospital recently. This was attended by colleagues from LTHT as well as the local MP. This was a very positive event and served to reinforce the very strong collaboration that we have with LTHT as well as the opportunities to develop this further.

13. The WYAAT LIMS (laboratory system) programme continues to be rolled out, with HDFT going live with the LIMS at the end of November. This was a successful roll-out, due to the diligence, hard work, and engagement undertaken by our team. This will bring benefits for patients in terms of quality and efficiency of care.

14. We continue to engage well with our Local Authority partners across all of our 0-19 service footprint. As the board will be aware, we will be providing 0-19 services for Cumberland and Westmoreland & Furness local authorities from April. This is a further positive reinforcement of our children's public health approach and we look forward to delivering an improved model of service to the children and families of these areas in partnership with the local councils.

15. We continue to be a strong partner within the local care partnership in Harrogate and district, and we are exploring opportunities with partners to further integrate services for the benefit of our local population.

## HDFT issues

### Introduction

16. As I regularly say, health and care services are services delivered to people by people, and without colleagues who are not just talented but reflect our values, we wouldn't be able to deliver the services we deliver across our hospital and communities. This is shown acutely at the moment, with the winter pressures and associated challenges bringing into focus the effort, kindness, teamwork and positive resilience that is present in many of our colleagues. This attitude is not switched on and off when things are difficult, it is down to the year round focus on what is important, and the importance of how we do things as well as what we do. There will always be areas that we want to improve, but we always need to recognise the care and support delivered every day to thousands of people in many communities, by those who make up HDFT. It is important to always remember this as we wrestle with some of the challenges that we inevitably have to deal with.

### Our people

17. 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. We remain focused on staff availability as a key indicator within the HDFT Impact programme, with a revised emphasis on colleague sickness, given the fact that our vacancy rates are now low.

18. The wellbeing programme of environmental improvement continues and is delivering improvements for colleagues both within the hospital and across our wide community footprint.

19. The national staff survey results have been confidentially released but remain under embargo. There will be an opportunity at a future workshop to explore the outcome in more detail. As discussed at the People and Culture Committee, we will continue to use the feedback from the staff surveys to guide our Gemba visits.

### Our Quality

20. As I mentioned earlier, there has been considerable pressure across the country in respect of urgent care demand. Our winter plan and the actions that we have taken have been focussed on maintaining the quality and safety of our services, and there has been understandably a very operational focus from our leaders over this period of time. As anticipated, there have been challenging days, but we have always endeavoured to protect the safety of our patients and at no time have we initiated 'corridor care'. It should be noted

that there has been a significant contribution to managing flow made by our domiciliary care service.

21. The winter flu jab campaign is a key part of our winter resilience plan. Our staff vaccination rate is over 60% at present, which compares very favourably with other organisations – we have the second highest rate across the North East and Yorkshire region. We continue to communicate with colleagues about the importance of the flu jab in an attempt to ensure that as many colleagues as possible take up the vaccination opportunity.

22. The CQC NHS maternity survey results have been published. This survey took place last year across all maternity providers in the NHS. Of the 57 questions, 47 were as expected in comparison with other units, 10 were better, and there were nil worse than expected. There were no areas where we got worse in year, and two where we had improved. Of note, we scored the highest in the region in relation to triage, which the Board will recall was the only 'must do' area of improvement from our CQC maternity inspection. These are excellent results and reflects the quality of service that is delivered by our maternity team.

23. I reported at the last meeting that we had agreed a new stroke pathway between ourselves, York and Leeds, facilitated by the WY stroke network. We are still finalising the date of implementation of this vital improvement so that it can go live and improve the service for our population. The aim is for this to begin as soon as possible.

## Our Services

24. 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. Of the 45 key mandatory indicators across our nine services, we are delivering against 43.This is very positive and we are engaging some 0-19 teams now in the roll out of HDFT Impact, as we look to improve and deliver strong outcomes.

25. As I have mentioned above, we are in the process of mobilising two new services, with the Directorate and corporate teams working effectively to ensure a safe transition.

26. Our urgent care pathway remains an area of concern in terms of delivering the quality of service we would like to our population, with our ED 4 hour performance in December being 67%, similar to last year, and not where we would want to be. Whilst this mirrors the national trend, and reflects in part the numbers of patients using the ED, we need to stay focussed on the improvement plan in place. As the Board is aware this is a key metric within our Impact programme, and currently is the area where I am most concerned.

27. In relation to cancer, this continues to be a real success story for this year in terms of the improvements that have been made in relation to both our FDS standard and 62 day standard. These are important improvements for the patients we serve.

28. 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. We have run very successful 'super Saturday' clinics, which is a model we will look to repeat regularly across our services. The elective care programme of the ICB performs strongly and is much improved when compared to other ICB areas.

29. I referred earlier that as part of planning for next year that we will need to sharpen discussions with the ICB/system in relation to services being commissioned. There are active discussions in relation to community dental services at the moment. There is a collective requirement to be realistic and transparent about what can be delivered within the resources available, and we are currently engaging partners urgently in some of these issues.

## Our money

30. Our month 9 financial position is a deficit of £12.5m, which is consistent with previous month's forecasts but not in line with achieving the breakeven plan. As I have referenced earlier there are significant discussions across the ICB in relation to the likely forecast outturn for the system, which at present is suggesting an outturn that is worse than the breakeven plan.

31. Our risks continue to relate to funding for the pay award (particularly for funding to be provided to Local Authorities to enable them to transfer funding to ourselves for the 0-19 services we provide), the costs of supporting the urgent care system and providing approved high cost drugs, and an element of our own internal WRAP programme.

32. We have delivered efficiency savings of over £15m in year, the most by the Trust in any year previously.

33. Our productivity performance as a Trust, when compared with the period just before the CoVid pandemic, remains one the best across the NHS, and our agency spend is very low.

## Corporate Risk Register

34. Since the last meeting of the Board in November, no new risks have been added to the Corporate Risk Register. I can confirm that all risks on the Corporate Risk Register have been reviewed in month by the relevant Directorates, Corporate Services, and the Executive Team. As an Executive Team, we have reviewed the risks and the potential impact on the Trust strategy. Any corporate risks impacting on the Trust strategy are detailed in the relevant sections of the Board Assurance Framework. I can confirm that one risk on the Corporate Risk Register has changed in rating during this period. This is CRR94: 24/25 Delivery of the Financial Plan. The risk increased in December 2024 from a rating of 12 to 16. Due to an increase in likelihood. No risks have exceeded their target date and no risks have been removed from the register.

## Other

35. Our capital programme continues to be delivered. Significantly, contractors are due to start construction of our new theatre and imaging building in early February, and we are on track with our EPR programme. We are exploring opportunities to improve the front entrance of the hospital site, and we will bring a proposal to the Board at a later date.

36. As the Board will be aware, Emma will be leaving us for a new role at the end of March. Whilst there will be opportunities to thank Emma over the next couple of months, this will be Emma's last public Board meeting at HDFT. So I just want to record in public my thanks to Emma for her fantastic contribution to HDFT over the last four years and to wish her well. HDFT is a better place for her time here.

**Jonathan Coulter**
**Chief Executive**
**January 2025**

# 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<br><br>*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<br><br>*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<br><br>*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<br><br>*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<br><br>*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<br><br>*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 November 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 the Overarching Financial Position. 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:

- Best Quality, Safest Care: the Breakthrough Objective – Pressure Ulcers has been closed. The Corporate Project – Patient Safety Incident Response Framework (PSIRF) has been closed.
- Healthcare Innovation: Revised Goals being develpped for 2025-26.
- Finance: The risk to achieving this metric has increased to 16

| 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** | |
| **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 | |
| 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 | |
| | 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

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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)

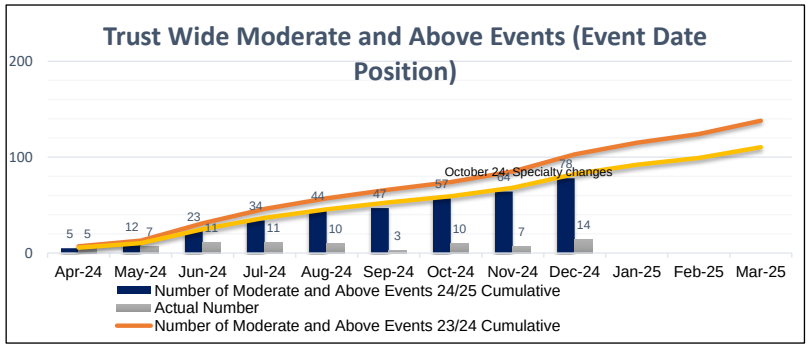
1. **Eliminating Moderate & Above Harm**
2. **Patient Experience Positive Response Rates**

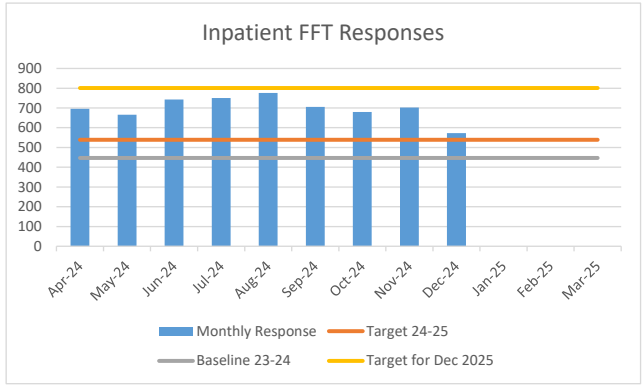
| | |
|---|---|
| **Breakthrough Objective:** | Pressure Ulcers |
| **Corporate Project:** | Patient Experience |
| **Overarching Risk Appetite:** | Clinical - Minimal |

**Overarching Risk Summary:**

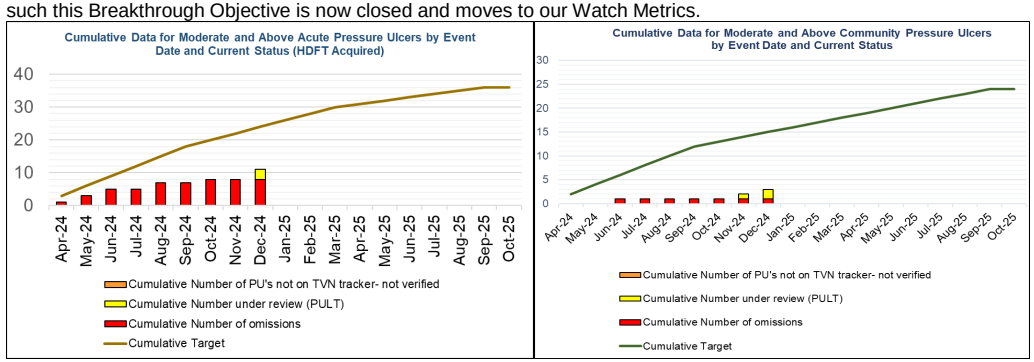
| Ambition | Workstream | True North Metric | Risk Appetite | Level of Risk to Achieve Metric – Linked to Risk Appetite | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20 |
| **Best Quality, Safest Care** | **Ever Safer Care** | **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<br>  <br>Excellent Outcomes<br>  | Eliminate Moderate & Above Harm<br><br>**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<br><br>Short term: 20% reduction each year for 3 years<br><br>Baseline: 170 per annum<br><br>Year 1: 136 now 110<br><br>Year 2: 109<br>Year 3: 87 | The target for Year 1 (2024-25) is 110 or less moderate and above incidents (approximately 9 per month).<br><br>This will be tracked from April 2024.<br><br>Falls Improvement Plan<br><br>Pressure Ulcers Improvement Plan<br><br>Quality Governance Framework in place<br><br>PSIRF Implementation Plan | **Break through Objective: Pressure Ulcers – noted below**<br>April 2024 **–** 5 Moderate and above Safety Events<br>May 2024 – 7 Moderate and above Safety Events<br>June 2024 – 11 Moderate and above Safety Events<br>July 2024 – 11 Moderate and above Safety Events<br>August 2024 – 10 Moderate and above Safety Events<br>September 2024 – 3 Moderate and above Safety<br>October 2024 – 10 Moderate and above Safety Events (data being validated and expected to reduce)<br>November 2024 – 7 Moderate and above Safety Events (data being validated and expected to reduce)<br>December 2024 – 14 Moderate and above Safety Events (data being validated and expected to reduce)<br><br>  <br><br><br>Strong progress continues to be made and the December cumulative position is below trajectory and expected to reduce further when full validation completed for October – December. I.E. once full assessment of level of harm following investigation has been completed. Trajectory would be a cumulative total of 81 incidents by the end of December, the current position stands at 78.<br><br>Of note when the data has been reviewed, Diagnostic, Treatment and Procedure is now the highest linked category of harm events. It is noted that this category has a wide range of themes and further work is required to determine the greatest area of impact.<br><br>No PSIIs were declared in November and December 2024. Including No Never Events declared. | | |

| 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<br><br>**Corporate Project** | For every patient to recommend our services | Long term: Development of a real time engagement tool<br><br>Short term: Increase the response to FFT by 20% over the next 12 months for inpatient (baseline 447)<br><br>By March 2025: 539 responses per month<br><br>By December 2025: 801 responses per month | Corporate Project on social value in development<br><br>Project on increasing engagement led by the Quality Team in development | Corporate Project on the development of a real time patient feedback is detailed in the Corporate Project section below.<br><br>In November 2024, 702 inpatient FFT responses have been inputted at the time of the report being generated.<br>In December 2024 573 inpatient FFT responses have been inputted at the time of the report being generated. Further response will be input during the month. With an average of 96% of patients rating their care good or very good.<br><br>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.<br><br>  <br><br><br>Plan in development of increased engagement in development with a focus on:<br>• Public engagement events<br>• Review of feedback systems (Datix, FFT, Surveys etc)<br><br>Watch Metrics: Complaints compliance at 95% for December 2024. With 22 Response due a response and 21 meeting time scales. | | |

**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 | Significant progress has been made since 1st April 2024 with regards to Pressure Ulcers. The Trust has seen a steady decline in both Acute and Community Acquired Category 3 and 4 Pressure Ulcers. The progress made has ensured that the numbers have remained significantly below the threshold trajectory since the beginning of the financial year. As such this Breakthrough Objective is now closed and moves to our Watch Metrics.<br>  <br><br>PULT = Pressure Ulcer Learning Tool – a method to review individual pressure damage to determine learning to reduce the likelihood of a similar event occurring. | Breakthrough Objective Closed | Breakthrough Objective Closed |

**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<br><br>Continuing to monitor FFT rates and response whilst project in development | Further meetings have taken place in month to develop a high-level plan. Four key workstreams have been implemented:<br>* Friends and Family Test Improvements: Working group continues to progress with good engagement and a business proposal is being drafted to present a number of options to improve collection methods and reporting. Monthly reports are now being delivered to Directorate QALs and admin staff, for a You Said, We Did approach, and until a more sustainable method can be found, we are ensuring any negative comments received via Netcall are being transcribed so we can identify any concerns more immediately.<br>· Real-time listening event: trial real-time listening event with focus on KITE values took place on the 28th of November 2024. The event and responses will be evaluated over the coming months. The evaluation of the real-time listening event will guide HDFT's Patient Experience Corporate Project.<br>· Patient Experience Team (PET) Visibility event: The listening event provide an opportunity to consider future events. Placement at the front of the hospital to gather feedback was less successful than anticipated.<br>· Feedback systems improvement: to seek improvements in the wider feedback and reporting systems available. Such as looking at trialling kiosks and other digital feedback methods, scoping exercise to see what feedback non-NHS organisation utilise to inform improvements and heighten customer experience, and to develop robust processes for sharing non-complaint feedback (FFT, surveys etc) with services and departments to inform change and improvements. This is included as part of the business proposal to update FFT/survey software that would provide a more centralised approach, more accessible reporting and thematic analysis and review of feedback weekly/monthly. | | |
| **Ever Safer Care** | Patient Safety Incident Response Framework (PSIRF) | Implementation of PSIRF | PSIRF Policy<br>PSIRF Plan<br>PSIRF Lead | PSIRF implementation continues at pace. The PSIRF Policy and Plan were developed 12 months ago and are now embedded within the organisation with a clear focus on areas of safety actions. On-going training continues across the organisation. In month, revised PSIRF template documents have been signed off by the Patient Safety Event Committee (PSEC).<br>The Corporate Project remained open whilst the last action was completed. This was to appoint a permanent PSIRF Lead. This has now concluded successfully. | **Project Complete** | **Project Complete** |
| **Ever Safer Care** | Accreditation | Implementation of a full Accreditation Programme | Accreditation Steering Group and wider Governance Arrangements<br>Accreditation Lead<br>Accreditation Workplan | Progress continues with the Accreditation framework. A clearly defined framework and governance arrangements are in place. There is ongoing work in building the resilience in the accreditation assessment team by increasing membership that will allow for a regular review schedule to be implemented. A wider communication strategy is in production with the development of internal and external webpages. | | |

**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. | | | | | |

teamHDFT At our best

# Visitor's Charter

NHS Harrogate and District NHS Foundation Trust

**We have created this charter to explain what you can expect from us during your visit and what we would like from you in return.**

## What you can expect from our staff:

### Supportive care

- Supporting patients to define their "family" and how they would like them to be involved in care, care planning and decision making
- Protected mealtimes: to provide a dedicated mealtime for patients, free from interruptions or distractions

### Information Sharing

- Providing a clear explanations regarding care and treatment
- Ensuring patient consent is given prior to sharing information with visitors
- Arranging time for you to speak to the ward manager or consultant to address any concerns about patient care or safety

### Privacy, Dignity & Respect

- Being polite & respectful at all times
- Politely ask you to leave when necessary e.g. to ensure patient confidentiality, privacy and dignity

### Infection Prevention

- Ensuring appropriate hand hygiene is adhered to at all times
- Complying with infection prevention control measures

## What we expect from our Inpatient & Outpatient visitors:

### Supporting Care

- Speak with nursing staff if you wish to be involved in supporting care according to patient preference
- Understand that occasionally you could be asked to temporarily leave the ward
- Help facilitate timely discharge as appropriate through planning with the wards, when appropriate
- Protected Mealtimes should be recognised and adhered to (unless support is being provided to the patient)

### Information Sharing

- Inform staff of any specific needs of the patient
- Ensure that personal information cannot be shared with visitors without the patients' consent
- Speak with the nurse in charge if you have any questions, worries, concerns or compliments – we welcome all feedback

### Privacy, Dignity & Respect

- Please be polite and courteous, and follow advice and guidance provided by hospital staff
- Anyone displaying aggressive or abusive behaviour may be asked to leave

### Infection Prevention

- Clean your hands thoroughly on both entering and exiting any ward or department
- Avoid visiting if you are unwell; if you have diarrhoea, vomiting or flu like symptoms do not visit until you have been clear of symptoms for 48 hours

- Children **under the age of 12 years** are welcome to visit relatives. However, this needs to be **checked with the Nurse In Charge** on the ward.
- Alternatively, if patients are well enough they could meet their young relatives at the coffee shop at the main entrance of Harrogate District Hospital which would be a better environment for children.
- **Scan the QR Code** with your Smart Phone Device for further information regarding visiting hours for each ward.

SCAN ME

2.2

# 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
- 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 Status | 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 by 10% | Revised Goals in November 2024<br><br>Goal 1: To achieve 90% or above on the performance of all mandated health child programme contacts – June 2025<br><br>Goal 2: To deliver the Great Start in Life pathway to all eligible children in Darlington and increase outcomes of agreed KPIs linked to Public Health high impact areas – from January 2026<br><br>Goal 3: Baseline for Darlington children graduating into universal services established – January 2025 | Revised Countermeasures will report in December 2024 and from January 2025. | The areas where we are currently not meeting delivery of the mandated healthy child program within national timescales consecutively for four months are; Co Durham 6-8wks and 2.5year reviews (due to pressures in the South of the county) and Wakefield new antenatal and new birth visits. Countermeasures for CYPD Exec PRM now updated to reflect the countermeasures required to support improvement. | | |
| 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.<br><br>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.<br><br>Develop a CYP Shadow Board with representation from | To embed the "Hopes for Healthcare" principles in all HDFT services | We have engaged with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare.<br><br>We have Great Start in Life Young Advisors and committees across the full geography of the Trust.<br><br>We have developed 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.<br><br>*Noted that National Institute of Health Visiting would like to publish HDFT's CYP 12 month project.* | Goal Achieved | Goal Achieved |

| Workstreams | Strategic Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving Goal (CxL) | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|---|
| | | | HDFTs geography who will provide consultancy to HDFT Board and Services | | Our Great Start in Life Committees will provide consultancy when required to the Trust and act as a CYP Shadow Board<br><br>**11.11.24** CYP Patient Experience Tool designed and built into Survey Monkey and MS Forms linked to a QR Code for each Directorate. Directorates are currently working together and with our GSIL Young Advisors to design Posters for Clinical Areas to display the QR Codes and strategies to increase uptake of Surveys. Data will be accessible by the central Patient Experience Team. The CYP PH Directorate will share a monthly Report including 'You Said We Did' Action which will be consulted by our GSIL Committees and Advisors.<br><br>**Next Steps:** countermeasures to be developed by Directorates. Further input into wider Corporate Project: Patient Experience. | | |
| 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 | Ensure staffing in the right place at the right time with the right skills. | One maternity divert occurred in December with one women being diverted.<br><br>The diverts will mainly be reduced by increased staffing at night. There may be some activity management however this is not the main area of impact.<br><br>Midwifery staffing establishment business case being developed.<br><br>Paediatric nurse staffing review ongoing – reviewing impact of Children's Admission Unit on requirements.<br><br>Completed review of allocation of staff to on call to ensure equity. | | |

| Workstreams | Strategic Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving Goal (CxL) | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|---|
| | | | | | Review of on call processes for hospital and homebirth to be completed once decision made regarding staffing model and budget.<br><br>SOP being developed for process returning from maternity leave and working nights.<br><br>Further details can be found in the Maternity Strengthening report. | | |

**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<br>March 25 | Clinical: Patient Safety | Minimal |

**Related External Risks**

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

Harrogate and District NHS Foundation Trust

3.2

# Strengthening Maternity and Neonatal Safety Report

## SMT

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

# STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT



## 1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of November 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 One new risks added to the risk register relating to the risk to staff burnout and patient pathways due to challenges to Consultant rota (Score 6). Locum Consultant recruited and will commence in post in March 2025.

