Public Board of Directors

Schedule	Thursday 4 November 2021, 9:00 — 12:00 GMT
Venue	Microsoft Teams
Organiser	Amber Fox

Agenda

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12:15	26.	Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room) • Finance and Performance Committee • Quality Committee • Audit and Risk Committee • Workforce Committee To Note - Presented by Richard Hopkin, Denise Sterling, Andy	358

Nelson and Karen Heaton

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1. Welcome and Introductions:

Bev Walker, Acting Chief Operating Officer

To Note

Presented by Philip Lewer

2. Apologies for absence:

Richard Hopkin, Non-Executive Director

Denise Sterling, Non-Executive Director

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 2 September 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 2 September 2021 at 9:00 am via Microsoft Teams

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Kirsty Archer	Acting Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
David Birkenhead	Medical Director
Helen Barker	Chief Operating Officer
Alastair Graham (AG)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Mandy Griffin	Managing Director, Digital Health (outgoing)
Jim Rea	Managing Director, Digital Health

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager
Nicola Hosty	Assistant Director of Human Resources **(for item 117/21)**
Sarah Bevan	Operations Manager, Service Planning, Medicine **(for item 117/21)**
Joanna Gadd	Benefits Lead, Digital Health **(for item 117/21)**
Devina Gogi	Guardian of Safe Working Hours **(for item 123/21)**

OBSERVERS

Christine Mills	Public Elected Governor
Stephen Baines	Public Elected Governor (Lead Governor)
Isaac Dziya	Public Elected Governor

107/21 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Kirsty Archer, Acting Director of Finance, Nikki Hosty, Assistant Director of Human Resources, Devina Gogi, Guardian of Safe Working Hours, Jim Rea, the new Managing Director for Digital Health, Christine Mills, Stephen Baines and Isaac Dziya public elected governors.

This Board meeting took place virtually and was not open to members of the public. The meeting was recorded, and the recording will be published on our website after the meeting. The agenda and papers were made available on our website.

108/21 Apologies for Absence

Apologies were received from Gary Boothby and Andy Nelson.

109/21 Declaration of Interests

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

110/21 Minutes of the previous meeting held on 1 July 2021

The minutes of the previous meeting held on 1 July 2021 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 1 July 2021.

111/21 Action log and matters arising

The action log was reviewed and updated accordingly.

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

112/21 Chair's Report

The Chair informed the Board that the Chair of the Integrated Care System (ICS) post has been advertised and shortlisted and interviews will take place on 14 September 2021. The Chief Executive post for the ICS has just been advertised and Rob Webster is currently the Acting Chief Executive.

The Chair reminded the Board of the Executive Leadership changes which will be taking place over the coming months. Our current Chief Operating Officer, Helen Barker leaves the Trust on 1 October 2021. The Chair formally thanked Helen who has been key in steering us through the pandemic and now recovery work and wished her every success in her new roles. The Chair reported a new Chief Operating Officer has been appointed, Jo Fawcus, who commences in post on 8 November 2021. The Deputy Chief Operating Officer, Bev Walker will be the interim Chief Operating Officer.

The Chair reported our current Managing Director for Digital Health, Mandy Griffin is retiring on 3 September. The Chair formally thanked Mandy Griffin for her work in progressing the digital agenda for our patients and wished her well in her future role as Non-Executive Director at a neighbouring Trust. The Chair welcomed Jim Rea who is the new Managing Director for Digital Health to his first Board of Directors meeting.

The Chair informed the Board that our current Chief Executive, Owen Williams is leaving the Trust on 7 November to become the Chief Executive of the Northern Care Alliance. The Deputy Chief Executive is Ellen Armistead who is also our Director of Nursing and will be taking on the Chief Executive role in the interim from November whilst we recruit for a new Chief Executive. The recruitment process is already underway.

The Chair formally recorded his appreciation and thanks to the outgoing Directors, Mandy Griffin and Helen Barker, for all of their hard work, commitment and enthusiasm during his three and a half years as Chair of the Board of Directors.

OUTCOME: The Board **NOTED** the update from the Chair.

113/21 Chief Executive's Report

The Chief Executive echoed the comments from the Chair with reference to the colleagues leaving and joining the Trust.

The Chief Executive provided an update on Non-Surgical Oncology. He explained services relating to cancer across West Yorkshire, particularly those that don't require a surgical procedure, remain challenging at this time. The West Yorkshire Association of Acute Trusts (WYAAT) is leading on several pieces of work alongside the Cancer Alliance. One of these pieces of work is being led by Sir Mike Richards who is helping WYAAT and the

Cancer Alliance develop a longer-term solution for providing services for non-surgical oncology.

The Chief Executive stated colleagues at CHFT, in particular oncology colleagues, nursing colleagues, therapies and all supporting services have been working very well in the Trust and cross-organisationally such as with the Mid Yorkshire Hospitals NHS Trust, Leeds Teaching Hospital NHS Trust, Bradford Teaching Hospitals Foundation Trust and Airedale NHS Foundation Trust to provide as much care as possible to patients. The Chief Executive formally thanked these colleagues for the sterling work they are doing and for putting the patients first across West Yorkshire. A significant amount of work is underway to ensure CHFT's clinical colleagues are fully engaged in the future direction of services in terms of resilience.

Given the pressures of Covid, overall cancer performance across West Yorkshire in comparison to other national systems is strong.

RH asked if the Trust is in a relatively strong position in terms of the review and the Chief Executive agreed this and explained it is in line with the Trust's clinical strategy and CHFT is supporting the wider West Yorkshire community.

OUTCOME: The Board **NOTED** the update from the Chief Executive.

114/21 Staff / Patient Story – Health Inequalities Video

The Director of Nursing introduced a short video which highlights the work the Trust have been doing in respect of striving for equality for people with a learning disability.

The Chair passed on the Board's appreciation for all the hard work focused on health inequalities.

OUTCOME: The Board **NOTED** the staff and patient story video on health inequalities.

115/21 Health Inequalities Progress Report

The Director of Nursing presented the Health Inequalities progress report to update the Board of Directors on activity and progress in relation to the workstreams.

The key points to note from the workstreams were:

- External environment: how we connect with our communities: Working with our partners continues. A project has commenced on the development of a Directory of Services for Emergency Department staff to enable them to help people who are homeless or asylum seekers by improving the signposting into support services. The equality impact assessment and quality impact assessment (EQIA/QIA) for the reconfiguration has been considered and concluded there was no differential discrimination to any protected characteristic groups.
- The lived experience, initial focus on maternity services: At the end of July 53% of women from a BAME background have been booked onto a Continuity of Carer pathway. Early feedback from the discovery interviews has shown overall experience to be positive and has highlighted areas for improvement around communication in relation to services on offer. Staff have completed an anonymous survey in relation to perceptions of levels of culturally competent care delivery. The survey is due to conclude at the end of August and will report into Quality Committee.
- Using our data to inform stabilisation and reset: Prioritisation of people with a learning disability is now embedded in wating list management with strong support

from clinical colleagues. A project manager is being recruited to oversee the learning disability workplan and lead the development of the care navigator roles.

- Diverse and Inclusive workforce: A "Say No to Racism" strategy has been developed. There is a more targeted approach to ensuring recruitment campaigns reach all sectors of the community. More BAME reps for interview panels have been recruited. The re-launch of the Leadership programme will include a focus on inclusive leadership.
- Digital Inclusion: CHFT has representatives on local authority Digital Inclusion Boards. There is strong partnership working with both public and third sector bodies to ensure our strategies are aligned and work in mutual support.

AG recognised the amount of great work taking place in relation to health inequalities. He commented it was particularly good to see good progress has been made in the priority two category in terms of waiting times. AG highlighted there is now minimal variation by ethnicity and asked about actions the Trust took which led to this success. The Chief Operating Officer explained this was a result of a combination of actions including a focus on and validation of data, waiting times reviewed weekly for P2, (priority two elective patients who should be seen within one month) by specialty each month by BAME and non-BAME and any activity moving adrift is acted upon promptly.

RH echoed the amount of progress and achievements made to date. He highlighted one of the priority areas is on mental health for patients and employees and asked what the Trust are doing to address this. The Director of Nursing responded to explain that the Trust have a refreshed mental health strategy in place and are part of numerous external partnership Boards. Targeted work is currently taking place around the experience of mental health patients in the Emergency Department (ED). A stocktake will take place to accelerate this work which will be picked up further at the Health Inequalities Group. She reported there are currently some issues being seen with Child and Adolescent Mental Health Services (CAMHS) patients in paediatrics and a lot of the long waiters in ED are often patients waiting for mental health services.

The Chief Executive added the Trust are being as progressive as possible on this agenda which is heartening to see and referenced a comment made by Mandy Griffin, Managing Director for Digital Health formally recognising the contribution of colleagues whose critical work providing information has enabled these important decisions to be made. The Chief Executive challenged the Board to think about 'front line' differently as all colleagues are affecting people's lives by the work they are doing.

DS stated she was pleased to see the Trust have spent time talking to staff to get their understanding of culturally competent care. She asked what the plans are going forward to meet the gap that has been identified and asked for assurance that patients will be involved in this ongoing learning and development. The Director of Nursing confirmed there has been some interesting learning in maternity which has identified a training and learning gap in not understanding the extent of health inequalities. A Board Development session took place focused on the social value and being an anchor institution. The maternity work is a pilot which will help form a training and development programme which will eventually be rolled out across the organisation.

KH re-iterated it is important that the Trust make this feel like the norm for staff and added it is a great piece of work that the Trust are leading on and the Trust should be very proud.

PW echoed the comments made by the Chief Executive with regards to how important the staff producing the data are. As Chair of the Health Inequality Group, he explained there is a huge sense of purpose and great attendance at the group which has now been meeting for six months and has achieved so much in a relatively short period of time.

OUTCOME: The Board **NOTED** the progress in relation to CHFT's response to NHS

expectations of providers in tackling health inequalities.

116/21 Month 4 Financial Summary 2021/22

The Acting Director of Finance presented the month 4 financial summary and highlighted the key points below:

- Year to date (YTD) surplus of £3m, a favourable variance compared to plan largely driven by receipt of planned Elective Recovery Funding in the first quarter of the year
- In July national guidance changed on Elective Recovery Funding, the clinical activity threshold to be achieved in order to secure the funding has been raised; therefore, the Trust are not forecasting to receive any further Elective Recovery Funding for the remaining months of the first half of the year
- Forecast to the end of September is a breakeven forecast
- Capital expenditure is slightly below plan due to timing changes
- Cash position remains healthy as a result of timely payment of invoices and achieving the better payment practice code target of 95% paid within 30 days in July and the Trust are very close to this achievement in the YTD position

RH added the breakeven for first half of the year is on plan.

OUTCOME: The Board **NOTED** the Month 4 Finance Report and the financial position for the Trust as at 31 July 2021.

117/21 Health and Wellbeing Update

Nikki Hosty, Assistant Director of Human Resources, introduced the Health and Wellbeing update and presentation to share with the Board the plan to roll out the health and wellbeing hour across teams and departments at the Trust. Examples were shared from teams which have successfully rolled out the wellbeing hour and those teams which have not and the barriers preventing them from doing so. The plan to roll out the wellbeing hour is centred on peer-to-peer support and positive role modelling and leadership from the Board and Divisional Senior Management teams.

Joanna Gadd, Benefits Lead for Digital Health and Sarah Bevan, Operational Manager for Emergency Medicine were in attendance and shared how they rolled out the health and wellbeing hour in their teams.

The Chief Executive re-iterated that 'One Culture of Care' is about being clear we value colleagues. He added the view that there are concerns around two aspects of the health and wellbeing hour which are the impact it has on patient care and availability of colleagues to provide care, and the potential recurring fiscal consequence of this which needs to be acknowledged for half 1 or half 2 of the financial year. He suggested there needs to be a discussion around what the Trust needs to stop doing to balance the roll out of this.

KH expressed her support of the continued roll out of the health and wellbeing hour and felt the cost element of this will be balanced by retaining staff and incurring less sickness absence. KH stated having the option of the wellbeing hour shows that the Trust value staff in the delivery of service and some staff may elect not to take the wellbeing hour. She suggested that when the Trust considers the fiscal costs it should take into account how this relates to sickness absence, which is a very big cost to any organisation.

The Acting Director of Finance added that the Trust need to be mindful of this cost and monitor if the interaction with the other metrics has the desired effect, such as sickness

absence costs. She explained this will become more challenging in the second half of the year.

The Chief Operating Officer explained there is still work to do in terms of the communication and colleagues understanding of the health and wellbeing hour and noted that no one had mentioned the wellbeing hour at recent listening events focused on recruitment and retention work.

The Board is asked to note the plan to roll out the health and wellbeing hour and the Task and Finish Group which is considering application of the hour for medical staff will come back with further recommendations.

AG asked for more detail on the cost and benefits in the next report to the Board, including re-assurance around the flexibility of it, for example, with teams who would not elect to use it. He acknowledged it may be difficult to quantify the benefits. The Director of Workforce and Organisational Development responded at the last Board Development Session it was agreed that this update would include how everyone could take this hour. There have been more detailed papers at Executive Board around the costs which can be circulated to the Board.

Action: Director of Workforce and OD to share the more detailed papers (inc. costs) on the Health and Wellbeing Hour presented to Executive Board with Board members

Action: Board members to provide any feedback and comments to the Director of Workforce and OD on what they would like to see in the next update to Board

The Chair thanked Nikki Hosty, Sarah Bevan and Joanna Gadd for attending the Board meeting.

OUTCOME: The Board **NOTED** the plan to roll out the Wellbeing Hour to all teams across Calderdale and Huddersfield NHS Foundation Trust, **NOTED** that not all services are rolling out the Wellbeing Hour in the same way and that services value flexibility and **NOTED** a task and finish group are reviewing the application of the roll out of the Wellbeing Hour to Doctors in Training and the Medical workforce.

118/21 Improving People Practices

The Director of Workforce and OD explained NHS England/NHS Improvement (NHSE/I) set a requirement for NHS organisations to review people practices and disciplinary policies and procedures following guidance issued based primarily on learning from a critical incident at Imperial College Healthcare NHS Trust.

The Improving People Practices paper describes the Trust's response and suite of policies and procedures that are in place. The Director of Workforce and OD explained the Trust were reviewing policies under One Culture of Care at the time of this requirement set by NHSE/I. The policies and procedures in place have been updated and the requirements set by NHSE/I have been welcomed. Consideration of the response satisfies an NHSE/I requirement that the Trust's disciplinary policy and procedure is reviewed and discussed at a Public Board of Directors meeting.

The Director of Nursing stated the key issue is the length of time these cases can take and asked if the Trust are developing any KPIs in relation to the length of investigation and hearings. The Director of Workforce and OD responded any policy has a recommended time period; however, it is inevitable that some investigations can be ongoing for a period of time due to the complexity.

