Board of Directors Meeting Held in Public

To be held on Wednesday, 27 November 2024 at 1.00pm – 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 25th September 2024**	Chair	Approve	Attached
1.5	**Matters Arising and Action Log**	Chair	Note	Attached
1.6	**Overview by the Chair**	Chair	Note	Verbal
1.7	**Chief Executive's Report**	Chief Executive	Note	Attached
1.8	**Board Assurance Framework:** Summary	Chief Executive	Approve	Attached
1.9	Corporate Risk Register	-	Note	Supp. Pack
SECTION 2: Ambition: Best Quality, Safest Care				
2.1	**Board Assurance Framework:** Best Quality, Safest Care	Director of Nursing, Midwifery and AHPs & Quality Committee Chair	Approve	Attached
2.2a	**Workforce Safeguards Report**	Director of Nursing, Midwifery and AHPs	Note	Verbal
2.2b	Safer Staffing Report – October 2024 SNCT Process	-	Note	Supp. Pack
2.3	Learning from Deaths Quarterly Report 2024-25 (Quarter 2)	-	Note	Supp. Pack
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
3.2	**Strengthening Maternity and Neo-Natal Safety**	Director of Nursing, Midwifery and AHPs / Associate Director of Midwifery	Note	Attached
SECTION 4: Ambition: Person Centred; Integrated Care; Strong Partnerships				
4.1	**Board Assurance Framework:** Person Centred; Integrated Care; Strong Partnerships	Chief Operating Officer / Resource Committee Chair	Approve	Attached
4.2	**Board Assurance Framework:** Finance	Finance Director / Resource Committee Chair	Approve	Attached
SECTION 5: Ambition: At Our Best: Making HDFT the Best Place to Work				
5.1	**Board Assurance Framework:** At Our Best: Making HDFT the Best Place to Work	Director of People & Culture / People & Culture Committee Chair	Approve	Attached
5.2	Freedom To Speak Up Annual Report	-	Note	Supp. Pack
BREAK (14:50-15:00)				
SECTION 6: Ambition: Enabling Ambitions				
6.1	**Board Assurance Framework:** Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience	Medical Director & Innovation Committee Chair	Approve	Attached
6.2	**Board Assurance Framework:** Healthcare Innovation to Improve Quality and Safety	Medical Director & Innovation Committee Chair	Approve	Attached
6.3	**Board Assurance Framework:** An Environment that Promotes Wellbeing	Director of Strategy & People & Culture Committee Chair	Approve	Attached
6.4	Premises Assurance Model	-	Note	Supp. Pack
SECTION 7: Escalation from Committees				
7.1	**Escalation from Sub-Committees of the Board**	All Executive and Non-Executive Directors	Discussion	Verbal
SECTION 8: Governance Arrangements				
8.1	**Emergency Preparedness Report & Statement**	Chief Operating Officer	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:** Wednesday 29 January 2025 at 1.00pm – 3.45pm Venue: Boardroom, Trust Headquarters, Harrogate District Hospital			

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

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

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NHS Foundation Trust

Board of Directors – Register of Interests

As at 19 November 2024

Board Member	Position	Relevant Dates From	To	Declaration Details
Jacqueline Andrews	Executive Medical Director	June 2020 June 2020 December 2023 April 2024 May 2024	April 2024 Current Current Current Current	1. Familial relationship with managing partner of Priory Medical Group, York 2. Lead for Research, Innovation and Improvement for Humber and North Yorkshire Integrated Care Board 3. Member, Leeds Hospitals Charity Scientific Advisory Board 4. Familial relationship with Director of GPMx Ltd (healthcare consultancy) 5. Member, Independent Advisory Group for the National Medical and Surgical Clinical Outcomes Review Programme (hosted by HQIP on behalf of NHSE)
Sarah Armstrong	Non-executive Director until 31 March 2022 Chair from 1 April 2022	October 2018 September 2024	Date Date	1. Company director for the flat management company of current residence 2. Chief Executive, The Ewing Foundation, Ovingdean Hall Foundation and Burwood Park Foundation 3. Director of Coffee Porter (family business) 4. Member of West Yorkshire Chairs & Leaders Forum 5. Member HNY Provider Chairs 6. Member HNY CAP Board 7. Trustee – NHS Charities Together
Azlina Bulmer	Associate Non-executive Director	November 2022 November 2022 February 2024	February 2024 Date Date	1. Executive Director, Chartered Insurance Institute 2. Familial relationship, Health Education England 3. Chief Operating Officer, Institute of the Motor Industry
Denise Chong	Insight Programme: Non-executive Director	January 2024	Date	1. Trustee, Learning Partnerships Leeds (Feb 2023) 2. Member, Kaleidoscope Learning Trust (KLT) (Dec 2023)
Jonathan Coulter	Finance Director Chief Executive from March 2022	March 2022		No interests declared
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Tipton Building Society 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman, Forget Me Not Children's hospice, Huddersfield

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

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Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020 July 2023 August 2023 September 2023 October 2023 August 2024	Current	1. Member of Society of Local Authority Chief Executives 2. Advisory Board Consultant – Commercial Service Kent Ltd. 3. Commissioner – Local Government Boundary Commission for England 4. Chair – Middlesbrough Independent Improvement Advisory Board. 5. Director and Shareholder – Sampson Management Services Ltd. 6. Member – Council of Governors, Leeds University
Julia Weldon	Non-executive Director	November 2022 May 2024	Date	1. Director of Public Health / Deputy Chief Executive, Hull City Council 2. Co-chair of the Population Health Committee, Humber & North Yorkshire Integrated Care Board 3. Voluntary role as Honorary Board Member of the National ADPH.
Angela Wilkinson	Director of People & Culture	October 2019	Date	1. Director of ILS and IPS Pathology Joint Venture

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

Register of Interests – 19 November 2024

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

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

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 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company. 7. Member of Challenge Board for Northumberland County Council. 8. Trustee for the Harrogate District Climate Change Coalition CIO (effective November 2021)

BOARD OF DIRECTORS MEETING – PUBLIC (DRAFT)

Wednesday, 25 September 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)
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)
Julia Weldon (JW)	Non-executive Director
Azlina Bulmer (AB)	Associate Non-executive Director
Denise Chong (DC)	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 and Allied Health Professionals and Deputy Chief Executive
Angela Wilkinson	Director of People & Culture

In Attendance:	
Leanne Likaj	Associate Director of Midwifery
Kate Southgate	Associate Director of Quality and Corporate Affairs
Lesley Danby	Matron *in attendance for Item 2*
Becky King	Care Support Worker *in attendance for Item 2*

Apologies:	
Chiara DeBiase (CD)	Non-executive Director (Chair of Audit Committee)
Kama Melly (KM)	Associate Non-executive Director

Observers:	
Governors	4 governors – Kevin Parry, Jackie Lincoln (*in attendance up to Item 18)* Tony Doveston, Jonathan Allen
Member of the public / press	1 member of the public / press

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BD/9/25/1 **1.1** **1.2**	**Welcome and Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.
BD/9/25/2 **2.1** **2.2**	**Patient Story** The Chair welcomed colleagues from Planned and Surgical Care Directorate (PSC) to present this month's patient story. The Team attended to provide information to the Board on an improvement approach undertaken in response to a number of complaints being received by two surgical wards in relation to end of life care at the start of 2024. Following implementation of the plan no further complaints linked to end of life care had been received.

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2.3	By assessing the common themes of communication, care and lack of empathy, the following had been implemented: • Every end of life patient has a nominated nurse on every shift. • Pop-up training and discussion events, hosted by the Palliative Care Team had taken place. • Complaints were shared with all teams and individuals to support learning. • Discussed at Department Multi-disciplinary Quality and Safety Meetings. • Staff training and competencies have been revised and revisited. • The Nurse in Charge will meet with each patient on an end of life pathway. • When there are changes in medical staff, they ensure they introduce themselves to the patient. • Involving care support staff in managing the complaint so they can hear the experience directly from the family.
2.4	Board members asked a wide range of questions about the information that had been shared.
2.5	The Non-executive Director (JW) noted the level of accountability and respect that colleagues had taken.
2.6	The Chief Executive noted that learning could be shared across the wider organisation. The Matron noted the importance of involving those who cared for the patients in complaint meetings.
2.7	The Non-executive Director (JC) queried when support of hospices would be used. It was noted that the Palliative Care Team acted as the link between the hospital and hospices.
2.8	The Non-executive Director (LR) noted that end of life patients were the responsibility of all staff, regardless of profession and grade.
2.9	The Board discussed the learning from the story and how it could be spread across the organisation and partners. The Board thanked colleagues for their leadership with improving care of end of life patients.
2.10	**Resolved:** The patient story was noted.
BD/9/25/3 **3.1**	**Declarations of Interest and Register of Interests** The register of interests was received and noted.
3.2	**Resolved:** The declarations were noted.
BD/9/25/4 **4.1**	**Minutes of the Previous Board of Directors meeting held on 31 July 2024** The minutes of the meeting were confirmed with the following minor amendments:
4.2	• Minute 7.3 – It was confirmed that the year end deficit plan of £50m was for the Humber and North Yorkshire ICB, not HDFT. • Minute 12.2 – Wording to be reviewed to ensure clarity that the aim was to support patients in returning to their original place of residence following their admission to hospital. • Minute 16.1 – It was confirmed that the Strengthening Maternity and Neo-natal Safety Report was the July 2024 report and not February as stated. • Minute 18.2 - Noted that the update to the minutes was as follows: Quarter 1 saw a £8.2m deficit which was £2.8m away from plan.

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4.3	**Resolved:** The minutes of the meeting on the 31 July 2024 were approved as an accurate record of the meeting subject to the amendments listed.
BD/9/25/5 **5.1** **5.2** **5.3**	**Matters Arising and Action Log** The actions were noted as follows: • BD/3/29/36.2 – Board Effectiveness Survey – Remain open to ensure continued improvements in our governance arrangements. • BD/5/29/35.1 – Great Place to Work – Closed. • BD/7/31/19.4 – Premises Assurance Model Delegation – Closed. • BD/7/31/24.6 – Investigation to be shared with the Guardian of Safe working hours – Closed. • BD/7/31/30.3 – Green Plan – Board to Board workshop to take place on Green activities in the Autumn 2024 – Closed. • BD/7/31/30.4 – Environment that promotes Wellbeing – Green plan – noted that the BAF would be updated to reflect the workstreams for the Green Plan - Closed. No further matters arising not noted on the agenda were raised. **Resolved:** All actions were agreed as above.
BD/9/25/6 **6.1** **6.2** **6.3**	**Overview by the Chair** The Chair noted a range of activities that had taken place since the last meeting of the Board. The Chair highlighted the following points: • The governance arrangements continued to be reviewed and improved and it was noted that Sub-Committees and Trust Board had been changed in month in terms of how time was spent within meetings. This would continue to be reviewed in the coming months. The changes recognised the role of Committees in reviewing information in depth and escalating areas of risk. Item 7 of the agenda was noted as a new area of the Board meeting that focused on escalation from Sub-Committees. It was also noted that Sub-Committees would move to bi-monthly with the exception of Audit Committee and Remuneration Committee. • The Annual Members Meeting had been held in September 2024. Thanks were expressed to those involved in preparations for the meeting as well as those that attended. • Flu Vaccinations had commenced. **Resolved:** The Chair's report was noted.
BD/9/25/7 **7.1**	**Chief Executive Report** The Chief Executive presented his report as read. The following were highlighted: • The Darzi Review had been published and it had noted the approach to improving services. It was highlighted that the Trust was in a positive place to respond to the challenges moving forward. • Winter pressures were highlighted and it was noted that planning was underway for the Trust to respond. The Board would be taken through the Winter Plan at the Board Workshop in October 2024. • The Board were reminded that the Trust continued to provide system support to our partners. • From a system perspective, the Humber and North Yorkshire ICB Design for the Future document continued to be developed. The financial plan

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	across the system continued to be monitored and a further independent review via Grant Thornton was in place. • The Trust had been confirmed as moving from Segment 2 to Segment 3 in the national oversight framework as discussed at the July 2024 Board meeting. The Board were reminded that this was solely based on financial activity and no areas of risk linked to quality and safety had been noted by NHS England. • Staffing levels remained in a positive position and the latest Inpulse survey had reported strong engagement scores.
7.2	**Resolved:** The Chief Executive's Report was noted.
BD/9/25/8 **8.1**	**Board Assurance Framework – Summary** 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.
8.2	**Resolved:** The Board Assurance Framework Summary was approved.
BD/9/25/9 **9.1**	**Corporate Risk Register** **Resolved:** The Corporate Risk Register was noted.
BD/9/25/10 **10.1**	**Board Assurance Framework – Best Quality, Safest Care** 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: Patient Experience.
10.3	Both True North metrics were within the Trust's risk appetite (tolerance).
10.4	It was noted that for the metric: a reduction in moderate and above harm, that the numbers were slightly above trajectory with countermeasures in place to bring back within range.
10.5	There were no Corporate Risks linked to this element of the BAF at this time.
10.6	The Chair of the Quality Committee confirmed that this element of the BAF had been discussed in detail at the Quality Committee. In addition, it was noted that a new Never Event had been declared and would be investigated through the PSIRF methodology.
10.7	**Resolved:** The update on the BAF: Strategic Ambition - Best Quality, Safest Care was approved.

BD/9/25/11	**Adult & Children and Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review (Workforce Safeguards Report)**
11.1	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 April 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 Developing Workforce Safeguards reinforced the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing. Compliance with the principles outlined in the document was to be assessed bi-annually.
11.3	The SNCT review provided assurance that the Adult Inpatient wards, establishment and skill mix, achieved optimal safe staffing requirements.
11.4	The Board were reminded of the work that continued with regards to paediatric service model and the impact this may have on the staffing levels.
11.5	**Resolved:** The Adult and Children & Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review was noted and approved.
BD/9/25/12	**Safeguarding Annual Report**
12.1	The Safeguarding Annual Report was accepted through the supplementary papers.
12.2	The Non-executive Director (WS) noted that there were areas for improvement and queried if a delivery and action plan was in place. The Executive Director of Nursing, Midwifery and AHPs noted that an improvement plan was in place and monitored through the Strategic Safeguarding Forum.
12.3	**Resolved:** The Safeguarding Annual Report was noted.
BD/9/25/13	**Board Assurance Framework – Great Start in Life**
13.1	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	There was one Corporate Risk linked to this element of the BAF: CRR34 Autism Assessment. This risk had been mitigated to its lowest extent within HDFT's funding and further work was required with commissioners.
13.5	The Chair of the Quality Committee confirmed that this element of the BAF had been discussed in detail at the Quality Committee especially in relation to Maternity.
13.6	The Non-executive Director (JC) noted that further metrics may be required for early year's intervention. The Executive Director of Nursing, Midwifery and AHPs

	noted that outcome data was required and a research project had commenced to establish benchmarking data.
13.7	**Resolved:** The update on the BAF: Strategic Ambition - Great Start in Life was approved.
BD/9/25/14	**Strengthening Maternity and Neonatal Safety**
14.1	The Executive Director of Nursing, Midwifery and AHPs and the Associate Director of Midwifery presented the August 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 August 2024 as set out in the Perinatal Quality Surveillance Model (Ockenden 2020).
14.3	Midwifery staffing levels were noted as an area of risk due to a high level of maternity leave within the service combined with some short term sickness. Mitigation was in place to minimise the risk. Two diverts were noted in August due to staffing levels, however, during this period of time no women were diverted.
14.4	The Chair of the Quality Committee noted that an in-depth discussion had taken place at the Quality Committee. The Committee had noted a number of risks including staffing levels and acuity of women within our care. The Executive Director of Nursing, Midwifery and AHPs noted that the complexity and co-morbidity of women had changed in the last 10 years and this had some links to higher levels of risk. This impacted on areas such as caesarean section rates and complications linked to complexity of women which increased areas of risk such as post-partum haemorrhage. The Chair of the Quality Committee noted that this would continue to monitored through the committee.
14.5	**Resolved:** The Strengthening Maternity and Neonatal Safety report was noted.
BD/9/25/15	**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.
15.2	This Strategic Ambition had four True North metrics.
15.3	Metric 1: 4 Hour ED standards – this was currently outside of risk appetite due to performance levels, with enhanced countermeasures in place to reduce risk. A Breakthrough Objective had been in operation linked to time to first clinical assessment – due to sustained improvements, this had been revised based on the data, with a Breakthrough Objective developed based on the time to a medical bed. In terms of performance, 79.6% compliance within the month of August 2024 for ED 4 hour standard had been achieved. Detail on the time to medical bed by directorate was detailed in the report.
15.4	Metric 2: Length of stay for frailty patients – a full workstream was in place with a focus initially on digital solutions to capture patients within HDFT systems to ensure monitoring of length of stay was accurate. This metric remained within risk appetite.
15.5	Metric 3: 18 week RTT – the ambition was for there to be no 52 week breaches by March 2025, this position was being maintained. This metric was currently slightly below risk appetite. The RTT 92% standard would be the target in 24 months and was on track for delivery.

15.6	Metric 4: Cancer 62 day treatment standard – To have less than 40 patients over 62 days was the current target with the current position at 41 patients. This was above risk appetite with countermeasures in place to reduce levels of risk.
15.7	There were two Corporate Risks linked to this element of the BAF: CRR41: RTT and CRR61: ED 4 Hour standard.
15.8	The Chair of the Resource Committee noted that the BAF had been discussed in detail at the Committee.
15.9	The Non-executive Director (WS) queried the delays in frailty length of stay and questioned if other activity would be put in place to support delivery of this workstream, prior to the full introduction of an EPR system. The Chief Operating Officer noted that Super September had taken place and a wide range of learning had been established that would support the delivery of this workstream.
15.10	The Non-executive Director (LR) noted the corporate risk in relation to 4 hour ED standard and the impact on mortality and morbidity of patients. The Chief Operating Officer noted that studies had been published on the impact of long waits in the ED. The Executive Medical Director noted that within the Trust, safety events were reported and reviewed that linked to long waits within the ED. The Executive Director of Nursing, Midwifery and AHPs also noted that 12 hour breaches were reported through the safety event system and investigated.
15.11	**Resolved:** The update on the BAF: Strategic Ambition – person centred, integrated care, strong partnerships was approved.
BD/9/25/16 **16.1**	**Board Assurance Framework – Finance** 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 was a wide range of corporate projects in place which had direct and in-direct positive implications for the financial position.
16.3	As at month 5, the Trust was reporting a deficit of £7.4m against the system plan of £7.4m deficit. There were a wide range of countermeasures in place to support this area of the BAF. This included: delivery of coding optimisation schemes, activity delivery schemes, wider Waste Reduction and Productivity (WRAP) schemes, a review of "unfunded" posts, controls and actions regarding Medical and Dental Agency spend, the approach to Clinical Supplies and Services, and an enhanced focus in Performance Review Meetings from budget change to run rate impact.
16.4	The metric remained within the Trust's risk tolerance.
16.5	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.
16.6	Watch metrics in relation to cash availability and capital investment were noted.
16.7	The Chair of the Resource Committee noted that a significant discussion had taken place at the Committee. It was highlighted that this Ambition was currently within risk appetite, however, future pressures for the last 6 months of the year may

	increase the Trust's level of risk and take it outside of risk appetite. Watch metrics had been discussed in detail at the Committee.
16.8	The Non-executive Director (WS) highlighted the capital programme and noted the need for visibility at Board level. The Director of Strategy confirmed that this was reviewed in the Environment area of the BAF.
16.9	The Non-executive Director (LR) noted that the Equality & Quality Impact Assessment process was in place to ensure that quality and equality were reviewed when schemes with a financial benefit were being considered.
16.10	**Resolved:** The update on the BAF: Ambition - Finance was approved.
BD/9/25/17	**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 Out 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. There remained a focus on response rates for colleagues with disabilities and long term conditions, areas of lower than benchmark engagement scores, and areas where there were no responses submitted.
17.4	Metric 2: Staff Availability. This area was linked to staff unavailable to work for a variety of reasons including vacancy and sickness absence. At the commencement of the project there had been 709 whole time equivalents (WTEs) unavailable for work, this was now 552. This was noted as a significant improvement. There was a breakthrough objective linked to this area – Vacancy Whole Time Equivalent. Due to the positive trajectory for over 3 months, this had been stood down as a breakthrough objective. The data had been re-stratified and the focus had moved to sickness absence. Countermeasures were being developed and implemented.
17.5	Both True North metrics were below the Trust's risk tolerance.
17.6	There were no Corporate Risks linked to this element of the BAF at this time.
17.7	The Chair of the People and Culture Committee noted that they were pleased that a focused area of work had commenced on those teams where no response were received to the Inpulse survey. They confirmed that significant discussions had been held on WRES, WDES and medical revalidation at the Committee. It was also confirmed that the Freedom to Speak Up arrangements were working well, however, further work was being undertaken to review contingency arrangements.
17.8	The Executive Director of Nursing, Midwifery and AHPs noted that in relation to the Freedom to Speak Up Guardian, we could have more than one Guardian, however they could not share information on individuals without their consent. It was also noted that Freedom to Speak Up was only one mechanism to raise concerns or queries.
17.9	**Resolved:** The update on the BAF: Strategic Ambition - At Our Best, making HDFT the best place to work was approved.
BD/9/25/18	**Workforce Race Equality Standards Report (WRES)**
18.1	The Workforce Race Equality Standards Report was accepted through the supplementary papers.