## 6.0 Recommendation

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

# Maternity December 2024 (November data)

| Matters of concern & risks to escalate | Major actions commissioned & work underway |
|---|---|
| *Obstetric/Gynaecological Consultant gap created by sickness and maternity leave – covered by substantive Consultants. Interim Clinical Leads for Obstetrics and Gynaecology in place.*<br><br>*Increased risk to patient experience and key performance indicators due to clerical staffing issues.* | • *Maternity workforce business case being written*<br>• *MAC call monitoring – awaiting telecomms*<br>• *Perinatal Culture action plan progressing*<br>• *Saving Babies Lives Care Bundle being embedded*<br>• *Day unit activity / MAC action plan progressing*<br>• *Maternity Incentive scheme submission being prepared*<br>• *Planning implementation of National Incentive Scheme for stop smoking*<br>• *On-going recruitment to midwifery vacancies*<br>• *Progressing training to uplift Band 2 Maternity Support Workers to Band 3*<br>• *Working to improve compliance on Tendable*<br>• *Training courses agreed for Professional Midwifery Advocates, Newborn Infant Physical Examination and Sonography.*<br>• *Induction of Labour project on-going.*<br>• *FFT focused area of improvement.*<br>• *Considering Generation genomics research study*<br>• *Pannal garden donation to be installed in January*<br>• *RSV vaccination continues with 50% uptake*<br>• *On-going work regarding improving consent process*<br>• *Safeguarding – work on-going with ensuring processes up to date and communication sharing processes in place*<br>• *Pregnancy and Birth Revisited waiting list increasing therefore being reviewed*<br>• *MNSI quarterly meeting occurred in November* |
| **Positive news & assurance** | **Decisions made & decisions required of QGMG** |
| • *Maternity Strategy published*<br>• *CQC Maternity Survey published – HDFT is in top 5 in country for service user experience in Triage and Assessment category*<br>• *NHSP usage reducing as establishment staffing increases*<br>• *Enhanced care funding received to improve offer to vulnerable families* | *Perinatal culture board report* |

**Narrative in support of the Provider Board Level Measures – November 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.** A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
**b.** 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)),
**c.** 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

Explanatory notes are available in Appendix A.

## 2. Obstetric cover on Delivery Suite, gaps in rota

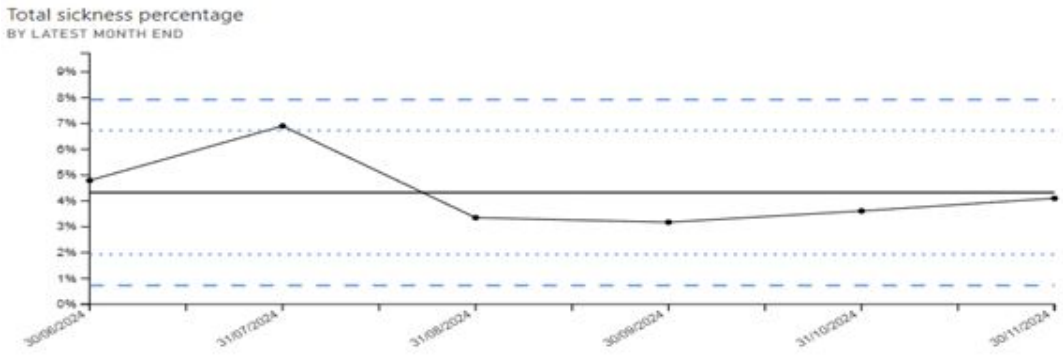
Appropriate cover has been provided to Delivery Suite during the month of November 2024. Due to long term sickness and maternity leave the rota will be reduced to 1:4.5 from January. Recruitment of a Locum Consultant has taken place and this person will be in post from March to cover maternity leave.

## 3. Midwifery safe staffing, vacancies and recruitment update

The Birthrate plus establishment setting report has been completed (Appendix A). 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 recent completion recommends the total clinical, specialist and management midwifery staffing should be 77.86WTE with 1.92WTE of the midwifery workload being provided by a Maternity Support Worker. These calculations include the current allowance of 20.78% uplift for annual, sick and study leave. Birthrate plus states this is at the lower end of the range of uplift seen across England of between 21 - 25%, and increasingly more Trusts are building in 23 to 24% to provide sufficient cover for study leave requirements. Utilising a 24% uplift would increase the midwifery requirement to 80.56WTE. Further review is ongoing to apply professional judgement and review at Directorate level. A staffing report is included in Appendix A.

### a. Absence position

Total sickness remains below 4%, 3.12WTE midwifery and 0.69WTE maternity support workers absence. 7.04WTE midwives are on maternity leave at present.




Staff in Post - Registered

| Year | Month | Day | Substantive FTE | Bank FTE | Agency FTE | Total FTE | Budget FTE | Vacancy FTE | In Pipeline FTE | Vacancy Rate | Maternity Leave FTE | FTE lost to sickness | Substantive minus sick and maternity | Staff Unavailability number without B&A played in |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | April | 30 | 78.35 | 3.23 | | 81.58 | 74.68 | -3.67 | | -4.91% | 5.71 | 2.46 | 70.18 | 4.50 |
| 2024 | May | 31 | 75.85 | 3.95 | | 79.80 | 74.68 | -1.17 | | -1.56% | 5.71 | 2.69 | 67.45 | 7.23 |
| 2024 | June | 30 | 75.35 | 3.79 | | 79.14 | 74.68 | -0.67 | | -0.89% | 5.83 | 3.03 | 66.49 | 8.19 |
| 2024 | July | 31 | 74.15 | 4.00 | 0.68 | 78.82 | 74.68 | 0.53 | | 0.71% | 6.03 | 4.45 | 63.67 | 11.01 |
| 2024 | August | 31 | 74.37 | 4.45 | 0.21 | 79.03 | 74.68 | 0.31 | | 0.42% | 6.03 | 2.33 | 66.01 | 8.67 |
| 2024 | September | 30 | 75.33 | 5.65 | 0.52 | 81.50 | 74.68 | -0.65 | | -0.87% | 7.95 | 2.57 | 64.82 | 9.86 |
| 2024 | October | 31 | 76.13 | 4.36 | 0.56 | 81.05 | 74.68 | -1.45 | | -1.95% | 7.75 | 3.05 | 65.33 | 9.35 |
| 2024 | November | 30 | 76.40 | | | 76.40 | 74.68 | -1.72 | | -2.30% | 7.04 | 3.12 | 66.24 | 8.44 |

Staff in Post - Unregistered

| Year | Month | Day | Substantive FTE | Bank FTE | Agency FTE | Total FTE | Budget FTE | Vacancy FTE | In Pipeline FTE | Vacancy Rate | Maternity Leave FTE | FTE lost to sickness | Substantive minus sick and maternity | Staff Unavailability number without B&A played in |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | April | 30 | 16.12 | 2.20 | | 18.32 | 16.28 | 0.16 | | 0.98% | 1.20 | 1.82 | 13.10 | 3.18 |
| 2024 | May | 31 | 16.12 | 2.51 | | 18.63 | 16.28 | 0.16 | | 0.98% | 1.20 | 0.80 | 14.12 | 2.16 |
| 2024 | June | 30 | 16.12 | 2.35 | | 18.47 | 16.28 | 0.16 | | 0.98% | 1.20 | 1.34 | 13.58 | 2.70 |
| 2024 | July | 31 | 15.51 | 3.54 | | 19.05 | 16.28 | 0.77 | | 4.75% | 1.20 | 1.72 | 12.59 | 3.69 |
| 2024 | August | 31 | 14.71 | 3.45 | | 18.16 | 16.28 | 1.57 | | 9.66% | 1.20 | 0.65 | 12.86 | 3.42 |
| 2024 | September | 30 | 16.51 | 3.04 | | 19.54 | 16.89 | 0.38 | | 2.27% | 1.20 | 0.30 | 15.00 | 1.89 |
| 2024 | October | 31 | 15.91 | 2.35 | | 18.26 | 16.89 | 0.98 | | 5.82% | 0.60 | 0.27 | 15.04 | 1.85 |
| 2024 | November | 30 | 16.43 | | | 16.43 | 16.89 | 0.46 | | 2.74% | 0.60 | 0.69 | 15.14 | 1.75 |

### b. Vacancy position

As demonstrated above there remains a vacancy of 5.3 WTE midwives when maternity leave cover is taken in to account however 4.3 WTE midwives are awaiting a start date.

### c. NHSP provision

Midwives -
Demand for NHSP midwives has continued to reduce this month as new staff commence in post.

Support workers –


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

**a. Neonatal absence position**

1.12 WTE nurse currently on maternity leave. 0.92 WTE non-QIS nurse long term sickness absence.

**b. Neonatal Vacancy**

1.22WTE remaining vacancy for QIS nurses due to candidate withdrawal. No appointable applicants from previous advert therefore to be re-advertised. 0.92WTE QIS nurse to commence post maternity leave April 2025.

**c. Qualified in Speciality (QIS) Nurses**

SCBU is budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS nurses. This equates to 8.274 WTE. The Operational Delivery Network (ODN) have clarified that the QIS compliance is based on staff in post excluding any vacancy. November QIS compliance was 67%.

There are plans in place to improve compliance with QIS staffing. All nurses working on SCBU are to be QIS qualified and the banding has been adjusted to Band 6 to reflect this. This will enable additional resilience in the event of short notice sickness. Recruitment to Band 6 QIS posts has taken place and staff already in post are undergoing training to become QIS qualified however the training can take up to two years. QIS compliance remains on the risk register for the department.

**5. Birthrate Plus Acuity Staffing Data**

**a. Delivery Suite Staffing and impact on clinical workload**

During November there were 16 Midwife shifts left uncovered (112 hours) and 22 Maternity Support Worker shifts left uncovered on the roster (170 hours). All shifts had been released to NHSP but not all had been filled. According to the Birthrate Plus acuity data capture there were delays in commencing induction of labour on eleven occasions and 31 incidences of delay in continuing induction of labour, two women's induction of labour was postponed whilst they were at home. 100% of women received one to one care in labour.

### b. Pannal Ward Staffing and impact on clinical workload

The Birthrate Plus Ward Acuity App had a 72.5% 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. During November, there were 34 Midwife shifts left uncovered and 15 maternity support worker shifts left uncovered on the roster. All shifts had been released to NHSP. According to Birthrate Plus acuity tool 64% of shifts have been at least one staff member short over the course of the month.

There were 11 elective section lists with 21 women in total on these lists. There were no elective caesarean sections completed on delivery suite during November which is a significant improvement.

There were twelve babies who received Transitional Care (TC) provision on Pannal Ward.

## 6. Red Flag Events Recorded on Birthrate Plus

### a. 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 no Red Flags recorded on Birthrate Plus during November 2024.

### b. Pannal Ward Red Flags

There were six occasions where there was a Red Flag identified from the Birth Rate plus Data. Three occasions related to 'Delayed or cancelled time critical activity', two occasions related to delayed pain relief and one occasion of delay in induction process.

During November there was one delay in induction of labour of over 24 hours which is an improvement on the previous month.

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

### a. Mandatory training (as at 01/12/24)

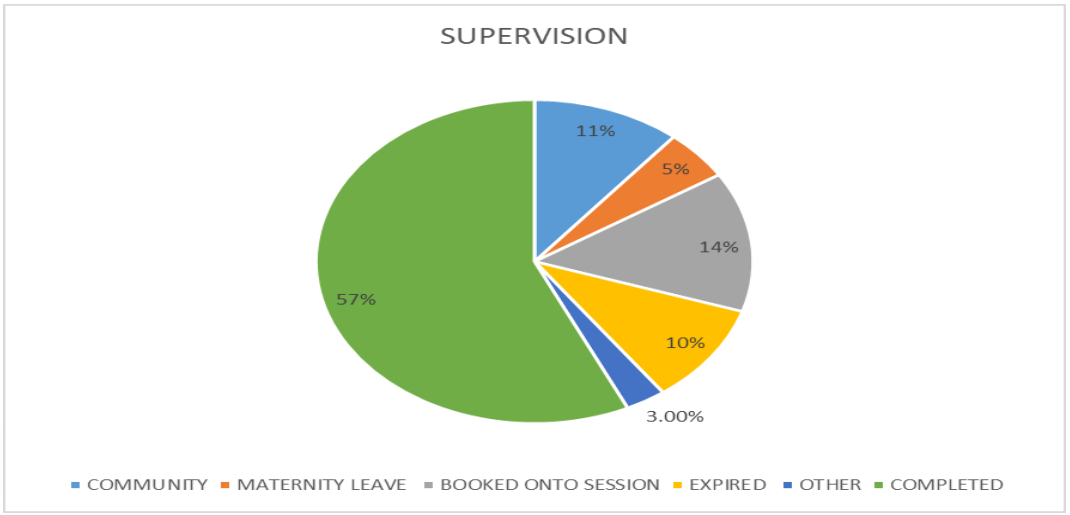
| Department | Assignment Count | Percentage Compliant |
|---|---|---|
| 421 Level 4 Ante Natal Clinic | 10 | 85% |
| 421 Level 4 Community Midwifery | 23 | 84% |
| 421 Level 4 Early Pregnancy Assessment Unit | 4 | 92% |
| 421 Level 4 Maternity Staffing | 56 | 83% |
| 421 Level 4 Obs & Gynae - Medical Staffing | 28 | 86% |
| 421 Level 4 Pannal Ward | 24 | 80% |

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

All requirements for the Maternity Incentive scheme in relation to training were met in November. Work is on-going to ensure all staff groups with training below 90% have a plan for improving this.

| Course Name | Midwives | Obstetric Consultants | Obstetric (Other Staff) | Anaesthetics Consultants | Anaesthetics (Other Staff) | Paediatric Consultants | Paediatric (Other Staff) | Maternity Support Worker |
|---|---|---|---|---|---|---|---|---|
| Adult Basic Life Support with paediatric modifications | 89% | 75% | 78% | | | 78% | 66% | 67% |
| Harrogate Immediate Life Support (HILS) | 58% | | | | | | | |
| Harrogate Advanced Life Support (HALS) | | | | 81% | 80% | | | |
| Harrogate Newborn Intermediate Life Support (HNILS) | 96% | | | | | | | |
| Harrogate Newborn Advanced Life Support (HNALS) | | | | | | 78% | 74% | |
| RCUK Newborn Life Support | 90% | | | | | 89% | 78% | |
| MAT - Growth Assessment Protocol (GAP) | 94% | 88% | 90% | | | | | |
| LMNS Fetal Wellbeing Competency Assessment | 96% | 100% | 100 % | | | | | |
| MAT – Maternity Training Day 2 | 96% | 100% | 100 % | | | | | |
| MAT - Prompt | 95% | 88% | 94% | 89% | 100% | | | 67% |
| MAT - Saving Babies Lives | 84% | 88% | 80% | | | | | |
| Safeguarding Adults | 78% | 100% | 100 % | 88% | 92% | 89% | 69% | 88% |
| Safeguarding Children | 93% | 100% | 90% | 100% | 100% | 90% | 70% | 90% |

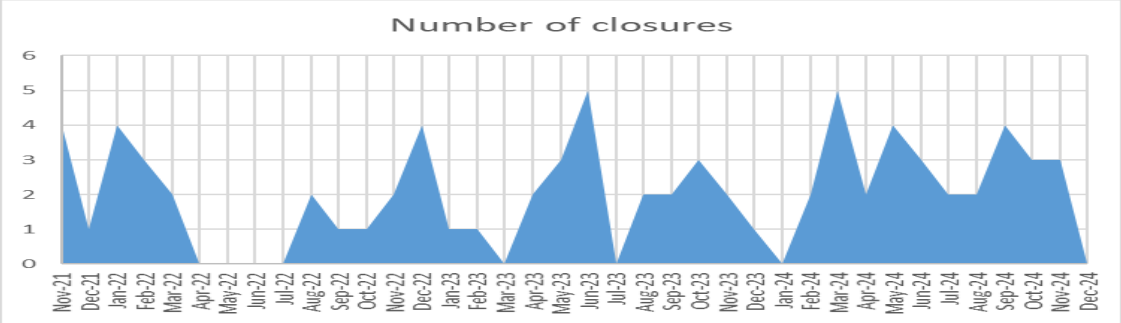
### c. Midwifery Safeguarding Supervision



## 8. Risk and Safety

### a. Maternity unit divert

There has been three events of divert of the unit in November 2024. No women were diverted elsewhere during these periods. Work is on-going to understand how divert can be avoided at periods of high activity and acuity. Staff availability at night has been identified to be impacting on divert being enacted and this is being reviewed as part of the staffing review.




### b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place, supported by the Local Maternity and Neonatal Systems, to review staffing, activity and the number of women awaiting induction of labour across the regions. During the month of November two women were captured in local paper records as being transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process or labour care.

### c. SCBU Incidents

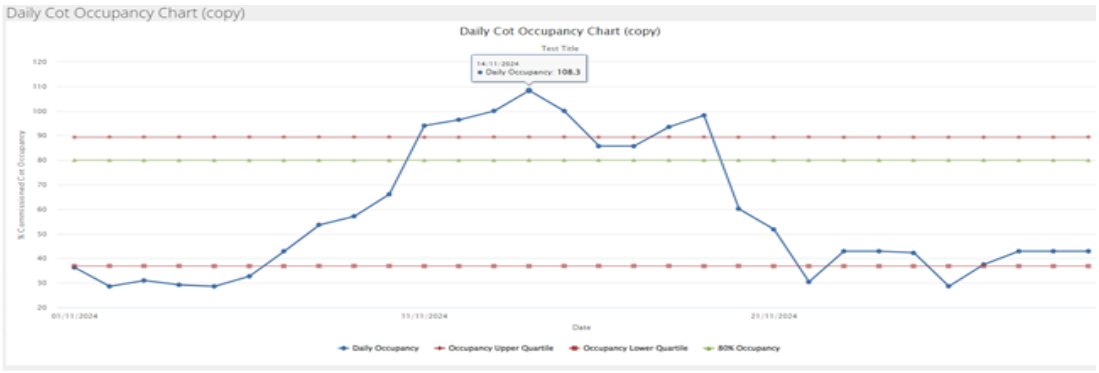
No moderate harm incidents.

### d. SCBU Risk Register

Vacancy of QIS staff remains on risk register.

### e. Cot occupancy and babies transferred out

Two babies were transferred out as medically indicated. Cot occupancy in November 2024 was 61%.



### f. Maternity Risk register summary

Risk Register formally reviewed in November 2024

One new risks added:

- Risk to staff burnout and patient pathways due to challenges to Consultant rota (Score 6). Some Consultant absences due to sickness and maternity leave which will result in risk to consultant obstetric cover. Locum consultant cover recruited and will commence in post in March 2025. On-call cover being prioritised but risk to staff burnout. Potential inability to meet compensatory rest and impact upon antenatal clinic and gynaecology elective work post on-call.

Twelve pre-existing active risks

- Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).
- Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8).
- Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8).
- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8).
- Risk of breaching NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6).
- Risk to patient experience due to delays in scheduling process for elective caesarean section (Score 6). Agreement to downgrade risk score.
- Risk due to inability to meet gold standard requirements for clinical documentation (Score 5).
- 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).
- Risk to patient safety due to lack of robust sharing of safeguarding information (Score 3).
- Risk to patient safety and satisfaction due to need to undertake elective caesarean section within Delivery Suite theatre (Score 2). Risk remains but likelihood of issue reduced due to additional elective list capacity. Downgraded to target.
- Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 2). Risk downgraded to target. Consider closure at next review if process continues working well.