The Medical Director agreed with the comments made regarding the complexity of investigations which may need external support. He added that the Trust aim to manage these in a timely manner; however, availability of those to be interviewed and investigators is a constant challenge.

OUTCOME: The Board **NOTED** the contents of the Improving People Practices report.

119/21 Freedom to Speak Up Annual Report

The Director of Workforce and OD presented the Freedom to Speak Up Annual Report which covers the period 30 June 2020 to 29 June 2021.

The key points to note were:

- The number of concerns reported and dealt with by the Freedom to Speak Up Guardian and Ambassadors was 88 in 2020 and 67 in 2021 - this reduction is considered to be a result of the 'Ask Owen' mechanism, Leadership events and listening events that have been held, as well as the impact of Covid-19
- Majority of concerns relate to colleague experience, as opposed to patient quality and safety which is the purpose of Freedom to Speak Up
- The main theme has been colleague attitude and behaviours and policies and procedures
- One of the benefits and limitations of freedom to speak up being managed in the Workforce and Organisational Development team is that colleagues come to Workforce instead of their manager
- A clinical lead has been appointed for freedom to speak up who will be managed within the Workforce and OD Department in an effort to bring more patient concerns to light, this will be monitored

The Chief Operating Officer stated the more colleagues use this mechanism the safer we will be. She asked if there has been a reduction in grievances and if this will be monitored as an early alert of concerns to reduce the need for formal procedures. The Director of Workforce and OD explained Freedom to Speak Up is primarily about patient safety and grievances are about colleague experience i.e., bullying and harassment; therefore, there is no correlation. The Chief Operating Officer asked if there has been any change in the number of incidents reported on Datix. The Director of Workforce and OD agreed that this needs to be cross-referenced to Datix incidents and complaints. She added that colleagues are encouraged to use Freedom to Speak up for patient safety issues; however, colleague experience issues are still encouraged.

The Director of Nursing highlighted there is a risk that people will be too tired or distracted due to winter pressures to raise concerns and asked if a reminder to raise any safety concerns can be circulated as part of winter planning arrangements. She added that she would have expected to see more numbers lately and recognised this may be due to operational pressures that have impacted on staff having the time to report. Nikki Hosty supported this and advised the new clinical Freedom to Speak Up Guardian will take forward the publicity campaign and that there are 30 Freedom to Speak Up ambassadors.

KH explained it is important that staff see an outcome to the concerns they have raised in order for staff to have confidence in the process.

OUTCOME: The Board **APPROVED** the Freedom to Speak Up Annual Report.

120/21 Winter Plan

The Chief Operating Officer presented the Winter Plan which is a moving plan and describes the structure within which operational pressures during the winter period will be

anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The Chief Operating Officer explained it is a particularly challenging winter in terms of volume and acuity and with current operational pressures it already feels like winter. The plan is part of a system plan and will reflect the response of the wider social health and care system.

In terms of content of the plan which responds to the national requirements of a winter plan, it has been built with Divisions and in particular, clinical colleagues.

The key points to note were:

- Key principles – focus on out of hospital care and pre and post discharge
- Active use of OPEL (Operational pressures escalation levels) and actions in relation to this
- Clinical and operational leadership is core
- 7 days a week, 24 hours a day
- Communication and implementation is to be worked through and is a main focus

AG asked if the Covid booster jab and flu jab can be provided at the same time, to gain a higher take up rate. He also asked if the Trust are responsible for the intermediate care at Brackenbed View and Heatherstones facilities. The Chief Operating Officer responded that the Local Authority rather than the Trust are responsible for the provision of care at Brackenbed View. She explained there is more work to do with regards to Heatherstones. She added that the winter plan is concentrating on out of hospital care and there is less opportunity for the local authority to influence the care home and home care sector.

The Director of Nursing added that the commissioning of the services we provide for Brackenbed View is undertaken by the Clinical Commissioning Group (CCG) which has responsibility for the quality of care and of the home. The Trust have regular meetings with the CCG, local authority and Brackenbed to ensure oversight of quality and concerns. There is a process for rapid escalation of concerns with an obligation to ensure our services are safe and the CCG is responsible for the quality agenda. The Director of Nursing added that Safeguarding and the CQC have been involved in the past.

The Medical Director responded that he is not sure at this point in time if both the Covid booster and flu jab can be provided at the same time. The current guidance says there should be a seven day gap between Covid and flu vaccines; however, this is currently being reviewed. The Medical Director added that the Covid vaccine may be available before the flu vaccine arrives and to deliver both the Trust would need to delay the Covid vaccine.

DS recognised the focus is on out of hospital care and asked what the numbers are being considered for flexible beds and whether the Trust are confident that they have the staffing required for these flexible beds. The Chief Operating Officer responded that the Trust are not confident they have the staffing required, the Trust are already running on 50 beds lower than this time last year and 70 less beds in terms of a winter plan. An additional 10 extra beds were opened on 1 September 2021 which had been challenging from a staffing perspective. The Chief Operating Officer added that they are actively looking at different staffing models focused on clinical staffing rather than just nursing staffing.

The Director of Nursing agreed with this and added if the Trust were to have an increase in sickness absence this would be a different challenge. Controls are in place to review the staffing position hourly over winter.

RH asked if the impending staffing changes in the Chief Operating Officer and Deputy Chief Operating Officer adds any additional risks this year and if the Trust are happy that the interim arrangements adequately cover these. The Chair explained this has been discussed with the Chief Executive who provided assurance the arrangements are adequate to cover this period of time, adding that the current Chief Operating Officer will remain in post until 1 October 2021, and noting a new Chief Operating Officer has an opportunity to provide a fresh look.

OUTCOME: The Board **APPROVED** the Winter Plan.

121/21 Director of Infection Prevention Control (DIPC) Q1 Report

The Medical Director presented the Healthcare Associated Infections (HCAIs) position of performance for Q1 from 1 April to 30 June 2021.

The key points to note were:

- Improved position in Q1 this year particularly around c.difficile with a reduction of cases this year; this may be due to improved antimicrobial prescribing
- Nationally targets have now been set and they have been reduced, the Trust are currently trying to clarify what cases need to be included i.e., infections with hospital onset as opposed to those acquired in community
- ANTT (Aseptic Non Touch Technique) competency assessments have improved significantly; however, still below the 90% target, continued work required
- Covid continues to present challenges, particularly due to relaxation to restrictions in the community, a great deal of focus on protecting patients remains
- Small number of hospital onset covid cases have been reported in the quarter
- Quality improvement audits continue to be in place

OUTCOME: The Board **NOTED** the performance against key Infection Prevention Control targets and **APPROVED** the report.

122/21 Learning from Deaths Q1 Report

The Medical Director presented the Learning from Deaths Q1 Report covering the period April to June 2021.

The key points to note were:

- In Quarter 1 (April – June 2021), there were 351 adult inpatient deaths, 12 of those deaths occurred in Covid positive patients
- 18% of all in-hospital deaths have been reviewed using the initial screening tool (ISR) in Q1. This falls short of the 50% target for mortality reviews
- Recovery plans are being agreed with the Respiratory and Elderly Mortality Leads, the specialities with the largest number of deaths, to achieve the 50% standard

RH commented the initial screening reviews target was nearer 100% at one time and acknowledged the current pressures staff are under are unlikely to change in the next six months. He asked how the Medical Examiner role might improve this process and how we may improve on the 18% of deaths reviewed. The Medical Director responded the Medical Examiner process is separate to learning from deaths process and looks at death certification. He explained any learning will be referred to the learning from deaths process. All deaths are reviewed by the medical examiner team. Around 40% of all deaths were achieved at a time when the Trust was less pressured which would be good for the Trust to get back to achieving. The Medical Director added that there is a discussion about whether the 50% target is realistic which will be taken through the Care of the Acutely Ill

Programme and the Quality Committee. He suggested that a 30% target may be more appropriate which is being achieved by other organisations.

OUTCOME: The Board **APPROVED** the Learning from Deaths Q1 Report and the recommendations.

123/21 Guardian of Safe Working Hours Q1 Report

The Chair welcomed Devina Gogi, Consultant Ophthalmologist and the new Guardian of Safe Working Hours to her first Board of Directors meeting.

Devina presented the Guardian of Safe Working Hours Q1 report which covers the period of April to June 2021. She added that she was not the Guardian of Safe Working Hours during this quarter. The key points to note were:

- Recovery toward a more normal work pattern / rota in all specialties in CHFT
- Overall decrease in exception reports in quarter 1
- Rota gaps were filled efficiently by agency staff and internal bank locums
- Successful hosting of Junior Doctors virtual awards in May 2021 with fantastic feedback, multiple categories included leadership, going the extra mile, compassionate care
- 15 exemption reports in total this quarter, 13 relating to the hours of working, only 2 related to educational opportunities
- The majority of exception reports were closed by overtime payments
- Challenges and the future for the next quarter includes a recovery phase, a new Director for Post Graduate Education and a new Medical Education Manager has been appointed. The Training Recovery Programme has started for junior doctors and successfully appointed a Trainee Recovery Junior Doctor to help implement this
- Recommendations – need of flexibility, support from the Division from all specialities during this recovery time to clear the backlog, to look at other ways of providing training and protecting self-development time
- Aspirations include improving the engagement process, Chairing the Junior Doctor Forum in September with good interest received so far from Junior Doctor representatives, looking forward to working with the Junior Doctor Director for Post Graduate Education and networking at a regional meeting on 6 October 2021.

The Chief Operating Officer shared they are doing some specific work around recruiting into Oncology, specifically Ward 12 and the helpline, and recognise there are some additional pressures from the regional on Non-Surgical Oncology work with some increased demand. We recently overrecruited into the Physicians Associate role and have agreed with the Oncology medical team to deploy one of these to ward12 to help with the Junior Doctor workload.

The Chief Operating Officer stated in the recovery framework a principle was included in prioritising access to training for Junior Doctors. The Chief Operating Officer offered to meet with the Guardian of Safe Working Hours if this needs to be worked through and be clear on what the core elements are to ensure protected time is allocated.

The Chair thanked Devina Gogi and invited her to the next meeting.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Report for quarter 1 and **ACKNOWLEDGED** the need for extra support and flexibility with training and rota for Junior Doctors in the next quarter as we enter the training recovery phase post pandemic.

124/21 Safeguarding Annual Report

The Director of Nursing presented the Safeguarding Annual Report covering the period April 2020 to March 2021.

Key achievements include:

- Developed safeguarding contingency plan to ensure safeguarding continued as business as usual
- Worked closely with and supported the work of the Safeguarding Boards/ Partnerships
- Provided assurance to CCGs and partners that CHFT continues to meet its statutory responsibilities
- Updated, developed and contributed towards policies and procedure development.
- Held a trust Virtual Safeguarding week September 2020
- Listened to staff concerns about safeguarding during the pandemic and developed a Safeguarding /Covid 19 intranet resource page for staff and distributed 7-minute briefings including top tips for virtual assessments to staff
- Delivered virtual safeguarding supervision
- Delivered bespoke and mandatory safeguarding training to maintain compliance with the Intercollegiate documents and covid restrictions
- As at March 2021, overall training compliance for safeguarding was 92.84%

Prioritises for 2021-2022:

- Continue to work with Divisions ensuring that safeguarding adults and children, including domestic abuse, is part of all considerations when managing the re-introduction of services
- Continue to learn from the effects of the pandemic on families, influencing safeguarding practice with what we have learned
- Review the recommendations from the Domestic Abuse Bill (April 2021) which will include training, staff updates and policies and procedures that may impact on practice
- Review the Domestic Abuse Policy

The key achievements and priorities for 2021-22 for Hidden Harms, Mental Capacity Act and Deprivation of Liberty Safeguards, Adult Safeguarding, Safeguarding Children, the Mental Health Act, Children Looked After were shared.

The Director of Nursing formally thanked the team who have been working very hard during the pandemic during difficult circumstances and vacancies within their team.

OUTCOME: The Board **NOTED** the Safeguarding Annual Report.

125/21 Quality Report (inc. Maternity Services Update)

The Director of Nursing presented the Quality Report which provides the Trust with ongoing oversight of the Quality agenda and the emerging issues that need to be considered. The following points were highlighted:

- CQC continued to meet throughout the pandemic looking at the elective and recovery plan
- 11 current open enquiries with CQC – 1 serious incident, 3 orange incidents, 3 concerns and complaints and 4 safeguarding concerns

- 3 journey to outstanding reviews of wards have taken place, these were paused due to current operational pressures, some have been undertaken and these will be re-instated during September
- Central Alert Systems – 4 overdue alerts relating to a specific sub set of actions within these alerts, aiming to close these off imminently
- Dementia Screening continues to be a significant challenge
- An approach to systematically involving our BAME communities approved at Patient Experience and Caring Group and connection made with CHFT BAME engagement officer
- Observe and Act is part of business as usual
- Seeing some improvements in complaints with increased capacity in the corporate team to support Divisions
- Recent coroner's enquiry reported in the media involving an incident in Emergency Department and all learning reviewed with opportunities identified around mental capacity assessment
- 1 never event in June currently under investigation – significant reduction in number of actions
- A new Patient Safety Incident Framework is being introduced
- To note the need to improve attendance at the Medicines Safety and Compliance Group
- Maternity services submitted evidence against the 7 Immediate and Essential Actions of the Ockenden Report by 30th June 2021. The expected site visit by the Regional Chief Midwife and her team, due by the end of July 2021is still awaited and the Director of Nursing has agreed with Local Maternity and Neonatal System partners that they will set up a West Yorkshire approach for a peer review around maternity services.
- Submitted a bid for national funding and have been successful in achieving funding for 10.9 wte midwives and 0.2 wte Consultant hours
- Continuity of carer remains a challenge for every organisation nationally and meetings with the Heads of Midwifery and Chief Nurses across West Yorkshire is taking place to discuss how to achieve continuity of carer
- Maternity staffing one to one care in labour is one of the key safety indicators, the Trust are achieving 99.6% of this, an excellent achievement
- The allocation of funding for 10.9 wte midwives will support the roll out of continuity of carer at CHFT however, recruitment to the posts will remain challenging.
- Quality and Focussed account priorities have been discussed at Divisional Performance Review meetings
- End of Life – successful in gaining funding for 7 day community palliative care cover and the bereavement line
- Bereavement line has been shortlisted for 3 different awards
- Pressure ulcers – invested in tissue viability team with some reductions in heel pressure ulcer incidents
- Clinical documentation discussion at Executive Board with more focus about how performance can be improved

AG acknowledged dementia screening remains a significant challenge and is discussed at Quality Committee and the report suggests substantial improvement activity is being undertaken. He highlighted that performance in the Integrated Performance report shows a deteriorating position in July and asked what the improvement activity is and what the practical impact of not screening was and if this impacts on the quality of care. The Medical Director responded that dementia screening is still a challenge and is being picked up in the clinical documentation piece. There has been a recent change of doctors and the importance of dementia screening has been highlighted in training. The requirement to undertake dementia screening is being included in EPR and a whiteboard approach. The main challenge is the cultural piece to enforce doctors to undertake this as an important task. In terms of whether this causes a quality of care issue, there has been no reference of any incidents or any harm. The Trust will take every opportunity to improve the care for

these patients. AG asked how long it takes to complete a dementia screening. The Medical Director confirmed no more than 10 minutes.