18.2	The Non-executive Director (WS) noted the metrics were helpful, however, there were disparities that had been highlighted in the report. The Non-executive Director (JW) noted that an in-depth discussion had taken place at the People and Culture Committee and the actions that had and would be taken were outlined. Further consideration was being given to the barriers in place for a number of groups.
18.3	The Chief Executive noted that Executive Directors would have equality and diversity as an objective in all of their appraisals for the next 12 months.
18.4	The Director of People and Culture noted that the WRES and WDES are data driven reports, however, it did not necessarily reflect the level of actions that had been taken over the last 12 months.
18.5	The Associate Non-executive Director (AB) queried if visa status could be noted prior to shortlisting. A discussion was held on the difficulties associated with this due to anonymised shortlisting processes.
18.6	The Non-executive Director (AP) noted that in previous years data had been unavailable and that this was a significant step forward, confirming that further work was still required to embed actions and improvements.
18.7	**Resolved:** The Workforce Race Equality Standards Report was noted.
BD/9/25/19 **19.1**	**Workforce Disability Equality Standards Report (WDES)** The Workforce Disability Equality Standards Report was accepted through the supplementary papers.
19.2	The Non-executive Director (WS) queried Metric 4 and why it was a number and not a percentage.
19.3	**Action:** The Director of People and Culture to review Metric 4
19.4	**Resolved:** The Workforce Disability Equality Standards Report was noted.
BD/9/25/20	**Board Assurance Framework – Enabling Ambition: Digital Transformation to Integrate Care and Improve Patient, Child and Staff Experience**
20.1	The Executive Medical Director provided the Board with an update on the Enabling Ambition: Digital Transformation.
20.2	The Enabling Ambition had two true north metrics: Metric 1: Quality & Safety – systems which enable staff to improve quality and safety of care and Metric 2: Electronic Patient Record (EPR). Both Metrics were currently below risk appetite.
20.3	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.
20.4	It was confirmed that the National EPR Investment Board had been held that morning and the Business Case had been fully approved. The Trust Board expressed their thanks to all that have been involved for the significant work that had gone into this to date.
20.5	There were no Corporate Risks linked to this element of the BAF at this time.
20.6	The Chair of the Innovation Committee noted that this had been discussed in detail at the Committee.

20.7	The Non-executive Director (JW) noted that a theme from the Committees this month had been the positive impacts that were starting to be seen from the Trust's digital solutions. The Executive Medical Director agreed and noted that this was also being seen with the Trust moving to a more data driven organisation. The Benefits Realisation digitisation was being realised.
20.8	**Resolved:** The update on the BAF: Enabling Ambition: Digital Transformation was approved.
BD/9/25/21	**Board Assurance Framework – Enabling Ambition: Healthcare Innovation to Improve Quality & Safety**
21.1	The Executive Medical Director and the Director of Strategy provided the Board with an update on the Enabling Ambition: Healthcare Innovation.
21.2	This Enabling Ambition had four True North metrics: Healthcare Innovation, HDFT Impact, Children's Public Health and Clinical Trials. All workstreams were on track and remained below the Trust's risk appetite.
21.3	There are no Breakthrough Objectives or Corporate Projects linked to this Ambition. There was however, a Strategic Programme: HDFT Impact linked.
21.4	The Chair of Innovation Committee noted that this had been discussed within the Committee.
21.5	**Resolved:** The update on the BAF: Enabling Ambition: Healthcare Innovation was approved.
BD/9/25/22	**Board Assurance Framework – Enabling Ambitions: An Environment that Promotes Wellbeing**
22.1	The Director of Strategy provided the Board with an update on the Enabling Ambition: Environment.
22.2	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.
22.3	All True North metrics remained below the Trust's risk appetite.
22.4	There were no Breakthrough Objectives or Corporate Projects linked to this ambition.
22.5	The Chair of the Resource Committee confirmed that this element of the BAF had been discussed in detail at the Committee.
22.6	**Resolved:** The update on the BAF: Enabling Ambition: An Environment that Promotes Wellbeing was approved.
BD/9/25/23	**Escalations from Sub-Committees of the Board**
23.1	The Chair welcomed Committee Chairs to raise any areas that they wished to escalate from the Committees that had taken place earlier in the day.
23.2	The Chair of the Innovation Committee noted congratulations on the approval of the full EPR business case. A new phase would now be entered into, in terms of mobilisation to go-live. This would be a significant phase for the organisation. A number of digital projects were being supported across the organisation and there was not an infinite resource. It was noted that capacity to deliver would be reviewed on an ongoing basis.

23.3	The Chief Executive noted that a Strategic Programme was in place regarding EPR and that this would have oversight on an operational basis through Senior Management Team (SMT) and further discussions would take place at a Board Workshop.
23.4	The Chair of the Quality Committee noted that the number of Safeguarding Referrals within 0-19 services had increased since COVID and this continued. It was also highlighted that the complaints response for August was 96%. It was noted that Maternity reporting and Safeguarding Annual Report had already been discussed as part of the Trust Board Agenda.
23.5	The Chair of Resource Committee noted that no further areas of escalation were raised.
23.6	The Chair of the People and Culture Committee noted that no further areas of escalation were raised.
23.7	The Chief Executive also noted that areas of good practice should also be noted as part of the agenda and relevant areas of the BAF.
23.8	**Resolved:** The escalations were noted.
BD/9/25/24 **24.1**	**Audit Committee Update** The Chair of the Audit Committee had provided an update via the Non-executive Director (JC). The meeting had focused on internal audits that had been completed, the corporate risk register, the counter fraud report and the Committee's Terms of Reference
24.2	**Resolved:** The Committee Chair's update was noted.
BD/9/25/25 **25.1**	**Medical Revalidation Assurance Report** The Executive Medical Director presented the report which was taken as read. An overview of the processes undertaken, the policies in place, and the compliance rates were highlighted.
25.2	The Chair of People and Culture Committee noted that the report had been discussed in depth in the Committee.
25.3	**Resolved:** The Medical Revalidation Assurance Report was approved by the Board.
BD/9/25/26 **26.1**	**WYAAT Programme Executive Minutes** The WYAAT Programme Executive minutes were accepted through the supplementary papers.
26.2	**Resolved:** The WYAAT Programme Executive minutes were noted.
BD/9/25/27 **27.1**	**WYAAT Memorandum of Understanding Review** The review of the WYAAT Memorandum of Understanding was accepted through the supplementary papers.
27.2	**Resolved:** The WYAAT Memorandum of Understanding Review was noted and approved.
BD/9/25/28 **28.1**	**Collaboration of Acute Providers Minutes** The Collaboration of Acute Providers minutes were accepted through the supplementary papers.
28.2	**Resolved:** The Collaboration of Acute Providers minutes were noted.

BD/9/25/29 **29.1**	**Any Other Business** On behalf of the Trust, The Chair took the opportunity to thank the Non-executive Director (Insight Programme) Denise Chong for her time with the Trust. The Trust wished Denise luck with her future Non-executive Director career moving forward. Denise thanked the Trust colleagues for their support.
BD/9/25/30 **30.1** **30.2** **30.3** **30.4** **30.5** **30.6** **30.7**	**Board Evaluation** Thanks were expressed to observers. The Chair asked members of the Board for reflections on the changes to the format of Committees and Board meetings. The Non-executive Director (AP) noted that the time had been well spent and had been much less repetitive. There were some logistical arrangements that needed to be amended. The format of using the BAF had provided more assurance to the Board than previous formats. The Chief Executive noted that the BAF had been used as the key tool for assurance to the Board. This had kept a clear focus on the Trust's strategy and risks associated with it. The Non-executive Director (JC) noted the role of Governors and the enhanced over-sight the BAF provided. Executive Directors noted the strong links between the Trust Strategy, HDFT Impact and the BAF. It was noted that significant work had gone into the development of the BAF and that whilst this had been time consuming initially it would save time and resource moving forward. The Non-executive Director (AP) noted that there were now clear links between the BAF and the corporate risk register.
BD/9/25/31 **31.1**	**Date and Time of the Next Meeting** The next meeting will be held on Wednesday, 27th November 2024.
BD/9/25/32 **32.1**	**Confidential Motion** **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 November 2024 Board Meeting (updated after September 2024 Board meeting)

Minute Number	Date of Meeting	Subject	Action Description	Responsible Officer	Due Date	Comments	Status - completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BD/3/29/36.2	29 March 2023	Board Effectiveness Survey	Discussions to be held at the August 2023 Board workshop regarding further developments as a result of the survey.	Associate Director of Quality and Corporate Affairs	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/7/31/19.4	31 July 2024	Premises Assurance Model - Delegation	The Premises Assurance Model to be included in the supplementary pack when appropriate	Director of Strategy	November 2024	It was noted that this would be included in the November 2025 Supplementary Papers	Closed
BD/7/31/24.6	31 July 2024	People & Culture Committee Chair's Report - Review of Guardian of Safe Working report	The findings of the investigation regarding the junior doctor working excessive hours to be shared with the Guardian of Safe Working.	Clinical Director for PSC	September 2024	The findings had been shared.	Closed
BD/7/31/30.3	31 July 2024	BAF Enabling Ambition: An Environment that Promotes Wellbeing	Green Plan to be included on the Board Agenda	Associate Director of Quality and Corporate Affairs	September 2024	Board to Board on the Green Plan to take place in December 2024	Closed
BD/7/31/30.4	31 July 2024	BAF Enabling Ambition: An Environment that Promotes Wellbeing	Metrics to be included for this element of the BAF	Director of Strategy	September 2024	Metrics included in the the BAF	Closed
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		Ongoing

BOARD OF DIRECTORS (PUBLIC)
27th November 2024

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

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

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

CHIEF EXECUTIVE'S REPORT

National and system issues

1. As I reported at the last meeting, the Darzi review concluded in September, and it is worth reminding ourselves of this context before outlining the developments (including a very significant budget) that have happened since the report was published. The Darzi report spells out the state of the NHS and diagnoses the problems that we are facing. It also set out how we can approach improving the service.

2. The report clearly outlines that health outcomes have been declining, quality is mixed, money is being spent in the wrong areas of the NHS, capital investment has been insufficient, we were under-prepared for the CoVid pandemic, and the constant and significant restructures of the architecture of the NHS have been at best a distraction.

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

4. The report laid the foundation for the launch of the consultation on the 10 year plan for the NHS. This widespread consultation is now in progress – there is a regional event this week for organisational leaders – with a view to having a final plan announced in May 2025. The plan will be based around the themes of hospital to community, treatment to prevention and analog to digital.

5. The budget at the end of October resulted in a relatively generous financial settlement for the NHS, certainly when compared with other government departments, and in particular a significant increase in capital resources. With this resource comes expectation and a responsibility to deliver improvements. We can always suggest that more funding would be welcome, but we also need to reflect on the fact that there are choices made about how national resources are raised and allocated. The message from the Secretary of State and the Chief Executive of NHSE is that to improve the NHS, a combination of resource and reform is needed, so having got the financial settlement in the budget, the focus is now on the reform element of the equation.

6. Recent announcements have been made to clarify the role of the ICB (a strategic commissioner, with a focus on developing neighbourhood health services) and NHSE (who will undertake the lead role in the performance management of providers), and to also outline the direction of travel towards greater autonomy for organisations based upon delivery of improvements. There is work being undertaken in respect of the Operating Model of the NHS to set this out more clearly.

7. There has also been announced the intention to provide greater leadership and management support, with a framework due, alongside a focus on leadership development. With this support is an expectation that leaders will be accountable for delivering the improvements sought after.

8. In respect of the key priorities going forward, Amanda Pritchard was clear that the five important things are delivering quality and safety (especially through this winter), living within our means, laying the foundations for the development of neighbourhood health services, embedding improvement to reduce waste, and operationalising changes that have been demonstrated (especially in respect of digital). The planning guidance for 2025/26 is also expected to be slimmer with a focus on reducing waiting lists, delivering urgent and emergency care when people need it, and improving access to primary care.

9. For us at HDFT, these announcements and potential policy priorities dovetail into our strategy and improvement programme. We are committed to delivering integrated care across our population, prioritising prevention through our 0-19 services and through the influence that public health can have on all that we do, reducing waiting times in all areas and improving the quality of services for the public. Our Impact programme, EPR implementation, and estates developments will be key enablers, again in line with the national direction of travel.

10. 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, and we are engaged with partners about how this is managed and at what point the system may need to initiate the protocol that signals this risk to NHSE nationally.

11. The HNY system have discussed the option of introducing a short term ‘firebreak’ in recruitment processes, to hold vacancies for three months as a means of reducing cost in this financial year. Whilst recognising the need to manage within our resources, we have responded to outline our way of working through our clinical directorates, who are empowered to make the right decisions for the services they run. This alternative approach has resulted in more staff being employed but with a reduced paybill, as our agency spending has reduced significantly.

12. As we reported at the last Board workshop, financial analysis undertaken by Grant Thornton has demonstrated that we have strong financial controls in place, with few opportunities to go further than we are already planning to do. This provides assurance that our approach and focus is the approach that will deliver the best outcomes.

13. HNY ICB is reviewing its own operating model and the role of the ICB and its constituent Places. This work will be aligned to the national review of the Operating Model. This will have an impact upon ourselves and how we work with our partners locally in our Local Care Partnership. We are currently engaged in discussions with North Yorkshire Council to work through the potential options and implications.

14. In West Yorkshire, we have initiated a service review across WYAAT trusts, to strengthen 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. The recent investment in Wharfedale Hospital and our joint work that we undertake in Otley for the local population is a foundation upon which we can explore further opportunities.

15. As this work continues, I will keep the Board informed, and we have arranged for the WYAAT Director to attend our Board workshop in February to discuss further, once some initial exploration of opportunities has been undertaken. It should be emphasised that this work is built upon collaboration and the established ways of working that we have across WYAAT.

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

17. We have received further communication from the Regional Office in relation to our segmentation for regulatory purposes, and the areas of improvement necessary to move the Trust back to segment two. We have yet to have a meeting to discuss this further, and a joint meeting between ourselves, the ICB and the Regional Office is being organised.

HDFT issues

Introduction

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

19. The values and behaviours that will no doubt be enshrined within the national leadership and management framework going forward will reinforce the importance of *how* we do things as much as *what* we do. We know that we will only succeed in delivering better services if we are consistently operating in line with our values. It is important to focus on doing the right thing for our patients and population, in the right way, and by doing so we will continue to make a positive difference to many people. It is important to always remember this as we wrestle with some of the challenges that we will inevitably have to deal with.

Our people

20. 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.

21. The wellbeing programme of environmental improvement is underway and progressing on plan.

22. The national staff survey is still in the process of being completed by colleagues, so there is no Inpulse survey being undertaken by colleagues this quarter. As discussed at the

People and Culture Committee, we are using the feedback from the quarterly staff surveys to guide our Gemba visits.

23. The national pay award for colleagues has now been paid. As we are a Real Living Wage employer (as set by the Living Wage Foundation), a number of lower paid colleagues who had been in receipt of a top-up did not feel the full benefit of the pay award. The new Real Living Wage rate has been set from November, and we will now be implementing this and providing the necessary top-up to colleagues. The rate is equivalent to just below the top of Agenda for Change Band 3. It is really important that we continue as an organisation to pay the Real Living Wage, despite the financial pressures of the NHS. It is the right thing to do on a number of levels and we will continue to support our lower paid colleagues in this way.

24. Nominations for our annual KITE awards have closed and we have over 200 nominations this year, which is more than last year. Thanks in advance to all Board members who will be part of the judging process, and I would hope that this is a very positive task to have to do.

Our Quality

25. As I mentioned earlier, one of the key priorities for the NHS that has been set out by Amanda Pritchard is to ensure we provide safe care over the winter period in particular. As we discussed at our Board workshop, we have agreed a winter plan for the Trust, with arrangements in place to escalate appropriately when needed and to ensure we have our services geared up to meeting the challenges of the next few months. The plan builds on the plans from last year, with additional improvements that we highlighted at the workshop, particularly in terms of how hospital services and community services integrate into the urgent care pathway at Directorate level.

26. The winter flu jab campaign is a key part of our winter resilience plan. Our staff vaccination rate is around 50% at present, which compares favourably with other organisations and is slightly ahead of where we were at the same point last year. We continue to communicate with colleagues about the importance of the flu jab, and we have also increased capacity recently in an attempt to ensure that as many colleagues as possible take up the vaccination opportunity.

27. As I have reported before, we continue to have occasions when our maternity unit has to divert patients to other units and also has to receive patients diverted from elsewhere in the local network. During the month of October five women were diverted to other units, whilst four women were transferred to Harrogate from other areas. Staff availability at night has been identified as a potential contributor to the need for diverts, and this is being reviewed as part of our biannual staffing review. There remain pressures in the system, but it is also a symptom of the standards and levels of staffing required in all maternity units. Our staffing levels our strong, but there are fluctuations in pressure which we have to manage across the system at times. As I have described previously, we have included the number of maternity diverts as a metric as part of the Impact programme of improvement, to ensure it is a key focus for the team and Directorate.

28. Our stroke pathway remains a concern in terms of acute stroke patients having timely access to services at Leeds and York for initial treatment. A meeting was held earlier this month with the WY stroke network, ourselves, and the York service, and a potential model was proposed for all partners to improve the pathway for our population. This model has now been agreed and we can begin the work to implement this revised approach.

Our Services

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

30. 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 October being below that of August. Whilst this mirrors the national trend, and reflects in part the record-breaking 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.

31. In relation to cancer, this continues to be an improving picture. Both our FDS standard and 62 day standard continue to be ahead of where we had planned to be.

32. We continue to deliver our elective recovery plan, and we continue to be on track to eliminate over 52 week waits by the end of the year. The elective care programme of the ICB performs strongly and is much improved when compared to other ICB areas. Nationally, there remain a significant number of people who have waited over 65 weeks (we have zero), and recovery plans for each system are in place to reduce the outstanding amount before Xmas. We are in discussions with colleagues in West Yorkshire about potential mutual aid.

33. I referred to needing to progress a number of commissioning issues with our Place/ICB in previous reports. Whilst we have shared information with the ICB, this is still the position and is becoming more relevant for our services in the current financial situation and the segmentation change that has been confirmed. We have been asked to respond to a procurement notice in respect of dental services, which we have done, and we are awaiting further information from the ICB around next steps.

Our money

34. Our month 7 financial position is a deficit of £4.3m, £0.9m worse than our 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.