Risks Closed:

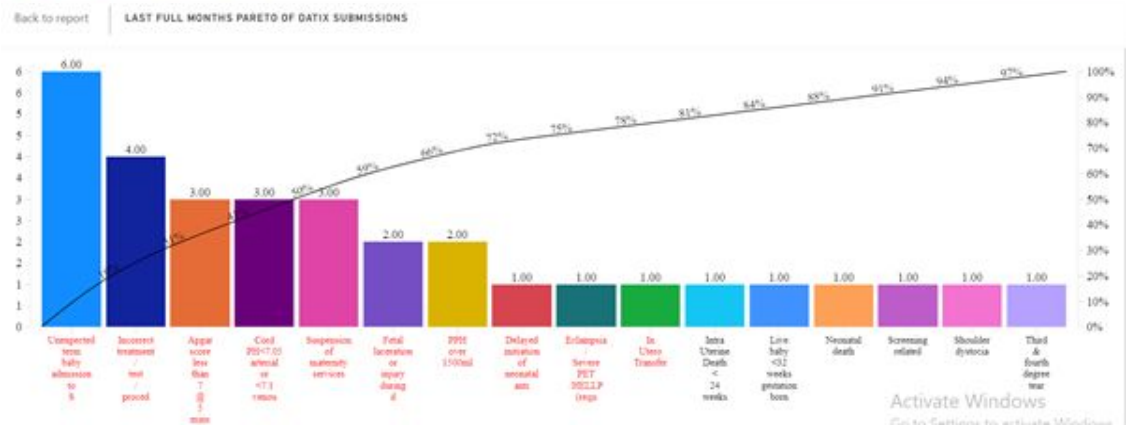
- Risk to patient safety and accurate data recording resulting from potential manual entry and transcription error of blood group in BadgerNet (Score 2). Agreement to accept risk and decision to archive.

### g. Maternity Incidents

In November 2024 there were 53 total incidents reported through DCIQ.

One moderate harm incident was reported in November for a baby who sustained a fractured clavicle during a difficult extraction at elective caesarean section. Duty of Candour letter has been sent. Though this represents a possible injury during delivery, some learning was identified in relation to the management of the baby following discharge who required two attendances for review of a bruise before x-ray was considered.

The number of incidents reported are as follows –




Link to the Power BI dashboard –

https://app.powerbi.com/groups/1e44fd58-1b56-4af1-9c97-003e92cd51b3/reports/d8178f25-948e-49f9-a8a7-98684cb0207b/854c5fe77200b430484d?action=OpenReport&pbi_source=ChatInTeams&bookmarkGuid=a1cd8e03-bc78-41bd-a709-6a98fe7b2ca6

**9. Perinatal Mortality Review Tool (PMRT)**

**a. HDFT PMRT Information**

No open cases.

**11. Feedback**

**a) CQC Maternity Survey**

This CQC survey looked at the experiences of pregnant women and new mothers who used NHS maternity services in 2024. Women who gave birth between 1 and 29 February 2024 were invited to participate. The report identifies NHS trusts where experiences of care were better or worse than expected when compared with survey results across all trusts in England. The analysis method used allows for an overall picture of performance across the survey, considering results for all evaluative (scored) questions simultaneously. Each trust has been assigned one of five bands according to their overall performance across the survey: 'much worse than expected', 'worse than expected', 'about the same', 'better than expected' or 'much better than expected'.

140 service users completed the survey for Harrogate Maternity Services out of 275 service users invited to take part. This equals a 51% response rate. Of the 57 questions asked Harrogate performed about the same as all other Trusts for 47 questions, somewhat better than expected in four questions, better than expected in six questions, and significantly better in two questions in comparison with last year. No questions scored somewhat worse, worse or much worse than expected. In relation to the Triage: Assessment and Evaluation section of the survey Harrogate maternity services scored as the fifth highest performing Trust in England with a score of 9.1 in comparison to a National average score of 8.4.

The results also demonstrate a significant improvement in two question responses in comparison with the previous year's results. A statistically significant different results means it is unlikely that this would have been obtained if there was no real difference (just be chance). The two questions were;

C11 - Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

D6. - Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

The area requiring most work according to the results relates to information, advice and decision making regarding induction of labour. Work had commenced on this area of care prior to receiving these results and a information pack has been developed with the support of the Maternity Voices Partnership and is discussed with service users undergoing induction of labour.

**b) Maternity Service User feedback – via Maternity Voices Partnership**

| Date feedback collected | Date of care | What was good about your experience with maternity services in Harrogate within the last 5 years? | What would you have liked to have been different about your experience with maternity services? | Do you have any ideas and suggestions? |
|---|---|---|---|---|
| 07/11/2024 | Pregnant and baby born in Aug 2023 | Friendly staff<br>Postnatal care on Pannal ward was excellent | Mine is a high risk pregnancy (twins) so whilst I am at hospital a lot, it is very medicalised and I think the holistic care of midwife-led care is missing. It my third pregnancy too so at 28 weeks I've not seen the community midwife for 3 months. | Nothing comes to mind. |
| 07/11/2024 | Pregnant | I have good, positive experience with the maternity services in Harrogate | | |
| 07/11/2024 | Pregnant and baby in 2022 | Lovely staff | Long wait times for appointments in pregnancy | Literally nothing everything is amazing other than wait time |
| 07/11/2024 | Pregnant. Previous baby in Leeds | Staff was always very helpful | I couldn't really change much as every appointment has gone smoothly for myself | Maybe more time range in the antenatal classes |
| 07/11/2024 | Pregnant and baby in March 2023 | Very caring<br>Prompt | Giving birth – didn't believe I was very far dilated when I was 8cm | A summary of the birth afterwards |

## 12. Complaints

Five formal complaint notifications received in November

- Complaint relating to ANC staffing, mental health, breastfeeding support and safeguarding
- Complaint relating to communication and informed choice, staffing and postnatal support
- Complaint relating to preterm birth and transfer to York, communication and follow up
- Complaint relating to skull fracture (April 2024) and safeguarding follow up
- Complaint awaiting consent (relating to diversion of patient to Braford during escalation)

One additional concern relating to missed community midwife appointment.

One formal compliment received through Patient Experience Team relating to positive antenatal classes.

## 13. Coroner 28 made directly to Trust

No Regulation 28 notifications have been received.

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

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

**15. Maternity and Newborn Safety Investigation (MNSI)**

No new MNSI incidents have been reported in November 2024.

**16. 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.

A Trust Board report is being completed for this year's requirements, detailing 100% compliance with the required standards and will be brought next month for sign off prior to reporting to NHS Resolution.

**17. National priorities**

**a) Three Year Delivery Plan For Maternity And Neonatal Services**

An action plan is in place that documents the steps required and completed to meet the requirements of this document. Significant progress has been made in meeting the requirements. The remaining actions relate to saving babies lives compliance and continuity of carer.

**b) Stop Smoking**

Harrogate Maternity team have been invited to join the National Smoke Free Pregnancy Incentive Scheme which will further enhance the local tobacco dependency advisor's role to encourage people to stop smoking during their pregnancy pathway. In November two women have been referred to the in-house tobacco dependency service and two women have achieved a four week quit.

**c) Vaccination**

Ninety-nine Respiratory Syncytial Virus (RSV) vaccinations have been administered this month and nine Pertussis (whooping cough) vaccines have been administered.

**d) Continuity of Carer**

No update this month.

**e) NHS England Perinatal Culture And Leadership Programme**

See Appendix B

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

Dashboard under review. Planning to move to North East and Yorkshire Dashboard.

**18. Local HDFT Maternity Services Dashboard**

**Maternity Dashboard**

## 19. Avoiding Term Admissions in Neonatal Units (ATAIN)

### a. Term Admissions to SCBU

There were four Unexpected Term Admissions to SCBU (ATAIN) in November 2024 noted from BadgerNet Neonatal. All cases are reviewed by the ATAIN MDT panel.

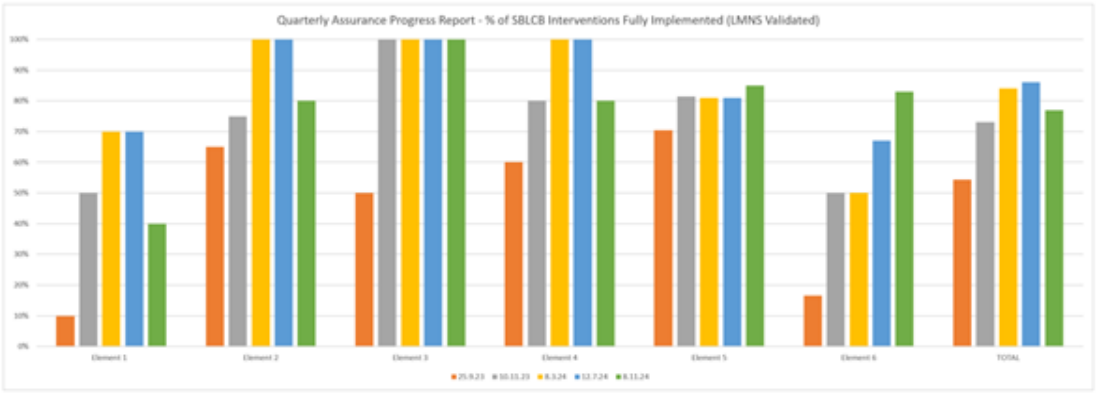
### b. ATAIN actions

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 | 30/04/24<br>On audit schedule. Quality improvement work ongoing. |
| 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<br>Additional requirement to monitor theatre environmental temperature. QI project planned |
| Reluctance for Pannal Ward staff to administer unfamiliar IV antibiotics | Review process and consider additional training requirements | 31/12/2024<br>Under consideration whether additional training required in view of rarity of uncommon antibiotics |
| Lack of consistency in obtaining satisfactory consistent newborn oxygen saturations | Production of short video on good practice for newborn oxygen saturations | 31/12/2024<br>Neonatal Educator producing video |
| Lack of clarity of identification of TC babies and consistent ward round | Production of TC leaflet for parents and laminated door labels for identification | 31/12/2024 |
| Neonatal staff being called simply to take SBR bloods | Review current provision and training requirements to support SBR by midwifery staff | 31/12/2024<br>Pannal Ward Manager following up with staff to check training requirements |
| Babies requiring numerous repeat SBR tests with prolonged jaundice | Amendment to guideline to enable Neonatal resident second on-call to be able make clinical decision to discontinue further testing | 31/12/2024 |

## 20.0 Saving Babies Lives' v3 (released 31 May 2023)

Both West Yorkshire and Harrogate LMNS and Humber and North Yorkshire LMNS attended the Maternity Risk Management Group in November to assess the compliance position. An action plan is in place, work is on-going, and compliance is reassessed by the LMNS quarterly. There has been a reduction in compliance this month on the LMNS assessment due to a manual audit data required to be collated for element one and two. Audits from Badgernet do not provide the required data unfortunately due to numerous recording and reporting fields being available. The team are confident that manual data audit will demonstrate an improvement in compliance.




## 21.0 Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. Positive service user feedback was received on the walk around on 18th November regarding the care provided. It was raised by a service user partner that there is no window in the bay on Pannal and the environment would have been nicer with a window. The Delivery Suite intercom had been awaiting repair to the microphone for a longer than ideal length of time at the time of the walk around. This has now been repaired.

## 22.0 Conclusion and recommendation

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

## Appendix A - Explanatory notes

### 1. Birthrate Plus Acuity Staffing Data

The Birthrate Plus acuity 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 Ward, 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. Due to recording the acuity four hourly there can be numerous occurrences of one event, for example the unit being placed on divert. The unit may be on divert for 12 hours which could be captured three times in this data. 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)

### 2. Red Flag Events Recorded on Birthrate Plus

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.*

### 3. Perinatal Mortality Review Tool (PMRT)

**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.

**4. 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.

**5. 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 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

**Appendix B**

## Perinatal Culture and Leadership Programme Overview and Outcomes

### 1. Introduction

This paper is intended to provide Trust Board with a summary of the Perinatal Cultural Leadership Programme, attended by members of the Perinatal Leadership Quadrumvirate, including insight into the SCORE culture survey findings and actions, successes, and achievements, identified areas for improvement, next steps and any Board level support required.

The national ambition is that every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme (PCLP). The intention of the programme is that every service completed work to meaningfully understand the culture of their services. This included the offer of undertaking a SCORE culture survey. Culture and Engagement are important because

- They reflect the behaviours and beliefs within an organisation.
- There are behaviours that create value individually, for the patient and the organisation.
- There are behaviours that create unacceptable risk.
- These attitudes and behaviours are reflected in how people interact with each other both internally and externally with patients and their families.
- Culture and Engagement are the social glue.

HDFT maternity and neonatal services were invited to join the third cohort of the programme in October 2023.

The Perinatal Leadership Quadrumvirate:

- Leanne Likaj, Associate Director of Midwifery
- James Wright, Operations Director, Planned and Surgical Care (PSC)
- Katherine Johnson, PSC Clinical Director, Consultant Obstetrician and Gynaecologist
- Patricia Gilbertson, Neonatal Clinical Lead, Consultant Paediatrician

The Perinatal Quadrumvirate attended four face-to-face events, individual action learning sets, and group learning sets with quadrumvirate members from other Trusts, over a six month period which were intended to support a positive and nurturing safety culture in perinatal services.

The programme culminated with the completion of the SCORE culture survey in all areas of the maternity and neonatal services, and external support was provided to assist in the analysis of the results and identified areas for improvement and action.

### 2. Summary of Learning

- Opportunity for the Perinatal Quadrumvirate to examine and reflect on their individual leadership styles, strengths, weaknesses, how they complement/ support each other as a quadrumvirate
- Opportunity to actively seek feedback on individual approach

### 3. Agreed collective vision/aspirations for the service

- Reflected on positive working relationships between neonatal and maternity colleagues
- At the time of the initial Quad face to face events and action learning sets, maternity and neonatal teams sat in separate directorates. It was established that closer working relationships of the management team would benefit the service
- Anaesthetic involvement would have been of benefit
- Pregnant people, babies and families are central to everything we do

### 4. Themes / insights from the SCORE culture survey

The SCORE survey had a 28% response rate overall.

Staff responded positively on the following elements:

- Positive team working
- Improvement and learning ready
- Local leadership recognised as being available at predictable times
- Being able to use their strengths and make a meaningful difference
- Feel safe being treated here as a patient
- Positive safety culture
- Can positively influence decision making
- High job certainty and plans to stay at the organisation

### 5. Areas for improvement:

- Staff rated emotional recovery related to work as low
- Staff felt frustrated by technology
- Staff didn't feel they received enough feedback about their performance
- Personal burnout domain scores were raised

### 6. Action taken:

- Neonatology and acute paediatrics move to Planned, Surgical and Children directorate.
- A number of key staff received training as 'Culture Coaches' to support and facilitate conversations with staff.
- Subsequent Listening Sessions were held to understand the issues further.

### 7. Themes / insights from the Listening Sessions

- Leadership - Leaders could do more on listening and wellbeing
- Staffing - skill mix could be improved and ensuring staff get breaks is important
- Environment and Technology – Technology not being maintained and appropriate for requirements.
- Workload and burnout – staffing gaps and complexity of workload impacting on wellbeing

**8. Achievements following the programme to date:**

- Perinatal Culture action plan developed
- HDFT Impact rolled out to ensure staff are involved in decision making
- Homebirth support reviewed and line manager oversight and clarity of availability of escalation communicated
- Training reviewed and headroom calculations adjusted
- Midwifery establishment review completed
- Maternity Support Worker Lead role re-implemented
- Additional Listening sessions scheduled
- Rosters reviewed for equity
- Support requested from IT to ensure technology is fit for purpose
- New Employee Assistance Programme reviewed and agreed. Details to be shared with staff once confirmed to support staff wellbeing
- Increased oversight of breaks not being taken.
- Ersoter rules implemented to ensure Working Time Directives not breached.

**9. Next steps:**

- Progress on the Perinatal Culture Leadership Programme and staff culture are included in the monthly perinatal update paper. This is the proposed method of how we continue to ensure this work remains visible.
- The Perinatal Culture action plan is monitored via Maternity and Quality Assurance Meeting
- Continue roll out of HDFT Impact

**10. Board Level Support Required:**

There are no current issues or concerns identified by the Perinatal Quadrumvirate requiring Board Level Support. Any future issues will be discussed at the Perinatal Safety Champion Meetings and any escalations requiring Board support will be presented by the Non-Executive Safety Champion representative.

**11. Plans to oversee and sustain this work following the Perinatal Culture and Leadership Programme:**

It is recommended that updates on the culture in Perinatal Services, including progress on SCORE, staff surveys, responses to local intelligence, will continue to be discussed at the Bi-monthly Perinatal Safety Champion meetings and included in the monthly Perinatal Services Update paper.

Any identified concerns or issues following the Perinatal Safety Champion meetings, requiring Board level support, will be escalated to Quality Committee and Trust Board.

There are no current issues identified by the Perinatal Quadrumvirate requiring Board level support.

Harrogate and District NHS Foundation Trust

3.2

# Strengthening Maternity and Neonatal Safety Report

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

# STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT



## 1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of December 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

The report covers the provider Board level measures required as part of the perinatal surveillance model. The report also includes additional neonatal measures.

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

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

Not applicable.

## 5.0 Risks and Mitigating Actions

No new risks.

## 6.0 Recommendation

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

# Maternity January 2025 (December 2024 data)

| Matters of concern & risks to escalate | Major actions commissioned & work underway |
|---|---|
| | • Maternity workforce business case being written<br>• MAC call monitoring – awaiting telecomms<br>• Perinatal Culture action plan progressing<br>• Saving Babies Lives Care Bundle being embedded<br>• Day unit activity / MAC action plan progressing<br>• Planning implementation of National Incentive Scheme for stop smoking<br>• On-going recruitment to midwifery vacancies<br>• Progressing training to uplift Band 2 Maternity Support Workers to Band 3<br>• Working to improve compliance on Tendable<br>• Induction of Labour project on-going.<br>• FFT focused area of improvement.<br>• Considering Generation genomics research study<br>• RSV vaccination continues with 50% uptake<br>• On-going work regarding improving consent process<br>• Safeguarding – work on-going with ensuring processes up to date and communication sharing processes in place<br>• Pregnancy and Birth Revisited waiting list increasing therefore being reviewed |
| **Positive news & assurance** | **Decisions made & decisions required of QGMG** |
| Pannal garden donation installation commenced in January<br>Maternity Incentive Scheme compliance standards met | **Maternity Incentive Scheme Report – sign off required by Trust Board**<br>Perinatal culture board report<br>PMRT Quarterly report<br>ATAIN Quarterly report<br>Neonatal Readmissions Quarterly report |

**Narrative in support of the Provider Board Level Measures – December 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.** A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
**b.** 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)),
**c.** 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

Explanatory notes are available in Appendix A.

## 2. Obstetric cover on Delivery Suite, gaps in rota

Appropriate cover has been provided to Delivery Suite during the month of December 2024. Due to long term sickness and maternity leave the rota will be reduced to 1:4.5 from January. Changes have occurred in the Clinical Lead role to cover the period of absence. Recruitment of a Locum Consultant has taken place and this person will be in post from March to cover maternity leave.

## 3. Midwifery safe staffing, vacancies and recruitment update

The Birthrate plus establishment setting report was completed in August 2024. The recent completion recommends the total clinical, specialist and management midwifery staffing should be 80.56 WTE using a 24% uplift for annual, sick and study leave. Birthrate plus states increasingly more Trusts are building in 24% uplift to provide sufficient cover for study leave requirements. The current funded establishment is 74.97 WTE (plus 6.03 WTE on maternity leave). Birthrate plus calculations don't include calculations for support staffing required in the clinical areas and this requires professional judgement. Currently there is a funded establishment for support staff of 13.6 WTE. A business case is being written to request to increase the establishment as required.

### a. Absence position

Total sickness in December was 3.07 WTE midwifery and 1.06 WTE maternity support workers absence. 6.03 WTE midwives are on maternity leave at present.

### b. Vacancy position

There remains a vacancy of 1.62 WTE midwives and 1.21 WTE maternity support workers. 3.32 WTE midwives are due to start work shortly. Maternity support worker interviews are taking place on 16th January.

### c. NHSP provision

Midwives -
Demand for NHSP midwives has continued to reduce this month as new staff commence in post.


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.

Three homebirths were booked for the month of December 2024. One woman birthed at home. Two women transferred or birthed in the hospital. One baby was born before arrival of the midwife (BBA). No homebirths were suspended due to unavailability of on call.

In the period 01/12/24 – 31/12/24, the home birth on call provision was unavailable on six occasions due to unexpected sickness and no volunteers to cover. The number of staff working longer days has been identified to be impacting on the availability of staff for on call shifts. This is under review with the support of HR.

