Public Board of Directors

Schedule	Thursday 2 July 2020, 9:00 — 11:00 BST
Venue	Microsoft Teams
Organiser	Jacqueline Ryden

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To note Quality and Workforce Committees combined from May 2020

• Finance and Performance Committee – minutes from meeting held 4.5.20 and 1.6.20
• Audit and Risk Committee – minutes from meeting held 16 June 2020 tbc
• Quality & Workforce Committee – minutes from meetings held 4.5.20 and 1.6.20
• COVID-19 Oversight Committee – minutes from meeting held 6.5.20, 26.5.20 and 5.6.20

Items for Review Room
• Calderdale and Huddersfield Solutions Limited – One Year Business Plan 2020/2021
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For Assurance

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24. Date and time of next meeting 232
Thursday 3 September 2020, 9:00 am
Venue: Microsoft Teams

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1. Welcome and Introductions:

To Note

2. Apologies for absence:

To Note

3. Declaration of Interests

To Note

STANDING ITEMS

4. Minutes of the previous meeting held on 7 May 2020

To Approve

Draft Minutes of the Public Board Meeting held on Thursday 7 May 2020 at 9:00 am via Microsoft Teams

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
Helen Barker	Chief Operating Officer
Alastair Graham **(AG)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director
Richard Hopkin **(RH)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director, Digital Health
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary
Jackie Ryden	Corporate Governance Manager (minutes)

OBSERVERS

Stephen Baines	Lead Governor

44/20 Welcome and introductions

The Chair welcomed Stephen Baines to the Public Board of Directors meeting and outlined how the meeting would be managed. He explained that in light of Government and NHS restrictions on groups of people meeting, this Public Board meeting was taking place virtually and was not open to members of the public. The agenda was made available on the CHFT internet and in due course the minutes will also be published.

The Chair formally thanked the Executive Team and all of their colleagues on behalf of the Governors and Non-Executives for their hard work in response to the Covid-19 pandemic. He fed back that the daily briefings and video were well received across the Board.

45/20 Apologies for absence

Apologies were received from Karen Heaton.

46/20 Declaration of Interests

The Board were reminded to declare any interests at any point in the agenda.

47/20 Minutes of the previous meeting held on 5 March 2020.

The minutes of the previous meeting held on 5 March 2020 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held 5 March 2020.

48/20 Action log and matters arising

The action log was reviewed. It was agreed, with the agreement of the Chair of the Finance and Performance Committee, that the A&E Delivery Board will in future report into the Finance and Performance Committee.

OUTCOME: The Board received and **NOTED** the updates to the action log.

49/20 Update on COVID-19

The Chief Operating Officer gave an update on COVID-19. The key points to note were as follows.

The current position shows an improved picture both in terms of the number of patients testing positive and from a staff perspective. The staff have been extremely flexible, positive and accommodating and the response has been a perfect example of One Culture of Care.

Outpatient activity has been constant at 10% of normal activity throughout the pandemic, and over the last week there has been an increase in the number of A&E attendances, which is up by approximately 100.

The provision of Personal Protective Equipment (PPE) has been a continual source of concern. The Director of Nursing reported that this has been the biggest cause of anxiety for colleagues. A dedicated PPE group meets daily and has representation from microbiology, infection control, procurement and stores. Current stock levels are adequate and there is a deployment strategy in place together with an escalation and risk management process if it should prove necessary. AN asked if the Trust now has more influence over central distribution of PPE, and the Director of Nursing explained that the Trust has regular contact and good links with the Centre but that the national supply can be inconsistent both in terms of quantity and quality. The Trust therefore continues to source suppliers in order to ensure that reliance is not solely placed on national supply. The West Yorkshire Association of Acute Trusts (WYAAT) is in the process of setting up a WYAAT-wide PPE group to ensure consistency in supply, quality of products and mutual aid.

The Trust is fortunate that testing can be carried out by the in-house pathology team. All non-elective admissions are now being tested including patients who are asymptomatic. A higher proportion of patients are from care homes and these admissions are now being placed into side rooms until test results are confirmed. A risk assessment is to be undertaken to determine the necessity of identifying zoned areas for patients awaiting results of tests. A high volume of care homes have both patients and staff who have tested positive for COVID-19, leading to increased staff absence in the care homes. Additional capacity has been put in place through the community teams to support the care homes and it is expected that this will continue after the plateau has passed.

RH asked if targets are in place for staff testing given that these numbers are still quite low. The Medical Director advised that CHFT is following national guidance which prioritises those members of staff where a result would enable a return to work. There is still capacity in-house to do the tests but it is possible to access other laboratories if that capacity is exhausted. The Trust is also commissioning a second testing platform which, subject to delivery of the test kits, will significantly increase capacity. There are no specific targets. There is some work on-going looking at testing asymptomatic staff but formal guidance is still awaited on this.

RH added that he would be interested to have details of the stepping up rate for staff testing. The Medical Director explained that in some cases the member of staff is absent because a family member has the symptoms. He is not aware of any metrics relating to this but consideration will be given to developing these.

The Director of Workforce and Organisation Development reported that the Trust has been liaising since mid-March with colleagues nationally and locally on a Health and Wellbeing Strategy to provide support for CHFT colleagues. The strategy covers three stages of: Prepare, Active and Recover. She advised that a counselling service has been in place on

a 24/7 basis since the start of the pandemic. Guides are available both for managers and for self-help.

The Charity and Engagement teams have been working jointly to manage the large amount of donations that have been received. Wobble rooms are in place for colleagues together with specific wrap around support for those colleagues who are involved heavily in COVID-19 activity.

The 'Prepare, Active and Recover plan will now extend to re-set, and support and guides are to be made available to address the re-connect phase. Strategies have been developed for colleagues who will return to work as well as those colleagues who have been re-deployed and will need to be re-orientated. On a national level well-being champions have been implemented as part of the recovery plan, and these will be in place for each ward and department.

The Director of Workforce and Organisational Development gave an update on a meeting of the BAME network held on 6 May 2020. Attendance at the virtual meeting was good and there was a wide range of questions covered. At the meeting data on local population and colleague absence and testing was shared, looking at any patterns or any disproportionately affected groups either by gender, age or ethnicity. This is being used to determine any at risk groups, cross referencing by protected characteristic, staffing group or clinical/non-clinical. It was noted that CHFT's data does not necessarily follow the national data reported in the media.

The Managing Director of Calderdale and Huddersfield Solutions (CHS) Limited gave a brief update on input by CHS. He explained that there is a daily equipment meeting with a dedicated Trust-wide team working to ensure the right equipment is in the right location and that there are sufficient consumables available. The equipment pool identified a need for asset tracking and stage one of this asset tracking has now gone live. Once this has been fully rolled out it will enable all equipment to be tracked. The asset tracking system was purchased using national COVID capital and further roll out will be funded by Scan4Safety.

The Chief Operating Officer outlined the structure of the Incident Management Team meetings. There is a full team meeting daily and a tactical meeting twice daily. Data is reviewed on a daily basis, as well as any national guidance received, updates from the various workstreams, finance governance relating to COVID-19 expenditure, freedom to speak up reports, staff concerns and any incidents. The tactical meetings also consider on an on-going basis what learning can be implemented.

The Chief Operating Officer reported concerns about the backlog of appointments, for both new and follow-up patients as well as diagnostic appointments. GPs also have a list of patients waiting to be referred. A working group has been established with the CCGs, senior GPs and Divisional Directors to begin looking at the learning to see how care pathways can be improved. Some key principles and actions were agreed and the process will start to be tested. Some cancer activity is continuing based on three priority categories and the surgical and oncology teams are working closely together.

The Trust received notification regarding the second phase of the NHS response to COVID-19 to step up non-COVID-19 urgent services planning two weeks ago, with primary care encouraged to refer patients. Caution is needed as the Trust will need to manage the challenges of COVID pressures, activity backlog and winter demand, a greater challenge than planning for COVID-19. Flexibility will be required to be able to respond to potential surges. e.g. for cancer patients, allow all staff time to recover and work differently, manage risks going forward, eg social distancing, waiting areas and PPE requirements, helping with expected pressures in the community and with key measures being more outcomes focussed.

The Chief Operating Officer noted that the benefits of our Digital advancement exceeded our expectations.

The Managing Director Digital Health gave an update on the recent digital journey which has been a great success. The team worked at pace at the very beginning of the COVID-19 outbreak to ensure that working at home was available for a wide range of colleagues. The focus now needs to be on how to spring the success forward into future working arrangements whilst concentrating on patient and colleague experience. Lessons have been learned across the whole organisation and the challenge will be to translate those lessons and ensure that the technology is in place to continue with the areas identified as good practice.

The Managing Director Digital Health advised that due to the necessity to move at pace, we now need to revisit and reflect on information governance processes such as the digital impact assessment and check our compliance with these. It will be necessary to re-launch those projects that were paused, for example Voice Recognition software. Asset tracking will be going live imminently, having fast-tracked this project which will be taken into the future and expanded to include non-COVID equipment.

Future areas of focus will be capacity, skills and support, resource requirements, including an investment plan to continue to progress, in addition to the funding received from NHSX as a Digital Aspirant Trust and Scan4Safety.

The Non-Executive Directors echoed the comments made by the Chair at the start of the meeting and expressed their support and appreciation to the Executive Team and all of their colleagues and noted the benefits of digital working in terms of both home working and real time data.

AG suggested that it would be useful for the Board to receive an update on the research projects which are currently being carried out.

AN asked how the private hospitals have been utilised to help with the COVID-19 pandemic. The Chief Operating Officer explained that a national contract with private providers (BMI and Spire) is in place until the end of June 2020, and to date approximately 30 patients have been cared for at the two local private hospitals, which are now undertaking endoscopies and cancer work.

The Chief Operating Officer gave an update on the COVID risk profile as at 3 May 2020 and movement of risk scores. She advised that the Incident Management Team receive daily updates on the risks and formally review them on a weekly basis. A comprehensive review was recently undertaken and a number of the scores were reduced but these will continue to be kept under review. A breakdown was provided of the divisional risks and it was noted that there are, as would be expected, a number of risks in the Family & Specialist Services division related to maternity pathways and guidance, and also in the Community Healthcare Division which are linked to the wider social care issues.

There are currently seven Covid-19 related red risks, 57 amber and 22 green across the Trust. The Chief Operating Officer provided details of the seven red risks which have a risk score over 15:

- Risk 7685 relates to the responsiveness of the supply chain affecting the availability of essential PPE which means the Trust has no control over supplies received from the Centre.
- Risk 7709 Limited supply of critical care medication including sedation and dialysis – this has a score of 16 as the Trust is not fully assured on this.

- 7683 Lack of isolation capacity. The score has been increased from 12 to 16 due to the plan for testing of all admissions included asymptomatic patients and this is limited by the number of side rooms.
- 7687 Maintenance of blood transfusion service due to reduced staffing which was already a risk as this is a small staff group.
- 7778 Staff becoming infected with the virus. This new risk has been added due to recognition both regionally and nationally of staff being infected and deaths of some healthcare workers.
- 7689 Deterioration in patient condition due to cancellations for those patients waiting for outpatient appointments, admission, diagnostics or operations.

AN asked for further details regarding the change of pathway from invasive to non-invasive treatment, risk 7717 for which the risk score had been reduced. The Medical Director explained that initial guidance had been received to ventilate patients early, but as time passed it could be seen that non-invasive ventilation led to better outcomes, and therefore the practice changed as the evidence accrued. The Chief Executive asked the Chief Operating Officer to ensure that this change in the pathway is recorded and, following implementation, information will be shared with the Board regarding the impact.

The Managing Director Digital Health updated the Board on recent developments with the National Pathology Exchange (NPex), a laboratory to laboratory messaging solution that is hosted by The Health Informatics Service (THIS), which NHS England (NHSE) requested THIS to scale up to all NHS laboratories including the Nightingale centres and testing hubs. Work on this has been undertaken over the last four weeks and great progress has been made. Whilst the connections have been progressing, the teams have also been working on a solution that will allow tests carried out locally to be captured automatically within NPex (currently the solution only captures send-away tests for tracking purposes). This solution was successfully tested earlier in the week at CHFT, the first Trust to do this. This is a crucial piece of work and will provide data to NHS England around COVID testing for the whole of the NHS including immunity testing when and if it is introduced. As well as supporting the NHS nationally it will generate additional on-going income for THIS and the Trust. As a result of this request, funding has been received from NHSE to support acceleration of the infrastructure to ensure resilience and robustness. This will allow more tests to be processed and improve turnaround times. In addition, it will enhance the performance of the network across the Trust and THIS customers.

OUTCOME: The Board **NOTED** the update on COVID-19.

50/20 Chair's Actions

The Company Secretary presented a report detailing two actions taken on behalf of the Board in line with the provision of the Board of Directors Standing Orders for Urgent Decision in accordance with the constitution of Calderdale and Huddersfield NHS Foundation Trust. The Company Secretary confirmed that this decision making process involved consideration by the Chair and Chief Executive, having consulted with at least two Non-Executive Directors not involved in recommending the decision.

The two items were:

1. Approval of revisions to Standing Financial Instructions (SFI), Standing Orders (SO) and Scheme of Reservation and Delegation in response to the Covid-19 Pandemic.
2. Establishment of a new Board Committee, the Oversight Committee to provide oversight of the decisions of the executive leadership arrangements during the Covid-19 pandemic.

The Board is asked to ratify the two urgent decisions as detailed in the paper.

OUTCOME: The Board **RATIFIED** the two urgent decisions outlined above.

51/20 Receipt of Minutes – COVID-19 Oversight Committee

The Minutes of the COVID-19 Oversight Committee meeting held on 15 April 2020 were received.

The key points to note were:

- Terms of reference were approved.
- The Committee discussed and supported the two decisions which had been approved by the Outer Core relating to the use of disposable PPE which had been supplied from the Centre and the agreement to stop non-emergency endoscopic procedures and the Bowel Cancer Screening Service.
- The Committee had requested that the COVID-19 risk register was shared with the Committee for context and details of the service changes that had been made to enable the Trust to manage capacity for COVID-19 and the implications for services, patients and the workforce, which was to be provided for the next meeting.

OUTCOME: The Board **NOTED** the Minutes of the COVID-19 Oversight Committee meeting held on 15 April 2020.

52/20 Delegation to the Audit & Risk Committee for Annual Accounts and Annual Report

The Company Secretary presented a paper to seek approval for the delegation of authority to the Audit and Risk Committee to approve the 2019/20 Annual Accounts and Annual Report and related self-certification document on behalf of the Board.

Changes to national deadlines for the 2019/20 annual accounts and annual reporting arising in response to the Covid-19 pandemic require a change to the agreed plan for Board approval of these. The Extra-ordinary Board meeting to approve the audited accounts and annual report scheduled for 20 May 2020 has been cancelled due to the late r national timeline.

The Company Secretary proposed an alternative route for sign off for the 2019/20 audited accounts, annual report and self-certification via delegation to the Audit and Risk Committee for the 2019/20 accounts on behalf of the Board based on the revised deadlines. This is consistent with national advice to streamline governance arrangements during the Covid-19 pandemic and permitted within the Trust's Scheme of Delegation.

The Company Secretary also requested approval for the delegation of authority to the Quality Committee for approval of the quality accounts. Changes to national deadlines mean that the quality accounts are to be submitted by mid-October. This had been discussed with the Chair of the Quality Committee who is supportive of this request.

The Director of Finance confirmed that the draft accounts were submitted on time and are currently being audited. The Chief Executive congratulated the Finance Team for the timely submission of the accounts, which was particularly noteworthy given the difficulties of working at home. RH commented that, as discussed at Finance & Performance Committee, we were not expecting any major areas of contention with KPMG in this year's audit.

OUTCOME: The Board **APPROVED** the delegation of authority to the Audit and Risk Committee to approve on behalf of the Board, at its meeting of 16 June 2020, the 2019/20 audited annual accounts and annual report and the content of the self-certification documents to confirm arrangements for the signature of declarations and **APPROVED** the delegation of authority to the Quality Committee to approve on behalf of the Board the 2019/20 Quality Accounts.

53/20 Board Attendance Register

The Company Secretary presented the Board of Attendance register for the period 1 April 2019 to 31 March 2020.

OUTCOME: The Board **APPROVED** the Board of Attendance register for the period 1 April 2019 to 31 March 2020.

54/20 Verbal Update of Meetings

Finance & Performance Meeting held on 30 March 2020

RH, Chair of the Finance & Performance Committee, gave a verbal update of the meeting held on 30 March 2020. The meeting had focussed on the impact of the COVID-19 pandemic, including the internal response to ensure continuity of the finance function, incorporating home working, and the external funding arrangements implemented. From 1 April 2020 a block contract was put in place for four months. COVID-19 costs are being collated and it is expected that these will be fully reimbursed. Discussions around CIP have been suspended.

Finance & Performance Meeting held on 4 May 2020

RH, Chair of the Finance & Performance Committee, gave a verbal update of the meeting held on 4 May 2020. Key points to note were:

- The month 12 and full year financial report were reviewed including the achievement of control total of c £10m deficit, resulting in an overall surplus of £50k due to additional Financial Recovery Funding (FRF), also reflecting a surplus across the ICS. The CIP target of £11m was achieved and agency costs were well below plan.
- There was a detailed review of the 2020/21 Budget Book approval (on a 'business as usual' basis) incorporating an underlying deficit of £27.5m offset by equivalent FRF to produce an overall breakeven position, CIP requirement of £14.8m, capital expenditure plan of £16.2m and conversion of c £130m of existing debt to Public Dividend Capital (thereby returning the overall net asset position to c £80m positive).
- Assessment of current 2020/21 financial performance risk at 12 and cash risk at 8, although both will be kept under close scrutiny with the impact of COVID-19.
- Abbreviated Integrated Performance Report which showed a March 2020 performance score of 71.3% (over 73% without COVID-19 impact), with all domains in amber or green, concluding a consistently strong overall performance in 2019/20. This was further demonstrated by a ranking of 3 out of 115 acute trusts on two key indicators – Emergency Care 4 hour Standard and 62 day Cancer targets. Work is now being carried out to determine the appropriate key measures (particularly around outcomes) during the COVID-19 pandemic.

Quality and Workforce Meeting held on 4 May 2020

DS, as Chair of the Quality Committee, gave a verbal update. Key points to note were:

- A Never Event in the Surgical division was recorded. Further information will be provided at the next meeting. The Commissioners and Care Quality Commission (CQC) have been informed.
- An improving position on complaints has been evidenced.
- There is still work to be done across serious incidents and complaints to share any learning, commonalities and joint training is required.
- An audit is to be carried out of 15 complaints over the past two or three years to check that the resultant learning was embedded and the actions have been completed.
- The IPR report was not discussed at the meeting due to the need to investigate further a number of inaccuracies in the data provided.
- The COVID-19 Health and Wellbeing Strategy was presented by the Director of Workforce & Organisational Development.
- The Chief Operating Officer gave an update on COVID-19 issues.

DS pointed out that there has already been an accumulation of deferred agenda items for the Quality Committee and it is assumed that this is also the case for other Board Sub-Committees. It was agreed that this needs to be included in recovery planning to ensure that there is compliance with governance processes and structures. The Company Secretary advised that a log is being compiled of meetings that have been deferred together with any decisions that have been made outside of the meetings. These will be incorporated into a report and discussions will be held with the Chairs of the Sub-committees and the Lead Executive to agree on what is to be carried forward and what is no longer relevant.

Action: Company Secretary to provide report for discussions with Board and Board Committee Chairs

Oversight Committee Meeting held on 6 May 2020

DS gave a verbal update on the meeting held on 6 May 2020. Key points to note were:

- The Committee discussed and supported the three decisions which had been approved by the Outer Core relating to the temporary re-location of services of the Ambulatory Assessment Unit and the MacMillan Unit and the potential temporary closure of the Huddersfield Birthing Centre.
- It had been noted that these decisions had been made retrospectively due to the pace but that structures were now in place to reduce similar scenarios happening in the future.

Audit and Risk Committee meeting held on 7 April 2020

AN, as Chair of the Audit & Risk Committee, gave a verbal update on the meeting held on 7 April 2020. Key points to note were:

- The Committee approved a temporary addendum to the Standing Financial Instructions and the Scheme of Delegation
- The Committee noted the changes to the annual report and accounts timetable for 2019/20.
- The Committee reviewed the draft annual governance statement and supported the recommendation to declare a significant control issue as a result of COVID-19.
- The internal audit plan and the counter fraud annual plan for 2020/21 were approved.

Actions:

- **The Minutes of the Finance & Performance Meeting held on 30 March 2020 and the Audit & Risk Meeting held on 7 April 2020 are to be uploaded to the Review Room on Convene.**
- **The Minutes of the Finance & Performance Meeting held on 4.5.20 and the Quality & Workforce meeting held on 4.5.20 together with the Minutes of the CHS meetings held on 25.2.20 and 24.3.20 will be presented at the Public Board Meeting on 2 July 2020**.

54/20 Any Other Business

The Chair advised that he had telephone discussions with each of the publicly elected governors during March and April 2020. He thanked Stephen Baines for attending the meeting and invited comments or observations.

Stephen Baines thanked the Chair for the opportunity to represent the governors at the Board meeting. He expressed his appreciation for the Trust across the board and that recognition is given to all staff groups. He added his appreciation that the Non-Executive Directors continue to provide challenge to the Executive Directors.

The Chief Executive, on behalf of the Executive Directors, thanked the Non-Executive Directors and the Chair for the support given to the Executive Team and added that the creation and adherence to the established leadership principles has been welcome. He also thanked the Company Secretary for her work and support.

Date and time of next meeting
Date: Thursday 2 July 2020
Time: 9:00 – 12:30 pm
Venue: To be confirmed

The Chair closed the meeting at 10.40

5. Action log and matters arising

For Review

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 7 May 2020

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.11.19 129/19	**AOB** Experience from 'back to the floor' week to be shared at a future Board workshop	SD	Scheduled for 2 April 2020 Board Workshop but cancelled due to private Board meeting held for Covid-19 pandemic.	TBC		
05.03.20 36/20	**Risk Management Strategy** EA to amend the strategy to reflect that the Chair of the Information, Governance and Records Strategy Group is the Managing Director Digital Health.	EA	Strategy amended. Checks being made to ensure this amendment is on the version on the intranet	May 2020		23.6.20.
05.03.20 36/20	**Risk Management Strategy** AM/AN to agree on a consistent approach for the structure and flow chart.	AM/AN	Final checks to be completed	May 2020		23.6.20.
07.05.20 54/20	**Verbal Update of Meetings** **Quality & Workforce Committee 4.5.20** Company Secretary to provide report for discussions with Board and Board Committee Chairs	AM	NED meeting discussed Committees and deferred items. Added CHS Board following discussion.	July 2020		18.6.20.
07.05.20 54/20	**Verbal Update of Meetings** The Minutes of the Finance & Performance Meeting held on 4.5.20 and the Quality & Workforce meeting held on 4.5.20 together with the Minutes of the CHS meetings held on 25.2.20 and 24.3.20 will be presented at the Board Meeting on 2 July 2020.	JR	The Minutes are on the agenda for 2.7.20	July 2020		2.7.20

6. Chair’s Report

To Note

7. Chief Executive’s Report

To Note

TRANSFORMING AND IMPROVING PATIENT CARE

8. Remote Visiting - Carole Gregson/Caroline Winkley

To Approve

9. Digital Health Strategy

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title:	CHFT Digital Strategy 2020-2025
Author:	Mandy Griffin/Luke Stockdale
Sponsoring Director:	Mandy Griffin
Previous Forums:	WEB Meeting December 2019 /BOD Workshop 6th February/ WEB meeting 25th June

Actions Requested:
To approve.

Purpose of the Report

Described the proposed direction of travel of the CHFT Digital Strategy including the Investment plan, governance and prioritisation process: to give assurance and gain approval

Key Points to Note

- The 1st Draft was presented to the board in February 2020
- The 2nd draft has been produced following various engagement sessions and 1 to 1 interviews and has been amended/ developed around the feedback
- The strategy now includes and investment plan
- The strategy aims to define clear governance and prioritisation processes
- The detailed strategy has been sent separately to board members to allow time to review a nd make any comments prior to approval.

EQIA – Equality Impact Assessment

The strategy has been designed and amended following a number of engagement workshops, group meetings and 1 to 1 sessions that have included, patients, public, primary care network s and the trust workforce, clinical and non-clinical staff involving over 300 individuals.

Recommendation

The Board is asked to:

- Approve overall direction of the strategy
- Approve Governance arrangements and prioritisation processes
- Approve investment plan

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

DIGITAL STRATEGY 2020 - 2025 CONTEXT

BOD- July 2nd 2020

Background

Digital Strategy

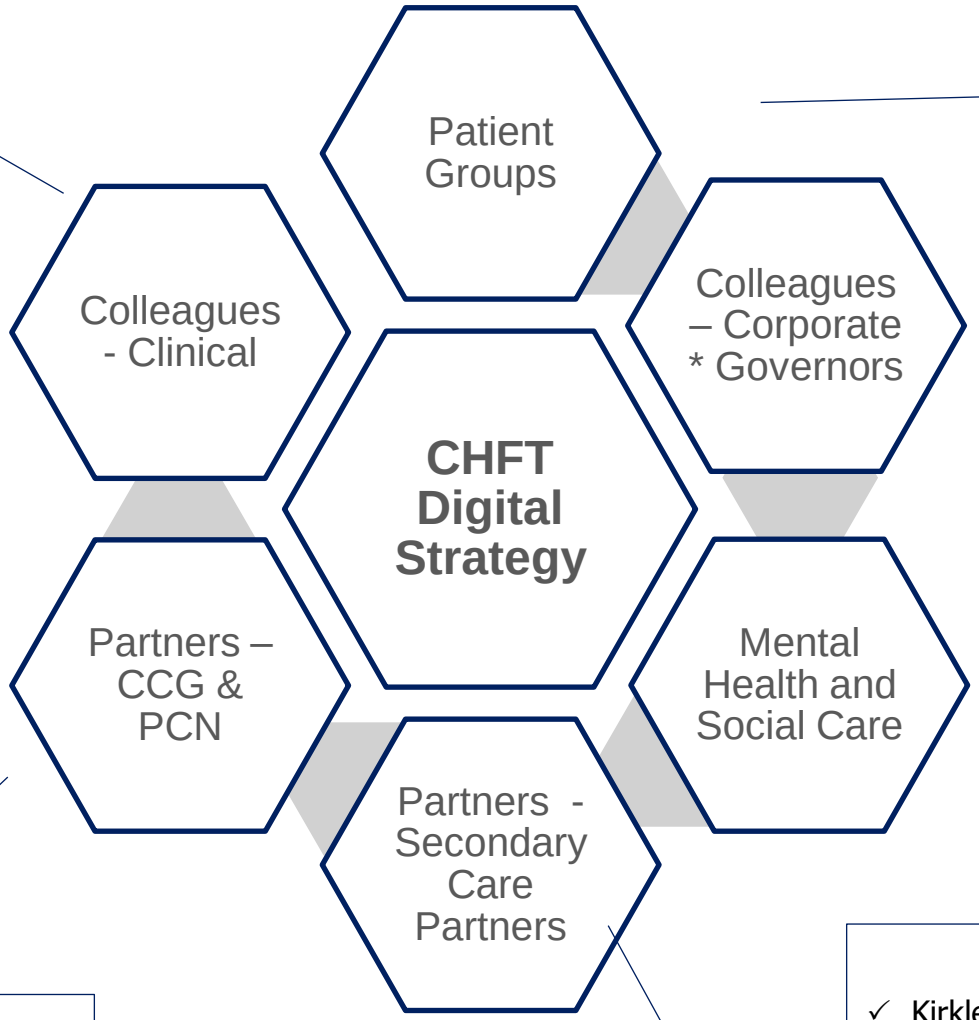
- It has been presented to WEB 25th June
- Last presented to WEB in December 2019
- Presented to BOD via a workshop in February 2020
- Engaged over 300+ stakeholders with the support of Catherine Riley
- Created an identity for the strategy to ensure it easily digestible
- Series of 1 to 1/ group meetings over the last 4 weeks

Stakeholders

Calderdale and Huddersfield NHS Foundation Trust

Patient Experience

- ✓ 4/6 Hot Houses
- ✓ Tea Trolleys
- ✓ Surveys
- ✓ Engaging community colleagues



- ✓ Public Engagement
- ✓ Feedback Healthwatch Survey's

- ✓ Hot Houses
- ✓ Meeting Governors 13th Feb 2020

- ✓ Calderdale/Greater Huddersfield Chair
- ✓ Attending CCG meeting

- ✓ Kirklees Digital Board

Structure of the Strategy

Following Feedback we amended the structure of the strategy:

- Foreword from CEO
- Exec Summary
- Purpose of Digital Strategy
- **Digital Journey**
- National and Regional Context
- Business Intelligence
- **Investment plan**
- **Digital Future**

We Said You Did – some common themes

	Feedback Theme from sessions	Included in the strategy is….	
1	Need to be more about the Patient	Patient experience now has a dedicated section including feedback from the recent engagement sessions and surveys	✓
2	Explain and reference compassionate care as well as one culture of care	Included at different and most appropriate parts of the strategy	✓
3	**Make what we have work**	Included optimisation as the key focus and building **interoperability** the allocation of funding to support	✓
4	Hardware is available and performing at its best	Investment in new hardware and the infra-structure to support. Allocate funding to better track assets.	✓
5	Data Quality needs to be addressed	Optimisation to ensure the design of the system promotes Data Quality. Introduced an Analytical Maturity model .	✓
6	Concern that patients are not able to access digitalised care	Digital Inclusion is included in the Strategy ensure we are working in conjunction with partners	✓
7	**Patients want to have access to their medical information**	A focus on developing the Patient Portal	✓
8	Concerns that the Strategy needs to be financially achievable	Investment Details included and highlighting the use of Trust Capital along with other sources of funding to achieve the strategy.	✓
9	The was a requirement for an approved investment plan	The trust needed to be committed to on-going investment	✓
10	A long strategy document won't mean anything to me	Creation of bitesize versions to help embed the strategy. Looking at options of providing updates throughout the duration (i.e. Year in Review Updates)	✓

Working Together To Get Results – what we need your support on

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Governance

The Board will champion the Digital Health Strategy that will enable the provision of high-quality care by investing in technology for innovation and transformation. Embedding good governance around the strategy is vital. Progress will be reviewed annually.

Investment/ prioritisation

The plan describes the known current commitment on investment over the next 5years :

- Capital = £12.8m
- Revenue = £36.5m

The necessary investment plans will need to be aligned to capital, revenue expenditure and resourcing plans to ensure the success of the strategy. New investments will be prioritised. Initially high-level benefits criteria considered will include:

- Patient Outcomes
- Statutory Regulations
- Burning Platform
- Availability of Funding

"Embedding good governance around the strategy is vital "

Key Next Steps

- **Approval**
- Digitalise the Strategy
- Bitesize Versions
- Launch Event and Engagement
- Regular Reviews – (i.e. Year in Reviews)

Thank You

Any questions?

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"We will provide easy to read bitesize versions"

10. 2020/21 Plan on a Page

To Approve

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Date of Meeting:	**2 July 2020**
Meeting:	**Public meeting of the Trust Board**
Title of report:	**2020-21 One Year Strategic Plan**
Author:	**Anna Basford**
Sponsor:	**Owen Williams**
Previous Forums:	**none**

Actions Requested:

- To approve

Purpose of the Report

To describe the annual strategic objectives that the Trust will deliver in 2020-21.

Key Points to Note

In March 2020 the Trust Board approved CHFT's ten-year strategic plan.
This report describes the one-year strategic objectives for 2020-21 that will support delivery of the ten-year plan. Each of the objectives has a named Director lead identified by initial who will be accountable for delivery. Quarterly updates on progress will be provided at future meetings.

EQIA – Equality Impact Assessment

For each objective described in the one year plan a Quality and Equality Impact Assessment will be undertaken. The accountable Director for each objective will be responsible for this and where it is possible will follow best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts. An update on the equality impact assessments undertaken will be provided in the quarterly reports submitted to the Trust Board.

Recommendation

Trust Board members are requested to approve the 2020-21 annual strategic objectives.

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2020 / 21 One Year Strategy

Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	**Sustainability**
	Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'. (AB)	Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleagues safety. (OW)	Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for Nurse staffing and specialist medical roles, thus retaining a turnover below 10%. (SD)	Deliver the 20/21 regulator approved financial plan. (GB)
	Trust Board approval of reconfiguration business cases for HRI and CRH. (AB)	Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating. (EA)	Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions. (SD)	Demonstrate improved performance against Use of Resources key metrics. (GB)
	Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire. (DB)	Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics (EA)	Roll out our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams. (SD)	Trust Board approval of a 10 year sustainability plan to support reduction in use of natural resources. (SS)
	Trust Board approval of a 10 year digital strategy supported by an agreed programme of work and milestones. (MG)	Develop an outcome based performance framework and deliver against key metrics. (HB)	Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	Collaborate with partners across West Yorkshire and in place to deliver resilient system plans. (AB)
	Use population health data to inform actions to address health inequalities in the communities we serve. (OW)	Deliver the actions in the Trust's 2020/21 Health and Safety Plan. (SD)	Assign a wellbeing champion to each Ward/Department/Service to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	

FINANCIAL SUSTAINABILITY

11. Month 2 Financial Summary

For Assurance

A WORKFORCE FOR THE FUTURE

12. Staff Survey Results and action plan

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	**2nd July 2020**
Meeting:	**BOARD OF DIRECTORS**
Title:	**STAFF SURVEY UPDATE 2019**
Author:	**SUZANNE DUNKLEY, EXECUTIVE DIRECTOR, WORKFORCE AND ORGANISATIONAL DEVELOPMENT**
Presented By:	**SUZANNE DUNKLEY, EXECUTIVE DIRECTOR, WORKFORCE AND ORGANISATIONAL DEVELOPMENT**
Previous Forums:	**BOARD, MAY 2019** **WORKFORCE COMMITTEE, February 2020**

Actions Requested:

- To note the report and approve the recommendations.

Purpose of the Report

The presentation updates the Board on the national Staff Survey Results for CHFT in 2019. The presentation shares with the Board the engagement plan developed in preparation for the Board meeting in April 2020. The report also includes the impact on the engagement plan as a result of COVID and the subsequent actions prioritised to improve the engagement of colleagues at CHFT.

The presentation also updates the Board on national plans for the 2020 Staff Survey.

Key Points to Note

- The NHS holds an annual national staff survey every year. In 2018, CHFT saw a small increase in its engagement score (to 6.9). This score was retained in 2019.
- CHFT's response rate fell to 46% in 2019 from 51% in 2018. Due to an outbreak of norovirus, the Survey ran for one week less in 2019.
- There were some improvements in CHFT's score in relation to Equality, Diversity and Inclusion and My Line Manager. Improvements were also made in CHFT's local questions, which focused on our digital maturity, 'Work Together Get Results' and our 'Four Pillars.'
- The areas for improvement Trust wide include IT/equipment, Health and Wellbeing, Progression and Training. Some service areas and staffing groups also need specific focus to improve as the survey results indicate that they do not feel as engaged as other service areas/staffing groups across the Trust.
- An action plan to respond to the 2019 Survey was finalised and presented to the Workforce Committee in February 2020, with a full roll out planned for the end of March for both the Trust as a whole and by Division. Due to the COVID pandemic, several listening events and activities that underpinned the action plan and were planned for April were cancelled.

- The focus of engagement since April both as a Trust and by Division has focused on supporting colleagues through the pandemic, with an emphasis on One Culture of Care, the provision of colleague and managers guides to leading positively and the provision of a 24/7 support line. Feedback from colleagues about the support they have received has been encouraged through Virtual Leadership Events, Virtual Listening Events and via the 24/7 support service.
- A revised action plan, based on feedback from colleagues has been developed focusing on 4 core actions.
- A discussion is taking place nationally to determine if the 2020 survey should run from September with the usual questions, or if the questions should be changed to reflect on the last 12 weeks. A decision on this is expected shortly.

EQIA – Equality Impact Assessment

The National Staff Survey responses are broken down across several characteristics, which enables CHFT to determine any differences in experience of engagement at CHFT by characteristics including gender, ethnicity, age and sexual orientation.
The results of the Staff Survey have been reviewed and are included in the presentation. Actions identified both in the original action plan and the updated priorities have also been impact assessed, with an additional assessment for colleagues who may require support with digital technology or access to learning.

Recommendation

The Board is asked to note the Staff Survey results 2019 and approve the actions to improve our staff engagement below:

1. Time for wellbeing and engagement activities built into diaries/rosters
2. Launch 3 interconnecting programmes of development – Leading One Culture of Care, Management Essentials and the Empower programme
3. Fund and support a continuing 24/7 health and engagement and wellbeing service, including trained counselling support, and appoint Wellbeing Champions to each ward/department/service
4. All managers have a ‘people’ related objective to create one culture of care and achieve key workforce targets

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Staff Survey Results 2019

Board July 2nd 2020

Suzanne Dunkley and Alex Jowett

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Headlines

- 6.9 overall engagement score – we have held our position as have most other Trusts
- Response rate down from 51% in 2018 to 46% in 2019 – open for one week less than 2018 due to norovirus and ‘early winter’
- There are some key themes and key service areas/departments that need special focus from us as a team but also some areas of improvement we should be ‘CHuFT’ about
- Other key workforce health indicators – IIP, Turnover, Attendance, EST and appraisal benchmark strongly
- COVID pandemic has helped us improve our approach, but has also identified some ‘gaps’ and areas for improvement in our engagement of colleagues

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Key Improvements and areas of strength

Trust wide

- Some teams improved their score, including Community Division, THIS and WOD
- Equality, Diversity and Inclusion
- My Line Manager
- Free text comments
- Local questions

ED&I

- Colleagues Age 16 – 30 are most engaged
- BAME Colleagues look forward to coming to work more than white colleague
- BAME Colleagues feel they are involved in changes that happen in the Trust
- BAME Colleagues view actions from Senior Leadership are positive and engaging
- Most engaged teams WOD, THIS

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Local questions

- **Do you agree that our digital systems and processes enhance the patient experience?** Improved score, with 10.1% people saying they strongly agreed, up from 6.1%
- **Do you understand the WTGR approach?** Improved score up to 80.3% from 76.9%
- **In the last 12 months, have you used WTGR?** Improved score and 91% said 'it worked'
- **To what extent are you aware of our 4 pillars?** 98.3% responded positively
- **How often do you display the 4 pillars in your behaviour with colleagues?** 74% said 'every day'
- **Are you aware of FTSU?** 66.55% people said they were
- **Are you aware of our BAME network?** 69.7% said they were, up from 56%
- **Are you aware of our LGBTQ forum?** 75.6% said they were, up from 59.3%

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Key themes for improvement

- IT/Equipment
- Staffing
- Health and Wellbeing
- Progression
- Training
- Patient feedback used to improve services
- And….car parking and quality of appraisals
- PMU
- Pathology
- Head & Neck
- Emergency care
- Operating Services
- Outpatients and records
- Pharmacy

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ED&I areas for improvement

- Age 51 – 65 (largest population of colleagues) feel less engaged than others
- Colleagues with a disability feel less engaged that others
- A higher % of BAME Colleagues feel they have witnessed/received bullying/harassment / discrimination than white colleagues
- BAME colleagues feel their immediate manager is less supportive in a crisis and not as interested in their well being as white colleagues
- BAME colleagues view career progression not as fair as white colleagues
- Female colleagues are less engaged than male colleagues
- Sexuality – majority of colleagues would prefer not to declare their sexual orientation, gay colleagues / bisexual colleagues feel less engaged than heterosexual colleagues
- Less engaged teams PMU & FSS

Reflection

- There are 9 questions that determine our overall engagement score – as well as our themes, we must put focus here
- We are able to launch our survey in September and run it for a whole 11 weeks*
- We need a detailed and tactical communications plan, as well as a wider plan of improvement
- Colleague engagement and one culture of care needs to be ‘owned’ by line Managers

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Questions	How are we doing now? 2019 results
I would recommend my organisation as a place to work	6.3 – needs major improvement
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	6.8 – needs improvement
Care of patients/service users is my top priority	7.3 - good
I am able to make suggestions to improve the work of my team / department	7.0 - good
There are frequent opportunities for me to show initiative in my job	7.0 - good
I am able to make improvements happen in my area of work	6.1 – needs major improvement
I look forward to going to work	6.3 – needs major improvement
I am enthusiastic about my job	7.5 – very good
Time passes quickly when I am working	7.7 – very good

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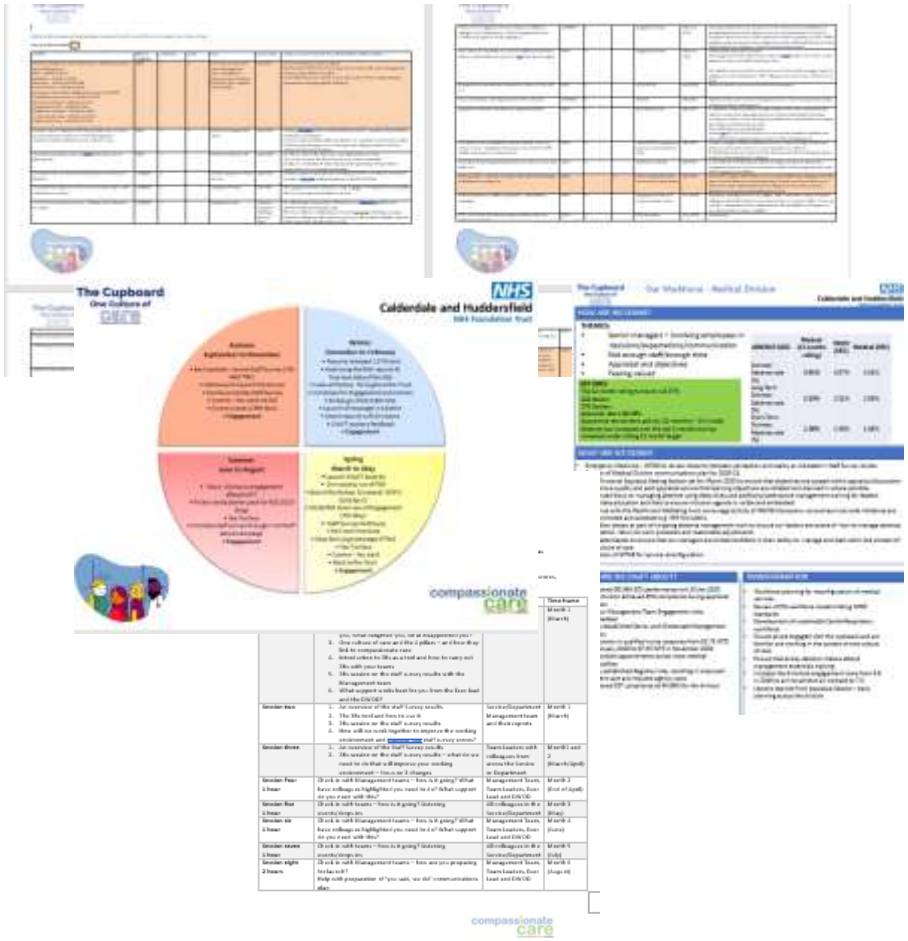
Response – key principles

- We need to continue with ‘One culture of care’ approach – remember, this is what our colleagues told us was missing in the engagement activity June 2018-April 2019. There are positive comments in free text, but also evidence of where we are not displaying one culture of care
- Team Leaders and Line Managers need to co-own colleague engagement, with support from Divisional Management and WOD
- Brand hierarchy and clarity over our ‘call to arms’ is required
- We need to continue with Trust wide engagement events and ‘nice to haves’ but ALSO focus more intensely on getting the basics right
- Progress against a coordinated action plan of all the activity that will support an improved staff engagement score must be monitored
- We must see our staff engagement results alongside other key workforce health indicators – those areas that score well in staff survey also have low absence, turnover, high compliance

Key activities

- Coordinated planning
- Leadership events and return of big brief, as well as podcasts
- Focused work with teams and staffing groups in need of support
- Friday visibility for all Execs
- ‘Listening clinics’
- 1 hour per month for every colleague to attend learning/an activity or event
- All teams to have quarterly events to discuss what they are CHuFT about, and what needs to improve
- All Managers to have an objective in appraisal relating to creating one culture of care and achieving workforce targets
- Anti bullying (positive behaviours) programme
- Positive comms on IT equipment



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Key ED&I activities

- BAME network is having a positive impact of colleague engagement – particularly 'look forward to coming to work', making change happen and interaction with Senior Leadership
- Further work needs to take place regarding victimisation/discrimination / bullying and harassment of minority groups – signed up to NHS bullying alliance scheme / working with YAS to learn from their 'Say Yes to Respect Scheme'
- Disabled Colleagues – Encourage declaration, Disability Passport, CDAG, Roadshows
- LGBTQ –Facebook group, Inclusion Roadshows, Pride Events
- Inclusive Leadership & Transparency – Leadership development programme (explain rather than tell, engage, encourage, nourish, develop, role model)/Unconscious Bias
- Communication – utilise a range of effective channels to cascade 'key' information
- More focus on working together/collaboration rather than individual groups
- Use role models in highly engaged teams to share best practice in lower engaged teams

Best of times, worst of times

- Accelerated understanding of ‘One Culture of Care’ with examples of good (and bad) application quoted by colleagues
- Clear leadership style requirements from colleagues
- How supported colleagues felt largely mirrored our staff survey results
- An amazing opportunity to provide support and care to colleagues – COVID Health and Wellbeing Strategy has ‘set the bar’ for how we want to continue to lead, support and develop colleagues

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Our new response plan

- Four key actions that will improve how colleagues feel about working at CHFT:

1. Time for wellbeing and engagement activities built into diaries/rosters

2. Launch 3 interconnecting programmes of development – Leading One Culture of Care, Management Essentials and the Empower programme

3. Fund and support a continuing 24/7 health and engagement and wellbeing service, including trained counselling support, and appoint Wellbeing Champions to each ward/department/service*
4. All managers have a ‘people’ related objective to create one culture of care and achieve key workforce targets

KEEPING THE BASE SAFE

13. COVID-19 Update and Key Messages

To Approve

14. Infection Prevention;

a) Infection Prevention Control Board Assurance Framework - to Note

b) Director of Infection Prevention Control Report (DIPC) Quarter 1 Report - to Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title:	Infection Prevention and Control Board Assurance Framework Assessment
Author:	Lindsay Rudge, Deputy Director of Nursing, Deputy Director of Infection Prevention and Control
Sponsoring Director:	David Birkenhead, Medical Director, Director of Infection Prevention and Control
Previous Forums:	None

Actions Requested:
To **note**

Purpose of the Report

NHS England and NHS Improvement on 4th May 2020 provided NHS Trusts with an infection prevention and control (IPC) board assurance framework.

The framework was developed 'to support all healthcare providers to effectively self-a ssess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risk'.

The framework is structured based on the existing 10 criteria set out in the Code of Practice on the Prevention and Control of Infection: this links directly with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CHFT commissioned an independent review of IPC assurance through an assessment against the Board Assurance Framework, conducted by two independent nurse consultants specialising in IPC.

Key Points to Note

- A summary assessment of assurance for each of the framework statement is provided in the report.
- The review included interviews with key members of staff and observations of practice were carried out on a number of wards to assess the level of adherence to policies and guidance.
- A review of systems and processes was also undertaken by shadowing the Incide nt Management Group and the Tactical work stream along with reviewing policies, SOPs, risk registers and minutes of meetings.

- Overall, the reviewers felt that there are good systems and processes in place that are able to recognise and manage the risks associated with COVID-19 in a co-ordinated way.

EQIA – Equality Impact Assessment

The IPC assurance framework and related policies and procedures have been equality impact assessed against all protected characteristics. Whilst PPE advice has been adopted in line with national guidelines, some groups of colleagues have been assessed and actions taken to further mitigate their risk, in addition to wearing appropriate PPE. Colleagues with physical health issues that may or may not be classed as a disability were contacted by Occupational Health and, following assessment, advised to shield if necessary. Colleagues who were able to wear masks instead of hoods were encouraged to do so, and any colleague who could remove beards/facial hair were also encourage to shave, in order to reserve hoods wherever possible for colleagues who wore beards for religious purposes. Colleagues who are pregnant have also been advised of risk factors, and where necessary have been removed from direct patient care. Trust communications in relation to IPC actions and processes have been reviewed to ensure that they are clear. consistent and concise to ensure they are easily read and understood. The Trust has recently launched a health and wellbeing risk assessment for all colleagues, and use of PPE is included in the assessment. Independent EQIAs have been undertaken on Trust policies referenced in this assurance framework.

Recommendation

The Board is asked to note that the Quality Committee will be receiving the report and will review and monitor an action plan to address the recommendations.

AC Independent
Nursing Consultants

Independent Infection Prevention and Control Board Assurance Review for Calderdale and Huddersfield NHS Foundation Trust

Report compiled by Carole Hallam and Dr Andrea Denton, Independent Nurse Consultants, AC Nursing Consultancy 24th May 2020

Contents

Introduction

NHS England and NHS Improvement on 4th May 2020 provided NHS Trusts with an infection prevention and control (IPC) board assurance framework. The framework was developed 'to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risk'. The framework is structured based on the existing 10 criteria set out in the Code of Practice on the prevention and control of infection; this links directly with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An independent review of IPC assurance was commissioned by Lindsay Rudge, Deputy Director of Nursing/Deputy Director of Infection Prevention and Control and carried out between 19th and 22nd May by Carole Hallam and Dr Andrea Denton, both Independent Nurse Consultants specialising in IPC. Assurance was assessed against the infection prevention and control board assurance framework.

Executive Summary

The IPC Board Assurance review included interviews with key members of staff including directors, senior nurses, managers and frontline staff (the names are listed in appendix 1). In addition, observations of practice were carried out on 4 wards to assess the level of adherence to standard operating procedures (SOPs) and policies. The systems and processes were also reviewed by shadowing the Incident Management Group and the Tactical workstream along with reviewing policies, SOPs, risk registers and minutes of meetings.

It is clear that an enormous amount of work has been undertaken in the trust to manage COVID-19 as safely as possible. Initially there was a great there was a great deal of anxiety amongst staff about the risks of acquiring COVID-19 and what personal protective equipment (PPE) was required. This was further compounded and caused confusion with the changes in the National guidance and guidance provided by some of the Royal Colleges that conflicted with the National guidance.

Overall the reviewers felt that there are good systems and processes in place that are able to recognise and manage the risks associated with COVID-19 in a co-ordinated way. This coupled with strong leadership across the organisation which has helped to address the initial confusion. In particular the reviewers felt that the Incident Management Team (IMT) provides a central hub for decision-making including any changes to National guidance alongside key messages for dissemination. In addition, the Trust has effective processes for the collection of COVID-19 data which are available in an e-dashboard making important data readily available. There are a number of work streams including a PPE group, a Tactical Command group and a clinical reference group each feeding back through the IMT to ensure that risks and communications are adequately managed.

On the ward visits, good practice was observed with hand hygiene and donning stations in the entrances of the wards although signage on PPE was not always visible. There are regular visits to each ward from the Leadership team, IPC team, Matrons and the PPE and Wellbeing Team to support both the well-being and correct use of the PPE. Frontline staff reported being well supported but sometimes felt that there were minor inconsistencies of the advice from the various teams and on occasions each group asking the same questions. The frontline staff have appreciated senior staff visiting clinical areas.

Overall there is evidence to provide the Board with assurance of the systems and processes to manage the risks of COVID-19. There are however, a few small gaps highlighted in the Board Assurance Framework. The full IPC Board Assurance document can be found in appendix 3.

A summary of their assessment of assurance for each of the framework statements is provided below in table 1. This information was obtained from interviews, observation of practices and documents such as minutes of meetings, policies and standing operating procedures. The review findings are based on information gathered during an onsite two-day visit. Therefore, there are limitations in that not all information and practice could be observed or obtained across the Trust during the visit. The reviewers have made some recommendations that may strengthen the IPC assurance, particular in view of moving into phase two as well as responding to a second wave of COVID-19.

Table 1: A summary of the assurance for each statement

Framework statement	**Summary of assurance**
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	The IMT provides a structure with strong leadership to manage and monitor COVID-19 including assessment and management of risk including any changes to National guidance. There are various workstreams that feed into the IMT to ensure risks are managed including PPE and plans for reset of clinical services.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Cleaning staff have been provided with additional training including appropriate use of PPE. There are dedicated teams for the COVID wards. The cleaning protocols and linen management are in line with PHE guidance. Where single use equipment is not available re-usable equipment is decontaminated in line with PHE guidance.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Antimicrobial stewardship continues but currently there is no reporting through the usual Infection Control Performance Board until these meetings resume.
4. Provide suitable accurate information	Information is provided on the Trust's website

on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	and signage throughout the hospital. There are systems and processes in place to identify and communicate infection status of patients within the electronic patient record.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	There are systems and processes in place to identify patients with possible and confirmed COVID-19. This includes risk assessment and testing of patients along with clear pathways to ensure they are treated timely, appropriately and in designated areas to reduce transmission of infection.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Training has been provided to all staff on COVID-19 including the use on PPE, where appropriate. The understanding of individual responsibility is reinforced through daily visits to clinical areas from the Leadership, IPCT, PPE/Well being Teams and Matron visits.
7. Provide or secure adequate isolation facilities	Isolation capacity is managed daily at the tactical command meeting and supported with a list of patients requiring isolation by the IPC Team. COVID-19 +ve patients are cohorted on dedicated wards. Isolation breaches are reported as incidents on Datix.
8. Secure adequate access to laboratory support as appropriate	The laboratory has SOPs in place and is running to full testing capacity. All acute patients specimens are processed in-house but staff and pre-op specimens are processed out of house.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Adherence to policies and SOP is managed through regular visits to wards from the Leadership, IPC and the PPE/Wellbeing Teams. In addition, assurance is provided through routine Frontline Ownership (FLO) and hand hygiene audits and reported through Divisional Patient Safety and Quality Boards (PSQB).
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	There has been extensive work to identify staff at risk and needed to be at home, those that could work from home, those to be redeployed or office based with social distancing. Staff are supported via help line and counselling where required for both those at home and those in work. Staff absence and well being is monitored and staff can access testing and support.

Recommendations

1. Consider how the improvement of IPC practices such as hand hygiene can be embedded and sustained into routine practice going forward.
2. Improve the communication between the various visiting teams (Leadership, IPC and PPE/Wellbeing Teams and Matrons) to ensure consistency of messages.
3. Consider how the current quality assurance visits can support the development of quality improvement at ward and department level to provide frontline empowerment, leadership and continual IPC improvement.
4. Clear signage at the entry points of the ward/departments so staff are aware of what PPE is required on entering the area.
5. A record of training should be included for all staff and linked to ESR, where appropriate.
6. Resume the IC Performance Board as soon as able to provide assurance on antimicrobial stewardship and healthcare associated infections.