35. Our risks 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.

36. The focus continues to be on our delivering our financial plans for the year, with a need to deliver the productivity improvements and waste reduction that will ensure we achieve our financial plan whilst delivering our expected quality and performance standards. The delivery of our internal programme is a positive position with teams engaged, and the position improving each month. The wider system discussions are more challenging.

37. It should be celebrated that our productivity performance as a Trust, when compared with the period just before the CoVid pandemic, remains one the best across the NHS.

Corporate Risk Register

38. Since the last meeting of the Board in September, two new risks have been added to the Corporate Risk Register. These risks are

    a. There is a risk that HDFT cannot deliver acute District General Hospital (DGH) services due to cardiology being a fragile service. The risk is detailed within the Person centred Care element of the BAF, and is currently scored as 12.

    b. There is a risk to patient care due to treatment for stroke patients being delayed. The risk is detailed within the Person centred Care element of the BAF, and is currently scored as 16.

39. There have been no changes to the remainder of the Corporate Risk Register during this time period.

Other

40. Our RAAC elimination programme and TIF2 schemes continue, with Block C now empty and demolished. We have hosted a visit by the regional RAAC and national TIF scheme teams to update them with progress made and also to talk through the timing and quantum of resources that this programme (and further RAAC elimination schemes) will require. The recent budget and rules around capital spending also need to be factored into the discussions. This will be picked up through our Resource Committee.

41. Our LIMS implementation within Pathology is happening at the end of November. This has been a WYAAT wide programme for which there have been some concerns that have needed to be addressed and have led to delays in delivery. We are now at the point where the majority of our pathology services will be transferring to the new system (histopathology has been delayed until the new year), and the team will be busy managing this process over the next few weeks. This is a significant development for the service.

42. It was a pleasure to attend this year's 'One Team' conference last week. This brought together our nursing, midwifery and AHP teams and colleagues to engage with eachother and to hear from colleagues about some of the work we've been doing and to focus on development, both personal and professional. It was a brilliant event and I'd like to record

my thanks to Emma and other colleagues for making it happen. This was a positive reinforcement of what we do at HDFT, the values we have, and the focus on positive improvement for and by staff, which we know leads to improved services for patients.

Jonathan Coulter
Chief Executive
November 2024

HDFT – BOARD ASSURANCE FRAMEWORK 2024-25

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

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

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

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

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

Summary of Risk

Summary of Activity since last report:

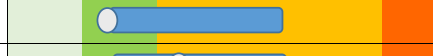
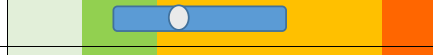
The report was last reviewed at the Trust Board in Public in Septemb2024. The report contains information in relation to the risk of non-delivery of our True North ambitions. The report provides details of the current level or risk and if the status of delivery is in line with our risk appetite.

There is one True North Metrics currently above our HDFT's risk appetite: 4 hour ED standard. Plans are in place to mitigate these risks and bring in line with our risk appetite. All other True North metrics remain within or below our HDFT Risk Appetite Tolerance.

Of note since the last report:

- Best Quality, Safest Care: Moderate and Above Harm Metric has reduced in risk rating to a 6 in line with improved performance
- Person Centred, Integrated Care, Strong Partnerships: 18 Week Referral to Treatment (RTT) has reduce in level of risk to an 8 in line with improved performance. Cancer 62 Day has reduced level of risk to an 8 in line with sustained imnprovements.
- Great Start in Life: Hopes for Healthcare has met its vision and this workstream is now closed.
- Best Place to Work: The Breakthrough Objective – Vacancy Whole Time Equivilant has met its aims and objectives. In the coming months data will be restratified and a new breakthrough objective will be determined.

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Best Quality, Safest Care	**Ever Safer Care** **Excellent Outcomes**	**Moderate & Above Harm**	**Clinical: Minimal**	
	A positive experience	**Patient Experience**	**Clinical: Minimal**	
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred , integrated care**	**4 hour ED standard**	**Operational: Cautious**	

	An exemplar system for the care of the elderly	Admissions of People with frailty	Operational: Cautious	
	Equitable, Timely Access to Best Quality Planned Care	18 Week RTT	Operational: Cautious	
		Cancer – 62 day Treatment Standard	Operational: Cautious	
Great Start In life	National Leader for Children & Young People's Public Health Services	Children at Risk of Vulnerability	Clinical: Minimal	
	Hopes for Healthcare	Children's Patient Experience	Clinical: Minimal	
	High Quality Maternity Services	Maternity Harm Events	Clinical: Minimal	
At Our Best – Making HDFT the Best Place to Work	Looking After our people Belonging	Staff Engagement	Workforce: Cautious	
	Growing for the future New ways of working	Staff Availability	Workforce: Cautious	
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

STRATEGIC AMBITION: BEST QUALITY, SAFEST CARE 2024-2025

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

GOALS:

Safety

Ever safer care through continuous learning and improvement

Effectiveness

Excellent outcomes through effective, best practice care

Patient Experience

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

GOVERNANCE:

Quality Framework

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

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

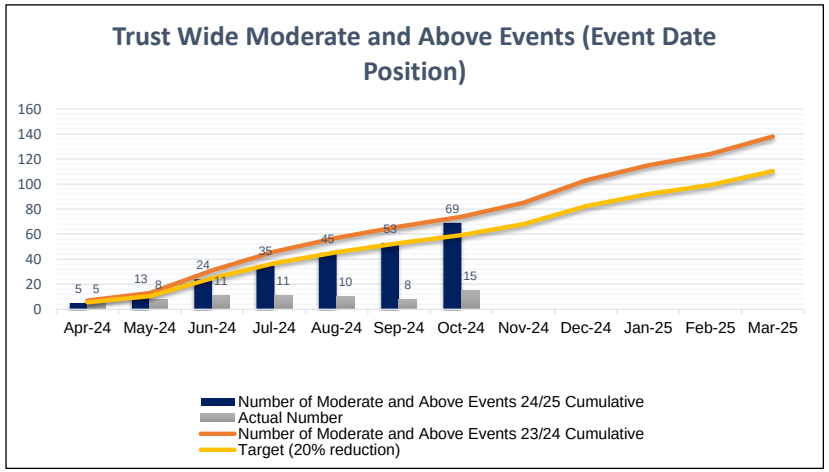
1. **Eliminating Moderate & Above Harm**
2. **Patient Experience Positive Response Rates**

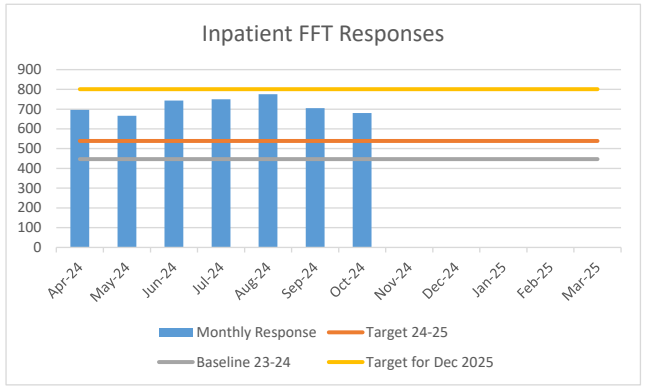
Breakthrough Objective:	Pressure Ulcers
Corporate Project:	Patient Experience
Overarching Risk Appetite:	Clinical - Minimal

Overarching Risk Summary:

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

True North Summary:

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
Ever Safer Care  Excellent Outcomes 	Eliminate Moderate & Above Harm **Breakthrough Objective**	Decrease the total number of moderate & above harm incidents while increasing reporting of low or no harm	Long term: Eliminate moderate & above harm Short term: 20% reduction each year for 3 years Baseline: 170 per annum Year 1: 136 now 110 Year 2: 109 Year 3: 87	The target for Year 1 (2024-25) is 110 or less moderate and above incidents (approximately 9 per month). This will be tracked from April 2024. Falls Improvement Plan Pressure Ulcers Improvement Plan Quality Governance Framework in place PSIRF Implementation Plan	**Break through Objective: Pressure Ulcers – noted below** April 2024 **–** 5 Moderate and above Safety Events May 2024 – 8 Moderate and above Safety Events June 2024 – 11 Moderate and above Safety Events July 2024 – 11 Moderate and above Safety Events August 2024 – 10 Moderate and above Safety Events September 2024 – 8 Moderate and above Safety Events (data being validated) October 2024 – **15** Moderate and above Safety Events (data being validated and expected to reduce)  When excluding un-validated October 2024 data, moderate and above incidents are currently within trajectory for year 1. 53 events up to the end of September 2024. Trajectory would have been 54 events to end of September. Of note when the data has been reviewed, Diagnostic, Treatment and Procedure is now the highest linked category of harm events. In October 2024, two Patient Safety Incident Investigations (PSIIs) were declared. Both of which were Never Events. Never Event 1 was a stent insert on the Wrong Side, Never Event 2 linked to a patient receiving the wrong procedure.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current State	Level of Risk To Achieving in year goal	Level of Risk for progressing actions
					Assurance is provided in month against Safe Staffing levels. A full review of staffing using the Safer Nursing Care Tool has been conducted for the last 6 months. Full details of which are provided in the Trust Board in Public papers.		
A Positive Experience 	Patient Experience Response Rates **Corporate Project**	For every patient to recommend our services	Long term: Development of a real time engagement tool Short term: Increase the response to FFT by 20% over the next 12 months for inpatient (baseline 447) By March 2025: 539 responses per month By December 2025: 801 responses per month	Corporate Project on social value in development Project on increasing engagement led by the Quality Team in development	Corporate Project on the development of a real time patient feedback in development In October 2024, **680** 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. Currently above trajectory (positive trend) with responses above baseline (2023-24 data) and above target for 2024-25. Steady pace being maintained to achieve the stretch target in December 2025.  Plan in development of increased engagement in development with a focus on: • Public engagement events • Review of feedback systems (Datix, FFT, Surveys etc) Watch Metrics: Complaints compliance at **100%** for October 2024.		

Breakthrough Objective: Pressure Ulcers

Workstream	True North Metric	Vision	Countermeasures	Current State	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Ever Safer Care	Eliminate Moderate & Above Harm	No Category 3 or 4 Pressure Ulcers	Pressure Ulcers Improvement Plan	April 2024 **–** 5 Moderate and above Safety Events – 1 related to an acute acquired pressure damage (omissions noted), 0 related to community acquired pressure ulcers May 2024 – 8 Moderate and above Safety Events - 2 related to an acute acquired pressure damage (omissions noted), 0 related to community acquired pressure ulcers June 2024 – 11 Moderate and above Safety Events - 2 related to acute acquired pressure damage (omissions noted), 1 related to community acquired pressure damage (omissions noted) July 2024 – 11 Moderate and above Safety Events - 0 related to acute acquired pressure damage, 0 related to community acquired pressure ulcers August 2024 – 10 Moderate and above Safety Events - 2 related to acute acquire pressure damage, 0 related to community acquired pressure ulcers September 2024 – 8 Moderate and above Safety Events (data being validated) – 0 related to acute acquired pressure damage October 2024 – **15** Moderate and above Safety Events (data being validated and expected to reduce) – 1 is potentially related to an acute acquired pressure ulcer and is currently being reviewed and 2 potentially related to community acquired pressure ulcer and are under review. PULT = Pressure Ulcer Learning Tool – a method to review individual pressure damage to determine learning to reduce the likelihood of a similar event occurring. Each directorate has used stratified data to determine the locations where pressure ulcers are reported in the highest number.		

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 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: • Friends and Family Test Improvements: to improve the collection methods and data reporting across the HDFT footprint, to ensure FFT feedback is being heard in real-time and themes being identified. Feedback and data will be shared regularly with services and department to help drive continues improvement. A working group has been set up. • Real-time listening event: to trail a real-time feedback event at HDH focused on a particular patient of a patient pathway. Trial to take place in November 2024. Date set for 28th November 2024. Focus for trial will be on the KITE values. • Patient Experience Team (PET) Visibility event: to host a PET stand outside Herriots for patients, visitors and staff to meet the team. • 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.		
Ever Safer Care	Patient Safety Incident Response Framework (PSIRF)	Implementation of PSIRF	PSIRF Policy PSIRF Plan 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). An interim PSIRF Lead is in place and leading on all aspects of the the PSIRF agenda. One action remains outstanding to complete this programme of work and move into Business as Usual Activity. The outstanding action relates to permeant funding being acquired for the PSIRF lead post. In October: 12 rapid reviews took place which result in 2 PSIIs being declared. The remaining had a wide range of safety actions identified for logging on the incident management system and progressing locally.		
Ever Safer Care	Accreditation	Implementation of a full Accreditation Programme	Accreditation Steering Group and wider Governance Arrangements Accreditation Lead 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.					

Quality Committee

November 2024

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

Purpose of the report and summary of key issues:	The purpose of this paper is to provide the Board of Directors with an overview of outcomes of the July 2024 Safer Nursing Care Tool (SNCT) for the Adult Inpatient ward, Emergency Department and Children and Young People (C&YP) Inpatient Nurse staffing levels at Harrogate District NHS Foundation Trust, as recommended by the Developing Workforce Safeguards (NHSI 2018) which builds on the National Quality Board (NQB) standards (2016). It is provided for the Board to receive as assurance around our Safer Staffing establishments. The Developing Workforce Safeguards, reinforces the requirement for Trusts to adopt a triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing. Compliance with the principles outlined in the document is to be assessed bi-annually.	
Trust Strategy and Strategic Ambitions:	**SNCT Safer Staffing**	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	Safer Staffing Levels; triangulated approach in relation to the use of evidence-based tools, professional judgement and patient outcomes to provide assurance of safe, sustainable and effective staffing.	
Report History:	SNCT Review Meetings August 2024 Establishment Review Panel September 2024	
Recommendation:	The Board / Committee is asked to agree the SNCT review of the Adult inpatient, Emergency Department and C&YP inpatient ward safer staffing review.	

	Adult Inpatient Wards The SNCT review has given us assurance that the Adult inpatient wards, establishment and skill mix, achieve optimal safe staffing requirements. There is ongoing work being undertaken to identify the most appropriate way to manage our Enhanced Care requirements and further SNCT data required to validate a potential Registered Nurse establishment change within the PSC wards. **Emergency Department** The SNCT review has given us assurance that the Emergency Department, establishment and skill mix, achieves optimal safe staffing requirements. Recruitment in to the senior Band 7 positions now means that there is a band 7 on all shifts to cover the 24 hour period. The focus is now on ensuring safe, effective rostering, recruitment in to substantive positions and retention of staff. **C&YP (Woodlands Ward)** There was acknowledgement that the SNCT demonstrates a slight establishment change for the Woodlands Ward. However, the Children's Assessment Unit (CAU) service review and redesign may influence additional changes. Therefore, no changes to be made until the CAU service review and establishment modelling has been completed. This should then come back through Establishment review panel. The next bi-annual safer staffing review will be undertaken in January 2025.

Freedom of Information:	

STRATEGIC AMBITION: GREAT START IN LIFE 2024-2025

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

GOALS:

Public Health

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

Hopes for Healthcare

Services which meet the needs of children & young people

Maternity Services

High quality maternity services with teh confidence of women and families

GOVERNANCE:

Great Start in Life

- Board Assurance: Quality Committe
- 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)

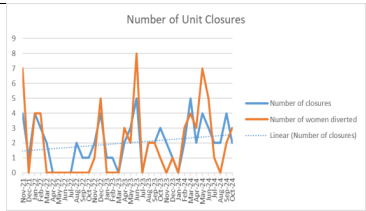
1. Early Intervention & Prevention
2. Child Patient Experience
3. Maternity Harm Events

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 Goal 1: To achieve 90% or above on the performance of all mandated health child programme contacts – June 2025 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 Goal 3: Baseline for Darlington children graduating into universal services established – January 2025	Revised Countermeasures will report in December 2024 and from January 2025.	During November 2024 a full review of the workstream was completed. Through the governance structures the following has been agreed: • Countermeasure against strategic metric will report the performance of mandated health child programme contacts for all 0-19 services. • Great Start in Life pathway will launch in Darlington 0-19 service January 2025 and be measured against high impact public health outcomes. This will be a sub-set directorate project to the CYP Strategy. The aim of the Great Start in Life pathway will be to achieve our True North vision.		
Hope for Healthcare 	Children's Patient Experience	Improve experience of care by considering elements that matter most to children & young people so we can measure their experience of care and shape services according to their specific needs	Engage with children and young people with lived experience across HDFT geography to re-establish their Hopes for Healthcare. Develop an HDFT CYP Patient Experience Test which will provide outputs that will translate into themes, trends and areas for improvement. This data set will be visible and accessible across Trust governance frameworks. Develop a CYP Shadow Board with representation from	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. We have Great Start in Life Young Advisors and committees across the full geography of the Trust. 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. *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 **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. **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.	 Staffing establishment review completed (including midwifery and QIS nurse numbers at night). Awaiting review of costings and to be presented at Establishment review meeting in November. Review of on call processes for hospital and homebirth to be completed once decision made regarding staffing model and budget.		

Workstreams	Strategic Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
					SOP being developed for process returning from maternity leave and working nights. Flexible working contracts have been reviewed consistently.		

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 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

Quality Committee

27th November 2024

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director for 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 October as set out in the Perinatal Quality Surveillance model (Ockenden, 2020).	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	√
	Person Centred, Integrated Care; Strong Partnerships	√
	Great Start in Life	√
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	√
	Digital transformation to integrate care and improve patient, child and staff experience	√
	Healthcare innovation to improve quality	√
Corporate Risks		
Report History:	Maternity Risk Management Group Maternity Quality Assurance Meeting	
Recommendation:	The Committee 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 October 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 Maternity Voices Partnership to move to Maternity and Neonatal Voices Partnership by end of November. Conversations on going regarding funding with Humber and North Yorkshire Local Maternity and Neonatal System (HNY LMNS).

5.2 Midwifery staffing gaps continue due to increased maternity leave. Incentive NHSP payments in place to encourage backfill. Recruitment is on-going.

6.0 Recommendation

6.1 The Board is asked to note the updated information provided in the report and for further discussion. Ensure escalation of the funding for the Maternity and Neonatal Voices Partnership is raised at ICB Quality Committee if the issue is not resolved.

Maternity November 2024 (October data)

Matters of concern & risks to escalate

Maternity Voices Partnership required to move to Maternity and Neonatal Voices Partnership by end of November however allocated funding not in place. Requires escalation to ICB Quality Committee.

Consultant long term sickness – interviewing for Locum Consultant in November

Medication incident – moderate harm to neonate (November)

Major actions commissioned & work underway

- *Workforce review continues*
- *MAC call monitoring - awaiting confirmation*
- *Perinatal Culture action plan progressing*
- *Saving Babies Lives Care Bundle – working on evidencing sustaining changes*
- *Maternity Strategy being published*
- *Day unit activity / MAC action plan progressing*
- *Maternity Incentive scheme evidence being collated*
- *Planning implementation of National Incentive Scheme for stop smoking*
- *On-going recruitment to midwifery vacancies*
- *Progressing training to uplift Band 2 Maternity Support Workers to Band 3*
- *Working to improve compliance on Tendable*
- *Training courses agreed for Professional Midwifery Advocates, Newborn Infant Physical Examination and Sonography.*
- *Induction of Labour project on-going.*
- *FFT focused area of improvement.*

Positive news & assurance

- *Increased cesarean section capacity in place and so risk of poor patient experience reducing*
- *Midwifery vacancy reduced*
- *Over 500 people recruited to BaBi research and agreed data usage against RSV analysis*

Decisions made & decisions required of the Board

Maternity Voices Partnership required to move to Maternity and Neonatal Voices Partnership by end of November however allocated funding not in place. Requires escalation to ICB Quality Committee.

Bi-annual staffing paper attached, including Birth Rate Plus establishment report. Currently undergoing professional judgement check and review with the Triumvirate ahead of establishment review meeting.