The Chief Executive recognised the ongoing trend of dementia screening which has been discussed at the Finance and Performance Committee. He agreed to pick up a further conversation with the Medical Director to undertake a stocktake on the position.

Action: Chief Executive / Medical Director to conduct a stocktake on the dementia screening position

The Chief Executive asked for further detail on stillbirths and any trends in community or vulnerable groups as an area of focus.

Action: Director of Nursing to progress a further review of stillbirth figures at the Quality Committee and provide a more detailed report for the next Board meeting

RH acknowledged that similar to dementia screening, performance on nutrition and hydration assessments is consistently below target.

OUTCOME: The Board **NOTED** the Quality Report and ongoing activities across the Trust to improve the quality and safety of patient care and **NOTED** the Maternity Quality report update.

126/21 Complaints Annual Report

The Director of Nursing presented the Complaints Annual Report. The key points to note were:

- Increase in PALS contacts / concerns over a four-year period
- Decrease in complaints over a four-year period and a significant drop in complaint numbers this year as opposed to the previous three years, this is linked to the COVID pandemic due to a national pause
- The top three concerns raised via PALs relate to appointments issues, communication with patients and communication with relative/carer
- Complaint performance dipped earlier in the year, now seeing an improving picture.
- The top three complaint issues relate to clinical treatment, the fundamentals of care and communication
- Despite significant and extraordinary pressures this year our staff have risen to the challenge and remain even more focussed on improving the care and experience for our complainants. Their commitment to learning from complaints and improving the care outcomes for our patients, families and carers is to be commended
- Implemented new standards in terms of national requirements
- A new Head of Complaints is in post, Emma Catterall

PW asked if there was another underlying issue or reason other than Covid in terms of the key theme of complaints being communication. The Director of Nursing explained the visiting restrictions impact on this as it has led to a gap in face-to-face communications. She added that communication is nearly always a key theme to complaints and how important it is to always put yourself in the patients or relatives' shoes. Part of the Time to Care Strategy which is being refreshed and relaunched is about remembering that having a conversation with a relative is an absolute integral part of each individual treatment plan. She added there is an issue with the nurse in charge role in ensuring all relatives have been informed.

The Director of Nursing stated she will include compliments in future reports.

OUTCOME: The Board **NOTED** the Complaints Annual Report.

127/21 Integrated Performance Report (IPR) – July 2021

The Chief Operating Officer presented the performance position for the month of July 2021 highlighting the key points which were:

- Slight improvement in the overall percentage
- Majority of the domains are improving; however, there are some KPI hotspots
- Starting to see impacts of pressures in relation to acuity and staff availability which has been discussed at the Finance and Performance Committee with a re-emphasis for other Committees to ensure there is a focus on the IPR as part of Committee agendas
- Deputy Directors continue to complete the narrative with further work to do on the next steps and provide some feedback

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for July 2021.

128/21 High Level Risk Register

The Director of Nursing presented the High Level Risk Register which highlights the new risks, existing top risks, risks moved since the last report and movement in risk scores. The key points to note were:

- Maternity pathway (8029) is a new risk and has subsequently been closed
- Caring for young people with acute mental health issues (7479) is a new risk
- Financial Risk (8057) – the Acting Director of Finance reported that this risk is focused on the second half of the year as no formal financial guidance on the financial regime for the second half of the year has been received, the financial plan noted the heightened efficiency requirement in the second half of the year which will be more challenging and there has been a change in the threshold for receipt of elective recovery funding
- The scale of this financial risk is in excess of £14M, considerably more challenging than the first half of the year

Mandy Griffin, Managing Director for Digital Health confirmed the risk relating to the data protection toolkit submission has been removed from the High Level Risk Register as this was submitted as compliant; however, there is still a need to meet 95% on data security training which has not yet been met and is deteriorating. The new data protection toolkit for next year still sits at 95%; therefore, this risk will not change.

The Chief Operating Officer stated there are a few risks rated as 25 for the Surgical Division in terms of recovery and further work is needed with clinical teams to understand the purpose of the risk register. Specific work will take place with the Division to increase their understanding of what should be on the risk register.

AG reported under existing top risks, there are two risks relating to eye issues and asked if these are both the same risks. The Chief Operating Officer confirmed this will be discussed with the Surgical Division team and support will be provided to the Division to help clarify this.

OUTCOME: The Board **APPROVED** the High Level Risk Register.

129/21 Risk Appetite Statement

The Company Secretary presented the updated risk appetite statement for approval. She reported a meeting took place in August 2021 to review the risk appetite statement and the 11 risk categories were agreed as still appropriate together with the appetite levels; however, two of the risks have been re-worded which are highlighted in red.

OUTCOME: The Board **APPROVED** the updated Risk Appetite Statement.

130/21 Governance Report

The Company Secretary presented the governance items for approval and noting in September 2021.

The enclosed paper detailed the current roles and responsibilities of the Non-Executive Directors (NED). On an annual basis the NEDs review their time commitments compared to their availability, including Board and Board Committee chairing roles and the additional activities undertaken by NEDs. This has identified issues of NED capacity and increasing competing pressures on their time. Following a discussion between the Non-Executive Directors and Director of Workforce and OD, the NEDs are being released from recruitment panels to help with capacity.

In recognition of the capacity issue the Trust has agreed, through discussion with governors via the Nominations and Remuneration Committee of the Council of Governors, to pilot the use of an Associate Non-Executive Director role with a focus on the quality agenda, with project work relating to the lived experience of patients, to supplement our existing NED capacity. The appointed Associate NED will not participate in any formal vote at the Board. The recruitment process for this Associate NED is currently underway.

The Board workplan for 2021-22 was shared for any additions and approval.

OUTCOME: The Board **NOTED** the current responsibilities of the Non-Executive Directors and proposed changes and **APPROVED** the Board Workplan for 2021-22.

131/21 Board Sub-Committee Chair Annual Reports

The following Committee Review Annual Reports for 2020/21 were received:

- Audit and Risk Committee

OUTCOME: The Board **RECEIVED** the Committee Review Annual Reports for the Audit and Risk Committee.

132/21 Board Sub-Committee Terms of Reference

The following terms of reference were reviewed as part of an annual review and approved by the Board:

- Audit and Risk Committee
-

OUTCOME: The Board **APPROVED** the terms of reference for the Audit and Risk Committee.

133/21 Board Sub-Committee Chair Highlight Reports

The following Chair highlight reports were received for the following sub-committees:

- Finance and Performance Committee – In addition to the report, RH highlighted an update in terms of fractured neck of femur performance, concern in times in getting patients to theatre and mortality rates. This will also be picked up by Quality Committee. Recovery performance detailed update noted good progress but with a number of ongoing challenges in terms of backlog.
- Quality Committee
- Audit and Risk Committee
- Workforce Committee – KH added a number of Deep Dives have taken place at the last few meetings which have been very thorough.

OUTCOME: The Board **NOTED** the Chair Highlight Reports for the above sub-committees of the Board.

134/21 Annual / Bi-Annual Reports in the Review Room

The following annual reports were available in the review room on Convene:

1. Medical Revalidation and Appraisal Annual Report
1. Emergency Planning Annual Report

135/21 Items for Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update June 2021

The following minutes of sub-committee meetings were provided for assurance:

- Council of Governors meeting held 15.07.21
- Annual General Meeting (AGM) meeting held 28.07.21
- Finance and Performance Committee meetings held 01.06.21 and 28.06.21
- Quality Committee meetings held 21.06.21 and 12.07.21
- Workforce Committee meeting held 09.08.21
- Audit and Risk Committee meeting held 21.07.21

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for June 2021 and the minutes of the above sub-committees.

136/21 Any Other Business

The Chair asked Stephen Baines and Isaac Dziya, public elected governors if they had any comments they wished to add to the Board meeting. Stephen Baines thanked the Director of Nursing for agreeing to include compliments in future quality and complaints reports.

There was no other business.

The Chair thanked the governors for their attendance and closed the meeting at approximately 11:48 am.

137/21 Date and time of next meeting

Date: Thursday 4 November 2021
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

5. Action Log and Matters Arising

- Stocktake on dementia screening

For Review

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 02.09.21

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
02.09.21 125/21	Quality Report (inc. Maternity Services Update) Director of Nursing to progress a further review of stillbirth figures at the Quality Committee and provide a more detailed report for the next Board meeting (inc. any trends in community or vulnerable groups)	EA	**07.10.21 Update** - Stillbirth paper to go to Quality Committee in November and Board in January 2022.	13.01.22		
02.09.21 125/21	Chief Executive and Medical Director to conduct a stocktake on the dementia screening position	OW/DB	Under matters arising on 04.11.21	04.11.21		04.11.21
02.09.21 117/21	Health and Wellbeing Update Director of Workforce and OD to share the more detailed papers (inc. costs) on the Health and Wellbeing Hour presented to Executive Board with Board members Board members to provide any feedback and comments to the Director of Workforce and OD on what they would like to see in the next update to Board.	SD All		04.11.21		
01.07.21 96/21	Fire Safety Annual Report 2020/21 Chief Operating Officer to provide assurance on personal evacuation plans and PEEPs i.e. personal evacuation plan where assistance is needed in terms of disabled, young children, elderly or frail	HB	02.09.21 update – HB assured the Board that from a patient perspective this is covered in the Fire Plan and a process is in place. From a staffing perspective, Suzanne's team are working this through with the fire team. Action closed.	02.09.21		02.09.21
01.07.21 89/21	Clinical Services Strategy Medical Director to reference how the Trust supports patients who don't use technology in the Strategy	DB	02.09.21 update – DB provided assurance to the Board that this is now referenced within the Clinical Services Strategy. Action closed.	02.09.21		02.09.21

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Stocktake on Dementia Screening
Author:	Lauren Green, Dementia Lead Practitioner
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	Dementia Operational Group, Clinical Outcomes Group, Medicine PSQB

Purpose of the Report

To update the Board of Directors of Dementia Screening compliance across the Trust and areas of focus.

Key Points to Note

Dementia Screening Compliance

Month	Oct-21 (to 22/ 10/2021)	Sep-21	Aug-21	Jul-21	Jun-21	May-21	Apr-21
Trust %	41.72%	46.32%	36.90%	22.59%	26.90%	29.34%	28.44%
FSS %	-	-	-	0.00%	-	100.00%	-
Medicine %	39.02%	49.10%	39.70%	23.08%	28.22%	30.54%	28.70%
Surgical %	53.57%	35.96%	22.78%	20.91%	21.57%	23.23%	27.27%

Ward / Date	Oct-21 (to 18/ 10/2021)	Sep-21	Aug-21	Jul-21	Jun-21	May-21	Apr-21
6 HRI %	64.71%	60.53%	54.55%	53.85%	76.09%	82.98%	70.97%
ACUTE FLOOR CRH %	47.37%	64.44%	60.91%	35.66%	33.60%	35.81%	38.94%
ACUTE FLOOR HRI %	45.24%	51.70%	35.26%	14.51%	21.11%	20.53%	17.58%
SAU HRI %	60%	38.78%	33.33%	21.62%	16.98%	21.74%	18.18%

Dementia screening has been added onto the risk register (risk no 8093). As screening compliance is improving, the risk will be reviewed accordingly. However, the risk remains as compliance is not yet near the 90% target.

Focussed delivery of training on Assessment Units such as the Acute Floors, Frailty and the Surgical Assessment Unit (SAU). Ad hoc training provided to new rotational medics with ongoing input. SAU have redeployed their green wristband initiative with some success.

A standard operating procedure (SOP) has been circulated with all new rotations and has been added onto Padlet for medics to review.

Daily email of list of patients with an overdue dementia screen being sent out to consultants/ward managers/ward sisters and matrons of the assessment units to prompt medical staff to complete. As Medical Director I continue to be visible on all assessment units to observe board rounds and reminding staff to discuss dementia screening and will continue to do so daily.

Also, in process of developing a bitesize educational package for medics to support them to understand the importance of dementia screening and impact on patient experience, we are aiming to roll this out for the next medical rotation. This training will aim to be part of the induction process for all new medical staff. As Medical Director, I plan to meet with senior medics to see how this can be implemented.

EQIA – Equality Impact Assessment

It has been identified that if a patient has not been screened for dementia whilst in hospital, this may have an adverse impact on their care and experience. A patient may go undiagnosed for some time if not appropriately screened and referred into the Memory Service via the GP practice. This, in turn, will then have an impact on the provision of health and social care for the patient and their families/carers.

Recommendation

The Board is asked to **NOTE** the plans and actions to improve dementia screening compliance.

6. Chair’s Report

- North East and Yorkshire Elective Recovery Event

- Chief Executive Appointment

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

- Non-Surgical Oncology Update

Presented by Owen Williams

Transforming and Improving Patient Care

8. Colleague Story - Apprenticeship Scheme - Presented by Pamela Wood

To Note

9. Nursing and Midwifery Time to Care Strategy

To Approve

Presented by Ellen Armistead

NURSING & MIDWIFERY STRATEGY

TIME TO CARE

Our focus for 2021-2022

How will we deliver the Nursing & Midwifery Strategy?

One Culture of care

WE PUT THE PATIENT FIRST

Sponsors: Ellen Armistead, Karen Spencer & Alex Keaskin

AMBITIONS

- *We care about how our patients feel.*
- *Our patients always feel safe in our care.*
- *Our patients and their loved ones feel welcomed in all our areas.*
- *Regardless of age, sexuality, religion or ability we will offer you individualised care.*
- *We will encourage you to share your story as a partner in your care and decision making.*
- *Every experience with us will be a positive experience, where we fall short of your expectations, we commit to learn and improve.*

PRIORITIES

- *Real time patient feedback*
- *We will continue to review visiting, enhancing the Virtual Visiting and Relatives Line*
- *We will focus upon understanding health inequalities and develop approaches to address the imbalance*

WE GO SEE

Sponsors: Andrea Dauris & Rachel Rae

AMBITIONS

- *We will be the "go to" place for others to Go See.*
- *We will promote continuous learning and use this to inform our plans for the future.*
- *We will learn from the best locally, nationally and internationally.*
- *We will go see to learn from outstanding examples of nursing and midwifery leadership.*
- *We will learn from the best to utilise digital solutions that support integrated nursing care.*
- *We will invite our people and our community to go see our successes and learning.*

PRIORITIES

Develop a practical clinical leadership programme

Develop a Nursing & Midwifery Expert Group

Develop a Writing for Publication and Award programme to share our learning and improvements across a range of platforms including digital media, professional journals and awards.