Appendix 1

Interviews

Name	Job role
Lindsay Rudge	Deputy Director of Nursing, Deputy Director of Infection
Jean Robinson	IPC Matron
Dr Anu Rajgopal	Infection Control Doctor
Dr Gavin Boyd	Consultant Microbiologist
Gillian Porter	CRH Cleaning Services
Claire Bushby	HRI Cleaning Services
Louise Croxall	ED Matron
Maxine Travis	Senior Risk Manager
Catherine Briggs	Lead Nurse
Dr Nicola Hardman	Antimicrobial Lead
Jacqui Booth	Comms Lead
Christine Bouckley	Lead Nurse Occupational Health
Chris Lord Tyler	Matron (medicine)
Sarah Bray	Matron (surgery)
Tracy Burdell	Matron (surgery)

Meetings attended

Name of the Group	Date and time of meeting
Incident Management Group	21st May at 2pm
Tactical	21st May at 12md

Observations of Practice

Ward	Date	Name of visitor/staff
CRH Acute Floor	21st May 2020	Andrea Denton and Mandy Holmes
CRH ??	21st May 2020	Andrea Denton and Mandy Holmes
HRI ward 20	21st May 2020	Carole Hallam and Belinda Russell
HRI ward 17	21st May 2020	Carole Hallam and Belinda Russell

Appendix 2

Ask Five feedback

Matrons	Ward staff
Where do your find the current information (relevant to your work) on COVID-19? Medicine – daily huddle; hour long huddle via teams Tactical and IMT – 2-way process Wednesday morning HB briefing Nursing management PPT – recorded and sent out. Division action log Lots of anxiety at first due to constant changes in national guidance but now clear guidance	*Where do you place patients on the ward when they are transferred to you?* Ward areas had systems in place for placement of patients whether positive possible or confirmed. On all areas any patient requiring AGPs were prioritized in side rooms – if not side rooms then cohorted in bay.
How is information cascaded to the teams from Tactical and IMT? Daily basis as and when changes – phone and follow up email if urgent points to link any info. Walk round – wards every day – smaller dept as and when mainly informal. PPE team feedback – Issues – via teams and staff. Issues visors – single use – sessional use. Terminology how and manner in which described. Communication idiot proof. Audits around Standard precautions still going ahead (FLO)	*What PPE do you wear (may depend on whether general COVID ward or COVID patients in single room and if AGPs (single room or general on ward).* Staff wore PPE as advised by IPCT. This was observed on the wards both for patient and non-patient contact. Donning and doffing areas were available and obvious. Some concern re face masks (fluid repellent) this was fed back to IPCN at the time). Confusion on one ward about use of face visors **No visual information on ward doors**
Walk rounds? 24/7 on call duty matron leadership and other walk rounds. Initially it was good to see some many people in – support and understand. Some staff getting fed up answering same question every day. Look to walk rounds being merged into one or two. Sometimes confusing and conflicting advice but generally supportive	*Where do you find the current information (relevant to your work) on COVID-19?* Information obtained via intranet and briefings which staff found useful. Sisters cascaded via team huddles daily. Had notice board in office for key information. Good support via IPCNs who also provided support and information. One ward area liked the increased walk rounds of different staff as found

	that supportive and felt that 'they cared'
How is ward level information passed back to you re any issues concerns? Telephone conversations – as know the staff – will clarify – picking up reinforcing the info and behaviour. COVID update every day from Helen Barker – staff say this is a bit woolly at times – better updating about new procedures (e.g. changes to swabbing). Those would be more Can feed back via tactical and HB.	*What is the criterion for COVID testing for patients and staff?* All patient swabbed on admission and staff is suspected – sent home and swab sent out via OH. All staff were aware of the procedures.
How do you ensure that fundamental IPC practice around SICPs TBPs cleaning is maintained? Flo audits? See above Visible assurance from walking around. Liquid soap usage has significantly increased!	*Have you/all your staff had training on caring for patients with COVID-19, was everything included, or do you think something was missing?* Training provided by IPCT – drop in sessions well attended and staff found useful Ad hoc training by IPCNs and information given out in briefings in form of PPT
Staff well-being and sickness how is that managed and cascaded? Nurse sickness – monitoring taking place liaising with OH Staff self-isolating and self-shielding after OH guidelines.Direct line managers inform matron and then directorate updated. Keeping in touch and providing reassurance. Info cascaded to staff re A/L initially via COVID update and Chief Nurse. Division also sent a briefing. Put out clear info – some argument that some were unhappy. Could have been done a bit sooner and in a different manner.	*Can you describe how you manage used linen from a COVID patient (suspected or confirmed)?* All staff were aware of how to manage linen and waste from patient with suspected or confirmed COVID- 19
IPCN contact? GM - zoning	*How do you manage other infections risks on the ward/area?* Staff outlined the process of other alert organisms and infection risks and use of EPR and IPCNs. Side room priorities highlighted
Future planning? Blue green and yellow ward areas looking at future planning and how to manage increase in 'normal' services being resumed. Reset in endoscopy has gone to IMT, lots of things needed to be	*What single use items are in use on the ward?* *How do you determine reusable items and how are these decontaminated?* Staff were aware of how to decontaminate and where possible used single use or single patient use.

considered including the return of specialist endoscopy staff that have been redeployed	
Area specific issues? Visiting caused the most concerns worse for cancer in particular initially – guidance changed – better now. Stroke – numbers reduced issues rehab side – have to be discharged and not always ideal. Double gloving practice on ICU – change in practice being supported by Dr Pnt Laloe	*What information would you give on transfer/ discharge of patients with COVID-19?* Handout taken from ward re transfer and discharge. Staff on both areas aware re advice re COVID and non COVID
Any gaps/concerns? Messages need to be clearer re PPE etc. Leadership walk rounds important but not all coming asking same questions – see above	*How would you clean the area/room once patient with COVID-19 has been discharged? What is the process for requesting terminal/additional cleaning?* Staff aware on both areas how to ask for terminal clean and aware re Amber clean for COVID-19 areas
What do you do with your uniform at the end of the shift? Reports of odd numbers of staff traveling to and from work in uniforms	*What do you do with your uniform at the end of the shift?* All staff stated that take home and wash as advised.

Appendix 3

Publications approval reference: 001559

Infection prevention and control board assurance framework

4 May 2020, Version 1

NHS England and NHS Improvement

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are

treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated appropriately.

Infection Prevention and Control board assurance framework

Assessment carried out over a two-day period at Calderdale and Huddersfield NHS Foundation Trust

1. Systems are in place to manage and monitor **the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients • patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates and any changes are	Standard Operating Procedures (SOP) were readily available on the intranet and compliant with PHE guidance and included • Risk assessment in ED • Movement of patients with COVID • Discharge/transfer of COVID pts • PPE (when and how to use PPE) All IPC policies were also available on the intranet and the Trust website Risk management for COVID-19 was evidenced from risk register, which is reviewed weekly, and new risks reported daily to the Incident Management Group (IMT). The IMT reports to the weekly Executive Board (WEB). There is check and challenge from the CEO led Outer group. All suspected and confirmed COVID-19 patients are reported to the Tactical Command group (TCG) that meets daily. The TGC reports to the IMT.	Pandemic policy is overdue for review, further review should include novel viruses and not just influenza. There was no COVID-19 policy developed due to the rapidly changing national guidance.	Specific SOP for COVID-19 along with the standard IPC policies are available

effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	All PHE updates in the national COVID-19 guidance are reviewed by the daily IMT. Changes to practice are cascaded in a number of ways • Red border email (limited to urgent trust wide information), • Daily walk round visit to clinical areas by IPC and PPE/Wellbeing Teams and Matrons • Friday briefing for nurses • Medical weekly live chat Non-COVID infections continue to be risk assessed and monitored including routine screening, isolation of patients with suspected and confirmed C. difficile, MRSA etc.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use	Dedicated teams of COVID and relief teams. Cleaning services HRI and CRH: HRI Training provide on PPE what and when to wear. Use of training sessions and videos used for donning and doffing. CRH – training given by IPCT	No record of when and what training took place.	Donning/doffing videos and PPE aide memoir for CHFT staff is available on the intranet

of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy • reusable equipment is appropriately decontaminated in line with local and PHE national policy	Use of team briefs and notice board to update on any new information. Fit testing for staff going on to AGP areas – medical engineering has info at HRI. Cleaning as per Trust Amber clean and additional cleaning to areas and touch points. Daily checks and additional checks by domestic supervisors. Information re other infection risk and alert organisms communicated via the Notice Board as per usual practice. Domestic supervisors still review cleaning for patients alert organisms. Issues reported back to CBM at HRI and Lead IPCN. QA system still in operation at CRH (ISS). Health and wellbeing – staff risk assessed and liaise with OH re actions depending on risk. Move to low risk areas or stay home etc. Sickness managed	No documented evidence re Domestic Supervisor checks just informal Communication poor initially – no input into tactical and or IMT – information often obtained via ward/areas domestic.	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Systems in place for COVID patients – EPR identifies +ve patients. Individual risk assessment for ICU and some other patients on use of Procalcitonin (part of the tool to detect severity of disease). Guidance from NICE and NHS England. Systems in place to monitor antimicrobial (AM) use via both Microbiologist and AM pharmacists. AM stewardship still going ahead in key areas via teams meetings or phone (e.g. haematology and oncology). Concerns and issues can be highlighted to Clinical Directors (pharmacy and pathology).	Reporting to Infection Control performance Board is not going ahead at present so no routine reporting. Clinical Outcomes group also not current. *(Concern re-lapse in CQUIN for UTI having made excellent progress to date).*	
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and	There is good information on COVID-19 including a link to the Government website, on the Trust website and includes visiting restrictions. Visiting is facilitated by special arrangement for patients with learning disabilities, dementia, end of life and for children. Visiting is restricted to one visitor per patient.		

where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	There is signage throughout the hospital including signage on ward doors and the green and amber segregation in ED Patients identified with COVID-19 have an alert added to their electronic patient record (EPR) for 14 days.	Clear signage on PPE requirements on ward doors and donning stations is missing or misplaced on the areas visited	Signage re PPE requirement is temporary at the moment but is currently available in entrance to each ward and department – plans in place to have permanent signage made
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly	Patients are triaged on arrival to ED with clear green and amber segregated areas to minimize cross infection. There are clear pathways for where suspected and confirmed COVID-19 patients are admitted to and testing is performed in a timely manner. Results are usually available for acute patients (in-house testing) within 12 hours. Patients that are suspected to have COVID-19 are segregated/isolated and reported daily to the TCG.		

• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	In-patients, exposed to an asymptomatic COVID positive patient are highlighted by IPCNs to the nursing staff and exposure details documented. This is to ensure that patients are monitored for COVID symptoms daily for 14 days post contact Patients are risk assessed for COVID-19 in the Outpatient departments and isolated if suspected to be infected with COVID-19		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	Both formal and informal training have been provided for all staff on COVID-19 and continues to be reinforced by ad-hoc sessions provided by the IPC team. There is a medical weekly live chat where questions related to COVID-19 can be answered. The medical director/DIPC shares the key IPC messages. Fit testing is carried out by a team of trained and competency assessed FFP3 respirator fit testers. The records of individual FFP3 respirators are held by the Medical Devices	There are no records for the informal training or evidence of competency or understanding of the training. Individual staff don't readily know which FFP3 respirators they have been fit tested with, which can cause confusion when there are alternative masks. (It was suggested that this information could be added to the individual ESR).	Daily walk rounds by the Leadership, IPC and PPE/Wellbeing Teams are able to identify gaps in knowledge and the IPC team provides additional support where this is needed. The different types of FFP3 respirators have been managed by the PPE group who standardise one type of mask to each area to reduce the different types being allocated anywhere, as supply allows.

• a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their	PPE is managed by the PPE group including when there is a need to reuse PPE. So far, PPE supplies have not required the need to re-use PPE other than full-face visors on a few occasions. Full advice was given to those areas re-using visors on how to clean the visors and allocate them to single staff members use. Compliance with IPC policies including hand hygiene and PPE is regularly monitored informally with the walk round visits by Leadership, IPC and PPE/Wellbeing Teams and local matrons. Formal monitoring of compliance of IPC policies is monitored through Frontline Ownership (FLO) audits and Hand hygiene audit Laundering of staff uniforms and scrubs is provided by the trust's laundry contract and changing facilities are provided. Staff are aware of their responsibility if they or a family member have symptoms of COVID-19. Staff sickness is monitored daily by the TCG and reported to the IMT. Adhoc training sessions re donning/doffing registers kept within IPC dept	Minor inconsistency of messages to frontline staff from the various visiting teams including the Leadership, IPC and PPE/Wellbeing teams and matrons. There are some gaps in the routine FLO audits and hand hygiene audit during the COVID-19 period A few staff are reported to be traveling to and from work in their uniforms Difficulties observed with compliance with social distancing in the public areas with both staff and the public, particularly on staircases.	

household display any of the symptoms.			
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Dedicated COVID wards have been set up on both hospital sites for confirmed COVID-19 cases. Suspected COVID-19 cases are isolated in single rooms on the Acute Floors. The IPC Team provide a list of patients requiring isolation on a daily basis. Isolation capacity is managed daily at the TCG meeting and reported to the IMT. Isolation breaches are reported as incidents on Datix as an established process. Policies exist for the isolation of patients with resistant/alert organisms. There has been no noted increase in alert organisms during the COVID period.		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place	Patient and staff COVID specimens are performed as per PHE guidance. The laboratory has SOPs in place and are currently doing all tests in-house including staff testing. Only specimen types (e.g sputum) that cannot be done on the machines are being referred. Routine screening of MRSA, MSSA and CPE continues as per local policies.	COVID testing has resulted in delays in C. difficile specimens being processed although these are still done within the day.	C. difficile processing is still performed each day but the testing is done after the COVID-19 testing. Results are provided in the evening rather than in the afternoon. Monitoring of C. difficile cases have not identified any significant increase in cases.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected	Support to adhere to the IPC policies and COVID-19 SOP is managed through regular visits to wards from the Leadership, IPC and the PPE/Wellbeing Teams. Any concerns with poor compliance is escalated through the appropriate work steam and to the IMT. Formal assurance is provided through routine Frontline Ownership (FLO) and hand hygiene audits and reported through Divisional Patient Safety and Quality Boards (PSQB).		

COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it	Observations carried out by the review team found good understanding of the IPC policies including appropriate use of PPE. PPE is monitored daily by the PPE/wellbeing team and reports to the PPE group to ensure staff have access to the appropriate PPE at all times		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	At risk staff initially identified via large scale comms – intranet, daily briefings, managers, CEO bulletins. Shielded staff identified either remotely or on site. Risk proforma used. Identified different staff groups (those that needed to be at home, those that could work from home, those to be redeployed, office based with social distancing etc). Staff supported via help line and counseling where required for both those at home and those in work. Feedback both ways via IMT and tactical (Deputy HR Director on IMT). Data collection re staff sickness linked to COVID-19 focusing on COVID wards and if any increases in sickness in those areas (none found to date). Also, data to explore sickness rates in different types of staff. SOP for staff testing and interpretation of results drafted in-line with national recommendations. Staff testing offered in-house with a rapid turn around time (12-24 hours)		

• staff that test positive have adequate information and support to aid their recovery and return to work.	Plans in place for return to work and how that will be facilitated. Use of intranet (seen on site) for key messages and information. Overall good leadership and mentioned in particular from CEO, Director and Deputy Director of Nursing.		

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2nd July 2020
Meeting:	Board of Directors
Title:	Quarterly DIPC report
Author:	Jean Robinson, Matron Lead IPC
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Actions Requested: To approve

Purpose of the Report

To provide the Board of Directors a report on the position of Healthcare Associated Infections (HCAIs) in Q1 2020-21 and to provide a summary position of performance for 2019-20, p ending submission of the annual DIPC report which is delayed a result of work to support the COVID-19 response.

Key Points to Note

- Compliance for ANTT and Level 2 IPC training has been escalated to Divisions for ongoing management.
- COVID-19 has impacted significantly on the use of side room accommodation requiring patients who would in normal circumstances to be isolated to be managed within bays or cohorted accommodation following risk assessment.
- The infection control team have managed an increased incidence of *Serratia marcescans* on ICU.
- There have been a small number of *C. dfficile* cases on a medical ward, two of these cases may be linked. Enhanced infection control procedures have been implemented with ongoing surveillance.
- The Infection Control team have contributed to the management of COVID-19 through the pandemic incident management processes ,attending a number of meetings /work streams. It is expected that this activity will continue to place significant demands on the team and their capacity.
- Provision of PPE has been challenging and requires day-day management, however the Trust has not at any point run out of supplies.
- Appendix 1 provides a summary of Infection Control Performance for 2019/20.
- Proposed Risk 7797 is rated 16 on the risk register regarding variable IPC compliance

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. The impacts of COVID due to ethnicity, age has been reported separately.

Recommendation

The Board is asked to **NOTE** the performance against key IPC targets and response to COVID-19 and the prioritisation of COVID positive patients for isolation facilities.

The Board is asked to note the general impacts of COVID-19 in relation to PPE use and enhanced cleaning and thence the impacts on capacity and support the ongoing contribution of the ICT in future planning to resume services.

The Board is asked to **APPROVE** the report.

compassionate care

Calderdale and Huddersfield NHS Foundation Trust

Quarterly DIPC Report
1st April 2020 to 31st May 2020

1. Introduction

This report covers the period from 1st April 2020 – 31st May 2020. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators. Appendix 1 contains a summary IPC highlight report for 2019/20.

2. Performance targets

Indicator	End of year ceiling 19/20	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	
C.difficile (trust assigned)	Awaiting DoH directive	**7**	5 HOHA 2 COHA
MSSA bacteraemia (post admission)	None set	**4**	
E.coli bacteraemia (post admission)	None set	7	
MRSA screening (electives)	95%	87%	A reminder has been sent to divisions re MRSA screening.
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.84%	Rolling 12 months
ANTT Competency assessments (doctors)	90%	62.2%	Divisions have been tasked to ensure medical staff complete ANTT assessment.
ANTT Competency assessments (Nursing and AHP)	90%	91.51%	
Hand hygiene	95%	99%	
Level 2 IPC training (Doctors)	95%	75%	This is now an e-learning package
Level 2 IPC training (Nursing & AHP)	95%	88%	As above

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	96.3%	
Isolation breaches	**Non set**	Not recorded during this time scale	COVID-19 patients were given priority over side room isolation during this time frame.
Cleanliness	Non set	93.5%	

4. MRSA bacteraemia:

None to report during this time period.

5. MSSA bacteraemia:

There have been 4 post-admission MSSA bacteraemia cases during 1st April to 31st May 2020. A review of cases has been undertaken and there are no common themes. The IPC team will continue to review these cases on a monthly basis.

6. Clostridium difficile:

The trust has yet to been notified of the ceiling for 2020/21. The current number of cases in the reported time frame is 7 (5 HOHA and 2 COHA). All cases are reviewed by a Senior IPCN and Microbiologist and if deemed as requiring further investigation an RCA is undertaken.

New national criteria for the reporting of C-difficile cases commenced on the 1st April 2019 as follows: -

a) **Healthcare onset healthcare associated (HOHA)**: cases detected in the hospital ≥2 days after admission,
b) **Community onset healthcare associated (COHA):** cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,

7. E. coli bacteraemia:

There have been 7 post-admission *E. coli* bacteraemia cases since the 1st April 2020, a quarterly review will be undertaken and will be included in the next report. New guidance was due to be published in Spring but due to the COVID-19 pandemic this has been delayed.

8. Outbreaks & Incidents:

Serratia:- We have had four central line infections, one exit site infection and one hospital-acquired pneumonia due to *Serratia marcescens* on CRH ICU. These infections occurred between the period of 13th April-7th May 2020. A further isolate of *S.marcescens* was isolated from a gloved hand on environmental swabbing. All isolates are identical on molecular typing. All four patients have since been discharged. IPC control measures and an action plan are in place which is currently being monitored via the trust Outbreak Control group (OCG). A deep clean and HPV of the unit has been completed. This has been reported as a Serious Incident (SUI) and is being investigated in line with trust policy. It was noted that there was an

increased risk of variable compliance with infection control practice due to new recommendations regarding PPE and staff working in unfamiliar areas and patient groups. This has been noted on the risk register as Risk 7797 Score 16.

C-difficile:- There is currently a cluster of C-difficile cases on Ward 17, HRI. 3 toxin positive post case patients and one gene detected case. These were identified between 25/04/2020 and 02/06/2020, 2 cases are indistinguishable on Ribotyping. An Outbreak Control group was convened in line with trust policy and actions are currently being monitored through this group.

Norovirus:- Norovirus outbreak associated with the COVID ward at CRH, only 2 patients affected and no further onwards transmission.

COVID-19 Pandemic:-
The COVID-19 pandemic has been managed and monitored via the Incident Management Team (IMT). IPC is represented at the following:- PPE Group; Tactical group and IMT; Social Distancing; Patient Experience; Staff exposure; Clinical Reference Group; plus other clinical areas to support ongoing plans. The development of a Covid IPC workstream is underway and will feed directly into IMT.

As we move through the reset stage of resuming services the impact on PPE, Covid-19 screening & testing and IPC needs to remain pinnacle in maintaining a safe service.

Patient data

So far to date over 6827 inpatient tests have been completed with 502 positive results.

COVID-19: Summary of Asymptomatic Positive in-patients (from 27th April-2nd June 2020):-

- 1932 asymptomatic in-patients tested on admission so far
- Number from care homes= 118
- Total positive=19 (10 were from care homes and isolated on admission)
- Of the nine non-care home asymptomatic admissions, four patients were isolated from admission because of symptoms OR previous positive covid results.

Staff data

PCR testing:- 856 staff and household contacts have been swabbed and 579 have been able to return to work sooner due to a negative result, saving 3,093 working days.

The current rate of staff swabbing has reduced to approx 20/week and no positive results in the last 10 days.

Antibody testing:- 4768 tests have been requested, 2138 have been booked a test to date and 1,523 have received their results..

Test and trace:- Occupational health support identification of staff contacts in relation to test and trace, and 2 staff have been isolated for workplace contact prior to the implementation of wearing surgical facemasks in all areas.

FFP3 FIT testing:- Respiratory protection is required to ensure staff safety when carrying out Aerosol generating procedure (AGPs) on patients with infectious respiratory conditions, and for providing cares for

patients with specific infectious diseases. This is achieved by using either FFP3 masks (fitted face piece) or positive pressure hoods. Fit tester training changed in 2017 following a review and since then approximately 160 staff have been trained to be fit testers.

Since the onset of the 2020 pandemic of Covid-19, and the fluidity of disposable masks supplied from the national stock means this has proved difficult.

9. Isolation Breaches

Isolation breaches since 1st April 2020 have not been reported

10. Audits:

Quality Improvement Audits
The programme was put on hold during the reporting period and was reinstated on the 15th June.

FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving.

Quarterly FLO audits: These are completed by the IPCNs on acute areas, again these were put on hold during the reporting period and have ben recommenced on the 15th June.

11. ANTT

All staff who undertakes ANTT requires re-assessment every three years. This has had an initial impact on the ANTT performance matrix as staff ESR records automatically lapsed to RED if their previous assessment was more than 3 years ago (before 1st September 2016). The current Trust compliance is 83.20% with nursing colleagues at 91.51% and medical colleagues 62.20%. The infection control performance board is monitoring compliance closely to ensure this is at the level expected.

12. Recommendations

The board is asked to note the performance against key IPC targets and approve the report.

NHS
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NHS Foundation Trust

APPENDIX 1

NHS
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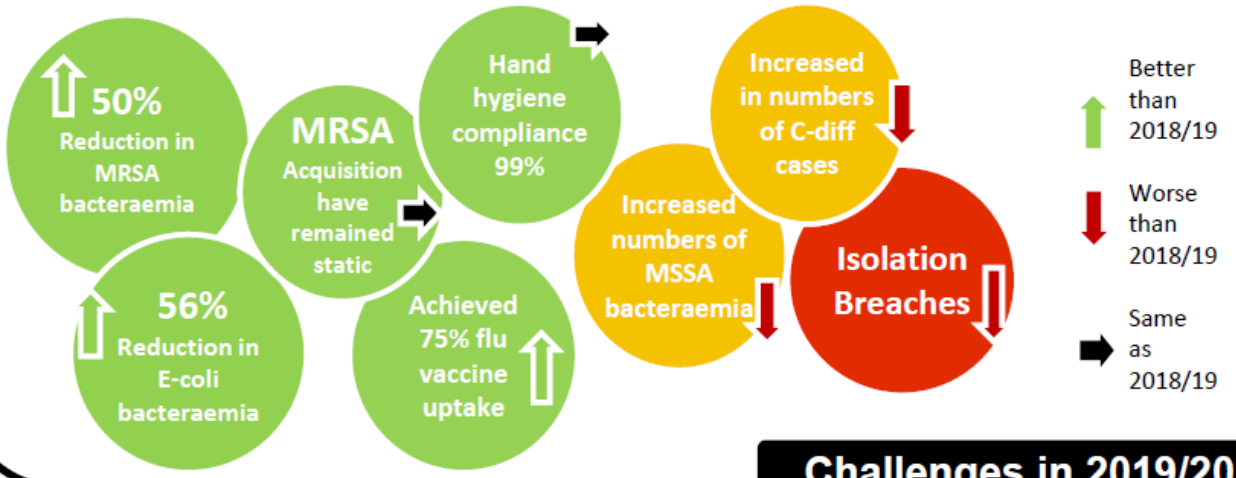
NHS Foundation Trust

Infection Prevention & Control 2019/20 highlight report

RESULT: safe, evidence based practice with reduction health associated infections.

REALITY 2019/20 with comparison to 2018/19

What we did well: What could be better: What needs significant improvement



Challenges in 2019/20

Clostridium difficile reporting changed to both Hospital Onset healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) – new systems introduced

Outbreak of Serratia in NICU

National Investigation of Listeria in Sandwiches

Initial response to the emergence of Covid-19

Key achievements for 2019/20

- 56% reduction in E-coli bacteraemia
- 75% flu vaccine uptake
- Improved MRSA bacteraemia
- ANTT update 3 yearly from Sept – 84% compliance by the end of the year, up by 40%
- Point of care testing for influenza implemented
- PCR introduced for Norovirus testing
- Integrated working with divisions
- All Policies reviewed
- Audit programme completed

Data overview for 2019/20

MRSA (Bact): 1 Pending: 0	MRSA (HAI): 26	CDIFF: 26 COHA: 5 Prev: 7 Unprev: 24 Pending: 0	ECOLI: 28	MSSA: 20	KLEB: 11	PSEUDO: 10	Hand Hygiene: 99.3%	Isolation Breaches: 430

15. Learning from Deaths Annual Report (incorporating Review of COVID-related Mortality)

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title:	Learning from Deaths Annual Report (incorporating Review of COVID-related Mortality)
Authors:	Cornelle Parker, Deputy Medical Director Gemma Pickup, Clinical Governance Support Manager
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Quality Committee 29.6.20

Actions Requested:
To approve.

Purpose of the Report

- To provide the Board of Directors with assurance of the Learning from Deaths mortality review process and escalation to Divisions
- To provide an early review of mortality during the Covid-19 pandemic 2020

Key Points to Note

Learning from Deaths Annual Report 2019/20

- Hospital Standardised Mortality (HSMR) remains a positive outlier and Summary Hospital-level Mortality (SHMI) remains within expected limits
- 433 Level 1 Initial Screening Reviews took place covering 32% of deaths against a target of 50%
- 156 Level 2 Structured Judgement Reviews (SJR's) took place analysing 128 deaths
- 15 out of 17 patient deaths were escalated to divisions for review and learning
- The gender and ethnicity distribution across Level 1 and Level 2 mortality reviews approximates to the gender and ethnicity distribution across all our deaths
- A greater proportion of deaths in younger patients are subject to SJR. This is likely to reflect the potential for avoidability in younger patients

Covid-19 mortality review 23rd March-19th May 2020

- During March-May 2020 there were a total of 348 inpatient deaths. Of these, 140 were Covid positive patients
- There was a 31% increase in the overall number of deaths (Covid positive and non-Covid) during this stage of the Covid pandemic
- Those that died with Covid-19 were more likely to be male, older, and have multiple co-morbidities

- A review of admission acuity of those patients who died without Covid between these date s suggests patients were more unwell on admission than those who died prior to the pandemic.

EQIA – Equality Impact Assessment

Equality impact in relation to the Learning from Deaths processes and the impact of Covid-19 mortality on our local population in respect of gender, age and ethnicity is examined in detail in the Learning from Deaths Annual Report.

Additional aspects of EQIA include:
Deaths of those with learning difficulties aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group.

Child deaths: Whilst all deaths are notified to the Child Death Overview Panel and a core data set collected, not all deaths will be reviewed in detail and are therefore considered for SJR review. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention.

Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group.

Stillborn and perinatal deaths are reported to the National MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) to allow confidential review and wider learning dissemination. These cases are also reported on Datix to ensure local governance and risk management structures are followed. Stillbirths and neonatal deaths are reviewed by a multidisciplinary team and reported nationally via the Perinatal Mortality Review Tool.

Recommendation

The Board is asked to approve the Learning from Deaths Annual Report and the following recommendations:

1. 50% of all in-patient deaths to be subject to Initial Screening Review by June 2021
2. To work with the new Lead Medical Examiner team to align the LfD processes
3. Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities
4. The lower ISR rate in Elderly Medicine should be a focus in measures to capture additional learning from deaths in older patients, including around end of life care
5. Further analysis of age and comorbidities should be undertaken to understand the ethnicity findings around mortality
6. Consideration of learning from mortality in relation to the Covid-19 pandemic

Executive Summary

This paper comprises two sections:

1. **Learning from Deaths (LfD) annual report for 2019/20**

This annual report to Board takes a different format due to the Covid-19 pandemic. The main body of the report covers 11 months, from April 2019 to February 2020. March 2020 mortalities are included as part of the review of Covid-19 mortality.

This year the annual report has a focus on a) demographic information to assess the equality impact of our LfD assessment processes and b) assurance of divisional escalation.

Key Findings

- During the 11 months from April 19-Feb 20 (inclusive) there were a total of 1350 adult inpatient deaths at CHFT
- **Measures of mortality**:
  - Crude mortality continues to decline year on year.
  - Nationally benchmarked indicators:
    - Hospital Standardised Mortality (HSMR) remains a positive outlier
    - Summary Hospital-level Mortality (SHMI) remains within expected limits
- **Initial Screening Reviews (ISR's)**
  - 433 Level 1 ISR's took place representing 32% of deaths. The target is 50%. Critical Care, Oncology and Orthopaedics have achieved this target. Of note, the latter part of the review period was impacted by Covid-19 reducing the availability of reviewers
- **Structured Judgement Reviews (SJR's)**
  - 156 Level 2 were requested. Allowing for 2nd opinion SJRs, this covered a total of 128 deaths
  - The SJR process was not suspended during the Covid-19 outbreak.

- **Assurance of escalation**: 36 SJRs returned a care score of Poor or Very Poor. Of these, 19 were 2nd opinion SJRs therefore a total of 15 out of 17 patient deaths were escalated to divisions for further consideration and learning. The detailed form of divisional response is provided in the paper

- **Demographics**:
  - The gender distribution across our LfD reviews approximates to the gender distribution across all our deaths
  - The distribution of age ranges across ISR's is similar to that across all CHFT deaths
  - A greater proportion of deaths in younger patients are subject to SJR. This is likely to reflect the potential for avoidability in younger patients
  - There is good correlation between the distribution of ethnicity across our in-hospital deaths and the likelihood of ISR or SJR review
  - For all patient contacts at CHFT the ethnic breakdown is 79% White, 13% BAME and 7% Not stated. For mortality, the figures are 87% White, 5% BAME, 7% Not stated.

2. Covid-19 mortality review 23rd March-19th May 2020

This is an early look at mortality in relation to the Covid-19 pandemic at CHFT. The main findings are:

- During March-May 2020 there were a total of 348 inpatient deaths. Of these, 140 were Covid positive patients and 208 non Covid patients
- Peak mortality at CHFT occurred the week commencing 10th April, a week prior to the other Trusts in our region but at approximately the same time as the national peak

- There was a 31% increase in the overall number of deaths at CHFT (Covid positive and non-Covid) during the Covid pandemic
- When Covid deaths were excluded, there were fewer non-Covid deaths than for the same 3 month period historically. This may be because patients were reluctant to attend hospital during the pandemic.
- The majority of patients who died had multiple comorbidities especially Type 2 diabetes, ischemic heart disease, chronic obstructive pulmonary disease, chronic kidney disease, hypertension and dementia
- A review of admission acuity of those patients who died between March and May 2020 suggests patients who died without Covid were more unwell on admission than those prior to the pandemic
- In keeping with the national picture, twice as many males died at CHFT with Covid than females
- Covid-19 mortality impacted elderly patients more prominently. Peak age range of death was 80-90 at CHFT similar to the national picture.
- The ethnicity distribution of Covid positive deaths mirrors both the distribution of non-Covid deaths in the same time period and the overall annual mortality. Our Covid positive mortality figures contrast with national data where deaths in BAME patients have been noted to be disproportionately high.

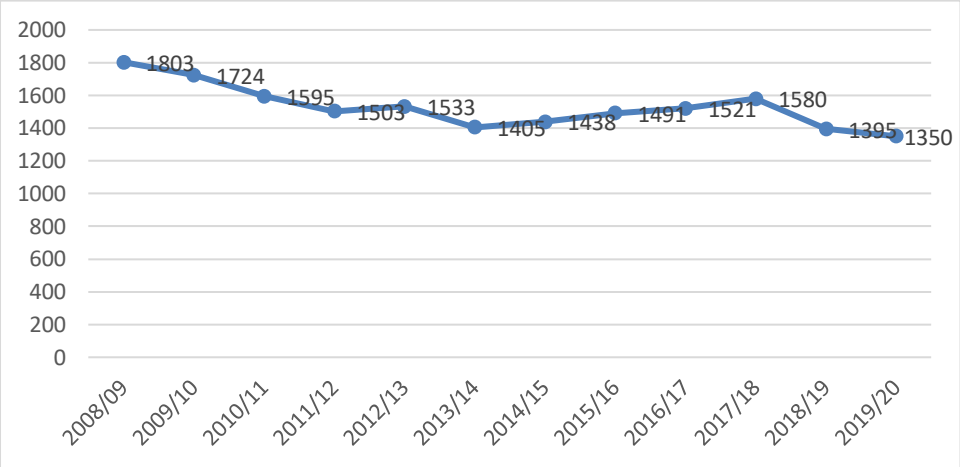
Recommendations

1. 50% of all in-patient deaths to be subject to Initial Screening Review by June 2021
2. To work with the new Lead Medical Examiner team to align the LfD processes
3. Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities
4. The lower ISR rate in Elderly Medicine should be a focus in measures to capture additional learning from deaths in older patients, including around end of life care
5. Further analysis of age and comorbidities should be undertaken to understand the ethnicity findings around mortality
6. Consideration of learning from mortality in relation to the Covid-19 pandemic

Learning from Deaths Annual Report 2019/20

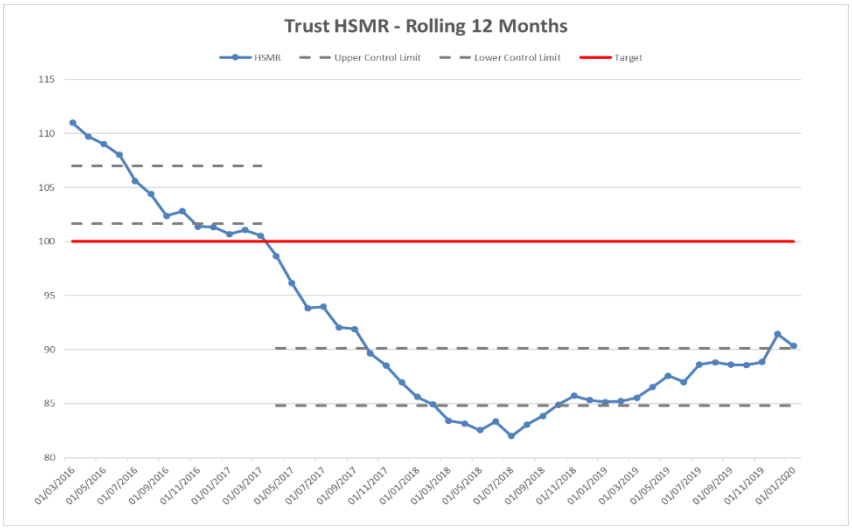
This year the annual report has a focus on a) demographic information to assess the equality impact of our LfD assessment processes and b) assurance of divisional escalation.
During the 11 months from April 19-Feb 20 (inclusive) there were a total of 1350 adult inpatient deaths at CHFT. The chart below shows year on year mortality numbers since 2008/09 – all years have been adjusted to reflect an 11-month period.

CHFT Annual Mortality
Figure 1



The Hospital Standardised Mortality Ratio (HSMR) compares how many patients die within 30 days of admission to hospital, with how many we would have predicted to die given their age, gender, area-level deprivation, diagnoses and co-morbidities. The Trust's HSMR position been consistently below the expected target of 100 since April 2017 and below 90 since October 2017.

Figure 2

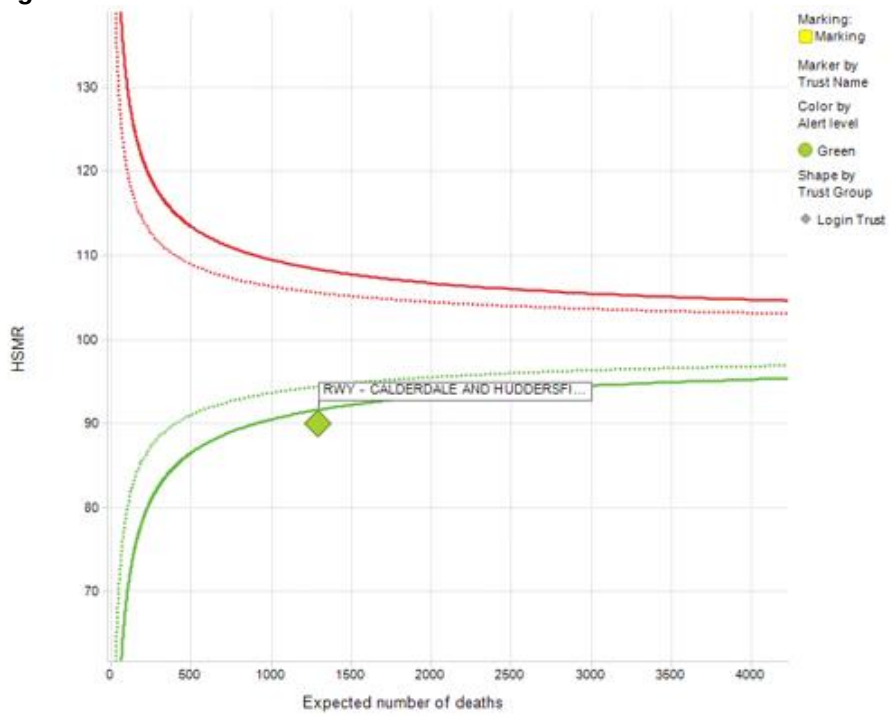


Improving HSMR has been a major drive of quality improvement in recent years. This suggests that compared to other Trusts in England, patients admitted to CHFT are less likely to die whilst in hospital.

The trend towards an increase during 2019, although still below the expected threshold, was examined in detail. Crude mortality was noted to have declined over this period and the apparent trend to increasing HSMR was related to two factors: a fall in palliative care coding and an issue with coding against the discharge diagnoses.

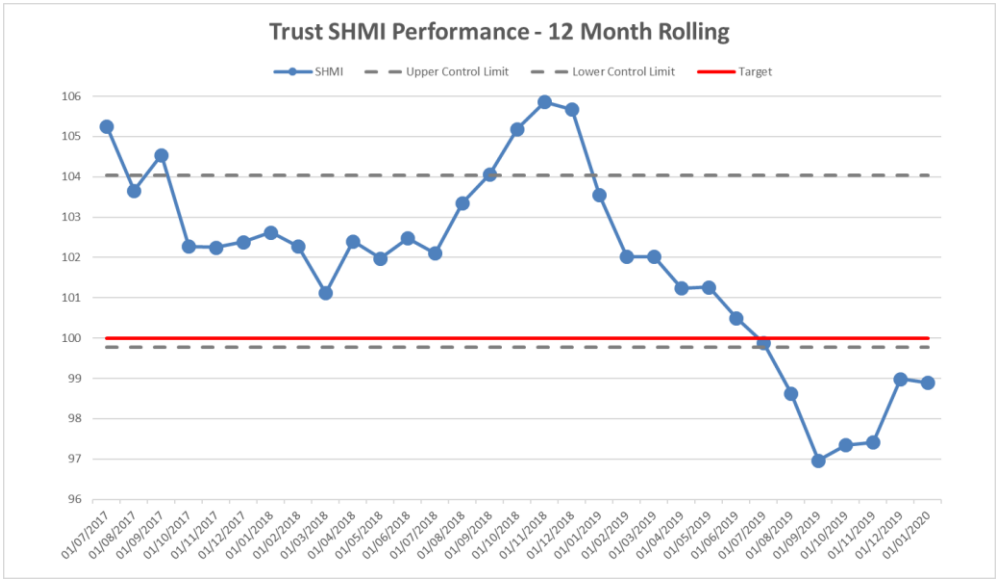
This funnel chart for HSMR illustrates the trust's current position.

Figure 3



The Summary Hospital-level Mortality Indicator (SHMI) is for non-specialist acute trusts and is the ratio between the actual number of patients who die and the expected on the basis of average England figures. It includes deaths in hospital and in contrast to the HSMR, deaths which occurred outside hospital within 30 days of discharge. SHMI performance shows that the Trust has been below the expected target of 100 since July 2019.

Figure 4



In combination, the HSMR and SHMI provide nationally benchmarked assurance. In the case of HSMR we are a positive outlier.

Mortality reviews

Learning from deaths of people in our care can help us improve the quality of the care we provide to patients and their families and identify where we could do more.

A CQC review in December 2016, *'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England'* found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

Each Trust should at a minimum ensure there is:
• Meaningful engagement and support of bereaved families and carers.
• The introduction of structured case record reviews when reviewing patient deaths.

The case record review consists of 2 levels –Initial Screening Reviews (ISRs) and second level Structure Judgement Reviews (SJRs).

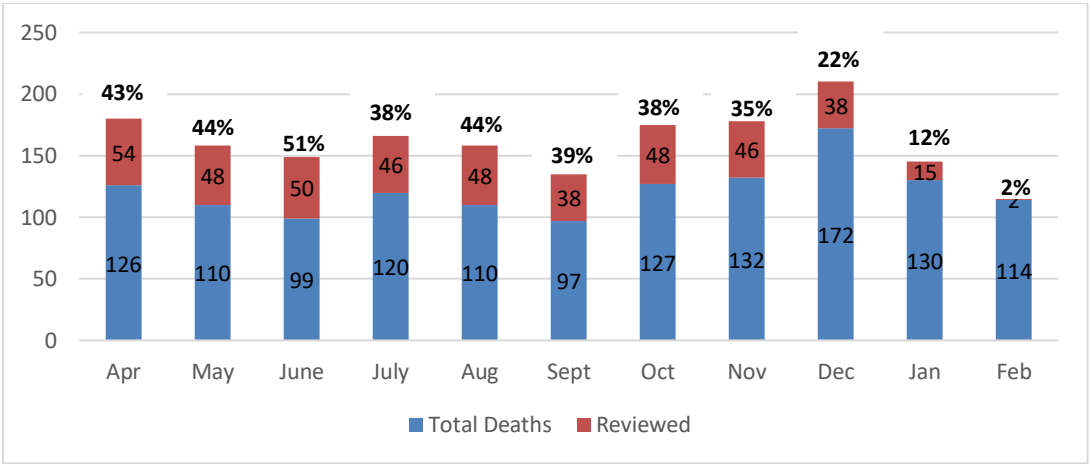
Initial Screening Reviews (ISR)

The online initial screening review tool focuses primarily on initial assessment, ongoing care and end of life management. Reviewers are asked to provide their judgement on the overall quality of care. On a monthly basis the specialities are informed of their mortalities and are asked to complete ISRs for their deaths.

Of the 1350 identified deaths that occurred in the 11 month period (Apr 19 – Feb 20), 1337 were adult inpatient deaths. Of these 433 (32%) have been reviewed using the initial screening tool (ISR). This process, whilst not screening all deaths, aimed to achieve an initial review of 50% of all CHFT adult inpatient deaths by the end of 2019. This target has not been met. It is a marginal improvement on 2018/19 when 30% of deaths were reviewed. Of note, the latter part of the review period was impacted by Covid-19 reducing the availability of reviewers.

The chart below shows the number of adult inpatient deaths reviewed by ISR by month

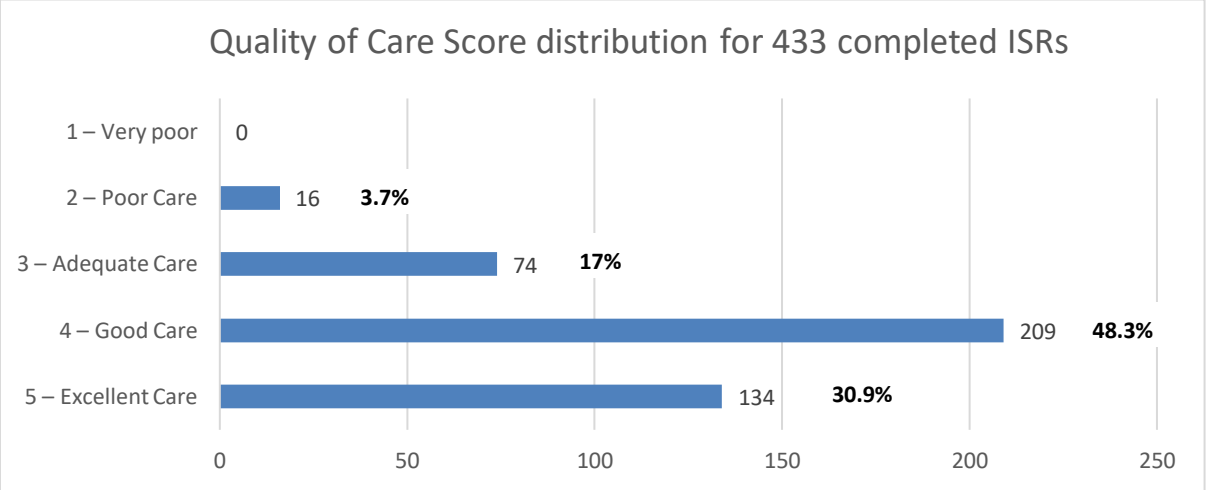
Figure 5



There is always a lag between death and completion of review. During the Covid-19 Pandemic completion of the ISRs was temporarily suspended. We anticipate the numbers of completed reviews will increase as Covid-19 pressure on services decrease.

In the 433 cases reviewed the quality of care was assessed as follows:

Figure 6



Poor or very poor care scores trigger further investigation using the structured judgement review (SJR) process.

Speciality-focused Initial Screening Reviews

In Q3 of 18/19 the Trust made the decision to support speciality specific reviews with the understanding that consultants would not be allocated reviews outside of their speciality if they committed to completing reviews within their speciality. The LfD team recognises that whilst the Covid pandemic will have impacted the number of reviews completed the monthly average overall is below the expected level in several areas.

The table below indicated the performance of each speciality using the following scale:

Table 1

Speciality	Total		Percentage reviewed
	Total	Reviewed	
Critical care	122	94	77%
Oncology	43	27	63%
Orthopaedics	37	20	54%
Gastroenterology	31	15	48%
Haematology	26	12	46%
Cardiology	35	15	43%
Acute Medicine*	304	90	30%
Stroke	89	27	30%
Elderly	258	64	25%
Respiratory	110	24	22%
Surgery	80	12	15%

	Target Achieved
	Above 40% but less than 50%
	Below 40%

This approach has successfully encouraged relevant specialist review. However, it does limit external, potentially more impartial scrutiny. The SJR Assurance Review process which is independent of speciality and division helps to address this issue as does oversight from the bimonthly Mortality Surveillance Group.

In addition to adult inpatient services, mortality reviews also take place in the Emergency Department, Maternity, Paediatrics and Calderdale Community (30 days post-discharge) using other specific review processes. These deaths are presented in biannual reports to the Mortality Surveillance Group.

Structured Judgement Reviews (SJR's)

SJR is a standardised case note review methodology. SJR blends traditional, clinical judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, including feeding back to members of the multi-professional team examples of excellent care and to score care for each phase.

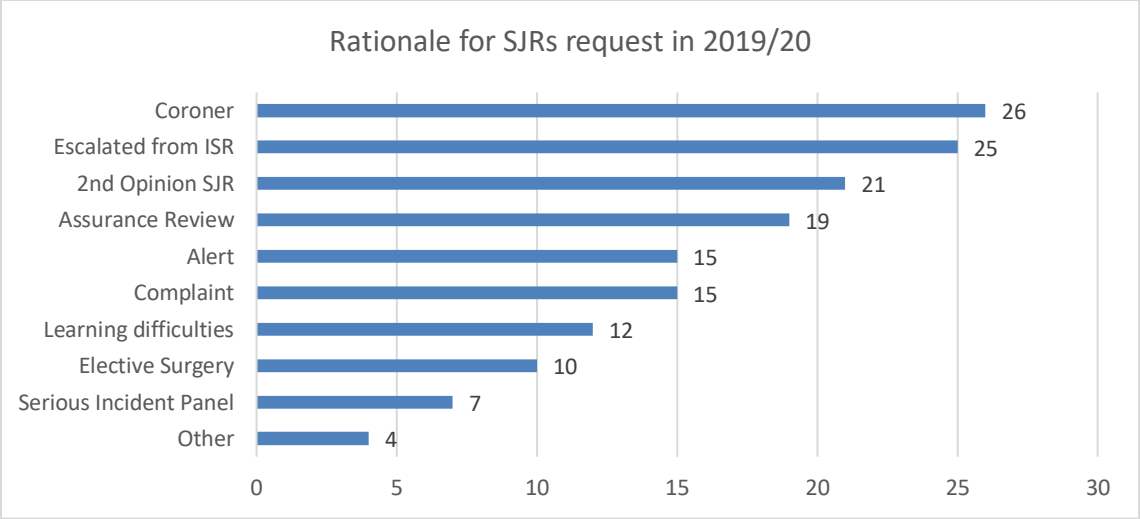
The identified phases of care are:

- Admission and initial care - first 24 hours.
- Ongoing care.
- Care during a procedure.
- Perioperative/procedure care.
- End-of-life care (or discharge care).
- Assessment of care overall.

The nature of structured judgment reviews means a full year can be reported. The SJR process was not suspended during the Covid-19 outbreak.

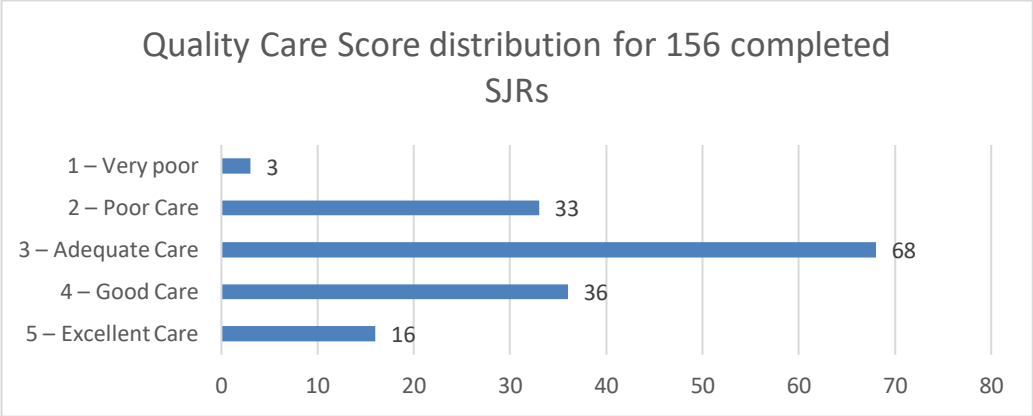
In 2019/20 156 SJRs were requested. Taking into consideration 2nd opinion SJRs this covered a total of 128 deaths.
The chart below shows the rationale for these SJRs. This includes Assurance Reviews requested by the Mortality Surveillance Group following the decision for specialities to review their own deaths.

Figure 7



As with the ISR's the SJRs give an overall care score. Figure 8 gives the breakdown of quality care scores for completed SJRs in 2019/20

Figure 8

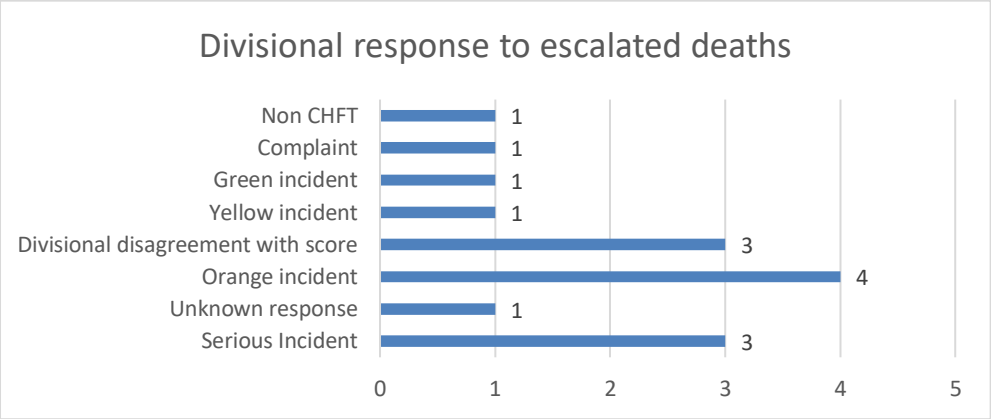


Assurance of escalation

- All SJR reviews, irrespective of care score, are to be shared with the relevant division.
- All cases given a care score of Poor or Very Poor should be reported as Orange incidents on Datix.
- In 2019, following feedback from divisions, a decision was made to complete 2nd opinion SJRs on any deaths given a care score or Poor or Very Poor.
- Following 2nd opinion SJRs any cases agreed as a care score of 1 or 2 are reported onto Datix if they have not already been reported by division.
- If there is a discrepancy between SJR scores, the 2 reviewers discuss the case to reach a common score.
- If agreement is not achieved then escalation takes place to the Deputy Medical Director for arbitration as the Executive lead for LfD.

This year's report has chosen to focus on all SJRs given a quality care score of Poor or Very Poor to provide assurance that Divisions are investigating concerns raised in SJRs. Of the 36 SJRs that returned a care score of 1 or 2, a total of 15 patient deaths were escalated to divisions for further consideration, the other 19 were 2nd opinion SJRs. The chart below illustrates the response from divisions.

Figure 9



Learning Disabilities

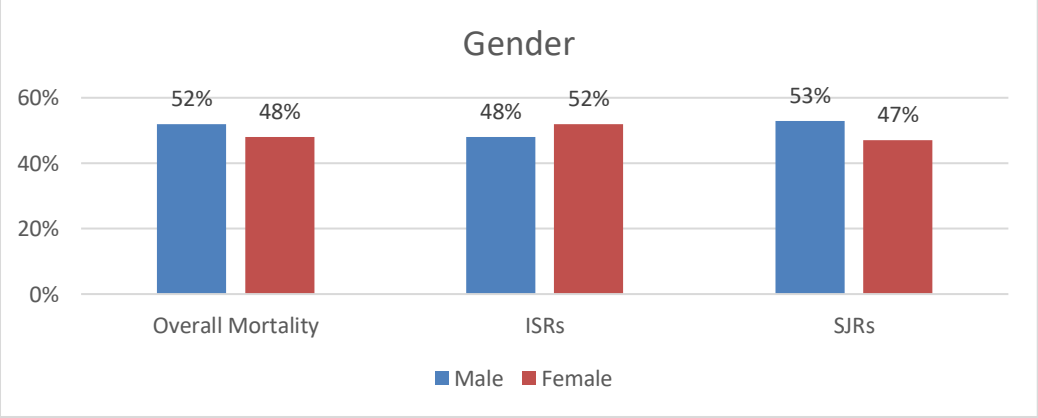
14 SJRs were completed for patients with learning disabilities. All Learning Disability deaths are also reported to LeDeR (Learning Disabilities Mortality Review) a national programme created to improve the quality of health and social care for people with a learning disability, by the CHFT Learning Disabilities Matron.

Demography

For 19/20 deaths we examined some key demographic characteristics to provide assurance that our LfD approach captures a representative distribution of these characteristics.

Gender

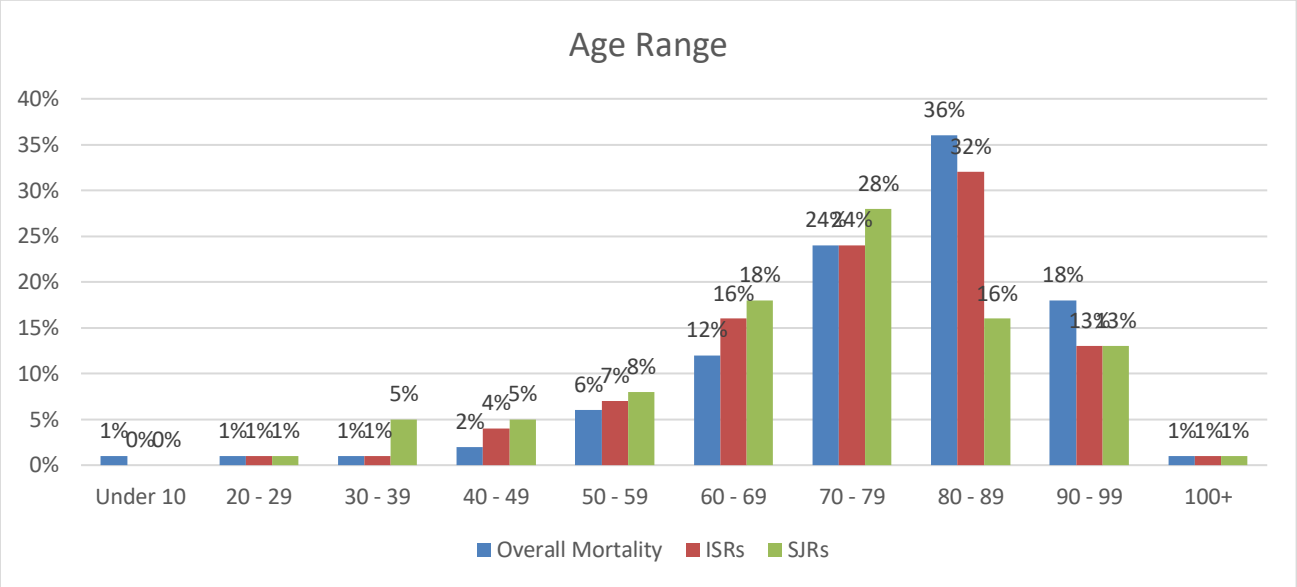
Figure 10



Conclusion: The gender distribution across our LfD reviews broadly approximates to the gender distribution across all our deaths.