ATAIN quarterly report attached.

Narrative in support of the Provider Board Level Measures – October 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

2. Obstetric cover on Delivery Suite, gaps in rota

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

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%, 3.03WTE midwifery and 0.27WTE maternity support workers absence. 7.75WTE midwives are on maternity leave at present.

workforce2WIP
MONTH END POSITIONS

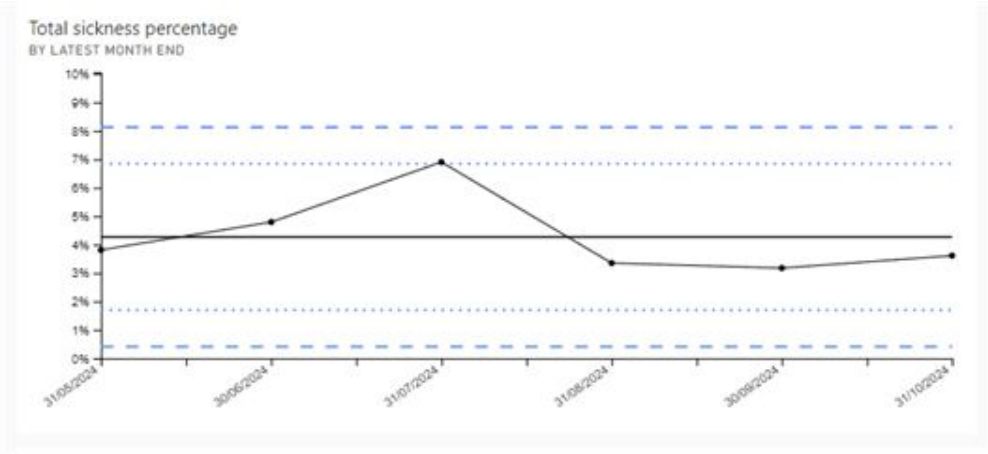
Directorate: All | Care Group: Care Group 1 | Service/ Ward/ department: Multiple selections

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			76.13	74.68	-1.45		-1.95%	7.75	3.05	65.33	9.35

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			15.91	16.89	0.98		5.82%	0.60	0.27	15.04	1.85



b. Vacancy position

As demonstrated above there remains a vacancy of 6.3 WTE midwives when maternity leave cover is taken in to account however 4.32 WTE midwives are awaiting a start date.

c. NHSP provision

Midwives -
Demand for NHSP midwives has started 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.

Eight homebirths were booked for the month of October 2024. Three women birthed at home. Three women transferred or birthed in the hospital for medical reasons, and two women have not yet given birth.

In the period 01/10/24 – 31/10/24, the home birth on call provision was unavailable on nine occasions due to unexpected sickness and no volunteers to cover. No homebirths were suspended due to unavailability of on call. One baby was born before arrival of the midwife (BBA).

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

Fully recruited at present. 2.14WTE QIS nurses awaiting a start date.

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. October 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.

6. 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)

a. Delivery Suite Staffing and impact on clinical workload

During October there were 17 Midwife shifts left uncovered (141 hours) and 20 Maternity Support Worker shifts left uncovered on the roster 158.5 hours. All shifts had been released to NHSP but had not been filled. As a result of these staffing gaps there were delays in commencing induction of labour on seven occasions and 47 incidences of delay in continuing induction of labour, six women's induction of labour was postponed whilst they were at home. There were also four episodes were it has been recorded on Birthrate plus acuity tool that the coordinator was not supernumerary at some point during the four period.

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

b. Pannal Ward Staffing and impact on clinical workload

The Birthrate Plus Ward Acuity App had a 62.9% 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. There has been an 8.8% reduction in completion since last month, mainly in the reporting period 2-8am. According to Birthrate Plus acuity tool 70% of shifts have been at least one midwife short over the course of the month however no clinical actions were required on 93% of the occasions. During October, there were 26 Midwife shifts left uncovered and 12 of MSW shifts left uncovered on the roster. All shifts had been released to NHSP.

There were 14 elective section lists with 34 women in total on these lists. There were seven elective caesarean sections completed on delivery suite during October.

There were nine babies who received Transitional Care (TC) provision on Pannal Ward. However there were several additional babies who were under observations/having investigations who did not meet the official TC criteria.

7. Red Flag Events Recorded on Birthrate Plus

a. Red Flags

According to NICE (2017), *a midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.*

b. Delivery Suite Red Flags

Delivery Suite record when the following Red Flag events occur, sometimes numerous Red Flags can occur at the same time. There were two Red Flags recorded on Birthrate Plus during October 2024 both related to delayed time critical activity.

c. Pannal Ward Red Flags

There was one occasion where there was a Red Flag identified from the Birth Rate Plus Data which was ‘Delayed or cancelled time critical activity’.

During October there were four delays in induction of labour of over 24 hours.

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

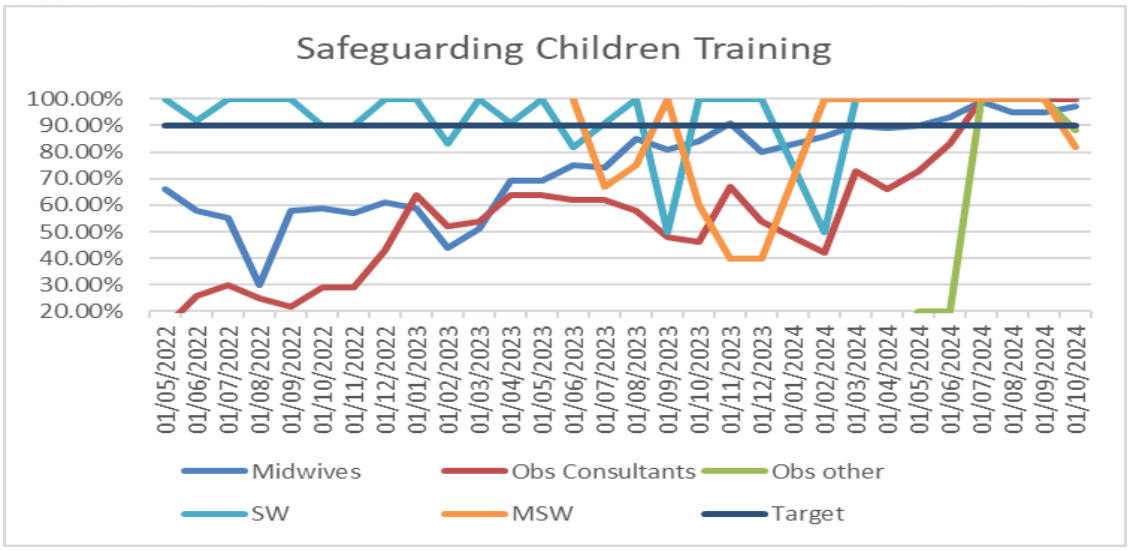
a. Mandatory training (as at 11/11/24)

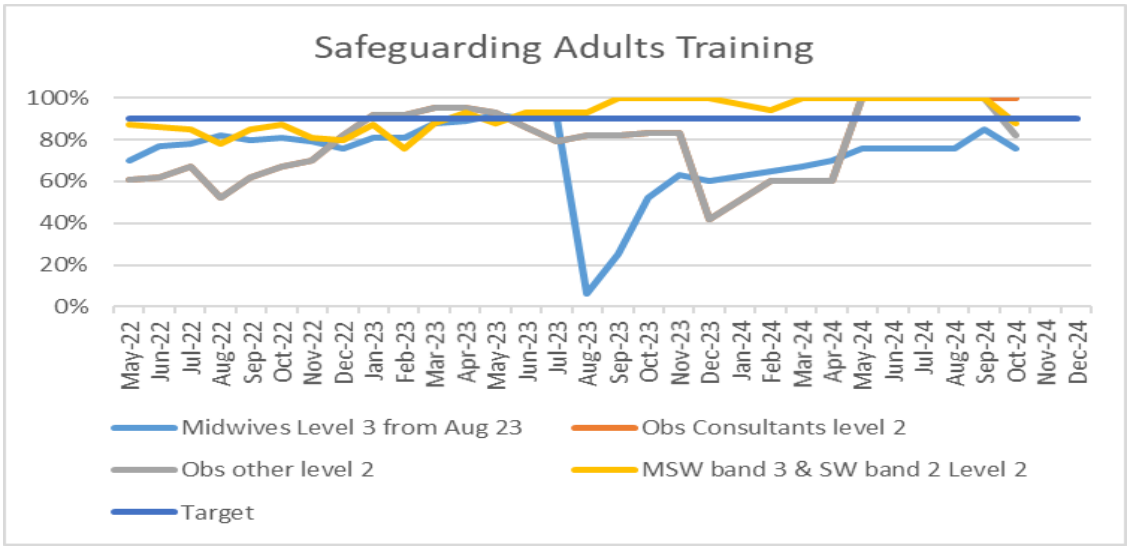
Department	Assignment Count	Percentage Compliant
421 Level 4 Ante Natal Clinic	9	93.1%
421 Level 4 Community Midwifery	20	87.5%
421 Level 4 Early Pregnancy Assessment Unit	3	95.5%
421 Level 4 Maternity Staffing	53	87.9%
421 Level 4 Pannal Ward	21	83.3%
421 Level 4 Obs and Gynae Medical Staffing	28	80.8%

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

Work is on-going to ensure 90% compliance with all core role specific training by the 30th November for Maternity Incentive Scheme requirements. Compliance is anticipated to be achieved before the deadline and all staff required to be updated are booked to attend sessions in November. Plans are also in place to ensure there is no requirement to pull clinical staff from the training days.

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%	89%	72%			71%	50%	100%
Harrogate Immediate Life Support (HILS)	70%							
Harrogate Advanced Life Support (HALS)				81%	83%			
Harrogate Newborn Intermediate Life Support (HNILS)	99%							
Harrogate Newborn Advanced Life Support (HNALS)						57%	76%	
RCUK Newborn Life Support	89%					86%	57%	
MAT - Growth Assessment Protocol (GAP)	88%	78%	70%					
LMNS Fetal Wellbeing Competency Assessment	88%	78%	77%					
MAT – Maternity Training Day 2	97%	89%	80%					
MAT - Prompt	91%	89%	81%	80%	100%			100%
MAT - Saving Babies Lives	90%	89%	80%					
Safeguarding Adults	76%	80%	94%	94%	92%	86%	77%	100%
Safeguarding Children	96%	90%	69%	100%	100%	88%	69%	50%

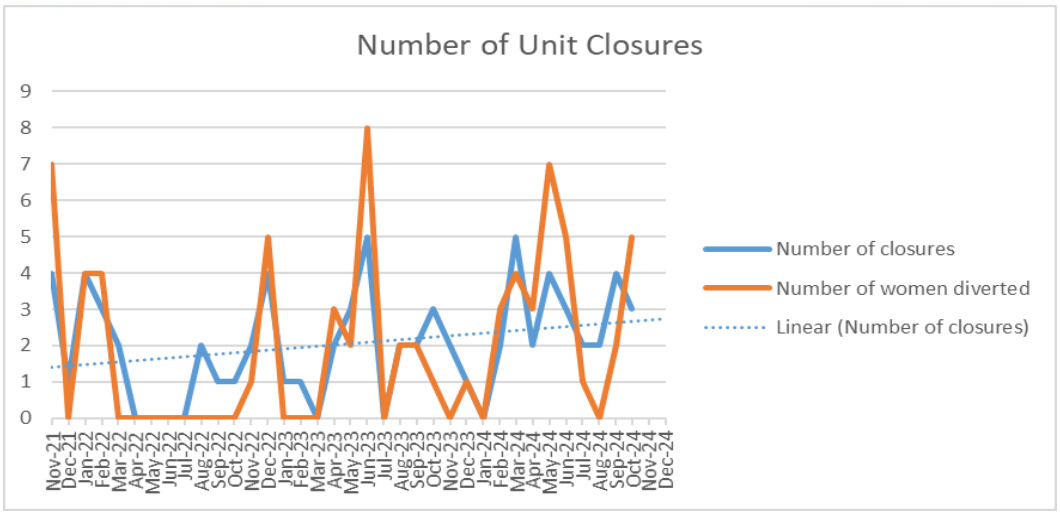




9. Risk and Safety

a. Maternity unit divert

There has been three events of divert of the unit in October 2024. Five 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 a divert being enacted and this is being reviewed as part of the staffing review (see Appendix A).



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 October four women were captured in local paper records as being transferred to Harrogate maternity service from elsewhere in the region for artificial rupture of membranes, on-going induction process or labour care.

c. SCBU Incidents

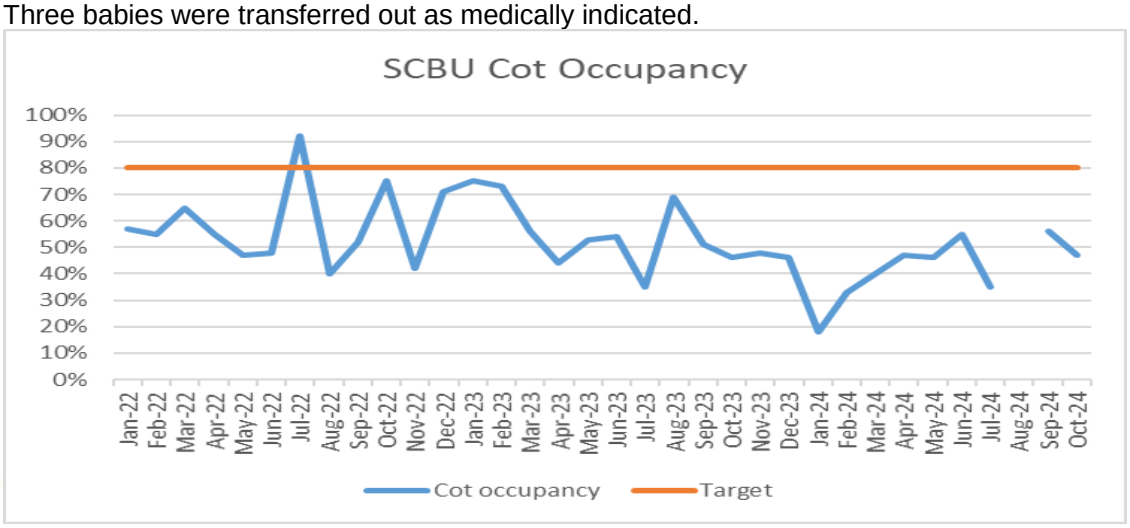
No moderate harm incidents.

d. SCBU Risk Register

Vacancy of QIS staff remains on risk register.

e. Cot occupancy and babies transferred out

Three babies were transferred out as medically indicated.



f. Maternity Risk register summary

Risk Register formally reviewed in October 2024

There are twelve currently active risks;

- Risk to patient experience and key performance indicators due to antenatal clinic process and clerical staffing issues (Score 10). Significant staffing challenges upcoming in Care Group 1 Medical Records team. One existing vacancy (band 4), two staff successfully offered new roles in patient systems team (band 3) and one staff member long term absence due to bereavement (band 2). Currently will be 1 / 5 WTE in post from 2 December. Plans to mitigate this risk include: interviews for vacant posts on 25/10, request for agency staff to support, reviewing options for re-deployment from other teams. Risk upgraded
- Risk to patient safety and experience due to increasing requirement for elective caesarean section list (Score 9). Additional list planned for launch this week which should increase elective caesarean section list capacity to meet increased demand. Still requires appropriate staffing levels of midwifery, obstetric, anaesthetic and theatre staff to support list and under review. Risk score currently to remain the same.
- Risk to patient experience and exposure to financial claim due to inadequate counselling and documentation of informed consent (Score 8). Additional work ongoing about informed consent regarding iron infusions and induction. No change to score at present.
- Risk to patient satisfaction and safety, and staff morale due to insufficient midwifery staffing (Score 8). Work ongoing at present for increased staffing and recruitment. Risk currently remain the same.
- Risk to patient experience and breach of triage timescales due to insufficient midwifery staffing in Maternity Assessment Centre (Score 8). Work ongoing to improve MAC triage assessment and staffing. No change at present.
- Risk to patient experience due to delays in scheduling process for elective caesarean section (Score 8).
- Risk of breaching Newborn Infant Physical Examination NIPE-SO4 standard and key performance indicator for review and clinical assessment by orthopaedic specialist (Score 6). Contract situation being reviewed for Orthopaedic surgeon. No change
- Risk due to inability to meet gold standard requirements for clinical documentation (Score 5). Notes audit review highlighted significant amount of documentation requirements within Maternity. Essential clinical documentation completed, but due to the extent of records requirement some non-essential and non-mandatory aspects are not being completed.
- Risk to patient safety and satisfaction due to need to undertake elective caesarean section within Delivery Suite theatre (Score 4).
- 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). Assurance received from Named Midwife for Safeguarding that WebV checking procedure implemented and being undertaken, so reducing likelihood of safeguarding concerns being missed. Score downgraded
- Risk to patient safety and accurate data recording resulting from potential manual entry and transcription error of blood group in BadgerNet (Score 2). Previous systems using PCS and paper-recording had similar risk from manual overwriting or transcription errors. Staff have been notified of alert and requested to use electronic requesting of

tests within Badgernet to enable electronic import of blood test results. Staff also reminded to use ICE as the required system when checking blood groups and not to rely on Badgernet entry. Blood products and Anti-D issued through Blood Transfusion lab, against ICE/LabCentre results rather than BadgerNet so not susceptible to transcription errors. Additionally blood transfusions routinely checked as a two person checking procedure and use ICE as the confirmatory record so should also reduce risk of error.

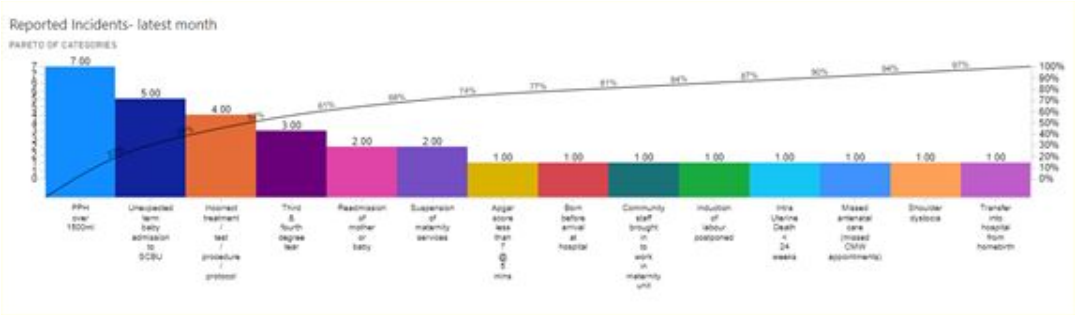
g. Maternity Incidents

In Oct 2024 there were 58 total incidents reported through DCIQ.

No incidents of Moderate Harm or above reported in October.

One significant incident of baby born following an antenatal placental abruption requiring significant resuscitation. The baby has been transferred to tertiary Neonatal Unit for ongoing care.

The number of incidents reported are as follows –



Open in Power BI
Maternity Summary v1
Data as of 08/11/24, 14:08
Filtered by **Category** (is Obstetrics & Maternity), **Date** (01/10/2024 - 31/10/2024)

10. Perinatal Mortality Review Tool (PMRT)

a. Principles for the conduct of local perinatal mortality reviews:

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

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

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

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

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

b. HDFT PMRT Information

No open cases. Quarterly report attached at Appendix C.