Images curtesy of Google

WE WORK TOGETHER TO GET RESULTS

Sponsors: David Britton, Janet Youd & Louise Croxall

AMBITIONS

- *We will provide integrated and seamless care based on patients' needs.*
- *We will work in partnership with service users to promote their own models of self-care.*
- *Develop digital leaders to improve outcomes.*
- *Foster innovation in the delivery of high quality care.*
- *We invest in our nurses and midwives to support their development.*
- *We work in partnership to develop workforce plans that are fit for the future.*

PRIORITIES

- Creation of a Practice Development Unit
- *Develop a comprehensive Workforce Plan*

WE DO THE MUST DO'S

Sponsors: Liz Morley & Lindsay Rudge

AMBITIONS

- *We create a safe environment by doing the must do's.*
- *We will display consistent professional behaviours and challenge poor behaviors.*
- *We will create a culture of critical enquiry and quality improvement.*
- *We will provide support and development opportunities for our workforce.*
- *We will foster an open learning culture that focusses on closing the loop and sharing best practice.*
- *All nurses and midwives will have the knowledge, skills and competencies to deliver outstanding care.*

PRIORITIES

- Clinical Documentation
- Pressure Ulcers
- End of Life Care
- "Our Journey to Outstanding in the delivery of the Fundamental Standards of Care"
- Safer Programme
- Learning; when things go well and not so well
- Falls

Nursing and Midwifery Strategy – Releasing Time to Care
Our 1 year Strategy

WE PUT THE PATIENT FIRST

Sponsors: Ellen Armistead, Karen Spencer, Alex Keaskin

- Real time patient feedback.
- We will continue to review visiting, enhancing the virtual visiting and relatives line.
- We will focus upon understanding health inequalities and develop approaches to address the imbalance.

WE GO SEE

Sponsors: Andrea Dauris & Rachel Rae

- Develop a practical clinical leadership programme.
- Develop a Nursing & Midwifery Expert Group.
- Develop a writing for publication and award programme and share our learning and improvements.

WE WORK TOGETHER TO GET RESULTS

Sponsors: David Britton, Janet Youd & Louise Croxall

- Creation of a Practice Development Unit.
- Develop a comprehensive Workforce Plan.

WE DO THE MUST DO'S

Sponsors: Liz Morley & Lindsay Rudge

- Fundamental Standards of Care
- Learning; *when things go well and not so well*
- Clinical Documentation
- Falls
- Pressure Ulcers
- *End of Life Care*
- *Safer Programme*

10. Health Inequalities Update

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title:	Health Inequalities Progress Report
Authors:	Ellen Armistead, Director of Nursing / Deputy CEO Anna Basford, Director of Transformation and Partnerships Helen Barker, Chief Operating Officer Suzanne Dunkley, Director of Workforce and OD Luke Stockdale, Director of Digital Transformation and Innovation
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy CEO
Previous Forums:	Health Inequalities Group

Purpose of the Report

The purpose of the report is to update the Board of Directors on activity and progress in relation to the current workstreams that support the Trust's ambitions to tackle health inequalities and noting key achievements to date.

Key Points to Note

The Covid 19 pandemic exposed and exacerbated long standing inequalities particularly amo ng the BAME communities. The NHS commissioned a review of the impact of Covid 19, report ing in July 2020 the report made clear there are 8 urgent actions requiring a response from se rvice providers. In response to this CHFT has set up a Health Inequalities Working Group to o versee progress and activity around the following workstreams:

- External environment: how we connect with our communities. Lead: Anna Basford, Director of Transformation & Partnerships. (Urgent Actions: 1,3,4,6,8)
- The lived experience, initial focus on maternity services. Lead: Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive. (Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Helen Barker, Chief Operating Officer. (Urgent Actions: 1,2,5,6,7,8)
- Diverse and Inclusive Workforce. Lead: Suzanne Dunkley, Director of workforce and OD. (Urgent Actions: 1,5,6,7,8)

External environment: how we connect with our communities: Working with our partners continues. A project has commenced on the development of a Directory of Services for ED st aff to enable them to help people who are homeless or asylum seekers by improving the signp osting into support services. The EQIA/QIA for the reconfiguration has been considered and c oncluded there was no differential discrimination to any protected characteristic groups.

The lived experience, initial focus on maternity services: At the end of July 56% of women from a BAME background have been booked onto a Continuity of Carer pathway. Early feedback from the discovery interviews has shown overall experience to be positive and has highlighted areas for improvement around communication in relation to services on offer and changes made as a result. Staff have completed an anonymous survey in relation to perceptions of levels of culturally competent care delivery. Planning for a training package is now underway.

Using our data to inform stabilisation and reset: Prioritisation of people with a learning disability is now embedded in wating list management with strong support from clinical colleagues. Patients with a learning disability identified as part of the clinical prioritisation process have no been treated and those entered on the waiting list have a TCI date.

Diverse and Inclusive workforce: International Colleague engagement continues with focus on trying to connect to as many international colleagues as possible. With support from a senior BAME clinician we have developed an International Colleague newsletter. A range of activities were delivered across the Trust during National Inclusion Week from menopause, womens 'lived experience', jerusalama dance, launch root out racism campaign and launching the national staff survey encouraging as many colleagues as possible to raise their voice and share their views.

Digital Inclusion: CHFT has reps on LA Digital Inclusion boards. There is strong partnership working with both public and third sector bodies to ensure our strategies are aligned and work in mutual support.

EQIA – Equality Impact Assessment

The purpose of the paper is to demonstrate the work currently underway to develop knowledge and facilitate a more informed EQIA process with the ability to utilise data and experience in decision making and prioritisation as well as monitor impacts.

The Trust has already reviewed and strengthened its processes for undertaking Equality Impact Assessment of proposed service changes. This has provided tools and training for colleagues to use and also includes processes for involving patients and carers in the assessments. Materials and information for this are available on the Trust intranet**.**

The aim of the lived experience workstream supports the triangulation of data to assess whether CHFT could be unintentionally disadvantaging service users.

Recommendation

The Board is asked to **NOTE** the progress in relation to CHFT's response to NHS expectations of providers in tackling health inequalities.

HEALTH INEQUALITIES PROGRESS REPORT

November 2021

1. Introduction

Health Inequalities are defined as:

Unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

The purpose of the paper is to update the Board of Directors on activity and progress in relation to the current workstreams that support the Trust's ambitions to tackle health inequalities.

2. Background and Context

The link between poor health outcomes and social deprivation has long been established and has been the subject of a number of significant independent reviews and research studies over many years. The Covid 19 pandemic exposed and exacerbated long standing inequalities particularly among the BAME communities.

The NHS commissioned a review of the impact of Covid 19, reporting in July 2020 the report made clear there are 8 urgent actions that needed to be progressed namely:

1. Protect the most vulnerable from COVID-19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action

In response to this CHFT has set up a Health Inequalities Working Group to oversee progress and activity around the following workstreams:

- External environment: how we connect with our communities. Lead: Anna Basford, Director of Transformation & Partnerships. (Urgent Actions: 1,3,4,6,8)
- The lived experience, initial focus on maternity services. Lead: Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive. (Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Helen Barker, Chief Operating Officer. (Urgent Actions: 1,2,5,6,7,8)
- Diverse and Inclusive Workforce. Lead: Suzanne Dunkley, Director of workforce and OD. (Urgent Actions: 1,5,6,7,8)

3 Strengthening Leadership and Accountability

The Health Inequalities Working Group is chaired by a Non-Executive Director and the group acts as an oversight group providing assurance that workstreams are delivering the ambitions as set out in the plan on a page (see appendix1).

A variety of development sessions have been held with the Board and the Council of Governors outlining the reality of the widening health gap nationally and locally as well as an update on the main workstreams.

Health Inequalities continues to be a regular agenda item on a number of trust wide leadership forums.

4 Workstream Updates

External environment: how we connect with our communities.

Partnership Working: The Trust has continued to work with system partners and communities to understand and develop actions that could support a reduction in inequalities experienced by people that are frequent attenders at A&E, homeless, asylum seekers or refugees. A possible way forward identified is to create a directory of services for A&E colleagues that could support them and help to signpost people to support that is available in the community. To inform this, work is being undertaken to conduct an internal audit to review A&E attendances and admissions for individuals in this group and also meetings with service users to learn about their experience has been facilitated by the St Augustine's Centre. The audit and service user experience stories will inform the development of a directory.

Work has continued with the Greenwood PCN who have an aim to reduce emergency respiratory admissions. Data exploration within CHFT confirmed an elevated admission rate compared to the wider CCG, with potential inequalities in IMD, age, ethnicity and potentially, gender. There was a suggestion of a BAME inequality in paediatric readmissions. Further meeting with the PCN refined the project further to asthma specifically and it was agreed to undertake a joint review of asthma attendances at CHFT. Following confirmation of a data sharing agreement, CHFT will provide data related to asthma attendances for Greenwood PCN. Internally we are linking with the Clinical Directors and General Managers in the Respiratory and Paediatric Services to support this.

Social Value: The Social Value Portal (SVP) has supported the Trust in measuring and reporting the delivery of social value. The SVP has provided an action plan that uses a nationally approved methodology for measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at CRH and HRI. This has quantified the expected social return that will be generated by contractors and their supply chain for example in relation to new jobs, apprenticeship weeks undertaken, hours of community engagement, tonnes of embodied carbon reduced etc. The Social Value assessment is based on a local needs analysis and targeted actions to support a reduction in health inequalities experienced by our local communities. The output from this will inform our implementation plans for the estate developments to ensure the investment secures wider social benefits that are targeted to reduce health inequalities.

Reconfiguration EQIA / QIA: As part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty a refreshed assessment of the EQIA and QIA impact of the proposed service changes and estate developments at CRH and HRI has been undertaken. This has used the new and strengthened process to assess the EQIA and QIA impact and included meetings with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required. The refreshed assessment has been reviewed by the Trust's Quality Committee and Transformation Programme Board in June. The conclusion of this work is that the overall impact in relation to EQIA and QIA is positive, there is no differential discriminatory impact, and appropriate mitigating actions have been identified.

<u>The lived experience, initial focus on maternity services.</u>

A key element of the Health Inequalities Group workplan over the next 12 months is to gain an insight into the lived experiences of women and their families when using maternity services. There is a well-established evidence base that demonstrates women from disadvantaged communities are at increased risk of poor perinatal outcomes. There is also a direct relationship between higher levels of socio-economic deprivation and higher stillbirth and neonatal mortality rates

There have been some studies that have concluded there is a high level of mistrust between mothers from BAME communities and healthcare resulting in a lower level of engagement with providers. Given the link between poor perinatal outcomes and the level of engagement with services how women are made to feel may have a direct impact of safety for both mother and baby.

Continuity of Carer: Work continues to achieve the targets for continuity of carer. While this is a very challenging target to achieve at the end of September 56% of women from a BAME background have been booked onto a pathway.

Service User Experience: As part of the Trusts response to improving the service for women and families from BAME and vulnerable groups the service has commenced a series of discovery interviews to gain an insight into how it feels to be cared for by CHFT. Interviews are currently being undertaken, early feedback from service users describes an overall positive experience with some areas for improvement around information to explain services on offer. Changes have been made as a result of feedback including welcome signs on display in 10 languages.

A function is now available on Athena EPR that automatically translates notes into the service user's language on the web-based notes access system.

Public Health Midwife attended Halifax Opportunities Trust with Covid-19 Vaccine champion GP. Two engagement sessions were held with presentations for staff and local Black & Asian women around Covid-19 vaccines. Issues relating to community concerns around vaccines affecting fertility, pregnancy and breastfeeding were covered and messages of reassurance given to take back to families living in HX1 / Park Ward.

Culturally Competent Care: Given the link with clinical outcomes and service user engagement the service is undertaking some anonymous interviews with staff to gain insight into the challenges of caring for service users from vulnerable groups and different ethnic backgrounds. Early feedback has highlighted some gaps in understanding the extent of health inequalities within the lower IMD groups. The survey has also shown staff would be welcoming of further training and education, this is now being developed.

Smoking Cessation: A local research project is underway to understand the barriers to smoking cessation in pregnancy. The aim will be to have the results of this published in relevant professional journals.

Using our data to inform stabilisation and reset

We continue to connect with other Trusts and ICS systems nationally, sharing our work and experience in the delivery of a Health Inequalities guided recovery framework. Particular interest is evident around Learning disabilities with CHFT increasingly viewed as a thought leader.

Learning Disability: Teams have been working to ensure data in relation to children living with learning disabilities can be identified on the waiting list. The number has now been confirmed that shows there are 19 children on the waiting list with confirmed learning disability. 11 of the children have been given a TCI date, work is ongoing to allocate a TCI date for the remaining 8.

All adults with a learning disability identified through the clinical prioritization process have now been treated and all others on the waiting list have a TCI date.

Waiting Times: In relation to ensuring equitable waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients in the Priority 2 category where treatment should take place within 30 days of prioritisation. There is minimal variation by ethnicity however previously data was suggesting waiting time differences between IMD groups – this differential has now significantly reduced as seen in appendix 1.

Initial discussions have taken place on the potential development of a health inequalities matrix for waiting list prioritisation however the priorities agreed in the recovery framework and as part of H2 will remain in place until this work is concluded and a formal recommendation agreed.

Data Quality: The quality of our data in relation to ethnicity has been reviewed an Action plan was put in place which included EPR enhancement, staff awareness training, learning from other organisations and the position now is much improved and in an excellent place with a performance of 98.7%. This is continually monitored through weekly performance report.

Diverse and Inclusive Workforce.

Progress and activity includes:

- International Colleague engagement continues with focus on trying to connect to as many international colleagues as possible. With support from the sponsor Ashwin Verma we have developed an International Colleague newsletter.
- WRES/WDES Action Plans have been developed in consultation with our equality groups and equality group chairs presented the plans to Workforce Committee asking for their approval
- This quarter 18 colleagues will graduate from the Empower programme. 21/22 Empower programme commences October 2021 and will continue to be sponsored by Cornelle Parker. Enhance our Inclusive Talent Approach will launch in November, encouraging quality dialogue between manager and colleague with particular focus on development, engagement and wellbeing.
- A range of activities were delivered across the Trust during National Inclusion Week from menopause, women's 'lived experience', jerusalama dance, launch root out racism campaign and launching the national staff survey encouraging as many colleagues as possible to raise their voice and share their views.
- Work is progressing on EDS2 event and Tahliah Kelly Martin, BAME Community Engagement Advisor visited the Women's Action Centre, to understand how our services support the local community share what we can do to improve.