Age

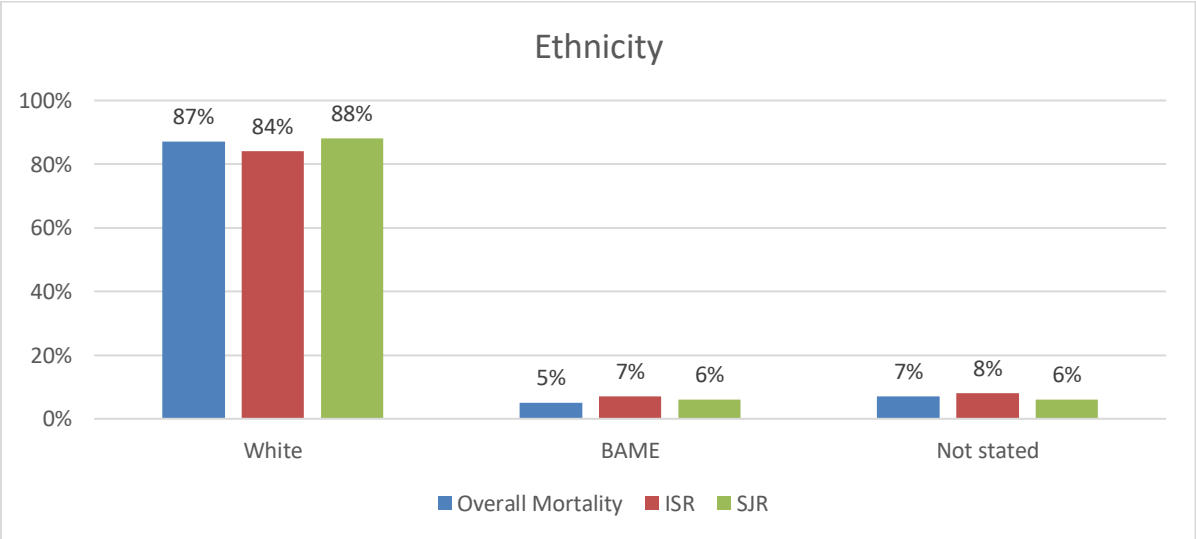
Figure 11



Conclusion: The distribution of age ranges across ISR's is similar to that across all deaths. The distribution is shifted to indicate a greater proportion of deaths in younger patients are subject to SJR. This is likely to reflect the potential for avoidability in younger patients. However, the lower ISR rate within Elderly Medicine (Table 1) is noted and should be considered in measures to capture additional learning from this age group, including around end of life care.

Ethnicity

Figure 12



In respect of our LfD review processes there is good correlation between the distribution of ethnicity across our in-hospital deaths and the likelihood of ISR or SJR review.

Data from the Knowledge Portal shows that for all patient contacts at CHFT across inpatient and outpatient settings, the ethnic breakdown of CHFT treated patients is 79% White,13% BAME and 7% recorded as not stated. Further analysis of age and comorbidities should be undertaken to understand this further. The not stated/recorded proportion is consistent but this should also be a focus for improved accuracy.

Thematic analysis of SJRs

The main themes arising from the 2019/2020 SJRs were:

- Failure to recognise or escalate a deteriorating patient
- Lack of early senior review
- Suboptimal end of life care
- Communication – between staff, teams and families/carers

A recent theme that has been highlighted through SJR is failure to escalate despite patient having a high NEWS2 (National Early Warning Score). This has been brought to the attention of the Clinical Directors for ED and ICU who are considering the findings.

LfD Actions taken in 2019/20

- A 2nd opinion SJR is no longer required if the case was given a care score of 1 or 2 at the ISR stage.
- The plan to transfer the SJR form to an electronic format has been actioned. 2020/21 SJRs will be recorded on the electronic system making result reporting more efficient.
- In 2019/2020 the LfD Forum was reinstated. The Forum comprising the LfD team and the SJR reviewers, encourages peer review and identification of learning themes to be shared across the organisation.
- Introduction of a buddy system in the LFD team pairing experienced SJR reviewers with newer members of the team. Reviewers can seek/offer support and conduct peer reviews to improve consistency in reviewing practice.

Recommendations

- 50% of all in-patient deaths to be reviewed by June 2021
- Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities
- To work alongside the new Medical Examiner team and align the LfD processes.
- Consideration of learning from Covid pandemic

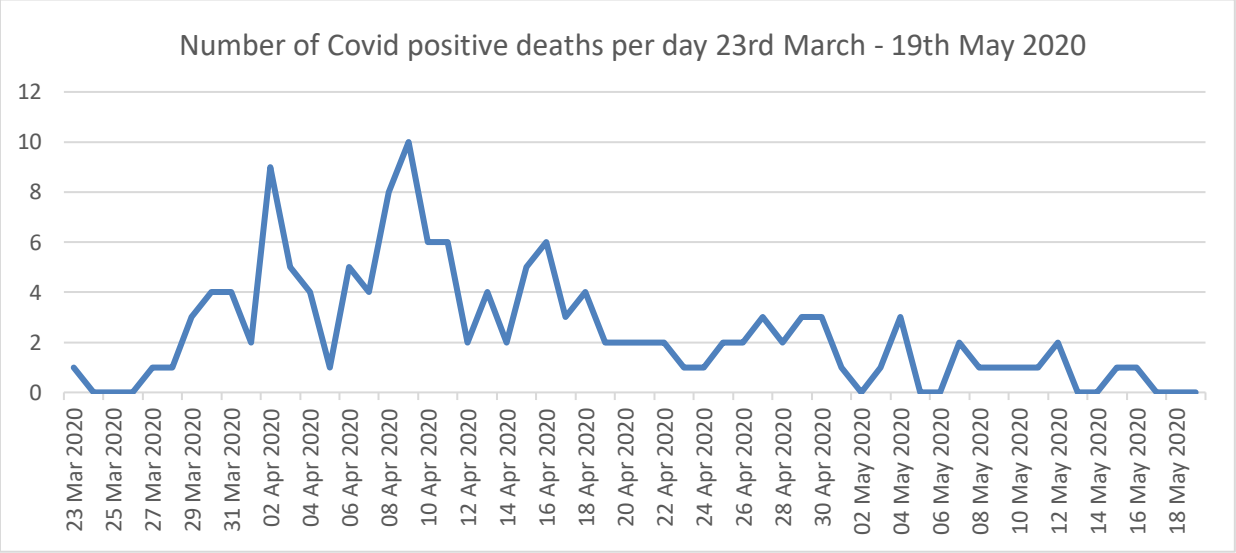
Covid-19 Mortality Review - 23rd March to 19th May 2020

Covid-19 is a disease arising from novel coronavirus infection that behaves very differently from other diseases that primarily affect the lungs. The Trust has had to respond quickly and has been on a steep learning curve in response to a rapidly emerging clinical picture. The 23rd March 2020 marked the first death in CHFT of a Covid positive patient. The 19th May was chosen as a cut off point for analysis for this early review of Covid-related mortality.

During the time period under consideration, the number of patients presenting to most acute areas with non-Covid - related illness fell precipitously as patients avoided coming in to hospital. There have been concerns raised at national level that those patients who were admitted acutely with non-Covid illness presented later than usual and as a consequence were more unwell with a higher mortality rate. We looked to examine this proposition in our population.

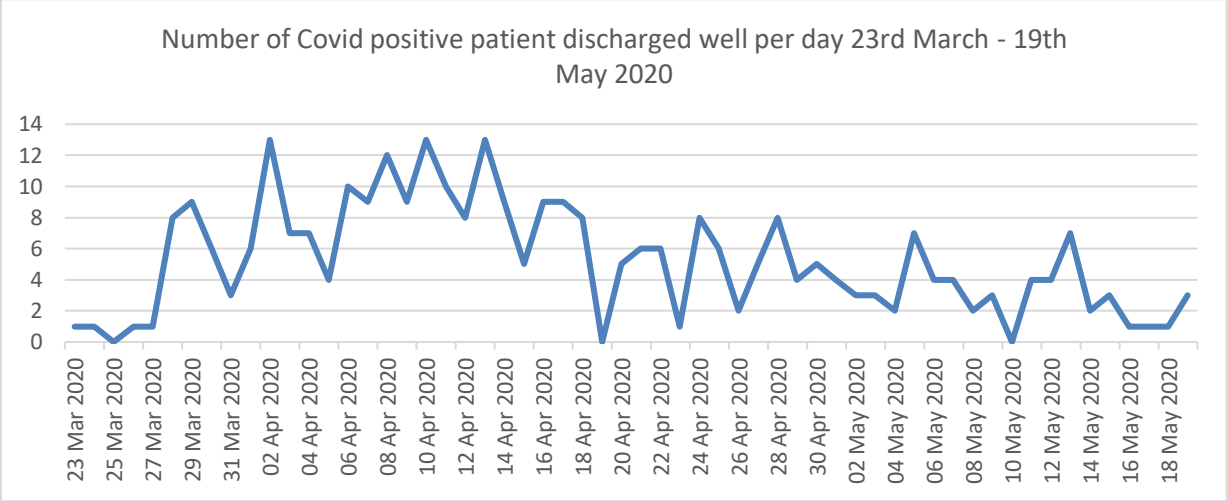
During March-May 2020 there were a total of 348 inpatient deaths. Of these, 140 were Covid positive patients and 208 non-Covid patients. Figure 13 shows that the number of Covid positive deaths per day peaked on 9th April with 10 deaths occurring on that day.

Figure 13



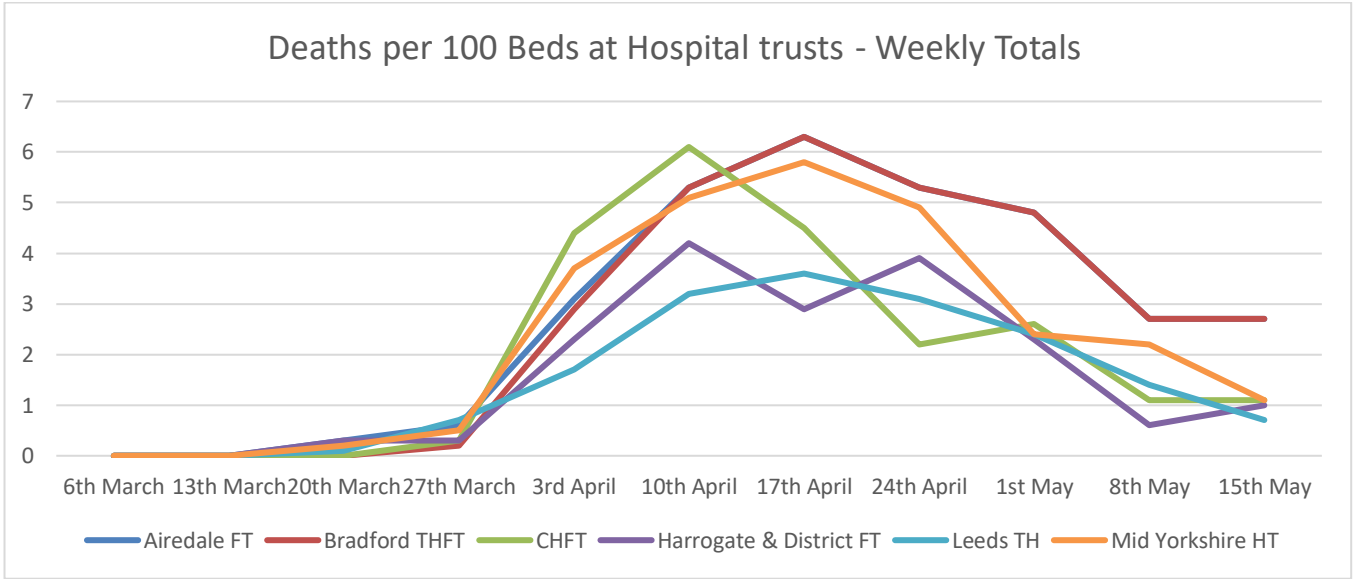
By way of comparison, Figure 14 shows the number of Covid positive patients (305 in total) discharged well per day in the same time frame.

Figure 14



The Health Service Journal produced comparison figures for acute trusts across the UK based on weekly number of deaths per 100 beds. Figure 15 compares the acute trusts across West Yorkshire and Harrogate. It shows that CHFT and Harrogate District FT experienced their peak mortality the week commencing 10th April, a week prior to the other Trusts in our region.

Figure 15



The national figures from NHS England for Covid positive deaths in hospital below show that the pandemic death toll peaked on 8th April almost identical with the timing of the CHFT peak.

Figure 16

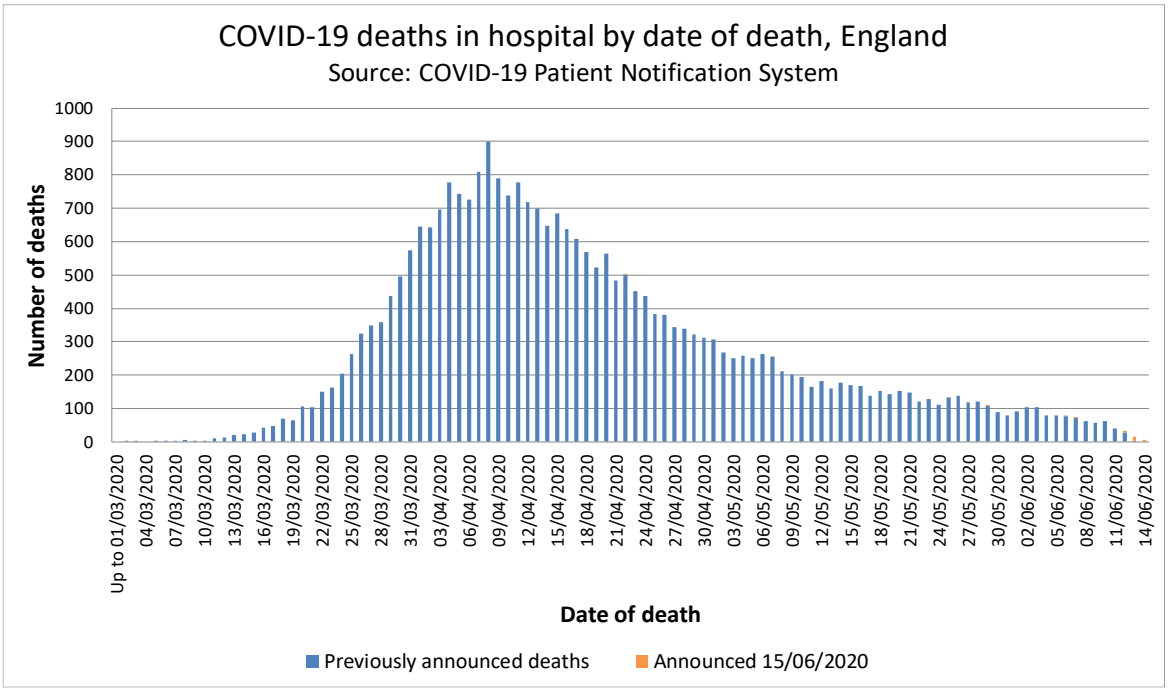
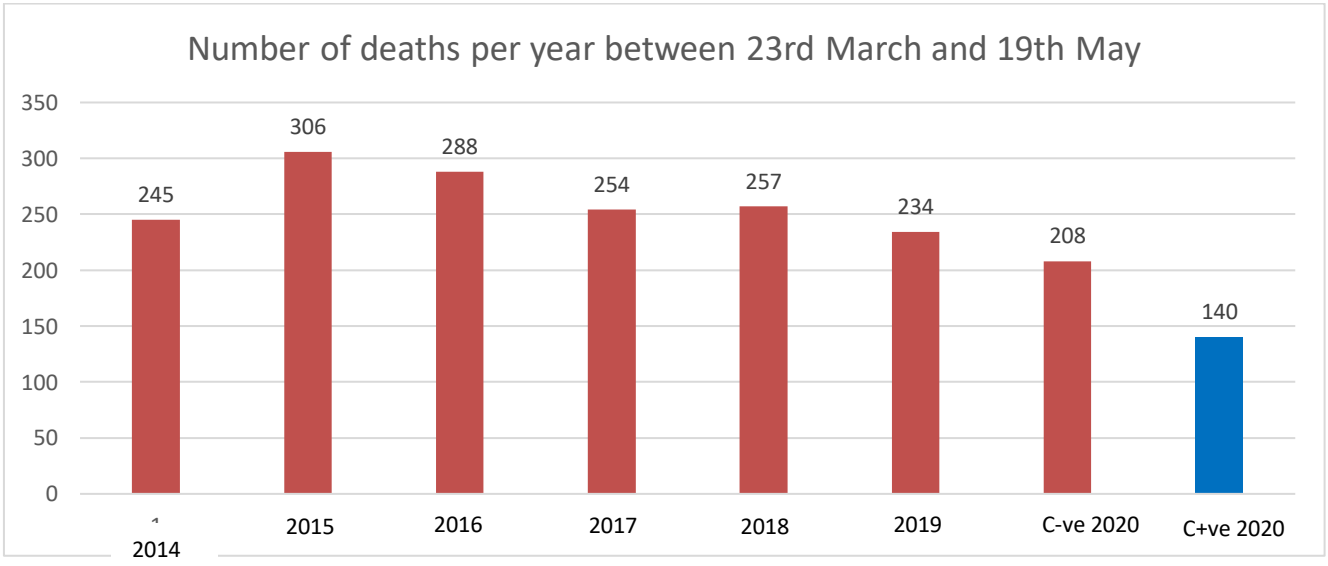


Figure 17 shows the number of deaths that have historically occurred in the same time period at CHFT.

Figure 17



The average number of deaths that occurred annually during the same timeframe over the previous 6 years was 264. 2020 saw a 31% increase in the overall number of deaths (348) during the Covid pandemic. Non-Covid deaths (208) were lower than the average, possibly reflecting lower attendances to hospital in this group. This is analysed further below.

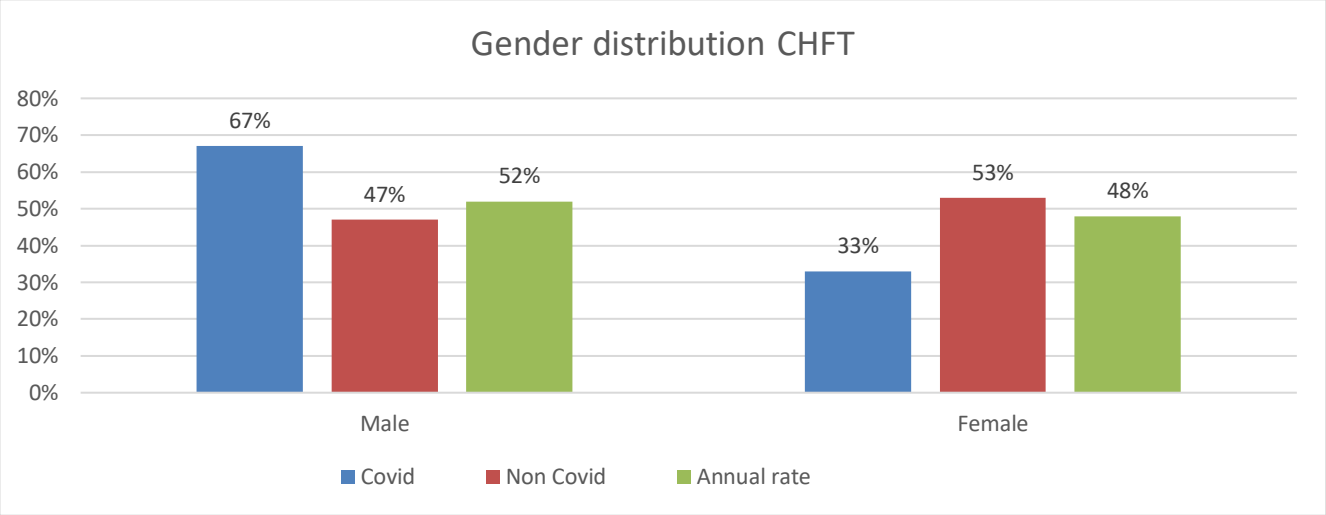
Risk factors

Several risk factors have been identified nationally over the course of the pandemic so far. We have examined gender, age, ethnicity and pre-existing co-morbidities in more detail.

Gender

National data suggests a higher proportion of deaths in males. Public Health England in their publication 'Disparities in the risks and outcomes of Covid 19' (June 2020) report that working aged males are twice as likely to die as similarly aged females in England. Figure 19 confirms the same pattern at CHFT with twice as many Covid positive deaths occurred in men.

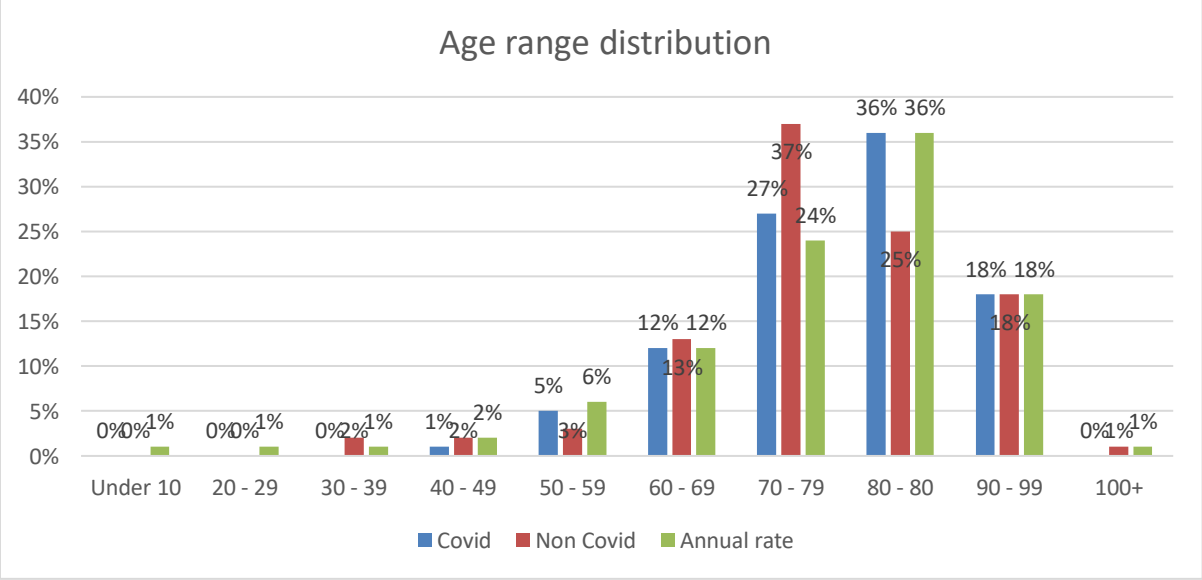
Figure 18



Age Range

National data suggests that at the peak of the national pandemic the largest proportion of deaths occurred in patients between 75 – 84 years old.

Figure 19

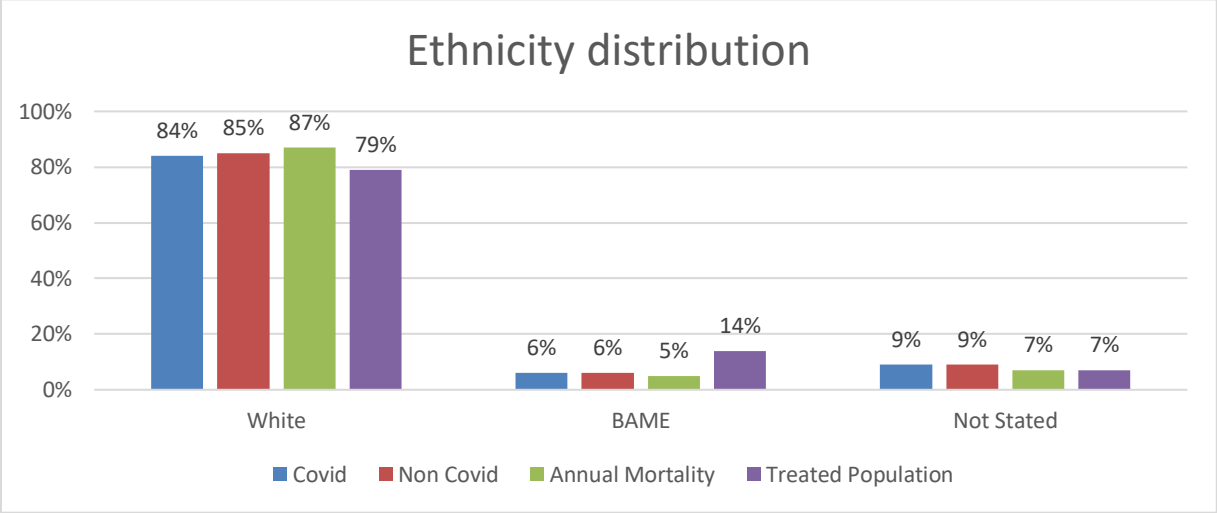


At CHFT the highest percentage of Covid positive deaths occurred in the 70-79 and 80-89 age ranges. This mirrors the overall annual rate and the national picture. No Covid positive deaths occurred in patients under 40.

For non-Covid deaths during the pandemic, the age peak was 10 years younger than Covid positive deaths and 10 years younger than the peak prior to Covid (Figure 11). This partially reflects the differential impact of Covid on older patients but may also point to a greater proportion of older patients dying in the community during the pandemic.

Ethnicity

Figure 20

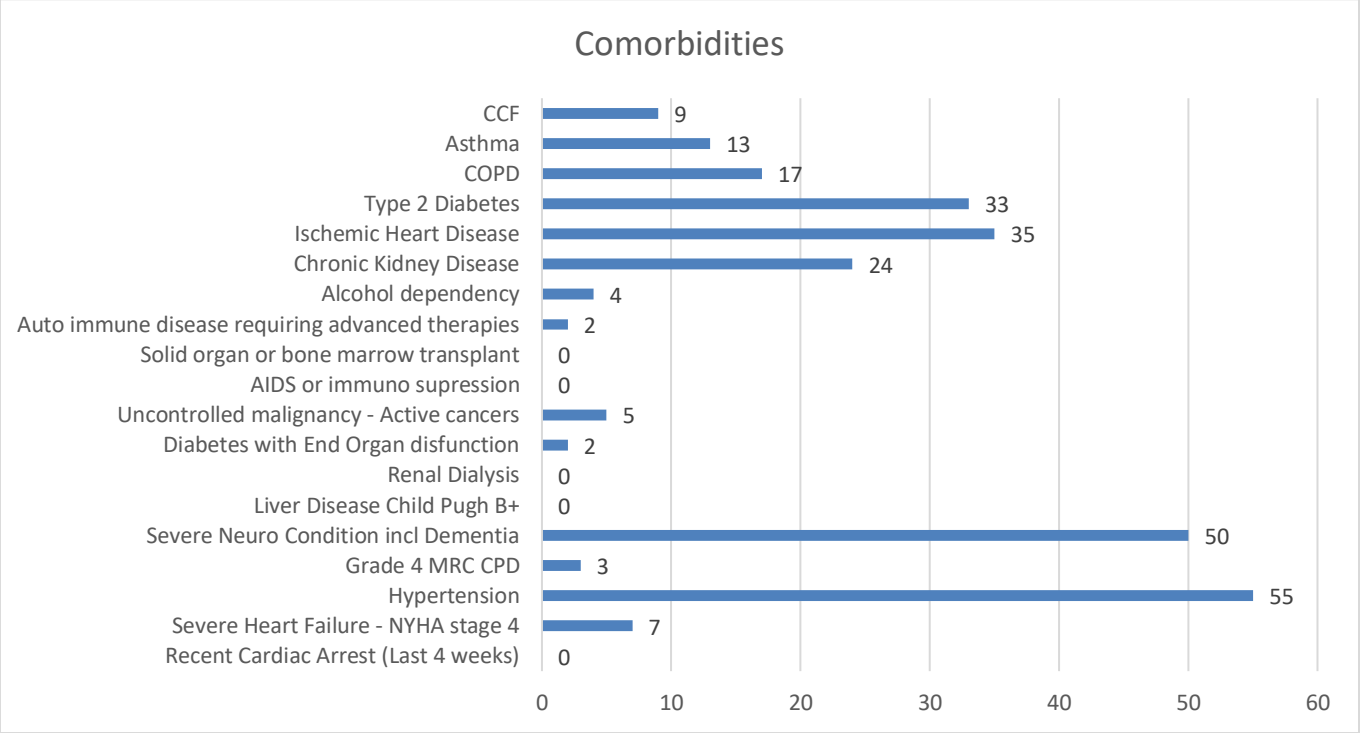


The ethnicity distribution of Covid positive deaths mirrors both the distribution of non-Covid deaths in the same time period and the overall annual mortality. However, as reported earlier in the paper (Figure 12) this pattern is discrepant with the ethnic distribution of our treated population in 2019/20 which is made up of a greater proportion of BAME patients.
Our Covid positive mortality figures contrast with national data where deaths in BAME patients have been noted to be disproportionately high. Further analysis of age and comorbidities is indicated to understand this difference further.

Comorbidities

National data has highlighted multiple risk factors associated with Covid-19. The clinical records of all 140 Covid positive patients who died were scrutinised. Figure 21 shows occurrences of these conditions. The majority of patients who died had multiple comorbidities

Figure 21



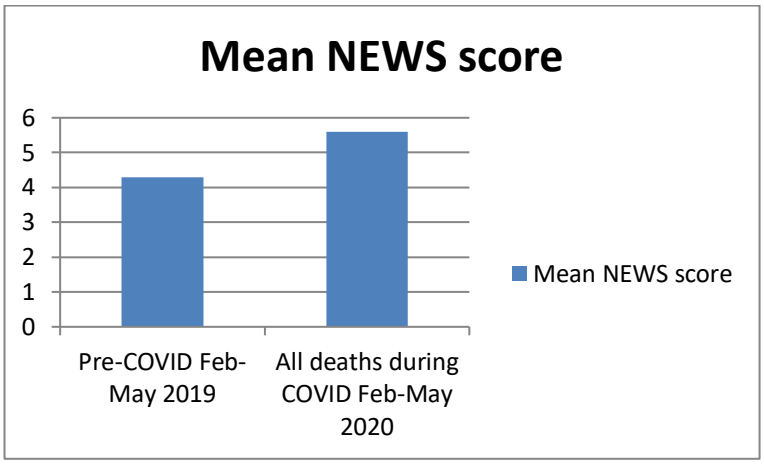
Acuity

Anecdotal reports suggest patients admitted to hospital during the Covid-19 pandemic were fewer in number but more severely unwell at the time of presentation.

The National Early Warning Score 2 (NEWS2) looks to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients. These scores are utilised to prompt early medical intervention in the deteriorating patient. Scores range from 0-20 with higher scores reflecting a greater degree of acute illness. A NEWS2 score of 5 or more is a key threshold for an urgent clinical alert and response. We analysed admission NEWS scores for all admissions from Feb-May 2020 and for the same months in 2019.

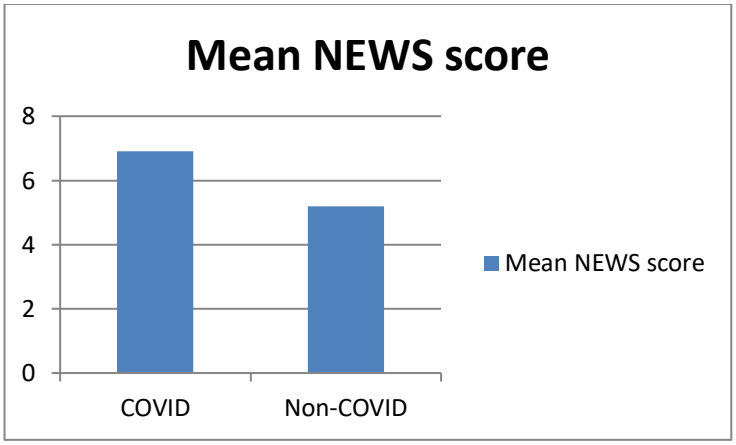
Figure 22 compares the mean admission NEWS score across February to May in 2019 (pre-Covid) and 2020 (Covid). Unsurprisingly, during the Covid pandemic, patients admitted were more unwell on admission (mean NEWS 5.6) than in 2019 (mean NEWS 4.3).

Figure 22



When we look more closely at deaths in the Covid period in Figure 23 we see that patients in the Covid group were more unwell (mean NEWS 6.9) than those without Covid (mean NEWS 5.2). This is unsurprising giving the severity of Covid-19 but the data may also point to the patients admitted who were Covid negative being more unwell than acute admissions prior to the pandemic. Other factors should also be considered, for example our testing patterns for Covid-19.

Figure 23



Conclusion

This early analysis of mortality over the coronavirus pandemic between 23rd March and 19th May suggests those that have died with Covid 19 at CHFT are more likely to be male, older, and have multiple co-morbidities. Those patients admitted over the same interval with non-Covid illness who subsequently died may be slightly more unwell on admission than those who were admitted and died over a similar interval prior to coronavirus.

16. High Level Risk Register (incorporating COVID-19 Risk Register)

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	June 2020
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Maxine Travis, Senior Risk Manager
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Trust Risk and Compliance Group, Quality Committee, Covid Incident Management Team

Actions Requested:
To approve.

Purpose of the Report

To provide the Trust Board with assurance as to the robust identification and management of risk and to present an update on risks on the High Level Risk Register.

Key Points to Note

The Covid IMT was established in response to the pandemic and has had oversight of risks associated with the pandemic throughout. In total, 90 new Covid-related risks have been logged during Q1, with 7 being recommended for inclusion on the High Level Risk Register.

Each risk has a nominated Executive Lead and risk lead who provide updates on mitigation, th is process is managed by the Senior Risk Manager. The Covid IMT reviews the High Level Risks on the Covid risk register on a weekly basis.

Whilst the Trust Risk and Compliance Group did not formally meet in May 2020, risk leads have continued to work with the Senior Risk Manager to provide updates to the Trust High Level Risk Register. The existing staffing risks on the HLRR are to be re-articulated in line with stabilisation and reset phase of the Covid pandemic.

EQIA – Equality Impact Assessment

There are no equality impacts in respect of this paper.

The equality impact of specific risks is articulated within the risk controls and gaps with mitigations put in place where indicated. The risk owner is accountable to determine any proposed actions to mitigate any equality impact arising from a risk.

Recommendation

The Board is asked to acknowledge that the established governance processes for the identification, scoping, management and oversight of risk have continued during Quarter 1:

The Board is asked to:
i. consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed

ii. approve the current risks on the risk register
iii. advise on any further risk treatment required

Calderdale and Huddersfield NHS Foundation Trust

High Level Risk Register – Board June 2020

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register are:

7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7527 (20) MaxFax and ENT failsafe process for follow up appointments

NEW – agreed by Covid IMT
7685 (20): PPE Supply Chain (Covid risk)
7689 (20): Waits for OPD, diagnostics and operations (Covid risk)

The Trust risk appetite is included below.

NEW RISKS

The following new High Level risks have been developed and agreed through Covid IMT:

7685 (20): PPE Supply Chain

7689 (20): Waits for OPD, diagnostics and operations

7778 (16): Risk of staff being infected with Covid

7783 (16): Unable to achieve national requirement for social distancing due to environmental constraints

7796 (16): Impact on whole teams of self-isolation required by Track and Trace

7797 (16): Variable IPC compliance resulting in infection outbreaks

7683 (16): Not having sufficient isolation facilities (side rooms)

REDUCED RISKS

The Trust Risk and Compliance Group did not meet in May 2020 therefore there have not been any high level risks agreed for reduction during this reporting cycle.

CLOSED RISKS

The Trust Risk and Compliance Group did not meet in May 2020 therefore there have not been ay high level agreed for closure during this reporting cycle.

CHFT RISK APPETITE January 2020

Risk Category	This means	Risk Level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to delvier high quality patient care (despite greater inherent risk)	**SEEK (4)**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN (3)**	**HIGH**
Financial and Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality, equality and patient safety, which will be subject to rigorous ~~quality~~ impact assessments. The balance of price, value and benefits will be considered. We will ~~aim to~~ allocate resources to capitalise on opportunities.	**CAUTIOUS (2)**	**MODERATE**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS (2)**	**MODERATE**
Legal	We will comply with the law.	**MINIMAL (1)**	**LOW**
Innovation / Technology	The risk appetite for innovation / technology is high as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**OPEN (3)**	**HIGH**

Commercial	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**OPEN (3)**	**HIGH**
Harm and Safety	We will take minimal risk, or as little as reasonably possible, when it comes to staff/patient safety and harm and clinical outcomes for patients.	**MINIMAL (1)**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. .	**MINIMAL (1)**	**LOW**
Quality Innovation and Improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK (4)**	**SIGNIFICANT**
Partnership	We will seek opportunities to work in partnership where this will support service transformation and operational delivery.	**SEEK (4)**	**SIGNIFICANT**

Risks High Level Risk Register

	Risk No	Div	Dir	Dep	Updated	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target
Very High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3

Very High	7078	Corporate	Medical Director's Office	Operational	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3

Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Establishment reviews/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077). Risk was also referenced in Risk 5937 - this has now been merged to Risk 6345.	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles eg Nurse associate	Low numbers of applications to nursing posts across grades and specialities National shortage of RGN's	16 4 x 4	20 4 x 5	9 3 x 3
Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover. - NHS Locum cover. - Lung and chest: Additional reporting support from external providers and temporary change to job plan. Ad hoc support from WYAAT Trusts. - IR: Support from neighbouring organisation (1 day per week); Support, 1 day per week, through private agreement with private provider; working with WYVAS to plan cover until vascular service reconfiguration complete. - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in all areas, including: - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave.	15 3 x 5	20 4 x 5	1 1 x 1

Very High	7527	Surgery & Anaesthetics	Head and Neck	All wards/departments Head & Neck	Aug-2019	Active	Keeping the base safe	There is a risk that patients will not receive appropriate follow up care for their clinical pathway which can cause delays for diagnosis and treatment in Maxfax and ENT	A failsafe process has been implemented for the post cancer patients , ? recurrent cancer / Surveillance through the cancer head and neck services. The validation team are prioritising the maxillofacial validation of 591 patients. Checks that all orders at placed following outpatients attendance Added onto careplans of review of follow ups dates required for all cancer diagnosed patients	EPR system (Lists) Lists of patients Failsafe Escalation process to implemented within appointment centre, secretaries. Appropriate training within the department	15 5 x 3	20 5 x 4	4 2 x 2

Very High	7685	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	PPE SUPPLY CHAIN There is a risk of the supply chain for PPE not being maintained or responsive Due to increased demand and reduced capacity Resulting in failure or delays in provision of essential PPE to frontline staff	National control of distribution by MOD - 01.04.2020 (Clipper logistics) Strategic and tactical command National Supply Chain Disruption arrangements Materials Management Group CHFT PPE Group - decision-making and governance PHE guidance is accepted as the definitive guidance for PPE.	Comprehensive list of stock including a PPE core list Reporting system with real-time stock position National distribution by MOD - no longer able to order our own stock: Range of PPE guidance being disseminated by professional bodies leading to confusion.	20 4 x 5	20 4 x 5	2 1 x 2

Very High	7689	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list. Recovery plan	20 4 x 5	20 4 x 5	4 2 x 2
High	7778	Trustwide	All Divisions	All Departments/Wards	May-2020	Active	Keeping the base safe	There is a risk of staff potentially becoming infected with Covid 19 Due to caring for patients with the virus Resulting in sickness and potentially death	Following PHE guidance PPE Identification and cohorting of patients Dissemination of safety messages Staff testing - asymptomatic testing of staff commenced. Evidence showing that frontline staff caring for Covid positive patients have infection rate 1%, which is higher than staff in non-frontline and non-covid work areas Social Distancing guidance Working from home - reduce infection and allow for greater social distancing	Inabililty to determine where the infection has been acquired - not able to account for staff movement and contacts out of the work environment - therefore clarity of application of RIDDOR in these cases Non-adherence to social distancing failure to properly wear, or remove PPE at appropriate times	15 5 x 3	16 4 x 4	5 5 x 1
High	7783	Trustwide	All Divisions	All Departments/Wards	May-2020	Active	Keeping the base safe	There is a risk of being unable to achieve national standard of social distancing of 2 metres Due to constraints of the environment and estate, the buildings, corridors and room sizes, and configuration of spaces in their current form and how they were utilised pre-Covid and staff failure to adhere to guidance Resulting in potential for cross infection from patients to/from staff, and staff to staff staff, a lack of confidence of patients to attend for necessary care and reputational damage to the Trust	Covid IMT oversight of risk, incidents and workstream Covid IMT oversight of Stabilise and Reset including proposals for commencement of activity Outpatient activity is limited to emergency clinics for vascular patients at SOPD. Following PHE guidance to offer PPE to any patient attending clinics Chairs in waiting areas are distanced.	SOPD Estate- not in an ideal location to meet face-to-face Surgical Clinics for Vascular, plastics, colorectal, urology. narrow corridor (3 metres), SOPD entrance doorway (1 meter) and small waiting area (3 metres) which get congested with footfall from patients arriving for multiple surgical clinics, activity in pharmacy opposite SOPD and passing staff who are attending other services on subbasement (endoscopy, pharmacy, medical engineering, Haematology OPD). High risk patients (Vascular Hot clinics) coming to SOPD. Canteen/restaurant and kitchen facilities - staff queueing and failing to adhere to social distancing requirements Open plan office areas with banks of desks	16 4 x 4	16 4 x 4	8 4 x 2

High	7796	Trustwide	All Divisions	All Departments/Wards	Jun-2020	Active	Keeping the base safe	There is a risk of staff or whole team shortages Due to the Government Track and Trace system advising self-isolation for contacts of Covid Resulting in potential for reduction in services and impact on patient care	Social Distancing guidance and Trust workstream PPE provision and guidance on wearing in the workplace	Some teams are unable to socially distance at the required 2 metres when working (eg. Pathology labs) Movement of staff outside of working hours	16 4 x 4	16 4 x 4	4 2 x 2
High	7797	Trustwide	All Divisions	All Departments/Wards	Jun-2020	Active	Keeping the base safe	There is a risk of variable compliance with IPC guidance Due to staff working in different areas and with different equipment and consumables whilst also wearing restrictive PPE Resulting in IPC outbreaks	IPC policy and guidance PPE guidance IPC Committee Outbreak meetings are established for incident clusters to support oversight and investigation	Staff movement into different working environments working in PPE, using PPE inappropriately	16 4 x 4	16 4 x 4	4 4 x 1
High	7617	Corporate	THIS	THIS -Operational	Dec-2019	Active	Keeping the base safe	Risk of: being in breach of contractual obligations, reputational damage to the Trust and becoming an NHS England/Improvement (the Cyber Risks and Operations group) trust of concern. Due to: non- compliance with the Data Security protection toolkit Resulting in: inability to trade due to contractual obligations not being met, loss of income and reputational damage. In addition, as a HSCN consumer, we are responsible for maintaining compliance with relevant NHS Digital Information Governance and data security standards and accreditation including the Data Security and Protection Toolkit (DSPT) which is one of our obligations under the HSCN Connection Agreement. It is not necessary to complete a Data Security and Protection Toolkit (DSPT) assessment in order to gain access to HSCN. However, all organisations that have or require access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Our current Trust status stands as 'Standards Not Met', If we are to publish a further DSPT with 'Standards Not Met', our Organisation may become a Trust of concern to NHS England/Improvement.	Control Group established – Governance Risk and Compliance (GRC) IT Workstreams in place to address areas of non-compliance Operational control by THIS Director Project management in place to steer progress Data Protection Officer oversight Digital Investment (Darktrace etc)	Clear plan with timescales and deliverables (in process) Password Policy	16 4 x 4	16 4 x 4	4 4 x 1

High	7683	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk of not having adequate isolation (Side room) facilities Due to an increase in demand and initiation of testing of asymptomatic patients Resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients	Infection Control policies and procedures PHE guidance In-house testing of patients. Daily IMC VC meetings. SITREPS Monitored by Tactical with reporting and escalation into Covid re bed capacity and patient flow.	One platform for testing and if this goes down will need to revert for testing to Leeds with results taking longer to receive Aerosol generating respiratory interventions should be in single side rooms or require all in the area to wear PPE.	12 4 x 3	16 4 x 4	6 3 x 2
High	6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Active	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products. Resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 and July 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition), update the product catalogue, and from June 2020 -outsource radiopharmacy (buy in MDVs of radioisotopes from Bradford)	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm . Potentially when CRH closes, will open HRI unit earlier at 7.30am to prepare those doses required at CRH and ensure timely transport. Delay in project- new unit not now due to open until Aug 20	15 3 x 5	16 4 x 4	3 3 x 1
High	7557	Medical	Emergency Care	Accident & Emergency CRH/HRI	Oct-2019	Active	Keeping the base safe	There is a risk to patient safety and experience for children and families visiting the Emergency Departments at CHFT. Due to the current workforce model which does not support the RCEM and National guidelines (RCPCH) which recommend 2 x Qualified Registered Children's Nurses on a shift in an ED at any one time. Resulting in the inability to : Provide care appropriately for sick children Recognise the sick and deteriorating child Have staff trained in appropriate distraction techniques for children Lack of awareness of all safeguarding flags and signs to be aware of in children attending the department.	2 RSCN nurses employed at Calderdale 6 Nurses currently on the Child In ED course via the university RN's working in the department who have previously completed the child in ED course APNP's attending the HRI site to care for sick children Work on going to look at an interim model while awaiting reconfiguration	Unable to recruit RSCN's in current workforce model Risk of recruiting RSCN's leading to poor morale and leaving the trust Unable to send a large proportion of staff on the Child in ED course due to study leave	16 4 x 4	16 4 x 4	1 1 x 1

High	6596	Corporate	Corporate Quality	Governance and Risk Quality	Jan-2016	Active	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Investigator Training - to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divisional	1. Operational pressures and impact on capacity to undertake investigations in a timely way 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans	16 4 x 4	16 4 x 4	4 4 x 1
High	7223	Corporate	THIS	THIS -Operational	Mar-2018	Active	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network - Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance:	Documented BCPs (Business Continuity Plans) within all critical areas Further awareness sessions for all staff to understand the potential risk and what they can do personally Maintenance windows for digital systems including resilience testing Patching process audit Password Policy	16 4 x 4	16 4 x 4	8 4 x 2

High	7248	Corporate	Workforce & Organisational Development	Workforce Development	Apr-2018	Active	Developing our workforce	The risk: Not all colleagues will complete their designated core 'Essential Safety Training' (EST) subjects. In addition not all colleagues will complete their role specific training. Resulting in: Colleagues practicing without the recorded required knowledge or understanding of core EST subjects. This could lead to unsafe practice, potentially leading to incidents involving colleagues and/or patients. EST consists of 10 'core' subjects which all colleagues must be consistently 100% compliant in. There are a further 35 subjects which are 'role specific' – subjects which are dependent on the role the colleague has. The Trust has a compliance target of 90%. Our core subjects have been consistently above this target since April 2019, with an average of 95.22%. The focus therefore is on the compliance of the 35 role specific subjects. Compliance for these subjects range from 97.60% to 50.04%. We expect all role specific training to be on target by August 2020.	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.	None	16 4 x 4	16 4 x 4	4 4 x 1
High	2830	Medical	Emergency Care	Accident & Emergency	Apr-2011	Active	Keeping the base safe	There is a risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department. Due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability. Resulting in a lack of supervision and care provided in the wrong place	Appropriate assessment from nursing team to identify high risk patients. (ReACT self-harm risk assessment at triage.) Nurse in visible areas use 1-1 nursing if deemed appropriate. Referral to Mental Heath Liaison Team, service available over 24 hours. Use of security service as necessary. Referral to CAMHS for children and adolescents. Missing Persons Policy for escalation if patients abscond	Delays in timely assessment from the CAMHS service. Mental health inpatient capacity limited locally and nationally. Absence of departmental guideline for rapid tranquilisation of mentally disturbed patients No clear pathway between SWYFT and the Local Authority in terms of the timeliness of Mental Health Assessments, Gatekeeping assessments and securing a bed in a MH facility Lack of additional resource availability to provide 1:1 when required.	3 3 x 1	16 4 x 4	9 3 x 3

High	3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Active	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum and agency staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3
High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver hot week vascular cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1 NHS Locum in post (on 12 month contract, due to be renewed in the Summer). - 1 NHS (Bank) Locum supporting thee service in tandem with the above. - 1 day per week support from a neighbouring organisation. - 1 day per week support under private agreement from a private provider. - Working closely with WYVAS to plan and secure adequate cover.	- Uncertainty over date vascular reconfiguration will be complete. - Difficulty in securing cover long term whilst reconfiguration discussions are ongoing.	16 4 x 4	15 5 x 3	6 2 x 3

High	7279	Family & Specialist Services	Pathology	Blood sciences	Jun-2018	Active	Keeping the base safe	Risk of: Point of Care Testing (POCT) results are not available in EPR Caused by: Lack of interfacing between POCT devices and EPR Resulting in: Patient harm through lack of availability of Point of Care results or mismanagement due to transcription errors	Manual transcription of POCT results into EPR as clinical notes by clinical teams Manual transcription of POCT results into the LIMS by laboratory staff for transmission into EPR (Full blood count results only) Most devices with the ability to connect are linked to Middleware (Cobas 1000 or POCcelerator) which archives patient results with limited user access.	1. Failure to transcribe results into EPR once tests are completed. 1a. Audit of flu testing Nov19-Jan20 showed 46% of flu tests were NOT recorded in patient notes. 2. Failure to record all available results produced by the device e.g missed calcium, missed potassium results when focus is on pO2 or lactate result. 3. Transcription errors not checked by person or machine. 4. Alerts not triggered by abnormal results as data not entered in designated fields e.g. Sepsis pathway 5. Clinicians not acting on abnormal results as no reference range available e.g. Low calcium 6. Lack of monitoring and trend review for patient conditions due to results not entered in tabular format.	15	15	3
											3 x 5	3 x 5	3 x 1

High	7315	Trustwide	All Divisions	All Departments/Wards	Aug-2018	Active	Keeping the base safe	There is a risk of delay to patient care, diagnosis and treatment Due to insufficient outpatient appointment capacity to meet current demands Resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Please refer to following individual risks: 4050 6078 6079 7199 7202	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15 3 x 5	15 3 x 5	6 2 x 3

High	7389	Family & Specialist Services	Pathology	Blood sciences	Jan-2019	Active	Keeping the base safe	Risk of: Inability to maintain adequate control over the QMS and Technical expertise within the transfusion department Due to: Loss of critical team members within the Transfusion Department and national shortage of suitable replacements. Resulting in: Potential Inability to conform with MHRA regulations and loss of UKAS accreditation. Refer to QP (RP-008) for full detail of risk	System Admin Role – DS and AF are supporting the system admin role on a part time basis QMS Slippage- Non-transfusion band 7 support staff for blood sciences can providing limited help with specific non-technical audits Loss of band 3 – Highly qualified staff members will be de-skilling to cover this role. Loss of band 7 – Other band 7 is learning some of the responsibilities that other solely performs, other band 6 staff are being developed in preparation for a Band 7 role. Loss of other staff – Other band 6 staffs are being developed in preparation for a Band 7 role, and where appropriate the quality role is being disseminated down to other Band 5/6 staff.	1 No recent review of the structure within the Transfusion Department for long term resilience and capacity planning 2 KPI/QMS needs to be controlled over longer term 3 Band 3 position needs filling 4 Continuity planning for critical staff retiring is not robust 5 Inadequate support for Transfusion Practitioner	15 3 x 5	15 3 x 5	1 1 x 1
High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience Due to inconsistently completed documentation on EPR Resulting in a potential increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2

High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1
High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1

High	7430	Family & Specialist Services	Radiology	All Radiology	Mar-2019	Active	Keeping the base safe	There is a risk of being in breach of IRMER regulations due to the way roles are set up within EPR, as this allows non medical staff who are not permitted to request Radiology exams as part of their role. Under IRMER 17 regulations a non medical health care professional can refer for radiological examinations but only under a clearly defined agreed protocol and only after receiving the appropriate irmer training. therefore access to radiology requesting should be restricted to these groups only.	There is an approval process within radiology to allow access to non medical referring that require access to this for their role. A register of all non-medical referrers is accessible to all staff. It is fully up to date and updated daily. Radiology staff can check unknown referrers against this list. When requests from inappropriate staff are noticed they are taken up with the staff in question. All radiology requests are vetted for appropriateness and justified in accordance with IRMER 2017. Please note this also includes requests that do not involve ionising radiation e.g. ultrasound and MRI. A quarterly audit is done of request made, and any prolific requestors are contacted.	Despite this gatekeeping the volume of requests that come into radiology mean this manual checking is ineffective. These requests will come through into the Radiology systems and although the name of the referrer is present with the request unless each one is individually checked staff would be unsure if an unrecognised name is a new FY1 or non medical referrer, thus there is a good chance the exam will be done. The numbers of requests received mean the controls in place can never be 100% effective There is no way to stop the problem at source without the creation of extra EPR requesting groups which would add to an admin burden to the system or potentially affect other systems within EPR.	15	3 x 5	15	3 x 5	9	3 x 3
High	7615	Medical	All Directorates Medical	All Departments/Wards Medical	Dec-2019	Active	Keeping the base safe	There is a risk of not meeting the four hour emergency care standard Due to increasing demand on Emergency Care (approximately 5% above plan) meaning significant workload above workforce model, inappropriate use of ED. ED team factors including medical and nurse staffing (Risk ID 2827 and 6044), not triaging, patient flow, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community Resulting in poor patient experience, potential risks to delivery of fundamental care standards and potential harm to the patients, increased scrutiny and reputational risk to the organisation	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - eg gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the fron tdoor and admission avoidance services - frailty, streaming,	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams	15	3 x 5	15	3 x 5	1	1 x 1

High	7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Active	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438 –(Rating 20) - There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, resulting in potential patient harm CHS Risk 7438 (Rating 15) CHFT Risk 7474 (Rating 15)	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 x 1 = 5	5 x 3 = 15	1 x 1 = 1

Action Plans	Progress Update	Review	Target	RC	Exec Dir	Lead
1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	Sept 2019 New rota's working well. To date there has been a reduced requirement for ad hoc locums. Nov 2019 New rota's working well. To date there has been a reduced requirement for ad hoc locums Feb 2020 There is no further progress to update April 2020 Focus on medical staffing rota's to respond to Covid-19 has seen significant changes to rota patterns, these remain compliant. See Covid risk 7678 May 2020 Clinical fellows recruited Continue to support and recruit ST3 & 4s	Jun-2020	Sep-2020	WEB	David Birkenhead	Dr Mark Davies

• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	December 2019 A number of interviews have been arranged at Consultant level during December. There are strong applicants for substantive posts at Consultant level for Urology, Respiratory Medicine, Rheumatology, Care of the Elderly, Acute Medicine, Neurology, Ophthalmology and Renal Medicine. In addition interviews are scheduled for fixed term appointments at Consultant level in Anaesthetics Haematology and Radiology. Current Vacancy data shows that there are 21 consultant level vacancies so if these applicants are appointed then we will be able to reduce this vacancy rate further. A recent paper regarding consultant recruitment has been presented to the Workforce Committee. This showed that consultant level vacancies have reduced from 31 gaps in October 2018 to 20 in October 2019. The changes to the pay arrangements for doctors in training with regards to their weekend allowances have all been applied and updates completed. Further work will be required next year to introduce the new rota rules for doctors in training which were agreed over the summer by NHS Employers and the BMA. Invites for the Local Clinical Excellence Awards have been sent out and all applications are to be submitted by the end of December for consideration by the Awards Panel. Briefing sessions for the panel are being delivered throughout December so that scoring can commence in January without delay. The Awards panel are due to meet Wednesday 12 February 2020. February 2020 Preparation and pre-employment checks for new trainees that will join the Trust in February is almost complete, with no delays anticipated. Given the volume of new starters to CHFT the Medical Education department have planned a Medic specific induction for Wednesday 5 February 2020. A large number of trainee vacancies are a cause for concern within Paediatrics and Emergency Medicine. The Medical Director has highlighted the concerns to Health Education England with regards to Paediatrics which has been caused by vacant posts, maternity leave and a number of less than full time trainees. The national shortage of paediatric doctors is compounding the problem. The number of gaps is creating pressure within the department as consultants are often required to ‘act down’ into registrar level roles to ensure safe patient care. Whilst post offers have been made for Paediatric Trust doctors, there will be a period of time before they are ready to commence in post as these are overseas candidates who will need to relocate to the UK. Two offers have been made for Trust doctor roles at ST3+ level in Emergency Medicine and whilst a large number of vacancies remain, these new appointments offer an opportunity for the trust to develop a skilled team that is not overly reliant on Agency workers. They are both very keen to progress through the CESR route to enhance skills and expand their experience. A number of overseas doctors attended the GMC Welcome to UK Practice session on 20 January 2020. This is a training session delivered by the GMC which gives a useful insight into the communication differences between different healthcare economies. All attendees felt it was useful and opportunities have been identified to improve the induction experience of Medical staff when joining the Trust from overseas. These suggestions will form part of the action plan for Medical HR to	Jun-2020	Aug-2020	WF	David Birkenhead	Pauline North