10. Feedback

a) Maternity service user feedback

Everyone we encountered in the maternity and delivery departments at Harrogate hospital were amazing! The staff working on Pannal Ward were incredibly supportive and attentive at all times, including on the phone to my husband and in the days following birth when we had concerns over health complications. Lauren and Rachel (our midwives in the delivery suite) were fantastic; they kept us as informed as we wanted to be, gave us authority over key decisions and made us feel truly cared for. All the staff who monitored our heart rate situation and performed the caesarean section when this was required showed professionalism and calm. We knew we were all in good hands, despite feeling fearful at the urgent changes. Since leaving hospital, all the community midwives have been wonderfully supportive and helpful in all respects. Sophie (and student midwife Katie) gave us sound advice and was a pleasure to have visit as she gave us such confidence during this new time. We cannot thank all of these people enough and want to reiterate how far above and beyond they went for us!

b) Formal Compliments

Two formal compliments received through Patient Experience Team for staff, one from patient and one from ambulance crew relating to support from a particular student midwife and wider team

*I'd like to thank the team on labour ward at Harrogate hospital for their compassion and kindness to me on ** October. I was part of the ambulance crew that bought a patient into labour ward as she was having an obstetric emergency. I came back up to labour ward shortly after taking mum in and talked to a student midwife. She hugely reassured me and was compassionate. She listened to me when I spoke about my previous maternity jobs and how my crewmate and I both needed to make sure mum and baby were well. She was fantastic. The minute she had information, she relayed this to me and ensured I was okay. The team at Harrogate were brilliant with mum and looked after her from the second we bought her in. I just wanted to say a massive thank you to them all and especially the lovely Jess.*

11. Complaints

One formal complaint received in October relating to neonatal readmission and birth experience. Four concerns have also been received this month, no theme has been noted.

12. Coroner 28 made directly to Trust

No Regulation 28 notifications have been received.

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

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

14. Maternity and Newborn Safety Investigation (MNSI)

No new MNSI incidents have been reported in October 2024.

15. Maternity Incentive Scheme – year six (NHS Resolution)

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

Work is on-going to ensure all Safety Action requirements are met. There is confidence that all requirements will be met before the deadline with the area most at risk being training compliance.

16. 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) RSV Vaccination

106 vaccinations have been administered.

c) Continuity of Carer

Funding from NHS England has been provided by Humber and North Yorkshire Local Maternity and Neonatal System to enable Harrogate maternity service to provide an enhanced offer to asylum seekers/refugees and young parents in community. An improved interpretation offer is also under consideration.

d) NHS England Perinatal Culture And Leadership Programme

An action plan has been developed and a report will be presented to Board next month.

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

Quarter One data not yet available.

18. Local HDFT Maternity Services Dashboard

Maternity Dashboard

19. Avoiding Term Admissions in Neonatal Units (ATAIN)

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

a. Term Admissions to SCBU

There were five Unexpected Term Admissions to SCBU (ATAIN) in October 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 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 Additional requirement to monitor theatre environmental temperature. QI project planned
Continue to monitor babies for longer on Delivery Suite with borderline saturations/respiratory symptoms before admitting (where safe to do so)	Modify and promote management of respiratory distress flow chart to include staying with the baby when appropriate	24/9/24 Good improvement in practice. QI project write-up in progress
Reluctance for Pannal Ward staff to administer unfamiliar IV antibiotics	Review process and consider additional training requirements	31/12/2024 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 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 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)

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

The tobacco dependency advisor service is becoming embedded with 10 of 12 women accepting the services offered being October.

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

	July – Sep 2024	
Small-for-gestational age detection rate [AN detection of SGA user reported or EFW <10th: Proportion of babies SGA (<10th) at birth that were reported by users to be suspected antenatally as SGA <10th or detected by EFW <10th]	SGA – 52.2% detection (<10th centile; 24 cases) (National average 49.4%)	
Fetal growth restriction detection rate [AN detection of SGA <3rd by EFW <3rd: Proportion of babies with birthweight<3rd centile who were detected as <3rd centile from one or more AN EFW]	FGR – 40.0% detection (<3rd centile; 6 cases) (National average 33.8%)	
	July-Sept 2024	October 2024
Percentage of babies <3rd centile >37+6 weeks' gestation	3.0% (10/430)	2.55% (4/157 babies born) as % of all babies born
Percentage of babies <10th centile >39+6 weeks' gestation	4.4% (19/430)	1.91% (3/157) as % of all babies born
SBLv3 Element 2 report: Percentage of babies <3rd centile who were born >37+6 weeks	62.5% (10/16) i.e. babies <3rd centile AND >37+6 as proportion of all babies <3rd centile	57.1% (4/7) i.e. babies <3rd centile AND >37+6 as

		proportion of all babies <3rd centile
Percentage of babies <10th centile who were born >39+6 weeks (% of all babies <10th centile)	30% (19/50) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile	18.8% (3/16) i.e. babies <10th centile AND >39+6 as proportion of all babies <10th centile
Incidence of women with singleton pregnancy (as % of all singleton births) giving birth (liveborn and stillborn):		
• In late second trimester (16+0-23+6 weeks)	7 fetal loss born 16-23+6 weeks (1.68%, 7/416)	1 fetal loss 16-23+6 weeks (0.64%, 1/155)
• Preterm (24+0-36+6 weeks)	4.3% (live, 18/416)	5.16% (live, 8/155)

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

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	30%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	50%	CNST Met
All Elements	TOTAL	Partially implemented	73%	Partially implemented	84%	CNST Met

21.0 Maternity Voices Partnership (MVP)

The MVP Chair has raised concerns regarding the funding required to move to being a Maternity and Neonatal Voices Partnership (MNVP). Harrogate MVP currently receives £14400 per year and an additional £1500 has been offered by the LMNS to move to hearing neonatal service user voices also. However £7,692 funding per unit was provided to LMNSs by NHS England as "*additional funding which recognised the central role MNVPs play in helping to improve care as outlined in Maternity and neonatal voices partnership guidance, and the need to strengthen the neonatal parental voice component"*. This amount of funding has not been made available to Harrogate Maternity Voices Partnership as yet. Conversations are on-going regarding this situation. There is a requirement to have a MNVP in order to achieve Maternity Incentive Scheme standards. The guidance states –

If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the

importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

This escalation will be followed in order to ensure the requirement is met.

22.0 Maternity Safety Champions

Bi-monthly Safety Champion executive and non-executive director walk around and meetings continue.

23.0 Conclusion and recommendation

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

Appendix A

Bi Annual Staffing Report	
	Time Period of Data **1st April 2024 – 30th September 2024**
Name & designation of person completing the summary	**Emma Barker, Matron for Maternity Service and EPAU and** **Leanne Likaj, Associate Director of Midwifery**
Clinical area/s covered by summary:	Delivery Suite Maternity Assessment Centre (MAC) Pannal Ward Community Midwifery Antenatal Clinic
Sources of data collection	Information obtained from E-Roster, BirthRate Plus acuity tool, NHS professionals.

Executive Summary

1. The aim of this bi-annual report (1st April 2024 – 30th September 2024) is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels in the maternity department. This is a requirement of the NHS Resolution Maternity Incentive Scheme, Safety Action 5.

2. The report provides assurance that there is the following:

- A systematic evidence based process that has been used to calculate midwifery staffing establishment within the last three years
- A midwifery staffing budget that reflects the establishment calculated above.
- A process is in place to manage daily workload activity and to address any shortfall in planned versus actual midwifery staffing levels.
- A calculated midwife to birth ratio.
- An appropriate percentage of specialist midwives employed and mitigation to cover any inconsistencies.
- 100% compliance with a midwifery coordinator in charge of labour ward who has supernumerary status; (defined as having a rostered planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service.
- An escalation plan which includes the process for providing a substitute coordinator in situations where there is no coordinator available at the start of a shift.

- One-to-one midwifery care for all women in active labour
- Monitoring of red flag incidents associated with midwifery staffing

3. The evidence described in this paper provides assurance that Harrogate and District NHS Foundation Trust (HDFT) has an effective system of midwifery workforce planning and monitoring of safe staffing levels in place.

Midwifery Establishment

NHS Resolution's maternity incentive scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment is completed and suggests Birthrate Plus (BR+) is utilised to provide this. The Royal College of Midwives (RCM) also strongly recommends using BR+ to undertake a systematic assessment of workforce requirements since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per NICE (2018) recommendation 1.1.3). It must however be recognised that one of the Ockenden (2022) recommendations was that

> *The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSEI, RCOG, RCM and RCPCH. Minimum staffing levels should be those agreed nationally or, where there are no agreed national levels, staffing levels should be locally agreed with the local maternity and neonatal system (LMNS). This must encompass the increased acuity and complexity of women, vulnerable families and additional mandatory training to ensure trusts are able to safely meet organizational Clinical Negligence Scheme for Trusts and CQC requirements. Minimum staffing levels must include a locally calculated uplift, representative of the 3 previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.*

A BR+ establishment review was last completed in August 2024 utilising three months data for December 2023, January and March 2024 and annual birth activity from 2023/24. The total births in 2023/24 review period was 1714. The Birthrate Plus establishment staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care. The 2024 BR+ establishment review recommended a total Clinical, Specialist and Management whole time equivalent (WTE) of 77.86 midwives, 10.45WTE of which are specialist and management. This is an overall increase of 1.65 WTE midwives from the previous BR+ report in 2021 and is based on a 20.78% headroom/uplift for absence. Given the increased training requirements for midwives it is proposed to move to an uplift of 24% which is more in line with other maternity departments across the UK. BR+ would therefore propose that 80.56 WTE midwives are required. The HDFT funding for midwives currently is 75 WTE (including LMNS/NHSE funded posts) and there is currently 73.57 WTE in post (plus 5.11 WTE midwives on Maternity Leave) as at the end of September 2024. The BR+ report is currently undergoing application of professional judgement and costing ahead of being presented at Establishment Review meeting.

In addition to establishment setting, BR+ also provide an acuity monitoring tool. The BR+ workforce planning calculation determines the required total midwifery workforce

establishment for all hospital and community services, whilst the Acuity App assesses real time staffing based on the clinical needs of women and babies for intrapartum and ward areas. Together they support the provision of safe and effective care which is both sensitive and responsive to changes in acuity and workforce. The BR+ acuity tool was purchased in September 2018 and BR+ updated the ward tool in 2024. Information from this BR+ tool is included within this report. Information is collected from in-patient areas only (Delivery Suite and Pannal ward). Unfortunately there isn't currently any system available to monitor acuity in a triage area like MAC.

The agreed staffing levels in all areas of the maternity department are outlined in the Minimum Staffing Guideline (Maternity). The minimum staffing levels have been agreed based on activity levels, current bed base and the numbers of midwives required to provide safe care to women and their babies. The maternity escalation policy provides clear guidance for the midwife in charge to follow in order to manage a shortfall in staffing (including the absence of a supernumerary Delivery Suite Coordinator) and the clinical and/or management actions to be taken. The clinical and management actions are also detailed in the BR+ acuity tool in order to capture the management of this shortfall. A review of the current and planned activity is undertaken to support the decision.

Establishment Deficits

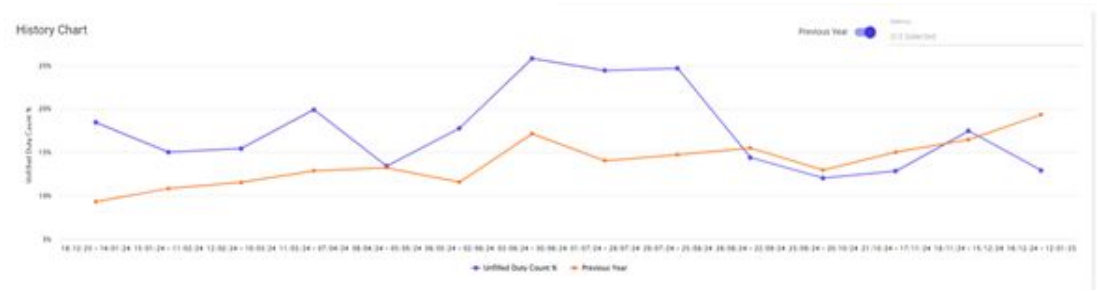
Maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

- There is an escalation policy for staff to use in the event of staffing short falls.
- A gap analysis will be completed against the recommended staffing levels in the BR+ report with any deficit being identified and actions taken to mitigate in the short and long term.

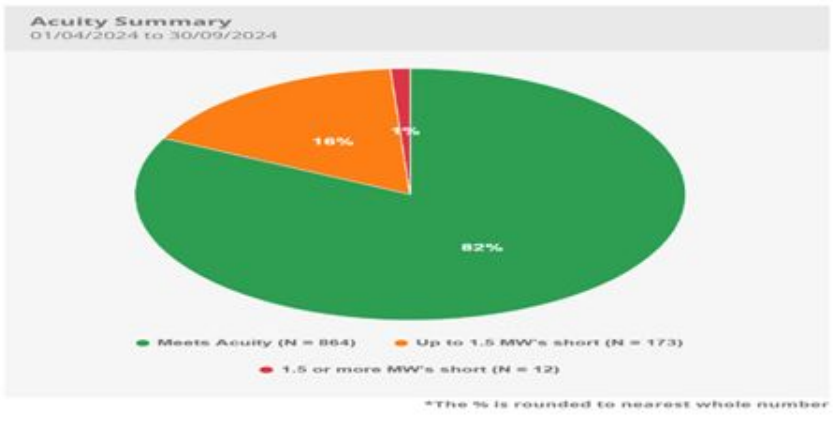
The maternity department continues to actively recruit new staff as required. The table below shows the number of starters (in WTE) balanced against the numbers of leavers between April 2024 and the end of September 2024.

	Midwives	Maternity Support Workers (MSW's)
New Starters	0.6	0.8
Leavers	4.1	1.4
Career break	1.0	0
Maternity Leave	7.17	1.2
Secondment	1.0	0

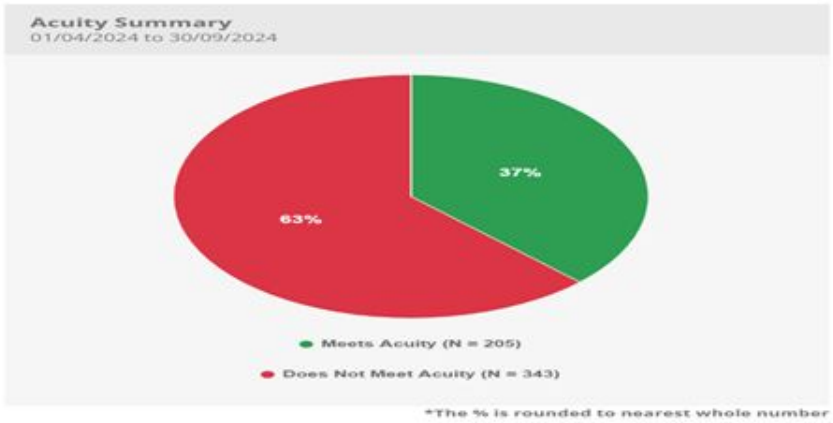
There has been a noted staffing gap during the last six months due to an increase in maternity leave (4.41WTE Oct23-Mar24), and an incentive has been applied for midwives working additional shifts through NHS Professionals (NHSP). Agency midwives have also been utilised when available. The below graph demonstrates that the unfilled roster percentage increased June 2024 to August 2024 as shown by the purple line. The orange line provides a reference point against the previous calendar year.



From the data submitted on BR+ over the six month period, staffing met the acuity on Delivery Suite 82% of the time, 16% of the time staffing was up to 1.5 midwives short and 1% of the time more than 1.5 midwives short (this is equal to 12 occasions). Compliance with completing the tool was 78.14%.

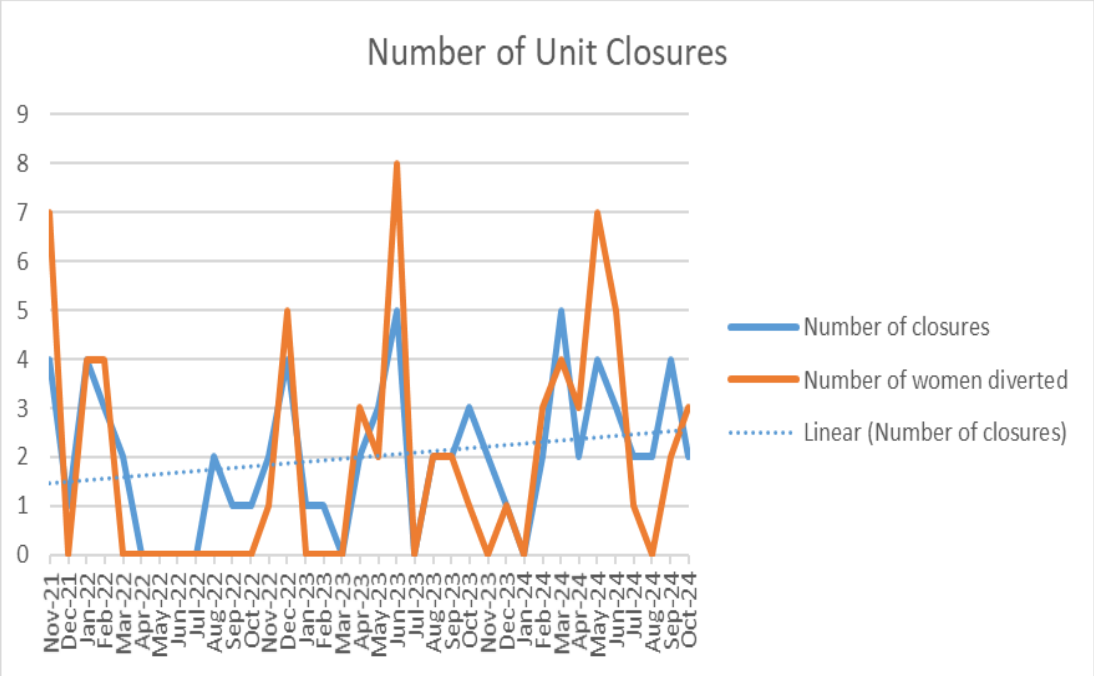


BR+ have developed the acuity app for Pannal ward over the course of the last six months for antenatal and postnatal care. The tool demonstrates that staffing does not meet acuity on Pannal 63% of the time.



The maternity unit has the ability to move staff around the unit and between inpatient and outpatient areas dependent on activity and acuity as and when required. Mitigation to cover

shortfalls is incorporated in the maternity escalation guideline and achieved in the short term by implementing clinical and management actions, collected in the BR+ acuity tool. Due to the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly or temporarily close to further admissions. During this period the maternity unit was on divert on seventeen occasions with eighteen women diverted to other hospitals. This an increase on the previous report and the graph below demonstrates that this is an overall increase.



A Datix incident form is completed when there is increased activity and the unit has closed or women in labour diverted to another unit as a consequence. All women diverted elsewhere are sent a letter apologising for the inconvenience of the diversion. All closures are reviewed by the Matron with the Labour Ward coordinator to discuss the activity, staffing and decision making before the escalation paperwork is signed off. There is an oversight of staffing issues through Maternity Risk Management Group (MRMG) meetings and monitored through Datix.

Planned Versus Actual Midwifery Staffing Levels

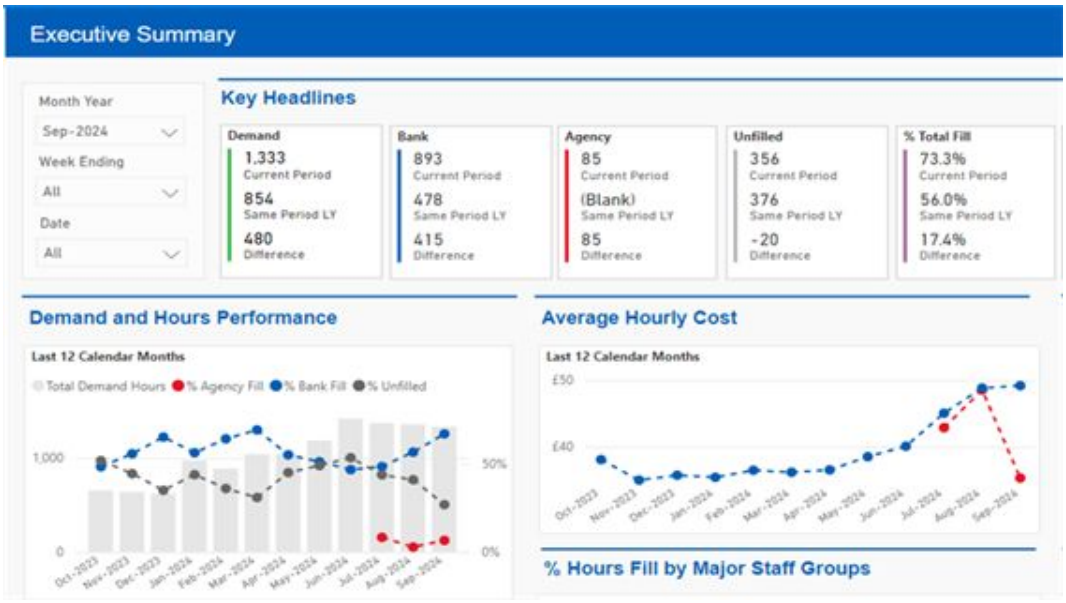
A weekly midwifery manager's huddle is in place to review the planned staffing against the agreed establishment for each clinical area with the ability to redeploy staff when required.