Digital Inclusion

We have taken action to ensure that digital access includes translation and interpreters in the top 6 languages spoken across our area and also includes British Sign Language. We know that some people do not have access to digital technology either the equipment or WIFI and /or may not have the skills to use technology. We are working with Council colleagues and partner organisations to understand how we can support people and develop digital inclusion strategies and action plans. For example by providing digital skills training, providing local support hubs, working with local communities and champions.

Summary

CHFT is actively addressing the 8 urgent actions as set out by the NHS. While this is a significantly challenging area the Trust can demonstrate significant progress and are becoming increasingly recognised as a leader in this arena. While the Trust has made good progress there is an acknowledgment there remains much to do and we are at the start of the journey to outstanding in tackling health inequalities.

Ellen Armistead,

Executive Director of Nursing/Deputy CEO

November 2021

Appendix 1

Calderdale and Huddersfield NHS
NHS Foundation Trust

Prioritised Backlog Analysis (on list - excluding surveillance/planned)

As at 18th October 2021

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Ethnicity P2 Backlog daily snapshot for 12 Mar, 19 Apr, 27 May, 18 Oct

Patient Group	12/03/21		19/04/21		27/05/21		18/10/21	
	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time
All Patients	427	8.9	417	10.8	406	12.6	266	6.0
White	348	8.0	336	10.1	338	12.0	235	5.7
BAME	54	15.2	54	17.6	45	19.8	28	8.8
Not Stated	25	8.2	27	6.7	23	7.7	3	2.3

Source: Knowledge Portal Plus

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Calderdale and Huddersfield NHS
NHS Foundation Trust

IMD P2 Backlog daily snapshot for 27 May, 18 Oct

Patient Group	27/05/21		18/10/21	
	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time
All Patients	406	12.6	266	6.0
IMD 1 & 2 Only	111	17.1	70	6.4
IMD 9 & 10 Only	51	8.6	23	3.9

Source: Knowledge Portal Plus

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Calderdale and Huddersfield NHS
NHS Foundation Trust

P2, P3, P4 Combined
27 May, 18 Oct

Patient Category	27/05/21		18/10/21	
	P2, P3, P4 Patient Numbers	Weekly Average Waiting Time	P2, P3, P4 Patient Numbers	Weekly Average Waiting Time
All Patients	5,038	33.3	4,656	28.6
White	4,152	32.7	3,939	28.2
BAME	599	37.8	573	29.8
Not Stated	287	33.7	144	35.0
IMD 1 & 2 Only	1,377	36.1	1,234	28.6
IMD 9 & 10 Only	503	30.5	460	26.4

Source: Knowledge Portal Plus

compassionate care

11. Strategic Objectives 2021-2023

To Approve

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title of report:	2020-21 Strategic Plan – Progress Report (period ending September 2021)
Author:	Anna Basford, Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

Provide an update on progress against the 2020/21 strategic plan for period ending September 2021.

Key Points to Note

This report highlights that of the 19 deliverables:

0 are rated red
5 are rated amber
12 are rated green
2 have been fully completed

This is the final progress report against the 2020-21 Strategic Plan.

A separate report providing updated strategic objectives for the period November 2021 – March 2023 (that will enable the Trust to continue to make progress to achieve the Trust's ten year strategy) has been submitted for approval by the Trust Board. Subject to approval, future quarterly progress reports will be provided in relation to the updated plan.

EQIA – Equality Impact Assessment

For each objective described in the one year plan the accountable Lead Director is responsible for ensuring that Quality and Equality Impact Assessment is undertaken and where possible that this follows 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.

Recommendation

The Board of Directors is asked to **NOTE** the assessment of progress against the 2020/21 strategic plan for the period ending September 2021.

Calderdale and Huddersfield NHS Foundation Trust
2020-21 Strategic Plan – Progress Report up to 30 September 2021

Purpose of Report

The purpose of this report is to provide an update on progress made against the four goals described in the Trust's plan for 2020/21:

- Transforming and improving patient care;
- Keeping the base safe;
- A workforce fit for the future;
- Sustainability.

Structure of Report

The report is structured to provide an overview of progress against key deliverables and this is rated using the following categories:

1. Completed (blue)
2. On track (green)
3. Off track – with plan (amber)
4. Off track – no plan in place (red)

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 19 deliverables:

0	are rated red
5	are rated amber
12	are rated green
2	have been fully completed

Recommendation

Note the assessment of progress against the 2020/21 goals.

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 the Trust's carbon footprint. (SS)
	Trust Board approval of a 5 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)	

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**AMBER** off track – with plan	During June 2020 engagement was undertaken to listen to people's views on the service changes implemented during the pandemic and to ask about their aspirations for future service delivery. Colleagues, health and care partner organisations (e.g. Councils, CCGs, Locala, SWYPFT, YAS, Primary Care Networks) and; patients and members of the public provided input to the engagement. The feedback provided from the engagement identified 12 key learning themes of new ways of working where there was agreement that this could have potential long-term benefit and should be sustained and amplified. Since then a programme of work has been implemented to support continued engagement and to take forward further developments in relation to each of these themes. This work is informing operational planning and longer term strategic plans in relation to integrated working, digital, estate, and workforce strategies. Quarterly updates on the progress have been provided to Trust Board sub-committees (i.e. Transformation Programme Board, Quality Committee, Finance & Performance Committee and WOD Committee). The last report in September 2021 highlighted that: 0 are rated red 5 are rated amber 6 are rated green 1 has been fully embedded The programme can demonstrate positive learning from the pandemic has informed and enabled the continuation of new ways of working and this is informing longer term strategic planning. However this objective is rated as amber overall as it is recognised that further work to measure the benefits are needed. This work is being progressed to develop a	**Lead: AB** Transformation Programme Board

		benefits register and updates on this will be provided going forward.	
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** on track	Formal Trust governance structures have been established. The Transformation Programme Board has oversight of the programme of reconfiguration plans. The Trust has quarterly review meetings with ICS, NHSEI and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). The Trust has procured the external professional and technical capacity and advice required. There has been continuous involvement of stakeholders and local people about the development plans. The Kirklees Strategic Planning Committee has granted full planning permission for development of a new A&E at HRI. The planning applications for the hospital expansion and new car park at CRH were submitted to Calderdale Council in July 2021.The Reconfiguration business cases are at an advanced draft stage of preparation prior to submission to NHSEI and DHSC.	**Lead: AB** Transformation Programme Board ICS, NHSEI, DHSC
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** on track	The Board approved clinical strategy will support future discussions within WYAAT and the ICS on the development of services into the future. Significant work progresses on the delivery of non-surgical oncology including support into the Mid Yorks service and an offer of support to Bradford. The Trust has provided information to an independent review of NSO by Professor Mike Richards. The Trust is engaging with partners to procure a single Chemotherapeutic prescribing system to further facilitate network development. Internal improvement work with the Stroke team has resulted in an SSNAP rating of A, and the Trust is currently working on the implementation of a joint laboratory computer system across WYAAT.	**Lead: DB** Weekly Executive Board Quality Committee Trust Board
Trust Board approval of a 5-year digital strategy supported by an agreed	**GREEN** on track	The 5-year Digital strategy was approved by the Trust BOD on 2nd July 2020. The key programmes are in flight and progress:	**Lead: MG** Divisional digital boards

programme of work and milestones.		• The Scan 4 Safety Project – 21/22 programme inflight capital delivery on track and the final year funding for 22/23 programme under development. Challenging delivery due to clinical/operational pressures further work is needed to support full adoption of digital solutions - amended programme to support. • Digital Aspirant Programme – final year of funding 21/22 projects underway with the major capital expenditure focused on Wi-Fi Replacement within year. All necessary reporting to NHS X delivered on time. • Currently defining Digital Optimisation Initiative with more on-site presence assessing different eco-systems, working on wards, engaging with colleagues has given insight to this. • The Infrastructure Strategy focused on Cloud now is complete, this will feature options surrounding an integration layer within the cloud. This will help promote and accelerate drive interoperability. • Multiple Digital funding bids have been submitted in line with Digital Strategy as part of the wider ICS agenda. There is acknowledgement of revenue/capital apportionment issues of the funding and issues of longer term revenue pressures.	Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.
Use population health data to inform actions to address health inequalities in the communities we serve.	**AMBER** off track – with plan	The Trust has established real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics. This analysis is being considered and discussed and discussed with a range of colleagues (e.g., Patients, Doctors, Nurses, Therapists, Medical Secretaries) alongside clinical prioritisation to inform the Trust's elective recovery plans going forward. The aim is to ensure that for people who have had their care unavoidably delayed due to the pandemic that the recovery plans are informed by clinical need and support reduction in health inequalities.	**Lead OW** Weekly Executive Board Board of Directors Learning Improvement Review Board Health Inequalities Oversight Group (England)

		CHFT, in line with all other Trusts nationally, has a significant backlog of patients awaiting access to outpatient, diagnostic and inpatient services. For inpatients and a percentage of outpatients these have all been clinically reviewed and a priority status assigned that links to the optimal waiting time based on their clinical presentation. This data has been incorporated into a Health Inequalities dashboard where we can then look at it in relation to: • Patients with a learning disability • By ethnicity • By Index of Multiple Derivation • By their Frailty score By reviewing the waiting list data in this way we have been able to look more holistically at patient groups and individuals and prioritise treatment taking account of additional risks factors. The two areas currently in focus are patients with a learning disability and patients from a BAME background. As a result of this work the Trust has been able to demonstrate an overall reduction in waiting lists and a reduction in the numbers of people waiting from BAME communities and for people that have a Learning Disability. It should be noted that the Trust is not doing this work in isolation and is deeply involved in influencing and partnering with other organisations to reduce health inequalities at place and neighbourhood levels; across the acute collaboration of WYAAT and as a part of the West Yorkshire & Harrogate Partnership's 10 big ambitions.	
Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**

Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleague's safety.	**AMBER** off track – with plan	Non-elective demand has increased although hospitalisations are lower than the same period last year. Kirklees and Calderdale have seen a significant increase in the number of Covid-19 infections in the past few weeks and is the highest regionally. We are continuing to work with all partners and communities to support increased population uptake of the Covid-19 vaccine and have commenced our internal winter COVID booster and flu vaccination programme. The Trust is ensuring IPC measures remain in place, so all patients and colleagues feel safe in our hospitals. We are placing priority on reducing the backlog of patients that have had their care and treatments delayed due to the pandemic and have ensured that our recovery plans support a continued reduction in health inequalities.	**Lead: OW** Weekly Executive Board Trust Board
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**AMBER** off track – with plan	The quality directorate have worked with the divisions and developed a new style accreditation Journey to Outstanding (J20). This was tested and has been rolled out. A number of areas have been assessed and improvement plans developed and actioned. The CQC continue to meet with the Trust and provide ongoing assurance to any emerging issues. We have had favourable feedback from CQC, however the monitoring visits put in place during the pandemic do not have ratings attached to them. Work in line with well-led continues. The amber progress rating reflects the gap in assurance around external validation as a result of CQC rating activity and the level of embeddedness of the J2O.	**Lead: EA** Quality Committee Weekly Executive Board

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	**GREEN** on track	Work continues on a range of activities around patient engagement. Observe and Act has been introduced and plans in place for the schedule of assessments. These align to our J20 programme. The Health Inequalities group are overseeing the work plan in relation to the lived experiences that involves some discovery interviews commencing in maternity services. LD has had an increased focus across the organisation.	**Lead: EA** Quality Committee Weekly Executive Board
Develop an outcome-based performance framework and deliver against key metrics.	**BLUE** completed	Performance and Accountability framework completed to plan and approved at Board of Directors. IPR updated to include a specific recovery section and an increased focus on outcome metrics which will continue to develop through 21/22	**Lead: HB / BW** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee
Deliver the actions in the Trust's 2020/21 Health and Safety Plan.	**GREEN** on track	Significant progress has been made in developing Health and Safety Sub Committees and the Trusts 5-year Health and Safety Strategy was presented to Board in July.	**Lead: SD** Quality Committee Trust Board
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**assurance route**
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,	**GREEN** on track	The Trust continues to implement actions identified through the Recruitment Strategy and progress updates have been presented at Workforce Committee. Rolling 12 month turnover for the Trust is at 7.74% as of September 2021 and vacancy rate is 2.5%. The Healthcare Support Worker programme continues with the target of 0 vacancies.	**Lead: SD** Workforce Committee

thus retaining a turnover below 10%.		43 International Nurses have commenced in the Trust, with 18 more in the recruitment pipeline. The Trust is committed to securing 70 International Nurses by December 2021. Following work with the universities, 80 newly qualified nurses have received offers of employment with the Trust. There are 3 current active cohorts of Nursing Associate apprentices and a further cohort of 20 recruited to start in December 2021. The vacancy rate for medical staff is below 5%. We have a year on year net increase of 41 more Medical and Dental staff employed (more starters than leavers). These increases can be seen in Emergency Medicine, Acute and General Medicine and General Surgery. However, there are a number of shortage specialties that remain, such as ED, Stroke Medicine and Pathology Specialties. We have AACs scheduled for the next couple of months including 2 Gastro candidates, 3 Cardiology candidates for 2 posts and 2 Respiratory Medicine candidates so the picture will further improve by early 2022. 3 areas were identified to trial workforce design processes and principles. This work has been delayed due to the impact of the pandemic however one workstream (Multi-skilled Worker in ED) has progressed and is currently at the options appraisal stage. The Recruitment Strategy will be relaunched from March 2022 following consultation with colleagues and taking into account learning from Covid-19 and the need to have a flexible workforce that is able to meet the challenges of responding to a changing healthcare environment.	
Develop an approach to talent management that further embeds our	**GREEN** on track	We have in place the following: - • a focus on Talent Management through The Cupboard	**Lead: SD** Workforce Committee

approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions.		• an Executive Board approved succession planning tool • Board level as well as divisional and directorate succession plan assessments • an agreed recruitment and selection policy • an agreed equality of opportunity policy • a recruitment statement about open competition • leadership development programme open to all • the Empower programme which nurtures talent from across the organisation • a commitment to create a 'development for all' programme of learning activity • the operational HR team is working with senior management teams to embed the use of the succession planning tool across Divisions as a must-do in order to establish a more robust understanding of the capability and readiness of individuals to fulfil their aspirations and/or critical roles • a significant investment has been made by the Trust to establish a 'widening participation' team in the Workforce and OD Directorate. This will enable an increased focus on ensuring that people in our local communities have access to healthcare employment opportunities and to pre-employment skills development support. In addition to this the Trust has developed 'Enhance' – an inclusive talent approach with a view to supporting quality conversations between colleague and manager with particular focus on development, engagement and wellbeing. • Enhance will support our integrated talent approach and will align with the other programmes on offer. The programme was approved at Workforce	