• Local/domestic recruitment - monthly assessment centres • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit (See attached milestone plan/tracker in documents)	December 2019 Update: New graduates now in post and going into shift fill - on new preceptorship programme International recruits progressing well (35 in post - 5 going through the OSCE training programme) Next TNA programme due to start on the 6th of Jan 2020 January 2020: Full review of the risk completed New graduates now in shift fill Planning for the deployment of the first NA cohort in June 2020 International recruitment continues Planning for the next cohort of TNA's Hosting increased numbers of undergraduate students Risk 5937 merged to this risk (6345) February 2020: Local and domestic recruitment activity continues. International recruitment on-going Plans continue to deploy the next cohort of nursing associate graduates into the workforce Work progressing to embed safe care live. March 2020: - Recruitment activity continues both locally and internationally - Continue to work with HEE to deliver on the national nursing associate expansion plans - Continue to progress action plan/work through the NHSi national retention plan - Progressing work around access to undergraduate nursing programmes via the apprenticeship route April 2020:: Focus on nurse redeployment to mitigate the impact on staffing and requirement for increased capacity in specific clinical areas has seen a significant impact on nursing rotas. See Coid risk 7676	Jun-2020	Aug-2020	WF	Ellen Armistead, Suzanne Dunkley	Michelle Bamforth
- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Actively seeking a second overseas fellow. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist, due to commence August 2020. Feb update - this consultant has now given back word.	August 2019: New Head & Neck Consultant Radiologist commenced end July 2019. October and November 2019 Update: We have recruited an overseas NHS locum (commenced November 2019) for Head & Neck and we have an overseas global fellow (junior consultant) for paeds/ neuro starting at the same time however 2 consultants have resigned (GI/uro and gynae) and will be leaving the department at the end of November. December 2019 Update: Introduction of a named Consultant each morning/afternoon who is assisting with prioritisation and validation of requests. February 2020 Update: Risk reviewed and description and other fields updated to reflect the current position.	Mar-2020	Aug-2020	PSQB	Stephen Shepley	Sarah Clenton

Review outstanding validations- Completed Develop process with appointment centre (Validation team) Completed Develop escalation process with appointment centre , secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Completed Communication plan within the head and neck services. Completed High level process to roll out within the division. - Ongoing , process map developed, awaiting sign off by division.	January/February 2020 Update clinical validation process to be sent to DMT for sign off and circulate wider through the trust. ENT Validations - Being monitored through customer contact awaiting latest update following 2018 validations MArch 2020 update: Validation team redeployment for COVID-19. Therefore incident raised by one point (likelihood 4 x impact 5). April 2020 Update Impact - Capacity for seeing surveillance patients Portal to be signed , expected end of the month to go live , to ensure surveillance patients are kept on track and can be monitored as a RAG rating system . Mitigation - Fast track team are tracking patients with daily updates and escalations . Telephone consultations also have been introduced to contact patients at check points and escalation process currently being developed. May 2020 Ongoing work to with trail of live portal	Jul-2020	Aug-2020	PSQB	Mel Addy	Laura Cooper

National Distribution model by MOD Respond to updated national guidance Establish centralised ordering process Region-wide (WYAAT) order for gowns Monitor use of masks in view of change to national guidance on useage in public areas for both staff and patients.	June 2020 - monitoring of increased use of surgical masks due to requirement to use in office spaces, public spaces by staff and by patients/public attending hospital premises. Increased use of PPE due to recommencement of some clinical activity. 21..05.2020 PPE group - surgical masks - staff concerns/preferences regards fit of some, different types and fastenings; need to ensure that staff are comfortable but understand purpose of mask. Specification is appropriate for purpose. Gowns - phased removal of yellow spanish gowns, had delivery 10,000 blue gowns that are level 3 and push delivery of level 4, white gowns. Blue gowns for swap out wards and depts first, then crash trolleys. Ensure stock for over w/e and BH period. MatMan Team working every morning. 22.04.2020 - Gowns CAS alert - national shortage: mitigations improve cohorting, ensure correct staffing levels in ICU, national planning for critical shortage. Progress procurements as ICS. 1500 theatre hats for covid areas hair protection - approved. 22.04.2020 PPE group Gowns - bought 500 disposible lab coat style - delivered. Fabric lab coats, reusable - being costed up, contract PAYG contract. Laundry can respond. Need an advisory note for staff with different types of gowns via the daily update. Spanish gowns - checking of batches for consistency of quality, but believe they meet the AAMI level 2 standard that we ordered. Some other Trusts have chosen to opt out of the contract. Completing an organisational stock take on gowns - update position by later today. Effective placement of patients/cohorting for AGPs will support best/sessional PPE use. Need internal controls for distribution of right type of gowns to right areas. To strengthen process for donations, and what is being brought in by individual staff - follow approved governance routes. Some ward-level stockpiling of coveralls, brought back into central store. Procuring head gear for hair protection - approved order. Hoods - tracking (add a risk) asset tracking system being developed, should include hoods. Request to Astra Zeneca to loan hoods - being progressed. 21.04.2020 Difficulty getting 'O' rings for hoods, can't buy them but have ordered the equipment to enable us to make them. Disposible mask 8833 (cone shaped) no planned delivery, escalate to NSDR - look at FIT testing to flat masks and prioritise distribution of cone shaped. Gowns 5000 delivered on saturday, large order signed. PPE working on ICS footprint. In a better position for gloves from big national delivery, long sleeved ok at present. 20.04.2020 - First delivery of gowns order across WYAAT arrived Saturday am, reviewed quality. Have 6 days disposible gown stock. Contingency plan for material gown, sending around technical guidance. 16.04.2020 long gloves same position as yest. 1000 coveralls instead of gowns, 5000 gowns due 17th. CHFT leading regional arrangement 640,000 gowns delivered @ 80000/wk to Yorkshire - first delivery due, to evaluate the quality and proceed - £2.4M with upfront payment £1.7M, working with NUSI for	Jun-2020	Aug-2020	NA	Ellen Armistead	Kate Roberts / Andrea Dauris

Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, sconsider remote or delay 3-6 months. Working up CAS model and recovery plan. .	June 2020 Clinical validation and prioritisation of appointments has commenced. Clinic letter templates being amended to include additional instruction to patients who are required to attend face-to-face appointments. Virtual clinics running across specialties. Response to contacts from patients awaiting treatment from Yorkshire Fertility Clinic. 02.04.2020 Medicine: risk assessment of all patients with an appointment booked and who are due an appointment to identify whether they can have their appointment remotely or if it can be delayed 3-6 months. Planning to implement a CAS model for all specialties once routine elective work recommences, this will help reduce the waiting time for new patient appointments and therefore the time to first treatment. A review is taking place of all clinics to allow us to identify what can remain remote (VC or telephone) in the future, so this doesn't all revert to routine face to face working. 30.3.2020 risk assessment in Divisions, essential patients are being identified. Medicine: Risk assessment, re-prioritisation and deferring 3-6 months for patients booked for April 2020 will be completed by end of March 2020. Work commenced on appointments for May and June 2020.	Jun-2020	Aug-2020	NA	Anna Basford	Mel Addy, Stephen Shepley, Asif Ameen, Lisa Willia
Monitor staff sickness absence Provision of Occupational Health advice Staff testing for symptomatic, asymptomatic and those isolating due to family symptoms Provision of PPE appropriate to task WYAAT position on application of RIDDOR	June 2020: Social Distancing workstream in place. Provision of surgical masks for public areas and offices with occupancy requiring PPE, and for patients. Work to encourage staff to adhere to social distancing guidance is ongoing with raising awareness, Greeter roles on main entrances, segretation of seating areas in restaurants, and prompting staff to consider behaviours. 18.05.2020 Social Distancing guidance and FAQs distributed 01.05.2020 recognition regionally, nationally and internationally that staff are catching Covid and some deaths of healthcare workers. Suggestion that BAME staff groups may be more affected. More community staff are testing positive. Planning for testing of all staff with recognition that 1-5% staff will have a positive result, impacting on workforce.		Oct-2020	NA	Helen Barker	Helen Barker
Plan for Stabilise and Reset (recovery) being conscious of requirements for social distancing Signage to support social distancing message in public spaces is ordered Signage for small meeting rooms ordered - one person/two person space Covid bulletin providing key messages regarding social distancing Top Tips for Managers and FAQs Social Distancing wardens in communal areas such as restaurant at busy times Monitor ED attendance and patient flow	19/5/2020- OPD and SAS meeting about clinics to discuss challenges for reinstating clinics safely. 15/05/2020 C-IMT Top Tips and FAQs formatted, Newsletter dissemination via line manager channel, bulletin route and Divisional Manager cascade. Signage 'walk on left and 'single person rooms' 14/5/2020 SOPD - outpatient activity is limited to emergency clinics for vascular patients.Patient attending for face-to-face clinic is asked to wear a face mask, gel hands and limited attendance. Chairs in waiting areas rearranged to limit to one patient waiting in clinic and 2 metre distancing in corridor. 2 patients can sit social distancing in waiting area and 5 can sit outside in corridor. Total that can be held using risk assessment is 7 at any one time. 13/5/202 SOPD is not fit for purpose to meet volume of patients and this must be factored in to reconfiguration of outpatients. 12/5/2020 SOPD Microsoft teams meeting to discuss and escalate to Divisional Director of FFS who has raised concerns at Incident Management Team (IMT) for COVID response.Outpatient Recovery Plan meeting scheduled.	Jun-2020		PSQB	Helen Barker	Rachel Roberts, Catherine Riley

Social Distance workstream - identify opportunities to social distance and reduce risk Communications to staff when guidance is updated	June 2020: Social Distancing work commenced, focus on public and work areas and signage, PPE, space utilisation. Recognition that some teams work in a restricted space and not possible to socially distance. Not possible in some cases to reduce the size of the team without significantly impacting the volume of activity that they can deliver, creating a further risk. .	Sep-2020	Nov-2020	NA	Jason Eddleston	Jason Eddleston
Investigate Serratia cluster of 5 line infection cases May/June 2020 in ICU	June 2020: Cluster of 5 incidents of line infections on ICU to jointly investigated. Outbreak meetings held. Declared Serious Incident for investigation.	Sep-2020	Oct-2020	ICPB	David Birkenhead	Anu Ragjopal / Jean Robinson
3 workshops have taken place to understand the resource and capital investment needed to close the gaps and meet the required level of compliance. The output from these workshops is the compilation of a plan with timescales and deliverables. This plan will be complete in Dec 19 with the first actions commencing in January 2020 where funding allows for resource and infrastructure investment. Plan underway with positive outcome expected July/Aug 2020.	Weekly meetings are being held to track progress and highlight any areas of concern. 3 initial workshops to understand the scale of the changes required have taken place during Nov/Dec 19 Raised at Divisional Board in both November and December 2019 with senior management engagement Feb 2020: There is a plan in place following the workshops however requests for supplementary funding (both capital and revenue pressures) has been rejected therefore THIS are working through the work plans that have been agreed over the next 6 months in order to complete a further DSPT self assessment in October 2020. No change in risk score. April 2020 - The DSPT submission has been moved to Sept 2020 due to C19. Investment in digital and implementation of the new password policy will mean that it is more probable that we will meet the standard. Alongside tested BCPs, the mitigation around some of the gaps in controls and an increased understanding of digital ways of working, the likelihood of this risk will reduce closer to the submission in Sept.	May-2020	Oct-2020	DB	Mandy Griffin	Rob Birkett

Establish in-house testing and turn-around of results to move negative out of isolation - in place Review anti-microbial protocols for antibiotic prescribing to reduce patient contact and move to early discharge Plan for commencement of testing of asymptomatic patients - in place Monitor patient flow	June 2020 all patients are tested on admission, isolated until result is back. Negative are cohorted or in side rooms. PPE used in line with national guidance. Bed flow management integral to Tactical and escalated to IMT. 01.05.2020 Planning for testing of asymptomatic patients who are admitted. Evidence currently indicates that 5% asymptomatic tests are positive. Need to segregate patients until results back. If non-positive are cohorted with asymptomatic positive case, then all will require cohorting. Commenced testing of all care home patients as higher prevalence. Potential for increased patient flow challenges. Tactical monitoring bed availability including side rooms, and beds blocked fully/empty. 30.3.2020 in-house testing providing results within 4 hours and enabling step down of patients not requiring isolation. Current capacity allowing for 4-bedded bays to be used as side rooms. IPC reviewing antimicrobial prescribing and antibiotic stewardship guidance	Jul-2020	Aug-2020	NA	David Birkenhead	Claire Speight, Bev Walker
Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to November 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in .. Phasing in of ready to use chemo batches also underway.	December 19 update. Delay due to Project Echo/ lease agreements with lenders solicitors being reviewed. CRH unit now due to close Jan 20 and enabling work start mid- Jan but awaiting confirmation from Associate Director of Finance re outcome of lease sign off debate. This is likely to delay opening of new unit to Aug 20 and reliance on HRI aseptic unit until that point. February 20 update- as Dec update- further delays in lease sign off / step in rights/ defect liability contract and therefore start of enabling work is further delayed. New unit at CRH unlikely to be open before Sept 2020. May 20 update- whilst Engie and Trust agreed to lease sign off, still awaiting lender sign off before Engie can be instructed to start enabling work. New unit unlikely to be open before Dec 20	Aug-2020	Dec-2020	DB	Ellen Armistead	Elisabeth Street
To subscribe to the child in ED course at every intake via the university. Create a business case to increase the work force model to achieve RSCNs on each shift	January 2020 - HLRR - Review of articulation of the Risk to be completed by Andrea Gillespie and Ellen Armistead January/February 2020: Task and finish group being set up to look at new ways of achieving cover with RSCN's in department. Visit to Frimley park planned Jan 2020. May 2020: Task and finish group currently suspended due to pandemic. Both areas segregated for COVID-19, therefore neither area is a sutable paediatrics currently. Continue to only have 2 qualified RSCNs at CRH site. Model worked up for converting both departments in paeds area when COVID pandemic over.	Jun-2020	Sep-2020	NWG	Ellen Armistead	Louise Croxall/Jayne Robinson

Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations as part of the investigation team To add EPR document access for non clinical SI investigators Learning Group to develop approach on learning and a learning event Paper with options for pool of trained investigators to WEB	Dec 2019 - challenges with operational pressures and time for investigation teams to progress investigations. Risk Team supporting by requesting statements, collating information. Escalated status of SIs to SI panel. Consideration to be given to options for pool of trained investigators. February 2020 - Discussion with Director of Nursing regarding written communication to line managers of investigators regarding their involvement in serious incident investigation to reduce withdrawal rates. Business case for pool of trained investigators in development. April 2020 continued pressure on delivery of SIs within timescales required by the framework. Majority of SIs now have at least one extension. Risk Team have taken over writing reports for most investigations, with specialist input sought to provide evidence base. Position escalated to AD Q&S and via senior management team meeting, additional investigator support requested within team but not forthcoming.	Jun-2020	Sep-2020	QC	Ellen Armistead	Maxine Travis
- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete).	Nov 19 - As per Octobers update, the DSP Toolkit Plan is still being pulled together with resource being identified for a Jan 2020 start. There is a separate risk logged for potential non-compliance of the toolkit (7617)however the overlap with this risk is significant enough to maintain (and potentially increase) the score. February 2020 - There are a number of associated Cyber/DSPT/Reliance risks relating to the reliance of CHFT on its digital platforms. Work has been ongoing in Jan/Feb 2020 towards DSPT however not to the extent that would change the scoring of this risk at this point. No further update. April 2020 - The DSPT submission has been moved to Sept 2020 due to C19. Investment in digital and implementation of the new password policy will mean that it is more probable that we will meet the standard. Alongside tested BCPs, the mitigation around some of the gaps in controls and an increased understanding of digital ways of working, this risk will meet its target score late 2020.	May-2020	Mar-2021	RC	Mandy Griffin	Rob Birkett

January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support. Additional training dates have been added for safeguarding and MCA/DoLS level 3.There are sufficient places to train ALL staff who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	June 2019 - The work identified above is continuing but the completion date has been put back to the end of July 2019. This is due to some technical issues identified in the process - the Workforce BI Team have raised these with the ESR Functional Advisor and IBM. Additional DSA classroom sessions have been attended to raise compliance in this subject. August 2019 - The 9 core subjects of EST have been 're-set' in the system and this has enabled colleagues to play the learning without difficulty. A 'deep-dive' into Infection Control Level 2 and all Resuscitation subjects has taken place to identify capacity. September 2019 - The core 9 subjects are consistently attaining a compliance of over 90%. Focussed activity is taking place on the role specific subjects where compliance is below 85%. This includes contacting SME's to ensure the target audiences are correct and working with HRBP's to share non-compliance with relevant departments. October 2019 - Activity remains focussed on the role specific subjects where compliance is below 85%. Specifically, Adult & Paediatric Basic Life Support where a capacity/demand issue has been identified. November 2019 - The core 9 subjects remain at over 90% compliance, with 5 subjects consistently over 95%. Fire Warden training has been assigned to all Band 6 Nurses which has seen a reduction in compliance, work is under way to review the target audience and increase capacity. December 2019 - Of the 34 role specific subjects, 19 are at below 85% compliance. Each of these is being scrutinised this month with a plan in place to increase compliance by end of March 2020. January 2020 - The core 9 subjects remain at over 90% compliance. Of the 34 role specific subjects, 18 are now below 85% compliance. An action plan is in development to address these and this will be shared with the Executive board this month. February 2020 - The core 9 subjects remain at over 90% compliance. A full deep-dive into the role specific subjects below 90% has taken place and the findings presented to Executive Board. For these subjects, details of non-compliant colleagues is being emailed to managers in February. An EST Line Manager Bulletin special is being sent to managers which explains where we are at and what we need to do to improve compliance. March 2020 - Moving and Handling compliance has dropped below 90% - work is being carried out in divisions to address this. Both Safeguarding Adults/Children Level 3 and Infection Prevention Control Level 2 classroom sessions have been cancelled due to COVID-19. E-learning is available for IPC and is in development for Safeguarding.	Mar-2020	Mar-2020	WF	Suzanne Dunkley	Charlotte North
Develop clear escalation process to support nurse staffing in the ED when demand exceeds capacity.	January 2020: Work ongoing in the department SOP produced to standardise care in the ED for this patient group. Awaiting results from recent serious incidents. February 2020 Review of Risk with Sarina Beacher no changes required to the wording April 2020 - Serious incident inestigations with SWYPFT are signed off, actions agreed. May 2020: Working with mental health teams to establish better ways of working 1 st meeting held last week and feedback given to Mental Health.	Jun-2020	Nov-2020	NA	Maggie Metcalfe	Louise Croxall/Jayne Robinson

- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019)	January/February Update Holding list currently 1249, 500 are diagnostic visual fields due to EPR scheduling error rather than genuinely overdue, Orthoptic team validating and identifying those to book. Failsafe co-ordinators proving effective in identifying capacity and monitoring overdue requests. Requested for a weekly report of % no. of patients seen 'on time', seen within '25% of the scheduled request', within 25-50% overdue request and over 50% their scheduled request. Continue to work on recruitment to full vacancies with substantive, locum, agency and transformational work utilising non-medical workforce. April 2020 - Due to the impact of COVID-19 and the cancellation of non-essential out-patient appointments and operations, Ophthalmology, Orthoptics and Optometry have risk stratified patients based on Moorfields risk stratification guidance which has been implemented nationally. The department continues to see high risk patients face to face, moderate risk patients by phone and video and low risk postponed between 4-9 months as appropriate (all done by Consultants, Orthoptist, Optometrists). These delays could lead to delayed diagnosis, investigations and treatment and potential sight loss.	Jul-2020	Aug-2020	DB	Will Ainslie	Pnt Laloe
1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching TH. 2. Working with WYVAS to progress a regional approach.	April 2019 update: -substantive consultant in post -ad-hoc locums supporting the service as no cover agreed with Leeds or Bradford - NHS locum for 12 months due to start in June 2019 - regional reconfiguration project will establish longer term solution although no definite timescales to date June 2019 Update - NHS locum in post for 12 months commenced June, undertaking a period of orientation into the UK. Substantive consultant left 21 June 2019, Working to secure a second agency locum for 2/3 months. Ongoing discussions with agency re:locum on-call, Leeds and Bradford regarding on-call cover. August 2019 Update: Position remains as per update above. October and November 2019 update: Mid Yorkshire Trust Consultant working at HRI 1 day per week, 2 locums booked in rotation until the end of the first week in January. NHS locum working with rotational support from the other 3 consultants. December 2019 Update: We now have a Vascular Radiologist from MYT/LTHT working at HRI one day per week. This will assist with stabilisation of the service and support for our new NHS Locum, in particular in relation to EVAR (Endo Vascular Aneurism Repair) provision. We continue to work with WYVAS. Actions underway from regional Chief Operating Officers meeting held in early October 2019 regarding Radiology. Looking to create regional contingency. February 2020 Update: Full review of risk and update to all section to reflect the current position.	Mar-2020	Mar-2020	DB	Stephen Shepley	Sarah Clenton

1. Create/identify test server for Cobas 1000 to develop interface with EPR test environment (THIS) 2. Test interface connections between Cobas and EPR (THIS/EPR) 3. Create Event Set Hierarchy for reporting all possible results into EPR (POC team/EPR) 4. Review data quality for patient testing on middleware 5. Identified as a risk as part of GIRFT and added to action plan for 2020. Previous actions up to Jan 2020 1. Develop interface (Path IT and THIS)- Ongoing discussions with CSC alongside other potential routes for connecting to APEX. 2. EPR training- lab to liaise with EPR trainers to embed training- Completed 07/08/2018 3. Encourage incident reporting- Completed July 2018 4. Revise current POCT training delivered by lab team to POCT users (include tests available from POCT and actioning of incidental findings) Completed July 2018 5.Lab to place guidance laminates above POCT machines and also issue to ward managers- Completed July 2018	01/0620: no update due to COVID restart pressures. Update 05/05/20-No progress due to COVID (additiona support required and staff absences within POCT due to COVID). EJ will be leaving the Trust in June so suggest deferring until new person is in post. Update 12/03/2020 A) Roche have populated the test server. B) Prototype of POCT specimen label created - requires more work C)POCT Team submitted Datix 78863 and 78864 relating to poor data entry by POCT end users to encourage better data entry Update 5/2/2020 1) Recent review and updating of risk description and rating 2)Project now prioritised as part of GIRFT 3) THIS have identified a test server - waiting for Roche to respond to progress 4)a POCT specimen label containing the MRN number in barcode format is being actively worked on by the EPR team Update 06/01/2020-Waiting for THIS to identify a test server to enable progress. Request with Neil Staniforth. Asfeen Malik has informed us this has now been put back due another Trust workstream Update 06/11/2019- Waiting for THIS to identify a test server to enable progress. Request with Neil Staniforth. Update 02/10/2019- server was upgraded in August as planned part of enabling work. EPR team are progressing with building the catalogue of POCT tests within EPR. Current action with THIS to identify a temporary server which can be used for testing. 01/09/2019 - No update this month Update 2/8/2019-Active workstreams with server upgrade planned for 5th August as part of preparation. However, risk remains as is for time being. Update 05/07/2019-1. List of POCT tests in use for EPR build supplied to EPR team - details tests in use at CHFT and those devices with connectivity capability. //// 2. Details of messaging transmitted from COBAS POCT middleware passed onto EPR team.	Jul-2020	Sep-2020	PSQB	Stephen Shepley	Emma James

Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	February 2020 Significant prgress made see below - monitoring whether this is a sustained improvement prior to reviewing risk score. FSS Update: 1. Paediatrics perspective – ASI managed on a weekly basis additional clinics put in specialties where we have long waits eg Allergy and enuresis. Follow ups longest waiters cardiology working to find solution – increased local offer reviewing visiting consultant offer from Leeds 2. Gynaecology – management of ASI – managed on a weekly basis. Adding additional clinics to support from registrar level - Further work to be undertaken with follow ups to look for other solutions. Medicine Update: Medicine ASI's currently at 378, a significant reduction in the last month (13.1.20. the number was 696, February 2019 was 1587, August 2019 was 1227. Specialities with the biggest reductions are Gastro, Cardiology due to implementation of the CAS service and Neurology due to Nurse Led Services. The division is on trajectory to further reduce ASIs by March 2020 as requested as part of the RTT 4 point plan. Surgery Update: ASI position improved, currently best position for 5 years, Opthalmoloyg remains a challenge due to Orthopaedic workforce, 2 fail safe pathways and triage of follow -ups. Specialty specific ASI risks to be developed. April 2020: appointment capacity impacted by cancellations due to covid-19. Develop recovery plan to assess and address the impact. (see Covid risk register entry)	Jun-2020	Aug-2020	PSQB	Helen Barker	Mel Addy, Asif Ameen and Stephen Shepley

1 No recent review of the structure within the Transfusion Department for long term resilience and capacity planning 1(a) Meeting between the management team to confirm a long term sustainable structure for the department. (HB)- Completed May 2019. Porgress since initial meeting has been minimal. Please see porgress updates section below for update against open action plan 2 KPI/QMS needs to be controlled over longer term - actions to mitigate still being investigated. - Re-addressed actions in may 2019-Please see monthly progress updates below 3 Band 3 position needed 3(a) Recruit into Band 3 and potential Band 7 vacancies within the transfusion department (HB by 4/1/2019) JD/VCF all completed nov 2011- recruitment process due Jan 2019- Ongoing May 2019. Band 3 and 7 posts filled.(COMPLETED) 4 Continuity planning for critical staff retiring is not robust 4(a)-Define a continuity plan for the critical role planning retirement April 2019 with the team and start to implement (to include options for recruiting at risk and any shadowing that can be started prior to formal notification of retirement) (HB -Jan 2019)- Ongoing - see monthly progress updates below 4(b) Prepare provisional JDs for posts where staff have expressed interest in moving (HB - Jan 2019) (band 7 post appointed to (CLOSED) 5 Inadequate support for Transfusion Practitioner - Needs to be written up as a separate risk - to discuss in PGB May 2019 (POST ADVERTISED AND RECRUITMENT UNDERWAY (CLOSED)	KPI continue to improve. New Capacity monitoring sysytem in place and being trialled from June 2020 Update 05/05/20 Update againts action plan: 1) 1 x Band 5/6 member of staff starting on 15th June 2020 2) Further recruitment delayed due to Covid-19 (unable to do face to face interviews) 3) KPI's looking very good with 3 months data in the green 4) Capactity planning tool awaiting HLB to complete. February Update 05/02/2020 against action plan 1) 2 x vacant band 6 post has been shortlisted - only two suitable applicants to interview. Interview date set. 2) 1 x Band 6 post has been approved and currently out to advert. 3)Capacity planning for long term stability. a)Capacity spreadsheet still underway -meeting arranged for 7/2/20 to review progress 4) KPI's continuing to improve 5)Seconded Band 7 now in post and off the 24/7 shifts. Update 09/01/2020 1) 2 x vacant Band 6 posts have been approved, advertised and awaiting shortlisting which will stabilise the rota and provide additional support into the quality management resources. 2) 1 x band 6 vcf awaiting approval 3) Capacity planning for long term stability- Tool developed and planning underway. 4) Free up capacity of current experts staff to concentrate on higher priority activities- devolving other tasks to staff in wider team. - Underway and being monitored. Progress being made KPI's are all reducing. 5) Band 7 post has been filled on a 12 month secondment.	Jul-2020	Jul-2020	PSQB	Julie O'Riordan	Hayley Baker
Establishment of clinical documentation group	December 2019 - Date arranged for visit to Leeds - 17th December with engagement from ED, Acute Floor and Training. E Cras Audit Tool being audited on Ward 6 CRH. Engagement nationally with counterparts who use the same electronic system looking at alternatives to improving digital clinical record. Continue to support the Discharge Quality Group factoring in digital clinical record. February 2020 - Digital Champions - received the go ahead from Chief Nurse and Chief Medical Officer to progress Digital Champions. Business case to be submitted detailing what this would look like and the associated benefits. Go See at Leeds carried out in December regarding proof of concept. - Re-education being scoped through Outpatients Department. Plan to re-educate all members of staff who deliver care in this area and to then move to inpatient services.	Mar-2020	Jun-2020	WEB	Ellen Armistead	Carol Gregson/Graham Walsh

Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard. Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. May 2019: Delivery of fire training June 2019: Fire risk assessments, installation of sockets July 2019: NHSI capital bid for 19/20 Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks.	FEBRUARY 2020 Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 26th Feb to review and submit the risks which will likely remove this risk. MARCH 2020 Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 8th April 2020 and will review / approve all Fire related risks. April 2020 additional fire risks due to impact of Covid-19, fire loading, increased use of oxygen, increased storage of supplies and equipment, movement of staffing, utilisation of theatres as critical care wards, fire evacuation routes altered. Full risk impact scoped and added to Covid risk register.	Jun-2020	Aug-2020	FIREC	Helen Barker	CHS / CHFT
Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	October 2019 The approach to cladding is being determined as part of the HRI Strategic Development Plan (SDP) to be presented to Board in November. This SDP will propose an estates strategy for the site and provide the Trust with an investment strategy to address the cladding risk in the short and longer term. A design solution will be developed following approval of the SDP. Dec 2019 - CHS carrying out re-inspection 12 months on, any remedial works will be carried out from the re-inspection. CHS awaiting finalisation of the SDP but continue to explore over cladding option following an option appraisal. FEBRUARY 2020 CHS continue to monitor cladding following works completed on high risk areas. Option appraisal provided to CHS which will be considered as part of capital works. MARCH 2020 Survey recommended inspection carried out at 6 monthly intervals which now takes place.	Apr-2020	May-2020	FC	Gary Boothby	C Davies / A Wilson

- To audit quarterly and contact referrers concerned - To continue to raise issue via digital board - To ensure Radiology record of approved requesters continues to be up to date - At last audit some 6707 (12% of total) requests were made by inappropriate referrers.	September 2019 - Radiation protection advisors are checking other similar cerner sites for solutions - Re-audit undertaken which has show a deterioration in position October 2019 -IRS have been in touch with Wirral who also use CRIS and Cerner EPR -They apparently have made some progress on this issue -They are happy to discuss and a call with both sites is being arranged for initial discussion of what we could learn from them November 2019 -We have met with Wirral and the EPR team and Wirral have a solution to this problem that could work at this trust. -We need to meet with EPR to discuss a pilot of this and how it could work. This meeting will take place in the next few weeks. December 2019 - Setting up a meeting to look at a pilot in one area. Possibly A&E. Some key staff are on AL which has delayed a date. Jan 20 - Meeting for pilot booked for 14 Jan. There is a freeze on EPR developments from 27th Jan till end of May where we will not be able to make any changes in any domain. This will halt work on this project while the EPR upgrade is done. Feb 20 A freeze is now in place on any EPR development work till the end of May. We will be unable to advance the pilot of this project till the EPR upgrade is completed. April 2020 as Feb 20 update - Freeze likely to be extended due to focus on Covid-related IT developments	Jun-2020	Aug-2020	PSQB	Stephen Shepley	Mark Williams
Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow action plan owner – Deputy COO, Accountability- Directors	February 2020 Update Position remains challenging. Mitigation continues April 2020 Profile of patients attending ED has changed due to impact of Covid. Segregation of patients and managing covid risk is focus. Breaches are still being montiored. Link to MH bed waits risk - see action plan agreed for delivery of SI recommendations.	Jun-2020	Aug-2020	WEB	Helen Barker/ Ellen Armistead	Bev Walker

Progress maintenance of out of service medical devices. Implement asset tracking.	June 2020 Asset tracking implemented February 2020 update 2020/02/04-High Risk numbers fell High risk (408 to 393), Medium fell (1722 to 1714), Low fell (1325 to 1283), a total of (3455 to 3390). Continuing efforts to reduce the number of devices at risk.	Mar-2020	Mar-2020	RC	Ellen Armistead	Robert Ross

17. Quality Report

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	**Thursday 2nd July 2020**
Meeting:	**Board of Directors**
Title:	**Quality Report**
Author:	**Andrea Dauris** **Associate Director of Nursing for Quality and Safety**
Sponsoring Director:	**Ellen Armistead** **Executive Nurse Director / Deputy Chief Executive**
Previous Forums:	**None**

Actions Requested
To note

Purpose of the Report

In response to the Covid pandemic the Trust had to make significant adjustment to how it operates in order to ensure resources were channelled into the emergency response. A governance structure was put in place to reflect the needs of the organisation during this phase, much of which has been around the specific quality and safety challenges that manifest as a result of managing a pandemic. An update on the management of the pandemic has been provided to the Board throughout this time.

The Trust has needed to operate very differently while at the same time responding to our pre-Covid priorities. The purpose of the paper is to provide the Board with assurance that during the response to the Covid pandemic the processes and systems to ensure quality and safety have been maintained, albeit in a more streamlined way.

The report provides a high-level overview and differs from previous Board reports and this reflects our operating model during this time, the Board can expect to see a return to the previously agreed format going forward as we enter the stabilisation and reset phase.

The report makes reference to the Trust quality priorities which have been reset to reflect our ongoing challenges and those more specific to operating in a post pandemic context. The Quality Committee are due to define the actions and reporting arrangements for these going forward. These will be reviewed at the end of Q4.

Key Points to Note

- Quality Committee arrangements: The Committee has continued to function and has been streamlined with the Workforce Committee.
- Risk management processes: A Covid risk register has been developed with regular review, local risk registers have continued to operate, however the Trust Risk and Compliance Group was temporarily stood down, this will be reinstated.
- Quality priority refresh: the priorities have been refreshed to reflect the some of the learning through Covid, pre-Covid quality priorities are largely included in the refresh. The priorities will be reviewed at the end of Q4.
- Quality Account timetable: NHSE have amended the timetable in response to Covid.

- Complaints: this remains a concern for the Trust and will be a key part of the stabilisation and reset workstreams.
- CQC engagement meetings and ongoing assurance around: Progression of investigations, open enquiries, incidents of interest to CQC, Personal and Protective Equipment, COVID-19 Service Provisions, Reset Plans, Changes to Governance due to COVID-19.
- Deterioration in CAS alerts and Serious Incident timelines: plans are in place to bring this back into compliance.
- Infection, prevention and control, Board Assurance: The Trust has had an independent review of our internal IPC controls (reported separately to Board), this will form the basis of CQC assessment going forward
- Successful appointment to the Assistant Director of Patient Safety and Assistant Director of Patient Experience.

EQIA – Equality Impact Assessment

All EQIA are a valuable method of internally scrutinising the Trust and everything that the Trust delivers, prior to external scrutiny from anyone including the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.

It is not anticipated that this proposal will have a detrimental impact on any of the protected characteristics.

However, the EQIA is an ongoing process and should be repeated on a regular basis to make sure that the Trust is offering a service that meets legislation, encourages equal access for all and reduces as many negative impacts identified as possible in terms of its overall delivery of high quality care.

Recommendation

The Board are asked to:

- note the content of the report and the systems and processes in place during the emergency response phase of Covid to ensure continues oversight of quality and safety of patient care.
- Note the CQCs approach to regulation during and post Covid emergency response

Introduction

The primary aim of Calderdale and Huddersfield Foundation NHS Trust is to treat and care for people in a safe and compassionate environment and to protect them from avoidable harm. The context of this report supports the principles of the Trust.

The declaration of the COVID-19 pandemic by the UK Government in March 2020, led the Trust to initiate a control and command operational model; this model operated as the Trust centre, providing surveillance, monitoring, coordination, and assurance. This meant that the Trust could support the challenges it faced with COVID-19. Utilising a control and command approach has enabled the Trust to oversee both COVID and non-COVID care and to assure the Board that care is and was properly managed and overseen by the relevant clinicians and managers.

The pandemic has required our organisation, in the same way as all other organisations, to work in different ways. However, throughout the pandemic, our core purpose continues to be keeping our patients safe.

The report has drawn together key measures that have been determined in response.

The report will provide an update on the following quality areas:

- Assurance on how we are managing risks during COVID pandemic
- Quality Priorities
- Quality Account revised timeline
- IPC Board Assurance
- Nosocomial Infection
- CQC oversight
- Complaints
- Serious Incidents

Assurance on how we are managing risks during COVID pandemic

The Board has a structured and comprehensive quality assurance programme, supported by a Quality Committee which provides the scrutiny, monitoring and assurance on all the quality programmes that are in place in the organisation. During the pandemic the Quality Committee continued to meet in conjunction with the Workforce Committee.

At the time of stepping down the Trust's elective and a reduction in non-elective activity, the Trust was aware of the potential impact this could have on non-COVID patient care. The Executive Management team provided a risk assessment of this step down. Risk registers were adjusted to reflect this change. Alongside the adjusted internal risk registers, a COVID risk register was created to support the Board Assurance Framework. The Covid risk register is considered formally at the Incident Management Team (IMT) and reviewed every 2 weeks and new risks or significant change to risk assessed at IMT daily.

The Deputy Chief Executive, supported by the interim Associate Director for Quality and Safety and the senior manager for Risk, have maintained oversight of the risk register. The interim Associate Director for Quality and Safety continued to have responsibility for the High-Level Risk Register with delegated responsibility to the Senior Risk Managers, whilst the Company Secretary still managed the Board Assurance Framework.

Quality Priorities Proposal

In early March 2020, our Governors and staff chose these three priorities, these were agreed as:

- *Safety* – ***Learning lessons to improve patient experience***

  We all want our care to be safe. As a patient you want to feel safe and have a positive experience when you are under the care of the Trust. One of the ways we can try and ensure that what we do is based upon best practice and safety and to learn from, when things go wrong.

- *Effectiveness* – ***Improve staff handovers to ensure they routinely refer to the psychological and emotional needs of patients, as well as their relatives/carers***

  Our mental health influences our physical health. It influences our capability to lead a healthy lifestyle and to manage and recover from physical health conditions, particularly long-term conditions.

- *Experience* – ***Improved resources for distressed relatives/breading bad news relating to End of Life Care (EOLC) – e.g. relatives' rooms relatives camp beds etc***

  Providing compassionate care for our end of life care patients is seen as a high priority for the Trust. When a patient is dying, the care and compassion the relatives receive, is critical to how we wish to work and behave.

In addition to these, initial discussions also identified the below list of areas that would require development into priority schemes of work:

- Nurse staffing levels
- Clinical documentation
- Children's pathways
- Mental Health in the acute setting
- Falls resulting in harm
- Medicines management

The choices above remain relevant given our previous work streams, however, in late March 2020, life as we understand and know, changed with the COVID-19 pandemic.

This has led the Quality Leads to review our next steps in response to the COVID-19 pandemic and in doing so, refresh the local quality priorities as part of the stabilisation and reset agenda.

The reality for any NHS Trust will be to ensure that these quality priorities can be measured and reported, so that we can assure the patients we care for, the Governors and the staff that we are moving forward in the 'new world' of healthcare we now find ourselves in.

Our refreshed quality priorities

- Clinical documentation
- Personal Protective Equipment (PPE)
- Medical Devices
- End of Life Care
- Falls resulting in harm
- Impact of deferred care pathways due to COVID-19 response
- Impact of "new" ways of working

The refreshed quality priorities will be discussed in detail within the next Quality Committee meeting on Monday, 29 June 2020. They will be formally reviewed at the end of Q4.

How we measure and incorporate these into our performance

Whilst considering the quality priorities, members of the Quality Committee will also be asked to inform the measurements of success recognising that improving quality is about making healthcare safe, effective, patient-centred, timely, efficient, and equitable. In the history of the NHS, there has never been such a focus on improving the quality of health services as there is now. The measurements of success will be determined within the Quality Committee.

Quality Account Timeline / Process

A Quality Account is a report about the quality of services offered by an NHS healthcare provider.

The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

On 1 May 2020 NHS England / Improvement issued regulations making revisions to quality account deadlines for 2019/20. The regulations indicate:

While primary legislation continues to require providers of NHS services to prepare a quality account for each financial year, the amended regulations mean there is no fixed deadline by which providers must publish their 2019/20 quality account. NHS England and NHS Improvement recommend for NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by COVID-19.

The regulation also indicates NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20.

In response to this regulation a revised timeline of key dates to note for the Quality Account are set our below. This includes delegating approval from the Board to the Quality Committee for final sign off given the changes to current meetings structures in light of the pandemic:

- **Monday, 3 August 2020** First draft of Quality Account to Quality Committee
- **Friday, 31 July 2020** Draft Quality Account to stakeholders for comments (comments to be incorporated by Friday, 14 August 2020)
- **Thursday, 22 October 2020** Draft Quality Account to the Council of Governors for confirmation of 2020 / 2021 quality account priorities
- **Monday, 2 November 2020** Draft Quality Account to Quality Committee for sign off

Infection Prevention and Control Board Assurance Framework

Introduction

NHS England and NHS Improvement on 4th May 2020 provided NHS Trusts with an infection prevention and control (IPC) board assurance framework. The framework was developed 'to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risk'. The framework is structured based on the existing 10 criteria set out in the Code of Practice on the prevention and control of infection: this links directly with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CHFT commissioned an independent review of IPC assurance through the Board Assurance Framework, commissioning two independent nurse consultants specialising in IPC.

The review included interviews with key members of staff including directors, senior nurses, managers and frontline staff. In addition, observations of practice were carried out on 4 wards to assess the level of adherence to standard operating procedures (SOPs) and policies. The systems and processes were also reviewed by shadowing the Incident Management Group and the Tactical workstream along with reviewing policies, SOPs, risk registers and minutes of meetings.

Findings

A summary of their assessment of assurance for each of the framework statements is provided below in table 1. This information was obtained from interviews, observation of practices and documents such as minutes of meetings, policies and standing operating procedures. The review findings are based on information gathered during an onsite two-day visit. Therefore, there are limitations in that not all information and practice could be observed or obtained across the Trust during the visit. The reviewers have made some recommendations that may strengthen the IPC assurance, particular in view of moving into phase two as well as responding to a second wave of COVID-19.

Framework statement	Summary of assurance
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	The Incident Management Team (IMT) provides a structure with strong leadership to manage and monitor COVID-19 including assessment and management of risk including any changes to national guidance. There are various workstreams that feed into the IMT to ensure risks are managed including PPE and plans for reset of clinical services.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Cleaning staff have been provided with additional training including appropriate use of PPE. There are dedicated teams for the COVID wards. The cleaning protocols and linen management are in line with PHE guidance. Where single use equipment is not available re-usable equipment is decontaminated in line with PHE guidance.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Antimicrobial stewardship continues but currently there is no reporting through the usual Infection Control Performance Board until these meetings resume.
Framework statement	**Summary of assurance**

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Information is provided on the Trust's website and signage throughout the hospital. There are systems and processes in place to identify and communicate infection status of patients within the electronic patient record.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	There are systems and processes in place to identify patients with possible and confirmed COVID-19. This includes risk assessment and testing of patients along with clear pathways to ensure they are treated timely, appropriately and in designated areas to reduce transmission of infection.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	Training has been provided to all staff on COVID-19 including the use on PPE, where appropriate. The understanding of individual responsibility is reinforced through daily visits to clinical areas from the Leadership, IPCT, PPE/Wellbeing Teams and Matron visits.
7. Provide or secure adequate isolation facilities	Isolation capacity is managed daily at the tactical command meeting and supported with a list of patients requiring isolation by the IPC Team. COVID-19 positive patients are cohorted on dedicated wards. Isolation breaches are reported as incidents on Datix.
8. Secure adequate access to laboratory support as appropriate	The laboratory has SOPs in place and is running to full testing capacity. All acute patients' specimens are processed in-house but staff and pre-op specimens are processed out of house.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	Adherence to policies and SOP is managed through regular visits to wards from the Leadership, IPC and the PPE/Wellbeing Teams. In addition, assurance is provided through routine Frontline Ownership (FLO) and hand hygiene audits and reported through Divisional Patient Safety and Quality Boards (PSQB).
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	There has been extensive work to identify staff at risk and needed to be at home, those that could work from home, those to be redeployed or office based with social distancing. Staff are supported via help line and counselling where required for both those at home and those in work. Staff absence and wellbeing is monitored, and staff can access testing and support.

(Table 1)

Overall, the reviewers felt that there are good systems and processes in place that are able to recognise and manage the risks associated with COVID-19 in a co-ordinated way. This coupled with strong leadership across the organisation has helped to address the initial confusion. In particular, the reviewers felt that the Incident Management Team (IMT) provides a central hub for decision-making including any changes to National guidance alongside key messages for dissemination. In addition, the Trust has effective processes for the collection of COVID-19 data which are available in an e-dashboard making important data readily available. There are a number of work streams including a PPE group; a Tactical Command group and a clinical reference group each feeding back through the IMT to ensure that risks and communications are adequately managed.

On the ward visits, good practice was observed with hand hygiene and donning stations in the entrances of the wards, although signage on PPE was not always visible. There are regular visits to each ward from the Leadership team, IPC team, Matrons and the PPE and Wellbeing Team to support both the well-being and correct use of the PPE. Frontline staff reported being well supported, but sometimes felt that there were minor inconsistencies of the advice from the various teams, and on occasions, each group asking the same questions. The frontline staff have appreciated senior staff visiting clinical areas.

Overall, there is evidence to provide the Board with assurance of the systems and processes to manage the risks of COVID-19.

A more detailed report will be presented to the Quality Committee on Monday, 29 June 2020 including next steps.

Nosocomial infections

Nosocomial infections are **infections** that have been caught in a hospital and are potentially caused by organisms that are resistant to antibiotics.

A letter from Amanda Pritchard, Professor Stephen Powis and Ruth May was published Tuesday, 9 June 2020 to help clarify the steps organisations should be taking to minimise nosocomial infections, protect staff and ensure the timely reporting and management of outbreaks and staff absence in the NHS

In response to the letter, work is already underway to develop a Hospital Onset COVID-19 Outbreak plan which, whilst developing new processes of alerting, will integrate with current processes outlined in the IPC Board Assurance Framework.

Care Quality Commission (CQC) Trust Workstreams

CQC-related workstreams were stepped down at the beginning of March due to the predicted COVID-19 pandemic related pressures. Following a statement published by CQC on Tuesday, 17 March 2020 advising of the immediate cessation of routine CQC Inspections, a decision was made by the Deputy Chief Executive that all CQC-related workstreams would be significantly streamlined.

The Trust CQC Compliance Manager, who co-ordinates all Trust CQC preparation and workstreams, was redeployed into another role to help relieve COVID-19 pressures.

CQC-related workstreams are yet to be fully reinstated across the Trust. The CQC Compliance Manager is now back in post after deployment and is picking up key pieces of work to enable

the planning of future CQC projects. These workstreams will need to be aligned with the Trusts timeframes moving into the recovery stage of the pandemic.

The CQC Response Group was reinstated in May 2020 and will continue to have oversight of all developing CQC Workstreams.

2019 / 2020 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust still had five actions to complete. These have been defined as must do (MD) and should do (SD).

Following a lengthy period of review and continuous work within the Divisions, the status of the must do and should do actions has been set out below; the status remains the same as quarter 3.

In brief, the two 'must do' and three 'should do' are not yet embedded in the Trust and have resulted as actions for specific focus for the CQC Response Group. Further, the two 'must do' actions remain incomplete pending further consideration of the quality and financial impact of the CQC actions.

The five remaining actions will continue to be monitored and progressed via a 2020-2021 Action Plan and monthly updates to be presented at the CQC Response Group

The exceptions plan below sets out, in detail, the present position:

Compliance	Quarter 2	Quarter 3	Quarter 4	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	Ongoing liaison with NHSI with regards to next steps on reconfiguration plans. Analysis work in conjunction with NHSI to gain greater understanding of premium costs being incurred through current configuration, demand and mix of services.	The Trust has submitted a five-year financial plan through the Integrated Care System and onward to regulators in line with the defined challenging Financial Improvement Trajectory. This trajectory sees a projected reduction in the deficit position but continues to require external funding support to achieve breakeven.	The Trust has started a Use of Resources Self-Assessment process, focusing on areas set out in the CQC Use of Resources Assessment Criteria. This piece of work is currently delayed due to COVID-19 pressures. **To remain Green**	**Substantial Assurance**

Compliance	Quarter 2	Quarter 3	Quarter 4	Assurance
MD8 – The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	This went to the Weekly Executive Board, yet to go to the Finance and Performance Committee. In terms of implementing, once signed off, this can be switched around with rota. The chair of the CQC Response group requested a view on progress as it is not clear how risk is being mitigated.	Further work is needed to make the proposal more palatable financially. Consideration is been made within the trusts planning cycle for 20/21. There is still no mitigation and therefore the risk remains red.	Work is been undertaken to assess HOOP data to see if there are any themes captured across the wider hospital where staff haven't been able to get an anaesthetist due to the anaesthetists being otherwise engaged in non-anaesthetics duties. A flow chart is in production to describe the escalation process for people to follow to get an anaesthetist. No further progress with this action at present due to COVID-19 pressures. **To remain Red.**	**Limited Assurance**
SD3 - The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	Work progressing on this for CAMHS and ED. As we go forward the strategy needs to ensure how these fits with reconfiguration plans, and to also get patients and public involvement.	Work has progressed with the strategy which is now going for Trust approval and through relevant governance processes.	The Mental Health Operational group is now in place. A Dashboard is currently under development. The Mental Health Strategy is now complete. Mental Health policy is pending approval. Mental Health SRG is now in place. Action to be taken to CQC Response Group once all related work is complete and implemented, with a recommendation that the action is now embedded with full assurance. **To remain Green**	**Substantial Assurance**

Compliance	Quarter 2	Quarter 3	Quarter 4	Assurance
SD6 - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	Vicky Thersby (Safeguarding Lead) has completed a briefing that can be used by on-call managers to test compliance.	Discussed at nursing huddles to strengthen staff knowledge. Plan to test staff knowledge in Q4. To remain Green.	Plans to test staff knowledge delayed initially due to staffing capacity then COVID-19 pressures. To formulate a plan to test with the safeguarding team post COVID-19 Pressures. **To remain Green**.	**Substantial Assurance**
SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	The ED consultant rota currently provides 14 hours/day cover on both sites on five days per week. Since August 2019, in line with the demand profile for the service, a second consultant is on each site from 11am-7.30pm on each site.	Still non-compliant with this standard given our current consultant workforce numbers. We are continuing with attempts to recruit to consultant numbers to deliver this standard.	At this stage we remain non-compliant and are slowly increasing our number to try and ensure compliance. **To remain Red.**	**Limited Assurance**

CQC Update and Engagement Meetings

CHFT are continuing to communicate with CQC via the CQC Relationship Managers. The last official engagement meeting between both parties took place on Thursday, 11 June 2020.

Regular catch-up meetings have been taking place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services relationship managers. These catch-ups are scheduled to continue on a monthly basis with the next full engagement meeting scheduled for September 2020.

A formal request has been made by CHFT that the next full engagement meeting in September is a combined Trust wide meet, led by both the Relationship Managers.

During the engagement sessions with CQC, CHFT have been able to successfully provide assurance in the following areas:

- Progression of investigations of any open enquiries with CQC
- Oversight of potential Serious Incidents of Interest
- PPE Supplies
- COVID-19 Service Provisions
- Reset Plans
- Changes to Governance due to COVID-19

CHFT currently have 11 open enquiries with CQC; six enquires have been closed since April 2020 and four new enquires raised.

CQC Emergency Support Framework (ESF)

At the June 2020 CQC engagement meeting, CHFT were informed that CQC will be rolling out an Emergency Support Framework (ESF) across the hospital directorate. This framework is currently being trialled amongst independent ambulance, and dialysis providers.

initial communication suggests that CQC envisage the ESF will need to be completed for each Core Service, by site. However, we have not yet received any official guidance on this.

The CQC Compliance Manager is in the process of identifying leads across the Trust within each of the Core Services to enable this workstream. A "predicted" framework is being developed to furnish Core Services with key areas of focus; this is to ensure services are aware of the expectations and workload which the official CQC ESF will bring to teams.

CQC Emergency Support Framework - Overview

The Emergency Support Framework underpins CQCs regulatory approach during the coronavirus pandemic. This approach will involve:

- **Using and sharing information to target support where it's needed most.**
  This will be from information that the Trust will share with the CQC and increasing their efforts nationally and locally to encourage feedback from the public and care staff, as well as whistleblowers.

- **Having open and honest conversations**
  The CQC will have open and honest conversations with Trusts, and wider stakeholders such as local authorities, and will use this information so that they can provide support to resolve issues, mitigate and manage risks and work through tough decisions to help them keep people and the system safe.

- **Taking action to keep people safe and to protect people's human rights**
  CQC will use their 'powers' to take action where they find unsafe or poor care.

- **Capturing and sharing what they do and how they do it**,
  This is so that the CQC are transparent about the action they have taken, and to inform how they approach the recovery phase of the pandemic, as well as learning for the future.

The CQC expect services to continue to do everything in their power to keep people safe during these unprecedented times. **The CQC's emergency support framework is not an inspection, and they are not rating performance.** It is expected that the ESF will focus on four key areas and there will be an expectation to self-assess and provide evidence as part of our response to the following Key Lines of Enquiry:

Prompt	Key Line of Enquiry
Safe Care & Treatment	PPE IPC

	Environment for staff / patient / visitors Medicine management Medical devices
Staffing Arrangements	Absences Skill mix Workforce plans
Protection from Abuse	Safeguarding referrals Protection of staff and patients Robust processes in place to raise concerns Safety & wellbeing of staff
Assurance Processes, Monitoring, and Risk Management	How are we monitoring the 'safe' domain? Risk registers Governance processes Escalation Patient records

CHFT CQC Intranet Page

The CHFT CQC Intranet pages are regularly updated to ensure colleagues have access to all information relating to CQC. The pages continued to be updated during the COVID-19 pandemic with links to all publications from CQC.

The updated page can be found at: https://intranet.cht.nhs.uk/non-clinical-information/chft-cqc-homepage/

CQC Insight Report

The most recent CQC Insight Report was published at the end of May 2020 with the previous report been published in February 2020.

A summary of the report can be found below. After a review of both the February and March 2020 reports, there have been no changes to CHFTs outlier status.

A particular area of concern is Central Alert System (CAS) alerts not being closed by the Trust – this has been highlighted to the Company Secretary and a Quality Improvement review has been initiated, to look at the standard operating procedure and governance processes.

Plan for Quarter 1 2020/21

During quarter 1 2020/2021, CQC workstreams will be guided by the Trust's response to the recovery plan and in line with national guidance and CQC expectations.

The anticipated CQC Emergency Support Framework will be a key workstream across the Trust during quarter 1, as well as further workstreams in relation to the COVID-19 pandemic and not the standard regulatory monitoring. CQC are yet to publish any further information as to when routine inspections will be reinstated.

The key objective for 2020-2021 is to ensure self-assessments and peer evaluation of Core Services become business as usual via revised Ward Accreditation scheme and CQC Self-Assessment "Umbrella", but this can only be implemented in line with the Trust's recovery plan.

Complaints

On 27 March 2020, directive was received from NHS England and NHS Improvement to pause the investigation of complaints for 12 weeks due to Covid-19.

The Complaints Team utilised this pause and worked with Divisions to pilot the 'buddy' system proposal. The 'buddy' system is a proposal whereby there are two investigators allocated to a complaint, one clinical and one administrative. The 'buddy' system was in response to survey results received from past and present complaint investigators.

Prior to the pause there were 89 open complaints and 35 breaching complaints, at the first week in June there were 64 open complaints and 1 breaching complaint (which was near finalisation). Without the intervention of the Complaints Team working with divisions the open and breaching complaints figures would have been much higher. This approach also supports releasing clinical time to respond to the fight against the Covid-19 pandemic.

The Complaints Team received a total of 292 formal complaints and concerns from 27 March 2020 to 18 June 2020, 106 of these were Covid-19 related, the top 3 main subjects of concern were communications, access to treatment or drugs and appointments including delays and cancellations.

The PALS Team following advice from the Government have worked from home and provided an email/letter service. The answerphone for the PALS telephone line was changed to notify members of the public that due to the pandemic the PALS Team were providing an email only service, however should they need urgent assistance they could contact the Duty Matron (this is the process out of hours). In addition, staff visited the office at least once per week to pick up any post and answerphone messages and to monitor any increase in calls. Telephone contact from the PALS team to complainants has been maintained using personal mobile phones where using email has not been appropriate.

In building upon the improvement work already underway, and ensuring the learning during the Covid-19, is not lost a new Complaints and Incident Group (referenced earlier) is to be established under the leadership of our Director of Nursing, with membership from services users and board of governors to continue our journey in developing a culture of learning.

Serious Incidents

There have been 40 serious incidents (SIs) declared from April 2019 to 17th June 2020 (Table 2). Of these, the highest categories of incident were diagnostic delays and treatment delays. These categories encompass radiological reporting discrepancies, delay in recognition and/or treatment of sepsis, and lost to follow up for surveillance where the patient has had a cancer diagnosis. Two investigations covering the care of six patients who had extended waits in the Emergency Department for a mental health bed made recommendations to support the Trust to mitigate the risks during this time.