Daily staffing reviews are also held by the Manager of the Day/Delivery Suite Coordinator to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

Actions have been taken as per the Maternity Escalation Policy to mitigate against unfilled shifts. This included "staff movement between areas" and "specialist midwives and team

leaders working clinically ” as reflected in the Red Flags reported, as well addressing staff shortfall by using the on-call midwife during the night shift.

NHSP bank staff are requested to fill all roster gaps which the majority of the time are due to sickness or vacancy. NHS Professionals demand and fill is demonstrated below.



Midwife: Birth Ratio

The monthly midwife to birth ratio is currently calculated by taking the total number of births per month, multiplying by 12 then dividing by the number of clinical midwives. This calculation does not take into account midwives who were unavailable for shifts due to sickness or absence. The midwife: birth ratio does not take into consideration the acuity/requirements of the woman being cared for in labour. The Associate Director of Midwifery and Matron are not included in the midwife to birth ratio however team leaders have their clinical time included.

HDFT midwife to birth ratio

Midwife to Birth ratio	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
Ratio	1:25	1:27	1:29	1:26	1:27	1:28
Number of births	134	150	150	132	138	153
Midwives in post	64.1	65.38	62.56	60.68	60.91	64.87

Specialist Midwives

BR+ suggests 15.5% (10.45WTE) of the midwifery establishment are not included in clinical numbers. This includes those in management positions and specialist midwives

The current percentage of specialist midwives employed is 15%. All midwives within this staff group support the maternity unit by working clinically if required at times high activity or acute sickness within office hours. A significant number of them also provide clinical care as part of their specialist role.

The specialist roles support national recommendations to ensure the service has the correct specialist posts for the demographic served and are in line with current national initiatives.
The service has a wide range of specialist midwifery posts at Band 7 and 8A as detailed below totalling 12.46 WTE;

- Bereavement Specialist Midwife 0.96 WTE
- Infant feeding Specialist Midwife 0.8 WTE
- Quality and Safety & Governance Lead 1.00 WTE
- Named Midwife for Safeguarding 1.0 WTE
- Antenatal and New-born Screening Specialist Midwife 1.0 WTE
- Professional Midwifery Advocate Lead Midwife 0.6 WTE
- Digital Midwife 0.8 WTE
- Midwife Sonographer 0.80 WTE
- Recruitment and Retention Midwife 1.00 WTE
- Perinatal Pelvic Health Midwife 0.4 WTE
- 2 x Professional Development Midwives 1.3 WTE (Inc. Fetal Monitoring Lead role)
- Clinical Educator Midwife 0.6 WTE
- Perinatal Mental Health Midwife 0.8 WTE
- Audit Midwife 0.8 WTE
- Diabetes Specialist Midwife 0.6 WTE

Compliance with Supernumerary Labour Ward Coordinator Status and Provision of One to One (1:1) Care in Active Labour

Data extracted from Birthrate plus during the six months shows there was a completion rate of 78.14% on the Delivery Suite and 74.86% for Pannal. A higher compliance completion rate provides more assurance that the interpretation of the results is accurate.

The labour ward coordinator has supernumerary status, (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift (NHS Resolution, Maternity Incentive Scheme, 2024) to enable oversight of all the birth activity within the service.

There is always a delivery suite coordinator (or suitably experienced band 6 midwife in exceptional circumstances) rostered to be in charge on Delivery Suite and they will aim to be supernumerary in order to provide oversight of all birth activity in the service. 100% compliance was achieved with having a rostered planned supernumerary coordinator and an actual supernumerary coordinator at the start of every shift.

Harrogate is a small maternity unit and there is full recognition of the advantages of the Delivery Suite coordinator being supernumerary in improving outcomes for both mother and baby.

All information was collated using the Birthrate Plus acuity tool. During this six month time period there were 30 occasions when during the shift the Delivery Suite coordinator became not supernumerary out of a 1098 opportunities to record (858 recorded occasions) which equates to 97.27% supernumerary status. Each completion refers to a four hour period and the occasions of none supernumerary status may only occur for a small amount of time during each four hour period. Predominantly these occasions were during the night and at weekends when there is no additional staff available to support the service (ward managers and specialist's midwives). There is a clear escalation process in place when the coordinator cannot be supernumerary which includes contacting the community teams at a weekend and the hospital midwife on call at night.

During this time period 1:1 care in labour was achieved 99.9% of the time for women admitted to the unit.

- 857 women birthed
- 2 women experienced a baby being born before the arrival (BBA) of the midwife,
- 7 women had a homebirth

The figure is not 100% for 1:1 care, as one woman arrived for induction on the ward and birthed before the process was commenced.

Red Flags

Red flag events have been agreed locally (including guidance from NICE) and are captured on the BR+ acuity tool on Delivery Suite. During the 6-month period between the following red flag events were identified on Delivery Suite;

Number of Red Flags recorded
01/04/2024 to 30/09/2024

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	1	11%
RF2	Missed or delayed care	0	0%
RF3	Missed or delayed mediation > 30 mins	0	0%
RF4	Delay in providing pain relief > 30 mins	0	0%
RF5	Delay between presentation and triage >30 mins	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	3	33%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Midwife unable to provide 1:1 high dependency care for AN or PN patient	5	56%
TOTAL		9	

*The % is rounded to nearest whole number

Within Birthrate plus there are a number of Management Actions listed which can be used with the aim of preventing progression to a red flag incident. These include delay in elective activity, use of non-clinical staff, and use of managers in clinical areas. Red flags are set to highlight when there is a safety issue that has not been prevented by utilising the management actions. HDFT strive to have no red flag incidents however, high acuity or staffing issues can lead to one or more of the red flag incidents occurring. Staff are encouraged to be open and honest in the recording of red flag incidents so that accurate oversight can be maintained of the maternity service, and action can be taken if necessary. There is a well embedded escalation policy which is followed in periods of high acuity or inadequate staffing cover.

Any time a red flag event occurs, a senior obstetric review will be required and a clinical pathway will be put in place. Good communication is shown with our service users during this time, keeping them informed of reasons for any delays, and likely timeframes for resuming their normal care pathway.

If the escalation policy is triggered, details of all activity during this time is recorded, and reviewed by the senior management team. This is to consider if alternative management could have prevented pressure on the service, and to review if all safety measures were

taken to minimise the risk of harm. Learning from the review will be discussed with the relevant team members.

Summary

Staffing levels are continually reviewed by the Associate Director of Midwifery, Matron and senior midwifery team leaders in line with known workload and projected maternity bookings in Maternity Services and information from the BR+ acuity tool. The minimum staffing levels are agreed within the Maternity staffing guideline for the department and the BR+ acuity tool offers additional information on these levels and the acuity of the women however, it is for in-patient areas only and does not include Antenatal clinic (ANC) or community midwifery teams.

Recommendations

1. Maternity budget review to be completed to ensure the HDFT funding aligns with BR+ recommendations and professional judgement
2. Ensure sufficient headroom applied to maternity staffing budget

Appendix B

ATAIN and Transitional Care provision report Quarter 2 (July –Sept 2024)

Report Overview

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

The National Ambition

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

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

Why is it important?

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

Collaboration between neonatal and maternity staff at HDFT has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use our service. Along with this HDFT maternity and neonatal services completed the first year as a Wave 1 Trust, with the National Maternity and New born Safety Collaborative (NHSI). This national quality improvement programme enabled our maternity and neonatal service to further develop and focus on key areas for improvement using a consistent Quality Improvement approach supported by the NHSI team and online resources. The improvement leads have focused on improving hypoglycaemia pathway of care and the jaundice pathway as well as communication with families and carers as part of the wider ATAIN programme of work. In addition to this babies requiring readmission for jaundice now attend Pannal ward as first contact. 16 midwives have achieved competence in obtaining Serum bilirubin tests from babies which this has streamlined the jaundice pathway and reduced delays between admission and commencing treatment. The maternity and neonatal teams review the Term neonatal admissions at 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.

ATAIN data: Quarter 3 2024/25:

During quarter 3 there were a total of 423 babies of all gestations born at HDFT, 403 of these were >37/40 weeks gestation and there for admissible for ATAIN audit. Of the 403, 11 babies of >37/40 gestation were admitted to the neonatal unit. SCBU admissions for this quarter were

lower than previous quarters that has been consistently reported (11 this quarter, 16 last quarter).

There is an escalation policy for any babies who are unwell which is well known by the team and followed should the need arise.

Cause	RDS	Hypoglycaemia	Infection	Low SATS	Jaundice
Number of Babies Reviewed	5	1	3	1	1

Potentially avoidable admissions:

Two of the above cases were potentially avoidable but managed well in line with the flowchart.

ATAIN actions

- Safe skin to skin poster being displayed - this is as a result of a neonatal collapse within the first hour of birth due to overlay/positioning.
- Video created to make staff aware where to plug in a resuscitaire in the recovery area in main operating theatres. This is an action following a neonatal collapse following an Elective caesarean section. The resuscitaire in theatre was in use and therefore unavailable.
- Preventing cold babies: video about thermoregulation created and updated respiratory flowchart.

Transitional Care Provision and Standards

Introducing Transitional Care (TC)

Through family integrated care, families have been encouraged to take an active role in caring for babies on the neonatal units (NNU). Introducing TC follows the same philosophy and thus services should be created with the needs of the family at the forefront.
One of the key advantages of TC is offering early intervention makes it less likely the neonate's condition will deteriorate. Thus, reducing the risk of maternal and neonatal separation and increasing the chance that neonates remain well. This also ensures that care is cost effective.
It is important that the staff working on the NNU and postnatal ward understand the difference between 'normal' post-natal care and TC. It is also vital that maternity and neonatal staff can evaluate and respond to the maternal and neonatal needs whilst being able to detect signs of deterioration as early as possible, therefore multidisciplinary collaboration is essential.
At HDFT, a review of TC babies occurs daily during dedicated ward rounds, where an assessment takes place and plans of care are made. This review takes place using the jointly approved neonatal/maternity document. There is an escalation policy for any babies who are unwell.

TC babies: includes pre-term as separate from ATAIN

July	August	September	Total TC
5	5	11	21

Transitional Care provision September 2023 to September 2024

2023 September	5
October	2
November	8
December	6
2024 January	3
February	8
March	9
April	8
May	7
June	8
July	5
August	5
September	11

Quarter 2 Transitional Care Data:

During this quarter 21 babies have been card for in a transitional care model.

20 of these babies have been on TC due to requiring intravenous antibiotics. One baby was on TC due to prematurity and was born at 35 weeks gestation.

TCU action log:

- Meeting planned with MVP lead, Pannal ward manager, Neonatal Educator and Governance Lead, and Infant Feeding Lead to review current service, improve obtaining patient feedback, communicating what a TC baby is, and improve how we recognise who is a TC patient next quarter.
- Continue to provide Badgernet training to medical staff on orientation and within this training discuss ‘how to do a TC ward round’

Appendix C

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, July-September 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.

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

Compliance of eligible perinatal deaths with MIS requirements

Table 1: Eligible perinatal death against MIS requirements

During Quarter 2, there were no perinatal deaths eligible to be reported to MBRRACE-UK and receive a panel review as part of PMRT.

The PMRT review and report for MBRRACE-UK Case ID 93563 has now been completed and published to MBRRACE-UK in line with the MIS requirements.

Ongoing Action Plan following PMRT review

Root cause/Contributory Factor	*Action*	*Risk at review*	*Evidence of Progress/Completion*	*Target completion date*
Lack of compassionate communication and care	Ongoing work into provision of compassionate care, including culture survey work with MVP around language. Complete SCORE (culture survey). Continue to provide staff with case studies and parental feedback to work on culture.		SCORE (culture survey) completed and closed 18.3.24. Ongoing culture conversations and action plan in development following on from completion of the culture survey results.	31.12.24
Symphysis fundal height measurements were not performed at correct times/intervals	Education and training with the obstetric team to reinforce fundal height measurements during antenatal appointments within antenatal clinic.		Education and training and communication with consultant body.	30.9.24 Completed
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.		Review of access to patient information leaflets audit and request for change for possibility of patient access to scanned documents.	31.12.24
Patient felt they did not have sufficient oversight from midwifery staff prior to imminent delivery.	Communication with staff and change to guidance to encourage low threshold for further management where bereaved patient is requiring further pain relief.		Bereavement guideline updated and reviewed in MQAM. To be disseminated to staff.	1.11.24

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

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

GOALS:

Best Place

The best place for person centred, integrated care

Exemplar System

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

Equitable & Timely

Equitable, timely access to best quality planned care

GOVERNANCE:

Person-centred Framework

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

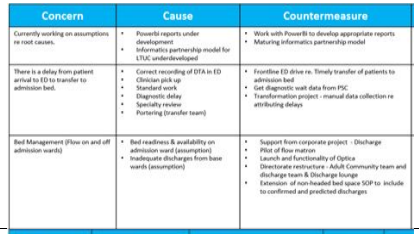
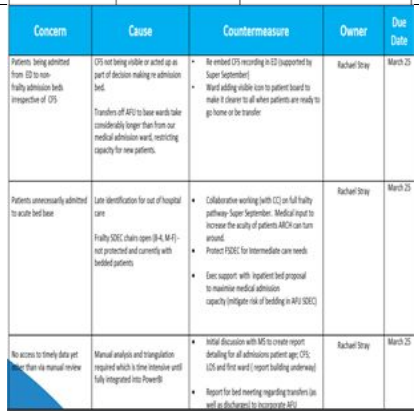
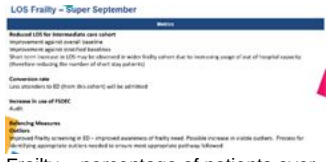
True North Metrics

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

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

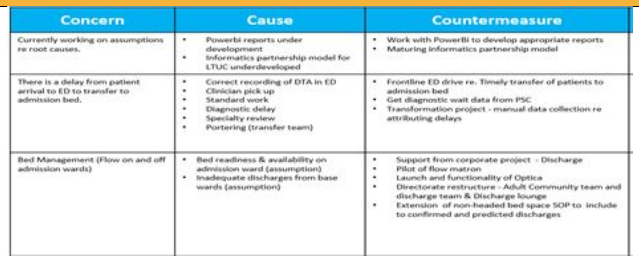
Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
Person Centred, Integrated Care, Strong Partnerships	**The best place for person centred , integrated care**	**4 hour ED standard**	**Operational: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

Strategic Metrics Summary:

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred, Integrated Care 	ED 4-hour standard	95% of non-admitted patients not requiring a bed to be assessed, diagnosed, treated and discharged with 4 hours. 95% of admitted patients to be moved to required department within 60 minutes of medical decision.	In 12 months, we want to be at 85% of patients having their care completed within 4 hours. In 24 months, we want to be at 95% of patients having their care completed within 4 hours.	Refresh of root cause analysis – revealed wait for medical bed as highest driver of 4-hour breach. Agreed (at PRM) switch of breakthrough objective to allow focus on this – switched to admission to inpatient bed within 120mins of decision to admit 	Breakthrough Objective: Time to inpatient bed less than 120mins from DTA Median time to PSC, LTUC or Paediatric bed ED performance breaches and LOS - Power BI LTUC – 386 mins *(180mins, 208 mins)* PSC – 405 mins *(212, 262 mins)* Paeds –110 mins *(121, 108 mins)* *( ) previous months* **Significant bed and flow pressures through October leading to deterioration in performance- root cause from LTUCC & PSC awaited.**		
Care of the elderly 	Length of Stay with frailty	To improve the health and wellbeing of our eldest and most frail patients by supporting care closer to home through the reduction in unnecessary emergency inpatient admissions and, for those who are admitted, ensure their length of stay is only as long as medically required. Top quartile LOS nationally for patients with frailty	1st Goal: To identify all patients with frailty by developing a suitable platform for recording and accessing Clinical Frailty Scores, and undertake more detailed evaluation of assessment admission pathways based on CFS data 2nd Goal: to reduce the overall number of patients with frailty who are admitted by improving access for all appropriate patients to early specialist review and intervention 3rd Goal: For those patients with frailty who do require inpatient care, to reduce the average length of stay through early specialist review and intervention		Delay due to timescales for EPR. Bed capacity issues have made it difficult to progress the Transformation of the admission process at present. Weekly discharge achievement by ward - Power BI Super September underway – learning and then data/metrics to be developed  Frailty – percentage of patients over a 7 day LOS has reduced. Average LOS has increased.		
Equitable & Timely	Elective Recovery (RTT) standard	No patients waiting 18 weeks.	In 12 months, no patients waiting over 52 weeks for treatment In 12 months, 18-52 weeks pathways reduced to 6,000 In 24 months, back to RTT 92% standard	Wharfedale Theatres (TIF1) gone live in September 2024, staffing in place HDH Additional Theatres (TIF2) build on track for 2025 delivery Outpatient Transformation, rollout of further faster programme and track 6 key metrics Theatres Productivity (78%)	On trajectory for clearance of 52 weeks. Over 52-week pathways end of year breaches active: 7168 (9111) down from 23,217(1st April 2024) Current pathways over 18 weeks = 7635 (7067) 18 week percentage = 67.9% (69%)		

Workstreams	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk to Achieving Goal (CxL)	Level of Risk for progressing actions
	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	Never greater than 60 patients over 62 days. Less than 40 patients over 62 days by 1st April 2025 Never lower than 70% of patients have their treatment commenced by 62 days 80% of patients have their treatment commenced in under 62 days by 1st April 2025	Developing workforce capability and expertise to better guide analyst time in creation of stratified data dashboard for cancer waiting times Ensure capacity to deliver first appointments within 19 Days Stratify impact of complex imaging waits on cancer performance - data now available (August 2024)	October 2024 – 42 patients over 62 days (41Sept) CANCER(FDS&62DAY) - Power BI October 2024 85.9 % patients treated by 62 days (Sept 2024- 82.9%) Cancer Dashboard v2(unvalidated) - Power BI		

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

Workstream	True North Metric	Vision	Countermeasures	Current Status	Level of Risk To Achieving Goal (CxL)	Level of Risk for progressing actions
The Best Place for Person Centred Care	4-hour ED Wait Time	All patients will move to a ward within 120mins of the decision to admit being made Goal:10% Reduction in number of medical bed delays by November 2024		Breakthrough Objective: Time to inpatient bed less than 120mins from DTA Median time to PSC, LTUC or Paediatric bed ED performance breaches and LOS - Power BI LTUC – 386 mins *(180mins, 208 mins)* PSC – 405 mins *(212, 262 mins)* Paeds –110 mins *(121, 108 mins)* *( ) previous months* **Significant bed and flow pressures through October leading to deterioration in performance- root cause from LTUCC & PSC awaited.**		

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. See the A3 & Breakthrough Objectives pertaining to this.	4 x 4 = 16	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 Aug 25	Clinical: Patient Safety	Minimal
NEW: Oct 24	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
NEW: Oct 24	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

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:

Financial Framework

- Board Assurance: Resource Committee
- Performance Review Meetings and Strategy Deployment Room
- SRO: Director of Finance
- Operational Lead: Deputy Director of Finance

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

1

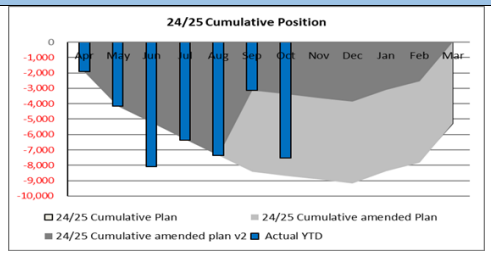
- **Financial Sustainability**

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

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

True North Metrics Summary:

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
Financial Sustainability	HDFT to be a financially sustainable organisation	In 2024/25 the Trust, and therefore directorates, should live within the financial resources available to us. Where this is not possible there is a need	In relation to the operational position the current countermeasures are in place – 1. Delivery of coding optimisation schemes 2. Activity delivery schemes 3. Wider Waste Reduction and Productivity (WRAP) Schemes 4. Review of "unfunded" posts	As at month 7 the Trust is reporting a deficit of £4.3 against the system plan of £3.3m revised planned deficit following confirmation of deficit funding. £5.2m. Funding has been confirmed for the Pay Award from some NHS Contracts, we are still awaiting confirmation from Education, Dental and Councils.		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		to develop wider mitigating actions. The Trust will return to segment 2 of the National Oversight Framework.	5. Controls and actions regarding Medical and Dental/Agency 6. Approach to Clinical Supplies and Services 7. PRM focus – move from budget change to run rate impact To support delivery there is also wider Monthly Financial reporting, REACH reporting (financial reporting system) has been rolled out to increase visibility and accessibility of spend information. Discretionary Spend controls and monitoring in place. Additional approval for spend over £10k introduced. NHS Supply Chain restrictions. Introduction WRAP Champions being developed. There is a formal plan in relation to the Price Waterhouse Cooper review commissioned by the West Yorkshire Association of Acute Trusts for the Trust, however, a number of countermeasures are responding to the findings. The Trust is currently participating in the Grant Thornton review of the financial grip and control in Humber and North Yorkshire Integrated Care System. Following the change in Trust segmentation work is being undertaken to establish the exit criteria associated with finance.	 Current forecast is from £0 (Best), £13m (likely) to £17m (worse) deficit. The 'best' assumes funding will be received for the wider system support HDFT currently provide ED/Ward, the Dental contract offer is honoured and pay award funding is received for Council contracts and shortfall on NHS contracts. The 'worse' case scenario assumes the impact of B2 to B3 negotiations, no further funding is received for pay awards, winter and the dental contract is not honoured. Further detail is contained within the finance A3 and regular finance report shared at Resource Committee. 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.		