5. **Neonatal services Special Care Baby Unit (SCBU) staffing, vacancies and recruitment update**
    a. **Neonatal absence position**

1.12 WTE nurse currently on maternity leave. 0.92 WTE non-QIS nurse long term sickness absence.

    b. **Neonatal Vacancy**

There remains a 1.2 WTE vacancy for QIS nurses. No appointable applicants from previous advert therefore to be re-advertised. A 0.92 WTE QIS nurse is planned to commence post maternity leave April 2025.

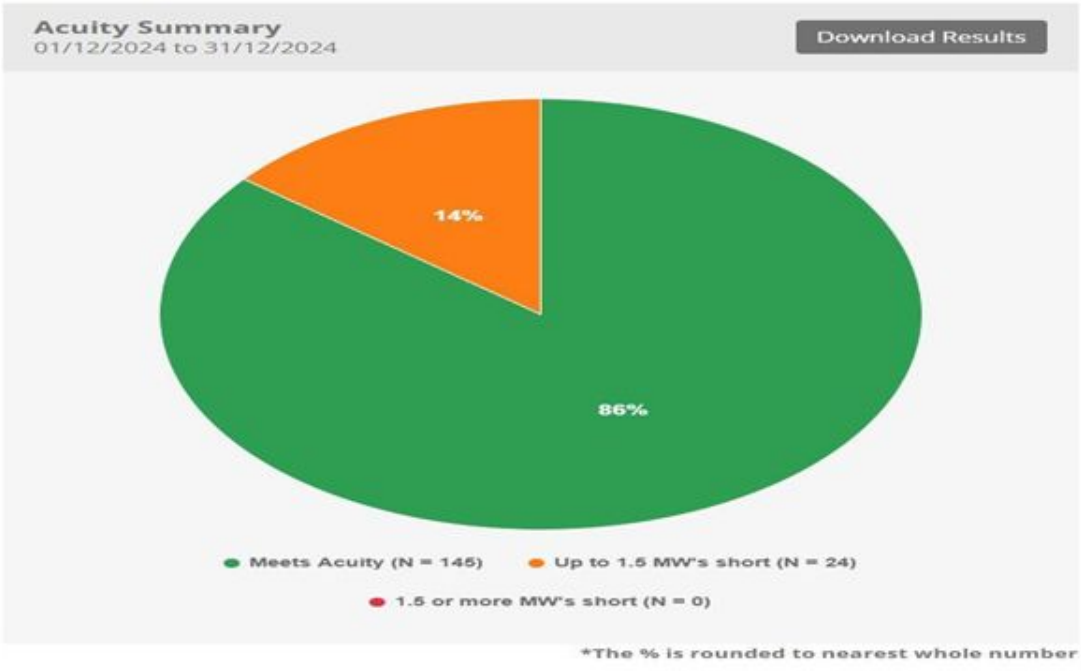
    c. **Qualified in Speciality (QIS) Nurses**

SCBU is budgeted for 11.82 WTE overall. To meet British Association Perinatal Medicine (BAPM) standards 70% of this is required to be QIS nurses. This equates to 8.274 WTE. The Operational Delivery Network (ODN) have clarified that the QIS compliance is based on staff in post excluding any vacancy. December QIS compliance was 67%.

There are plans in place to improve compliance with QIS staffing. All nurses working on SCBU are to be QIS qualified and the banding has been adjusted to Band 6 to reflect this. This will enable additional resilience in the event of short notice sickness. Recruitment to Band 6 QIS posts has taken place and staff already in post are undergoing training to become QIS qualified however the training can take up to two years. QIS compliance remains on the risk register for the department.

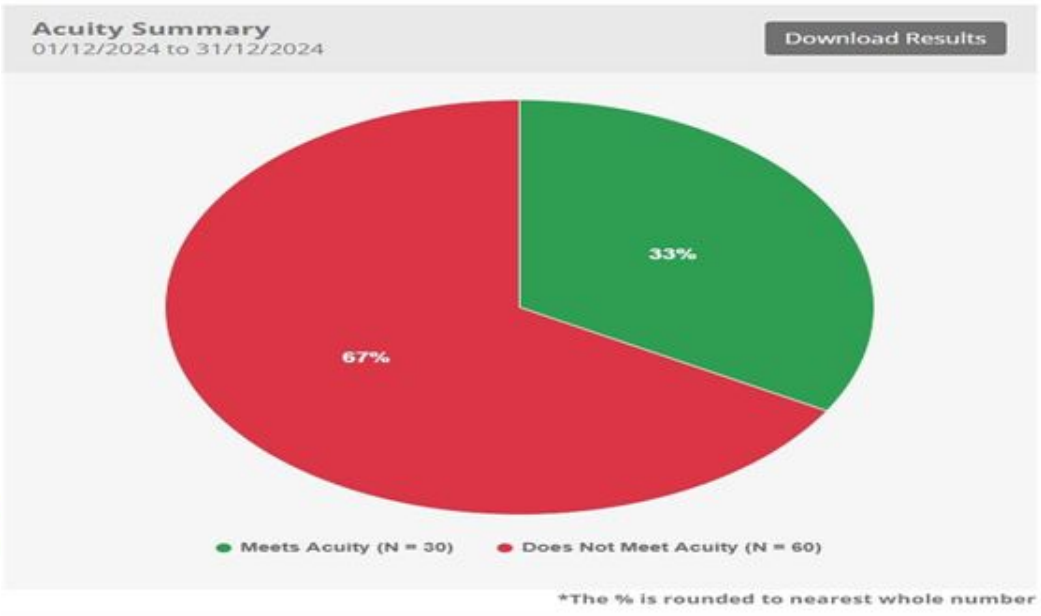
6. **Birthrate Plus Acuity Staffing Data**
    a. **Delivery Suite Staffing and impact on clinical workload**

During November there were 29 Midwife shifts left uncovered (212 hours) and 40 Maternity Support Worker shifts left uncovered on the roster (296 hours). All shifts had been released to NHSP but not all had been filled. According to the Birthrate Plus acuity data capture there were delays in commencing induction of labour on six occasions and 27 incidences of delay in continuing induction of labour, two women's induction of labour was postponed whilst they were at home. On six occasions during a shift the Delivery Suite Co-ordinator has been unable to maintain supernumerary status overnight however this has quickly been resolved. A supernumerary delivery suite co-ordinator was rostered and available at the start of every shift. 100% of women received one to one care in labour. Staffing has been maintained at no more than 1.5 midwives short throughout December.




**b. Pannal Ward Staffing and impact on clinical workload**

The Birthrate Plus Ward Acuity App had a 72.5% 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. During December, there were 39 Midwife shifts left uncovered and 33 maternity support worker shifts left uncovered on the roster. All shifts had been released to NHSP. According to Birthrate Plus acuity tool 44% of shifts have been at least one staff member short over the course of the month, with staffing not meeting acuity 67% of the time.



On further review this is due to insufficient midwifery and support staff being available.

**Number of Staffing Factors**
01/12/2024 to 31/12/2024

Download Results

| Factors | Breakdown of Factors | Times occurred | Percentage |
|---|---|---|---|
| SF1 | Unexpected MW absence/sickness | 8 | 20% |
| SF2 | MW redeployed to other area | 3 | 7% |
| SF3 | Unexpected support staff absence/sickness | 3 | 7% |
| SF4 | Unable to fill vacant MW shifts | 11 | 27% |
| SF5 | Unable to fill vacant support staff shifts | 15 | 37% |
| SF6 | Staff on transfer duties | 0 | 0% |
| SF7 | Support staff redeployed to other area | 1 | 2% |
| SF8 | Admin staff less than rostered numbers | 0 | 0% |
| TOTAL | | 41 | |

*The % is rounded to nearest whole number

Staff have been redeployed where possible to support the ward with the clinical activity however there has been an impact on staff being unable to take their breaks and two episodes of delayed clinical activity recorded.

There were 19 elective section lists with 24 women in total on these lists. There were no elective caesarean sections completed on delivery suite during December.

There were six babies who received Transitional Care (TC) provision on Pannal Ward.

**7. Red Flag Events Recorded on Birthrate Plus**

**a. 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 was one Red Flag recorded on Birthrate Plus during December 2024 due to a ‘delayed or cancelled time critical activity’. Appropriate actions were taken to manage the situation.

**b. Pannal Ward Red Flags**

There were no occasions where there was a Red Flag identified from the Birth Rate plus Data.

During December there was one delay in induction of labour of over 24 hours which is consistent with the previous month.

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

### a. Mandatory training (as at 01/01/25)

| Department | Assignment Count | Percentage Compliant |
|---|---|---|
| 421 Level 4 Obs & Gynae - Medical Staffing | 27 | 83% |
| 421 Level 4 Pannal Ward | 23 | 85% |
| 421 Level 4 Ante Natal Clinic | 10 | 85% |
| 421 Level 4 Community Midwifery | 21 | 86% |
| 421 Level 4 Maternity Staffing | 52 | 87% |
| 421 Level 4 Early Pregnancy Assessment Unit | 4 | 93% |

| Course Name | Midwives | Obs& Gynae Consultants | Obs& Gynae (Other Staff) | Anaesthetics Consultants | Anaesthetics (Other Staff) | Paediatric Consultants | Paediatric (Other Staff) | Maternity Support Worker |
|---|---|---|---|---|---|---|---|---|
| Adult Basic Life Support with paediatric modifications | 93% | 86% | 82% | | | 67% | 65% | 88% |
| Harrogate Immediate Life Support (HILS) | 69% | | | | | | | |
| Harrogate Advanced Life Support (HALS) | | | | 71% | 79% | | | |
| Harrogate Newborn Intermediate Life Support (HNILS) | 94% | | | | | 89% | 70% | |
| Harrogate Newborn Advanced Life Support (HNALS) | | | | | | | 100 % | |
| RCUK Newborn Life Support | 93% | | | | | 100 % | 79% | |
| MAT - Growth Assessment Protocol (GAP) | 97% | 100 % | 89% | | | | | |
| LMNS Fetal Wellbeing Competency Assessment | 96% | 100 % | 90% | | | | | |
| MAT – Maternity Training Day | 96% | 100 % | 100 % | | | | | |
| MAT - Prompt | 97% | 100 % | 100 % | 80% | 100 % | | | 88% |
| MAT - Saving Babies Lives | 91% | 86% | 89% | | | | | |
| Safeguarding Adults | 76% | 86% | 94% | 89% | 92% | 89% | 67% | 100 % |
| Safeguarding Children | 87% | 71% | 72% | 94% | 100 % | 100 % | 60% | 50% |

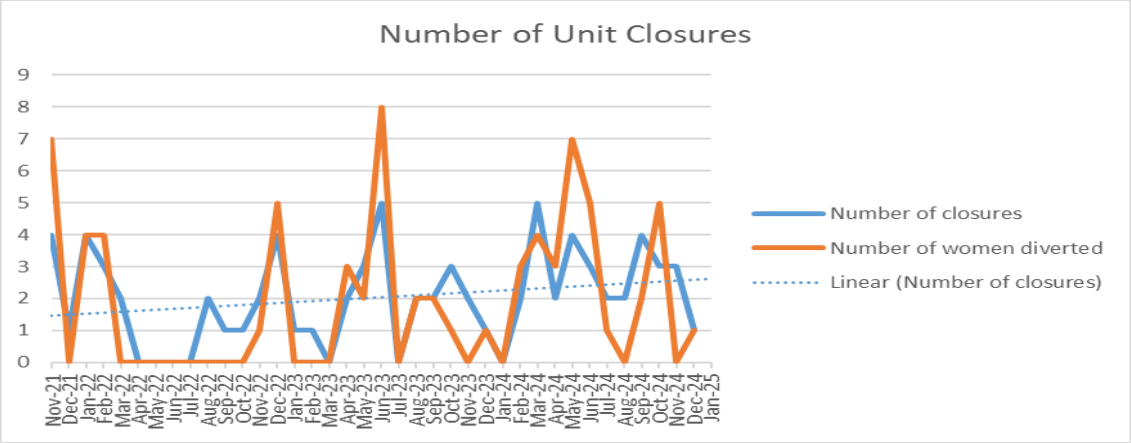
### b. Maternity Incentive Scheme and Core Competency version 2 Training Compliance

Steps are being taken to improve compliance in all areas currently reporting below 90%.

## 9. Risk and Safety

### a. Maternity unit divert

There has been one events of divert of the unit in December 2024. One woman was diverted elsewhere during this periods. Work is on-going to understand how divert can be avoided at periods of high activity and acuity. Staff availability at night has been identified to be impacting on divert being enacted. A business case is being developed to request an uplifted midwifery establishment at night to resolve this issue.




### b. Maternity Accepted Diverts

A daily (Monday – Friday) regional meeting is in place, supported by the Local Maternity and Neonatal Systems, to review staffing, activity and the number of women awaiting induction of labour across the regions. During the month of December one woman was captured in local paper records as being transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process and labour care.

### c. SCBU Incidents

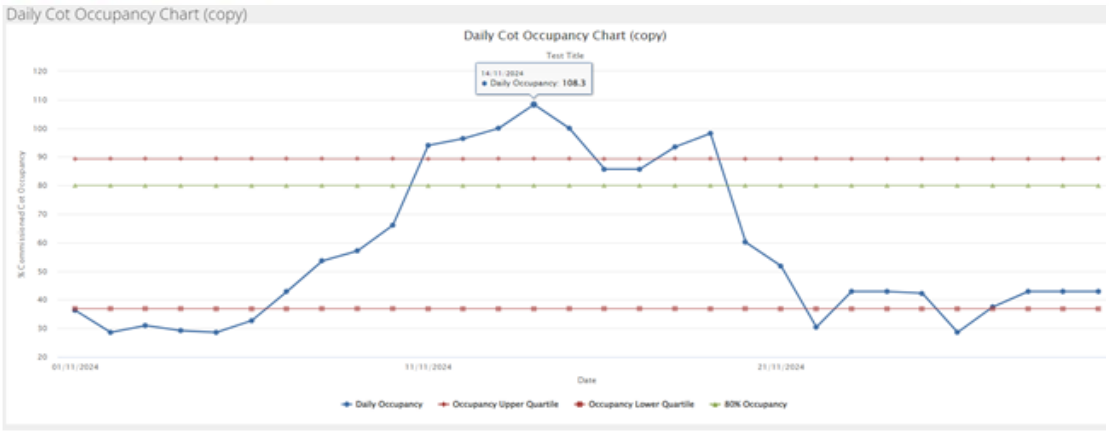
No moderate harm incidents.

### d. SCBU Risk Register

Vacancy of QIS staff remains on risk register.

### e. Cot occupancy and babies transferred out

One baby was transferred out for surgical review and cot occupancy in December 2024 was 57%.




### f. Maternity Risk register summary

The Risk Register was formally reviewed in November 2024. No new risks have been added. 12 pre-existing active risks;

- **Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10).** Interim staff in place. Backfilling being supported by service manager and clerical officer. New staff start dates planned 6th January 2025. Situation being managed daily. Score unchanged at present.
- **Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8).** No significant change at present. Further recent incident relating to informed consent. Some work ongoing about patient access to information leaflets. No change to score.
- **Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8).** Work ongoing. Now 2 WTE vacancies. Recruitment has occurred but gaps in roster remain and issues ongoing. Staffing review being completed. Risk score remains the same at present
- **Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8).** Planning additional staffing to support MAC. Datix submissions not currently being received relating to breaches. Staff struggling with paperwork and documentation of breach times. Work ongoing about removal of day unit activity. For audit of timeframes and breaches. Consideration of real-time monitoring of situation of data capture.
- **Risk of breaching NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6).** No change at present. To follow up with Service Manager for review of service level agreement. Score remains unchanged at present.
- **Risk to patient experience due to delays in scheduling process for elective caesarean section (Score 6).** Occurrence of patient satisfaction issues reduced recently due to additional list capacity. Process for booking of lists improved but still requires additional process mapping and improvement to be able to stand down lists if not required. Planned driver metric within HDFT Impact work. Agreement to downgrade risk score at present.
- **Risk to staff burnout and patient pathways due to challenges to Consultant rota (Score 6).** Some Consultant absences currently and planned which will result in risk to consultant obstetric cover. Locum consultant cover recruited but unable to commence in post until March 2025. On-call cover being prioritised but risk to

staff burnout. Potential inability to meet compensatory rest and impact upon antenatal clinic and gynaecology elective work post on-call.

- **Risk due to inability to meet gold standard requirements for clinical documentation (Score 5).** Work ongoing on risk assessment and management plans. Video produced for staff. Not a new risk as was similar issue with paper records but now more obvious within electronic patient record system. Risk to remain unchanged at present.
- **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).** Plans in place for continuity of carer implementation for vulnerable groups and teenage pregnant patients. Proposal submitted to H&NY LMNS for additional funding to support recruitment of additional staff/resources to support continuity of carer. Not yet in place but work proceeding when capacity to implement. Risk score remains the same.
- **Risk to patient safety due to lack of robust sharing of safeguarding information (Score 3).** Some additional issues identified in relation to backwards sharing of safeguarding information i.e. information entered within the Maternity service cannot be seen if attending Emergency Dept. Consider that there should be an opportunity for a summary of safeguarding at birth to be shared within WebV. Named Midwife for Safeguarding following up with Digital midwife. Risk score remains unchanged.
- **Risk to patient safety and satisfaction due to need to undertake elective caesarean section within Delivery Suite theatre (Score 2).** Risk remains but likelihood of issue reduced due to additional elective list capacity. Downgraded to target.
- **Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 2).** Additional list in place. Risk downgraded to target. Consider closure at next review if process continues working well.

### g. Maternity Incidents

In Dec 2024 there were 50 total incidents reported through DCIQ.

One severe harm incident was reported in December for a patient who suffered a uterine rupture at 19 weeks. A RROSE review was completed and the actions of emergency department and obstetric team were commended. A Duty of Candour letter is in preparation.

An additional incident of maternal hyponatraemia due to water intoxication also occurred in December. Patient had initial symptoms of confusion but recovered well without need for further treatment. In view of occurrence after recent work on fluid balance, a RROSE review was completed. After review some good practice was noted with fluid balance, recognition of positive fluid balance and appropriate request for blood test. However, upon recognition of low sodium, patient should have been more strictly fluid restricted. Action in place for additional emphasis about management when hyponatraemia recognised.

Further details regarding the types and number of incidents reported during December can be found on the Power BI dashboard –

https://app.powerbi.com/groups/1e44fd58-1b56-4af1-9c97-003e92cd51b3/reports/d8178f25-948e-49f9-a8a7-98684cb0207b/854c5fe77200b430484d?action=OpenReport&pbi_source=ChatInTeams&bookmarkGuid=a1cd8e03-bc78-41bd-a709-6a98fe7b2ca6

## 10. Perinatal Mortality Review Tool (PMRT)

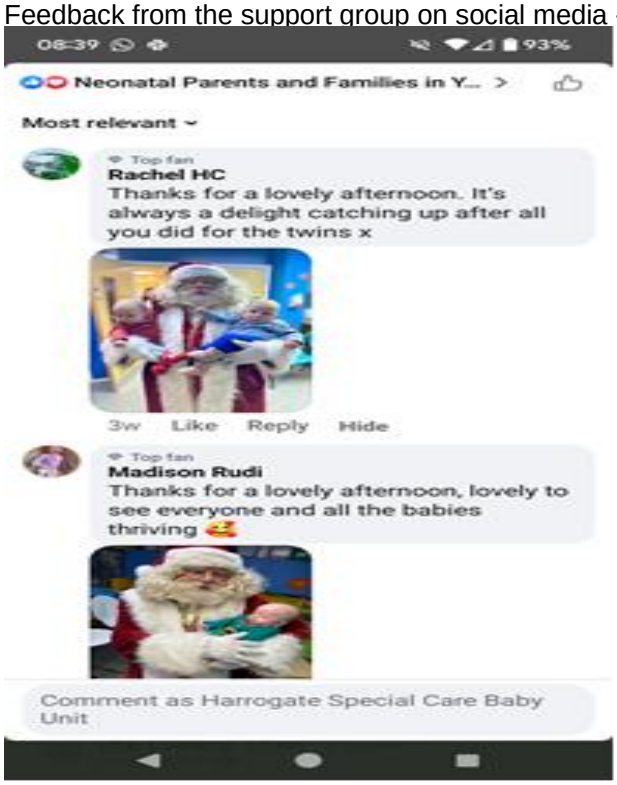
### a. HDFT PMRT Information

A quarterly report is attached at Appendix B. This document provides a summary of current compliance against Safety Action 1 of the Maternity Incentive Scheme (MIS) for the second quarter, October-December 2024. During Quarter 3, there were two perinatal deaths eligible to be reported to MBRRACE-UK. This included a neonatal death at 21+4 weeks' gestation and a medical termination of pregnancy at 25+0 weeks' gestation. These cases were only reportable to MBRRACE-UK and do not meet the criteria for a PMRT review.