StEIS Category	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Total
Diagnostic incident incl delay (incl failure to act on test results)	1	1			2		1			1				1	7
Treatment delay	3	2						1		1					7
Slips/trips/falls	1		1		2	1	1								6
Maternity/obstetric incident : baby only (incl foetus, neonate, infant)						1	1		1			1			4
Surgical/invasive procedure							1	1	1				1		4
Sub-optimal care of the deteriorating patient	1					1		1							3
Apparent/actual/suspected self-inflicted harm					1									1	2
HCAI/Infection control incident							1							1	2
Abuse/alleged abuse of child patient by third party					1										1
Accident e.g collision/scald (not slip/trip/fall)							1								1
Mother & baby (incl foetus, neonate, infant)				1											1
Maternity/obstetric incident : Mother only			1												1
Medication incident														1	1
Total	6	3	2	1	6	3	6	3	2	2	0	1	1	4	40

(Table 2)

During the pandemic period the Trust has not changed our approach to recording and managing incidents and SIs. Divisional panel processes continue, as do SI panels, of course held virtually. We continue to identify incidents of moderate and above harm for scrutiny through our governance processes and declare SIs via StEIS as usual. Duty of Candour is delivered in accordance with policy.

The Risk Team continues to put in additional support to the investigation process for serious incident investigations, facilitating statements and other evidence to continue to progress investigations. The Senior Risk Manager has written SI reports where necessary to maintain traction and allow operational colleagues to focus on operational pressures.

With the onset of Covid-19 the challenges for the Trust has been to achieve the 60-day deadline. However, with frontline staff being redeployed to frontline services during the pandemic this has had a knock-on effect to the achievement of this deadline. Therefore, for the purpose of this report it is important to note that the Trust is failing to achieve this across serious incident investigations, and this means that as an organisation we are potentially delaying our ability to learn lessons at the earliest possible opportunity.

Mitigation plans are being discussed with the A/D Quality and Safety and this should have some impact on compliance within the next 6 months.

In addition, the Complaints and Incidents workstream, as part of Covid stabilisation and reset programme will allow for a fresh focus on investigation processes utilising the quality improvement methodology as an approach to identify potential solutions to this longstanding risk. This will include enhanced engagement with medical and non-medical clinicians.

We have included a new field in Datix to capture all Covid-19 related incidents. This has supported analysis and learning of key themes and trends emerging from this pandemic and will allow us to be responsive to key issues. A significant focus of the Risk Team in the last two months has been immediate review of these Covid related incidents, with quality checking of contributory factors and prompting of review and implementation of proportionate actions to mitigate risk.

The Risk Team has coordinated management of the Covid Risk Register and risk profiling that has reported through Covid Incident Management Team (IMT). Contribution to the daily Covid IMT and weekly to the Personal and Protective Equipment Group and Equipment Group has enabled development and maintenance of a dynamic risk register process, informed by triangulation of data from incidents and complaints and emerging risks identified through the Covid workstream specialist groups.

There have been no serious incidents declared that have a direct link with Covid.

18. Guardian of Safe Working Hours Report Quarter 1 - Anu Rajgopal

To Approve

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	2nd July 2020
Meeting:	Board of Directors
Title:	Quarter 1 report (1st April 2020- 22nd June 2020) from the Guardian of safe working hours, CHFT
Author:	Anu Rajgopal
Sponsoring Director:	David Birkenhead
Previous Forums:	none

Actions Requested:
To note

Purpose of the Report

To provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors across the Trust and to highlight and detail any areas of concern

Key Points to Note

1. Successful implementation of a pooled junior doctor rota during the pandemic surge
2. An overall decrease in exception reports over Q1

EQIA – Equality Impact Assessment

The medical workforce is ethnically diverse and exception reports submitted by our junior doctors have been split by ethnicity and gender. The analysis shows that the data is representative of the junior doctor population in the Trust.

Recommendation

1. The Board is asked to note and approve the report
2. To support the actions taken in response to queries raised by junior doctors following transition back to pre-pandemic rotas (attached as appendix)
3. To acknowledge the commitment and hard work of our trainees, the medical Human Resources team, medical education and divisional teams who have successfully managed to support changes to the junior doctor rota over the pandemic

Q1 report: (1st April 2020 to 21st June 2020)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

The past few months have seen our junior doctors alongside other healthcare workers across the country demonstrating extraordinary levels of commitment and willingness to go above and beyond usual expectations in response to the COVID-19 pandemic.
At CHFT pooled COVID rotas were created with effect from 13/4/20 to give adequate numbers of all training grade doctors to manage increased acute clinical activity and to facilitate flexible deployment in response to clinical intensity and unpredictable sickness and self-isolation absence.

This quarter included the transition period to and from the temporary COVID rotas. The number of exception reports has fallen significantly during this quarter compared to previous years. Majority are from Medicine and are related to working hours.

During the COVID rota, there were daily meetings /chats (via Microsoft teams) between the junior doctors, medical education, rota coordinators, medical HR and the deputy medical director to ensure effective communication and resolve any rota issues or concerns in a timely manner. As GOSWH I was not made aware of any immediate safety concerns.

A few trainees raised multiple concerns during the transition back to the pre-COVID rota from June 2020. The main themes were annual leave carry-overs, payment for working extra hours on the COVID rota when compared to their peers and adequacy of rest days over the swap-over period. These were addressed collectively within the Trust and a comprehensive list of FAQs and responses was drafted by medical HR and circulated. No trainee suffered a financial loss as a result of this transition to and from the COVID rota.

a) Exception reports and trends

There have been only eight exception reports this quarter which is half of those reported in previous years. Whilst this coincides with the pandemic surge and a temporary amendment to the TCS for junior doctors, the process of exception reporting remained available during this period.
Six of these were submitted over the duration of temporary COVID rotas.
Two were from senior trainees in oncology and related to overtime.
There were a couple of exception reports from an ophthalmology junior doctor submitted due to busy clinics and lack of adequate breaks. For future clinics, the trainee has been requested to escalate any issues in clinic to the consultant in real time and focus on improving their time management skills.
There has been a further exception submitted from a junior doctor in medicine who had to complete mandatory training outside of hours. This seems to be a recent trend and I will request the division to include this time in work schedules and ensure that the trainees are aware of it and notify their supervisors prior to completion outside contractual hours.
No guardian fines have been levied this quarter and no work-schedules were requested.

b) Rota changes in response to COVID-19 at CHFT

There was a joint statement from NHS Employers and BMA on the application of contractual protections during the pandemic which stated that during the current crisis it may not be realistic to maintain all of the 2016 revised TCS contractual limits and that a more pragmatic approach will be necessary. They agreed that when not possible to implement, the working hours restrictions and rest requirements in the TCS will be suspended and that the Working Time Regulations 1998 (WTR) will be the fallback position for the duration of the pandemic.

Move to a pooled COVID rota

The decision to change rotas for doctors in training was made to support trainees in a number of different ways;

- To provide additional cover on night shifts than would ordinarily be available
- To 'pool' doctors in training at FY1/FY2 and CT1/CT2 and ST1/2 to combined rotas in order to facilitate movement from one specialty to another
- To maintain resilience of trainees many of the average hours have reduced overall

A temporary emergency rota was introduced from 13th April 2020 in response to the COVID 19 pandemic. Daily, and initially twice daily, deployment meetings have taken place remotely via Microsoft teams since the pooled rotas were introduced. Feedback regarding the rotas was received from a number of sources including junior doctors, deputy medical director, the director of medical education, clinical directors, medical HR and rota coordinators. The combined rotas that were created had cross divisional support to try and ensure that we continued to deliver a safe service to our patients, whilst maintaining a balanced rota.

While recognising that for some rotas there may be less working hours than the 'normal' rota, this has been deliberate as the intensity of the work is likely to be much greater, in addition to an increase in night duties and frequency of weekend working. No junior doctor suffered a financial detriment as a result of working these rotas.

Transition back to pre-COVID rotas

With declining COVID-19 activity, gradual restoration of non-acute services at CHFT, a requirement of trainees to be redeployed back to their specialities and to enable trainees to take annual leave, a decision was taken to suspend the COVID-19 pooled rotas with effect from the 1st June 2020 and communication to that effect was sent out to the trainees.

c) Issues arising and their resolution

Transition back from COVID to pre COVID rotas

A few trainees raised multiple queries around annual leave, payment for hours worked and the adequacy of rest days following the move back to the pre-COVID rota. These were discussed with trainee representatives and involved the deputy medical director, DME, medical HR, rota coordinators and GOSWH and a response to frequently asked questions was circulated to the junior doctors (appendix).

Extra registrar overnight in medicine: Senior medicine trainees expressed concern that since the advent of the COVID-19 pandemic, patients are presenting with a higher acuity than would historically be seen and therefore a second registrar on a night shift would be beneficial. This may impact on the number of daytime shifts and by default the speciality training but the agreed preference was to continue to keep a second registrar on the night shift. There is an opportunity to develop a new rota from August 2020 and meetings within the medical division are in progress to agree and implement this.

d) Junior doctor forum (JDF)

The April 2020 JDF was cancelled due to the pandemic. There is one scheduled this month and I will report on this in my next quarterly report.

e) Junior doctor awards 2020

Nominations closed last week. We have received over 40 nominations spread across all categories. The awards meeting will be held in July remotely via a Microsoft teams meeting.

Recommendation

At CHFT, the trainees have been significantly involved in the changes to their working pattern over the pandemic and well supported by the Trust. They should be commended for their commitment to patient safety and the willingness to be flexible during these extraordinary times. The long term psychological effects are likely to be not insignificant and the Trust's support of the trainees is highly relevant.

The Trust Board is asked to receive and note the Guardian of Safe Working Hour's report and support actions taken in response to the queries raised by junior doctors following their transition back to pre-COVID rotas.

Anu Rajgopal
Guardian of safe working hours
June 2020

Appendix

Response to main concerns raised 08.0

19. Integrated Performance Report – May 2020 - TO FOLLOW

To Approve

Date of Meeting:	**2nd July 2020**
Meeting:	**BOARD OF DIRECTORS**
Title of report:	**QUALITY & PERFORMANCE REPORT**
Author:	**Peter Keogh, Assistant Director of Performance**
Sponsor:	**Helen Barker, Chief Operating Officer**
Previous Forums:	**Executive Board, Finance & Performance Committee, Quality Committee**

Actions Requested:

- To approve

Purpose of the Report

To provide the Board of Directors with the performance position for the month of May 2020 and changes to IPR content.

Key Points to Note

Trust performance for May 2020 was 72.8%. There was one never event relating to a wrong site surgery in Dermatology with a full investigation due to be completed by 28th July.

A number of indicators are still being affected adversely by the COVID situation including Sickness, Diagnostics 6 week waits, ASIs and 52 week waits.

More positively the Emergency Care 4 hour standard was achieved for the whole of May.

The Trust IPR has already started to change as discussed last month with the introduction of a new appendix showing COVID Metrics.

In addition a number of readmission indicators in the form of SPC charts have been included as an addition to the Effective domain.

Further outcome based indicators are being considered as current metrics are removed from the IPR.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board is asked to:

- Note the current level of performance recognising the impact of COVID19 on several KPIs and the work in progress in relation to developing a more outcome focussed IPR.
- Acknowledge the position on several KPIs where there is an impact as a result of prioritisation based on clinical need

Calderdale and Huddersfield NHS Foundation Trust

Performance Update

May 2020

1. Performance

Trust performance for May 2020 was 72.8%. There was one never event relating to a wrong site surgery in Dermatology with a full investigation due to be completed by 28th July.

A number of indicators are still being affected adversely by the COVID situation including Sickness, Diagnostics 6 week waits, ASIs and 52 week waits.

More positively the Emergency Care 4 hour standard was achieved for the whole of May.

In line with the Trust Board approved recommendation patients will be treated in order of need rather than time waited however it should be recognised for some patients the speed of intervention plays a key role in over outcomes and experience for example cancer pathways and as such there remains a focus on timely access to cancer diagnosis and treatment. This is reflected in the prioritisation of capacity for these patients.

May 2020

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover

2. Indicator Changes

The Trust IPR has already started to change as discussed last month with the introduction of a new appendix showing COVID Metrics across North East and Yorkshire and North West, WYAAT and CHFT following the one page summary included last month. This also includes mortality rates and CHESS (Covid19 Hospitalisation in England Surveillance System) information for CHFT.

The CIP indicator has been removed for the first 4 months of this financial year due to the COVID situation.

3. Patient Outcome based KPIs

The following Readmission indicators in the form of SPC charts have been included as an addition to the Effective domain and will open a debate on our performance in these outcome based areas.

- Acute and unspecified renal failure
- Acute bronchitis
- Acute cerebrovascular disease
- Acute myocardial infarction
- COPD and bronchiectasis
- Fluid and electrolyte disorder
- Fracture of neck of femur
- Pneumonia
- Septicaemia
- Urinary tract infections

Additional COVID indicators are being considered for June's IPR including:

- Screening %
- Retesting after 5 days for patients who are negative
- % staff FIT tested (front-line)
- Infection control

Quality Indicators

Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable. In the history of the NHS, there has never been such a focus on improving the quality of health services as there is now.

Quality improvement draws on a wide variety of methodologies, approaches and tools. However, many of these share some simple underlying principles, including a focus on:

- understanding the problem, with an emphasis upon what the data tells you
- understanding the processes and systems within the organisation – particularly the patient pathway – and whether these can be simplified
- analysing the demand, capacity and flow of the service
- choosing the tools to bring about change, including leadership and clinical engagement, skills development, and staff and patient participation
- evaluating and measuring the impact of a change.

Regardless of the approach used, how the change is implemented – including factors such as leadership, clinical involvement and resources – is vital. Replacement indicators for the Safety Thermometer are still being considered.

In addition the following outcome based indicators will become available over the next couple of months:

- Surgical site infections
- Delayed diagnosis of cancer/grade of tumour
- Mortality rate of non-COVID versus pre-COVID
- Frailty scoring
- NEWS scores

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

May 2020

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

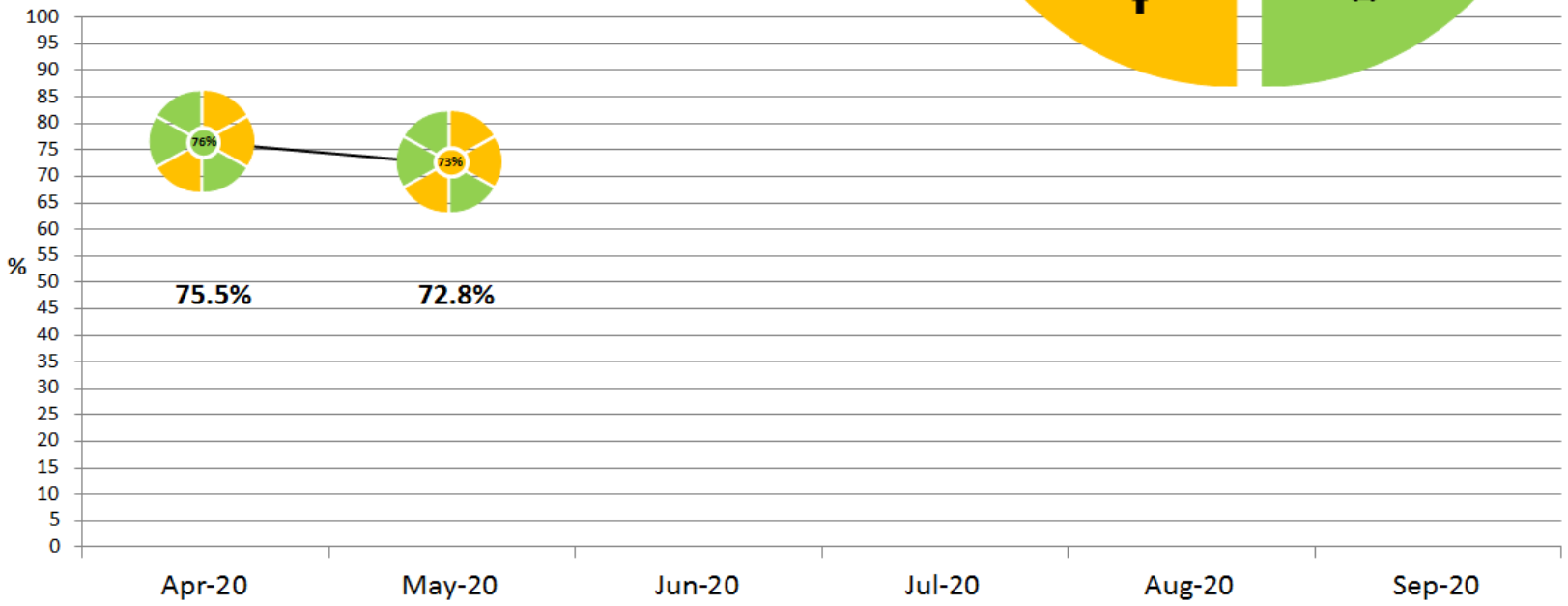
Performance Summary

May 2020

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover



Key Indicators

	19/20	Apr-20	May-20	YTD	Performance Range		
SAFE					Green	Amber	Red
Never Events	1	0	**1**	**1**	0		>=1
CARING					Green	Amber	Red
% Complaints closed within target timeframe	42.00%	94.0%	**82.0%**	**87.0%**	100%	86% - 99%	<=85%
EFFECTIVE					Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	1	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5			**5**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.63			**98.63**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	88.6			**88.6**	<=100	101 - 109	>=111
RESPONSIVE					Green	Amber	Red
Emergency Care Standard 4 hours	87.48%	92.59%	**95.24%**	**92.59%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	51.21%	71.43%	**71.93%**	**71.43%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.59%	98.24%	**99.02%**	**98.71%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	100.00%	**100.00%**	**100.00%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.41%	**97.03%**	**98.52%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	96.88%	**96.00%**	**96.49%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	75.00%	**40.00%**	**64.71%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	93.49%	**90.91%**	**92.56%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	70.59%	**50.00%**	**65.22%**	>=90%		<=89%
WORKFORCE					Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.93%	4.11%		-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.50%	2.61%		-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.43%	1.50%		-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.81%	93.61%	94.11%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	97.63%			-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	84.10%			-	>=95%	>=90%	<90%
FINANCE					Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	9.76	(0.00)	**0.00**	**0.00**			

Safe - Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
Falls / Incidents and Harm Free Care																Green	Amber	Red
All Falls	1,815	160	150	116	126	134	164	165	163	169	154	161	93	**120**	**213**	Refer to SPC charts		
Inpatient Falls with Serious Harm	25	2	1	0	0	1	4	3	6	1	1	4	0	**2**	**2**	Refer to SPC charts		
Falls per 1000 bed days	7.7	8.5	8.0	6.0	5.9	6.9	7.3	8.3	7.7	8.0	7.9	9.4	8.6	**10.1**	**9.3**	Ongoing Monitoring		
Number of Serious Incidents	36	6	3	2	2	7	3	6	3	2	2	0	1	**1**	**2**	Refer to SPC charts		
Number of Incidents with Harm	2,236	209	185	208	196	166	215	176	153	180	166	145	137	**167**	**304**	Refer to SPC charts		
Percentage of Duty of Candour informed within 10 days of Incident	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	100%	**100%**	**100%**	100%	96 - 99%	<=95%
Never Events	1	0	0	0	0	0	0	0	1	0	0	0	0	**1**	**1**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	50.00%	none to report	66.00%	100.00%	100.00%	50.00%	none to report	0.00%	0.00%	none to report	0.00%	none to report	25.00%	**0.00%**	**12.50%**	100%	96% - 99%	<=95%
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	75.00%	78.00%	80.00%	78.00%	84.00%	72.00%	72.00%	70.00%	74.00%	74.00%	72.00%	70.00%	78.00%	**Reported quarterly**	**78.00%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	68.26%	70.00%	78.00%	68.00%	72.00%	76.00%	50.00%	64.29%	61.11%	71.43%	70.00%	68.75%	64.86%	**Reported quarterly**	**64.86%**	>=90%	86% - 89%	<=85%
Maternity																		
Elective C-Section Rate	10.41%	11.20%	9.40%	10.40%	10.90%	9.29%	10.84%	8.29%	11.06%	8.96%	11.85%	11.89%	9.86%	**9.30%**	**9.58%**	<=10% Threshold		
Emergency C-Section Rate	15.77%	15.56%	17.69%	15.60%	15.89%	17.92%	17.59%	15.28%	14.75%	12.83%	14.88%	14.08%	14.25%	**14.93%**	**14.58%**	<=16% Threshold		
Total C-Section Rate	26.17%	26.79%	27.08%	25.96%	26.82%	27.21%	28.43%	23.58%	25.81%	21.79%	26.72%	25.97%	24.11%	**24.23%**	**24.17%**	<=27% Threshold		
% PPH ≥ 1500ml - all deliveries	3.06%	3.10%	5.10%	2.30%	3.40%	3.98%	3.13%	2.33%	1.61%	3.15%	2.75%	3.16%	3.01%	**2.54%**	**2.78%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	92.13%	93.32%	91.53%	91.22%	93.71%	91.46%	93.71%	93.32%	91.55%	90.02%	91.79%	92.50%	92.93%	**93.02%**	**92.97%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	12.35%	13.50%	12.10%	14.20%	12.20%	11.30%	11.60%	14.50%	12.67%	9.69%	11.57%	13.11%	14.50%	**11.50%**	**13.06%**	<=12.9%		>=13%
Pressure Ulcers																		
Number of Trust Pressure Ulcers Acquired at CHFT	98	25	33	33	20	23	26	29	23	26	25	21	46	**under validation**	**46**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	1.38	1.33	1.76	1.71	0.93	1.18	1.15	1.46	1.09	1.23	1.28	1.22	4.26	**under validation**	**4.26**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	291	22	28	31	16	22	26	26	20	23	23	20	23	**under validation**	**23**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	33	3	5	2	4	1	0	3	3	3	1	1	0	**under validation**	**0**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	0	0	0	0	0	1	0	0	**under validation**	**0**	0		>=1
Number of Deep Tissue Injuries	38	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	15	**under validation**	**15**	0		>=2
Number of Unstageable Pressure Ulcers	38	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	8	**under validation**	**8**	0		>=3
Number of patients with a Pressure ulcer	282	24	29	31	18	19	22	29	23	24	24	17	45	**under validation**	**45**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	92.07%	96.88%	100.00%	100.00%	100.00%	100.00%	100.00%	97.22%	100.00%	86.40%	80.00%	26.30%	40.00%	**44.40%**	**42.10%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.04%	96.43%	95.90%	95.88%	95.87%	95.72%	95.98%	96.60%	96.38%	95.97%	96.06%	95.46%	95.56%	**96.05%**	**95.82%**	>=95%	86% - 89%	<=85%
Safeguarding																		
Health & Safety Incidents	220	23	19	23	27	20	18	19	14	19	14	17	4	**28**	**32**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	4	0	0	1	1	0	0	1	0	1	0	0	2	**2**	**4**	0		>=1
Medical Reconciliation within 24 hours (excluding Children)	36.70%	36.40%	37.00%	38.90%	36.40%	36.80%	37.10%	37.60%	38.10%	38.80%	39.00%	39.60%	73.30%	**64.40%**	**73.30%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	96.58%	97.05%	97.51%	97.78%	97.02%	97.36%	96.43%	96.99%	96.63%	95.15%	93.74%	93.58%	88.73%	**in arrears**	**88.73%**	>=95%	91% - 94%	<=90%

Caring - Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
Complaints																Green	Amber	Red
% Complaints closed within target timeframe	42.0%	38.0%	58.0%	37.0%	22.0%	47.0%	40.0%	41.0%	50.0%	51.0%	47.0%	64.0%	94.0%	**82.0%**	**87.0%**	100%	86% - 99%	<=85%
Total Complaints received in the month	494	47	40	48	42	49	53	40	32	43	31	27	10	**14**	**24**	no target		
Complaints re-opened	68	4	5	7	7	3	7	6	5	8	5	3	1	**2**	**3**	no target		
Inpatient Complaints per 1000 bed days	2.12	2.51	2.18	2.54	2	2.46	2.39	2.01	1.61	2.13	1.64	1.57	0.93	**1.17**	**1.05**	no target		
No of Complaints closed within Timeframe	222	22	18	15	10	24	29	20	24	19	18	13	15	**18**	**33**	Refer to SPC charts in Appendix		
Total Complaints Closed	545	58	34	45	45	51	73	55	53	36	40	21	16	**22**	**38**	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % would recommend the Service	96.88%	97.56%	96.91%	97.40%	96.40%	97.31%	97.63%	96.78%	97.06%	95.79%	96.44%	COVID	COVID	**COVID**	**COVID**	>=96.7%	93.8% - 96.6%	<=93.7%
Friends and Family Test Outpatients Survey - % would recommend the Service	91.98%	90.36%	91.81%	92.11%	92.31%	91.92%	91.70%	92.80%	92.68%	92.68%	92.08%	COVID	COVID	**COVID**	**COVID**	>=96.2%	93.4% - 96.1%	<=93.3%
Friends and Family Test A & E Survey - % would recommend the Service	84.54%	84.79%	85.60%	82.29%	86.82%	80.28%	85.86%	81.84%	85.78%	86.49%	86.25%	COVID	COVID	**COVID**	**COVID**	>=87.2%	82.8% - 87.1%	<=82.7%
Friends & Family Test (Maternity) - % would recommend the Service	99.20%	99.19%	99.43%	99.53%	98.61%	98.66%	99.60%	98.70%	98.73%	99.30%	99.50%	COVID	COVID	**COVID**	**COVID**	>=97.3%	94.3% - 97.2%	<=94.2%
Friends and Family Test Community Survey - % would recommend the Service	96.32%	95.48%	97.96%	98.15%	98.21%	97.07%	96.20%	94.66%	96.70%	97.46%	93.91%	COVID	COVID	**COVID**	**COVID**	>=96.7%	94.4% - 96.6%	<=94.3%
Caring																		
Number of Mixed Sex Accommodation Breaches	3	0	3	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	46.23%	57.29%	57.91%	48.45%	45.69%	45.83%	46.50%	35.45%	39.50%	40.72%	42.89%	40.74%	35.28%	**40.15%**	**37.66%**	>=90%	88% - 89%	<=87%

Effectiveness - Key measures

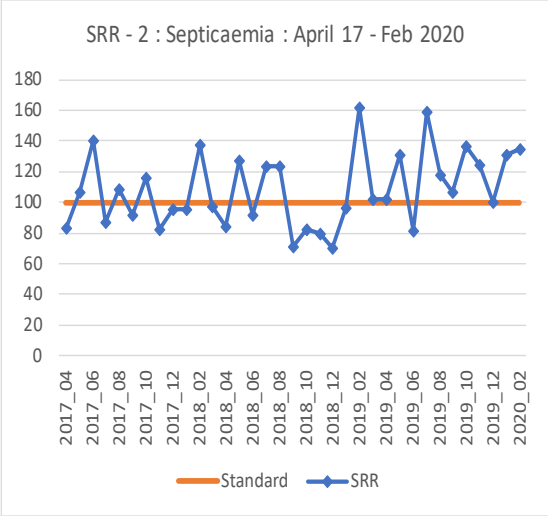
	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
																Green	Amber	Red
Infection Control																		
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	26	3	1	4	1	2	1	2	0	2	3	5	1	**2**	**3**	No target		
Preventable number of Clostridium Difficile Cases	5	0	0	3	1	0	0	0	0	1	0	0	Awaiting Figure	**Awaiting Figure**	**Awaiting Figure**	<=4 & YTD <=40		
Number of MSSA Bacteraemias - Post 48 Hours	19	2	3	1	2	1	1	2	2	4	1	0	0	**2**	**2**	No target		
Number of E.coli - Post 48 Hours	29	3	4	1	4	4	2	0	1	3	1	5	2	**5**	**7**	No target		
MRSA Elective Screening – Percentage of Inpatients Matched	96.22%	95.60%	96.88%	94.90%	96.20%	96.00%	95.00%	96.70%	94.20%	95.20%	94.90%	95.80%	87.00%	**69.00%**	**87.00%**	>=95%	94% - 93%	<=92%
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.16%	0.25%	0.00%	0.67%	0.00%	**0.00%**	0.24%	0.00%	0.45%	0.00%	0.00%	0.24%	0.27%	**0.00%**	**0.14%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.10%	0.00%	0.30%	0.20%	0.00%	0.00%	0.24%	0.00%	0.00%	0.24%	0.27%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.63	99.43	100.49	99.88	98.63	Due Jun 20									**98.63**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	88.6	87.56	86.84	88.62	88.62	88.6	Due Jun 20								**88.6**	<=100	101 - 109	>=111
Crude Mortality Rate	1.25%	1.10%	1.02%	1.17%	1.15%	0.96%	1.22%	1.27%	1.73%	1.21%	1.14%	1.62%	4.66%	**2.30%**	**3.41%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	8.11%	8.59%	8.41%	7.87%	8.08%	7.90%	8.10%	8.09%	7.39%	8.22%	8.05%	7.10%	5.32%	**7.95%**	**6.71%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.52	5.48	5.41	5.63	5.59	5.08	5.41	5.10	5.58	5.55	5.65	6.38	6.99	**6.64**	**6.81**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.06	6.01	6.01	6.00	5.97	5.69	6.05	5.91	6.11	6.03	6.24	6.64	7.85	**7.89**	**7.87**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	83.33%	81.30%	79.50%	81.20%	78.10%	88.00%	86.30%	87.70%	82.10%	82.30%	83.50%	82.90%	83.34%	**83.10%**	**83.22%**	>=80%	76% - 79%	<=75%
Best Practice Guidance																		
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	75.96%	81.25%	54.55%	73.47%	80.85%	75.86%	77.55%	91.89%	72.41%	77.36%	67.57%	77.08%	56.10%	**58.62%**	**57.14%**	>=85%	84% - 83%	<=82%
IPMR - Breastfeeding Initiated rates	76.39%	78.50%	76.10%	76.60%	76.50%	76.30%	77.80%	76.20%	74.30%	75.50%	78.00%	76.40%	78.57%	**77.70%**	**78.16%**	>=70%	66% - 69%	<=65%
Readmissions																		
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Trust (excluding ambulatory)	8.80%	8.43%	8.01%	8.24%	9.00%	7.60%	9.09%	8.66%	9.56%	8.82%	8.81%	10.41%	16.58%	**11.98%**	**14.28%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG (excluding ambulatory)	9.70%	9.24%	8.92%	8.95%	9.57%	8.79%	9.83%	9.42%	10.93%	9.15%	10.16%	11.85%	16.22%	**11.97%**	**14.50%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG (excluding ambulatory)	9.62%	9.36%	9.16%	9.50%	9.95%	7.82%	9.94%	9.45%	10.15%	10.26%	9.19%	10.39%	17.41%	**13.18%**	**15.29%**	<=7.96% as per Model Hospital		>=8.99%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	5.78%	1.60%	3.00%	1.60%	3.70%	5.60%	10.00%	9.70%	7.00%	6.80%	5.10%	8.10%	17.50%	**7.70%**	**12.60%**	No target		
Hospital admissions avoided by Community Nursing Services	2,995	196	160	244	210	252	291	315	283	320	259	277	350	**267**	**617**	>=186		

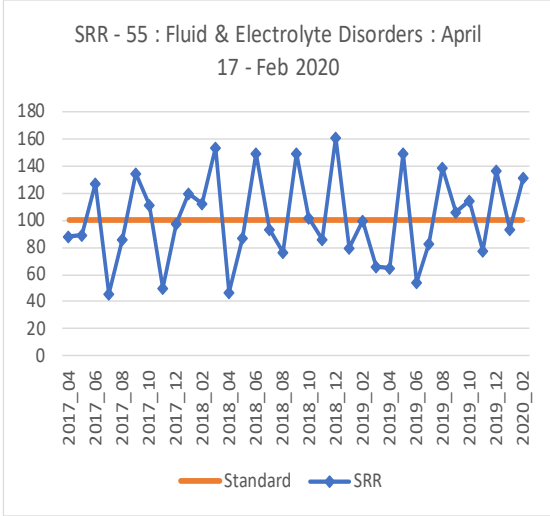
Outcome Indicators

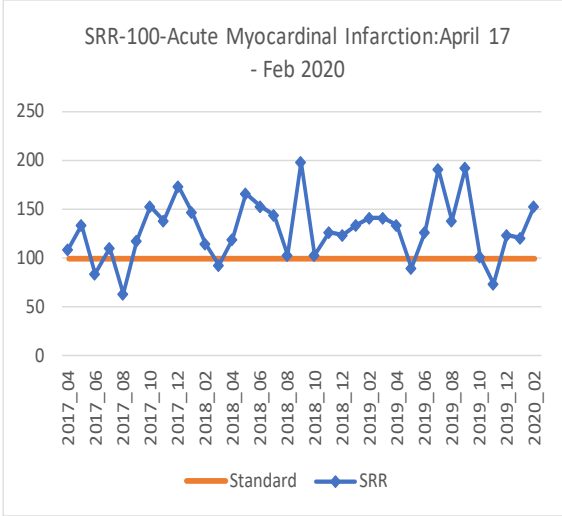
Approach taken - worked with our Benchmarking software providers Healthcare Evaluation Data (HED) to understand if they provided facility to monitor these areas as per Insight Report
Insight Report focuses on 10 Clinical Classification System (CCS) Diagnosis Groups - there are in total over 250, need to consider deep dive into all that are areas of potential concern.
HED advised that they do provide a facility within the Clinical Quality Module of their tool but it uses a marginally different methodology. The table below is used to illustrate how close the HED assessment is when balancing to the figures provided in the Insight report.
The latest 12 month figure from HED (March 19 to Feb 20) is also provided as is a graph for all 10 areas showing the trend over time going back to April 2017
In addition the number of additional readmissions than expected is provided as an attempt to illustrate the scale of any issue
All figures quoted in table are the relative risk score unless stated. A value greater than 100 means that the patient group being studied has a higher readmission level than NHS average performance

Insight Report Emergency Readmissions

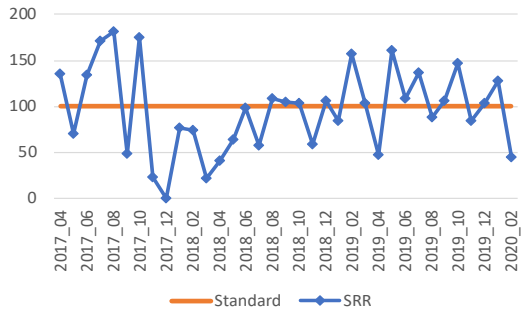
	Oct 17 - Sep 18		Oct 18 - Sep 19		Mar 19 - Feb 20			
CCS No & Diagnostic Group	Insight	HED	Insight	HED	HED	95% Confidence Interval	No of Discharges	No of Additional Readmissions
2 - Septicemia (except in labor)	101.5	102.2	112.7	107.2	121	(101.00, 143.90)	473	22.2
55 - Fluid and electrolyte disorders	110	105.8	106.9	97.1	100.2	(83.90, 118.80)	503	0.3
100 - Acute myocardial infarction	137.8	139.2	134.8	138.1	129.6	(107.70, 154.60)	631	28.1
109 - Acute cerebrovascular disease	114.4	72.4	131.1	105	107.4	(85.30, 133.50)	573	5.6
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	117.6	105.8	114	107.7	102.3	(93.70, 111.40)	2260	11.5
125 - Acute bronchitis	113.1	98.6	112.2	99	93.6	(83.20, 105.00)	1748	-19.9
127 - Chronic obstructive pulmonary disease and bronchiectasis	117.9	119.7	106.9	111.8	111.7	(100.30, 124.00)	1179	36.7
157 - Acute and unspecified renal failure	122.5	121.9	108.3	108	114.8	(96.40, 135.70)	479	17.7
159 - Urinary tract infections	117.9	109.2	120.8	111.9	112.5	(102.20, 123.50)	1822	48.9
226 - Fracture of neck of femur (hip)	94	87.2	79.7	84.3	89.3	(68.10, 114.90)	432	-7.2



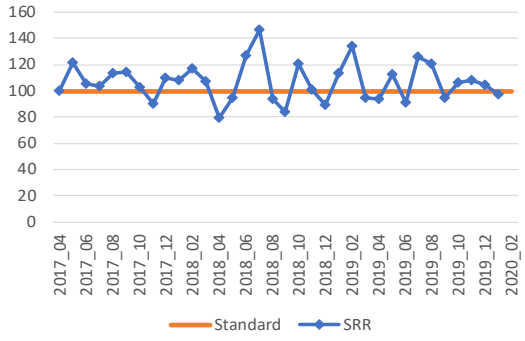




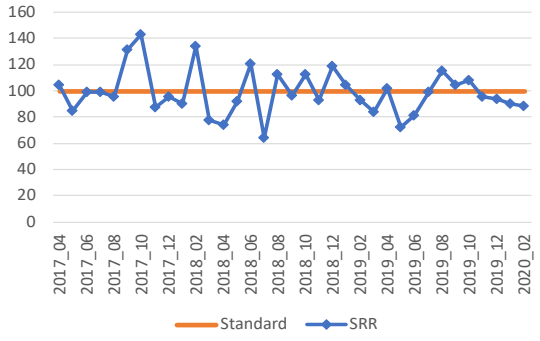
SRR - 109 Acute Cerebrovascular disease: Apr 17-Feb 20



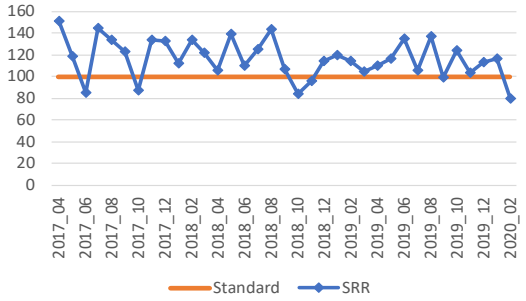
SRR-122 Pneumonia: Apr 17-Feb20



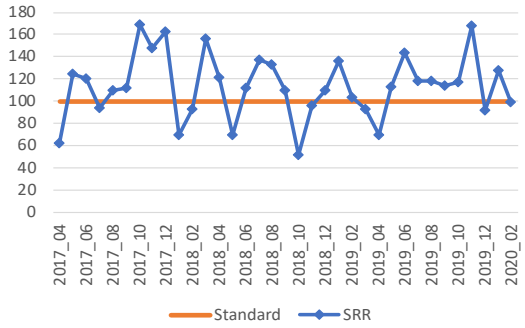
SRR - 125 Acute Bronchitis : April 17 - Feb 2020



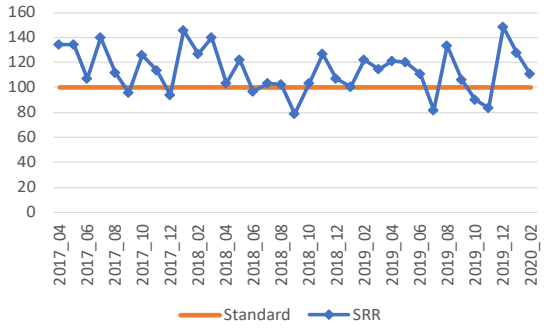
SRR - 127 : Chronic obstructive pulmonary disease and bronchiectasis : April 17 - Feb 2020



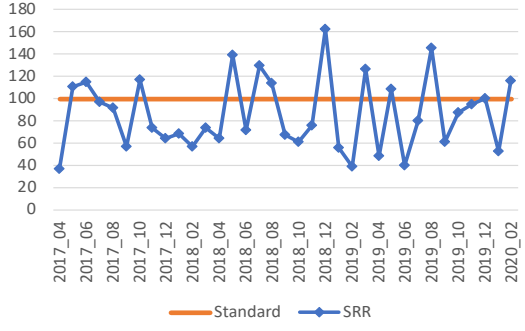
SRR 157 - Acute and unspecified ren : April 17 - Feb 2020



SRR 159 - Urinary tract infections : April 17 - Feb 2020



SRR - 226 - Fracture of neck of femur (hip): April 17 - Feb 2020



Responsive - Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	87.48%	92.30%	89.32%	91.44%	91.37%	86.82%	84.19%	82.68%	81.97%	85.88%	85.55%	87.96%	92.59%	**95.24%**	**92.59%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	89.08%	93.33%	90.68%	92.44%	92.48%	88.44%	86.23%	85.06%	84.42%	87.70%	87.41%	89.26%	93.12%	**95.52%**	**93.12%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	9,469	743	786	837	817	821	859	840	941	802	632	641	255	**254**	**509**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	369	10	25	41	31	20	35	48	41	32	40	14	3	**0**	**3**	0		>=1
A&E Ambulance 60+ mins	20	2	1	0	0	3	4	0	2	1	5	0	0	**0**	**0**	0		>=1
A&E Trolley Waits (From decision to admission)	9	0	0	0	0	0	0	9	0	0	0	0	0	**0**	**0**	0		>=1
Patient Flow																		
Delayed Transfers of Care	3.30%	2.26%	2.94%	2.66%	3.27%	3.63%	4.06%	3.17%	3.93%	3.33%	3.65%	3.94%	0.15%	**0.21%**	**0.18%**	<=3.5%	3.6% - 4.9%	>=5%
Coronary Care Delayed Discharges	591		48	45	39	61	43	54	53	57	51	33	not available	**not available**	**not available**	No target		
Green Cross Patients (Snapshot at month end)	25	89	80	78	92	105	88	90	90	104	106	25	17	**48**	**48**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours			82.03%				77.52%	82.09%	79.53%	76.96%	not available Nationally	not available Nationally	not available Nationally	**not available Nationally**	**not available Nationally**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	73.62%	77.19%	85.37%	77.19%	80.60%	77.50%	58.93%	67.24%	63.50%	83.02%	79.49%	86.76%	92.86%	**91.23%**	**92.86%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	51.21%	50.88%	63.41%	55.36%	58.21%	62.50%	41.82%	47.37%	40.40%	49.06%	58.97%	55.88%	71.43%	**71.93%**	**71.43%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	77.78%	57.14%	66.67%	100.00%	60.00%	80.00%	81.82%	63.64%	85.70%	100.00%	25.00%	75.00%	62.50%	**53.85%**	**62.50%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	53.99%	52.63%	53.66%	55.17%	52.24%	59.52%	55.17%	50.79%	53.80%	50.94%	48.72%	45.71%	48.84%	**50.88%**	**48.84%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.92%	1.16%	0.97%	0.87%	0.67%	0.76%	1.31%	1.07%	0.92%	1.06%	0.79%	0.81%	0.32%	**0.30%**	**0.31%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	0	0	0	0	0	0	0	0	0	0	0	0	17	**0**	**17**	0		>=2
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=2
18 week Pathways (RTT)																		
18 weeks Pathways >=26 weeks open	1,396	773	714	764	994	1,447	1,489	1,472	1,680	1,730	1,305	1,396	2,306	**3,542**	**3,542**	0		>=1
RTT Waits over 52 weeks Threshold > zero	5	0	0	0	4	0	0	3	8	7	6	5	28	**76**	**76**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	95.04%	84.81%	83.43%	90.45%	88.80%	91.18%	97.11%	98.80%	98.32%	98.62%	99.70%	95.04%	40.24%	**34.60%**	**34.60%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.59%	96.92%	98.00%	98.75%	98.24%	99.09%	99.15%	99.40%	99.20%	99.07%	99.59%	99.20%	98.24%	**99.02%**	**98.71%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	94.01%	93.56%	97.87%	100.00%	99.27%	96.77%	97.92%	98.38%	99.41%	98.66%	99.24%	100.00%	**100.00%**	**100.00%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.40%	100.00%	99.40%	100.00%	100.00%	98.51%	100.00%	100.00%	99.45%	100.00%	99.30%	99.41%	**97.03%**	**98.52%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	100.00%	100.00%	100.00%	100.00%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%	96.88%	**96.00%**	**96.49%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	31.58%	55.56%	84.21%	41.67%	40.91%	59.09%	57.14%	54.17%	57.69%	63.16%	61.11%	75.00%	**40.00%**	**64.71%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	91.72%	89.02%	89.69%	94.06%	91.76%	87.56%	91.85%	91.49%	87.08%	96.15%	91.44%	93.49%	**90.91%**	**92.56%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	96.30%	100.00%	100.00%	86.67%	88.89%	77.50%	100.00%	92.86%	95.45%	80.00%	90.48%	70.59%	**50.00%**	**65.22%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	29.0	2.5	0.5	3.0	2.5	0.5	4.5	3.5	3.5	3.5	1.5	2.5	0.0	**2.0**	**2.0**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	7	4	4	6	4	6	7	7	8	7	5	7	4	**10**	**14**	0		>=1
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	79.19%	79.22%	82.45%	78.66%	82.34%	79.72%	71.34%	71.98%	71.54%	79.41%	79.81%	71.15%	**89.69%**	**79.79%**	>=70%		<=74%
Elective Access																		
Appointment Slot Issues on Choose & Book	28.15%	28.65%	36.37%	35.40%	25.95%	25.18%	22.97%	31.20%	23.50%	18.26%	25.39%	20.40%	in arrears	**in arrears**	**in arrears**	<=20%		>=21%
Total Holding List	10,663	5,232	4,733	6,539	8,594	9,282	8,887	8,291	9,600	8,406	8,661	10,663	14,562	**17,946**	**17,946**	No target		
Holding List > 12 Weeks	1,832	621	852	803	1,142	1,115	1,326	1,244	1,501	1,090	1,513	1,832	3,081	**4,314**	**4,314**	0		>=1

Workforce - Key Metrics

	18/19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Target	Threshold/Monthly
Staff in Post																	
Staff in Post Headcount		5569	5565	5604	5625	5690	5712	5717	5694	5733	5733	5721	5858	5869	-	-	
Staff in Post (FTE)		4896.63	4897.19	4922.66	4956.12	4988.09	5010.90	5037.98	5015.81	5050.59	5044.89	5049.46	5168.35	5173.65	-	-	
Vacancies																	
Establishment (Position FTE)**		5194.76	5191.43	5216.26	5218.93	5221.81	5228.41	5248.77	5249.17	5248.92	5250.42	5219.02	5314.42	5312.37	-	-	
Vacancies (FTE)**		298.13	294.24	293.60	262.81	233.72	217.51	210.79	233.36	198.33	200.96	50.67	146.07	138.72	-	-	
Vacancy Rate (%)**		5.74%	5.70%	5.60%	5.00%	4.48%	4.16%	4.00%	4.45%	3.80%	3.90%	3.25%	2.75%	2.61%	-	-	
Staff Movements																	
Turnover rate (%) - in month		0.52%	0.63%	0.69%	0.56%	0.50%	0.54%	0.42%	0.59%	0.60%	0.41%	0.73%	0.48%	0.57%	-	-	
Executive Turnover (%)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	
Turnover rate (%) - Rolling 12m		8.69%	8.37%	8.26%	8.09%	7.97%	7.87%	7.55%	7.43%	7.36%	7.35%	7.26%	7.09%	7.20%	-	**11.50%**	<=11.5% Green <=12.5 >11.5% >12.5% Red
Retention/Stability Rate (%) - rolling 12m		90.13%	90.22%	90.54%	90.16%	89.79%	89.91%	90.29%	90.11%	89.63%	89.55%	89.49%	90.38%	90.29%	-	-	
Sickness Absence - Rolling 12 month																	
Sickness Absence rate (%) - rolling		3.64%	3.61%	3.61%	3.63%	3.66%	3.71%	3.74%	3.84%	3.86%	3.86%	3.93%	4.11%	*	-	**4.00%**	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
Long Term Sickness Absence rate (%) - rolling		2.36%	2.33%	2.33%	2.35%	2.39%	2.41%	2.42%	2.47%	2.48%	2.49%	2.50%	2.61%	*	-	**2.50%**	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
Short Term Sickness Absence rate (%) - rolling		1.28%	1.28%	1.28%	1.28%	1.27%	1.30%	1.33%	1.37%	1.37%	1.37%	1.43%	1.50%	*	-	**1.50%**	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
Attendance rate (%) - rolling		96.36%	96.39%	96.39%	96.37%	96.34%	96.29%	96.26%	96.16%	96.14%	96.14%	96.07%	95.89%	*		**96.00%**	
Sickness Absence - Monthly																	
Sickness Absence rate (%) - in month		3.20%	3.26%	3.45%	3.72%	3.86%	3.95%	4.07%	4.34%	4.25%	3.89%	4.63%	5.47%	*	-	-	
Long Term Sickness Absence rate (%) - in month		2.19%	2.11%	2.34%	2.59%	2.75%	2.54%	2.51%	2.69%	2.58%	2.52%	2.72%	3.35%	*	-	-	
Short Term Sickness Absence rate (%) - in month		1.01%	1.15%	1.11%	1.13%	1.11%	1.41%	1.56%	1.65%	1.67%	1.37%	1.91%	2.12%	*	-	-	
Attendance rate (%) - in-month		96.80%	96.74%	96.55%	96.28%	96.14%	96.05%	95.93%	95.66%	95.75%	96.11%	95.37%	94.53%	*		**96.00%**	
Attendance Management																	
Sickness Absence FTE Days Lost		4922.80	4918.38	5304.90	5818.70	5935.10	6245.80	6233.03	6728.98	6628.90	5687.70	7238.10	8363.71	*	-	-	
Average days lost (FTE) per FTE		13.29	13.18	13.18	13.25	13.37	13.54	13.66	14.02	14.09	14.09	14.34	14.80	*	-	-	
Sickness Absence Estimated Cost (£)		£0.41M	£0.41M	£0.47M	£0.51M	£0.52M	£0.57M	£0.57M	£0.62M	£0.60M	£0.52M	£0.67M	£0.79M	*	-	-	
Return to work Interviews (%)		68.69%	76.74%	73.14%	74.48%	72.36%	85.22%	78.11%	76.43%	71.27%	69.43%	58.15%	51.54%	*	-	**90.00%**	90% Green 65%-89% Amber <65% Red
Spend																	
Substantive Spend (£)		£19.40M	£19.47M	£19.37M	£19.35M	£19.50M	£19.69M	£19.76M	£19.64M	£20.05M	£19.95M	£20.15M	£21.07M	£20.89M	-	-	
Bank Spend (£)		£1.27M	£1.36M	£1.30M	£1.35M	£1.44M	£1.34M	£1.46M	£1.55M	£1.40M	£1.71M	£1.93M	£1.68M	£1.52M	-	-	
Agency Spend (£)		£0.75M	£0.80M	£0.73M	£0.73M	£0.54M	£0.62M	£0.58M	£0.38M	£0.45M	£0.46M	£0.47M	£0.37M	£0.21M	-	-	
Proportion of Temporary (Agency) Staff		3.52%	3.68%	3.42%	3.42%	2.50%	2.85%	2.67%	1.74%	2.06%	2.08%	2.07%	1.59%	0.94%	-	-	
Essential Safety (12m rolling)																	
Overall Essential Safety Compliance		93.40%	93.36%	94.68%	94.58%	95.22%	95.30%	95.32%	95.13%	94.79%	94.88%	94.81%	93.61%	94.11%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)		92.90%	93.55%	95.11%	94.52%	95.68%	96.17%	96.55%	96.39%	95.96%	96.26%	96.27%	94.73%	95.94%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)		90.30%	89.02%	91.80%	92.02%	93.25%	92.24%	92.51%	92.95%	93.94%	94.14%	94.32%	92.73%	90.76%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Dementia Awareness (No Renewal)		98.97%	99.05%	99.05%	99.19%	99.38%	99.35%	99.31%	99.14%	99.13%	99.39%	99.34%	97.49%	97.73%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)		95.27%	95.89%	96.82%	96.21%	96.99%	97.60%	97.94%	97.68%	97.10%	97.26%	97.54%	96.07%	96.93%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)		93.77%	93.30%	94.37%	95.51%	95.77%	95.21%	95.03%	94.60%	94.31%	94.77%	93.42%	90.40%	90.27%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)		96.68%	97.32%	98.13%	97.54%	98.56%	98.64%	98.46%	98.34%	98.21%	97.95%	97.98%	96.28%	96.96%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)		87.31%	89.17%	92.27%	94.22%	94.63%	94.19%	93.97%	93.51%	94.04%	93.99%	94.86%	92.89%	92.84%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)		92.59%	92.05%	93.45%	92.98%	93.10%	93.87%	93.70%	93.01%	90.90%	89.77%	89.81%	89.30%	91.57%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)		90.94%	88.93%	91.15%	89.45%	89.98%	90.29%	89.97%	90.32%	89.62%	89.96%	89.55%	91.03%	91.62%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Appraisal																	
Appraisal (1 Year Refresher) - Non-Medical Staff		50.88%	96.43%	97.63%	96.97%	96.11%	95.21%	94.65%	93.65%	92.75%	91.62%	90.12%	6.20%	20.85%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)		86.89%	85.28%	86.21%	85.27%	86.71%	83.81%	88.42%	83.23%	82.21%	78.61%	84.10%	80.76%	76.37%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red

*	Data one month behind
**	Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment information stored in the Trust's financial systems.
-	Sickness absence data does not include self / household / shielding isolation due to COVID-19.
-	Data is based on substantive ESR primary assignment information which may not be refelctive of temporary COVID-19 redeployments
-	Staff in Post data, and therefore vacancy data, includes year 2 and 3 student nurses, recruited on a temporary basis to support the Trust during the COVID-19 crisis.
-	Due to the postponement of the Appraisal season, the montly Metric is lower than would normall be expected

Workforce Key Metrics

Workforce - Key Metrics

* The recruitment data has been realigned to take into account the National Streamlining agenda and targets set locally. Data shows agenda for change (AFC) recruitment and Medical and Dental (M&D) only and excludes recruitment activity relating to deanery doctors, retirement, volunteers and rolling adverts.

WORKFORCE	Current Month Score	Previous Month	Trend	Change	NHSi Submitted Position
Staff In Post (Headcount)	**5869**	5858	↑	11	-
Staff In Post (FTE)	**5173.7**	5168.3	↑	5.30	-
Establishment (FTE)	**5312.4**	5314.4	↓	-2.05	-
Starters	**30.08**	30.73	↓	-0.65	-
Leavers	**28.19**	20.89	↓	7.30	-
Vacancies (FTE)	**138.72**	146.07	↑	-7.35	-
Vacancies (%)	**2.61%**	2.75%	↑	-0.14%	-
Turnover Rate (rolling 12 month) (%)	**7.20%**	7.09%	↓	0.11%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Sickness Absence Rate (rolling) (%)	**4.11%**	3.93%	↓	0.18%	4.0%
Long Term Sickness Absence Rate (rolling) (%)	**2.61%**	2.50%	↓	0.11%	2.5%
Short Term Sickness Absence Rate (rolling) (%)	**1.50%**	1.43%	↓	0.07%	1.5%
Sickness Absence Rate (month) (%)	**5.47%**	4.63%	↓	0.84%	4.0%
Long Term Sickness Absence Rate (month) (%)	**3.35%**	2.72%	↓	0.63%	2.5%
Short Term Sickness Absence Rate (month) (%)	**2.12%**	1.91%	↓	0.21%	1.5%
Return to work interviews completed (%)	**51.5%**	58.2%	↓	-6.61%	90.0%

APPRAISAL	Current Month Score	Previous Month	Trend	Change	Target
Appraisal (YTD)	**20.85%**	6.20%	↑	14.65%	-
Medical Appraisal (YTD)	**76.37%**	80.76%	↓	-4.39%	-

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	**90.76%**	92.73%	↓	-1.97%	90.00%
Infection Control (1 Year Refresher)	**92.84%**	92.89%	↓	-0.05%	90.00%
Fire Safety (1 Year Refresher)	**90.27%**	90.40%	↓	-0.13%	90.00%
Manual Handling (2 Year Refresher)	**91.57%**	89.30%	↑	2.27%	90.00%
Safeguarding (3 Year Refresher)	**91.62%**	91.03%	↑	0.59%	90.00%
Conflict Resolution (3 Year Refresher)	**95.94%**	94.73%	↑	1.21%	90.00%
Equality & Diversity (3 Year Refresher)	**96.93%**	96.07%	↑	0.86%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	**96.96%**	96.28%	↑	0.68%	90.00%
Dementia Awareness (No Renewal)	**97.73%**	97.49%	↑	0.24%	90.00%

Key

↔	No movement from previous month	*	Internal target rather than NHSi Submitted Position
↑	Improvement from previous month		Not achieving target
↓	Deterioration from previous month		Achieving target

RECRUITMENT	Current Month Avg Days	Previous Month	Trend	Change	Target (Days)
Vacancy approval to advert placement	**7.2**	8.3	↑	-1.1	8
Shortlisting to interview	**9.0**	8.2	↓	0.8	12
Interview to conditional offer	**4.2**	4.2	↔	0.0	6
Pre employment to unconditional offer	**22.1**	25.8	↑	-3.7	18
Unconditional Offer to Acceptance	**20.4**	24.6	↑	-4.2	3

Vacancy approval to advert placement-The average number of days between a vacancybeing submitted for approved and the advert being placed.

Shortlisting to interview- The average number of days between date vacancy closed and date invited to interview

Interview to conditional offer- The average number of days between the interview date and the date of informing of a decision.