		Committee on 30/09/2021 and will launch in November 2021.	
Roll out our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams.	**GREEN** on track	The Trust's on-line leadership development programme was launched on 31 July 2020. A full review of the content is to be conducted in 2021/2022 with a relaunch to be scheduled. New material is added to the programme as it becomes available and new leadership modules are in development (for example, collaborative health system working). A leadership Hot House event was held on 7 June 2021 with 70 participants focusing attention on the skills/attributes required in our leader's post-pandemic. This will inform the development of our leadership and management development programmes. We have relaunched our leadership development offering and aim to deliver 5 cohorts over the year reaching 100 colleagues. The first 3 cohorts have been advertised and uptake has been strong across all divisions, professions and experience. The sessions will be branded as 'key club' as colleagues will unlock learning for themselves and share their learning with others in the organisation. The online modules will complement the virtual sessions and they will be underpinned by challenge and support groups to encourage networking and sharing of experiences. This will help to build on the groundwork established of our One Culture of Care and the importance of role modelling and challenging when this is not happening for our patients or our people.	**Lead: SD** Workforce Committee
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	**AMBER** **off track with plan**	The NHS People Plan emphasises the importance of improvement work in relation to equality and diversity and recruitment. It makes specific reference to an 'overhaul of recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.' A review of how current inclusive recruitment is operating completed in February 2021 highlighted there are areas for development. The engagement and	**Lead: SD** Workforce Committee

		recruitment teams are working with our established equality network groups to improve processes, expand membership on panels, increase interview training and enhance decision making linked to our 4 pillars. Refreshed training will be implemented at the end of June 2021. It is anticipated that activity will ensure compliance by September 2021. Tahliah Kelly Martin, BAME Community Engagement Advisor has designed inclusive recruitment workshop with the aim of widening participation from inclusion allies on recruitment panels. Tahliah has engaged a range of inclusion allies (25 currently with a view to having 20 more colleagues going through the workshop by the end of the year) who are now available to support recruitment panels for bands 6 and above.	
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)	**GREEN** on track	145 Wellbeing Ambassadors are now in place. A network has been established with regular communication and bi-monthly meetings. Work continues to expand the network to ensure all teams have access to an Ambassador. Wellbeing Advisers operating as part of the Engagement Team based in the Workforce and OD Directorate are aligned to service areas to ensure maximum health and wellbeing support. The implementation of the wellbeing hour continues. A Non-Executive Director (Richard Hopkin) has been appointed as our Board level Wellbeing Guardian. The 2020 national staff survey results show a significant increase in our health and wellbeing score. In response to a question about the organisation taking positive action on health and wellbeing a 10% improvement in responses occurred, from 22% in 2019 to 32% in 2020. As we look to support our people through winter our wellbeing ambassadors are working with their teams	**Lead: SD** Workforce Committee

		and departments to ensure the wellbeing offer in understood and to promote additional support. Wellbeing ambassador connectivity sessions continue to be delivered with the founder of Andys Man Club presenting at the last session. We have listened to our colleagues and there was growing appetite to support employees going through the Menopause. Therefore, we have introduced a Menopause support group where colleagues can chat in a safe space and learn from others. A CHFT Special Mental Health bulletin was developed in recognition of World Mental Health Awareness Day. During inclusion week we hosted jerusalama dance to promote physical wellbeing.	
Goal: Sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver the 20/21 regulator approved financial plan. (GB)	**GREEN** on track	The Trust delivered the Board approved H1 plan agreed within the ICS for 2021/22. The plan for H2 has yet to be agreed and will be submitted to Trust Board for approval in November.	**Lead: GB** Reported to Finance & Performance Committee / Estates Sustainability Committee Monthly regulator discussions
Demonstrate improved performance against Use of Resources key metrics.	**GREEN** on track	The finance use of resource metric is presented monthly at Finance and Performance committee. This shows improvement from when our assessment took place. Whilst the metric is no longer being collected by NHSEI we have continued to monitor. A report was published to F&P in June 2021 that demonstrated progress against other KLOE and progress against all CQC actions identified.	**Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions

		The Trust is reviewing and establishing governance arrangements for oversight of use of resources in H2 and beyond.	
Trust Board approval of a 10-year sustainability plan to support reduction in the Trust's carbon footprint.	**BLUE** completed	On the 5th November 2019, the Trust Board adopted the NHSE targets for carbon neutrality and approved the proposed strategy set out in the report for its delivery through the adaptation plan.	**Lead: SS** Transformation Programme Board Trust Board
Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** on track	The Trust is working with West Yorkshire Association of Acute Trusts, the West Yorkshire Integrated Care System (ICS) and with place-based leaders in Calderdale and Kirklees to support delivery of collaborative system plans and new ways of working related to legislative changes. The Trust's Clinical Strategy provides information of the Trust's ambitions to support the resilience of service delivery for patients by working in partnership across West Yorkshire.	**Lead: AB** Plans reviewed by Board and WYAAT Committee in Common System Leadership Meetings with NHSE and ICS

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Trust Board of Directors
Title of report:	Annual Strategic Plan
Author:	Anna Basford, Director of Transformation and Partnerships (with inputs from all Executive Directors)
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

To describe the strategic objectives that the Trust will deliver in the period November 2021 to March 2023.

Key Points to Note

In March 2020 the Trust Board approved CHFT's ten-year strategic plan and in July 2020 annual objectives to support delivery of the 10 year plan were approved by the Trust Board. This report provides an updated set of strategic objectives for the period November 2021 to March 2023 that will support continued progress to deliver 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.
Prior to the pandemic annual objectives would usually be set for delivery during a single financial year i.e. from 1st April to 31st March. The Pandemic has impacted on annual planning timescales and to realign this the delivery period for the objectives described in this report is November 2021 to March 2023.

EQIA – Equality Impact Assessment

For each objective described 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 progress reports submitted to the Trust Board.

Recommendation

Trust Board members are requested to **APPROVE** the strategic objectives.

Strategic Objectives (November 2021 – March 2023)				
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' demonstrating benefits delivered. (AB)	Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleagues safety. (EA)	Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for clinical roles, thus retaining a turnover below 10%. (SD)	Deliver the regulator approved financial plan. (GB)
	Approval of business cases for HRI and CRH to enable construction of new A&E to commence at HRI and the development of a Full Business Case for 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)	Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond (SD)	Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint. (SS)
	Implement the Trust Board approved 5 year digital strategy with an agreed programme of work and milestones. (JR)	Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery. (JF)	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 and implement actions to address health inequalities in the communities we serve. (EA)	Deliver the actions in the Trust's Health and Safety Plan. (SD)	Develop health and wellbeing support plans for all Departments to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	

AB – Anna Basford, Director of Transformation and Partnerships; DB – David Birkenhead, Medical Director; EA - Ellen Armistead Executive Director of Nursing / Deputy Chief Executive; GB – Gary Boothby, Director of Finance; JR - Jim Rea, Managing Director Digital Health; JF – Joanna Fawcus, Chief Operating Officer; SS - Stuart Sugarman, Managing Director Calderdale and Huddersfield Solutions, SD - Suzanne Dunkley, Director of Workforce and Organisational Development.

Sustainability

12. Month 6 Financial Summary

For Assurance

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title:	Month 6 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 6 (September 2021).

Key Points to Note

Year to Date Summary

In Month 6 the Trust is reporting a £2.18m deficit, an adverse variance of £1.62m due to a significant increase in costs linked to both Covid and Recovery. Year to date the Trust has delivered a break-even position as planned. This position has only been possible due to the favourable variance reported in Quarter 1 which was driven by a combination of: slippage on developments, vacancies and lower than planned recovery costs. This is the second month in a row that the Trust's underlying deficit has been circa £2m.

- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). For H1 the Trust planned to deliver a break-even position. The plan for H2 is currently being finalised but is expected to be much more challenging.
- Funding for both H1 and H2 is on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H1, the Trust was allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m received equally across the first 6 months of the year.
- In addition the Trust continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £4.02m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M3 has now been approved and received, the remainder remains subject to approval.
- In total the Trust has incurred costs relating to Covid-19 of £11.13m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
- These costs have been offset to some extent by an underspend on activity reset, slippage on new developments and lower than planned recovery costs in Quarter 1.
- For H1 the Trust had an efficiency savings target of £3m, which has been delivered but largely on a non-recurrent basis.
- Agency expenditure year to date is £2.89m, £1.52m lower than the NHS Improvement Agency expenditure ceiling. However there has been a large increase in Bank costs that has accelerated over the last 3 months due to the enhanced pay agreement.

- Clinical activity is higher than planned year to date across Elective and Outpatients points of delivery, but Daycase activity has remained below plan. The Trust has secured £3.63m of additional ERF in support of recovery as advised by the Integrated Care System (ICS) all for Quarter 1 activity. No ERF has been assumed for Quarter 2 due to an increase in the threshold and a reduction in planned activity due to the impact of Covid-19.

Key Variances

- Income is £5.17m higher than planned year to date. This includes £3.57m income to support the backdated 21/22 pay awards. A further £4.02m of additional income has been accounted for to offset outside of system envelope Covid-19 costs and this is offset to some extent by lower than planned commercial income. ERF is now below the planned level at £3.63m, an adverse variance of £0.67m year to date.
- Pay costs are £5.76m above the planned level year to date, although this includes £3.57m of backdated pay awards which are funded, leaving an underlying variance of £2.19m adverse. £0.76m of Covid-19 costs are outside of envelope and therefore also offset by additional income, this is offset by Recovery costs that are £0.75m lower than planned. The adverse variance is largely driven by the agreed enhanced pay for Bank staff, an additional cost of £0.77m in month and £1.82m year to date. Covid pressures have also increased over the last two months; Emergency Department segregation and enhanced staffing models on Wards and in Critical Care continue to drive higher costs.
- Non-pay operating expenditure was lower than planned by £0.24m. Given that the position also includes Covid-19 related expenditure of £3.26m for vaccination costs and Covid-19 testing that are outside of envelope, the underlying position was a £3.50m underspend, linked to lower than planned commercial activity.

H2 (Oct-Mar) Forecast

The plan for H2 is currently being finalised but is expected to be much more challenging. The H2 forecast after mitigations and efficiencies is showing a £3.8m deficit. Costs have increased significantly over the last 2 months due to high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse. This increased cost has been mitigated in the forecast by assuming a very challenging efficiency target of £6.7m for H2. The Trust is continuing to work with partners at Place and ICS level to manage this risk and to maximise Elective Recovery Fund access to further mitigate this position.

Attachment: Month 6 Finance Report

EQIA – Equality Impact Assessment

The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

Recommendation

The Board is asked to receive the Month 6 Finance Report and **NOTE** the financial position for the Trust as at 30 September 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2021 - Month 6

KEY METRICS

	M6				YTD (SEP 2021)				Forecast 21/22			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£0.57)	(£2.18)	(£1.62)		£0.00	£0.00	£0.00		£0.00	(£3.80)	(£3.80)	
Agency Expenditure (vs Ceiling)	(£0.74)	(£0.54)	£0.20		(£4.41)	(£2.89)	£1.52		(£8.82)	(£5.82)	£3.01	
Capital	£1.06	£0.98	£0.08		£6.30	£4.08	£2.22		£18.99	£14.78	£4.21	
Cash	£40.77	£46.05	£5.28		£40.77	£46.05	£5.28		£37.07	£40.52	£3.46	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	94%	-1%		95%	94%	-1%					
CIP	£0.49	£0.49	(£0.01)		£3.00	£3.00	(£0.00)		£17.23	£9.70	(£7.53)	
Use of Resource Metric	3	3			2	2			2	2		

Year to Date Summary

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Total Group Financial Overview as at 30th Sep 2021 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	1,884	2,094	210
Non-Elective	29,369	26,936	(2,432)
Daycase	23,242	22,835	(407)
Outpatient	199,475	200,250	774
A&E	79,535	88,964	9,429
Other NHS Non-Tariff	815,583	836,434	20,851
Other NHS Tariff	46,903	45,217	(1,686)
Total	**1,195,991**	**1,222,730**	**26,738**

TOTAL GROUP: INCOME AND EXPENDITURE

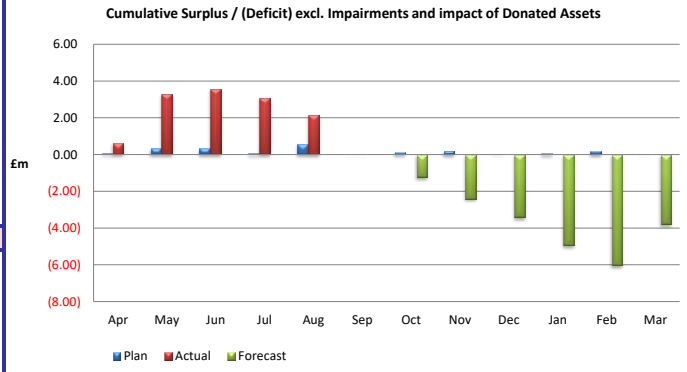
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£5.72	£5.72	£0.00
Non Elective	£57.41	£57.41	£0.00
Daycase	£13.01	£13.01	£0.00
Outpatients	£17.12	£17.12	£0.00
A & E	£12.00	£12.00	£0.00
Other-NHS Clinical	£81.95	£89.55	£7.60
CQUIN	£1.71	£1.71	£0.00
Other Income	£25.37	£22.99	(£2.38)
Total Income	**£214.29**	**£219.51**	**£5.22**
Pay	(£145.27)	(£151.03)	(£5.76)
Drug Costs	(£20.94)	(£20.16)	£0.78
Clinical Support	(£17.03)	(£18.58)	(£1.55)
Other Costs	(£32.29)	(£31.27)	£1.01
PFI Costs	(£6.51)	(£6.51)	£0.00
Total Expenditure	**(£222.04)**	**(£227.56)**	**(£5.52)**
EBITDA	**(£7.75)**	**(£8.05)**	**(£0.30)**
Non Operating Expenditure	(£14.44)	(£14.13)	£0.30
Surplus / (Deficit) Adjusted*	**(£22.18)**	**(£22.18)**	**£0.00**
Conditional Funding (MRET/FRF/Top Up)	£22.19	£22.19	£0.00
Surplus / Deficit*	**£0.00**	**£0.00**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE) and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£42.53)	(£44.87)	(£2.35)
Medical	(£50.65)	(£57.31)	(£6.66)
Families & Specialist Services	(£42.33)	(£42.19)	£0.13
Community	(£12.93)	(£13.02)	(£0.09)
Estates & Facilities	(£0.04)	(£0.00)	£0.04
Corporate	(£25.93)	(£26.57)	(£0.65)
THIS	£0.92	£1.04	£0.11
PMU	£1.48	£1.17	(£0.31)
CHS LTD	£0.44	£0.45	£0.01
Central Inc/Technical Accounts	£178.70	£178.18	(£0.52)
Reserves	(£7.15)	£3.14	£10.29
Surplus / (Deficit)	**£0.00**	**£0.00**	**£0.00**

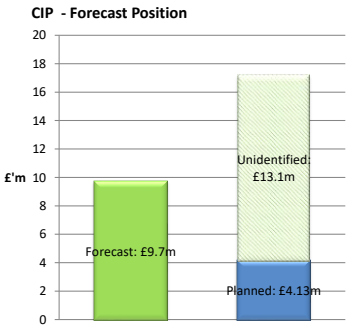
TOTAL GROUP SURPLUS / (DEFICIT)

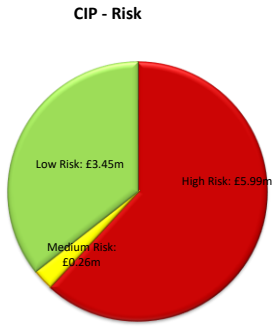


KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	£0.00	£0.00	£0.00	£0.00	(£3.80)	(£3.80)
Capital	£6.30	£4.08	£2.22	£18.99	£14.78	£4.21
Cash	£40.77	£46.05	£5.28	£37.07	£40.52	£3.46
Invoices Paid within 30 days (BPPC)	95%	94%	-1%			
CIP	£3.00	£3.00	(£0.00)	£17.23	£9.70	(£7.53)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £17.23m[1] **Total Forecast £9.7m**

[1] Estimated target based on internal planning assumptions. The scale of the efficiency requirement for H2 is currently being confirmed, but is expected to be c. £6.7m (Total for 21/22 £9.7m).