## 11. Feedback

### a. Neonatal service user feedback

Feedback from the support group on social media -




### b. Maternity Service User feedback – via Maternity Voices Partnership

| Date feedback collected | Date of care | What was good about your experience with maternity services in Harrogate within the last 5 years? | What would you have liked to have been different about your experience with maternity services? | Do you have any ideas and suggestions? |
|---|---|---|---|---|
| 05/12/2024 | Currently pregnant | My community midwife and MH liaison team have managed to fit me in with extra appointments when needed which has massively helped and made me feel very validated. | I have no concerns with my care and am looking forward to having my baby girl at HDFT. | I feel very strongly about 'birth revisited' for anyone who feels they need it. My sister missed out on this which I feel would have benefitted her hugely and potentially impacted on if she will have another baby. |

| | | | | |
|---|---|---|---|---|
| 05/12/2024 | Currently pregnant | Very thorough, lots of information shared. | Access to more reading around pregnancy / birth etc. - I spoke to this lady and she said she didn't know about the leaflets in BadgerNotes! | None other than try have appointments on time. |
| 05/12/2024 | Currently pregnant | The staff are friendly, professional.<br>They provide us about all the information we need. | Waiting time. | |
| 05/12/2024 | Currently pregnant | Friendly staff. Nice welcoming atmosphere in waiting room. | Hospital parking a bit difficult. | |
| 05/12/2024 | Currently pregnant Previous pregnancy in 2019 (Oct - July 19) | All appointments were received in a timely manner (and on time).<br>MAC - really relaxed, helpful and welcoming for advice, monitoring and when my waters went pre-c-section date.<br>Completely different experience at Harrogate compared to my 1st at LGI. Much smoother, more personal.<br>All test results have been acted upon super quick too.<br>Side room available after c-section made world of difference. | N/A - I would have all my care here.<br><br>Only thing at the moment Badger app and pregnancy notes (Leeds/Horsforth) don't link smoothly. | |

**10. Complaints**

Three formal maternity complaint notifications received by PET in December

- Unspecified concerns about birthing experience in May 2024 – awaiting consent and further details
- Concerns about gentamicin overdose in Oct 2024 and mislabelled blood bottle resulting in additional blood test
- Concerns regarding care during birth

Additional concerns/feedback:

- Concern about antenatal and postnatal care
- Concern by a patient that she should have been given aspirin in pregnancy to reduce risk of pre-eclampsia

One formal compliment received through Patient Experience Team relating to positive experience of midwifery care by two staff members.

**11. Coroner 28 made directly to Trust**

No Regulation 28 notifications have been received.

**12. 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.

**13. Maternity and Newborn Safety Investigation (MNSI)**

No new MNSI incidents have been reported in December 2024.

**14. 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 ended on 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. A Trust Board report has been completed for this year's requirements, detailing 100% compliance with the required standards for sign off prior to reporting to NHS Resolution. Please see separate Board Paper.

**15. National priorities**

**a) Three Year Delivery Plan For Maternity And Neonatal Services**

An action plan is in place that documents the steps required and completed to meet the requirements of this document. Significant progress has been made in meeting the requirements. The remaining actions relate to saving babies lives compliance and continuity of carer.

**b) Stop Smoking**

Harrogate Maternity team have been invited to join the National Smoke Free Pregnancy Incentive Scheme which will further enhance the local tobacco dependency advisor's role to encourage people to stop smoking during their pregnancy pathway. In December four women have been referred to the in-house tobacco dependency service.

**c) Vaccination**

72% of women who birthed in December and received antenatal care from HDFT were vaccinated against Respiratory Syncytial Virus (RSV). New systems are in place to ensure out of area women are given opportunities to receive vaccinations in pregnancy.

**d) Continuity of Carer**

No update this month.

**e) NHS England Perinatal Culture And Leadership Programme**

Work is ongoing on the action plan as per the submission last month.

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

The dashboard remains under review. A North East and Yorkshire Dashboard is being developed to replace the Yorkshire and Humber dashboard.

**18. Local HDFT Maternity Services Dashboard**

[Maternity Dashboard]

**19. Neonatal admissions**

**a. Avoiding Term Admissions in Neonatal Units (ATAIN)**

All cases are reviewed by the ATAIN MDT panel. Please see the attached quarterly report in Appendix C.

**b. Neonatal readmissions**

All neonates readmitted within 28 days are reviewed monthly. A quarterly report is contained at Appendix D.

**20.0 Saving Babies Lives' v3 (released 31 May 2023)**

Both West Yorkshire and Harrogate LMNS and Humber and North Yorkshire LMNS attended the Maternity Risk Management Group in November to assess the compliance 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 | 40% | Partially implemented | 40% | Action plans in place |
| Element 2 | Fetal growth restriction | Partially implemented | 95% | Partially implemented | 95% | Action plans in place |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | Fully met |
| Element 4 | Fetal monitoring in labour | Partially implemented | 80% | Partially implemented | 80% | Action plans in place |
| Element 5 | Preterm birth | Partially implemented | 85% | Partially implemented | 85% | Action plans in place |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | Fully met |
| All Elements | TOTAL | Partially implemented | 83% | Partially implemented | 83% | Action plans in place |

**21.0 Maternity Safety Champions**

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue. The next meeting is scheduled in January.

**22.0 Conclusion and recommendation**

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

## Appendix A - Explanatory notes

### 1. Birthrate Plus Acuity Staffing Data

The Birthrate Plus acuity 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 Ward, 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. Due to recording the acuity four hourly there can be numerous occurrences of one event, for example the unit being placed on divert. The unit may be on divert for 12 hours which could be captured three times in this data. 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)

### 2. Red Flag Events Recorded on Birthrate Plus

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.*

### 3. Perinatal Mortality Review Tool (PMRT)

**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.

**4. 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.

**5. 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 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

**Appendix B**

**Compliance of completion of Perinatal Mortality Review Tool, Quarter 2, July-September 2024**

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

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

Requirements of the Maternity Incentive Scheme Safety Action 1:

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

Compliance of eligible perinatal deaths with MIS requirements

| MBRRACE-UK Case ID | Date of death | Date of birth | Reported to MBRRACE (within 7 working days) | Review started (within 2 months) | Report published (within 6 months) | Parents informed of review and questions/concerns sought |
|---|---|---|---|---|---|---|
| 95993 | 6.11.24 | 8.11.24 | 11.11.24 | N/A | N/A | N/A |
| 96287 | 29.11.24 | 29.11.24 | 2.12.24 | N/A | N/A | N/A |
| Overall Compliance against targets of Safety Action 1 | | | 100% - Compliant (target 100%) | N/A | N/A | N/A |

Table 1: Eligible perinatal death against MIS requirements

During Quarter 3, there were 2 perinatal deaths eligible to be reported to MBRRACE-UK. This included a neonatal death at 21+4 weeks' gestation and a medical termination of pregnancy at 25+0 weeks' gestation. These cases were only reportable to MBRRACE-UK and do not meet the criteria for a PMRT review.

Ongoing Action Plan following PMRT review

| ***Root cause/ Contributory Factor*** | ***Action*** | ***Risk at review*** | ***Evidence of Progress/Completion*** | ***Target completion date*** |
|---|---|---|---|---|
| Lack of compassionate communication and care | Ongoing work into provision of compassionate care, including culture survey work with MVP around language.<br><br>Complete SCORE (culture survey). Continue to provide staff with case studies and parental feedback to work on culture. | | SCORE (culture survey) completed and closed 18.3.24.<br><br>Ongoing work, culture conversations, and action plan in development following on from completion of the culture survey results. | 31.12.24 |
| Access to patient information leaflets | Review process of automatic posting of patient information leaflets with audit of patient access. Confirmation and discussion with women about access to reading material made available to them via BadgerNotes. | | Ongoing work to compress current patient information leaflets, to ensure that the essential leaflets are accessed by patients.<br><br>BadgerNet has confirmed scanned documents patient access is not possible through BadgerNotes. | 31.12.24 |

**Appendix C**

**ATAIN and Transitional Care provision report Quarter 3 (Oct-Dec 2024)**

1. **Report Overview**

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

2. **The National Ambition**

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

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

3. **Why is it important?**

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

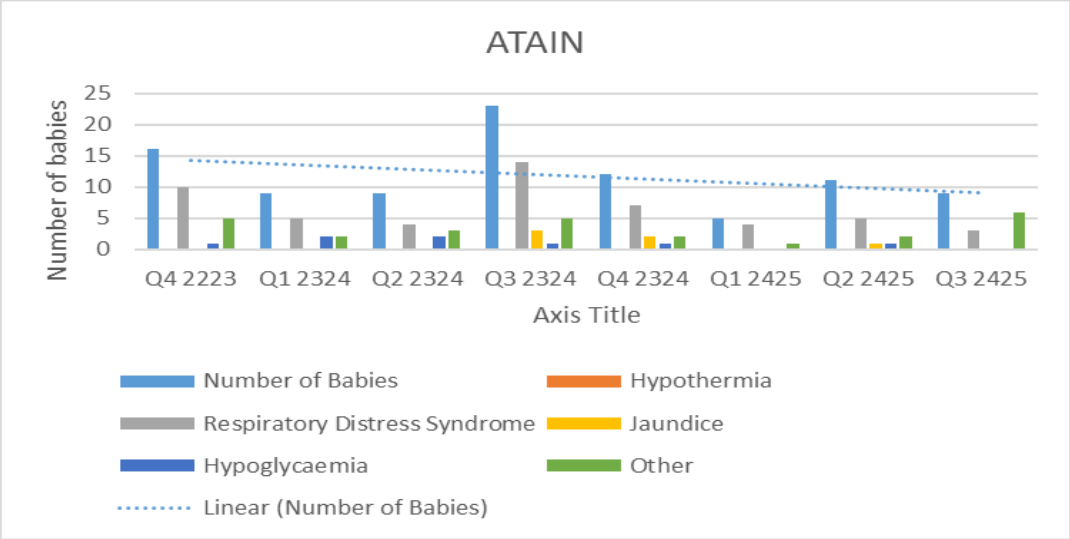
The maternity and neonatal teams review the babies born at or over 37 weeks (term) who were admitted to Special Care Baby Unit (SCBU) at a designated monthly ATAIN meetings and the joint maternity and neonatal meeting. The monthly term admission rate for HDFT is reviewed and tracked on the dashboard and shared with the local maternity and neonatal system. Actions are also generated in response to any themes or concerns.

4. **ATAIN data: Quarter 3 2024**

During quarter three there were a total of 424 registerable babies of all gestations born at HDFT. 393 of these were born at term and therefore admissible for ATAIN audit. Of the 393, nine babies were admitted to SCBU. SCBU admissions for this quarter were lower than previous quarter. One of the nine cases has not yet been reviewed in their entirety as yet. This is for a palliative care case.

| Reason for admission to SCBU | Respiratory distress syndrome (RDS) | Other clinical | Total |
|---|---|---|---|
| Number of babies | 3 | 6 | 9 |

## 5. ATAIN data trend




## 6. Transitional Care Provision and Standards

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

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

At HDFT, a review of TC babies occurs daily during dedicated ward rounds, where assessment takes place and plans of care are made. This review takes place using the jointly approved neonatal/maternity document. There is an escalation policy for any babies which are unwell which is well known by the team and followed should the need arise. We are continuing to within our MDT to ensure these occur at a set time every day and increase representation from both services.

## 7. Transitional Care babies: includes pre-term as separate from ATAIN

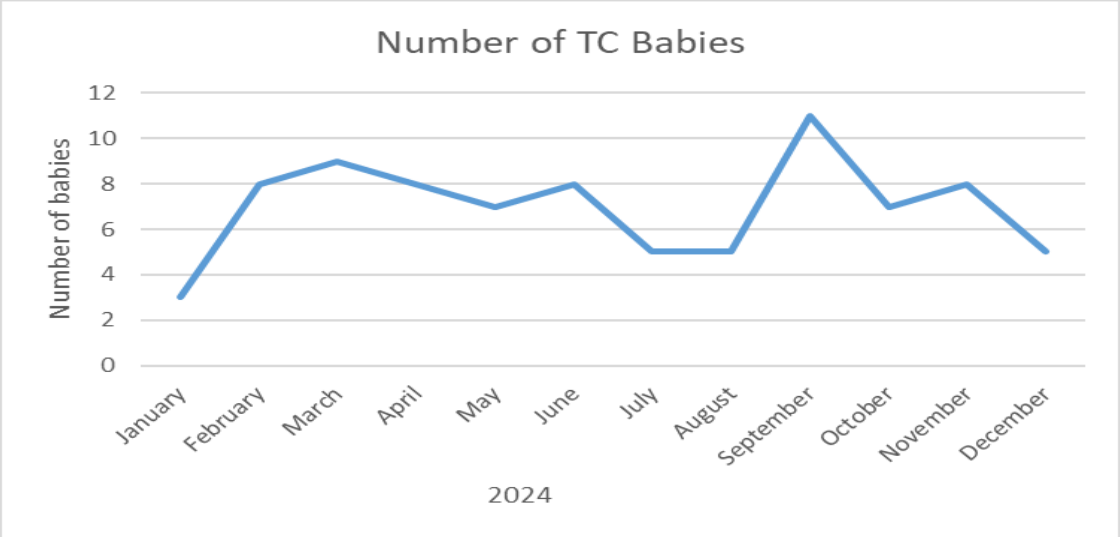
| Month | October | November | December | Total TCU |
|---|---|---|---|---|
| Number of babies | 7 | 8 | 5 | 20 |

## 8. ATAIN action plan

- Consider staying longer than 40-60 minutes with baby on Delivery Suite or Pannal as this may reduce the transfer to SCBU admission. We have encouraged medical staff to cannulate over on Pannal rather than admitting directly to SCBU for example.

- Video to be created of how to record saturations and what equipment staff should be using.
- Completed: Video created to make staff aware where to plug in resuscitaires at a resuscitation in recovery in main operating theatres following a neonatal collapse following an EL LSCS, but the only resuscitaire was in use in the following EL LSCS. This is the very first instance this has occurred at the trust but action plan implemented and also a resus trolley has now been provided during the elective lists.
- Completed: Preventing cold babies: video about thermoregulation, updated respiratory flowchart following RDS.

## 9. Transitional Care provision January – December 2024




## 10. Quarter 3 Transitional Care Data

During this quarter we have had 20 babies on transitional care. 18 of these babies where on TCU due to ABX, this may include some being stepped down from SCBU and still being on ABX when on Pannal. These babies remained on TCU on Pannal for between 2 – 5 days. 2 babies was born preterm, one at 35+1, one at 35+6, and was on TCU on Pannal for 6 - 7 days.

## 11. TCU action log

- Follow up meeting planned with MVP lead, Pannal ward manager, Neonatal Educator and Governance Lead, infant feeding lead to review current service improve obtaining patient feedback, communicating what a TCU baby is, improve how we recognise who is TCU patient next quarter. First meeting was very positive making sure we were meeting BAPM TCU standards.
- Continue to provide Badgernet training to medical staff on orientation and within this training discuss ‘how to do a TCU ward round’

**Appendix D**

Hospital readmissions of babies within 30 days of life

**Quarter 3** October – December 2024

### 1.1 Report Overview

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

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

### 1.2 Process for data collection

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

### 1.3 External reporting

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

### 1.4 National guidance

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

### 1.5 Local guidance and preventative measures

- Unicef UK Baby Friendly weight loss guidance has been adapted locally to ensure plans of care are introduced early and are supportive of long term breastfeeding.
- A breastpump loan scheme supports mothers to implement plans of care.
- Specialist help with breastfeeding is available to all mothers via a weekly support group at Harrogate Library and a frenulotomy service is provided for those needing referral for tongue tie.

### 1.6 Individual readmission data of babies with jaundice and/or feeding issues in the first month of life - Quarter 3

| Jaundice | Age when readmitted | Gestation at birth | Treatment | Length of stay |
|---|---|---|---|---|
| Baby 1* | 2 days | 35+1 | Phototherapy | 4 days |
| Baby 2 | 5 days | 36+0 | Phototherapy | 24 hours |
| Baby 3 | 5 days | 36+4 | Phototherapy | 2 days (twin 1) |
| Baby 4 | 5 days | 36+4 | Phototherapy | 2 days (twin 2) |
| Baby 5 | 5 days | 36+6 | Phototherapy | 2 days |
| Baby 6* | 3 days | 38+0 | Phototherapy | 4 days |
| Baby 7 | 2 days | 39+6 | Phototherapy | 2 days |
| Baby 8* | 5 days | 37+4 | Phototherapy | 24 hours |
| Baby 9* | 3 days | 39+3 | Maternal request | overnight |
| Baby 10 | 5 days | 36+2 | Phototherapy | 3 days |
| Baby 11 | 2 days | 39+4 | Phototherapy | 2 days |

| Feeding issues | Age when readmitted | Gestation At birth | Weight loss | Treatment | Length of stay |
|---|---|---|---|---|---|
| Baby 1* | 3 days | 37+6 | 12.5% | Feeding plan | 48hours |
| Baby 2* | 3 days | 37+3 | 12.1% | Feeding plan | 24 hours |
| Baby 3 | 4 days | 41+1 | 12% | Feeding plan | 48 hours |
| Baby 4* | 3 days | 41+1 | 12.8% | Feeding plan | 2 days |
| Baby 5* | 3 days | 39+6 | 12.8% | Feeding plan | 24 hours |
| Baby 6* | 3 days | 39+4 | 13.7% | Feeding plan | 24 hours |
| Baby 7* | 3 days | 41+1 | 12.6% | Feeding plan | 24hours |

**Comments ***

**Babies with jaundice:**

**Baby 1 –** Baby jaundiced whilst still an inpatient, transferred to Special Care Baby Unit (SCBU) on day two, and received multiple phototherapy as serum bilirubin (SBR) measurement was above exchange transfusion level. At eight days old, attended for repeat SBR and required further treatment. Breastfeeding well with minimal weight loss.

**Baby 6 –** Admitted from home with jaundice. Weight loss 11.4%. No capacity on Pannal so cared for on SCBU. Two further weight losses whilst in hospital before gaining and being discharged. A clearer feeding plan for this baby may have shortened the stay. Jaundice treated effectively.

**Baby 8 –** Baby treated for jaundice at 2 days old whilst still an inpatient. Transferred to community at 4 days old, then required further treatment at 6 days old. Weight loss slightly more than average at 9%.

**Baby 9 –** Ward attender for SBR. Delay in taking SBR due to ward activity. Results back just after midnight, parents requested to stay overnight. (**Avoidable** but kind, considerate care)

**Babies with weight loss:**

**Baby 1 –** Baby 2080g at birth, appeared to be breastfeeding well before discharge however 12.5% loss on day 3 (1820g) clinically appropriate to admit. Good volumes of expressed milk but requirements higher than normal due to low birth weight. Discharged following weight gain.

**Baby 2 –** Baby 2230g at birth, weight loss 12% (1960g). Due to low birth weight paediatricians requested readmission. Good volumes of expressed milk but requirements higher than normal, gained weight and discharged home.

(Babies 1 and 2 both remained on volumes higher than 150mls/kg to achieve further weight gains.

**Baby 3** – Early discharge, out of area. 10% loss on day 3 (unable to review feeding plan), 12% loss on day 4. Lactation delayed, feeding plan commenced in hospital and gained weight. Referred to frenulotomy service and tongue tie divided.

**Babies 4, 5, 6, 7 –** Admitted with weight loss and not effectively feeding, however mothers all had good volumes of expressed breastmilk due to early initiation of expression in hospital.