Related Corporate Risks

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

Related External Risks

ID	Title	Description	Current Rating (CxL)	Target Rating (CxL) & Date	Risk Type	Risk Appetite
	Cash Balance	The cash forecast highlights the need for Cash Support for Qtr 3, request has been submitted. There are a number of drivers which include lack of confirmation on when funding will be received for the pay award, contracts and ERF.	5 x 2 = 12	4 x 1 = 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  Belonging 	Staff Engagement Index	Central to HDFT's strategic vision is that it should create a great place to work with the right people, with the right skills in the right roles. This includes providing a caring working environment that promotes wellbeing and innovation whilst improving quality and safety. The ambition is to understand how colleagues are feeling towards HDFT as a place to work and as an employer using a range of emotional indicators. The twin ambitions are to: 1. Continuously improve the level of survey response rates. 2. Improve the overall Staff Engagement Score	To continually improve our Employee Engagement Score against Pulse survey benchmark by having a framework for leaders and line managers which supports colleagues to bring their whole selves to work and that they belong, that they feel they can influence their role and suggest improvements and that they feel their Health & Wellbeing is a key priority in the Trust **Goals:** 1. Continuously improving trend regarding Inpulse survey response rate. 2. Continuously tracking above our benchmark group engagement score. 3. Validate the improvement by seeing an improvement in the National Staff Survey Overall Engagement Score in the 2024 survey results.	Incorporating the NHSE "Expectations of Line Managers" into HDFT people management infrastructure and developing appraisal and diagnostic tool to reflect IMPACT behaviours. Implementation of Workforce Disability Equality Standard action plan and a focused piece of work on age and disability discrimination. (Also implementing the Workforce Race Equality Standard action plan.) HDFT IMPACT programme (Transformation and Continuous Improvement): methodology implementation across the Trust will enable staff to influence how their role is carried out. 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.	Teamwork survey, which closed 31.7.24 response rate was 30%. Engagement score for July 2024 is 7.15 against a benchmark score of 6.55. This is an increase on the previous engagement score in April 2024 of 6.79. Executive Director Appraisal process up-dated to incorporate HFDT IMPACT Leadership Behaviours and methodology and NHSE Competency Framework for Board Level Leaders. 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. 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. People Promise Manager working across identified areas of high turnover to support retention. Flexible working to be a key workstream in Q4.		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
Growing for the future 	Staff Availability (Staff unavailability = vacancies WTE + WTE lost to sickness + Career Break WTE + Maternity WTE + Secondment WTE + Turnover WTE + Inefficient rostering practice + time to hire) .	To ensure HDFT is the 'best place to work' there must be the right number of staffing available each day for deployment to ensure quality of care and to enable those staff to have a good experience and do their best. The combination of vacancies against the budgeted establishment or service line versus the number of staff that can be deployed from it at any given time determines how many staff are available for work. The budgeted establishment figures in August were 4,528.34 WTE for the whole of HDFT with an overall 4,179.37 WTE in post (this equates to 349 WTE vacancies). However, there are a further 392 WTE unavailable for work for a variety of reasons including sick leave, turnover, maternity/paternity leave and careers breaks and time to hire that expand the vacancy position by creating a "workforce deployment gap". Therefore, the total gap in establishments of vacancy plus deployment gap equates to 764 WTE that were unavailable in August.	To reduce the establishment gap we will focus on vacancy rates and on increasing workforce deployment. Where we know a vacancy cannot be filled through recruitment advertising (e.g. National or Local shortage occupations) we will ensure there is a plan to cover this gap longer term through apprenticeships, training programmes or the development of new roles. **Goals:** 1. A vacancy rate that does not exceed 6% 2. A Turnover rate that does not exceed 12% (HNY is 12.2%) 3. Staff leaving within their first year of employment to not exceed 15% 4. 100% of rosters signed off and issued 8 weeks before. 5. Sickness levels throughout HDFT to not exceed 4.5% (HNY is 4.8%) 6. Apprenticeship or training plan/development of new role in the medium to longer term for shortage occupations	HRBPs working with Directorates to set up 2 weekly meetings (ideally) in current governance structure to discuss and review top 50 staff off sick (by cost or length or other metric) with General Managers/Service Managers. This is following the launch of the new/updated Sickness Absence and Support Policy on 1 November 2024. (HRBPs to work with GMs to identify actions to tackle top 3 sickness absence reasons in each of the top 5 care groups per Directorate)	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." 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. Staff unavailability has seen an increase in October 2024 from 515.84wte to 559.05wte and the main factor is due to an increase in sickness from 204.90wte to 241.67wte. This supports the move of the True North focus from vacancy rate to sickness absence. The Trust vacancy rate is 3.42% at the end of October 2024, which is below the Trust target of 7% (A3 threshold of 6%). The overall Trust vacancy rate is currently 3.42% at the end of October 2024, which is below the Trust target of 7% and the A3		

Workstream	True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving in year Goal	Level of Risk for progressing actions
New Ways of Working 					threshold of 6%. This is an increase from 3.09% last month and is due to an increase in the budgeted establishment by 28.90wte. All clinical Directorates have seen a decrease in vacancy rates this month, with 'Children's and Young Peoples Public Health' seeing the greatest decrease from 4.97% to 2.78%. The Clinical Directorates are all below the Trust target of 7% and A3 threshold of 6% for vacancy rates in October 2024, with CYPPH at 2.78%, LTUCC at 4.99% and PSC at 5.25%. (It should be noted that following a Directorate restructure from 1st October 2024, the data for October 2024 is not entirely comparable to the previous month.) Trust turnover is 11.28% -Sickness is 5.45% -Staff leaving within 1st year is 18.50% (this has decreased from 19.13% last month) - Rosters signed off and issued 8 weeks before (at 67.3% excluding HIF).		

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.	The overall Trust vacancy rate is 3.42% at the end of October 2024, which is below the Trust target of 7% and the A3 threshold of 6%. This is an increase from 3.09% last month and is due to an increase in the budgeted establishment by 28.90wte. The Clinical Directorates are all below the Trust target of 7% and A3 threshold of 6% for vacancy rates in October 2024, with CYPPH at 2.78%, LTUCC at 4.99% and PSC at 5.25%.		

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:

Quality & Safety

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

Information

Timely, Accurate Information to enable continuous improvement

Electronic Health Record

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

GOVERNANCE:

Digital Framework

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

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

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

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

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

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	Removal of complex, high risk, manual data validations leading to a reduction in the length of time required for RTT team to undertake validation activities. Expected saving c.1-2 minutes per validation. % Reduction in temporary staffing spend measured by comparing agency/bank spend against WTE establishment, vacancy and unavailability rates with 'expected' 24/25 - £150k saving 25/26 - £300k saving	Luna RTT Tracking (May 22) Medic Rostering (Jul 23) Datix Cloud (Mar 23) ASCOM Nurse Call (Sep 23)	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 Medical Rostering project completed and closed. Datix Cloud Project completed and closed. ASCOM Nurse Call Bell, initial go-live completed in February 2024 with further roll-out in the process of development. 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

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

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

GOALS:

Healthcare Innovation

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

Children's Public Health

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

Clinical Trials

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

GOVERNANCE:

Healthcare Innovation Framework

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

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

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

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

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite
				1 – 3 | 4 – 6 | 8 – 9 | 10 | 12 | 15 | 16 | >20
Healthcare Research and 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	

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	Support at least 2 external innovations, at least 2 internal innovations and establish at least 1 strategic partnership with industry.	Establishment of a regional Innovation Hub A developed workforce creating a culture of innovation A robust innovation governance structure A developed innovation infrastructure Strong, professional innovation partnerships Identification of areas of unmet need	Innovation Hub in situ and due for soft launch in Winter 2024 with larger event in Spring 2025. Workforce in develop with 2 x preceptorship sessions attended, Innovation Training Programme developed in partnership with local Trust and Medipex. A 2 year Clinical Entrepreneur fellows cycle in place. Governance Structures continue to be developed including revised and new Standard Operating Procedures. Partnership funding in development. Collaborative partnerships with key partners continues to progress.		
Children's Public Health 	To be a leading trust for the Children's Public Health Services Research	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 . .	An evidence base for Children's PH Services to improve outcomes for children Identified some key Children's public health needs and research priorities.	Identified National validated 'SORT tool' to scope training needs of 0-19 workforce. Plan to implement in trust by March 25 Continue BaBi Harrogate: target for 2024-2025 = 172 current recruitment 561 Research prioritisation workshop planned late November. Delayed until to Jan 25 . Work with the ICB and NIHR 0-19 network to identify opportunities for data sharing and collaborative projects. Watch metric to be developed for this area.		

Clinical Trials 	To increase access for patients to clinical trials through growth and partnerships	To continue to deliver contractual agreement with RD partner organisation to provide research opportunities and sustain Research Delivery Network (RDN) income through delivery of HLOs. a) trust recruitment target of 2001 annually b) 80% of studies recruiting to time and target c) Patient experience survey annual target 52 To increase commercial research by 10% this year and to generate income to maintain and increase research staffing . Develop 2 new academic partnerships by end March 2025 Develop clinical leadership Increase Patient engagement in research. Develop 4 patients ambassadors and one speciality patient research group by end March 25	Contractual Agreements Academic Partnerships	Current recruitment at 1820 -on target for this financial year. Currently 8th position in region. Studies on time and target 98%. PRES (Patient Research Evaluation Survey 24 returned - active campaign to improve - new monthly reviews in place. Plans for a dedicated CRF underway, charitable funding secured – plan to open Q4 2024 delayed due to new plan development and costing delays .Now estimated March 2025 Scoping possible funding sources for staff funding . New commercial partnership with INCYTE formed. (Oncology and Dermatology trials) . Two new commercial dermatology studies open in November 24. 3 studies in set up. Working with the Skin Research Centre at the University of York Clinical Lead for Research appointed June 2024		

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:

Environment Framework

- Board Assurance: Resource Committee
- Programme Board: Environment Board
- SRO: Director of Strategy
- Operational: Assistant Director of Strategy (Capital Planning)

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

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

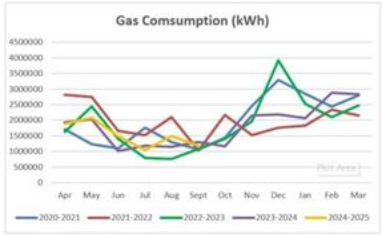
Breakthrough Objective:	N/A
Corporate Project:	N/A
Overarching Risk Appetite:	Operational - Cautious

Ambition	Workstream	True North Metric	Risk Appetite	Level of Risk to Achieve Metric – Linked to Risk Appetite							
				1 – 3	4 – 6	8 – 9	10	12	15	16	>20
An Environment that promotes wellbeing	Wellbeing	Wellbeing works capital spend vs Budget	Operational: Cautious								
	Quality & Safety	Major projects capital spend vs Budget; High risk backlog maintenance cost	Operational: Cautious								
	Environmental Impact	Natural gas consumption	Operational: Cautious								

True North Metrics Summary:

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

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
		To improve reliability and capacity of imaging services	• Design concept – Jan 23 • Decision to revise project from reconfiguration of the existing imaging department to fitting out the ground floor of the new block replacing Block C – Oct 23 • Pre-construction phase complete – Sep 24 • Fit out complete – TBC • Go Live – TBC	• Complete • Complete • On Track • TBC – financial risk • TBC		
		CT Business Continuity To ensure HDFT has a reliable CT service to support emergency care	• Canon Dismountable on site: 26 May 23 • Canon dismountable operational 10 Jun 23 • Portakabin on site 22 Jun 23 • Siemens CT in Portakabin operational 24 Jul 23 • Additional works to Portakabin needed for CT installation – August 24 • Go Live – Planned September 24	• Complete • Complete • Complete • Delayed to July 24 due to delays in completing the environment to accommodate the Siemens CT Scanner delivery. • CT installation - complete October 24 • Delayed to November 24 due to contractor availability for final fix and external works.		
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. • 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. • 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.	• 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. • 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. • A travel survey is required this year and funding needs to be identified		

True North Metric	Vision	Goal	Countermeasures	Current Status	Level of Risk To Achieving Goal	Level of Risk for progressing actions
			• Food –HIF undertaking a Food waste project in line with the ERIC return requirements • 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 oxide (N2O) which is used as an anaesthetic gas is 300 times more harmful than CO2 • Supply Chain & Procurement. Mandatory 10% net zero and social value weighting for every tender. • 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 	• HIF at feasibility stage in looking at technologies and software solutions which will improve meal ordering and wastage • External funding has been identified and order placed for Trolleys to house localised canisters. Then the piped network will be capped off. Entonox project to be initiated following this. • 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. • Produce standard carbon reduction criteria within the digital investment decision making process. • 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 Mar 25	Operational: Health & Safety	Minimal
	CHS3 – Health & Safety: Managing the risk of injury from fire.	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others due to the failure to ensure that suitable and sufficient assessment of the risk from fire has been carried out, and that the necessary control measures are in place. H&S Managing the risk of injury from fire	5 x 3 = 15	5 x 2 = 10 Nov 24	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 Dec 24	Operational: Health & Safety	Minimal
CRR98	Containment Level 3 Laboratory	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	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

No Related External Risks

Trust Board

27th November 2024

Title:	Emergency Preparedness, Resilience & Response Assurance Process 2024-25
Responsible Director:	Russell Nightingale, Accountable Emergency Officer
Author:	*Alexander Chatten, EPRR & Site Support Officer*

Purpose of the report and summary of key issues:	*The NHS core standards for EPRR are the minimum EPRR requirements commissioners and providers of NHS-funded services must meet.* *These core standards are the basis of the EPRR annual assurance process. Commissioners and providers of NHS-funded services must assure themselves and subsequently, NHS England, against these core standards.* *The Trust has been assessed against the 10 domains containing 62 applicable core standards.* • *This year, the Trust has been determined to have:* *28 Standards fully compliant* *30 Standards partially compliant* *4 Standards non-compliant* *The Trusts' overall compliance rating against the NHSE Core Standards is therefore categorised as 'non-compliant.' (<76% of standards fully compliant)* *The process also involves the assessment of a separate domain which is a deep dive investigation into a particular area that isn't included in the main assurance process. This year there were 11 standards included in the deep dive.* *Appendix A – Statement of Compliance* *Appendix B – 2024-25 EPRR Core Standards Action Plan*
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities
	Best Quality, Safest Care
	Person Centred, Integrated Care; Strong Partnerships
	Great Start in Life
	At Our Best: Making HDFT the best place to work

8.1

	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:	HDFT's previous EPRR Core Standards Assurance rating in 2023 was 10% fully compliant (6 standards)	
Recommendation:	*The HDFT Final Self-Assessment Submission automatically creates an associated action plan (appendix B) including the deep dive, to continue to work towards achieving better compliance in the 2025 Core Standards Assurance.* *The Board is asked to:* • *Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.* • *Approve the overall compliance rating and associated action plan for the 2024-25 work programme.*	

1. INTRODUCTION

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. Under the Civil Contingencies Act (2004) and Health and Social Care Act 2012, NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

2. NHSE EPRR CORE STANDARDS ASSURANCE PROCESS

The NHS EPRR Core Standards were introduced to clearly set out the minimum standards expected of NHS organisations and providers of NHS funded care with respect to emergency preparedness, resilience, and response.

The NHSE EPRR Core Standards enable agencies across the country to share a common purpose and to coordinate EPRR activities in proportion to the organisation's size and scope. In addition, they provide a consistent cohesive framework for self-assessment, peer review and assurance processes.

These standards will be reviewed and updated as lessons are identified from testing, national legislation, and guidance changes and/ or as part of the rolling NHSE EPRR governance programme.

The assurance process changed in 2023 to include evidence submission against each core standard, formal review and subsequently a check and challenge. In the wake of lessons identified from recent incidents such as the Manchester Arena, Grenfell and COVID-19, it is clear that the standard which organisations must achieve is one which requires a dedicated robust assurance process which can ensure our collective system resilience.

Last year's model remained the same as the 2023 process, except the responsibility of the review process was handed to the ICB EPRR Team instead of the NHS England Regional EPRR Team.

The process continues to be an open, honest and transparent review of evidence associated with the core standards with the objective of improving our collective resilience for our patients and communities.

3. PREVIOUS YEAR'S POSITION (2023-24)

In the 2023-24 NHSE Core standards assurance process, the Trust was determined to have a compliance rating of 10% - 'Non-Compliant.'

Percentage Compliance	**10%**
Overall Assessment	**Non-Compliant**

3.1. Domains

A breakdown of the 10 domains, and the deep dive into EPRR Training, is seen below:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant	Not Applicable
Governance	6	0	6	0	0
Duty to risk assess	2	0	2	0	0
Duty to maintain plans	11	0	11	0	0
Command and control	2	0	2	0	0
Training and exercising	4	0	4	0	0
Response	7	3	4	0	0
Warning and informing	4	0	4	0	0
Cooperation	4	0	4	0	3
Business continuity	10	1	6	3	1
Hazmat/CBRN	12	2	10	0	7
Total	**62**	**6**	**53**	**3**	**11**

3.2. Deep Dive

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant	Not Applicable
EPRR Training	10	1	5	4	0
Total	**10**	**1**	**5**	**4**	**0**

4. CURRENT POSITION

This year, we have self-assessed the Trust against the 62 applicable core standards and 11 deep dive standards.