YEAR END 21/22

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	3,790	4,181	391
Non-Elective	58,196	53,995	(4,201)
Daycase	46,367	46,766	400
Outpatient	402,979	408,019	5,040
A&E	154,885	173,647	18,762
Other NHS Non- Tariff	1,637,434	1,680,613	43,179
Other NHS Tariff	94,178	89,891	(4,287)
Total	**2,397,829**	**2,457,112**	**59,283**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£11.44	£11.44	£0.00
Non Elective	£113.53	£113.53	£0.00
Daycase	£25.34	£25.34	£0.00
Outpatients	£34.99	£34.99	£0.00
A & E	£23.42	£23.42	£0.00
Other-NHS Clinical	£156.69	£176.37	£19.68
CQUIN	£3.39	£3.39	£0.00
Other Income	£51.25	£46.57	(£4.68)
Total Income	**£420.05**	**£435.05**	**£15.00**
Pay	(£285.06)	(£305.21)	(£20.15)
Drug Costs	(£42.06)	(£41.19)	£0.86
Clinical Support	(£32.35)	(£38.08)	(£5.73)
Other Costs	(£55.95)	(£56.91)	(£0.97)
PFI Costs	(£13.03)	(£13.46)	(£0.43)
Total Expenditure	**(£428.44)**	**(£454.85)**	**(£26.41)**
EBITDA	**(£8.39)**	**(£19.80)**	**(£11.41)**
Non Operating Expenditure	(£29.05)	(£27.34)	£1.71
Surplus / (Deficit) Adjusted*	**(£37.45)**	**(£47.14)**	**(£9.70)**
Conditional Funding (MRET/FRF/Top Up)	£37.45	£43.34	£5.89
Surplus / Deficit*	**£0.00**	**(£3.80)**	**(£3.80)**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE) and Impairments

DIVISIONS: INCOME AND EXPENDITURE

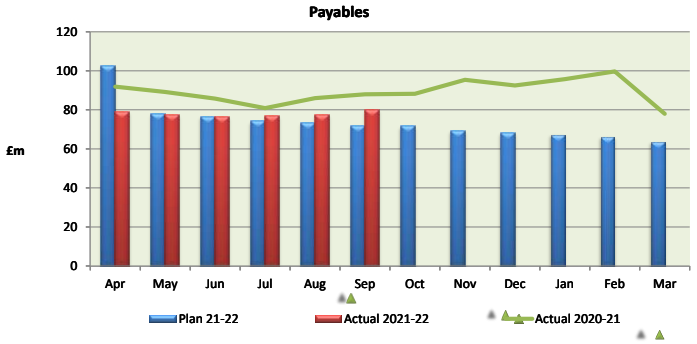
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£85.12)	(£93.40)	(£8.29)
Medical	(£102.35)	(£118.03)	(£15.68)
Families & Specialist Services	(£84.61)	(£85.71)	(£1.10)
Community	(£25.90)	(£26.72)	(£0.82)
Estates & Facilities	(£0.07)	(£0.00)	£0.07
Corporate	(£52.08)	(£53.13)	(£1.05)
THIS	£1.88	£1.75	(£0.13)
PMU	£2.96	£1.81	(£1.15)
CHS LTD	£0.88	£0.80	(£0.08)
Central Inc/Technical Accounts	£341.75	£356.32	£14.56
Reserves	£2.65	£12.52	£9.87
Surplus / (Deficit)	**£0.00**	**(£3.80)**	**(£3.80)**

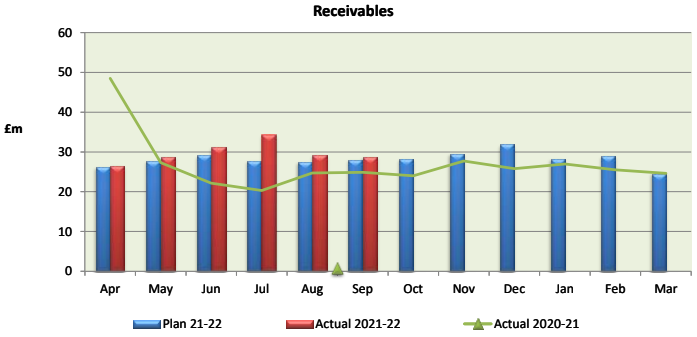
Total Group Financial Overview as at 30th Sep 2021 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

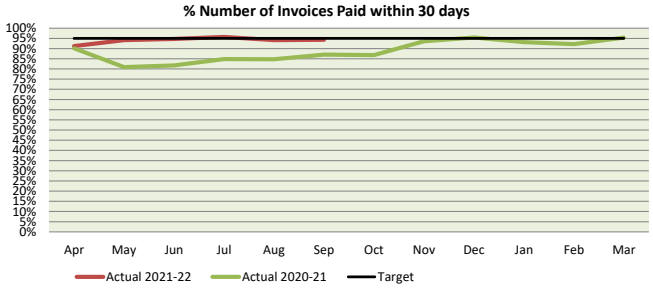
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£71.68)	(£79.93)	£8.25	
Receivables	£28.02	£28.67	(£0.65)	



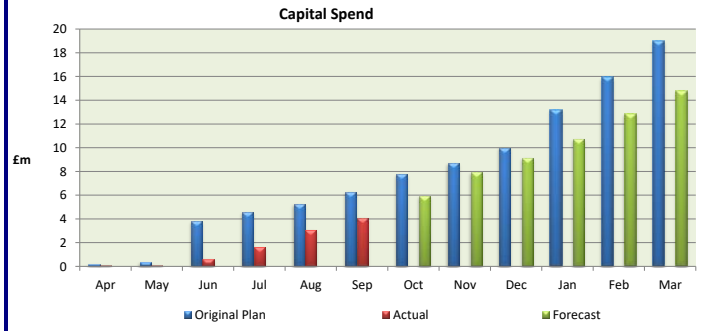


BETTER PAYMENT PRACTICE CODE



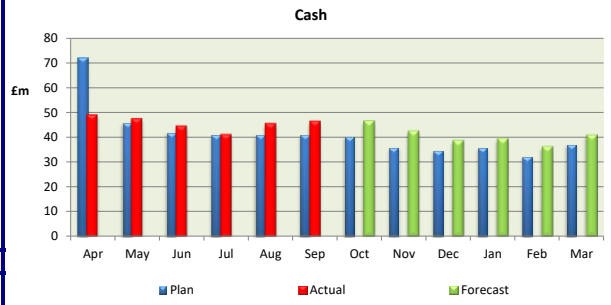
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£6.30	£4.08	£2.22	

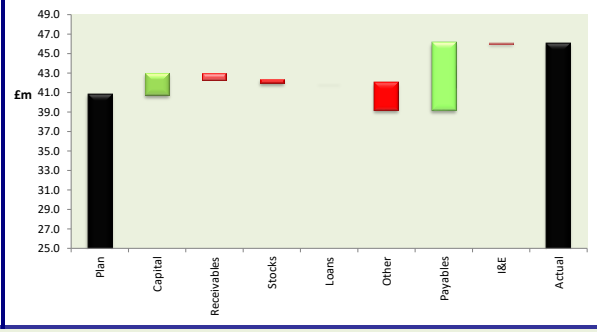


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£40.77	£46.05	£5.28	
Loans (Cumulative)	£18.77	£18.77	£0.00	



CASH FLOW VARIANCE



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- In Month 6 the Trust is reporting a £2.18m deficit, an adverse variance of £1.62m due to a significant increase in costs linked to both Covid and Recovery. Year to date the Trust has delivered a break-even position as planned. This position has only been possible due to the favourable variance reported in Quarter 1 which was driven by a combination of: slippage on developments, vacancies and lower than planned recovery costs.
- Funding for H1 has been on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H1, the Trust was allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m received equally across the first 6 months of the year.
- With the exception of Non-Elective and Daycase, all activity points of delivery are above the planned level year to date. Activity was above the required threshold to secure Elective Recovery Funding (ERF) for Quarter 1 only. The Trust has assumed £3.63m of additional ERF in support of recovery as advised by Integrated Care System (ICS). No ERF has been assumed for Quarter 2 due an increase in the threshold from a planned 85% to 95% of 19/20 activity.
- The Trust has incurred costs relating to Covid-19 of £11.13m, of which £4.02m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is lower than planned at £4.08m against a planned £6.30m.
- H1 CIP has been delivered as planned at £3.00m, although most of these efficiencies were non recurrent in nature.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2.

NOTES

- Planning for H2 is still underway, but based on the latest funding allocations, the Trust is forecasting an £3.8m deficit for H2.
- The scale of the £3.8m deficit is aligned with the expected cost of Independent Sector contracts in H2. Based on the current activity plan, it is looking unlikely that the Trust will be able to claim any ERF to offset this cost.
- The Trust is continuing to discuss opportunities to close the remaining gap and support the operational position with CCG partners at Place level.
- The Trust has a cash balance of £46.05m, £5.18m higher than planned.
- Funding allocations for H2 are higher than were originally planned going into this financial year and resulting in a lower efficiency requirement than originally feared. The expected level of efficiency required for H2 is £6.7m, bringing the total requirement for the year to £9.7m. This target remains subject to final confirmation of the financial envelope for H2.
- The total loan balance is £18.77m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £14.78m on Capital programmes in this financial year, a reduction of £4.21m compared to the planned value. Further Capital funding bids have been put forward via the Targeted Investment Fund (TIF) for recovery, but these will not be included in the Capital Plan until funding has been confirmed.

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

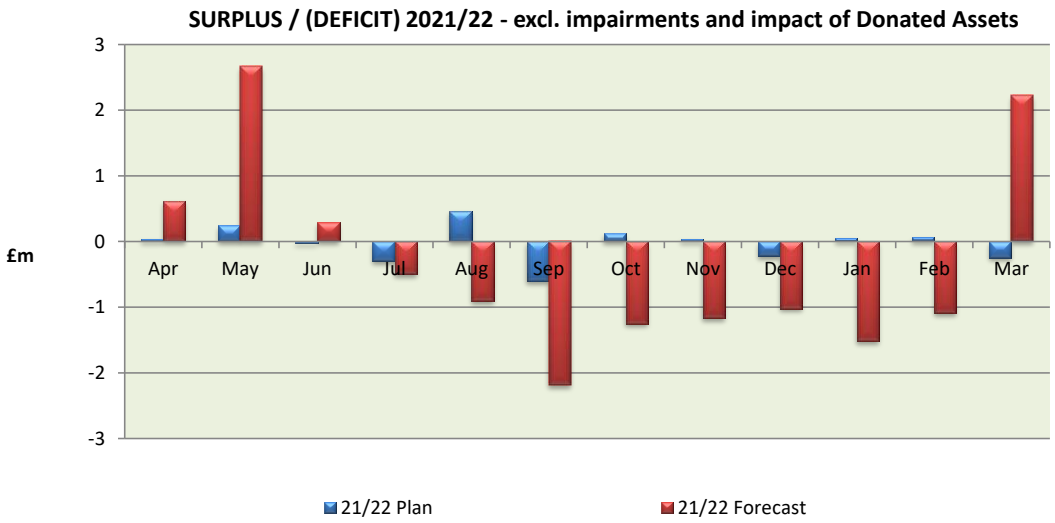
FORECAST POSITION 21/22

H2 Forecast (31 Mar 22)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£457.58	£478.68	£21.10	
Pay expenditure	(£285.06)	(£305.21)	(£20.15)	
Non Pay Expenditure	(£143.38)	(£149.64)	(£6.25)	
Non Operating Costs	(£29.48)	(£27.78)	£1.70	
Total Trust Surplus / (Deficit)	**(£0.34)**	**(£3.95)**	**(£3.61)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.43	£0.43	£0.00	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.29)	(£0.21)	
Net impact of donated consumables (PPE etc)	£0.00	£0.01	£0.01	
Adjusted Financial Performance	**£0.00**	**(£3.80)**	**(£3.80)**	

Notes:
1. AME - Annually Managed Expenditure - spend that is unpredictable and not easily controlled by departments

MONTHLY SURPLUS / (DEFICIT)



Forecast for H2 (Oct 21 - Mar 22)

- The H2 forecast after mitigations and efficiencies is a £3.8m deficit.
- The scale of the £3.8m deficit is aligned with the expected cost of Independent Sector contracts in H2.
- Costs have increased significantly over the last 2 months due to high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse.
- Recovery costs are expected to increase in H2 and no associated Elective Recovery Funding (ERF) has been assumed at this stage. As in H1, ERF funding will only be available to Systems that exceed the required thresholds in totality and the increased threshold requirements make it likely that there will much less funding available to the system than that received in H1.
- The increased costs have been mitigated in the forecast by assuming a very challenging efficiency target of £6.7m for H2.
- The Trust is continuing to discuss opportunities to close the remaining gap and support the operational position with CCG partners at Place level.