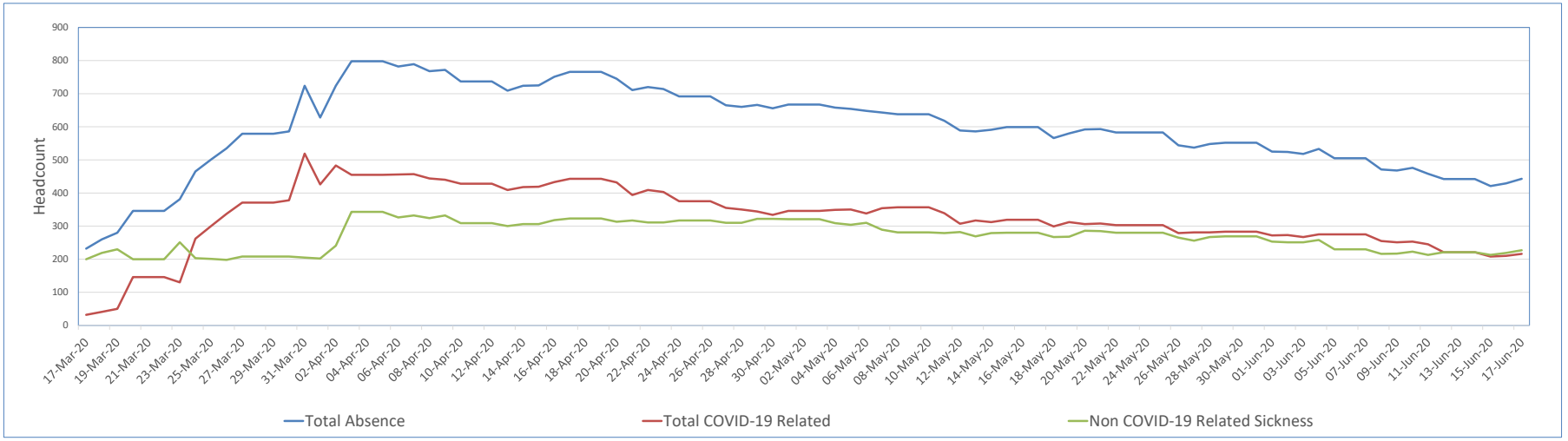
Pre employment to unconditional offer -The average number of days between the date Conditional Offer letter Sent / Reference Checks Started

Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to start date or Booked start date

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	**£20.89M**	£21.07M	↑	-£0.18M	£19.92M
Agency Expenditure	**£0.21M**	£0.37M	↑	-£0.15M	£0.81M
Bank Expenditure	**£1.52M**	£1.68M	↑	-£0.16M	£1.05M

COVID-19 - Key Metrics

ABSENCE



The data above is taken from the Trust daily situation report. 17-18 March represents ESR absence data only. 19 March to 1 April 20 represents combined ESR absence data and Occupational Health call log data. 2 April 20 includes Roster isolation information. 3 April 20 onwards represents the full absence picture, combining ESR absence data, Roster absence data, and isolations recorded via the Occupational Health call log.

Workforce Absence @ 17 June 2020

	Headcount	% of workforce
Absence - COVID-19 Related	216	3.4%
Absence - Sickness (Non COVID-19 Related)	227	3.6%
Total Absence	443	7.0%

Testing

Location	Number Tested
CHFT	799
Locala	7
Home	36
External	11

Results		
Negative	696	82%
Positive	153	18%
Awaiting	4	0%

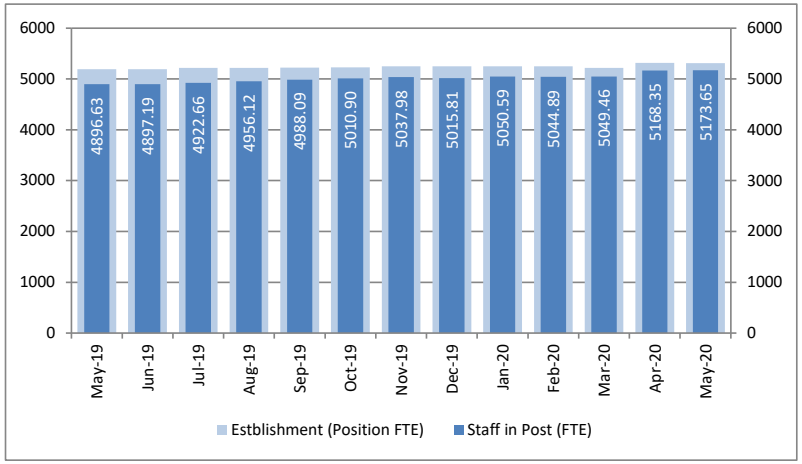
7 Day Isolation (Staff Presenting Symptoms) Testing*

	Number Tested	Negative	Positive	Awaiting
BAME (incl mixed and other)	120	73%	27%	0%
White	445	82%	17%	1%
Not Stated	40	90%	10%	0%

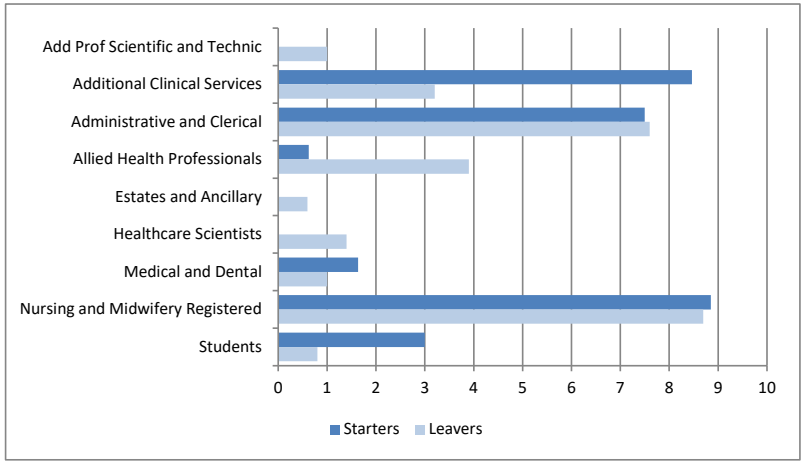
Covid Related Key Metrics

Reality

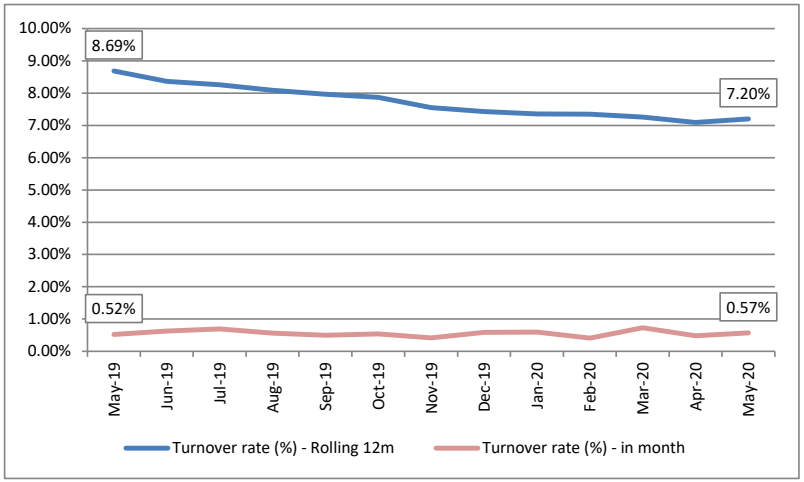
Staff in Post (FTE) v Establishment (FTE)



Starters & Leavers (FTE) by Staff Group - May 2020



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	0.47%	5.49%
Additional Clinical Services	0.30%	7.42%
Administrative and Clerical	0.75%	7.03%
Allied Health Professionals	1.01%	7.82%
Estates and Ancillary	1.19%	5.80%
Healthcare Scientists	1.23%	9.27%
Medical and Dental	0.27%	10.65%
Nursing and Midwifery Registered	0.55%	6.41%
Students	0.00%	0.00%

Result

Have a Retention Strategy with interventions aimed at key staff groups which currently have a high turnover.

Response

The increase in staff in post seen in April 20 on the adjacent Staff in Post graph is due to the temporary recruitment of year 2 and 3 nursing students

Retention

The Trust has developed its People Strategy, which includes a focus on Recruitment and Retention. Specific initiatives have included:-

- More streamlined recruitment
- Improved induction
- Health and wellbeing
- Colleague engagement
- Recognition and Reward
- Career development

Further work is being developed to enhance our People Strategy in 'The Cupboard'.

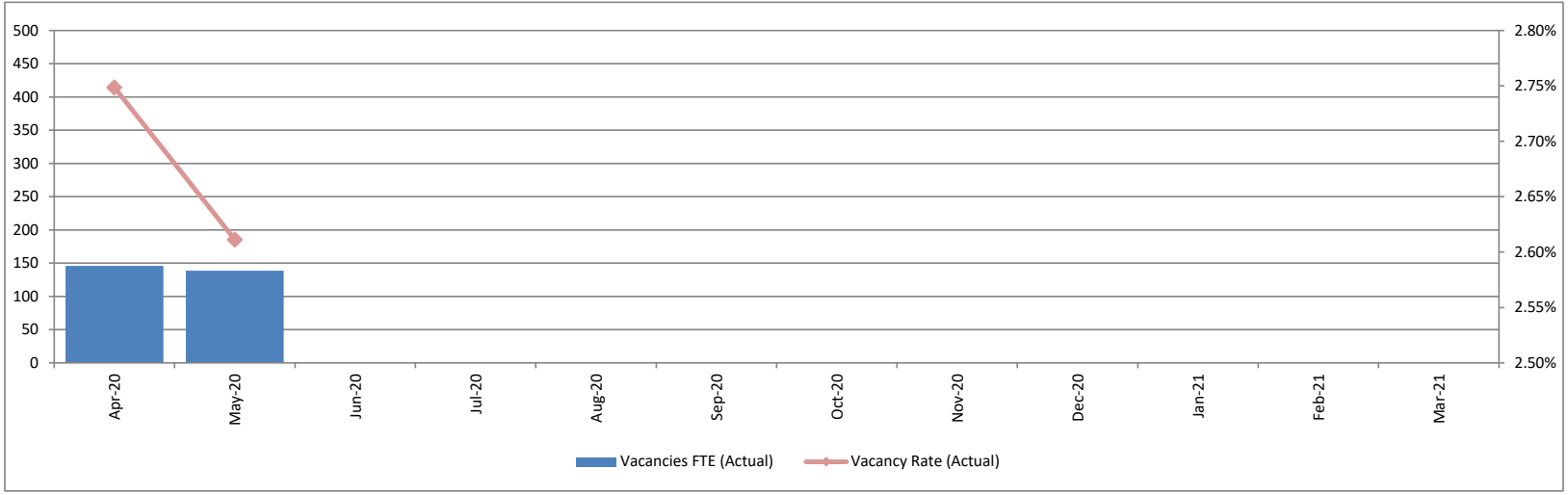
To support the retention of the Nursing workforce, the Trust offers a comprehensive induction and all new starters are enrolled on a year long graduate programme which is supported by the preceptorship programme.

The Trust is part of cohort 4 of NHSi 'Retention Direct Support Programme' which is a clinically led programme aimed at supporting Trusts to improve their Nursing retention rates. The programme is currently on hold due to COVID-19 pressures.

Staff in Post / Starters & Leavers / Turnover

Reality

Vacancies



Vacancies by Staff Group

Staff Group	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Add Prof Scientific and Technic	222.70	211.04	11.66
Additional Clinical Services	1087.83	1061.16	26.67
Administrative and Clerical	1043.95	1014.09	29.86
Allied Health Professionals	392.71	387.12	5.59
Estates and Ancillary	56.77	49.60	7.17
Healthcare Scientists	126.52	113.55	12.97
Medical and Dental	640.33	618.45	21.88
Nursing and Midwifery Registered	1741.56	1592.44	149.12
Students*	0.00	126.20	-126.20
Total	**5312.37**	**5173.65**	**138.72**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	28.43	27.61	0.82
Health Care Support Worker	82.35	69.15	13.20
Healthcare Assistant	698.97	617.88	81.09
Nursery Nurse	1.83	1.83	0.00
Nursing Associate	3.51	8.00	-4.49
Trainee Nursing Associate	2.00	70.00	-68.00
Total (Unregistered Nursing)	**817.09**	**794.46**	**22.63**
Other Additional Clinical Service	270.74	266.70	4.04

* Year 2 and 3 nursing students recruited on a temporary basis to support the COVID-19 crisis.

Result

CHFT to be the employer of choice in a competitive environment through a recruitment strategy which includes candidate attraction to the Trust.

Achieve and maintain a vacancy rate below 5.4%.

Response

The Trust is participating in the regional streamlining agenda focused on enabling staff movement. Due to the work the Trust has already completed through the Stepchange reviews and the implementation of Trac, the focus is on internal efficiencies through the utilisation of ESR, further use of Trac and the revision of the Recruitment and Selection line managers training course

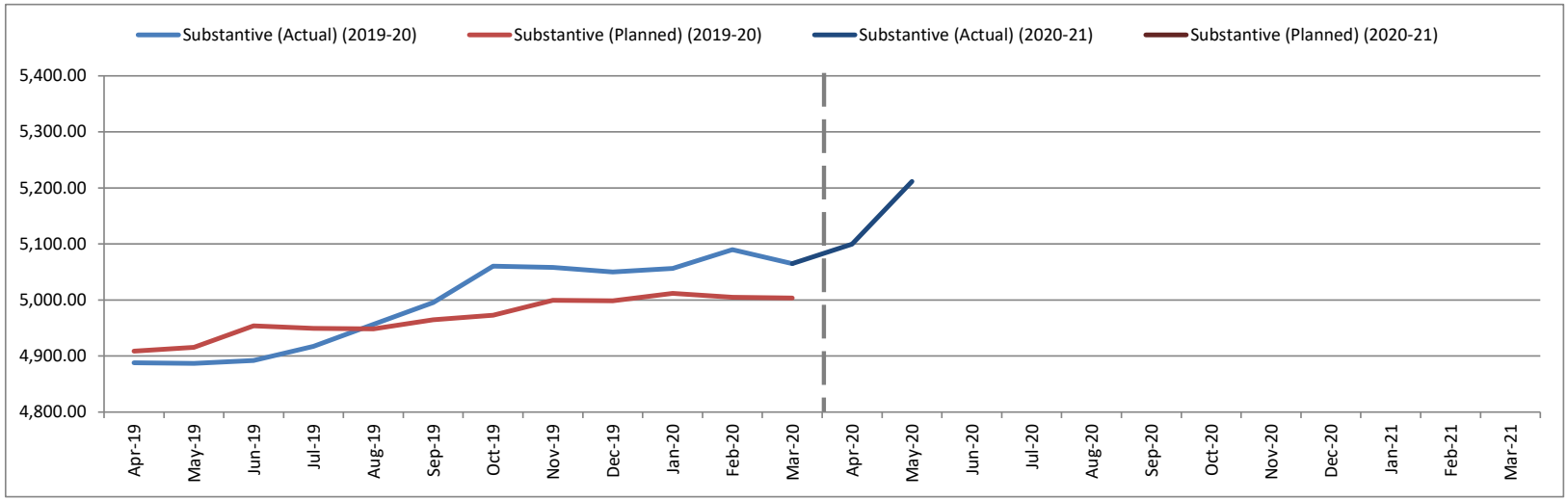
Recruitment
Due to the ongoing COVID-19 situation the Trust has seen an increase in the numbers of clinical and non-clinical staff being recruited into both substantive and bank roles across all Departments.
International applications are currently on hold whist the Trust await further government advise regarding travel and universities open up to deliver OSCE assessment.
The Trust currently has 67 student nurses and midwifes under conditional offer for start dates on programme completion in September 2020.

Medical Recruitment
On 11 May 2020 the Trust had 19 new trainees, known as FiY1 doctors, who were cleared to join the organisation to support the response to the pandemic. They have graduated from Medical School and are due to commence as Foundation Year 1 trainees in August 2020
Recruitment activity has continued and a number of posts have been appointed to including a Consultant in Acute Medicine, Consultant Anaesthetist and a Locum Consultant in Radiology. A number of Trust doctors have been appointed in different specialties, most notably 9 doctors in Emergency Medicine, who are expected to commence in August 2020. .

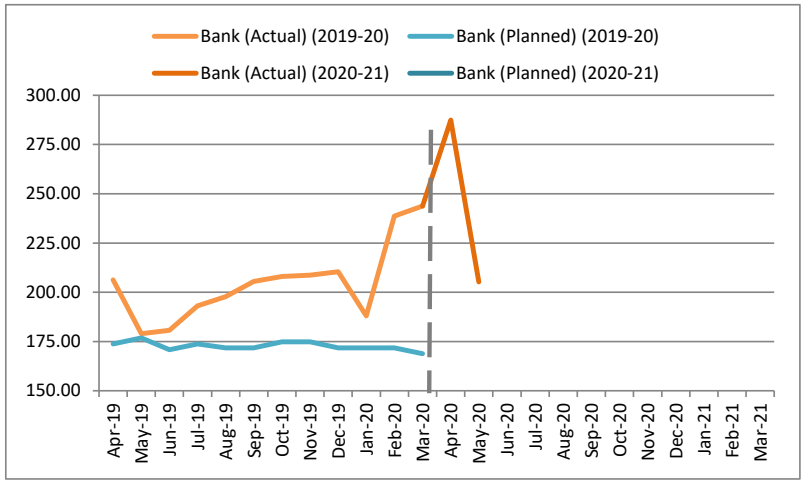
Vacancies

Reality

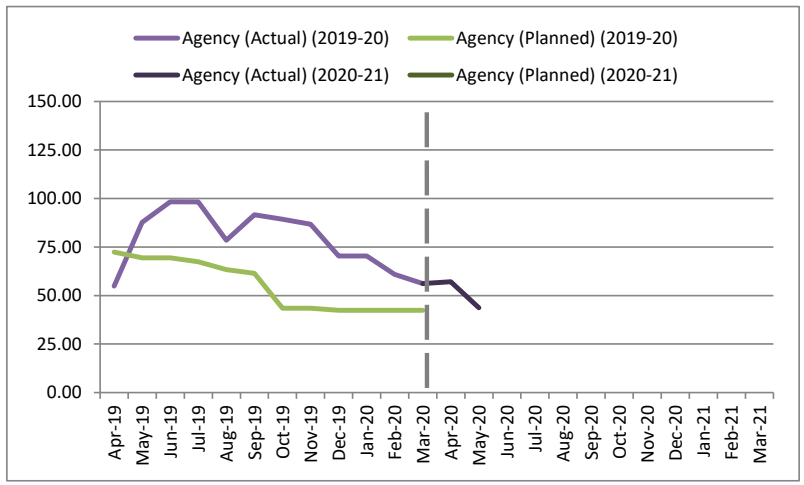
Substantive



Bank



Agency



Result

Increasing the substantive workforce whilst reducing the reliance on bank and agency usage.

These graphs show the FTE worked in-month for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the

Response

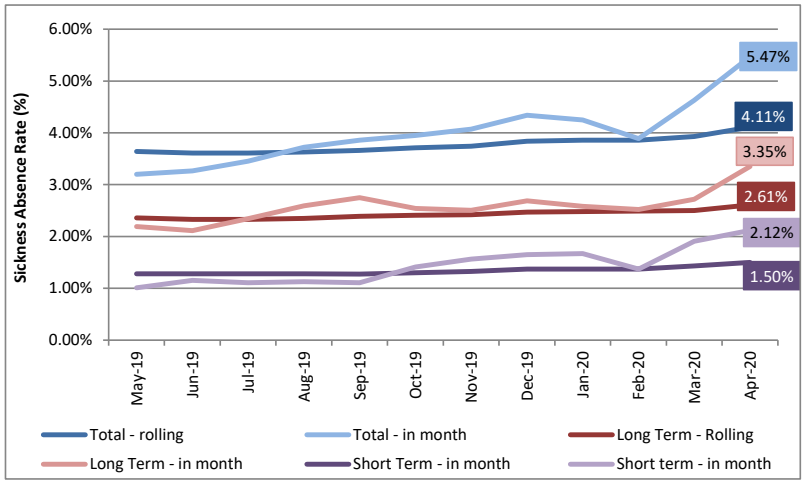
These graphs show the hours worked in-month converted into FTE for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the service year. In 2019/20 whilst the Trust reduced agency usage within the Medical & Dental staff group in particular, usage remained high in Nursing and Midwifery and The Health Informatics Service (THIS). This resulted in agency FTE being above plan.

Operational planning has been suspended by NHSi for an initial period of 1 April 2020 to 31 July 2020, so workforce plans have not been submitted for 2020/21.

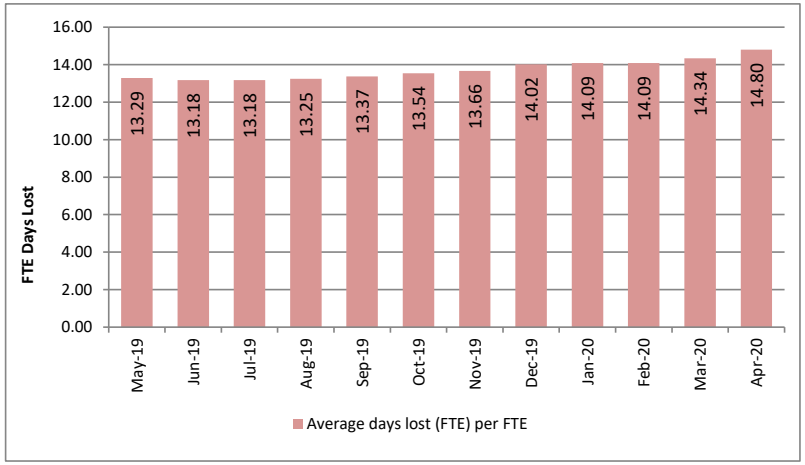
Workforce Plan

Reality

Sickness Absence



Average Days Lost Per FTE - rolling 12 month



Sickness Absence Reasons - April 20

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	2351.25	28.11%
S15 Chest & respiratory problems	1357.17	16.23%
S13 Cold, Cough, Flu - Influenza	1247.55	14.92%
S12 Other musculoskeletal problems	632.83	7.57%
S28 Injury, fracture	384.11	4.59%
S25 Gastrointestinal problems	364.01	4.35%
S11 Back Problems	271.82	3.25%
All Other Reasons	1754.97	20.98%

Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

Sickness absence data does not include self / household / shielding isolation.

The Trust has a robust attendance management approach agreed with staff side partners, which is supported by in-house occupational health provision and effective support to line managers.

Staff antibody testing is progressing well, and remains open to all staff along with PCR (swab) test for staff or their household members who develop symptoms. A staff wellbeing risk assessment questionnaire was issued on 16 June to engage staff in support for working going forward.

A Wellbeing Support service was developed in March to support colleagues with their stress and anxiety as we work through the different phases of Covid.
We aimed to implement a service that is accessible, friendly and tailored to support each individuals needs.
We supported our first colleague on the 26 March, and 10 weeks later:
-100 colleagues have contacted the 1 to 1 emotional and psychological support service
-6 colleagues have accessed specific bereavement support
-88 colleagues have gained support via group face to face debrief sessions
-17 colleagues have volunteered to be wellbeing buddies and funding has been secured through Socrates
Underpinning all of the above is 'self care' resources which have been made available on the cupboard / intranet

Sickness Absence

Reality

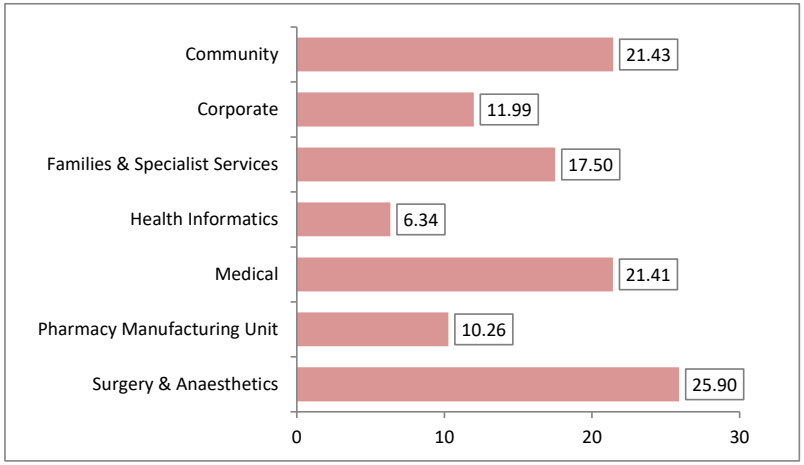
Sickness Absence - in-month

Division	Mar-20	Apr-20
Community	3.89%	5.87%
Corporate	2.90%	3.28%
Families & Specialist Services	3.83%	4.80%
Health Informatics	2.53%	1.74%
Medical	4.20%	5.87%
Pharmacy Manufacturing Unit	5.61%	2.81%
Surgery & Anaesthetics	4.24%	7.10%

Sickness Absence by Staff Group - rolling 12 month

Staff Group	Short Term	Long Term	Total
Add Prof Scientific and Technic	1.59%	2.00%	3.59%
Additional Clinical Services	2.22%	3.96%	6.18%
Administrative and Clerical	1.16%	2.27%	3.43%
Allied Health Professionals	1.27%	1.61%	2.88%
Estates and Ancillary	1.78%	5.15%	6.94%
Healthcare Scientists	1.16%	1.50%	2.66%
Medical and Dental	0.67%	0.80%	1.47%
Nursing and Midwifery	1.59%	2.91%	4.50%
Students	0.09%	0.00%	0.09%

Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

In **Surgery & Anaesthetics**, Absence is a priority for the Surgical Division and support is being provided by HRAs and HRBPs to ensure managers are able to support colleagues through the Attendance process. Focus is being given to individuals who are struggling as a result of the pandemic using support services available through Occupational Health, counselling service etc. RTW has seen a significant decrease and we will be working with managers to improve the return on a weekly basis.

In **Medicine**, the Division continues to see an increase in absence during COVID. Each period of absence is being reviewed by the HRBP/HR Adviser for the Division with managers to ensure support to employees and management of absence in line with policy. The organisational HR team for the Medicine Division are meeting w/c 22nd June to conduct a deep dive into all absence (covid and non-covid)

In **FSS**, absence has increased with a higher proportion of absence attributable to Covid, along with other absence. Data is now provided weekly , utilising extracts from roster and ESR to ensure attention is focused on the most up to date position. Focus has been given to stress and anxiety cases to ensure support is offered from day 1 of absence. RTW will be recirculated to ensure that RTW conversations are being recorded in the correct system.

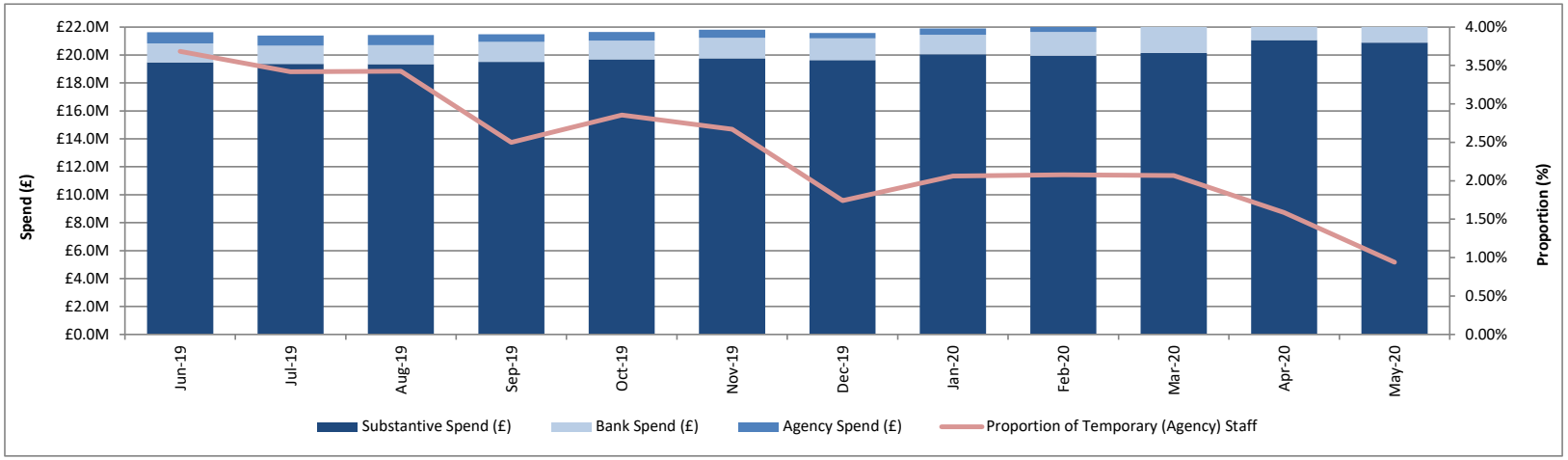
In **Community**, regular contact is established to offer appropriate support, with reminders of Health & Wellbeing packages on offer. RTW will be re circulated to ensure correct system recording

In **Corporate, PMU & THIS**, as with the Community, work is ongoing to understand an increase in Stress / Anxiety / Depression. and to ensure correct recording of RTW conversations

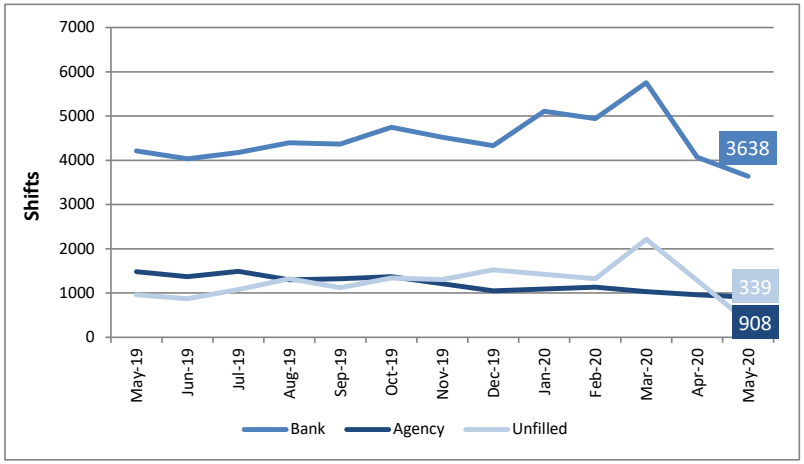
Sickness Absence - Divisional/Staff Group

Reality

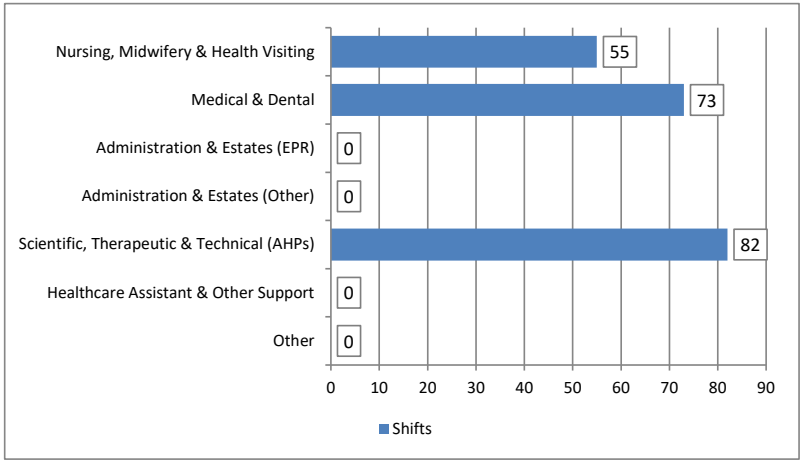
Workforce Spend



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - May 2020



Result

Continue to reduce the use of agency colleagues and reduce the bank paybill in 2019/2020.

Response

A total of 210 shifts broke the agency cap in May 2020, this is almost a 50% decrease from 419 in April 2020

From 6 April 2020 the Trust removed usage of short notice, high cost Tier 3 agency shifts for Nursing and migrated Tier 2 agencies to Tier 1.

Whilst agencies that supplied at Tier 2 and Tier 3 were framework providers, the shifts still represented a significant cost to the Trust when in comparison to Registered Nursing Staff through Bank and Tier 1.

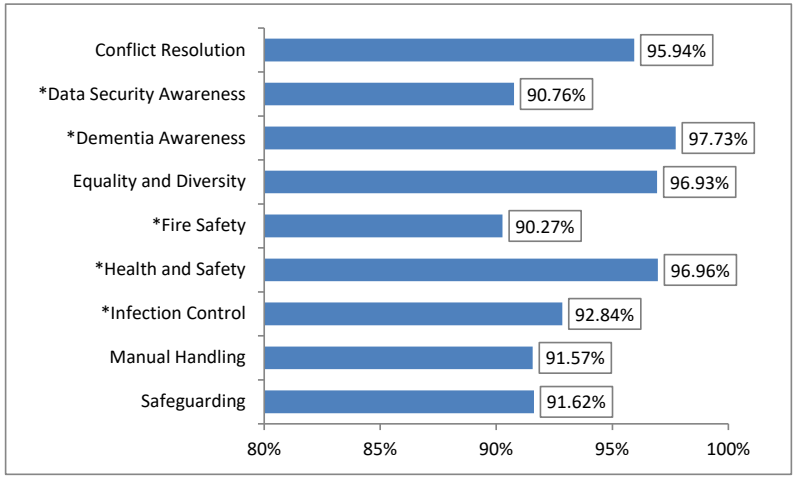
Removing these two Tiers has helped to achieve lower average hourly rates, from £34.01 to £31.17 per hour.

Agency usage remains low with 76% of Nursing shifts and 87% of Medical shifts filled by Bank.

Workforce Spend / Agency Usage

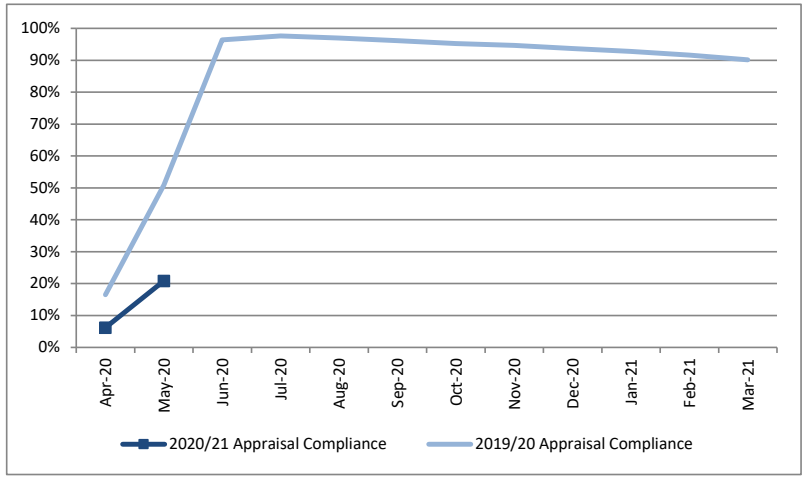
Reality

Essential Safety Training

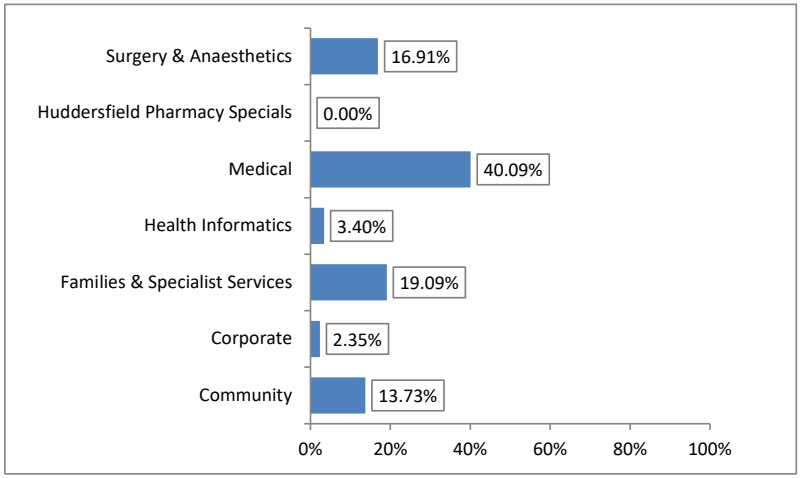


* Essential Safety Training elements that are covered at Corporate Induction.

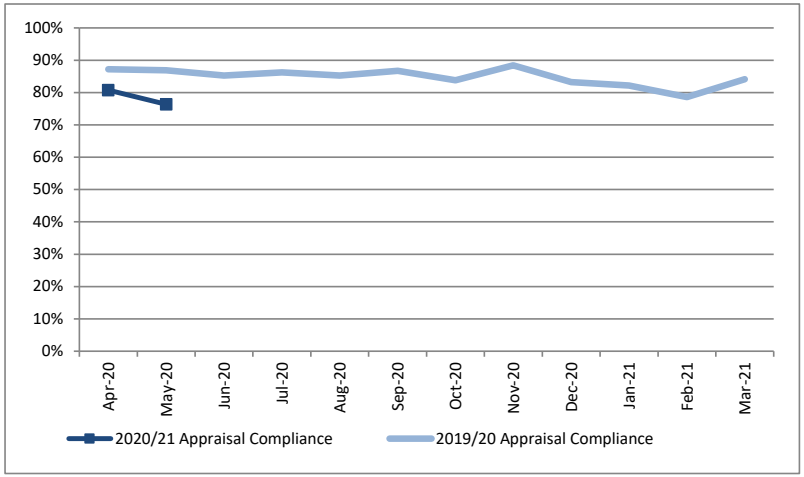
Non-Medical Appraisal Compliance



Non-Medical Appraisal Compliance by Division



Medical Appraisal Compliance



Result

Appraisal compliance is consistently above 95%.

Essential safety training compliance is consistently above 90% stretching to 95%.

Response

Essential Safety Training
A paper is presented weekly to Executive Board highlighting the compliance figures for all EST including role specific training.

The focus remains on improving role specific subjects with less than 85% compliance.

Appraisal
The Trust now adopts an appraisal season approach. The appraisal season runs from 1 April to 30 June every year. The final position for the 2019/20 appraisal season was 97.63%.

The appraisal season and Medical appraisals for 2020/21 have been postponed due to the ongoing COVID-19 situation.

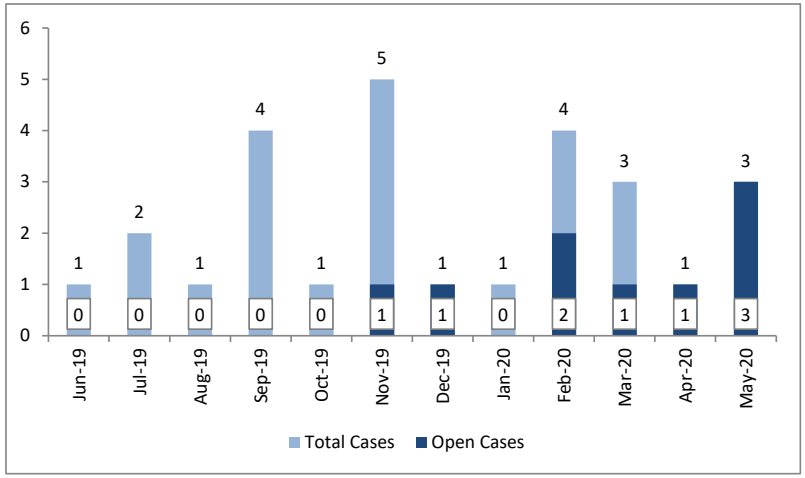
A shortage of Medical Appraisers has now been resolved through recruitment and training existing colleagues.

Oral Surgeons have now been excluded from the denominator in the medical appraisal compliance as the General Dental Council undertake the appraisal.

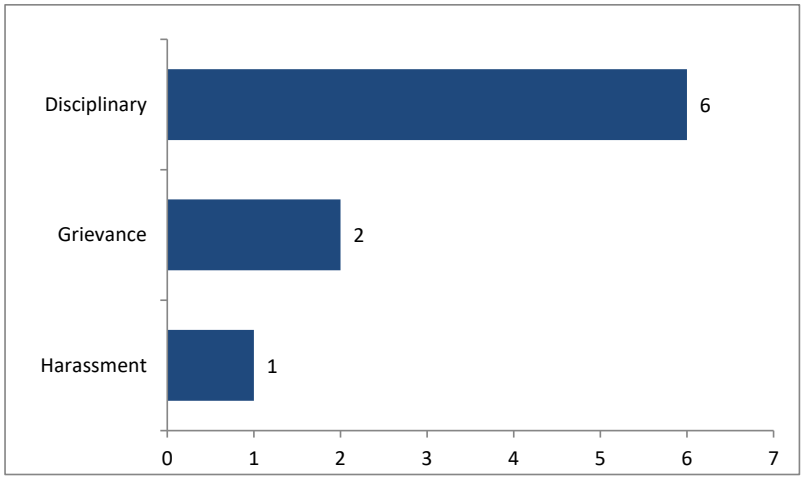
Essential Safety Training / Appraisals

Reality

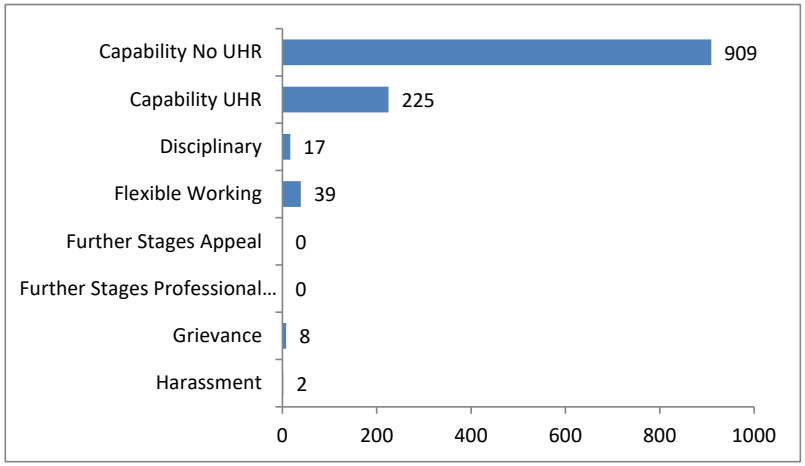
Disciplinary, Grievance, Harassment cases opened last 12 months



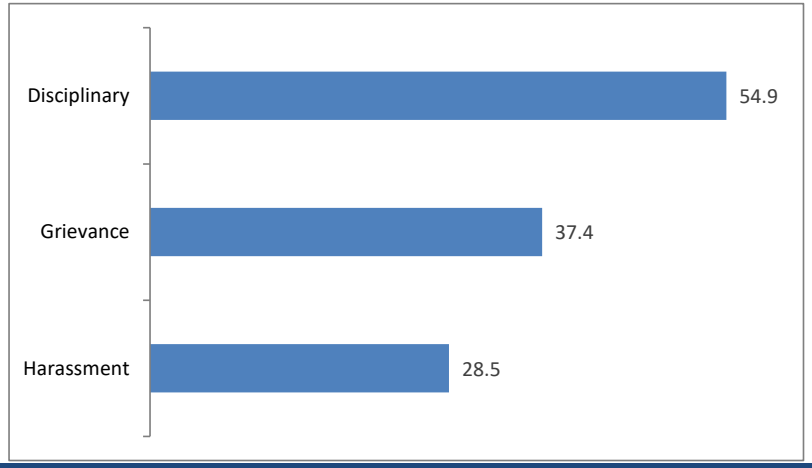
Open Disciplinary, Grievance, Harassment cases by type



All cases opened in the last 12 months by case type



Average number of days to close cases



Result

Maintain a robust capturing process.

Response

Following a deep dive into employee relations cases, the HR Team reviewed the way in which employee relations cases were been recorded and updated. This has resulted in a number of changes which will ensure consistency and enable automated reporting of case management.

- ESR will now be the sole recording system for employee relations cases. Previously the HR Team had been trying to maintain two different systems which led to discrepancies.

- If the employee has a registered disability, absence management cases will now be recorded under 'Capability UHR'. All other absence management cases will be recorded under 'Capability No UHR'.

- Long term sickness absence will now be captured on ESR.

- Unsatisfactory performance during a probationary period will now be captured on ESR.

Employee Relations

Model Hospital

All Substantive Staff - FTE and WAU per FTE

	Period	Trust Actual	WAU Per FTE
All Substantive Staff	2016/17	5830.17	17
Medical Staff	2016/17	654.16	155
Nursing and Midwifery Staff	2016/17	2753.77	37
Allied Health Professionals	2016/17	422.64	239
Healthcare ST&T	2016/17	576.9	175
Corporate, Admin & Estates	2016/17	1422.71	71

Use of Resources - People

	Period	Trust Actual	Nat. Median
Staff retention rate	Jan-18	84.90%	85.70%
Sickness absence rate	Dec-17	4.30%	4.59%
Total cost per WAU	2016/17	2315	2157
Medical staff cost per WAU	2016/17	505	526
Nursing staff cost per WAU	2016/17	834	718
AHP cost per WAU	2016/17	151	127

Skill Mix - FTE Ratio

	Period	Trust Acutal	Nat. Median
Qualified Nursing & Midwifery to Consultants	2016/17	7.1	5.9
Qualified AHPs to Consultant	2016/17	1.4	1.1
Consultants to Non Consultant Career Grade	2016/17	3.0	3.1
Consultants to Trainee Doctors	2016/17	0.9	0.8
Qualified Nursing & Midwifery to All Nursing Support (inc HCAs & others)	2016/17	2.2	2.1
Qualified AHPs to AHP Support Staff	2016/17	5.9	4.5
Clinical to Non Clinical Staff	2016/17	8.0	8.9
Qualified Nursing & Midwifery to Non Consultant Career Grade Doctors	2016/17	21.5	18.3
Qualified AHPs to Qualified Nursing & Midw	2016/17	0.2	0.2

* The FTE and Cost/Spend figures on Model Hospital are not recognised by the Trust. NHSi are currently investigating this with help from the Workforce Business Intelligence Team.

Commentary

The information held on Model Hospital is at a point in time and is not retrospectively updated.

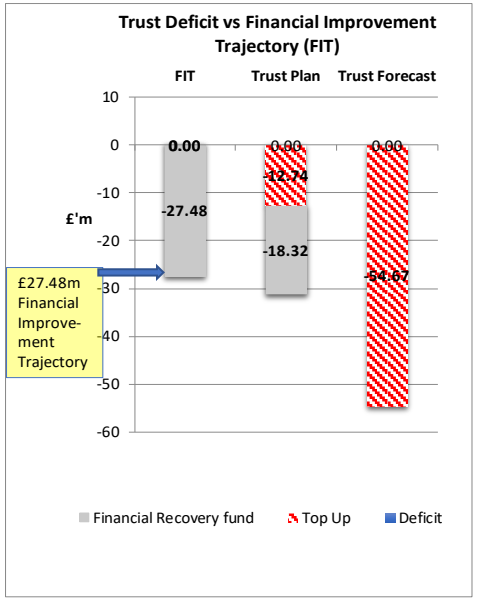
The RAG rating indicates whether CHFT is performing better or worse than the national median, where appropriate. There is no RAG rating set for certain indicators such as FTE and Skill Mix Ratios.

Cost per WAU is one of the headline productivity metrics used within Model Hospital. It shows the amound spent by the Trust to produce one Weighted Activity Unit (WAU) of clinical output.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2020 - Month 2

KEY METRICS

	M2				YTD (MAY 2020)				Forecast 20/21			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	£0.00	£0.00	£0.00		(£0.00)	(£0.00)	£0.00		£0.46	£0.46	£0.00	
Agency Expenditure	(£0.48)	(£0.21)	£0.27		(£0.96)	(£0.58)	£0.38		(£6.77)	(£3.84)	£2.93	
Capital	£1.60	£1.22	£0.38		£1.92	£1.54	£0.38		£16.21	£15.87	£0.34	
Cash	£6.05	£55.19	£49.14		£6.05	£55.19	£49.14		£3.99	£47.06	£43.07	
Borrowing (Cumulative)	£161.70	£161.70	£0.00		£161.70	£161.70	£0.00		£19.88	£19.88	£0.00	
CIP	£1.23	£0.31	(£0.91)		£2.46	£0.64	(£1.82)		£14.77	£8.52	(£6.25)	
Use of Resource Metric	3	2			3	2			3	2		



Year to Date Summary

The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for at least the first four months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £5.80m of retrospective top up funding: £3.39m in M1 and £2.41m in M2.

- Year to date the Trust has incurred £6.82m in relation to Covid-19, of which £2.36m relates to gowns which were purchased by the Trust on behalf of the region. The underlying cost of Covid-19 from a Trust perspective is therefore £4.46m.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £1.03m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- Divisional plans have been retained as per the original business as usual internal plan. The adjustment to the NHSI derived breakeven plan has been held centrally at Trust level. NHS Clinical contract income has been allocated to divisions based on their planned level of activity and income, following the fixed block principle of the national allocations. As such divisional variances represent the financial impact of operational changes as a result of Covid-19 on other income generation and most notably to expenditure.
- Whilst there is no national expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is £0.64m, £1.82m lower than planned.
- Agency expenditure year to date is £0.58m, £0.38m below the planned level.

Key Variances (compared to NHSI derived plan)

- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The assumed 'Retrospective Top Up' of £5.80m drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients. Overall the direct impact of Covid-19 on income generation is a £0.72m adverse variance, including a reduction in Car Parking and Catering income.
- Pay costs are £1.42m above the planned level year to date due to the impact of Covid-19 which are calculated to be £2.24m year to date. The costs attributed to Covid-19 were offset to some extent by underspends in some specialties due to reduced activity and a level of unfilled vacancies in non-Covid impacted areas.
- Non-pay operating expenditure are higher than planned by £2.07m. The costs directly attributable to the Covid-19 response are £4.58m, offset to some extent by lower than planned costs for specialties that have seen lower than planned activity over the last few weeks. This includes lower than planned consumables and a favourable variance on high cost drugs which would usually be treated as pass-through, but related income is temporarily fixed.

Forecast

Covid-19 costs and the ongoing impact of the current situation on activity and income have been assessed for M3 and 4 and a retrospective top up of a similar scale to that required in M2 is forecast for the next couple of months. Pending further guidance on M5-12, the forecast assumes that the Trust will continue to receive CCG clinical income at current block levels, that Covid-19 costs and activity levels will remain at a broadly similar level to those seen in M2 and that the Trust will continue to have access to some sort of top up funding in future months to bridge the financial gap. Work to assess future capacity and the cost of delivering services based on current infection prevention and control guidance is ongoing but is not yet sufficiently progressed to accurately inform the financial forecast at this stage.

Total Group Financial Overview as at 31st May 2020 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	896	167	(729)
Non-Elective	9,977	6,817	(3,160)
Daycase	6,783	1,517	(5,266)
Outpatient	58,152	22,606	(35,546)
A&E	26,699	16,336	(10,363)
Other NHS Non-Tariff	282,910	81,356	(201,554)
Other NHS Tariff	21,130	10,775	(10,355)
Total	**406,547**	**139,575**	**(266,972)**

TOTAL GROUP: INCOME AND EXPENDITURE

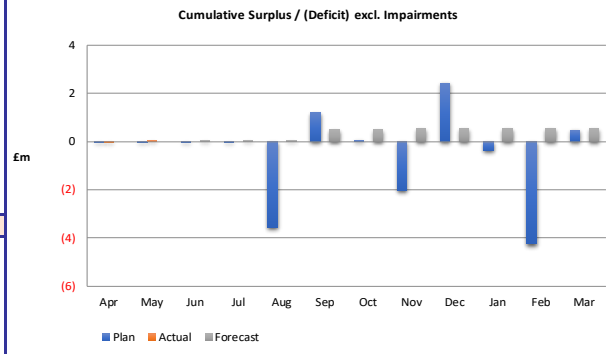
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£2.93	£2.93	£0.00
Non Elective	£18.63	£18.63	£0.00
Daycase	£4.80	£4.80	£0.00
Outpatients	£7.25	£7.25	£0.00
A & E	£3.91	£3.91	£0.00
Other-NHS Clinical	£19.04	£18.97	(£0.07)
CQUIN	£0.63	£0.63	£0.00
Other Income	£9.26	£7.12	(£2.14)
Total Income	**£66.46**	**£64.25**	**(£2.21)**
Pay	(£44.51)	(£45.93)	(£1.42)
Drug Costs	(£7.08)	(£6.45)	£0.63
Clinical Support	(£4.39)	(£4.47)	(£0.08)
Other Costs	(£10.50)	(£13.11)	(£2.61)
PFI Costs	(£2.21)	(£2.21)	£0.00
Total Expenditure	**(£68.69)**	**(£72.18)**	**(£3.49)**
EBITDA	**(£2.22)**	**(£7.93)**	**(£5.71)**
Non Operating Expenditure	(£4.15)	(£4.24)	(£0.09)
Surplus / (Deficit) Adjusted*	**(£6.37)**	**(£12.17)**	**(£5.80)**
Conditional Funding (MRET/FRF/Top Up)	£6.37	£12.17	£5.80
Surplus / Deficit*	**(£0.00)**	**(£0.00)**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£2.03	£3.60	£1.56
Medical	£6.51	£5.60	(£0.92)
Families & Specialist Services	(£1.59)	(£0.91)	£0.68
Community	(£0.35)	(£0.53)	(£0.18)
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£7.25)	(£7.74)	(£0.49)
THIS	£0.38	£0.15	(£0.24)
PMU	£0.59	£0.56	(£0.04)
CHS LTD	£0.07	£0.06	(£0.01)
Central Inc/Technical Accounts	(£1.28)	(£0.55)	£0.72
Reserves	(£0.47)	(£0.22)	£0.24
Unallocated CIP	£1.34	£0.00	(£1.34)
Surplus / (Deficit)	**(£0.00)**	**(£0.00)**	**£0.00**

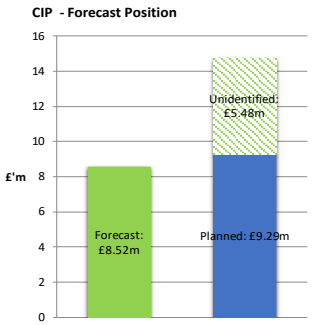
TOTAL GROUP SURPLUS / (DEFICIT)

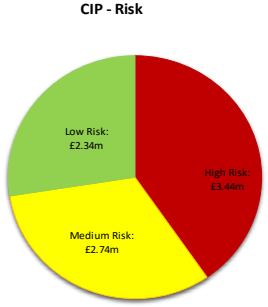


KEY METRICS

	Year To Date			Year End: Forecast		
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£0.00)	(£0.00)	£0.00	£0.46	£0.46	£0.00
Capital	£1.92	£1.54	£0.38	£16.21	£15.87	£0.34
Cash	£6.05	£55.19	£49.14	£3.99	£47.06	£43.07
Loans	£161.70	£161.70	£0.00	£19.88	£19.88	£0.00
CIP	£2.46	£0.64	(£1.82)	£14.77	£8.52	(£6.25)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	2		3	2	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £14.77m

Total Forecast £8.52m

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,574		
Non-Elective	60,676		
Daycase	43,418		
Outpatient	368,867		
A&E	158,149		
Other NHS Non- Tariff	1,835,796		
Other NHS Tariff	131,518		
Total	**2,603,999**		

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	(£0.00)
Non Elective	£114.89	£114.89	(£0.00)
Daycase	£30.72	£30.72	(£0.00)
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£110.48	£108.10	(£2.39)
CQUIN	£3.79	£3.79	(£0.00)
Other Income	£55.25	£46.21	(£9.04)
Total Income	**£402.43**	**£391.00**	**(£11.43)**
Pay	(£268.59)	(£277.44)	(£8.86)
Drug Costs	(£42.41)	(£40.27)	£2.13
Clinical Support	(£27.63)	(£26.48)	£1.14
Other Costs	(£58.35)	(£62.67)	(£4.31)
PFI Costs	(£13.19)	(£13.36)	(£0.17)
Total Expenditure	**(£410.17)**	**(£420.22)**	**(£10.06)**
EBITDA	**(£7.74)**	**(£29.22)**	**(£21.49)**
Non Operating Expenditure	(£25.16)	(£24.98)	£0.17
Surplus / (Deficit) Adjusted*	**(£32.89)**	**(£54.21)**	**(£21.31)**
Conditional Funding (MRET/FRF/Top Up)	£33.35	£54.67	£21.32
Surplus / Deficit*	**£0.46**	**£0.46**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

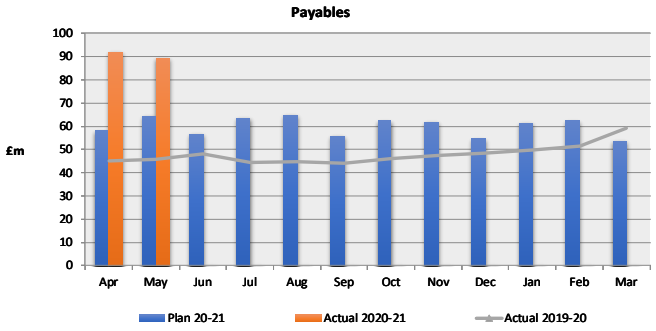
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£14.95	£20.14	£5.19
Medical	£44.08	£40.16	(£3.92)
Families & Specialist Services	(£7.03)	(£4.21)	£2.82
Community	(£1.92)	(£3.06)	(£1.14)
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£43.21)	(£46.04)	(£2.82)
THIS	£2.31	£1.14	(£1.17)
PMU	£3.55	£3.55	£0.00
CHS LTD	£0.75	(£0.03)	(£0.78)
Central Inc/Technical Accounts	(£15.45)	(£9.23)	£6.22
Reserves	(£4.17)	(£4.34)	(£0.17)
Unallocated CIP	£6.62	£2.39	(£4.22)
Surplus / (Deficit)	**£0.46**	**£0.46**	**£0.00**

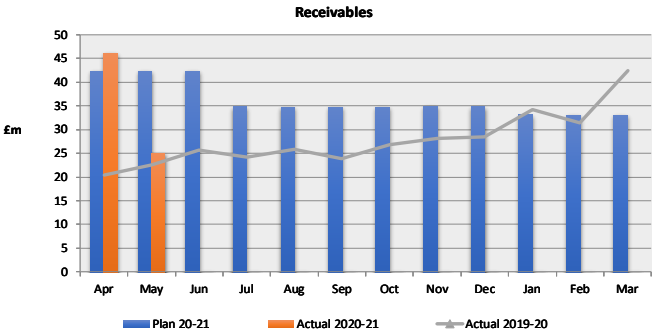
Total Group Financial Overview as at 31st May 2020 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

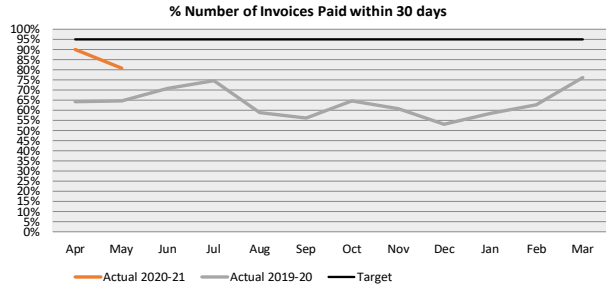
WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£64.24)	(£89.14)	£24.90	
Receivables	£42.40	£24.92	£17.48	



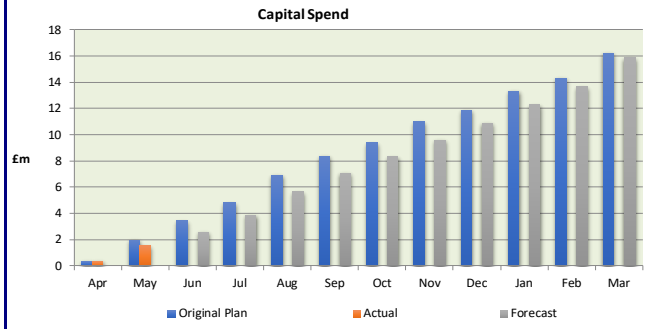


BETTER PAYMENT PRACTICE CODE



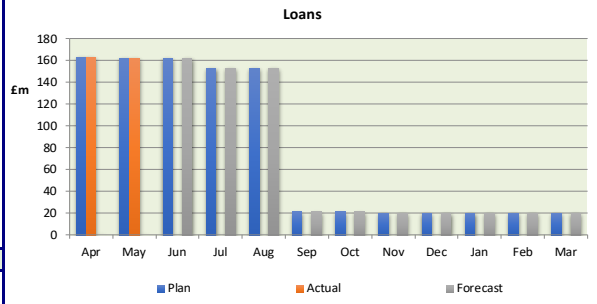
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£1.92	£1.54	£0.38	

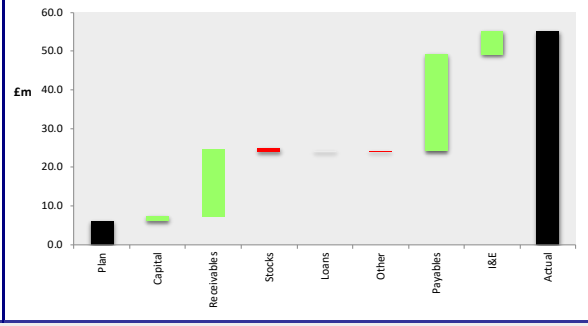


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£6.05	£55.19	£49.14	
Loans (Cumulative)	£161.70	£161.70	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for at least the first four months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £5.80m of retrospective top up funding.
- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The assumed 'Retrospective Top Up' of £5.80m accounts drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients.
- Year to date activity is well below plan for all points of delivery as a result of the Covid-19 response.
- The Trust has incurred £6.83m in relation to Covid-19, of which £2.36m relates to gowns which were purchased by the Trust on behalf of the region.
- Year to date Capital expenditure was lower than planned at £1.54m against a planned £1.92m.
- Cash balance is £55.19m, £49.14m above plan: payments for June's Block and Top Up received in advance and £10m bonus Financial Recovery Funding (19/20)
- No interim Revenue loans or PDC were required in month.
- Year to date CIP schemes have delivered £0.64m of savings, £1.82m lower than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 3. The Trust's Internal Plan was for a deficit position year to date, where as the interim NHSI Plan is for a break-even position, improving the overall UOR.