Our overall position for this year has therefore been determined as non-compliant with us meeting full compliance with 76% or less with the core standards. Our total percentage of compliance for 2024 is 45%, being fully compliant with 28 of the 62 core standards. This is a significant increase from 2023.

Any standard that has been rated as partially or non-compliant has been automatically transferred into an action plan that will form part of the Trusts EPRR Work plan for the following 12 months.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisations Board has agreed with this position
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisations Board has agreed an action plan to meet compliance within the next 12 months. The action plan will be monitored on a quarterly basis to demonstrate progress towards compliance.

4.1. Summary of compliance with Core Standards for 2024-25

A breakdown of the 10 domains, and the deep dive into Cyber Security, can be seen below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	2	4	0
Duty to risk assess	2	1	1	0
Duty to maintain plans	11	4	7	0
Command and control	2	2	0	0
Training and exercising	4	2	1	1
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	3	5	2
Hazmat/CBRN	12	0	11	1
CBRN Support to acute Trusts	0	0	0	0
Total	62	28	30	4

8.1

4.2. Deep Dive

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	3	2	6
Total	11	3	2	6

4.3. Overall position

Percentage Compliance	**45%**
Overall Assessment	**Non-compliant**

5. ACTIONS

Actions that have been identified from the Core Standards and Deep Dive process have been compiled into an action plan contained within the EPRR Core Standards Self-Assessment Tool.

Please see 'Appendix B' for the EPRR Core Standards Action Plan

Any outstanding actions will continue to form the basis for the 2025-26 EPRR Work Programme.

6. CONCLUSION

Whilst the summary position for EPRR Core Standards Assurance Process has remained the same from 2023 to 2024, significant work has been completed to raise the Trusts percentage of compliance from the previous year.

A breakdown of the changes can be seen below:

	Standards		
	Fully Compliant	**Partially Compliant**	**Non-Compliant**
2023	6	53	3
2024	28	30	4
Difference	**+22**	**-23**	**+1**

2023 Compliance	9.67%
2024 Compliance	46.16%
Difference	**+36.49%**

This is a 350% increase in compliance from last year's position, the largest increase in the region.

The increase in Non-Compliant standards from 3 to 4 is a result of the YAS CBRN Audit conducted prior to the EPRR Assurance Process. The CBRN Audit involved a colleague from Yorkshire Ambulance Service reviewing documentation and training related to domain 10 of the EPRR Assurance. The audit was expanded in 2024 to also include evidence review which resulted in a slight drop in compliance with domain 10.

7. RECCOMENDATIONS

The Trust Board are asked to:

- Consider the compliance self-assessment, rating and associated guidance and provide feedback accordingly.
- Approve the overall compliance rating and associated action plan for the remainder of 2023-24 and into 2024-25.

Appendix A:
North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-25

STATEMENT OF COMPLIANCE

Harrogate & District NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool V2.

Where areas require further action, Harrogate & District NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's Accountable Emergency Officer (AEO) pending submission to the Board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer: 

Date Signed: 20/11/24

Date of Board/Governing Body meeting:	Date to be presented at public Board:	Date to be published in Annual Report:
27/11/2024	27/11/2024	September 2025

Appendix B: HDFT 2024-25 EPRR Core Standards Action Plan

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG	Action to be taken	Lead	Time-scale	Comments
Domain 1 - Governance									
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	Partially compliant	Current board report only reports on compliance/associated action plan and not on any training/exercising/incidents since the last report and lessons identified as a result. Staff awareness of EPRR reported to board. BC to be taken to board.	Russell Nightingale	Q2 2025	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Partially compliant	Needs to be brought in line with post-assurance Action Plan	Roseanne Kirkham	Q4 2024	Standard PC last year

5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant	Assessment of EPRR Resource required	Roseanne Kirkham	Q3 2025	Standard PC last year
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Partially compliant	Unclear of the roles/responsibilities around this, where/how they are collated (e.g. tracker) and how they are reported. The strategy says this is done in the board report but see standard 3 - cannot find evidence of this.	Alex Chatten	Q2 2025	
Domain 2 - Duty to risk assess									
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Partially compliant	Trust Risk Management Policy does not detail individual departments etc.	Alex Chatten	Q2 2025	Standard PC last year
Domain 3 - Duty to maintain Plans									
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Partially compliant	HCID Policy In draft. Needs to include swabbing too	Alex Chatten	Q1 2025	

13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Needs aligning with New and Emerging pandemics not just respiratory virus Requires exercising	Alex Chatten	Q2 2025	Standard PC last year
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	Partially compliant	Would be beneficial to expand this section into a separate Countermeasures Plan	Alex Chatten	Q1 2025	Standard PC last year

15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Partially compliant	Would be beneficial to expand this section into a separate mass casualty plan	Alex Chatten	Q1 2025	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Evacuation plan needs to make reference to PEEPS	Alex Chatten	Q1 2025	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Needs to be tested/ exercised	Alex Chatten	Q3 2025	Standard PC last year
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	Need to detail how we would care for VIP (decontamination/ Major Incident)?	Giles Latham	Q2 2025	Op carp & steeple. Standard PC last year
Domain 4 - Command and control									

Domain 5 - Training and exercising									
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially compliant	TNA currently being reviewed	Alex Chatten	Q2 2025	
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Non-compliant	Creation of an Annual Exercising and Testing Schedule to consolidate and plan ahead 1 Communications Test missing	Alex Chatten	Q3 2025	Standard PC last year
Domain 6 - Response									
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Training records. Evidence of loggists responding to communications test	Alex Chatten	Q2 2025	Standard PC last year
Domain 7 - Warning and informing									
Domain 8 - Cooperation									

Domain 9 - Business Continuity									
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis (es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Partially compliant	BCPs require some more work to become fully compliant including reviews	Alex Chatten	Q2 2025	Standard PC last year

47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Partially compliant	Need expanding further?	Alex Chatten	Q2 2025	Standard PC last year
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this substandard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	Non-compliant	Overarching schedule of BC testing required	Roseanne Kirkham	Q3 2025	Standard PC last year

50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Partially compliant	Take to Board	Alex Chatten	Q2 2025	Standard NC last year
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• Process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Partially compliant	Internal audit scheduled for 2025	Alex Chatten	Q1 2025	Standard NC last year

52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self-assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Partially compliant	Some elements already there but some need further work	Alex Chatten	Q1 2025	Standard PC last year
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers' business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Non-compliant	Need to work with procurement to establish this process	Alex Chatten	Q2 2025	Standard NC last year

Domain 10 - CBRN									
55	Hazmat/ CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Partially compliant	Trust to provide Job Descriptions or standard operating procedures relevant to the team/person/department responsible for training/equipment Ensure it is clear within the plan who has responsibility for the delivery of training and management of CBRN/Hazmat equipment Trust to evidence of minutes or historical peer review feedback from partner agencies that show approval or guidance/advice of the CBRN Plan. Note that only final approved minutes should be submitted as evidence and will need to be dated within the last 12 months. Trust to provide evidence that shows compliance against section 29 of the Plan (monitoring compliance and effectiveness). Evidence must be submitted that falls within the last 24 months as detailed in the table. Evidence of the process for managing CBRN audits. This may be in a different document to those already submitted. All relevant national guidance is referred to e.g. JESIP IOR to incidents suspected to involve hazardous substances or CBRN materials Version 1.1 NHSE EPRR: Guidance for the initial management of self-presenters from incidents involving hazardous materials V1 JESIP CBRN(e) JOP's 1st Edition JESIP Joint Doctrine: The Interoperability Framework Edition 3.1 Radiation Regulations 2019 (REPPIR)	Alex Chatten	Q2 2025	Standard PC last year Working with YAS to achieve compliance in 2025
56	Hazmat/ CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Non-compliant	Evidence of a risk assessment against the CBRN/Hazmat capability that includes controls/gaps in controls etc. and covers all elements of the capability e.g. training, PPE, Equipment, Locations etc. YAS can provide a template to support if required. Trust to evidence that the risk assessment submitted has been approved through submission of the minutes from the relevant governing group. All relevant plans have an approval date on them. Trust to review current practices and training	Alex Chatten	Q1 2025	Standard PC last year Working with YAS to achieve compliance in 2025

						provided to staff on the application of safe systems of work. All current trainers have attended a YAS train the trainer course (PRPS Instructor and CBRN/Hazmat Awareness) in the last twelve months and that the relevant training material is utilised to support the correct delivery of safe system of work training. A risk assessment is completed around safe systems of work for waste management, use of CBRN/Hazmat equipment and minimum staffing numbers required to support the response to a CBRN/Hazmat incident			
57	Hazmat/ CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Partially compliant	Ensure contact numbers for specialist advise are relevant and up to date: UKHSA Chemicals Advice: 0344 892 0555 UKHSA Radiation: 01253 583 1600 National Poisons Information Service: 0344 892 0111 (Or Toxbase - Online account needed) YAS HazMed: (Hazardous Area Response Team Leader): 07592271116 YAS Regional Operations Centre (ROC): 0330 678 4129 - Note the number you list has changed YAS Emergency Operations Centre Duty Manager (EOC DM): 0330 678 4190 YAS EOC Bronze: 0300 330 0238 Emergency Coordination Of Scientific Advice: 0300 3033 493. Future training courses provide the information on where specific advice can be sought. Trust to review and simplify current action cards according to role rather than agent. To ensure contact numbers are up to date.	Alex Chatten	Q1 2025	Standard FC last year Working with YAS to achieve compliance in 2025
58	Hazmat/ CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: • command and control structures • Collaboration with the NHS Ambulance Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability • Procedures to manage and coordinate communications with other key stakeholders and other responders • Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) • Pre-determined decontamination locations	Partially compliant	CBRN plan supporting arrangements are current and have been reviewed in the past 12 month. Procedures for decontamination are aligned to national response (as taught on the YAS train the trainer sessions). Trust to review comments against CBRN Plan and address accordingly. The CBRN plan clearly defines the command and control structure. Document that shows command and control for an incident. The FRS and YAS are consulted on changes/reviews etc. of the CBRN plan moving forward.	Alex Chatten	Q1 2025	Standard PC last year Working with YAS to achieve compliance in 2025

				with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control • Distinction between dry and wet decontamination and the decision making process for the appropriate deployment • Identification of lockdown/isolation procedures for patients waiting for decontamination • Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • Arrangements for staff decontamination and access to staff welfare • Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes • Plans for the management of hazardous waste • Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities • Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident		Trust to clarify (and submit supporting evidence if appropriate) if an MOU is in place for the provision of PRPS suits in the event of a protracted incident. In the absence of an MOU or process, the plan (or standalone process that the plan refers to) includes how equipment can be replaced to ensure the Trust can support a protracted incident. Trust to provide evidence that a process is in place to ensure the CBRN plan is updated following lessons learnt or national changes			
59	Hazmat/ CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Partially compliant	Trust to establish a safe system of work for the decontamination unit and associated procedures and ensure the Plan, action cards and training is updated. Trust to provide evidence of dip testing as per NHSE actions in 2023. Trust to conduct a risk assessment that considers safe systems of work for staffing numbers, findings to then be included in future training/processes and plans. (This may require input from YAS). There are systems in place to ensure the welfare and safety of staff supporting the response to a CBRN/Hazmat incident. There is a clear process in place for the management and rotation of staff working in decontamination roles.	Alex Chatten	Q2 2025	Standard PC last year Working with YAS to achieve compliance in 2025

			decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.			Trust to produce multi-lingual or pictorial action cards for patients whose first language may not be English or who have any other disability that may require an aid to support their ability to undertake and understand the decontamination process. Trust to liaise with supplier to clarify if an upgrade can be applied to their current tent to turn it from one lane into two. Trust to conduct a risk assessment on its current tent, to determine what controls (if any) can be put in place to ensure both patient and wearer decontamination can continue. If a solution cannot be found, recommend the Trust place this on their corporate risk register. YAS will update on any additional advice provided by NHSE to support the Trust. Trust to clarify the process for identifying staff able to support an incident. In the absence of a rapid process, Trust to review on duty rota template provided by YAS as an example and consider implementation as a way to evidence their ability to identify trained staff on shift in the absence of a rapid electronic process. Partially Compliant: Trust to provide inventory for PRPS, RamGene, Re-robe and de-robe kits and all other associated CBRN/Hazmat equipment			
60	Hazmat/ CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist:	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required.	Partially compliant	Trust to provide SOP for patient conveyor and any other equipment used to support non-ambulant patients. Trust to provide evidence of adaptations in place to support a range of individuals e.g. deaf/blind/other language/wheelchair etc. Trust to provide evidence of SOP/Procedure/Annual Finance Forecast for replacement of CBRN/Hazmat equipment. Ensure an action for escalation to ICB and NHSE is included in relevant action card (To include notification of an incident, shortfalls in equipment/PPE or loss of capability. Ensure a process is in place to escalate any shortfalls in CBRN equipment and PPE regardless of if an incident or BAU to the ICB and NHSE. Sufficient time is allocated to the management of CBRN/Hazmat equipment to include annual service and maintenance, monthly checks, ad hoc auditing and inventory management.	Alex Chatten	Q2 2025	Standard PC last year Working with YAS to achieve compliance in 2025

			https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.		Trust to take an action to produce a full and detailed inventory that captures PRPS, Ram Gene, Tent and associated ancillaries			
61	Hazmat/ CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, and calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for its disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Partially compliant	Trust must ensure the equipment aligned to the CBRN/Hazmat capability is managed efficiently. This must include a detailed inventory, regular internal checks, annual calibration or servicing from a certified supplier. The equipment most also be located in an easily accessible location, that allows for a swift response in the event of an incident. Trust to evidence monthly checks on Ram Gene and annual certificates of service/calibration. Trust to evidence a preventative maintenance contract is in place with NSC. Trust to evidence a process for the reporting of missing or damaged equipment. Trust to provide evidence of a process for the safe disposal of equipment (Ram Gene/PRPS etc.) Trust to provide evidence that shows the ability to continue decontamination services in the event of the use of or damage of primary equipment. Trust to provide evidence that a preventative maintenance contract is in place and that the contractor has BC arrangements in place to ensure the Trust will continue to receive a service	Alex Chatten	Q1 2025	Standard PC last year Working with YAS to achieve compliance in 2025

			required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks						
62	Hazmat/ CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Partially compliant	Ensure they include a step to check if their waste disposal contractor is licenced to remove the 'on day' contaminant. All relevant legislation for waste/water management is included in the plan. E.g. The document should also refer to the Water resources Act 1991 which is the primary piece of legislation for the protection of water resources in England and Wales and the Gov. UK Guidance: Pollution Prevention for Businesses. Trust to provide evidence that their waste disposal provider has a BC Plan. Ensure action cards include a step to contact relevant agency for authorisation of the release of contaminated water. YAS and FRS continue to be included in peer review in the plan on an annual basis. Trust to update action cards to include arrangements for materials to be held as evidence where required.	Alex Chatten	Q1 2025	Standard FC last year Working with YAS to achieve compliance in 2025
63	Hazmat/ CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Partially compliant	Trust to produce detailed TNA that evidences which departments are required to support the CBRN/Hazmat response and the type of training they will receive. Trust to provide evidence of trainers teaching qualification. In cases where a minimum teaching qualification has not been established, Trust to review with appropriate training leads, establish an agreed standard against a risk assessment and provide the details as evidence against the core standards. Formal TNA report for CBRN/Hazmat. Trust to produce formal training plan that includes the national training standards for CBRN/Hazmat as taught by YAS on the train the trainer sessions. Trust to rationalise any deviation from the	Alex Chatten	Q2 2025	Standard PC last year Working with YAS to achieve compliance in 2025

						national training standards and times within the training plan and include a risk assessment that identifies all control/gaps in controls. Trust to provide evidence of staff training records, health decelerations, certificates. Trust to provide evidence of an annual training programme that includes dates, class capacity and numbers to be trained. Completed: Trust to evidence how training compliance is monitored. Updated: Trust to evidence how roles are allocated during an incident			
64	Hazmat/ CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Partially compliant	Annual training schedule that includes dates/type of training/class numbers/allocated educators etc. Trust to provide clarity on how temporary/bank staff will support an incident (if at all). Updated: Trust to provide evidence of monitoring against training effectiveness e.g. secret shopper style no notice exercise for reception e.g. what are the IOR principles. NIC, how many CBRN Trained staff are on duty etc.? All educators to attend YAS train the trainer course within last 12 months. Current educators are allocated sufficient time for administration and course review alongside course delivery. Trust to clarify if different departments receive different training and to submit relevant training packages as supporting information. Actions aligned to other standards, however strong recommendation that the Trust conducts a risk assessment to support in identifying those that may be required to support in a CBRN/Hazmat incident and use those findings to establish minimum training standards for those in command or senior roles. Trust educators to work with YAS lead on a review of the current training provided based on the training observation outcome	Alex Chatten	Q3 2025	Standard PC last year Working with YAS to achieve compliance in 2025

65	Hazmat/ CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Partially compliant	Risk assessment that shows how the PPE levels have been determined. Evidence how staff are allocated suitable PPE and subsequent training and that allocation conforms to manufacturer guidance (specifically Respirex and Suits sizes). Evidence dip testing of rotas. Evidence of the communication methods/process in place for staff working in or supporting the Clinical Decontamination Unit. Evidence that shows how temporary staff are managed in an incident e.g. the type of roles they may be expected to support in and if adequate training has been provided. Conduct an immediate risk assessment on the current storage location of both live and training CBRN/Hazmat equipment. If an alternative location cannot be sourced, the Trust should consider placing this on their corporate risk register as it will have an impact on their ability to respond to an incident.	Alex Chatten	Q2 2025	Standard PC last year Working with YAS to achieve compliance in 2025
66	Hazmat/ CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Partially compliant	Pre/post exercise report for CBRN/Hazmat exercise held in the last 12 months Annual exercise schedule/programme that details CBRN/Hazmat exercising, which should include wet and dry decontamination. Evidence of learning being captured from exercises, which are then subsequently managed and monitored Formalise inclusion of YAS and FRS in future CBRN/Hazmat exercises Formalise notification to YAS lead in the event of CBRN/Hazmat incident so that additional evidence can be captured to support the core standards moving forward. Exercise schedule for CBRN/Hazmat considers scenarios where FRS and YAS are players in order to test CBRN Plan (specifically areas where FRS and YAS may be required to support e.g. substance testing/interim decontamination/CBRN body bags/PRPS wearers etc. Evidence that post exercise reports are submitted to a formal group for review/approval of recommendations	Roseanne Kirkham	Q3 2025	Standard PC last year Working with YAS to achieve compliance in 2025

Deep Dive Assessment (not included in assurance rating)

Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)									
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	Non-compliant	Include Head of IT and Cyber Security in Emergency Planning Steering Group TOR	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	Partially compliant	No mention of cyber in EPRR Communications plan	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	Non-compliant	Cyber exercise to be scheduled	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	Partially compliant	Link with IT/ L&D	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams

DD8	Deep Dive Cyber Security	EPRR Training	The organisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	Non-compliant	Currently no "EPRR awareness training"	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD9	Deep Dive Cyber Security	Business Impact Assessme nts	The Cyber Security and IT teams are aware of the organisation's critical functions and the dependencies on IT core systems and infrastructure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	Non-compliant	Potentially but further investigation needed. Link with IT	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD10	Deep Dive Cyber Security	Business Continuity Managem ent System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	Non-compliant	Include Cyber as part of BC strategy Risk assessments regarding Cyber & Business Continuity	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams
DD11	Deep Dive Cyber Security	Business Continuity Arrangem ents	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Non-compliant	Disaster recovery plans for core systems IT/ Cyber BCP BC plans for all core systems	Rosean ne Kirkham	Q4 2025	Link in with IT and Cyber Security Teams