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

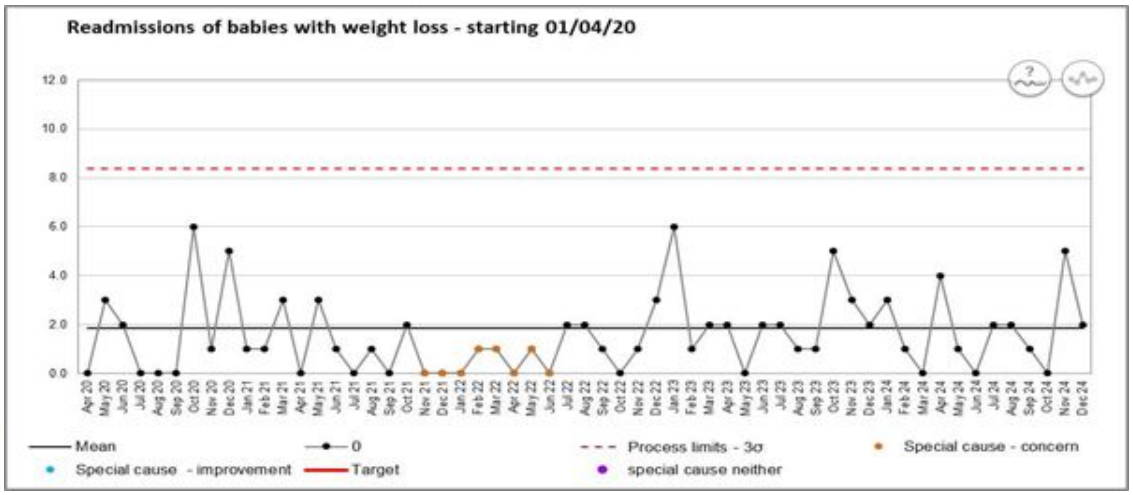


**Chart 2 SPC chart for readmissions with jaundice since April 2020**

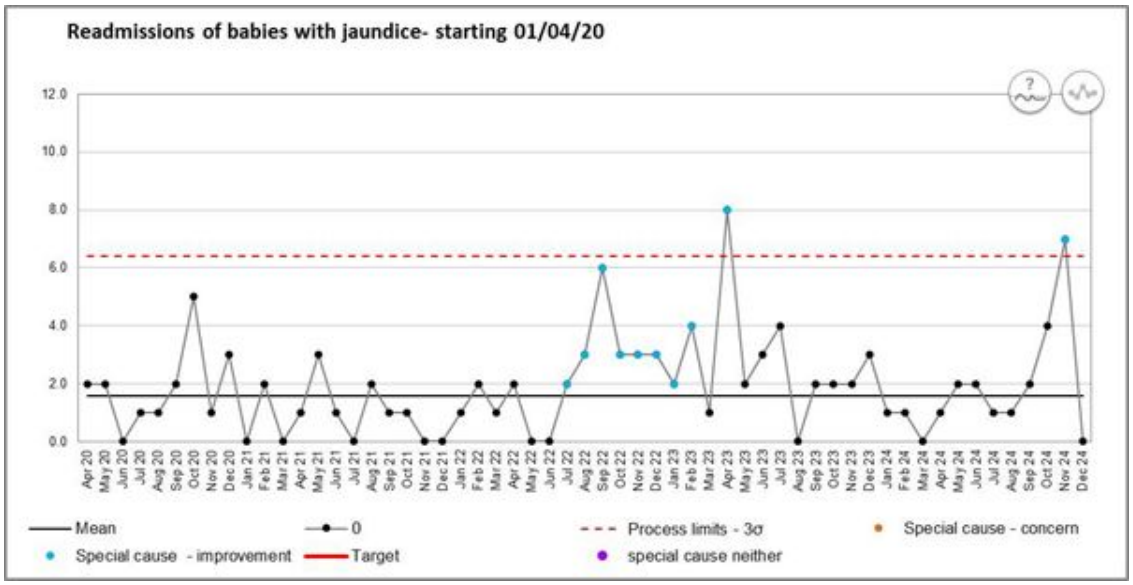
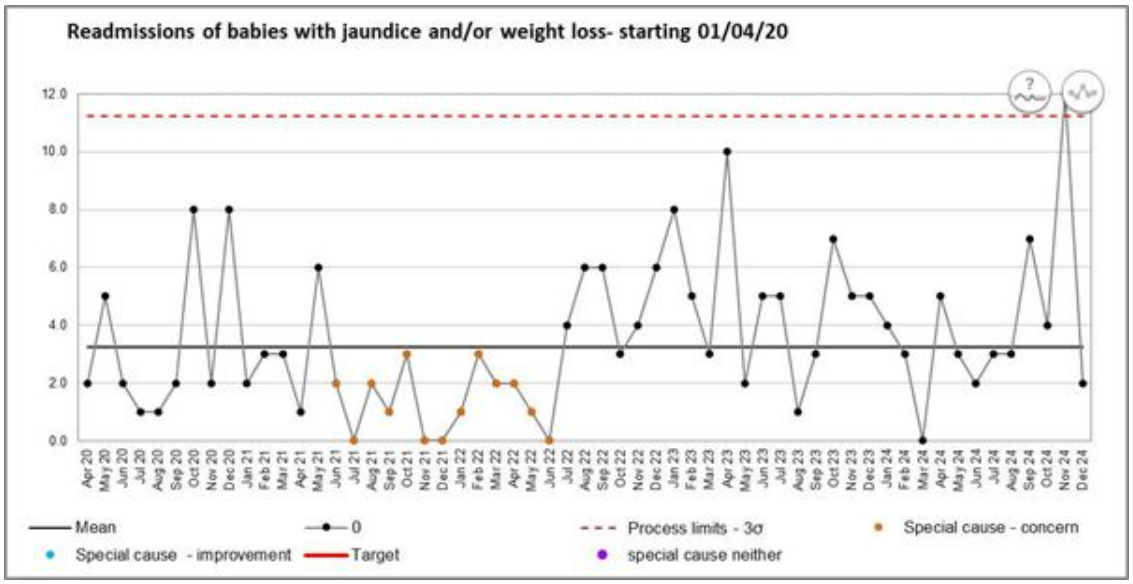



**Chart 3 SPC chart including *all* babies' readmitted for jaundice and/or feeding problems since 2020**



### 1.7 Recommendations

**Action plan**

| Recommendations from datix review | Action To Achieve Compliance with Recommendation (SMART) | Lead Responsible | Expected Completion Date | Comments |
|---|---|---|---|---|
| Ensure accurate weighing and recording of babies weights in hospital and community | Ensure staff:<br>• Check weight with another person, except where not possible in exceptional circumstances<br>• Take a photograph for evidence.<br>• Enter the weight on BadgerNet immediately.<br>• Take care not to transpose digits.<br>• Make sure equipment is set to zero prior to placing baby on the surface.<br>• Baby to be weighed naked. | Andy Brown | **Completed** | 'Learning from incidents' news letter sent to all staff |
| When possible avoid overnight stays for babies with weight loss that have normal blood test results | 1. Explore cost of purchasing a hospital grade double breastpump to loan to parents overnight to help with feeding plan.<br>2. Remind staff to give parents an individual plan of care, which where appropriate, includes a plan to re weigh baby on the | Jo Orgles | **April 2025** | October 2024: Bereavement support group contacted but no available funding at present. To consider other sources of funding. |

| | | | | |
|---|---|---|---|---|
| | postnatal ward in 24 hours. | | | Jan 2025: application submitted to HDFT charities |
| Ensure feeding plans are consistent for babies readmitted with weight loss. | 1. Arrange meeting with the Paediatric clinical lead for postnatal and the infant feeding co-ordinator to discuss more formal feeding plans for larger weight loss in babies. Include when to supplement and when to repeat weight and bloods.<br>2. Update guideline to reflect outcomes of decisions made at meeting.<br>3. Communicate updated guideline to staff.<br>4. Ensure training includes updated guidance. | Pat Gilbertson<br>Jo Orgles | **April 2025** | October 2024: Draft SOP completed. Requires discussion with paediatric clinical lead and then agreement at Paediatric governance. Jan 2025: Meeting arranged with paediatric consultant. |
| Ensure moderately preterm babies on the postnatal ward receive the same level of care as babies on SCBU | 1. Work with neonatal nurses to develop a plan of care for moderate/late preterm babies on the postnatal ward. Include feeding, thermoregulation, increased risk of jaundice and neurodevelopmental care.<br>2. Train all midwives in care of late preterm babies<br>3. Develop an information package for parents.<br>4. Ensure any changes to care are included in appropriate guidelines | Jo Orgles<br>Amy Howard | **March 2025** | October 2024: Work in progress with Neonatal Educator and Governance Lead for SCBU. January 2025: Training for midwives commenced. |

| | | | | |
|---|---|---|---|---|
| Share learning with the community team to improve care and consistency | 1. Arrange dates to meet with community midwives<br>2. Share good practice and discuss individual cases where care could possibly be improved<br>3. Develop plans of care for static weight / weight loss following introduction of a feeding plan | Jo Orgles<br>Ellie Kay | **Completed** | |

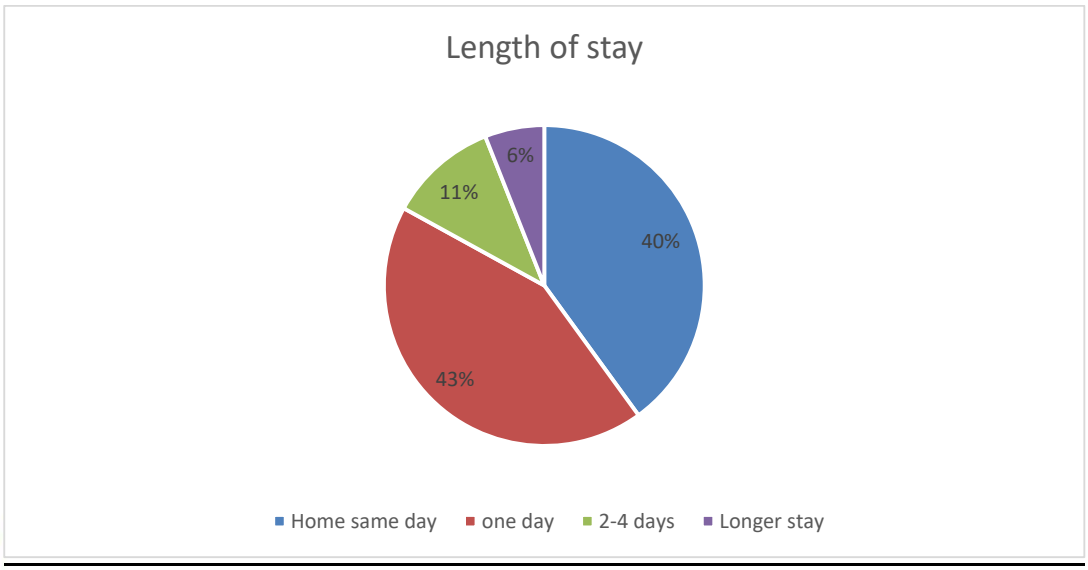
### 1.8 Increased readmissions to paediatrics

All babies with no concerns other than jaundice and/or feeding are seen directly on Pannal ward rather than Woodlands Ward. This pathway ensures a suitable environment for the needs of mothers and babies, supports breastfeeding and reduces the risk of hospital acquired infections. Alerts from HED continue to have been received due to higher than expected readmissions of babies under a month of age.

### 1.9 Paediatric readmission data – Quarter 3

A total of 30 babies, with an age range between 3 and 27 days, had 35 readmissions for a variety of reasons during this quarter. Babies discharged on the same day as admission stayed between one and nine hours. Further work is ongoing to ensure babies that are reviewed and discharged within 12 hours are not recorded as admissions.

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



### 1.10 Conclusion

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

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

Harrogate and District NHS Foundation Trust

3.3

# Final Report for the Maternity Incentive Scheme – Year 6

## Trust Board

## January 2025

| | |
|---|---|
| Title: | Final Report for the Maternity Incentive Scheme – Year 6 |
| Responsible Director: | Emma Nunez, Executive Director of Nursing, Midwifery & AHP's |
| Author: | Leanne Likaj (Associate Director of Midwifery), James Wright (Operations Director), Kat Johnson (Clinical Director), |

| | | |
|---|---|---|
| Purpose of the report and summary of key issues: | The purpose of this report is to detail compliance against the ten Maternity Incentive Scheme safety actions and to highlight areas of potential non-compliance. | |
| Trust Strategy and Strategic Ambitions | **The Patient and Child First**<br>Improving the health and wellbeing of our patients, children and communities | |
| | Best Quality, Safest Care | √ |
| | Person Centred, Integrated Care; Strong Partnerships | √ |
| | Great Start in Life | √ |
| | At Our Best: Making HDFT the best place to work | √ |
| | An environment that promotes wellbeing | √ |
| | Digital transformation to integrate care and improve patient, child and staff experience | √ |
| | Healthcare innovation to improve quality | √ |
| Corporate Risks | | |
| Report History: | Quality and Governance Management Group<br>Quality Committee<br>Senior Management Team - SDR<br>Maternity Risk Management Group<br>Safety Champions Meeting | |
| Recommendation: | Board are asked to review the evidence submission, note the compliance position against each of the standards and agree declaration of compliance. | |

# Final Report for the Maternity Incentive Scheme – Year 6

## 1.0 Executive Summary

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

## 2.0 Introduction

Year six of the Maternity Incentive Scheme was launched on 2nd April 2024. The Maternity Incentive Scheme (MIS) is a financial incentive program designed to enhance maternity safety within NHS Trusts. It rewards Trusts that can demonstrate they have implemented a set of core safety actions, ultimately aiming to improve the quality of care for women, families and newborns.

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

Trusts that do not achieve all safety actions must develop an action plan for safety improvements and can apply for discretionary funding to support this. ICBs must ensure that any discretionary funding awarded is utilised to support the action plan.

This report provides detail of position and progress with compliance with the ten maternity safety actions.

## 3.0 Proposal

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

## 4.0 Quality Implications and Clinical Input

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

## 5.0 Equality Analysis

5.1 An equality analysis has not been undertaken

## 6.0 Risks and Mitigating Actions

6.1. The MIS is a self-certification scheme, with all scheme submissions requiring sign-off by Trust Boards and ICBs following conversations with trust commissioners.

6.2. All submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC).

## 7.0 Recommendation

7.1 The Board is recommended to declare compliance with the Maternity Incentive Scheme Year Six Standards.

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

7.3 Signatures of both the Trust's Chief Executive Officer (CEO) and Accountable Officer (AO) of the Integrated Care System (ICS) will be required in order to confirm compliance. Both signatures will show that they are ‘for and on behalf of’ the trust name, rather than the ICS. The signatories will be signing to confirm that they are in agreement with the submission, the declaration form has been submitted to Trust Board and that there are no external or internal reports covering either 2023/24 financial year or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration.

## Maternity Incentive Scheme – Year Six

### Introduction

Now in its sixth year of operation, 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 MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund.

The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI). Full guidance regarding the required standards can be found at https://resolution.nhs.uk/wp-content/uploads/2024/09/20240904-MIS-Year-6-v1.2-1.pdf

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

- MBRRACE-UK data (safety action 1 standards a, b and c).
- NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).
- National Neonatal Research Database (NNRD), MNSI and NHS Resolution for the number of qualifying incidents reportable (safety action 10, standard a).

Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year

The evidence for each Safety Action can be found in the following location - W:\Labour\Maternity Incentive Scheme\2024

**Safety Action One**

| | | | |
|---|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard? | | ***Required standard –***<br><br>***Pages 11 and 26-32 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation – Compliant*** |

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

**Safety Action Two**

| | | | |
|---|---|---|---|
| 2 | Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? | | ***Required standard –***<br><br>***Pages 12 and 33-34 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation - Compliant*** |

11 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the “Clinical Negligence Scheme for Trusts: Scorecard” in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. July 2024 data contained a valid ethnic category (Mother) for 100% of women booked in the month.

**Safety Action Three**

| | | | |
|---|---|---|---|
| 3 | Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies? | | ***Required standard –***<br><br>***Pages 13 and 35-36 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation - Compliant*** |

A Transitional Care pathway is in place on to reduce separation of mums and babies. Babies admitted to Transitional care are reviewed on a daily basis by a paediatrician as required and the care of babies admitted to Transitional Care are reviewed following the care provision. Joint maternity and neonatal reviews are in place and information regarding ATAIN is shared with the quadrumvirate, maternity, neonatal and Board level safety champions, Local Maternity and Neonatal System and ICB. Quality Improvement Projects are underway to

decrease admissions to Special Care Baby Unit. These are improvement in delayed cord clamping and improved timeliness of intravenous antibiotics. An action plan is in place and is submitted to trust Board within the Strengthening Maternity and Neonatal Safety Board Report. Reports are available in the evidence folder which demonstrate the details of compliance with this safety standard.

**Safety action 4**

| | | | |
|---|---|---|---|
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | | ***Required standard –***<br><br>***Pages 14-16 and 37-43 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation - Compliant*** |

The Obstetric medical workforce is in line with RCOG guidance in relation to locums and a guideline is in place to implement compensatory rest. During the relevant period there were 81 locum shifts, all of which were covered with internal locums. The audit of compliance with consultant attendance for the clinical situations listed in the RCOG workforce document demonstrated 100% compliance with the 28 cases which required a consultant present. The audit in relation to this is presented in Appendix A.

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times.

British Association of Perinatal Medicine (BAPM) standards are not met for neonatal medical and neonatal nurse staffing and an action plan is in place. Harrogate Special Care Baby Unit (SCBU) do not have a supernumerary shift co-ordinator on every shift however there is a Band 7 Unit Manager on site Monday - Friday 08:00 - 16:00 to support shift responsibilities. Cross cover is also provided from co-located Paediatric ward in event of unwell baby being born.

For the neonatal medical workforce there currently is one in seven on the Tier 3 doctors rota (rather than one in eight) however there is cover for the unit 24 hours a day. A neonatal staffing report and action plan are available in the evidence folder to demonstrate full compliance with this safety standard for neonatal medical and nursing staff.

**Safety action 5**

| | | | |
|---|---|---|---|
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | | ***Required standard –***<br><br>***Pages 17-18 and 44–45 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation – Compliant*** |

Midwifery staffing establishment is calculated using BirthRate plus. An updated establishment calculation was completed in August 2024. The maternity budget is under review in order to be adjusted in line with this. There is a supernumerary Labour Ward Co-ordinator rostered for every shift and this is ensured to be in place at the start of every shift. All women receive one to one care in active labour. The bi-annual midwifery staffing report demonstrating compliance was submitted to the Board May 2024 and November 2024 and is available in the evidence folder.

**Safety action 6**

| | | | |
|---|---|---|---|
| 6 | Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? | | ***Required standard –***<br><br>***Pages 19 and 46 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation - Compliant*** |

Harrogate maternity services have demonstrated progress in achieving compliance with all six elements Saving Babies Lives Care Bundle version three. Progress and detailed conversations have occurred at two quarterly quality improvement discussions with the ICB/LMNS. Work is ongoing to sustain and embed the actions. The compliance report has also been shared with Trust Board. The report and implementation tool in the evidence folder provides more detailed information to support compliance with this safety standard.

**Safety action 7**

| | | | |
|---|---|---|---|
| 7 | Listen to women, parents and families using maternity and neonatal services and coproduce services with users | | ***Required standard –***<br><br>***Pages 20-21 and 47 of Maternity Safety Incentive Scheme Document***<br><br>***Recommendation - Compliant*** |

The Maternity Voices Partnership works closely with maternity service leaders and service users to co-produce services and review service provision. The MVP engages with the local community and prioritises hearing the voices of those with the worst outcomes. Terms of reference are in place showing the MVP Lead as a member at maternity safety and governance meetings.

Infrastructure for the MVP is in place although concerns regarding appropriate funding to be an MNVP have been raised by the MVP Chair. Escalation within the Trust and to the LMNS and ICB Quality Committee has occurred as required and a resolution has been reached.

The annual CQC maternity survey data has been reviewed with the MVP and an action plan is in place. Evidence is available in the evidence folder which demonstrates compliance with each requirement of this standard.

**Safety action 8**

| | | | |
|---|---|---|---|
| 8 | Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?<br><br>90% of attendance in each relevant staff group at:<br><br>1. Fetal monitoring training | | ***Required standard –***<br><br>***Pages 22 and 48 – 52 of Maternity Safety Incentive Scheme Document***<br><br>**Recommendation - Compliant** |

| | | | |
|---|---|---|---|
| | 2. Multi-professional maternity emergencies training<br><br>3. Neonatal Life Support Training | | |

Over 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring. Over 90% of each relevant maternity unit staff group have attended an ‘in house’ one day multi-professional training day that includes maternity emergencies. At least one emergency scenario is conducted in a clinical area as part of each emergency training day. Over 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Resuscitation Council UK (RCUK) Newborn Life Support (NLS) course. Registered Resuscitation Council UK trained instructors deliver the local NLS courses and the in-house neonatal basic life support annual updates. All neonatal staff undertaking responsibilities as an unsupervised first attender / primary resuscitator attending any birth have reached a minimum of ‘basic capability’ as described in the BAPM Neonatal Airway Capability Framework. An SOP is in place to ensure that there is an up to date RCUK trained member of staff present at each neonatal resuscitation event.

**Safety action 9**

| | | | |
|---|---|---|---|
| 9 | Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues? | | ***Required standard***<br><br>***Pages 23-24 and 53 –58 of Maternity Safety Incentive Scheme Document***<br><br>**Recommendation - Compliant** |

All Trust requirements of the Perinatal Quality Surveillance Model are fully embedded.

Discussions regarding safety intelligence take place at the Trust Board and include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF) and demonstrate evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

There is a visible Maternity and Neonatal Board Safety Champion (BSC) and non-executive Board Safety Champion who are able to support the perinatal leadership team in their work to better understand and craft local cultures.

On-going engagement sessions with staff occur bi-monthly and progress with auctioning named concerns are visible to staff.

**Safety action 10**

| | | | |
|---|---|---|---|
| 10 | Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December | | ***Required standard –***<br><br>***Pages 25 and 59-62 of Maternity Safety Incentive Scheme Document*** |

| | | | |
|---|---|---|---|
| | 2023 to 30 November 2024? | | **Recommendation - Compliant** |



There has been qualifying cases requiring notification to MNSI between 8th December 2023 and 30th November 2024.

**Conclusion**

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

The Trust Board need to be satisfied that the information within this report and evidence folder satisfies these requirements prior to final sign off by the Chief Executive and submission to NHS Resolution by 12 noon on 3rd March 2025.