NOTES

- The Forecast assumes that the Trust will continue to receive sufficient funding to achieve a break-even position.
The forecast position shown includes a planned gain on disposal of £0.46m, (assumed excluded for the purposes of FRF).
- The Forecast position assumes that the Trust's underlying deficit and ongoing costs relates to Covid-19 will be supported by either a continuation of the current Block and Top Up arrangements (as per the Interim Plan) or Financial Recovery Funding as per the Draft Plan submission / internal Trust plan.

- The Trust is forecasting Agency expenditure of £3.84m, considerably below the NHSI ceiling of £8.82m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting delivery of £8.52m savings against a Trust CIP plan for 20/21 of £14.77m.
- The Trust is not planning to borrow during this financial year due to changes in the cash regime and planned Financial Recovery Fund / Top Up payments that should bring the Trust to a break-even position.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) are expected to be either repaid or replaced by PDC funding by 30th Sept 20.

- Capital expenditure is forecast at £15.87m, £0.34m lower than the recently resubmitted 20/21 Capital Plan due to a reduction in costs relating to reconfiguration, offset to some extent by additional Covid-19 related expenditure.

RAG KEY: (Excl: UOR)	
	Actual / Forecast is on plan or an improvement on plan
	Actual / Forecast is worse than planned by <2%
	Actual / Forecast is worse than planned by >2%

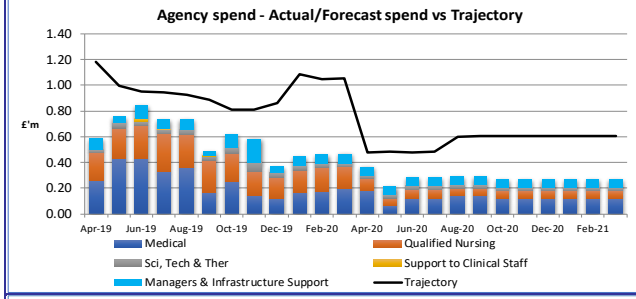
NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

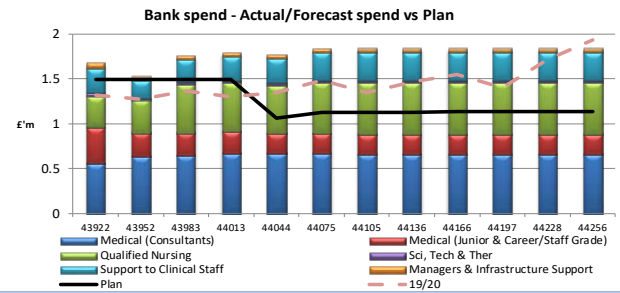
RAG KEY: UOR	
	All UOR metrics are at the planned level
	Overall UOR as planned, but one or more component metrics are worse than planned
	Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	30	63	22	154	- 99	169
Staff in post (WTE)	712	1,404	618	1,592	1,187	5,513
% Vacancies	4%	4%	3%	9%	-9%	3%





Cumulative Agency and Bank Spend	Plan	Actual	Var	
	£'m	£'m	£'m	
Agency Year to Date	(£0.96)	(£0.58)	£0.38	
Agency Forecast	(£6.77)	(£3.84)	£2.93	
Bank Year to Date	(£2.99)	(£3.20)	(£0.21)	
Bank Forecast	(£14.93)	(£21.35)	(£6.42)	

Vacancies
At the end of Month 2 the Trust was carrying 169 vacancies, 3% of the total establishment. Medical vacancies reduced from 6% to 3% largely due to the temporary contracts issued to 18 student doctors, while Nursing vacancies increased from 8% to 9%. Nursing vacancies are offset to some extent by the interim deployment of 126 WTE student nurses into HCA posts (Support to Clinical). These contract are due to end on the 31st of July. Admin & Estates vacancies remained stable at 4%.

Agency rate cap
Overall Cap breaches reduced further in Month 2 compared to Month 1 and are well below the 12 month average. The last six months has seen a significant reduction in both Nursing and Medical breaches.

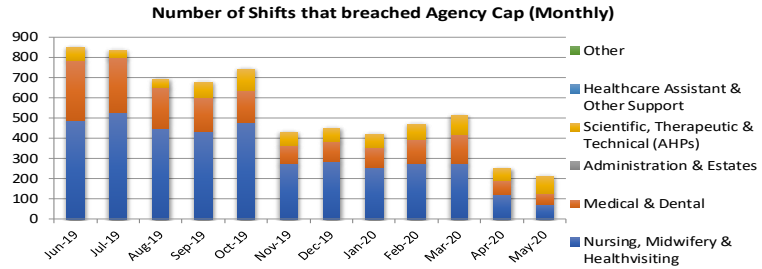
Agency ceiling
Total reported agency expenditure year to date is £0.58m; £0.38m below the planned value. This reduction is offset by a significant increase in the cost of internal Bank staff, with expenditure on Bank £0.21m higher than planned.

The planned agency trajectory for 20/21 is £6.77m, which is lower than the £8.82m NHS Improvement ceiling and currently the Trust is forecasting agency expenditure for the full year of only £3.84m based on the current run-rate, £2.93m below plan.

Nursing agency reduced (£0.04m) in month to £0.06m, due to a reduction in both hours and average hourly rate. Overall this is a year to date favourable variance to plan of £0.20m reflecting the progression of plans to reduce reliance on agency staff, particularly higher Tier agencies and replace with an increase in the use of bank nurses, but also reduced activity and the influx of additional student nurses that have temporarily bolstered staffing numbers and reduced reliance on other forms of temporary staffing.

Medical Agency costs also reduced significantly in month (£0.12m) to £0.06m and are now slightly below the planned level with a year to date favourable variance of £0.05m. Additional staffing costs due to Covid-19 have been offset by a reduction in planned activity that would usually be supported by a level of agency expenditure.

Bank usage
Expenditure on internal Bank staff is £3.20m, £0.21m higher than planned year to date. £0.57m of these costs relate to the Covid-19 response including: additional medical costs of £0.29m due to changes to rotas and segregation of patient pathways; and nursing costs of £0.25m due to backfill for higher sickness absence and plans to release bed capacity.



INTERIM FORECAST

M1-4 20/21

	Plan	Forecast	Var	
	£m	£m	£m	
NHS Clinical Income	£114.40	£113.44	(£0.96)	
Other Clinical Income	£2.30	£1.72	(£0.59)	
Other Income	£16.22	£13.99	(£2.23)	
Total Income	**£132.92**	**£129.15**	**(£3.77)**	
Pay	(£89.01)	(£92.61)	(£3.60)	
Drug Costs	(£6.12)	(£5.67)	£0.44	
Clinical Support	(£8.77)	(£9.70)	(£0.93)	
Other Costs	(£29.07)	(£31.68)	(£2.60)	
PFI Costs	(£4.40)	(£4.45)	(£0.06)	
Total Expenditure	**(£137.37)**	**(£144.11)**	**(£6.74)**	
EBITDA	**(£4.45)**	**(£14.96)**	**(£10.51)**	
Non Operating Expenditure	(£8.30)	(£8.48)	£0.17	
Surplus / (Deficit) Control Total basis*	**(£12.75)**	**(£23.44)**	**(£10.70)**	
Total Forecast Top Up	£12.74	£23.44	£10.70	
Surplus / Deficit*	**(£0.00)**	**(£0.00)**	**£0.00**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast Top Up

Forecast Top Up required	M1	M2	M3	M4	Total
	£'m	£'m	£'m	£'m	£'m
Planned Top Up	£3.19	£3.19	£3.19	£3.19	£12.74
Retrospective Top Up	£3.39	£2.41	£2.63	£2.27	£10.70
Total	£6.57	£5.60	£5.82	£5.46	£23.44

Covid-19 costs and the ongoing impact of the current situation on activity and income have been assessed for M3 and 4 and a retrospective top up of a similar scale to that required in M2 is forecast for the next couple of months. Pending further guidance on M5-12, the forecast assumes that the Trust will continue to receive CCG clinical income at current block levels, that Covid-19 costs and activity levels will remain at a broadly similar level to those seen in M2 and that the Trust will continue to have access to some sort of top up funding in future months to bridge the financial gap. Work to assess future capacity and the cost of delivering services based on current infection prevention and control guidance is ongoing but is not yet sufficiently progressed to accurately inform the financial forecast at this stage.

Key Variances:

- Covid-19 costs for the next two months are estimated to be circa £2.4m per month. This includes additional PPE costs of £0.8m per month for gowns (regional) and masks, Covid-19 testing costs of £0.3m per month and additional staffing costs of at least £0.5m per month. Further costs will also be incurred for the hire of additional mobile scanners, for estate modifications and the segregation of patient pathways.
- The Trust will continue to lose income relating to Car Parking, Catering and Private Patients estimated at £0.4m per month.
- These losses will continue to be offset to some extent by lower consumables expenditure in some areas as planned activity is expected to remain well under plan.
- Pay costs are likely to increase in future months as many Covid-19 requirements remain, but most redeployed substantive staff will return to their usual areas in support of reset plans.

The estimated forecast retrospective top-up value includes an increase of £0.29m per month in relation to a shortfall in non-clinical care income. This is following clarification from NHSI that non-clinical CCG income in relation to the provision of Health Informatics Services should be covered by the CCG block funding and cannot therefore be recovered from CCGs in addition to this. This now results in a shortfall against the NHSI derived plan for non-clinical care income which requires an increase in the retrospective top-up in order to achieve a break-even position.

COVID-19

Revenue Impact of Covid-19 - YTD MAY 2020					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	0	4,017,705	208	0	4,017,913
Medicine	0	1,308,209	(413,575)	0	894,634
Families & Specialist Services	0	368,270	(49,381)	163,780	482,669
Calderdale & Huddersfield Solutions Ltd	0	281,555	(8,500)	14,750	287,805
Corporate Services	0	86,654	0	533,234	619,888
Community	0	256,543	0	12,139	268,682
Health Informatics	0	42,550	0	0	42,550
Surgery & Anaesthetics	0	462,091	(872,198)	0	(410,107)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**-**	**6,826,841**	**- 1,343,446**	**723,903**	**6,207,298**
Retrospective Top Up requested					**5,796,511**

Capital Impact of Covid-19 - MAY 2020	
Details	**Covid-19 Costs**
	£
NPEX (PDC received)	330,000
Equipment	444,686
Asset Tracking	105,422
Total costs identified	**880,108**
PDC Confirmed	**330,000**

The Trust has incurred Covid-19 direct costs totalling £6.827m as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up'.

Key areas of spend are as follows:

Pay - £2.243m

Reported Covid-19 costs are the 'net cost' and represent the additional staffing costs incurred due to the Covid-19 response and do not include the cost of substantive staff that have been redeployed into expanded capacity areas. Pay costs relating to the Covid-19 response were primarily linked to the requirement for existing staff to work additional shifts, in particular over the Easter Bank Holiday weekend which coincided with a peak in the number of Covid-19 cases across the two hospitals. There were also significant additional costs incurred as a result of increased shifts in community services with most staff working the April bank holidays and additional shifts to support 7 day working which have continued into May. Almost 150 students (nursing, therapies and medical) have been added to the payroll, some of which have been working in a supernumerary capacity. Changes to medical rotas also had a financial impact with additional enhancements paid to junior medical staff. Increased substantive costs were offset to some extent by a reduction in agency and bank costs and lower than planned pay costs in some non Covid ward areas where bed occupancy was lower than usual.

Non Pay - £4.580m

Clinical Supplies costs linked to Covid-19 were £0.91m, including costs related to increased ICU capacity of £0.18m, £0.35m on Covid testing and £0.12m on CT scanner hire.
Other non pay costs attributable to Covid-19 totalled £3.67m but included the full cost incurred for the purchase of gowns (PPE) on behalf of the whole region (£2.36m). The remaining £1.31m includes other PPE costs of £0.74m (masks, additional scrubs, respirators etc), additional equipment, minor works for social distancing / segregation and patient transport.

Nightingale Hospital - £0.003m

The Trust has not accounted for any costs relating to the Nightingale hospital in Month 2.

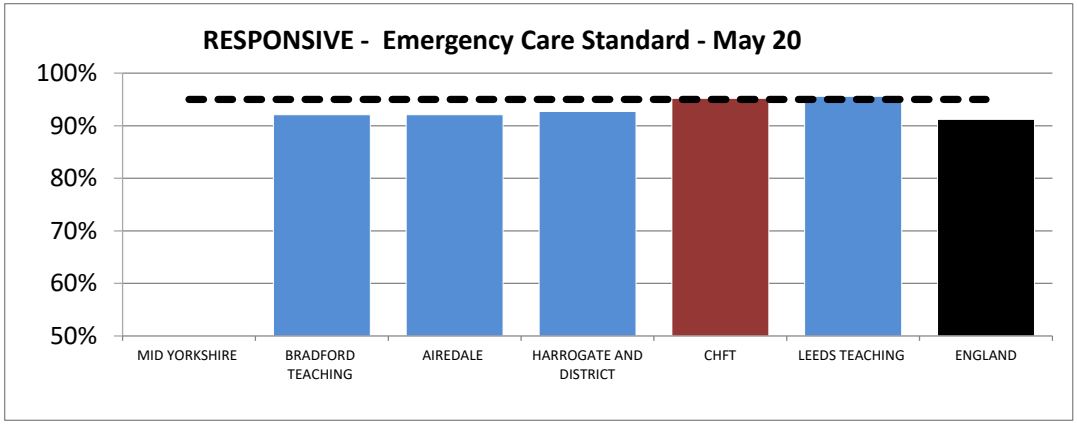
Income Losses

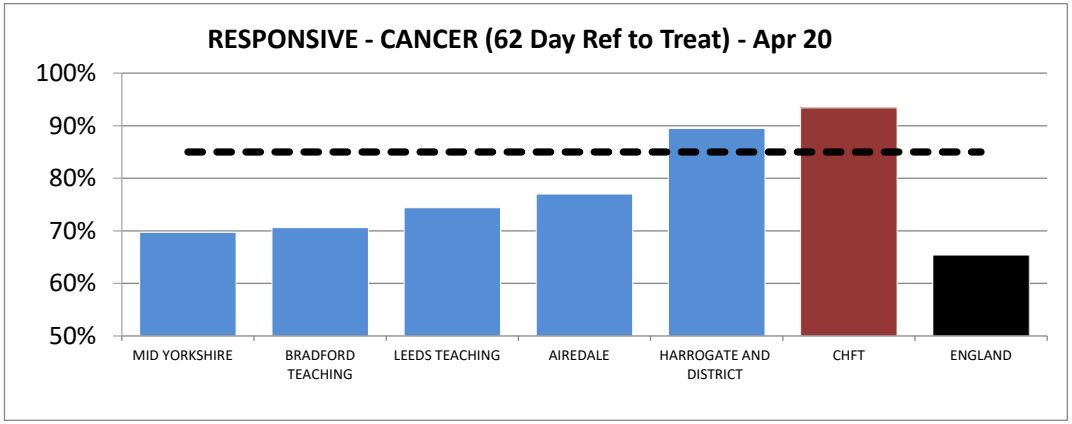
In addition, the Trust has lost income totalling £0.72m due to loss of Car Parking Income, (£0.43m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.06m), loss of apprentice levy income (£0.04m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (in particular from Yorkshire Fertility).

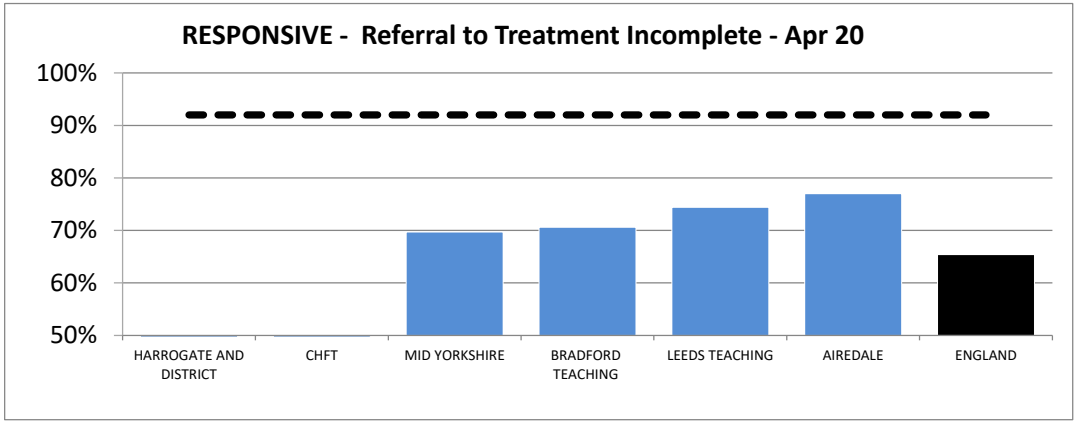
These costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

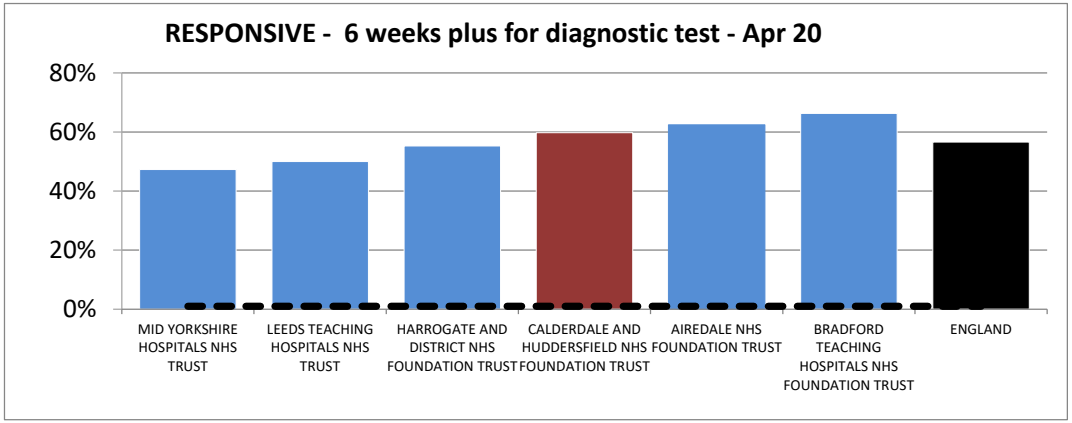
Capital funding for Covid-19 costs has also been requested as shown. The Trust is waiting for confirmation of PDC funding to cover most of this additional expenditure.

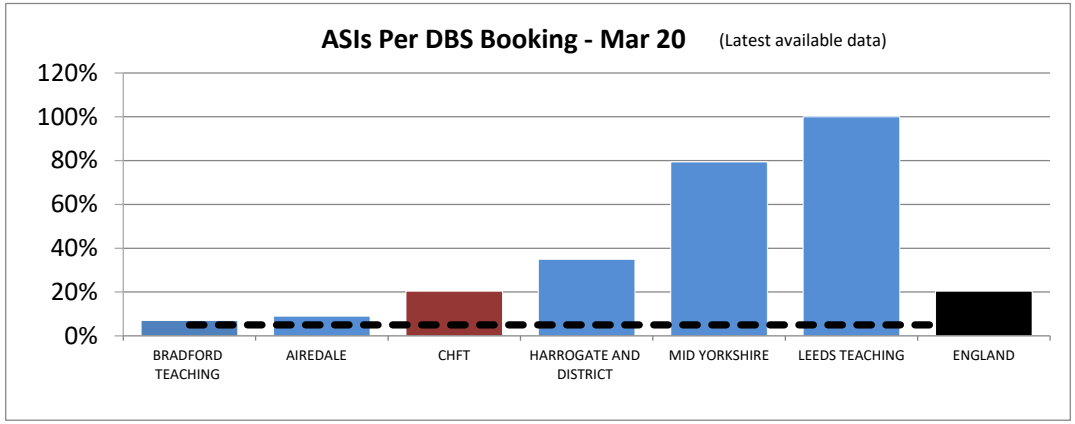
Benchmarking - Selected Measures





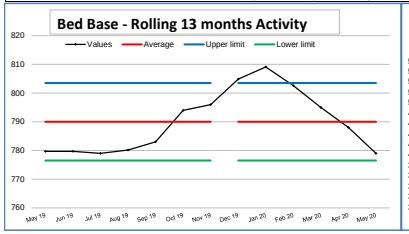


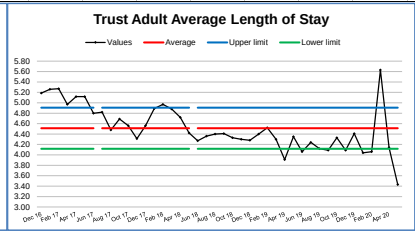


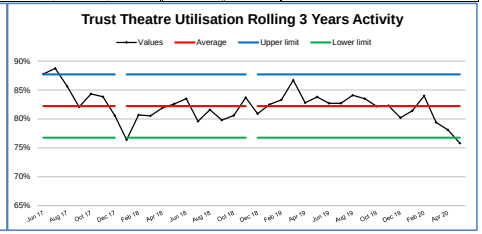


Efficiency & Finance - Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
Did Not Attend Rates																Green	Amber	Red
First DNA	7.70%	8.34%	8.03%	7.97%	7.92%	8.29%	6.92%	7.25%	7.44%	6.94%	7.20%	8.02%	4.22%	**3.56%**	**3.90%**	<=7%	7.1% - 7.9%	>=8%
Follow up DNA	6.67%	7.81%	6.90%	6.74%	7.19%	6.51%	6.18%	6.50%	6.43%	6.21%	6.06%	6.72%	5.46%	**4.52%**	**5.08%**	<=7%	7.1% - 7.9%	>=8%
Average length of stay																		
Average Length of Stay - Overall	4.26	4.35	4.06	4.24	4.12	4.09	4.33	4.09	4.41	4.04	4.06	5.63	4.14	**3.43**	**3.76**	<=5.19 / <=4.25 from April 20		>=5.30
Average Length of Stay - Elective	2.27	2.40	2.15	2.36	2.29	2.00	2.01	2.32	2.39	1.94	2.60	2.30	1.44	**1.54**	**1.48**	<=2.49 / <=2.30 from April 20		>=2.60
Average Length of Stay - Non Elective	4.50	4.57	4.31	4.46	4.32	4.36	4.62	4.31	4.63	4.26	4.25	6.03	4.25	**3.47**	**3.83**	<=4.62 / <=4.40 from April 20		>=5.50
Average Length of Stay - Non Elective - Excluding Ambulatory	5.64	5.70	5.47	5.49	5.40	5.57	5.8	5.5	5.72	5.36	5.42	7.28	4.86	**4.19**	**4.51**	<=5.56		
Average Length of Stay - Overall - Excluding Ambulatory	5.20	5.29	5.00	5.10	5.02	5.06	5.28	5.06	5.34	4.96	5.03	6.66	4.73	**4.10**	**4.4**	<=5.15 / <=5.10 from April 20		>=5.25
Pre-Op Length of Stay - Elective Patients	0.05	0.11	0.03	0.03	0.01	0.06	0.03	0.05	0.12	0.04	0.04	0.05	0.07	**0.04**	**0.06**	<= 0.02 as per Model Hospital		>0.04
Pre-Op Length of Stay - Non Elective Patients	0.64	0.68	0.64	0.67	0.67	0.64	0.66	0.57	0.58	0.57	0.59	0.85	0.57	**0.52**	**0.00**	<=0.73 as per Model Hospital		
Non Elective with zero LOS (not ambulatory)	8,055	732	653	759	617	624	663	709	670	694	640	620	439	**579**	**1,018**	Not applicable		
Elective Inpatients with zero LOS	907	62	82	53	56	91	102	91	66	88	68	73	27	**11**	**38**	<=65 / <=75 from April 20		>=80
Day Cases																		
Day Case Rate	89.66%	90.08%	88.89%	90.45%	89.28%	89.33%	89.37%	89.45%	89.90%	90.53%	89.42%	89.43%	91.94%	**94.54%**	**93.29%**	>=89.25%	80.1% -89.24%	<=80%
Failed Day Cases	1,483	109	118	131	136	119	111	134	113	123	149	116	31	**23**	**54**	<=120	YTD <=1440	>=125
Beds																		
Beds Open in Month - Plan	801	778	778	778	778	778	778	778	778	801	801	801	785	**770**	**770**	Not applicable		
Beds Open in Month - Actual	795.00	779.70	779.70	779.00	780.16	783.00	794.00	796.00	804.88	809.10	802.60	795.00	788.00	**779**	**779**	Not applicable		
Hospital Bed Days per 1000 population - Adults	40.44	45.86	44.85	45.34	45.65	45.78	48.7	46.89	48.26	48.65	45.27	40.44	24.97	**30.11**	**24.97**	18/19 Baseline		
Emergency Hospital Admissions per 1000 population - Adults	0.08	0.10	0.09	0.10	0.10	0.09	0.10	0.10	0.10	0.11	0.09	0.08	0.06	**0.08**	**0.06**	18/19 Baseline		
Occupied Bed Days							19,636	18,990	19,428	19,273	17,829	16,007	9,269	**11,578**	**20,847**	Not applicable		
Cancellations																		
Clinical Slots not Utilised	8.70%	9.90%	8.70%	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	0.10	0.32	**0.33**	**32.30%**	Not applicable		
Endoscopy Utilisations - Trust level	98.30%	98.52%	97.90%	98.03%	98.99%	98.51%	97.88%	98.61%	98.36%	97.20%	99.30%	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - CRH	99.69%	99.89%	100.00%	99.30%	100.00%	99.74%	99.56%	99.84%	99.54%	99.65%	99.64%	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - HRI	97.22%	97.51%	96.32%	97.01%	98.34%	97.70%	96.73%	97.49%	97.18%	95.39%	98.73%	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Hospital Cancellations within 6 Weeks	3,431	1,228	1,076	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	8,273	17,022	**7,545**	**7,545**	0		>=1
Theatre Utilisation																		
Theatre Utilisation (TT) - Main Theatre - CRH	83.60%	85.20%	85.00%	84.80%	86.00%	85.40%	82.00%	83.80%	81.30%	82.10%	84.00%	79.90%	89.16%	**82.80%**	**86.50%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - Main Theatre -HRI	87.80%	89.70%	85.00%	87.70%	90.30%	86.70%	88.90%	89.20%	84.60%	88.20%	89.30%	82.70%	63.15%	**72.30%**	**67.00%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - HRI DSU	73.80%	74.50%	74.50%	72.80%	74.60%	76.00%	74.80%	70.80%	72.80%	72.30%	78.50%	73.30%	57.62%	**58.70%**	**58.50%**	>=88%	85% - 87%	<=84%
Theatre Utilisation (TT) - Trust	82.40%	83.80%	82.70%	82.70%	84.10%	83.50%	82.20%	82.30%	80.20%	81.40%	84.00%	79.40%	78.09%	**75.80%**	**77.00%**	>=90%	84% - 89%	<=83%
% Theatre Scheduled Late Starts > 15 mins - Trust	37.29%	35.75%	40.53%	35.49%	34.07%	37.23%	37.29%	37.35%	39.05%	32.71%	36.50%	44.93%	56.45%	**55.10%**	**55.86%**	Not applicable		
Total Fallow lists - Trust	705	88	63	47	70	39	53	40	84	58	52	30	0	**0**	**0**	To be confirmed		
Flow																		
No. of Ambulatory patients	12,405	1,027	1,014	983	1,052	1,042	1,071	1,131	1,011	1,195	1,076	787	434	**653**	**1,087**	0		>=1
Emergency Hospital Discharges	51483	4326	4126	4443	4135	4130	4500	4551	4,449	4,729	4,033	3,732	2,618	**3,092**	**5,710**	<=4181 / <=4200 from April 20		>=4300
Stranded 7 Days	48.07%	49.53%	48.01%	45.19%	46.28%	48.32%	48.90%	46.64%	47.45%	47.88%	48.22%	50.70%	37.50%	**37.36%**	**37.43%**	<=30%	31% - 99%	>=40%
Super Stranded 21 Days	97	101	97	87	82	90	102	100	93	104	106	97	24	**22**	**23**	<= 95	96 - 97	>=98
Average time to start of reablement (days)	6.94	10.00	8.10	7.50	9.50	8.20	6.00	5.80	6.10	4.60	4.20	4.20	2.00	**2.50**	**2.30**	<=5 days	6 - 8 days	>= 9 days
% Catheter Lab Utilisation	89.00%	90.00%	79.00%	90.00%	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	**in arrears**	**in arrears**	No target		







Efficiency & Finance Frailty- Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range
Acute Admissions - Aged 75+ Years																Green / Amber / Red
Acute Admissions aged 75+	9,851	826	727	866	763	744	852	822	936	947	784	757	581	**635**	**1,216**	not applicable
Frail* patients admitted aged 75+	3927	323	285	338	261	286	323	316	433	437	307	295	188	**203**	**391**	
% patients admitted aged 75+ who are frail**	39%	39%	39%	39%	34%	38%	38%	38%	46%	46%	39%	39%	32%	**32%**	**32%**	
Frailty Admissions with LOS < 3 days																
Patients 75+ with a LOS < 3 days	5060	429	380	474	389	374	434	451	446	503	408	320	260	**327**	**587**	not applicable
Frail* patients with a LOS < 3 days	1595	133	112	144	95	105	141	140	167	184	130	91	81	**83**	**164**	
% of patients with a LOS < 3 days who are frail**	32%	31%	29%	30%	24%	28%	32%	31%	37%	37%	32%	28%	31%	**25%**	**32%**	
Patients 75+ occupied bed days	69085	6305	5253	6063	4945	5215	5827	5372	6,533	6,267	4,940	7,011	3,409	**3,005**	**6,414**	
Frail* occupied bed days	32362	2956	2480	3058	2278	2433	2254	2405	3,414	3,536	2,358	2,926	1,074	**1,170**	**2,244**	
Average frail* non-elec IP LOS	42.0	9.15	8.7	9.05	8.73	8.51	6.98	7.61	7.88	8.09	7.7	9.9	5.7	**5.8**	**5.7**	
Re-admitted back to the Frailty Team within 30 days	1035	70	**60**	62	60	59	87	107	113	124	98	93	in arrears	**in arrears**	**in arrears**	
% Re-admitted back to the Frailty Team within 30 days	20%	11%	**12%**	11%	12%	11%	14%	18%	17%	18%	17%	18%	in arrears	**in arrears**	**in arrears**	

* Data is based on the following Treatment Functions: General Medicine; Endocrinology; Hepatology; Diabetic Medicine; Respiratory; Nephrology; Neurology; Rheumatology; Geriatric Medicine
** The frailty team at Calderdale and Huddersfield Foundation Trust have defined frail patients as being a patient over and including the age of 75 with one of the ICD 10 diagnosis codes described by the Acute Frailty Network (AFN).

Activity - Key measures

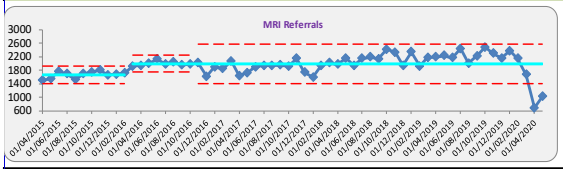
	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	35,430	3,237	3,037	3,396	3,083	3,360	3,606	2,937	2,447	2,993	2,421	1,885	654	**941**	**1,595**	**-75.83%**
03A - NHS GREATER HUDDERSFIELD CCG	32,540	2,922	2,655	3,109	2,811	2,999	3,245	2,726	2,199	2,721	2,461	1,873	701	**949**	**1,650**	**-72.50%**
Other	6724	715	539	691	573	657	609	550	426	555	470	325	95	**84**	**179**	**-88.03%**
Trust	74,694	6,874	6,231	7,196	6,467	7,016	7,460	6,213	5,072	6,269	5,352	4,083	1,450	**1,974**	**3,424**	**-74.32%**
Trust - % Change on Previous year	0.09%	1.60%	-1.48%	12.78%	0.89%	21.13%	12.61%	7.91%	-6.54%	-4.62%	-2.22%	-37.31%	-77.56%	**-71.28%**	**-74.32%**	
03J - NHS NORTH KIRKLEES CCG	2,533	275	197	257	197	274	239	211	155	198	190	119	36	**29**	**65**	**-87.18%**
02R - NHS BRADFORD DISTRICTS CCG	0	0	0	0	0	0	0	0	0	0	0	0	35	**13**	**48**	**-87.94%**
03R - NHS WAKEFIELD CCG	912	94	83	92	65	88	87	64	67	68	58	49	6	**10**	**16**	**-89.61%**
02W - NHS BRADFORD CITY CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**10**	**10**	**-91.60%**
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	75	4	6	4	8	8	10	6	1	7	7	2	0	**0**	**0**	**-100.00%**
03C - NHS LEEDS WEST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
03G - NHS LEEDS SOUTH AND EAST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02V - NHS LEEDS NORTH CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0.00%**
15F - NHS LEEDS CCG	83	4	6	7	12	9	8	5	8	7	3	5	0	**0**	**0**	**-100.00%**
ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case Variance against Contract	-284	-74	39	36	1	49	-123	92	162	-12	121	-760	-2,796	**-2,470**	**-5,266**	
% Day Case Variance against Contract	-0.74%	-2.12%	1.17%	0.96%	0.01%	1.40%	-3.20%	2.62%	5.42%	-0.33%	3.62%	-20.68%	-80.27%	**-77.63%**	**-74.85%**	
Elective Variance against Contract	-53	-33	26	-24	31	14	-21	11	-5	-37	39	-76	-364	**-365**	**-729**	
% Elective Variance against Contract	-1.06%	-7.01%	5.90%	-4.99%	7.25%	3.11%	-4.05%	2.28%	-1.17%	-8.10%	9.18%	-16.08%	-79.12%	**-81.36%**	**-83.71%**	
Non-elective Variance against Contract	-962	-175	-229	2	-131	-166	54	65	-81	367	-94	-823	-1,959	**-1,201**	**-3,160**	
% Non-elective Variance against Contract	-1.75%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-38.67%	**-31.67%**	**-24.46%**	
Outpatient Variance against Contract	162	-1,642	-517	-1,226	-1,819	-289	-296	-347	1,232	-70	-1,066	-6,806	-18,441	**-16,695**	**-35,136**	
% Outpatient Variance against Contract	0.07%	-5.23%	-1.74%	-3.87%	-7.56%	-0.96%	-1.03%	-1.13%	5.09%	-0.30%	-3.62%	-21.48%	-61.92%	**-61.13%**	**-60.29%**	
Accident and Emergency Variance against Contract	3,199	-732	-49	276	628	256	103	614	346	647	538	-2,310	-6,037	**-4,326**	**-10,363**	
% Accident and Emergency Variance against Contract	0.58%	-5.32%	-0.38%	2.02%	5.04%	1.99%	0.78%	4.92%	2.66%	5.19%	4.68%	-18.02%	-46.70%	**-38.81%**	**-31.41%**	

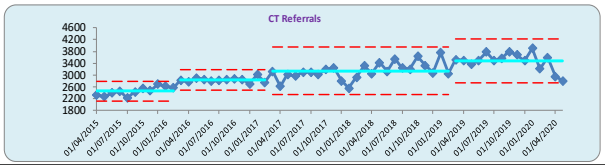
Please note further details on the referral position including commentary is available within the appendix.

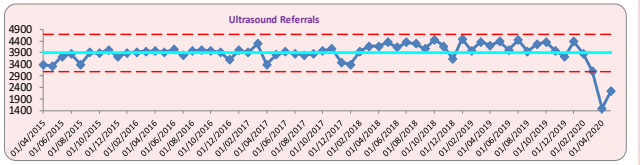
Radiology Summary of Activity of Key Modalities - May 2020

Referrals into Service

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD 20/21	YTD 19/20	Increase	%
MRI	1969	2159	1945	2152	2192	2134	2422	2327	1946	2345	1921	2176	2188	2230	2173	2444	2004	2228	2479	2303	2154	2374	2153	1671	689	1026	1715	4418	-2703	-61%
CT	3058	3426	3131	3553	3244	3199	3632	3325	3077	3763	3051	3519	3497	3380	3498	3785	3481	3572	3790	3683	3482	3911	3212	3599	2949	2807	5756	6877	-1121	-16%
Obstetrics	2288	2437	2369	2486	2417	2270	2452	2329	2087	2468	2131	2294	2288	2481	2247	2581	2400	2329	2480	2276	2287	2394	2175	2301	1909	1951	3860	4769	-909	-19%
General Radiology	17208	18772	17404	17601	16123	16456	17774	16323	15515	18264	15866	17064	16923	17116	16434	18090	16876	16765	17406	16472	15653	18242	15665	12489	6629	8962	15591	34039	-18448	-54%
Ultrasound	4174	4349	4131	4350	4282	4062	4463	4172	3631	4490	3980	4369	4205	4382	4011	4445	3962	4256	4364	3975	3741	4375	3861	3112	1500	2266	3766	8587	-4821	-56%
Total	28697	31143	28980	30142	28258	28121	30743	28476	26256	31330	26949	29422	29101	29589	28363	31345	28723	29150	30519	28709	27317	31296	27066	23172	13676	17012	30688	58690	-28002	-48%





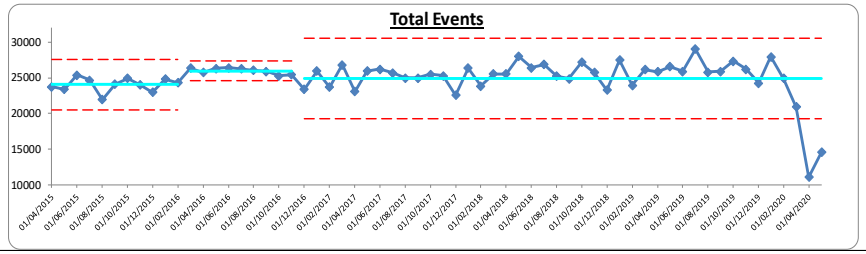


How does this compare to Trust activity Trend?

A&E Activity has decreased by 37%, Outpatients decreased by 26% and Inpatients (excluding Maternity) decreased by 49%

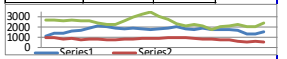
Activity

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD 20/21	YTD 19/20	Increase	%
Total Events	25,525	27,999	26,411	26,860	25,252	24,877	27,165	25,739	23,304	27,467	23,929	26,136	25,856	26,555	25,921	29,002	25,777	25,871	27,344	26,191	24,262	27,950	24,917	20,906	11,080	14,583	25,663	52,411	-26,748	-51%
MRI	1677	1616	1671	1652	1703	1611	1760	1890	1682	1926	1843	2042	1900	1778	1905	2041	1874	1992	1990	2132	1849	2068	1974	1832	502	698	1200	3678	-2478	-67%
HRI -MRI	608	596	625	611	616	575	669	696	601	661	577	699	675	629	647	682	637	658	698	701	677	690	703	643	221	261	482	1304	-822	-63%
CRH - MRI	496	469	456	450	496	479	469	533	492	562	561	539	463	500	498	558	479	492	582	551	446	533	473	455	160	164	324	963	-639	-66%
Mobile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
New Scanner - HRI	567	549	581	584	577	546	616	649	579	691	659	629	626	561	643	703	675	752	606	735	621	744	679	579	118	151	269	1187	-918	-77%
CRVAN	0	0	0	0	0	0	0	0	0	0	36	171	127	76	108	90	78	84	92	134	98	92	112	143	0	0	0	203	-203	-
Unknown	6	2	9	7	14	11	6	12	10	12	10	4	9	12	9	8	5	6	12	11	7	9	7	12	3	122	125	21	104	495%
CT	2,708	2,989	2,869	3,090	2,888	2,785	3,078	2,906	2,682	3,434	2,743	3,015	3,053	2,925	3,072	3,302	3,009	3,206	3,331	3,132	3,024	3,389	3,187	2,718	1,755	2,576	4,331	5,978	-1,647	-28%
General Radiology	15,518	17,341	16,076	16,256	14,730	15,030	15,999	14,982	13,998	16,314	14,365	15,609	15,364	15,664	15,003	17,202	15,071	15,031	15,911	15,148	14,361	16,532	14,381	11,438	5,865	7,941	13,806	31,028	-17,222	-56%
Obstetrics	2,166	2,278	2,249	2,316	2,279	2,112	2,292	2,200	1,937	2,265	1,971	2,116	2,098	2,367	2,131	2,392	2,257	2,196	2,316	2,144	2,112	2,242	2,071	2,123	1,786	1,853	3,639	4,465	-826	-18%
Ultrasound	3,456	3,775	3,546	3,546	3,652	3,339	4,036	3,761	3,005	3,528	3,007	3,354	3,441	3,821	3,810	4,065	3,566	3,446	3,796	3,635	2,916	3,719	3,304	2,795	1,172	1,515	2,687	7,262	-4,575	-63%
Total Exams	27,857	30,675	28,928	29,551	27,758	27,176	29,686	28,136	25,455	29,722	26,190	28,570	28,260	29,008	28,480	32,306	28,619	28,405	29,930	28,739	26,521	30,743	27,471	23,073	12,387	16,402	28,789	57,268	-28,479	-50%
MRI	1748	1710	1753	1739	1784	1683	1848	1978	1757	2025	1924	2120	1964	1845	1985	2134	1956	2069	2058	2215	1934	2151	2046	1908	515	712	1227	3809	-2582	-68%
HRI -MRI	633	641	670	652	651	617	714	728	625	717	615	724	698	654	663	707	667	680	711	729	708	700	719	670	223	273	496	1352	-856	-63%
CRH - MRI	516	487	471	461	518	493	486	554	509	574	582	562	471	513	524	575	495	512	598	572	456	556	486	462	168	168	336	984	-648	-66%
Mobile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
New Scanner - HRI	592	578	603	619	600	561	642	684	612	722	680	655	653	587	681	751	706	783	643	766	663	790	721	618	121	149	270	1240	-970	-78%
CRVAN	0	0	0	0	0	0	0	0	0	0	37	175	133	78	108	93	81	87	94	137	99	96	113	145	0	0	0	211	-211	-
Unknown	7	4	9	7	15	12	6	12	11	12	10	4	9	13	9	8	7	7	12	11	8	9	7	13	3	122	125	22	103	468%
CT	4,006	4,424	4,220	4,673	4,291	4,141	4,477	4,231	3,937	4,629	4,033	4,377	4,439	4,253	4,498	4,979	4,366	4,719	4,826	4,586	4,363	4,999	4,741	4,167	2,825	4,056	6,881	8,692	-1,811	-21%
General Radiology	16,110	18,095	16,765	16,917	15,350	15,534	16,589	15,597	14,486	16,889	14,924	16,234	15,971	16,342	15,657	18,318	16,062	15,647	16,560	15,785	14,885	17,253	14,974	11,820	5,948	8,068	14,016	32,313	-18,297	-57%
Obstetrics	2,171	2,283	2,250	2,322	2,283	2,117	2,293	2,208	1,941	2,270	1,974	2,119	2,107	2,372	2,134	2,398	2,264	2,200	2,320	2,153	2,119	2,248	2,079	2,125	1,791	1,856	3,647	4,479	-832	-19%
Ultrasound	3,822	4,163	3,940	3,900	4,050	3,701	4,479	4,122	3,334	3,909	3,335	3,720	3,779	4,196	4,206	4,477	3,971	3,770	4,166	4,000	3,220	4,092	3,631	3,053	1,308	1,710	3,018	7,975	-4,957	-62%



Waiting List at Month End

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD 20/21	YTD 19/20	Increase	%
Total number on MRI Waiting List	1131	1384	1405	1602	1693	1894	2129	2006	1897	1797	1864	1803	1774	1803	1878	2044	1845	1761	1913	1779	1780	1755	1671	1295	1335	1527				
Total number on CT Waiting List	945	933	809	889	776	803	792	752	744	851	843	904	856	873	931	945	973	925	855	845	757	770	614	562	581	553				
Total number on US Waiting List	2706	2670	2609	2713	2586	2581	2432	2229	2283	2612	3004	3252	3454	3025	2727	2353	2085	2226	2111	1766	2024	2106	2231	2042	2008	2409				



Number of Exams reported

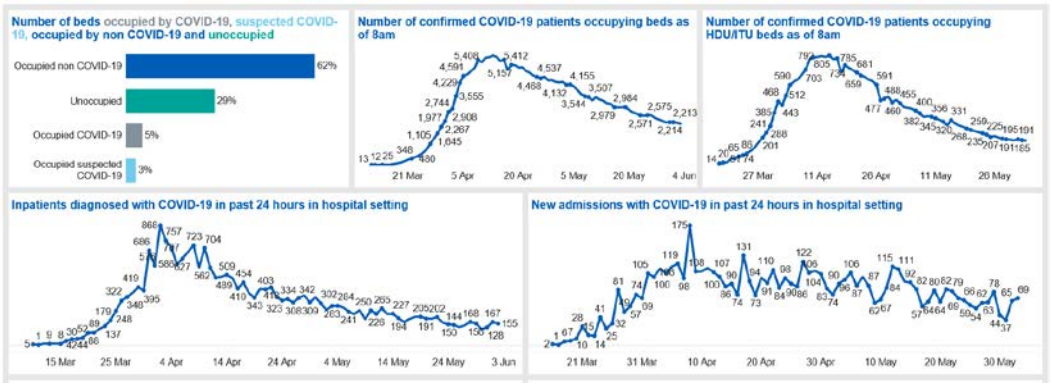
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD 20/21	YTD 19/20	Increase	%
Internal (Planned)	20918	21509	19512	19286	20063	17909	21896	21675	17070	20696	17525	15201	13589	13823	12320	15530	13995	12592	13511	12221	12550	13959	12956	15532	9098	11411	20509	27412	-6903	-25%
Insourced (Extras)	0	0	0	0	0	0	0	1110	0	0	0	419	253	152	102	283	17	0	0	0	0	0	46	23	0	0	0	405	-405	-
Locum Radiologist/Sonagropher	45	68	96	110	0	0	0	0	0	0	0	359	288	392	690	1114	217	1161	502	454	512	783	581	479	727	409	1136	680	456	67%
Auto Reported	3657	3407	3505	5066	4505	4702	4337	3217	4425	4773	4559	3192	4216	2861	2476	2372	2126	3042	3266	3128	3458	4694	3355	2869	562	1042	1604	7077	-5473	-77%
Outsourced	3165	3968	4977	3839	2767	3149	3111	2436	3094	2633	3040	2431	3278	7511	7279	8759	7481	7409	8055	8310	10180	11003	10037	5418	707	1059	1766	10789	-9023	-84%
Total	27785	28952	28090	28301	27335	25760	29344	28438	24589	28102	25124	21602	21624	24739	22867	28058	23836	24204	25334	24113	26700	30439	26975	24321	11094	13921	25015	46363	-21348	-46%
% Outsourced	11%	14%	18%	14%	10%	12%	11%	9%	13%	9%	12%	11%	15%	30%	32%	31%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	7%	23%	-16%	
% Insourced/Outsourced	11%	14%	18%	14%	10%	12%	11%	12%	13%	9%	12%	13%	16%	31%	32%	32%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	7%	24%	-17%	

Appendices

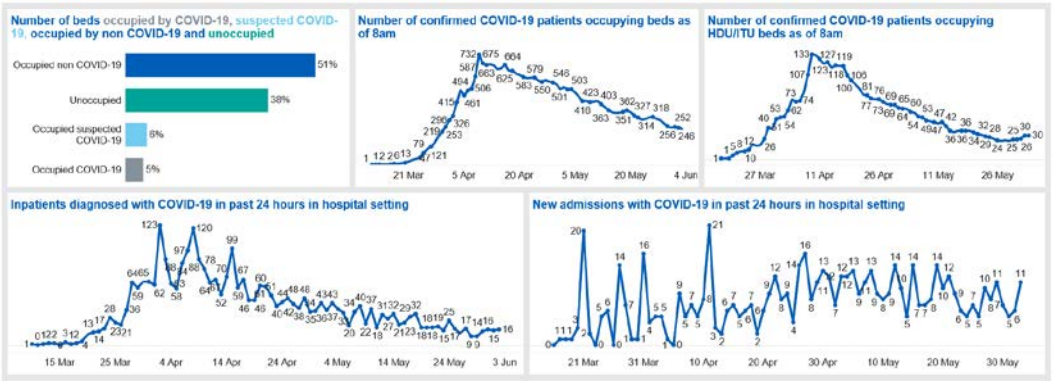
COVID-19 IPR APPENDIX

COVID Metrics across the Region:

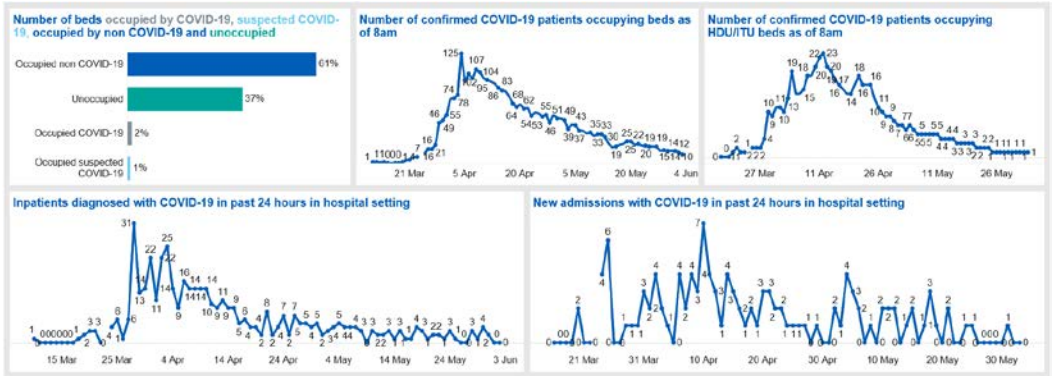
North East and Yorkshire and North West: Sustained reduction across the regions in occupied beds (including ITU's) since mid-April. Peak of Covid19+ inpatients in early April with overall reduction since this time. New Covid19+ admissions peaked first week in April with daily variability but an overall reduction since.



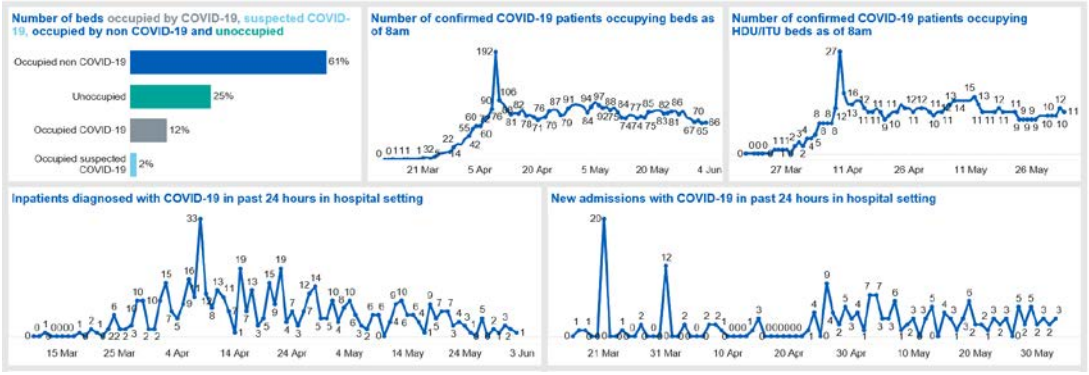
WYAAT: Sustained reduction across the regions in occupied beds (including ITU's) since mid-April. Peak of Covid19+ inpatients in early April with overall reduction since this time despite additional peaks early – mid April. New Covid19+ daily admissions showing significant variability.



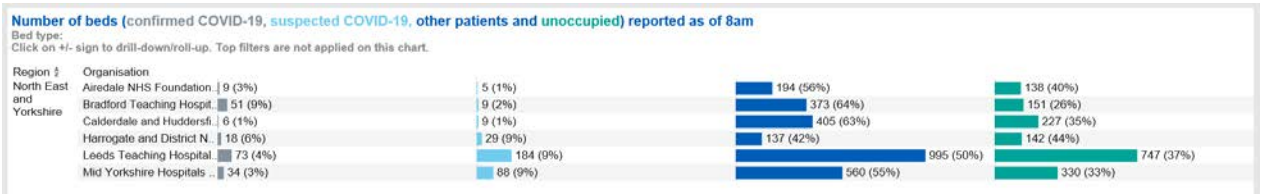
CHFT: Continued reduction in Covid19 occupied beds since peak in early April (mid-April for ITU beds). Peak of Covid19+ inpatients in late March to early April with continued reduction since this time. New Covid19+ daily admissions showing significant variability but with overall lower numbers since end of April.



BTHFT: After an initial reduction following a peak of occupied bed days (including ITU beds) in early - mid April Bradford have not seen the sustained reduction that other Trusts in the region have seen.



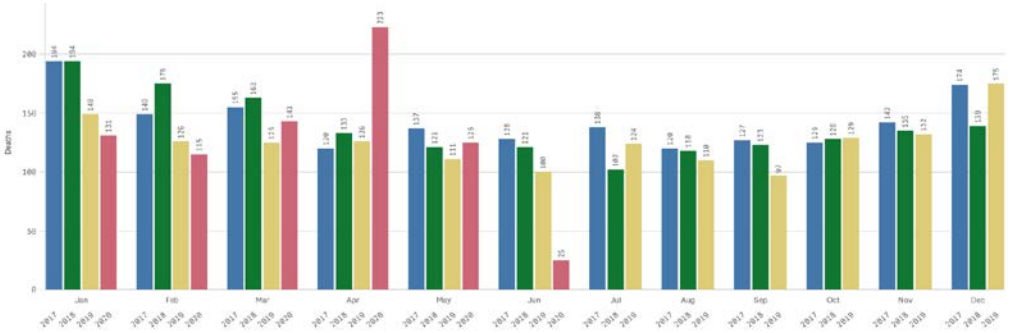
Beds Occupied Position as at 9th June across WYAAT



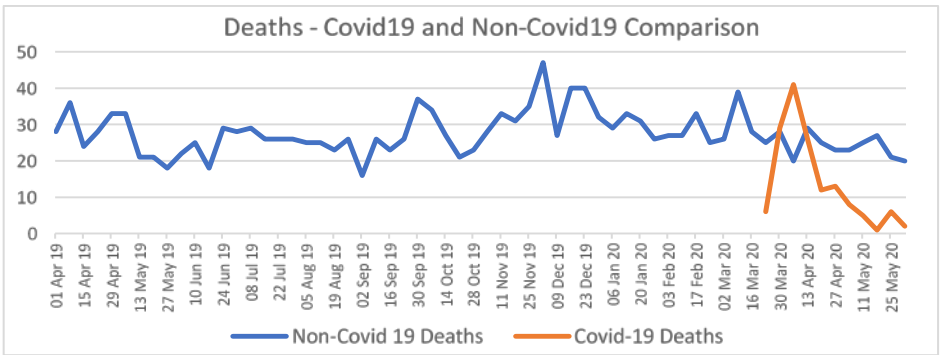
It is worth noting that CHFT has the lowest bed occupancy of confirmed Covid19 patients at 1% and 2nd highest bed occupancy of non-Covid19 patients at 63%. Bradford continue to have the highest bed occupancy of confirmed Covid19 patients at 9%

Mortality:

Historical Comparison

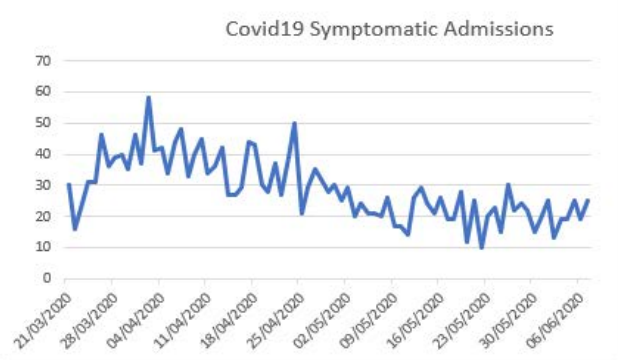


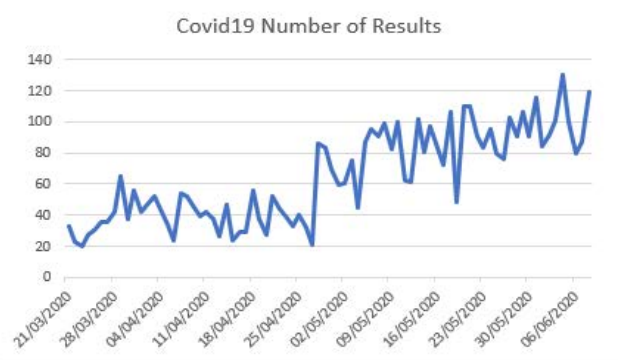
Impact of Covid19 deaths on historical trends seen particularly in April and less so in March and May.



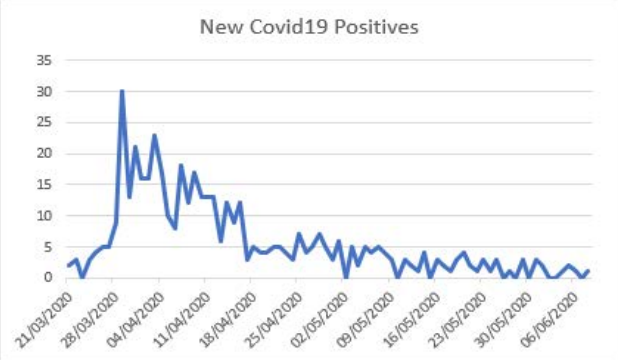
Peak number of Covid19+ deaths in early April with a sustained reduction since then to date.

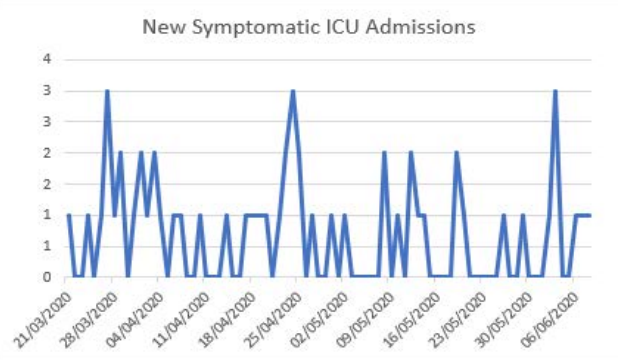
Covid19 Hospitalisation in England Surveillance System (CHESS) was developed by Public Health England (PHE) for monitoring hospitalised COVID-19. The scheme is based on the existing UK Severe Influenza Surveillance Scheme (USISS) that was created following the 2009 influenza pandemic. Objectives of CHESS are to monitor and estimate the impact of Covid19 on the population.



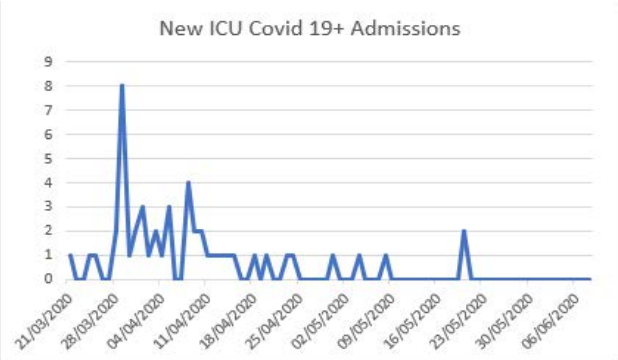


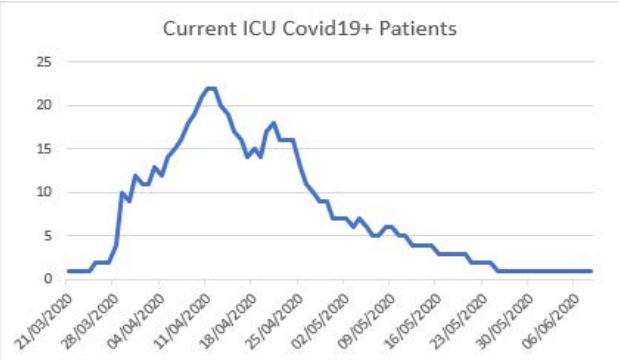
Since peak in late March/early April there has been an overall reduction in symptomatic admissions to CHFT. The increase in number of Covid19 results from start of May relates to a change in testing policy to include asymptomatic admissions.





Since 29th March the trend has been for a gradual decrease in new Covid19+ inpatients





There have been no new confirmed Covid19+ admissions to ICU's since 18th May. There was a peak of Covid19+ patients in ICU's 10th -12th April and other than a small increase around 22nd April there has been a continual decrease in patients in ICU since the Easter bank holiday weekend.

Appendix - Appointment Slot Issues

ASIs

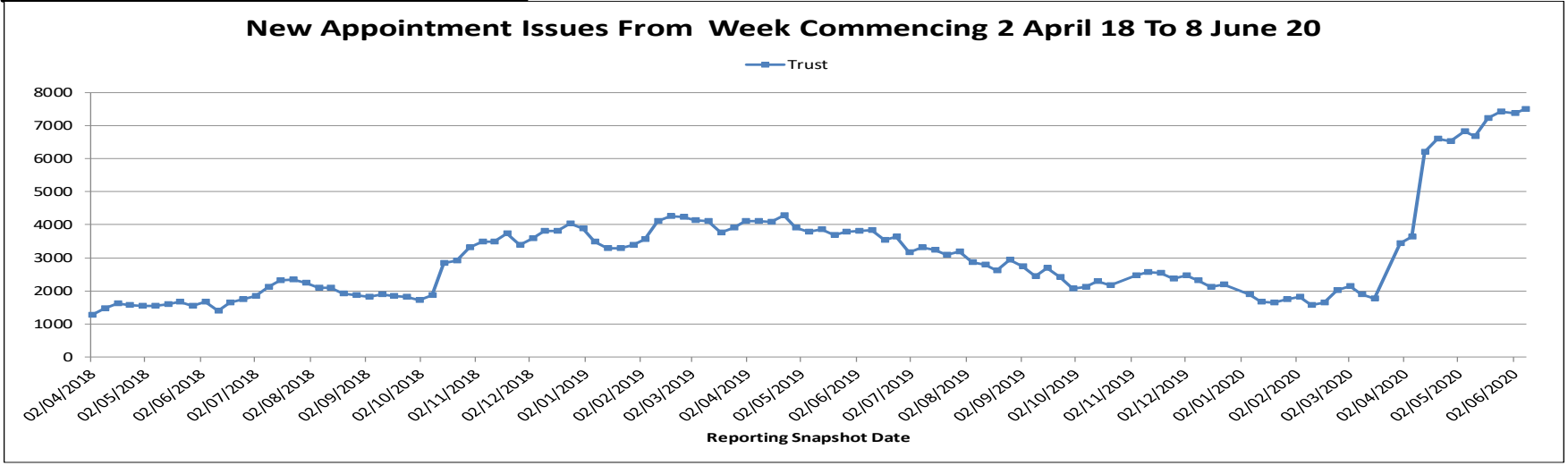
As at 15th June there were 7,483 referrals awaiting appointments.

The top specialties for ASIs backlog are:
ENT (1,147)
Ophthalmology (561)
Paediatric ENT (505)
Trauma and Orthopaedics (382)
Neurology (820)
Rheumatology (406)
Cardiology (381)

with smaller backlogs also in :
Urology (151)
Colorectal Surgery (133)
Pain Management (131)
Gastroenterology (131)

741 patients have been waiting over 6 months, (this was 566 on the last report)

Divison	Specialty	Weeks Waitng								
		Total	0-6	7-13	14-17	18-21	22-25	26-29	30-51	52+
FSS	Total	881	209	151	290	132	29	43	27	0
	Chemical Pathology	57	1	11	21	7	7	9	1	0
	Paediatric Epilepsy	6	2	4	0	0	0	0	0	0
	Paediatrics	444	92	98	114	87	12	23	18	0
	Gynaecology	374	114	38	155	38	10	11	8	0
Medicine	Total	2182	506	506	482	318	121	83	161	5
	Cardiology	381	123	66	57	53	28	24	30	0
	Endocrinology	115	38	36	28	8	4	0	1	0
	Gastroenterology	131	46	36	34	9	3	0	3	0
	Diabetic Medicine	84	26	20	27	6	3	2	0	0
	General Medicine	21	0	2	7	7	3	1	1	0
	Geriatric Medicine	44	8	4	14	10	5	1	2	0
	Clinical Haematology	29	20	0	2	3	3	0	1	0
	Medical Oncology	0	0	0	0	0	0	0	0	0
	Nephrology	89	16	29	15	12	0	6	11	0
	Rheumatology	406	85	141	115	44	3	7	11	0
	Neurology	820	116	156	173	162	68	42	98	5
	Respiratory Medicine	62	28	16	10	4	1	0	3	0
Surgery	Total	4212	941	732	1118	802	216	171	210	22
	Colorectal Surgery	133	47	35	22	13	9	1	5	1
	Breast Surgery	44	41	0	1	1	0	1	0	0
	General surgery	130	89	13	10	10	3	2	2	1
	Ophthalmology	561	78	168	185	71	18	17	19	5
	Paediatric Ophthalmology	65	11	21	19	10	2	1	1	0
	Orthoptics	124	14	36	49	15	5	3	2	0
	Pain Management	131	22	21	47	24	13	2	2	0
	Urology	151	134	12	1	2	2	0	0	0
	Paediatric Urology	74	10	7	25	17	8	1	5	1
	Audiology	26	7	7	3	2	2	5	0	0
	ENT	1147	236	118	395	294	45	30	29	0
	Paediatric ENT	505	57	87	146	157	26	13	17	2
	Maxillo-Facial Surgery	552	9	36	125	152	69	85	76	0
	Plastic Surgery	63	25	20	9	7	1	0	1	0
	Paediatric Plastic Surgery	4	3	0	1	0	0	0	0	0
	Trauma and Orthopaedics	382	75	143	78	23	9	8	38	8
	Paediatric Trauma and Orthopaedics	72	43	4	0	4	4	2	11	4
	Vascular Surgery	48	40	4	2	0	0	0	2	0
Community	Total	158	16	29	51	39	6	10	6	1
	Podiatry	73	14	17	15	12	2	7	6	0
	MSK	85	2	12	36	27	4	3	0	1
Unkown	Total	50	8	24	7	6	3	1	1	0
	Not CHFT	2	1	0	1	0	0	0	0	0
	Other CHFT	0	0	0	0	0	0	0	0	0
	-	48	7	24	6	6	3	1	1	0
Total	Total	7483	1680	1442	1948	1297	375	308	405	28



Appendix - Referrals

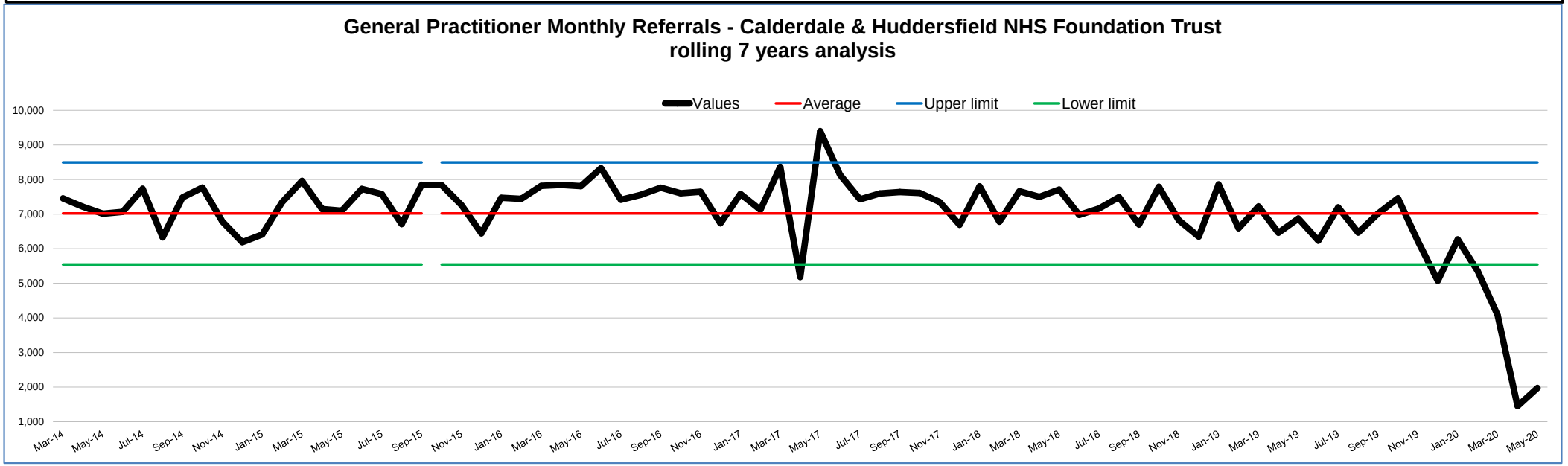
May 2020 Referrals

GP Referrals down 74% financial YTD May 2020 compared with May 2019. This is completely understandable following the ceasing of all routine referrals during the Covid19 pandemic.
- In April and May 2020, there were 39 working days, compared with 40 for the corresponding period 2019.
- This 1 less working day could indicate an anticipated decrease of GP referrals of 5% but clearly the impact of Covid19 on referral demand has been far more dramatic.
- NHS Calderdale GP referrals have seen a decrease of 75% (4,685) for the year to date and NHS Greater Huddersfield has had a very similar decrease overall of 72% (4,144).

Detailed Investigation of movement at specialty level has not been considered as a result of the large overall decrease.

Other CCGs with contracts with CHFT have all had similar marked reduction in referral volumes
A brief summary is as follows:

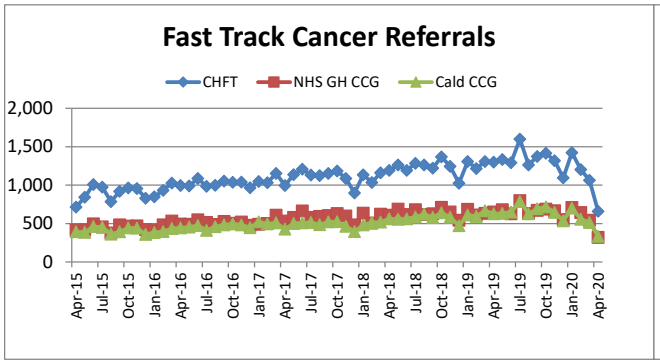
19/20 YTD	20/21	YTD	Var	% Var
NHS Calderdale	6280	1595	-4685	-75%
NHS Greater Huddersfield	5794	1650	-4144	-72%
NHS North Kirklees	483	65	-418	-87%
NHS Bradford District	356	48	-308	-87%
NHS Bradford City	108	10	-98	-91%
NHS Wakefield	178	16	-162	-91%
NHS Heywood	16	0	-16	-100%

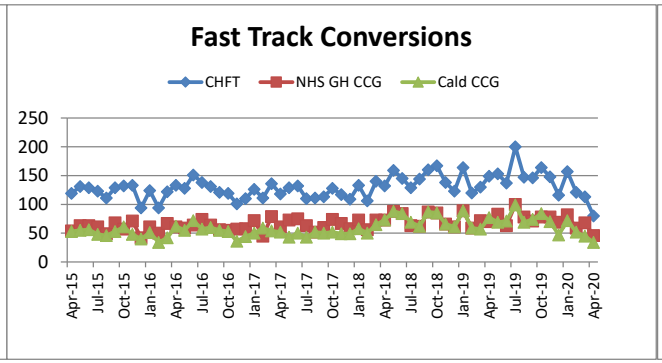


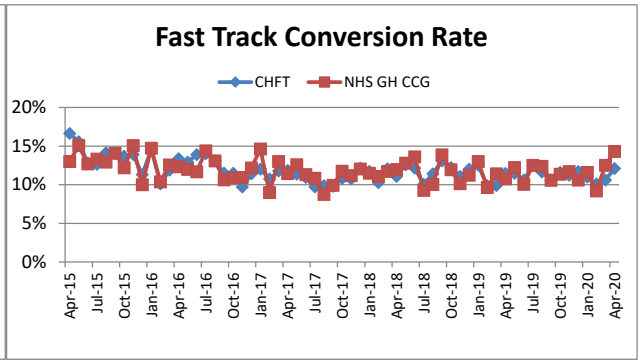
Activity - Key measures

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	YTD % Change
Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)																
NHS CALDERDALE CCG Referrals	7,664	632	646	784	626	691	712	644	531	702	558	515	334	in arrears	in arrears	
NHS CALDERDALE CCG Conversions	874	69	71	100	69	75	85	78	53	82	62	45	34	in arrears	in arrears	
NHS CALDERDALE CCG Conversion Rate	11.4%	10.9%	11.0%	12.8%	11.0%	10.9%	11.9%	12.1%	10.0%	11.7%	11.1%	8.7%	10.2%	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Referrals	7,836	679	628	799	629	666	686	662	551	707	643	543	321	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversions	929	83	63	101	77	71	84	81	76	91	59	68	46	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversion Rate	11.9%	12.2%	10.0%	12.6%	12.2%	10.7%	12.2%	12.2%	13.8%	12.9%	9.2%	12.5%	14.3%	in arrears	in arrears	
Other CCG Referrals	159	24	19	16	5	14	15	8	8	12	2	6	4	in arrears	in arrears	
Other CCG Conversions	16	1	3	1	0	3	2	1	0	3	0	0	0	in arrears	in arrears	
Other CCG Conversion Rate	10.1%	4.2%	15.8%	6.3%	0.0%	21.4%	13.3%	12.5%	0.0%	25.0%	0.0%	0.0%	0.0%	in arrears	in arrears	
CHFT Fast Track Referrals	15,659	1,335	1,293	1,599	1,260	1,371	1,413	1,314	1,090	1,421	1,203	1,064	659	in arrears	in arrears	
CHFT Fast Track Conversions	1,819	153	137	202	146	149	171	160	129	176	121	113	80	in arrears	in arrears	
CHFT Fast Track Conversion Rate	11.6%	11.5%	10.6%	12.6%	11.6%	10.9%	12.1%	12.2%	11.8%	12.4%	10.1%	10.6%	12.1%	in arrears	in arrears	
% Change on Previous year																

Note YTD Change for conversions is a month in arrears as latest month will still have conversions to feed through.

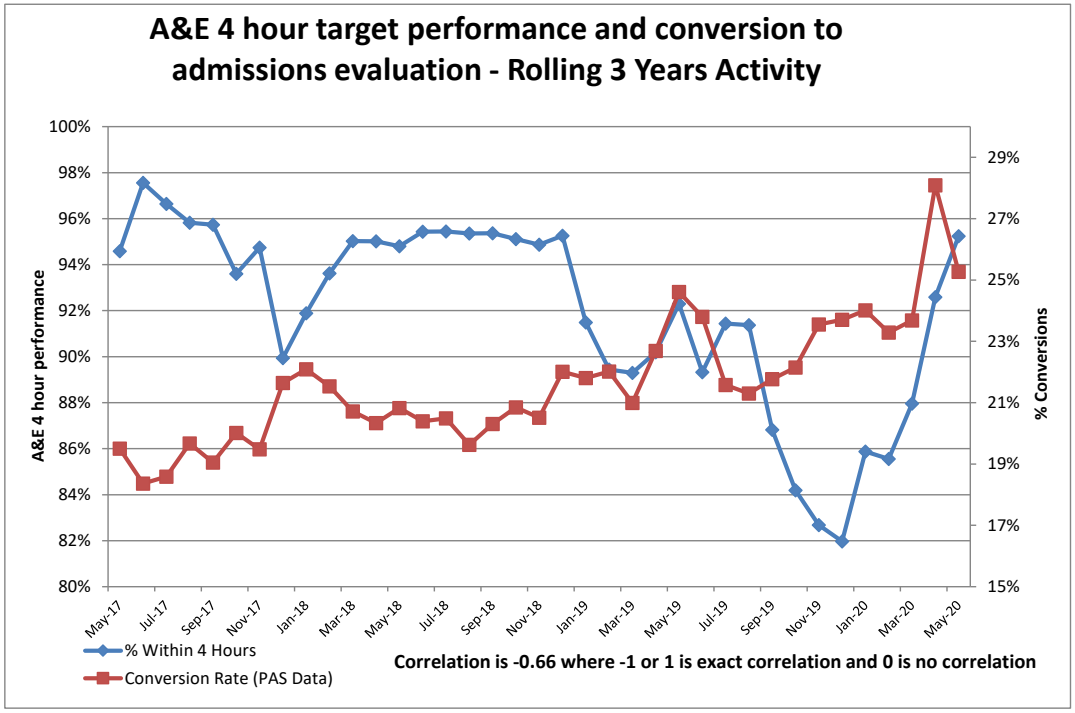






Appendix - A and E Conversion rates and Delayed Transfers

	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	YTD % Change
Analysis of A and E activity including conversions to admission																
A and E Attendances	154,445	13,009	12,927	13,898	13,101	13,153	13,311	13,091	13,336	13,105	12,017	10,511	6,895	**9,445**	**16,340**	-37.1%
A and E 4 hour Breaches	19,339	1,002	1,380	1,190	1,130	1,734	2,105	2,267	2,404	1,851	1,736	1,266	511	**450**	**961**	-57.8%
Emergency Care Standard 4 hours	87.48%	92.30%	89.32%	91.44%	91.37%	86.82%	84.19%	82.68%	81.97%	85.88%	85.55%	87.96%	92.59%	**95.24%**	**92.59%**	0.3%
Admissions via Accident and Emergency	34,851	2,819	2,806	2,999	2,791	2,864	2,949	3,083	3,160	3,146	2,799	2,489	1,937	**2,387**	**4,324**	-25.0%
% A and E Attendances that convert to admissions	22.57%	21.67%	21.71%	21.58%	21.30%	21.77%	22.15%	23.55%	23.70%	24.01%	23.29%	23.68%	28.09%	**25.27%**	**28.09%**	14.1%



Delayed Transfers of Care (Reportable & Not reportable) Snapshot on 15th June 2020	Calderdale	Kirklees	Other	Total
Total number of patients on TOC Pathway	23	17	1	41
Awaiting Completion of Assessment	13	6	1	20
Awaiting Care package in own home	6	5		11
Awaiting Residential home placement	1	1		2
Awaiting public funding				0
Awaiting further non-acute NHS Care	1	3		4
Awaiting community equipment and adaptations	2	1		3
Awaiting nursing home placement				0
Disputes				0
Patient or Family choice				0
Housing - Patients not covered by Care Act		1		1

Appendix - Cancer - By Tumour Group

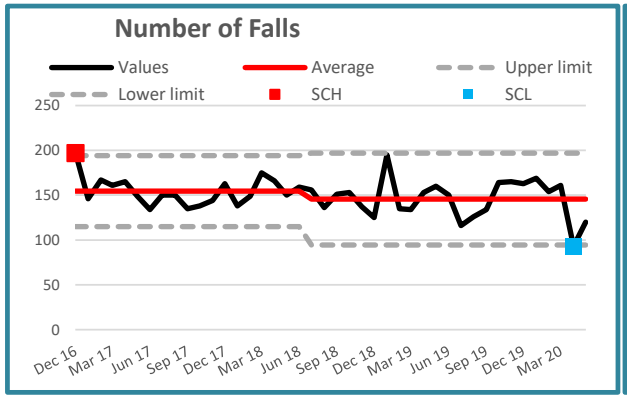
	19/20	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD	Performance Range		
62 Day GP Referral to Treatment																Green	Amber	Red
Breast	99.19%	94.74%	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Gynaecology	91.67%	100.00%	100.00%	83.33%	100.00%	78.95%	100.00%	100.00%	90.00%	80.00%	100.00%	100.00%	90.00%	**93.33%**	**91.43%**	>=85%	81% - 84%	<=80%
Haematology	87.40%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	76.92%	60.00%	66.67%	100.00%	90.91%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Head & Neck	56.72%	0.00%	100.00%	70.00%	100.00%	40.00%	57.14%	none to report	33.33%	36.36%	100.00%	60.00%	53.85%	**0.00%**	**46.67%**	>=85%	81% - 84%	<=80%
Lower GI	83.08%	88.89%	80.00%	83.33%	62.50%	80.00%	61.11%	100.00%	91.67%	78.95%	88.89%	100.00%	90.91%	**61.54%**	**80.00%**	>=85%	81% - 84%	<=80%
Lung	82.26%	80.00%	78.57%	86.36%	88.24%	87.50%	78.95%	81.82%	88.00%	91.67%	84.62%	73.08%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Sarcoma	87.50%	none to report	none to report	none to report	100.00%	none to report	none to report	100.00%	100.00%	100.00%	none to report	0.00%	none to report	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Skin	99.76%	97.78%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Upper GI	84.81%	77.78%	54.55%	100.00%	100.00%	100.00%	92.31%	82.61%	66.67%	75.00%	100.00%	100.00%	75.00%	**91.67%**	**85.00%**	>=85%	81% - 84%	<=80%
Urology	89.96%	93.02%	82.86%	76.92%	92.73%	88.89%	82.50%	88.00%	95.74%	91.53%	93.18%	91.11%	96.00%	**77.78%**	**93.22%**	>=85%	81% - 84%	<=80%
Others	100.00%	none to report	100.00%	100.00%	none to report	100.00%	100.00%	none to report	none to report	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Two Week Wait From Referral to Date First Seen																		
Brain	94.70%	100.00%	100.00%	73.91%	100.00%	100.00%	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	**100.00%**	**91.67%**	>=93%	86% - 92%	<=85%
Breast	98.43%	96.79%	98.44%	99.03%	97.21%	98.42%	99.07%	99.04%	98.25%	99.50%	100.00%	99.01%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Childrens	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Gynaecology	98.48%	96.49%	99.12%	100.00%	97.50%	98.53%	98.40%	98.18%	99.20%	97.30%	100.00%	100.00%	100.00%	**97.73%**	**98.81%**	>=93%	86% - 92%	<=85%
Haematology	98.59%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.48%	95.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Head & Neck	99.16%	100.00%	98.37%	100.00%	96.84%	100.00%	98.29%	99.21%	100.00%	100.00%	99.17%	97.56%	94.34%	**96.00%**	**95.51%**	>=93%	86% - 92%	<=85%
Lower GI	99.26%	98.18%	98.61%	99.42%	98.62%	99.34%	100.00%	100.00%	100.00%	99.60%	99.63%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Lung	98.67%	95.83%	97.06%	100.00%	100.00%	97.37%	96.43%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Sarcoma	96.48%	92.31%	84.21%	100.00%	100.00%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Skin	98.42%	95.16%	97.68%	98.38%	98.24%	99.36%	99.69%	99.61%	99.02%	99.62%	99.53%	98.76%	98.18%	**99.50%**	**99.04%**	>=93%	86% - 92%	<=85%
Testicular	97.47%	87.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Upper GI	96.87%	94.74%	96.30%	97.92%	99.11%	98.37%	97.30%	97.98%	96.84%	96.46%	99.04%	98.18%	89.80%	**100.00%**	**96.03%**	>=93%	86% - 92%	<=85%
Urology	99.34%	98.17%	98.57%	99.30%	99.01%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.39%**	**99.15%**	>=93%	86% - 92%	<=85%

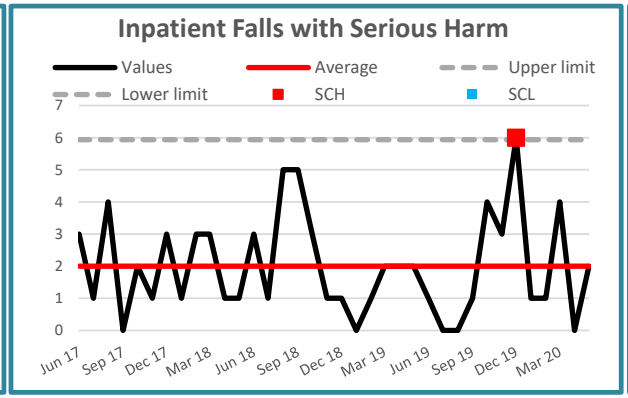
Appendix 1 - ESR Staff Groups - Roles

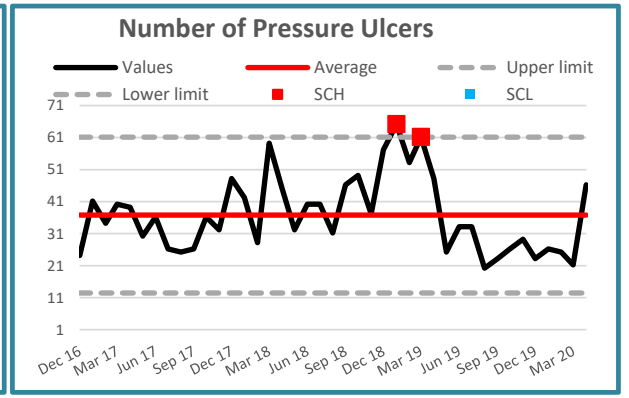
Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals
Chaplain	Assistant	Accountant	Advanced Practitioner
Clinical Director	Assistant Practitioner Nursing	Adviser	Chiropodist/Podiatrist
Manager	Assistant/Associate Practitioner	Analyst	Chiropodist/Podiatrist Manager
Operating Department Practitioner	Counsellor	Architect	Dietitian
Optometrist	Health Care Support Worker	Board Level Director	Dietitian Manager
Pharmacist	Healthcare Assistant	Chair	Dietitian Specialist Practitioner
Physician Associate	Healthcare Science Assistant	Chief Executive	Multi Therapist
Practitioner	Healthcare Science Associate	Clerical Worker	Occupational Therapist
Psychotherapist	Nursery Nurse	Finance Director	Occupational Therapist Manager
Technician	Nursing Associate	Librarian	Orthoptist
	Phlebotomist	Manager	Orthoptist Manager
	Technical Instructor	Medical Secretary	Physiotherapist
	Technician	Non Executive Director	Physiotherapist Manager
	Trainee Healthcare Science Practitioner	Officer	Physiotherapist Specialist Practitioner
	Trainee Healthcare Scientist	Other Executive Director	Radiographer - Diagnostic
	Trainee Nursing Associate	Personal Assistant	Radiographer - Diagnostic, Manager
		Receptionist	Radiographer - Diagnostic, Specialist Practitioner
		Researcher	Speech and Language Therapist
		Secretary	Speech and Language Therapist Manager
		Senior Manager	
		Technician	

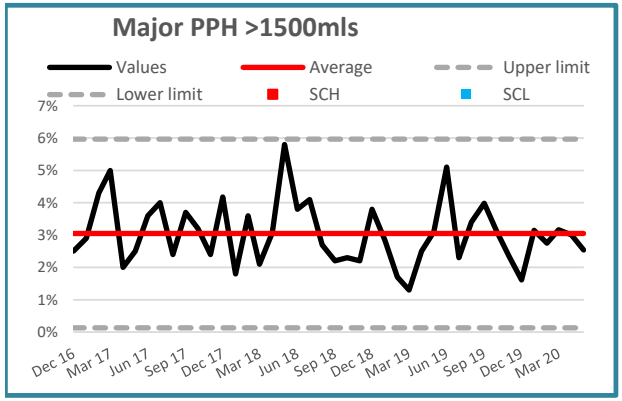
Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Assistant	Healthcare Science Practitioner	Consultant	Advanced Practitioner
Cook	Healthcare Scientist	Foundation Year 1	Community Nurse
Driver	Manager	Foundation Year 2	Community Practitioner
Engineer	Specialist Healthcare Science Practitioner	Specialty Doctor	Director of Nursing
Gardener/Groundsperson	Specialist Healthcare Scientist	Specialty Registrar	Midwife
Housekeeper		Staff Grade	Midwife - Manager
Maintenance Craftsperson		Trust Grade Doctor - Foundation Level	Midwife - Specialist Practitioner
Porter		Trust Grade Doctor - Specialty Registrar	Modern Matron
Supervisor			Nurse Consultant
Support Worker			Nurse Manager
Technician			Sister/Charge Nurse
Telephonist			Specialist Nurse Practitioner
			Staff Nurse

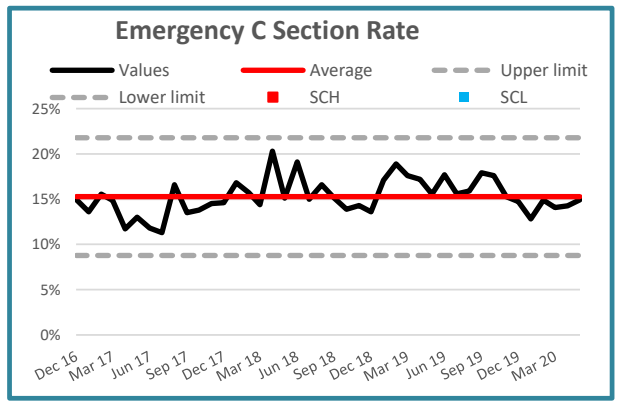
Safe - SPC Charts

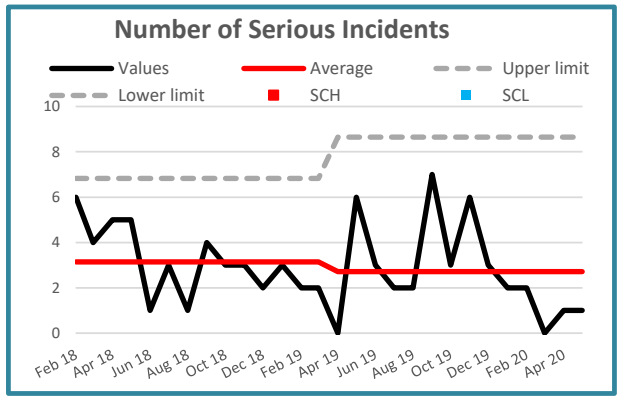




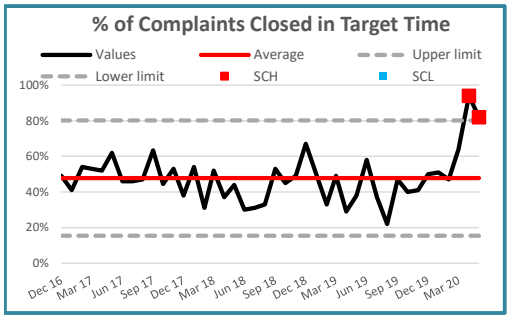


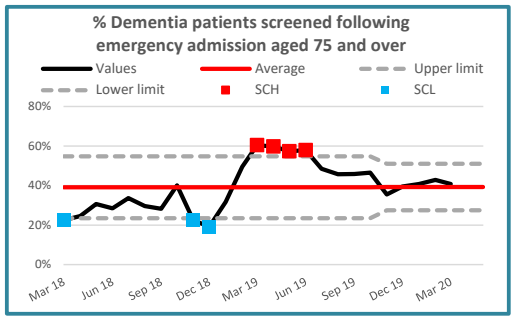




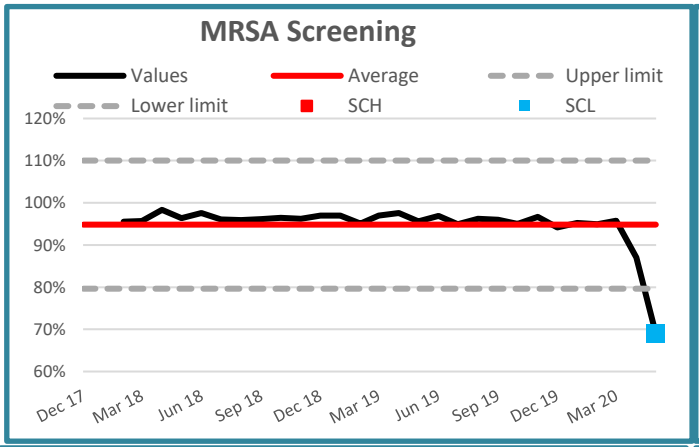


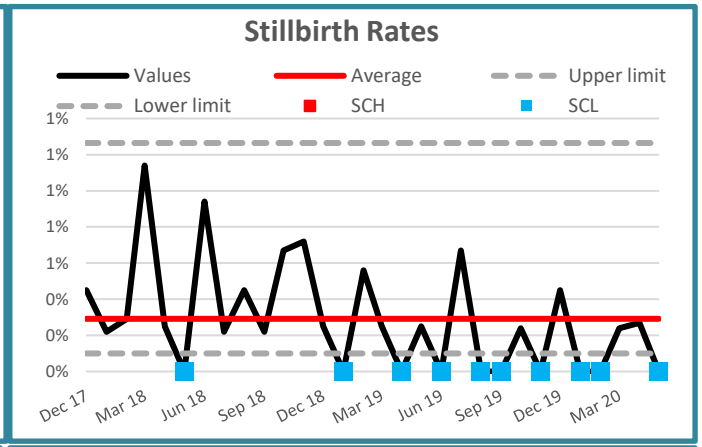
Caring - SPC Charts

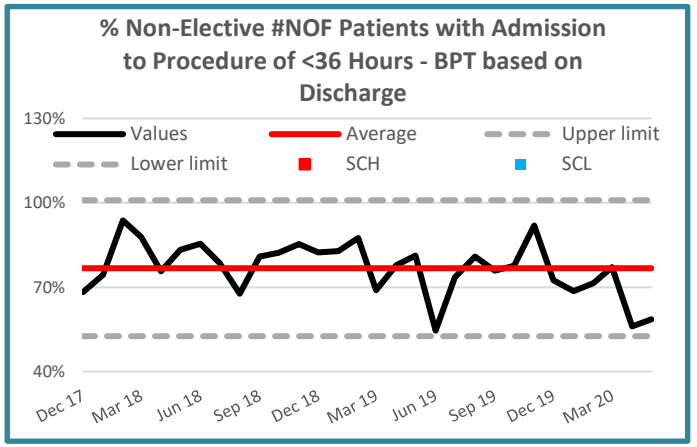


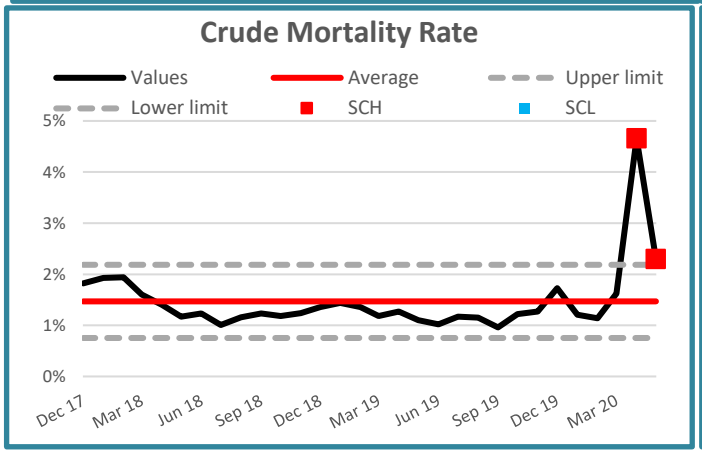


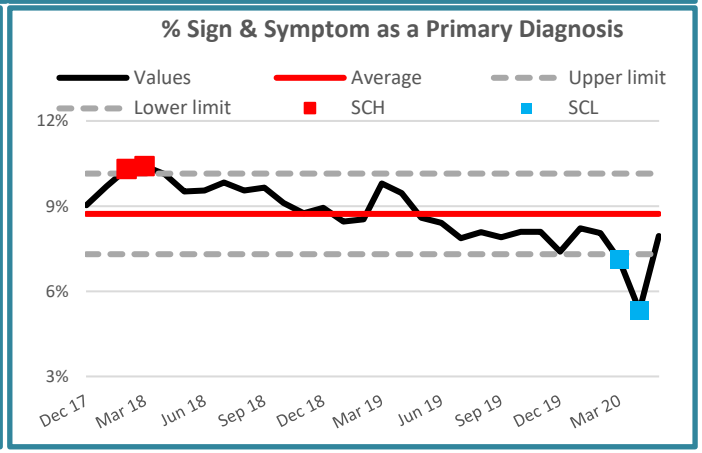
Effective - SPC Charts

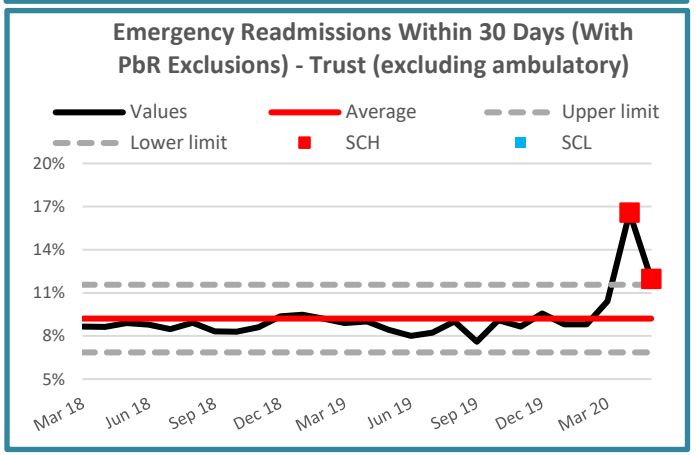




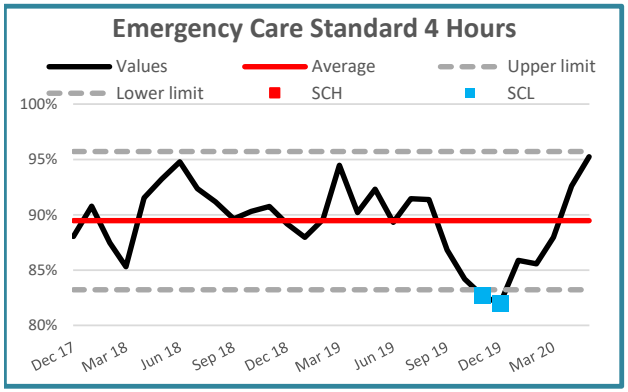


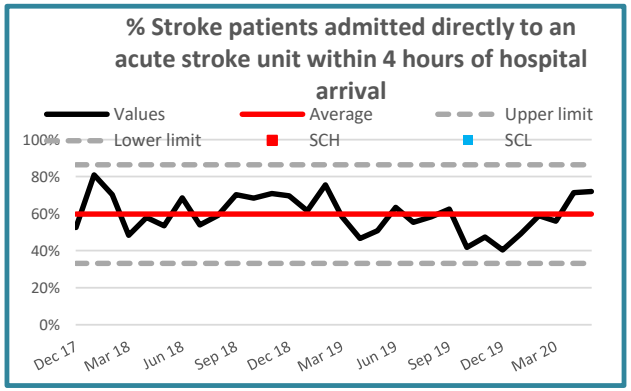


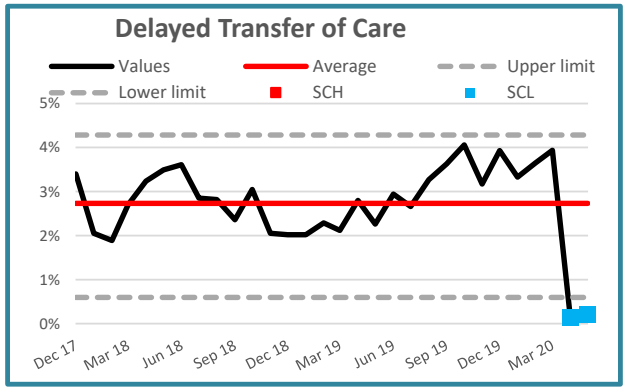


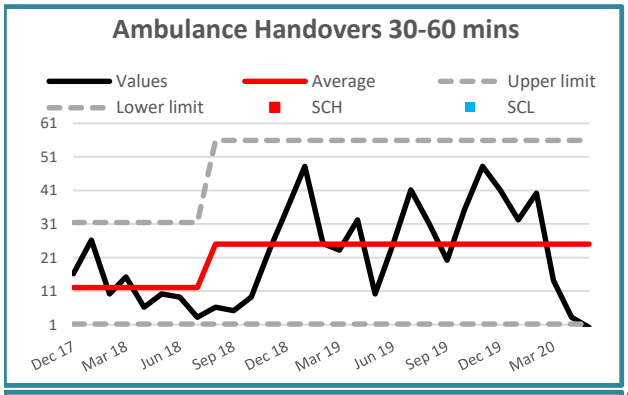


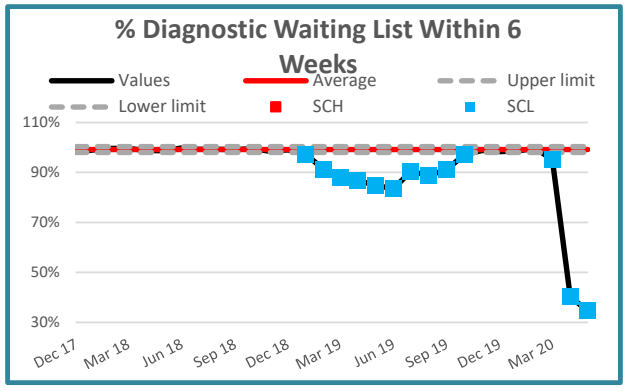
Responsive - SPC Charts

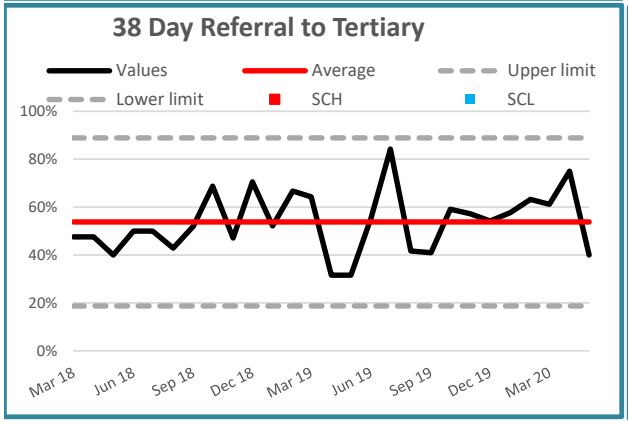


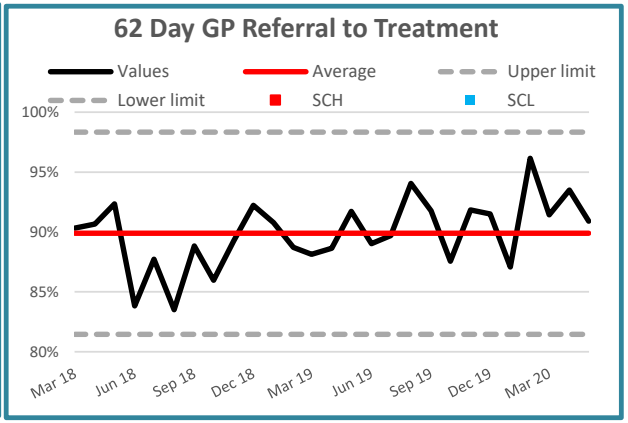












Methodology for calculating the performance score

The "key" targets are all measures included in NHS Improvement's Single Oversight Framework or measures on which the Trust is particularly focussing and are deemed more important.

Standard KPIs and "Key" targets

- Each RAG rating has a score - **red** 0 points; **amber** 2 points; **green** 4 points
- For "Key" targets, scores are weighted more heavily and are multiplied by a factor of 3 - **red** 0 points; **amber** 6 points; **green** 12 points

Calculating Domain Scores

- Add up the scores for each KPI per domain; divide by the maximum total score possible for that domain to get a percentage score.
- Apply the thresholds for the overall domain to get a RAG rating for each domain.
- Thresholds: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green.**

Calculating Trust Performance Scores

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains to get a percentage
- Apply the same thresholds as above to RAG rate the overall score

Glossary of acronyms and abbreviations

- **A&E** - Accident & Emergency
- **ADN** - Associate Director of Nursing
- **AED** - Accident & Emergency Department
- **ASI** - Appointment Slot Issue
- **ASU** - Acute Stroke Unit
- **BPT** - Best Practice Tariff
- **CCG** - Clinical Commissioning Group
- **CCU** - Critical Care Unit
- **CD** - Clinical Director
- **CDiff** - Clostridium Difficile
- **CDS** - Commissioning Data Set
- **CDU** - Clinical Decision Unit
- **CEPOD** - National Confidential Enquiry into Patient Outcome and Death
- **CHPPD** - Care hours per patient day
- **CIP** - Cost Improvement Programme
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **CRH** - Calderdale Royal Hospital
- **CT** – Computerised tomography
- **DH** - Department of Health
- **DNA** - did not attend
- **DSU** - Decision Support Unit
- **DTOC** - Delayed Transfer of Care
- **EBITDA** - Earnings before interest, tax, depreciation and amortisation
- **ECS** - Emergency Care Standard
- **EEA** - European Economic Area
- **EPR** - Electronic Patient Record
- **ESR** - Electronic Staff Record
- **FFT** - Friends and Family Test
- **FSRR** - Financial Sustainability Risk Rating
- **FSS** - Families and Specialist Services
- **GM** - General Manager
- **GP** - General Practitioner
- **GH** - Greater Huddersfield
- **HAI** - Hospital Acquired Infection
- **HCA** - Healthcare Assistant
- **HDU** - High Dependency Unit
- **HOM** - Head of Maternity
- **HRG** - Healthcare Resource Group
- **HR** - Human Resources
- **HRI** - Huddersfield Royal Infirmary
- **HSMR** - Hospital Standardised Mortality Rate
- **I&E** - Income and Expenditure
- **ICU** - Intensive care unit
- **IT** - Information Technology
- **KPI** - Key Performance Indicator
- **LOS** - Length of Stay
- **LTC** - Long Term Condition
- **MAU** - medical admission unit
- **MRI** - Magnetic resonance imaging
- **MRSA** - Methicillin-Resistant Staphylococcus Aureus
- **MSK** - Musculo-Skeletal
- **MSSA** - Methicillin Susceptible Staphylococcus Aureus
- **NHSE** - NHS England
- **NHSI** - NHS Improvement
- **NICU** - Neonatal Intensive Care Unit
- **NoF** - Neck of Femur
- **OD** - Organisational Development
- **PAS** - Patient Administration System
- **PbR** - Payment by Results
- **PHE** - Public Health England
- **PHSO** - Parliamentary and Health Service Ombudsman
- **PPH** - Postpartum Haemorrhage
- **PRM** - Performance Review Meeting
- **PTL** - Patient Tracking List
- **PU** – Pressure Ulcer
- **QIPP** - Quality, Innovation, Productivity and Prevention
- **RAG** - Red Amber Green
- **RCA** - Root Cause Analysis
- **RN** - Registered Nurse
- **RTT** - Referral to Treatment
- **SACT** - Systemic Anti-Cancer Treatment
- **SAU** - Surgical Admission Unit
- **SH** - Safety Huddle
- **SHMI** - Summary Hospital-level Mortality Indicator
- **SI** - Serious Incident
- **SITREPs** - Situation reports
- **SSNAP** - Sentinel Stroke National Audit Programme
- **SOP** - Standard Operating Protocol
- **SRG** - Systems Resilience Group
- **SUS** - Secondary Uses Service
- **UCLAN** - University of Central Lancashire
- **UTI** - Urinary Tract Infection
- **UoR** – Use of Resources
- **Var** - Variance
- **VTE** - Venous Thromboembolism
- **WLI** - Waiting List Initiative
- **WTE** - Whole Time Equivalent
- **YAS** - Yorkshire Ambulance Service

20. Delegation of approval of Freedom to Speak Up Annual Report

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title:	Delegation to Workforce Committee of the Freedom To Speak Up (FTSU) Annual Report 2019/20
Author:	Nicola Hosty
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and OD
Previous Forums:	N/A

Actions Requested: To approve

Purpose of the Report

To seek approval for the delegation of authority to the Workforce Committee of the Fre edom to Speak Up (FTSU) Annual Report 2019/20

Key Points to Note

As part of our response to COVID 19, our Freedom to Speak Up Guardian has led our Health and Wellbeing Response for colleagues, including the provision of a 24/7 helpline. As part of this support offer, the service has also received an increase in FT SU concerns. This increased workload has led to a delay in the report being finalised (the responsibility for the report cannot be delegated to another colleague as it needs Guardian approval). It was not possible to meet the paper deadline date for the Board. The option of deferring the report until the September Board was offered, however the annual report needs to be submitted to the national Guardians office in advance of September.

EQIA – Equality Impact Assessment

No impact identified

Recommendation

The Board is asked to delegate authority for the approval of the FTSU annual report to the Workforce Committee at an Extraordinary Meeting to approve on behalf of the Board.

compassionate care

compassionate care

21. Annual Reports:

a) Guardian of Safe Working Hours Annual Report - Anu Rajgopal

b) Fire Safety Action Plan Update - Helen Barker

For Assurance

22. Governance Report

a) Use of the Trust Seal

b) Governor Update

c) 2019/20 Annual General Meeting

d) Board Workplan 2020-2021 including Annual Reports schedule

e) Board Meeting Dates 2021-2022

To Note

23. Update from sub-committees and receipt of minutes & papers
To note Quality and Workforce Committees combined from May 2020

• Finance and Performance Committee – minutes from meeting held 4.5.20 and 1.6.20
• Audit and Risk Committee – minutes from meeting held 16 June 2020 tbc
• Quality & Workforce Committee – minutes from meetings held 4.5.20 and 1.6.20
• COVID-19 Oversight Committee – minutes from meeting held 6.5.20, 26.5.20 and 5.6.20

Items for Review Room
• Calderdale and Huddersfield Solutions Limited – One Year Business Plan 2020/2021
• Complaints Policy

For Assurance

24. Date and time of next meeting

Thursday 3 September 2020, 9:00 am

Venue: Microsoft Teams