MIS_SafetyAction_2025_Protected_V12.xlsx

**Appendix A**



# Planned & Surgical Care

# Maternity

# Consultant attendance in clinical situations

| | | | |
|---|---|---|---|
| **Author(s):** | **Dr Shaheer Saleh Specialty Doctor O&G** | | |
| **Project Sponsor(s):** | **Rachael Tabram** | | |
| Draft Report Distributed to: | **Andy Brown** | Date: | 5/12/24 |
| Final Report Distributed to: | **Andy Brown** | Date: | 6/12/24 |

| QUALITY ASSURANCE CHECKLIST – final report includes: | | |
|---|---|---|
| • **Key Successes & Concerns** | **Yes ☒** | **No ☐** |
| • **Recommendations** | **Yes ☒** | **No ☐** |
| • **Action Plan** | **Yes ☒** | **No ☐** |
| *Please note that a report cannot be considered "complete" until the items above are submitted* | | |

## Contents

## 1. INTRODUCTION

The RCOG produces workforce guidance as an aid to good clinical practice. It presents recognised methods and techniques for clinical practice, based on published evidence, for consideration by obstetricians/gynaecologists and other health care professionals. It is committed to supporting the delivery of high quality women's healthcare and has developed a range of resources to inform and support healthcare professionals.

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

As the most experienced clinician, consultants are now often needed to be physically present, including out-of-hours, to support the care of more complex women or during high levels of activity. It is not unusual for a clinician whose primary role is gynaecology to be the most experienced clinician on labour ward and be required to attend a complex emergency. There is a need for O&G consultants who provide out-of-hours cover for both obstetrics and gynaecology to continue to develop post CCT/CESR and maintain their skillset across both modalities. This particularly applies to less common emergency obstetric scenarios as these are time-critical situations where the confidence, skillset and support of the attending consultant will often define the outcome.

As well as this, the "Towards Safer Childbirth" document arose from continuing concerns in a number of areas about the quality of care that women and their babies were receiving during labour and birth. The RCOG had worrying evidence that, in some circumstances, consultant obstetricians did not see the labour ward as a part of their regular duties and so the care of women with potential or actual serious conditions fell below an acceptable standard.

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

All consultant obstetricians who work on the labour ward should:

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

## 2. CURRENT PROCESS

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

**Monday – Friday 08:00 – 20:30h**

**Saturday/Sunday 08:00 – 12:00h & 20:00 – 21:00h**

Each morning starts with a thirty minute multi-professional handover, followed by a ward round. It is expected that the ward round will include a consultant review of all high risk obstetric patients on labour ward, all obstetric antenatal patients, any postnatal readmissions and any gynaecology non-elective admissions. Elective gynaecology patients may be

reviewed by the consultant of care or the middle grade on call, with the on call consultant reviewing where there are clinical concerns. Any staffing concerns should be discussed during the handover and it is the responsibility of the consultant on call to ensure appropriate contingency plans are made where there is staff absence. If the on call consultant is expected to change during the on call period, any contingency plans should be relayed to them as soon as known.

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

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

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

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

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

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

In the following situations the consultant must attend in person (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2021)*:

| **Situations in which the consultant MUST attend in person** |
|---|
| **General** |
| In the event of high levels of activity (e.g. a second obstetric theatre being opened or unit closure) |
| Any return to theatre for obstetrics or gynaecology |
| Team debrief requested |
| If requested to do so |
| **Obstetrics** |
| Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary |
| Caesarean birth for major placenta praevia/abnormally invasive placenta |
| Caesarean birth for women with a BMI >50 |
| Caesarean birth <32 weeks |
| Caesarean section for premature twins <32 weeks |
| Vaginal twin delivery – consultant to be present for delivery |
| Vaginal breech birth |
| 4th degree tear repair |
| Unexpected stillbirth – antepartum or intrapartum |
| Eclampsia |
| Maternal collapse (e.g. septic shock, massive abruption) |
| PPH > 2L where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated |

In the following situations the consultant should attend in person or be immediately available if the Second on call (middle grade) doctor on duty has not been assessed as competent; usually by OSATs where available (*Adapted from roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG 2022):*

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

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

## 3. OBJECTIVES

This reaudit is designed to assess compliance with consultant attendance in clinical situations between March 1st 2024 and August 31st 2024 at Harrogate Hospital.

## 4. METHODOLOGY

The Electronic Birth Register identified how many babies were born between March 1st 2024 and August 31st 2024 at Harrogate Hospital. From this, we were then able to identify births in which consultant attendance is compulsory. We reviewed DATIX submissions for unit closures and Badgernet for maternity records.

## 5. RESULTS

### 5.1. Clinical situations in which a consultant must attend

5.1.1. Event of high levels of activity (second theatre or unit closure)

There were 14 instances when the unit was closed during the timeframe. All of these were discussed with and agreed upon by the consultant on call. However, in only one case was it documented that the consultant was in the unit while the decision to close was being discussed. In the other cases, it is unclear from the Datix reports whether the consultant was present at the time or if the decision was made following a telephone discussion.
There was one occasion when a second theatre needed to be opened, and the consultant was present.

5.1.2. Any return to theatre for obstetrics or gynaecology

There were three occasions when we needed to go back to the theatres, and on all of them, a consultant was present.

5.1.3. Caesarean birth for major placenta praevia/abnormally invasive placenta

During the time scale, there were three caesarean sections performed for placenta praevia. All were performed by consultants.

5.1.4. Caesarean birth for women with a BMI >50

There was one caesarean section with BMI >50 in the timeframe which was done by a consultant.

5.1.5. Caesarean birth <32 weeks or Caesarean for preterm twins <32 weeks

There were two caesareans with gestations of less than 32 weeks, all were singleton pregnancies. Two were performed with consultants operating or assisting.

5.1.6. Vaginal twin delivery

There were two sets of twins delivered vaginally, a consultant was present at both deliveries.

5.1.7. Vaginal breech birth

There was one vaginal breech birth in the timeframe. A second twin was delivered in the presence of two consultants.

5.1.8. 4th degree tear repair

There were no 4th degree repairs in the timeframe.

5.1.9. Unexpected stillbirth

There was one antepartum still birth & the consultant was there.

5.1.10. Eclampsia

There were no cases of eclampsia in the timeframe.

5.1.11. Maternal Collapse

There was one maternal collapse (cardiac arrest) during the timeframe. The consultant on call attended.

5.1.12. Estimated blood loss >2L or ongoing bleeding

There were 19 cases in Badgernet with over 2000ml of blood loss. In 13 of these, a consultant was present while the bleeding was ongoing. In the remaining 6 cases, the consultant was informed, and the blood loss had settled.

**5.2. Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent**

5.2.1. Any patients in obstetrics OR gynaecology with and EBL >1.5 litres and ongoing bleeding

There were 24 patients who had blood losses over 1.5 litres. In 10 cases, a consultant attended. In the remaining cases, the bleeding was controlled either pharmacologically or after suturing.

5.2.2. Trial of instrumental birth

There were 13 trials of rotational instrumental deliveries during the time frame which were performed by doctors who were not yet signed off. A consultant was present for all of them.

5.2.3. Caesarean birth at full dilatation

There were 9 caesarean sections performed at full dilatation (or caesareans performed in the second stage, as recorded in Badgernet). A consultant was present for 8 of them, and one was performed by a competent middle-grade doctor.

5.2.4. Caesarean birth for women with BMI >40

Seven women were identified as having a caesarean birth with a BMI >40. In six of these cases, a consultant was present, or the procedure was performed by a competent middle-grade doctor. The other caesarean section was done during the daytime after the morning ward round, so it is assumed that the consultant was around, although there is no documentation confirming this.

5.2.5. Caesarean birth for transverse lie

There was only one CS for transverse lie in the time frame which was done by a consultant.

5.2.6. Third degree tear repair

There were 23 third-degree repairs, all performed by doctors competent in the procedure or in the presence of a consultant assisting.

## 6. CONCLUSION

The findings out this audit are brilliant – with almost all of women being seen by the appropriate medical staff considering the risk factors during labour. 28 cases required a consultant present, on all of these occasions that was the case. It is also worth highlighting that in many cases where a doctor had been assessed as competent, there was also a consultant present

too. This shows a willingness of consultant attendance when requested, but not necessarily required – demonstrating effective working relationships and good patient care.

A total of 77 clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent were identified during this audit time period.

| Criteria | Expected level of performance | Actual level of performance |
|---|---|---|
| Clinical situations in which a consultant must attend | 100% | 69% |
| (Excluding unit closures) | 100% | 100% |
| Clinical situations in which a consultant must attend or be immediately available if the middle grade on duty has not been assessed as competent | 100% | 97.9% |

## 7. RECOMMENDATIONS

- Ensure documentation of all names which are present in the labour room and not referring to individuals as their job titles. This enables us to clearly see on review whether consultant attendance was required
- Disseminate results to all staff.
- Ensure that second on call doctors are aware of the clinical situations when a consultant must be present, and that if there is any variation from this, that there is adequate documentation to demonstrate the discussion and decision making process.
- It needs to be determined whether the consultant's presence is required when the decision about the unit closure is made. If so, it should be clearly documented.

# 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

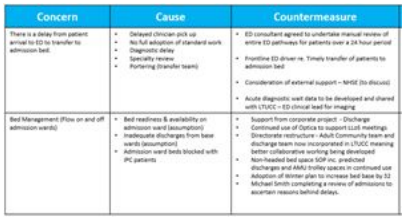
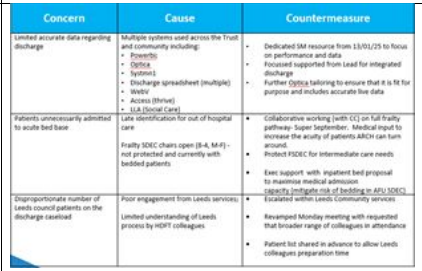
## True North Metrics

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 move to medical bed from decision to admit in Emergency Department |
| **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.<br><br>95% of admitted patients to be moved to required department within 60 minutes of medical decision. | By March 2026, we want to be at 85% of patients having their care completed within 4 hours.<br><br>By March 2027, we want to be at 95% of patients having their care completed within 4 hours.<br><br>**Breakthrough Objective**<br>All patients will move to a ward within 120mins of the decision to admit being made. | Updated Driver Metric to Time to Medical Bed with new countermeasures below:<br>  | **Breakthrough Objective**:<br>**Time to inpatient bed less than 120mins from DTA**<br><br>Median time to PSC, LTUC or Paediatric bed<br>ED perforance breaches and LOS - Power BI<br>LTUC – 525 mins *(180mins, 208, 386, 487 mins)*<br>PSC – 260 mins *(212, 262, 405, 421 mins)*<br>Paeds –104 mins *(121, 108, 110, 178 mins)*<br>*( ) previous months*<br><br>Significant bed and flow pressures linked to rising acuity and respiratory viruses through October, November and December leading to deterioration in performance. Winter Planning measures coming online to mitigate acuity/demand/system pressures. Early opening of winter escalation enacted. Optica now fully rolled out | | |
| **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.<br><br>Top quartile LOS nationally for patients with frailty. | For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention. |  | Delay due to timescales for EPR. Bed capacity issues have made it difficult to progress the Transformation of the admission process at present.<br><br>Weekly discharge achievement by ward - Power BI<br><br>Frailty – percentage of patients over a 7 day LOS has climbed after last month's reduction. Average LOS in frailty has increased with acuity and viral load issues through December. | | |
| **Equitable & Timely** | Elective Recovery (RTT) standard | No patients waiting 18 weeks. | By March 2026, no patients waiting over 52 weeks for treatment.<br><br>By March 2026, 18-52 weeks pathways reduced to 6,000.<br><br>By March 2027, back to RTT 92% standard. | Wharfedale Theatres (TIF1) gone live in September 2024, staffing in place.<br><br>HDH Additional Theatres (TIF2) build.<br><br>Outpatient Transformation, rollout of further faster programme and track 6 key metrics. | On trajectory for clearance of 52 weeks.<br><br>Current pathways over 18 weeks = 7123 (7143).<br><br>18 week percentage = 67.8% (68.2%). | | |

| Workstreams | True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk to Achieving Goal (CxL) | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|---|
|  | | | | Outpatient Board Actions.<br><br>Theatres Productivity (78.25%). | | | |
| | 62 Day Cancer standard | No patient would wait longer 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.<br><br>80% of patients have their treatment commenced in under 62 days by 1st April 2025. | Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times.<br><br>Ensure capacity to deliver first appointments within 19 days.<br><br>Stratify impact of complex imaging waits on cancer performance - data now available (August 2024). | December 2024 – 32 patients over 62 days (39 October).<br><br>December 2024 - 85 % patients (provisional) treated by 62 days. (Sept 2024- 83.5%, Oct 83.6%, Nov 75.2%)<br><br>Cancer Performance Report - Power BI | | |

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

**Related Corporate Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| CRR61 | Emergency Department (ED) 4 Hour Standard | Risk of increased morbidity/ mortality for patients due to a failure to meet the 4-hour standard.<br><br>See the A3 & Breakthrough Objectives pertaining to this. | 4 x 2 = 12 | 4 x 2 = 8 | Clinical: Patient Safety | Minimal |
| CRR87 | Community Dental | Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025. | 3 x 4 = 12 | 3 x 2 = 6 | Clinical: Patient Safety | Minimal |
| CRR105 | Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover | Risk to HDFT being able to deliver acute DGH services due to the fragility of the cardiology service. | 3 x 4 = 12 | 3 x 1 = 3 | Clinical: Patient Safety | Minimal |
| CRR96 | Stroke: Provision at HDFT for Stroke | Risk to patient care and safety due to delayed treatment caused by: - Lack of HASU Capacity at LTHT and YTHFT and aspects of the regional stroke pathway not being followed; - Potential delays in assessment of patients self-presenting with stroke at HDFT ED. Variation of access to HASU for patients suffering an inpatient stroke at HDFT. | 4 x 4 = 16 | 2 x 2 = 4 | Clinical: Patient Safety | Minimal |
| CRR106 | Imaging for ED patients | Risk to patient safety due to potential delays to diagnostic imaging | 4 x 3 = 12 | 4 x 1 | Clinical: Patient Safety | Minimal |

**Related External Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | System (HNY) Urgent Care Pressure | Risk that Pressure across HNY providers will increase demand at HDFT, extend patient waiting times and numbers of patients exceeding 6 hours in the emergency department requiring admission leading to increased harm. | 4 x 3 = 16 | 2 x 3 = 6 | Clinical: Patient Safety | Minimal |

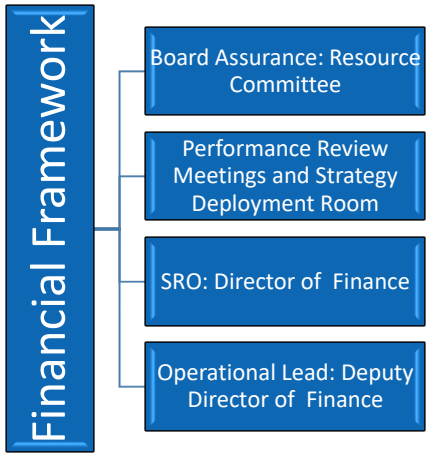
# STRATEGIC AMBITION: OVERARCHING FINANCE 2024-2025

**GOALS:**

**Financial Sustainability**

**HDFT To be a financial sustainably organisation**

**GOVERNANCE:**




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

1

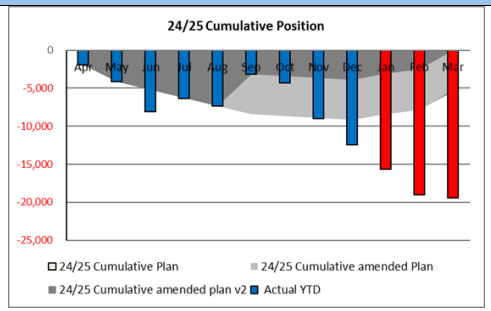
- **Financial Sustainability**

| | |
|---|---|
| **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.<br><br>Where this is not possible there is a need | In relation to the operational position the current countermeasures are in place –<br><br>1. Delivery of coding optimisation schemes<br><br>2. Activity delivery schemes<br><br>3. Wider Waste Reduction and Productivity (WRAP) Schemes<br><br>4. Review of “unfunded” posts | As at month 9 the Trust is reporting a deficit of £12.5m against the system plan of £3.6m, £8.6m away from plan.<br><br>Confirmation on Council pay awards still remains outstanding but we aware that public health grants have been uplifted for their quarter 4 allocations. Communication continues with Local Authorities in securing the uplifts. | | |

| 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.<br><br>The Trust will return to segment 2 of the National Oversight Framework. | 5. Controls and actions regarding Medical and Dental/Agency<br><br>6. Approach to Clinical Supplies and Services<br><br>7. PRM focus – move from budget change to run rate impact<br><br>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.<br><br>Discretionary Spend controls and monitoring in place.<br><br>Additional approval for spend over £10k introduced.<br><br>NHS Supply Chain restrictions.<br><br>Introduction WRAP Champions being developed.<br><br>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.<br><br>The Trust is currently participating in the Grant Thornton review of the financial grip and control in Humber and North Yorkshire Integrated Care System.<br><br>Following the change in Trust segmentation work is being undertaken to establish the exit criteria associated with finance. |  <br><br>Current forecast is from £18m (likely) to £20m (worse) deficit.<br><br>The 'likely' assumes winter impact, pay award funding received for Council and Dental contracts. System wide pressures continue such as Drugs and ED.<br><br>Further detail is contained within the finance A3 and regular finance report shared at Resource Committee.<br>The Trust has been moved into Segmentation 3+ following our current financial performance.<br><br>To note there are already a number of controls in place however more unpalatable decisions may need to be considered to deliver a breakeven position, this is also being discussed with the ICB and through OMG. | | |

**Related Corporate Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| CRR94 | Delivery of Financial Plan | The trust position has continued to deteriorate through the year and the forecast protocol will be enacted as the likely forecast for 24/25 is a £18m deficit. The Trust has been moved into segment 3+ due to the financial performance to date. | 4 x 4 = 16 | 3 x 4 = 12 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. £2m financial pressure if no funding is forthcoming. Local Authorities have received an uplift to their public health grants in quarter 4, ongoing conversations continue on the transfer of these funds. | 3 x 4 = 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 |
|---|---|---|---|---|---|---|
| | Cash Balance | Although cash support was anticipated for Qtr3 this was not required due to payments being received for the pay award and ERF. The cash forecast still highlights support being needed in March so this will continue to be monitored closely. | 4 x 3 = 12 | 4 x 2 = 8 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 this includes wider systemwide support. | 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<br>  <br>Belonging<br>  | 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.<br><br>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:<br>1. Continuously improve the level of survey response rates.<br>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<br><br>**Goals:**<br>1. Continuously improving trend regarding Inpulse survey response rate.<br><br>2. Continuously tracking above our benchmark group engagement score.<br><br>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.<br><br>Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on age and disability discrimination.<br>(Also implementing the Workforce Race Equality Standard action plan.)<br><br>HDFT IMPACT programme (Transformation and Continuous Improvement): methodology implementation across the Trust will enable staff to influence how their role is carried out.<br><br>Additional countermeasure added to the Staff Engagement A3 showing data regarding the teams with a below 5% completion rate. This data to be included in Clinical Directorate Performance Review Meetings and additionally followed up via Directorate Boards. | Trust National Staff Survey response rate is 49% against a 50% benchmark for Acute/Community Trusts. This is a 3% increase on last year's response rate.<br><br>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.<br><br>Executive Director Appraisal process up-dated to incorporate HFDT IMPACT Leadership Behaviours and methodology and NHSE Competency Framework for Board Level Leaders.<br><br>Work programme underway to introduce Line Manager appraisal and strengthen the 4S appraisal for all staff to align with HDFT IMPACT and address feedback regarding the efficacy of the current process in aiding colleagues to understand their objectives and how their improve their area of work.<br><br>Reasonable Adjustments Toolkit launched 1 November 2024 to assist colleagues and line managers in establishing appropriate adjustments to enable them to remain in or return to work. The passport is reviewed annually as a maximum timescale and the colleague takes the passport with them if they change roles, avoiding the need to repeat discussions and agreement to adjustments. | | |

| Workstream | True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving in year Goal | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|---|
| | | | | | People Promise Manager working across identified areas of high turnover to support retention. Flexible working to be a key workstream in Q4. | | |
| Growing for the future  | Staff Availability<br><br>(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.<br><br>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.<br><br>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).<br><br>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".<br>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.<br><br>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.<br><br>**Goals:**<br><br>1. A vacancy rate that does not exceed 6%<br>2. A Turnover rate that does not exceed 12% (HNY is 12.2%)<br>3. Staff leaving within their first year of employment to not exceed 15%<br>4. 100% of rosters signed off and issued 8 weeks before.<br>5. Sickness levels throughout HDFT to not exceed 4.5% (HNY is 4.8%)<br>6. Apprenticeship or training plan/development of new role in the medium | Directorates focusing on sickness locally using the new Trust Policy. | Current strong educational performance and commitment to high-quality training. Key tools like MPET, NETS, and GMC NTS reflect positive feedback and benchmarks. Harrogate is well above the peer average in several areas, with a 95% positive placement rating, marking continuous improvement. Notable achievements include record "green flags" and exemplary areas such as geriatrics and sexual safety, with minimal "red flags."<br><br>The Trust's governance framework is maturing, emphasising interprofessional collaboration and responding effectively to feedback data. This governance approach supports learner satisfaction, educational quality, and a safe learning environment, with the organisation recognised as an "exemplar site" by the GMC for its work in sexual safety.<br><br>Staff unavailability has seen a small increase in December from 561.38wte to 583.90wte, which is an increase of 22.52wte. This is due to vacancy, sickness and maternity leave. However, it is the increase in vacancies of 13.91wte that is the key factor accounting for 62% of the overall increase.<br><br>The Trust vacancy rate is 3.78% at the end of December 2024, which is below the Trust target of 7% (A3 threshold of 6%).<br>-Trust turnover is 11.07% | | |
| New Ways of Working  | | | | | | | |

| Workstream | True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving in year Goal | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|---|
| | | | to longer term for shortage occupations | | -Sickness is 5.36%<br>-Staff leaving within 1st year is 17.61% (this has decreased from 17.61% last month. | | |

**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 – Breakthrough Objective | To improve the vacancy rate at Directorate level and for Directorates to be below the Trust target of 7%. | New/updated Sickness Absence and Support Policy launched 1 November 2024. Directorates focussing on sickness absence locally using new Policy. | The Trust vacancy rate is 3.78% at the end of December 2024, which is below the Trust target of 7% (A3 threshold of 6%).<br>-Trust turnover is 11.07%<br>-Sickness is 5.36%<br>-Staff leaving within 1st year is 17.61% (this has decreased from 17.61% last month.<br><br>The Clinical Directorates are all below the Trust target of 7% and A3 threshold of 6% for vacancy rates in December, with CYPPH at 2.83%, LTUCC at 5.32% and PSC at 5.92%. | Breakthrough Objective Closed | Breakthrough Objective Closed |

**Related Corporate Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | | | | | | |

**Related External Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | | | | | | |

# 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:**

**True North**

**deliverable)**

**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**

**Digital Framework**

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

**GOVERNANCE:**

**Metrics (Executive Lead: 10-15 Year**

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** | |

**True North Metrics Summary:**

| True North Metric | Vision | Goal | Countermeasures | 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 | Revised Goals for 2025-26 currently in development. | Revised Countermeasures for 2025-26 currently in development.<br><br>Luna RTT Tracking (May 22)<br><br>Medic Rostering (Jul 23)<br><br>Datix Cloud (Mar 23) | The programmes of work for 2024-25 have completed as detailed below. Whilst not all benefits realisation were fully achieved in year, significant progress on the digital agenda has been made. A revised programme of work for 2025-26 is in development and will be detailed in April 2025.<br><br>Luna RTT Tracking in place. Expected 1-2 minutes saving not realised, but the system is an enabler to improved data quality of the PTL; in that it is easier to identify: Non recorded outcomes, Duplicate pathways/ referrals, ED/SDEC/SAU referral source to untick as an RTT pathways, Closed pathways LUNA project closed.<br><br>Medical Rostering project completed and closed.<br><br>Datix Cloud Project completed and closed. | **Programme Complete** | **Programme Complete** |

| True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving Goal (C x L) | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|
| | | | ASCOM Nurse Call (Sep 23) | ASCOM Nurse Call Bell, initial go-live completed in February 2024 with further roll-out in the process of development.<br><br>Development of programme for 2025-26 on track. | | |

**Strategic Programme: Electronic Patient Record**

| Title | Description |
|---|---|
| Electronic Patient Record | A Strategic Programme is in place for the delivery of an Electronic Health Record to enable effective collaboration across all care pathways. |

**Related Corporate Risks**

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

**Related External Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | | | | | | |

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

# 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

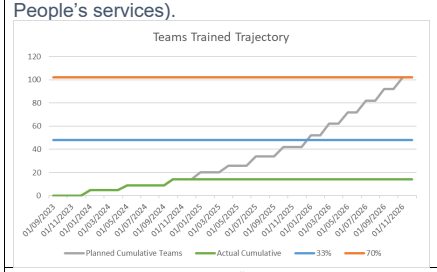
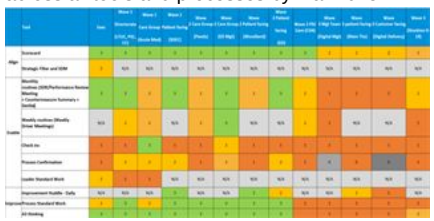
## True North Metrics (Executive Lead: 10-15 Year deliverable

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

| 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:<br>1. moving into new dedicated estate by end of 2024<br>2. Holding launch event/opening by end of 2024<br>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<br>2. Plan for local opening event Autumn/Winter 24 and larger launch event early 2024<br>3. Planning IRIS Innovation Community of Practice networking event for Nov 24. | 1. Lease complete, move in date – 1st Oct<br>2. Planning on track to new deadline<br>3. Planning on track to new deadline | | |
| | | **Develop workforce and create a culture of innovation** by:<br>1. providing introductory innovation training at least twice yearly<br>2. providing in-depth innovation training at least yearly<br>3. establishing unique Clinical Entrepreneur Fellow programme for at least 3 trainee doctors | 1. Work with Medipex to deliver regular intro innovation training events;<br>Present at nurse preceptorship programme.<br>2. Deliver innovation training programme in partnership with LTHT, BTHFT Medipex, HI Y&H – Autumn/Winter 2024<br>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<br>2. Planned 2nd cohort of training Oct 2024.<br>3.i Fellows agreed - June 24<br>ii. Mentors appointed – July 2024<br>iii. 3 industrial partnerships established for placements – BT, B Braun and Visfo | | |
| | | **Develop robust innovation governance** processes by:<br>1. Developing and implementing new processes for approving and adopting medical devices through a New Interventional Procedure form<br>2. Developing new Intellectual Property Policy<br>3. Develop system for prioritising projects | 1. Work with Deputy MD (CO&WD) to develop novel governance processes for innovation<br>2. Work with Medipex and other Trusts on IP and contractual aspects - ongoing<br>3. Adapt Impact Strategic filter to fit in with innovation key priorities | 1. Complete - May 24; seeking approval - July 24<br>2. New IP Policy written - seeking approval and adoption - Autumn 2024<br>3. Complete | | |
| | | **Develop innovation infrastructure** by:<br>1. Securing at least 1 industrial sponsorship by March 25<br>2. Identifying, applying for and securing at least 1 grant to support infrastructure by March 25 | 1. Develop partnerships with industry<br>2. Apply for funding from UK Share Prosperity Fund and/or Mayoral Investment Fund – Nov 24<br>Continue to identify other funding opportunities – ongoing | 1. Applied for funding from B Braun – Dec 23, awaiting outcome<br>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<br>2. Close collaborative working with IRIS = Networking event with HNY-ICB IRIS being organised – Nov 24<br>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. | 1. On track, identifying areas of shared work.<br>2. Planning on track for event in Nov 24<br>3. Met July & Aug 2024 and supporting an innovation strategy<br>4. Jointly working on funding bid to Mayoral Investment fund. Supporting visit by | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | 4. Working with the NY Combined Authority – bimonthly meetings<br>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 | delegation of Polish biotech companies.<br>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<br>2. Integration of AI into radiology reporting pathways for fracture detection | 1. Working with HIYH to proactively identify key priority areas and unmet needs<br>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. | **Impact Improvement Operating Model**: 70% of teams trained by July 26. (Subject to change due to recent contract awards for Children & Young People's services).<br>  | Now: Wave 4, Oct 2024<br>Next: Wave 5, Jan 2025 / Wave 6, Apr 2025 | 14 teams trained.<br>6 in process. | | |
| | | All trained teams rated as "Level 3 – Maturing" across all tools and processes by Mar 2025.<br>  | Roadmap implementation for waves 3 and 4, Jan 2024 | On track | | |
| | | | Process Confirmation – 90% green tickets by Apr 2025. | On track – 60% green tickets | | |
| | | | Practice and refine performance review systems within Directorates through Care Groups to Frontline teams. | Directorate PRMs & SDR established and under refinement.<br>Variation in reliability of intra-directorate improvement operating model processes. | | |
| | | **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 | | |

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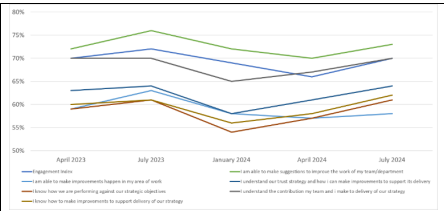
|---|---|---|---|---|---|---|
| | |  | | | | |
| Children's Public Health  | To be a leading trust for the Children's Public Health Services Research | Build the evidence base for Children's PH Services to improve outcomes for children;<br><br>Identify some key Children's public health needs and research priorities by January 25<br><br>. | 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<br><br>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 .<br><br>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<br><br>Continue to recruit into BaBi Harrogate: target for 2024-2025 = 172 current recruitment since March 24 397<br><br>Research prioritisation workshop planned for late November, plan in progress. Now changed to March because of resource issues.<br><br>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.<br>a) trust recruitment target of 2001 annually<br>b) 80% of studies recruiting to time and target<br>c) Patient experience survey annual target 52 | Align HDFT strategy with the strategy of the newly formed Research Delivery Network (RDN).<br>Create new trust research strategy by March 2025.<br>Working to deliver agreed HLOs as outlined by RDN<br>Regular performance mapping / reporting for RDN | Current recruitment at 2430 which is 426 over the target .for this year . Currently 8th Position in region for number of patients in research.<br>Studies on time and target 95%<br>PRES (Patient Research Evaluation Survey) 11 returned - active campaign | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Aligning with strategic working of the regional non- surgical oncology (NSO) research group<br><br>Increasing research workforce capacity through training and education:<br><br>-Increase awareness and workforce capacity through training and education:<br>-Continue delivery of Nursing preceptorship course<br>-Research included in medical induction<br>-Awareness sessions for SAS staff, 0-19 service managers and AHP professionals on-going<br>- Develop research fundamentals course to pilot and then produce learning hub version By March 25 .<br>- Develop research internship programme in collaboration with local l university | to 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<br><br>2 Nurse preceptorship courses completed this month both evaluated extremely well. Input on doctors in training induction continues .<br><br>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**<br>Establishing a clinical research facility (CRF) at HDFT by Dec 24<br><br>Increasing research workforce capacity for commercial research. Find funding and recruit new team by June 25<br><br>Developing commercial research partnerships. “new partnership by March 25<br><br>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<br><br>Scoping possible funding sources for staff funding .<br><br>New commercial partnership with INCYTE formed. ( Oncology and Dermatology trials ) . Two new commercial dermatology studies open in November 24. Delays re these studies, opening March. | | |
| | | 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<br>a) Supporting 2 HYMS academic clinical fellows | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | appointed June 2024 and September 2024<br>b) developing further clinical studies and translational research projects<br>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<br><br>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.<br><br>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<br>Encourage development of speciality patient research groups via social media and research engagement days<br>Continue to have lay people involved in research key meetings<br>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 | | | | | |

# 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**

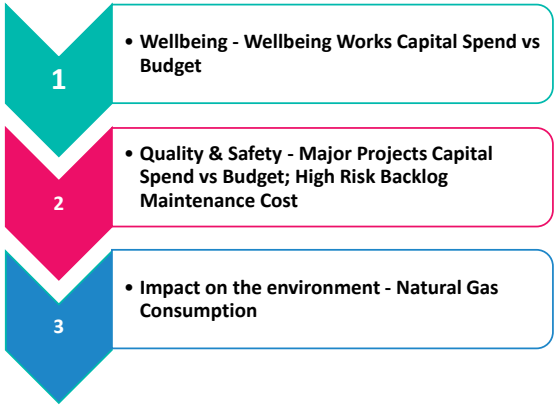
**An environment and equipment that promotes best quality, safest care**

**Environmental Impact**

**Minimise our impact on the environment**

## GOVERNANCE:


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



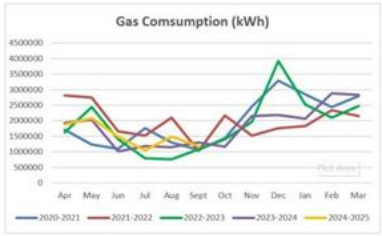

| | |
|---|---|
| **Breakthrough Objective:** | N/A |
| **Corporate Project:** | N/A |
| **Overarching Risk Appetite:** | Operational - Cautious |

| Ambition | Workstream | True North Metric | Risk Appetite | Level of Risk to Achieve Metric – Linked to Risk Appetite | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20 |
| An Environment that promotes wellbeing | Wellbeing | Wellbeing works capital spend vs Budget | Operational: Cautious | | | | | | | | |
| | Quality & Safety | Major projects capital spend vs Budget;<br><br>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**<br><br>To meet standards for aseptic production for medicines safety and staff safety | • Initial Design complete – Aug 22<br>• Tender & Contract award and Design – Mar 23<br>• Build complete – November 23<br><br>• Commissioning complete – Due Dec 23<br>• In service – Due Dec 23 | • Complete<br>• Complete<br>• Complete (delayed to Feb 24 due to Drainage issues, AHU, Design sign off, supply chain issues)<br><br>• Delayed. Further works needed to provide assurance with ventilation. Awaiting timeframe. | | |
| | | **RAAC – Block C, Therapies**<br><br>To eradicate RAAC from Block C, Therapies by demolishing and rebuilding the block | • Relocation of services to new locations – end of Mar 24<br>• Pre-construction for demolition complete – Mar 24<br>• Demolition starts – Apr 24<br>• Demolition complete – Sep 24<br>• Pre-construction for new block starts – Oct 24<br>• New block (shell) construction starts – Feb 25 | • Complete - June 2024<br><br>• Complete - complete June 2024<br><br>• Complete – commenced June 2024<br>• Complete – complete October 2024<br>• Complete – complete November 2024<br>• On Track | | |
| | | **HDH New Theatres, Treatment Rooms and Ward (TIF2)**<br><br>To increase elective operating capacity and improve waiting time performance. | • NHSE BC approval Sep 22<br>• HDFT capital to support enabling schemes agreed – Dec 22<br>• Internal BC approval – Jan 23<br>• Complete tender, appoint contractor – Jun 23<br>• 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<br>• Pre-construction phase complete – Sep 24<br>• New block (shell) construction starts – Feb 25<br>• Stage Completion due – Aug 26 | • Complete<br>• Complete<br><br>• Complete<br>• Complete<br>• Complete<br><br><br><br>• Complete – complete November 2024<br>• On Track<br>• On Track | | |

| True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving Goal | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|
| | | **Imaging Department**<br><br>To improve reliability and capacity of imaging services | • Feasibility study, including phasing – Sep 22<br>• Initial costs – Oct 22<br>• Design concept – Jan 23<br>• 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<br>• Pre-construction phase complete – Sep 24<br>• New block (shell) construction starts – Feb 25<br>• Stage Completion due – Oct 26 | • Complete<br>• Complete<br>• Complete<br>• Complete<br>• Complete – complete November 2024<br>• On Track<br>• On Track | | |
| Environmental Impact | Minimise our impact on the environment | HDFT to be net zero by 2040 | • People & Leadership- New Sustainability Governance Structure developed to provide clear accountability and reporting lines for HDFT & HIF responsibilities and the sub work groups. The Green Plan is required to be refreshed for April 2025.<br>• Estates & Facilities – HIF lead on submissions for Salix / PSDS funding and working with CEF (Carbon and Energy Fund) to support the decarbonisation of the hospital site. Procurement of fleet for Euro 6 ULEZ compliant and an electric can.<br>• Travel & Transport-HIF manage the Travel Plan with its own action plan, liaising with local public transport companies to provide staff discount and promoting modal hierarchy.<br>• Food –HIF undertaking a Food waste project in line with the ERIC return requirements<br>• Medicines. • Delivery a “Nitrous Oxide Project” following a recognised methodology which has identified system waste and will improve medical gas management- Nitrous oxide project (nitrous | • New governance structure to be socialised and meeting arranged with the HDFT & HIF leads identified for the sub working groups. Funding required for Green Plan refresh. This will also shape the actions going forward and align with national and local priorities.<br>• HIF looking at feasibility for new carbon reduction technologies and innovation. Development of a decarbonisation strategy. New vans have been ordered –arrival first quarter 2025.<br>• A travel survey is required this year and funding needs to be identified<br>• HIF at feasibility stage in looking at technologies and software solutions which will improve meal ordering and wastage<br>• External funding has been identified and order placed for Trolleys to house localised canisters. Then the piped network will be | | |

| True North Metric | Vision | Goal | Countermeasures | Current Status | Level of Risk To Achieving Goal | Level of Risk for progressing actions |
|---|---|---|---|---|---|---|
| | | | oxide (N2O) which is used as an anaesthetic gas is 300 times more harmful than CO2<br><br>• Supply Chain & Procurement. Mandatory 10% net zero and social value weighting for every tender.<br><br>• Digital Transformation. The sub group has been involved in this process and agreed necessary sustainability and carbon reduction wording and criteria to be included in the new digital strategy. Sustainable Models of Care- To understand what opportunities there are to deliver care in a more sustainable way and connect these new models of care to reduction of carbon<br><br>  | capped off. Entonox project to be initiated following this.<br><br>• Further Supply Chain & Procurement initiatives need to be identified such as by 2025 we are required to use 50% less office paper and use 100% recycled paper.<br><br>• Produce standard carbon reduction criteria within the digital investment decision making process.<br><br>• Review of recent innovations and changes to models and pathways of patient care to review the sustainability benefits of work which we have already undertaken. Sustainability manager has summarised potential opportunities/projects for the group to review, are there any they wish to peruse. Carbon reduction as a criteria within service change decisions and to be included within the business case approval process. | | |

**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<br>Mar 25 | Operational: Health & Safety | Minimal |

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | | | | | | |
| | 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. H&S Managing the risk of injury from fire | 5 x 3 = 15 | 5 x 2 = 10 Jan 25 | Operational: Health & Safety | Minimal |
| | 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 = 8 Jan 25 | 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. | 3 x 5 = 15 | 3 x 2 = 6 March 25 | Operational: Health & Safety | Minimal |
| CRR102 | Physical security provisions, training and support resources | Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation. | 4 X 4 = 16 | 4 X 2 = 8 April 2025 | Operational: Health & Safety | Minimal |

**Related External Risks**

| ID | Title | Description | Current Rating (CxL) | Target Rating (CxL) & Date | Risk Type | Risk Appetite |
|---|---|---|---|---|---|---|
| | | | | | | |

**Board of Directors (Public)**

**29 January 2025**

| | |
|---|---|
| **Title:** | Use of Trust Seal |
| **Responsible Director:** | Chair |
| **Author:** | Kate Southgate, Associate Director of Quality and Corporate Affairs |

| | | |
|---|---|---|
| **Purpose of the report and summary of key issues:** | To report the use of the Trust Seal to the Trust Board for ratification. | |
| **Trust Strategy and Strategic Ambitions:** | **The Patient and Child First**<br>Improving the health and wellbeing of our patients, children and communities | |
| | Best Quality, Safest Care | 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:** | n/a | |
| **Recommendation:** | The Trust Board is requested to ratify the use of the Trust seal as detailed in the report. | |
| **Freedom of Information:** | The paper can be made available under the Freedom of Information Act once published on the HDFT Website as part of the Board papers. | |

**HARROGATE AND DISTRICT NHS FOUNDATION TRUST**

**USE OF TRUST SEAL**

**January 2025**

## 1.0 PURPOSE

The Trust Seal is used by the Board of Directors to execute legal documents (such as formal contracts and lease agreements) agreed on behalf of the Trust.

A register is be kept to record the sealing of these documents and should be reviewed at least annually by the Board.

## 2.0 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

The Trust Board is requested to ratify the use of the Trust seal as follows:

| SEAL | DESCRIPTION OF DOCUMENTS SEALED | DATE | DIRECTORS |
|---|---|---|---|
| No 208 | Gateshead Section 75 Agreement | 17/09/2024 | Jonathan Coulter (Chief Executive) and Jordan McKie (Director of Finance) |
| No 209 | Deed of Novation: L Rowland & Company (Retail) Ltd | 5/12/2024 | Sarah Armstrong (Chair) and Jonathan Coulter (Chief Executive) |
| No 210 | Lease – Units 14 & 15, Cedar Business Centre, Wakefield | 13/12/2024 | Sarah Armstrong (Chair) and Jonathan Coulter (Chief Executive) |



## 3.0 RECOMMENDATION

The Trust Board is requested to authorise the use of the Trust's seal**.**

**Kate Southgate**
**Associate Director of Quality and Corporate Affairs**
**20 January 2025**