Forecast Assumptions:

- The forecast assumes £7.01m of recovery costs, including £3.8m for Independent Sector contracts.
- The forecast assumes that Bank pay enhancements of 50% will continue, but will reduce to some extent in future months.
- No Elective Recovery Funding (ERF) assumed at this stage.
- Assumes that Covid-19 costs continue at the current rate for the remainder of the year.
- Assumes £6.7m of currently unidentified efficiency is delivered.
- Forecast includes a level of assumed non-recurrent benefits that will not continue into 2022/23.

Risks and Potential Benefits

- The forecast does not include any potential financial impact relating to Project Echo. If approved in this financial year by NHSI this could result in a £5m non recurrent technical accounting adjustment and a subsequent increase in the deficit position
- The Trust may be able to access some ERF funding if activity thresholds are exceeded at both Trust and System level.
- Discussions continue at both Place and System level regarding final funding allocations and there may be further opportunities to reduce the remaining forecast deficit.

COVID-19 & Recovery

Covid-19 Expenditure YTD SEP 2021	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	406	0	406
Remote management of patients	251	374	625
Support for stay at home models	30	0	30
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	527	101	628
Segregation of patient pathways	3,890	199	4,089
Existing workforce additional shifts	386	67	453
Decontamination	0	145	145
Backfill for higher sickness absence	177	2	179
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	1	1
Sick pay at full pay (all staff types)	2	0	2
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	349	26	375
Enhanced PTS	0	159	159
COVID-19 virus testing - rt-PCR virus testing	85	1,753	1,838
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	482	1	483
COVID-19 - Vaccination Programme - Vaccine centres	0	1,481	1,481
COVID-19 - Vaccination Programme - Local vaccination service	0	0	0
NIHR SIREN testing - antibody testing only	13	2	15
COVID-19 - International quarantine costs	0	23	23
COVID-19 - Deployment of final year student nurses	182	0	182
Total Reported to NHSI	**6,779**	**4,334**	**11,113**
PPE - locally procured	0	15	15
Internal and external communication costs	0	1	1
Grand Total	**6,779**	**4,350**	**11,129**

Recovery Costs YTD SEP 2021	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	0	2,418	2,418
Additional Staffing - Medical	403	0	403
Additional Staffing - Nursing	162	0	162
Additional Staffing - Other	181	0	181
Non Pay	0	646	646
Enhanced Payment Model - Medical	371	0	371
Enhanced Payment Model - Nursing	576	0	576
Total	**1,692**	**3,064**	**4,756**

Covid-19 Costs

Year to date the Trust has incurred £11.13m of expenditure relating to Covid-19. Planned Covid costs year to date were £4.50m, but this plan does not include Covid-19 costs that are outside of System envelope and for which funding can be claimed retrospectively. These costs are highlighted in the table to the left and total £4.02m year to date **The underlying overspend on Covid was therefore £2.61m** and was driven by the continuation of some enhanced workforce models on wards and in ICU, a continuation of Emergency Department segregation and enhanced Bank pay rates. In the first Quarter, these pressures were offset by vacancies in Outpatients and underspends on consumables and drugs linked to elective and daycase activity were lower than historic levels, but in Quarter 2 these underspends have reduced and are no longer sufficient to offset the additional costs incurred.

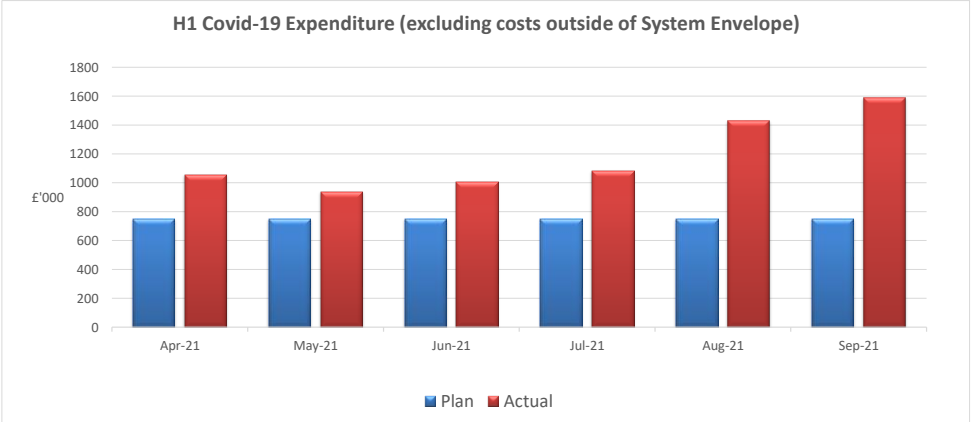
Covid-19 Funding

The Trust has been allocated block funding by the ICS to cover any Covid-19 costs totalling £11.3m year to date. In addition the Trust will be requesting retrospective Covid-19 funding of £4.02m to cover costs relating to Vaccinations, Covid-19 Testing, 3rd year student nurses and Isolation Hotels for overseas recruits.

Recovery

Recovery costs totalling £5.4m for H1 have been approved in conjunction with the Trust's activity plan. These costs were to be funded by a combination of Elective Recovery Funding planned to be circa £4.3m and Trust Reserves set aside to cover Covid-19 and excess Recovery costs.

- Year to date Recovery costs are £4.76m.
- The majority of the costs incurred related to use of the Independent Sector for outsourcing and insourcing. The Trust has agreed outsourcing contracts with Optegra, BMI, Spire and 'This Is My', as well as insourcing arrangements with Remedy, Ormis and Pioneer.
- Elective Recovery Fund (ERF) Funding is allocated at System level and only paid where the Integrated Care System (ICS) as a whole exceeds activity thresholds.
- The ICS has confirmed that the Trust is eligible to receive additional funding via the Elective Recovery Fund as the thresholds agreed for April, May and June activity have been exceeded. £3.63m of income has been assumed in the year to date position, £0.66m less than planned.
- The announcement by NHS Improvement that the threshold for ERF has been increased to 95% from Month 4 has resulted in a significant reduction in forecast ERF for the Trust. No ERF has been assumed for Quarter 2 due to the increase in the threshold.



13. 2021/22 Finance Plan (H2)

To Approve

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	H2 (Oct-Mar) Planning Update
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

This paper will outline the Financial Plan for H2 (Oct 21-Mar 22) in the context of activity and performance plans that have already been submitted to the Integrated Care System (ICS). The Board is asked to approve this plan.

Key Points to Note

System financial envelopes have now been confirmed as have draft Provider funding allocations. The Trust has already submitted a draft financial plan to the ICS and is now required to finalise those plans prior to the final ICS submission due on the 12th of November.

- 3% Pay Award including H1 backpay funded through allocations.
- Funding allocations reduced by £3.4m vs H1 – inbuilt efficiency requirement.
- Additional allocation of £2.18m Capacity funding to support winter / emergency activity pressures
- Run rate is driving a higher cost in the second half of the year and therefore a bigger efficiency requirement – expected to be at least £6.7m for H2.
- Activity plans suggest that we may not be able to access any Elective Recovery Funding to offset increasing Recovery costs, including £3.8m for Independent Sector spend.
- Forecast deficit for H2 of £3.8m
- Continuing to discuss opportunities to close remaining gap with CCG and System partners.

Targeted Investment Fund capital allocation of £32m for our ICS for investments in support of recovery. CHFT have submitted bids of £6.5m against this.

Recommendations:

To approve H2 Financial Plan comprising:

- £6.7m efficiency target
- H2 Recovery costs of £7.1m
- H2 Covid-19 costs of £8.7m
- Enhanced Bank rate impact of £3.2m (subject to further review)

Driving a residual financial gap of £3.8m*

- Further mitigation offered, *subject to final agreement with System partners*: £2.1m additional ICS funding allocation in recognition of current challenges.

Will reduce financial gap to £1.7m.

- against which opportunities are being pursued to secure additional funding through either Elective Recovery Funding (ERF), flexibilities within 'place' or through the ICS risk management protocol.

Options:

- to submit a balanced plan at risk
- or declare a £1.7m deficit

Recommendation of Finance & Performance Committee is to submit a balanced plan at risk*

To note the Targeted Investment Fund capital bids of £6.5m

Attachment: 2021/22 H2 Planning Update

EQIA – Equality Impact Assessment

All efficiency programmes will undergo EQIA on an individual basis prior to implementation, to assess the effects that they are likely to have on people from different protected groups, as defined in the Equality Act 2010.

Recommendation

The Board is asked to **APPROVE** the H2 (Oct-Mar) Financial Plan.

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2021/22 H2 Planning Update
4th November 2021

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H2 (Oct-Mar) Planning

Delayed planning guidance received on the 30th of September.

Overall financial settlement for the NHS provides **additional £5.4bn above original mandate**: includes £1.5bn funding for recovery of elective and cancer services (£1bn revenue, £0.5bn capital).

Recovery Funding can be accessed via:

- Elective Recovery Fund (ERF) (£1bn)
- New Targeted Investment Fund (TIF) £0.5bn capital plus further £0.2bn flexible capital or revenue (£32m for our system, £6.4m CHFT share)

System Envelopes for H2 have been confirmed as have draft Provider allocations.

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H2 (Oct-Mar) Planning Timetable

Deadline	Requirement	Notes
12 Oct 21	Place-based planning submission	Activity and Performance trajectories
14 Oct 21	**ICS submission deadline:** Activity and Performance	Elective Recovery and Winter Capacity. Submitted by ICS with provider level breakdown.
14 Oct 21	**Targeted Investment Fund**	Regional shortlist of investments submitted
28 Oct 21	**Targeted Investment Fund**	Business Cases for Digital and schemes >£5m
12 Nov 21	**Provider templates submitted to ICS:** Activity & Performance; Workforce; Narrative; System Financial Plan	Provider functional templates will need to be approved and submitted to the ICS
16 Nov 21	**ICS final submission deadline:** Activity & Performance; Workforce; Narrative; System Financial Plan	
25 Nov 21	**Provider Finance Plan submission**	Mandatory Provider Plans must support System Financial Plans

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Key Priorities

Further Key Recovery Priorities:

- Eliminate 104 week waits by March 2022, except where patients choose to wait longer (P5 and P6)
- Hold or where possible reduce the <52 week waiters
- Stabilise waiting lists around the level seen at end Sept 2021
- Cancer – return >62 day waits to level seen in Feb 2020 (based on overall national average) by March 2022
- Meet Faster Diagnosis Standard by Q3, ensuring at least 75% of patients have cancer ruled out or diagnosed with 28 days of referral for diagnostic testing.

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Activity and Performance Submission

- ✓ 104 week waits – eliminated by end of Mar'21, except for P5 and P6 patients
- ✓ 52 week waits – reduced from Sept levels
- ✓ Waiting list – stabilise waiting lists from Sept levels

MeasureName	Sep-2	Oct-	Nov-	Dec-	Jan-	Feb-	Mar-
RTT 104 Week Waits	71	40	51	64	80	90	97
RTT 52 Week Waits	3,154	3,061	2,967	2,873	2,779	2,686	2,592
RTT Waiting List	38,302	38,465	38,628	38,791	39,094	38,757	38,420

- ✓ Cancer 62 day – delivering on performance

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Activity and Performance Submission

- **Day case and Elective Inpatients**
  - ✓ CHFT delivered activity – based upon year-to-date run-rate levels
  - ✓ Additionality through outsourced and insourced activity – BMI, Spire, Optegra, Remedy and Pioneer

POD	H1 (Apr-Sept)		H2 (Oct-Mar)		Movement	
	H1 Activity	% of 2019/20	H2 Activity	% of 2019/20	Activity	% of 2019/20
DAYCASE	22,835	96%	23,931	100%	1,096	5%
ELECTIVE	2,094	78%	2,087	80%	- 7	2%
TOTAL	**24,929**	**94%**	**26,018**	**98%**	**1,089**	**4%**

- **Non-elective Inpatients**
  - ✓ Based upon year-to-date run-rate levels plus winter seasonality
  - ✓ Assumes Covid-19 levels continue at current levels for Oct-Dec and reduce slightly in Jan-Mar
  - ✓ General and acute beds remain at current levels = 590 beds at 96% occupancy

POD	H1 (Apr-Sept)		H2 (Oct-Mar)		Movement	
	H1 Activity	% of 2019/20	H2 Activity	% of 2019/20	Activity	% of 2019/20
NEL 0 LOS	9,345	98%	9,406	100%	61	2%
NEL 1+ LOS	17,591	89%	17,653	91%	62	2%
TOTAL	**26,936**	**92%**	**27,059**	**94%**	**123**	**2%**

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Elective Recovery Fund

Elective Recovery Fund (ERF) (£1bn)

- now based upon completed RTT pathways above a 2019/20 threshold of 89% (at system level) **but CHFT & BTHFT measured under H1 activity based rules at 89%**
- central Independent Sector fund – for IS spend above 2019/20 levels (CCG Commissioned only) (at system level)

- The CHFT draft H2 Plan suggests potential ERF of £1m
- However, **no ERF assumed to be received** due to risk of ICS achievement.

	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
ERF Threshold	89%	89%	89%	89%	89%	89%	89%
CHFT H2 Plan	92%	88%	93%	92%	92%	89%	91%
ERF Value	£0.25m	-	£0.32m	£0.20m	£0.22m	£0.02m	£1.02m

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H2 Financial Plan

- 3% Pay Award including H1 backpay funded through allocations.
- Funding allocations reduced by £3.4m vs H1 – inbuilt efficiency requirement.
- Additional allocation of £2.18m Capacity funding to support winter / emergency activity pressures
- Run rate is driving a higher cost in the second half of the year and therefore a bigger efficiency requirement – expected to be at least £6.7m for H2.
- Activity plans suggest that we may not be able to access any Elective Recovery Funding to offset increasing Recovery costs, including £3.8m for Independent Sector spend.
- **Forecast deficit for H2 of £3.8m***
- Continuing to discuss opportunities to close remaining gap with CCG and System partners.

*Excludes £5m non recurrent technical accounting adjustment relating to Project Echo, that is dependent on NHSI approving the transaction in this financial year.

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Financial Bridge

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Bridge from H1 actual to H2 forecast	Sub Totals £'m	Total H2 Plan £'m	Notes
Surplus / (Deficit) H1	**0.005**	**0.005**	H1 reported position
Non Recurrent income / expenditure:			
ERF Income (Non-Recurrent)	(3.631)		Supported recovery costs in H1
Non Recurrent Costs & Benefits	(0.515)		
H1 underspend due to activity	(0.622)		
Underlying Run Rate	**(4.763)**	**(4.758)**	
Increased costs for H2:			
Winter	(1.800)		£0.5m approved winter schemes plus non pay seasonal profile
Approved Developments	(1.316)		Includes: ARCU and HPS product development
Enhanced Bank Rate	(1.494)		Assumes reduction from current rate in future months
Covid-19	(1.641)		Increase vs Q1
Recovery	(2.256)		Increase vs Q1: H2 includes £3.8m Independent Sector spend
Other Cost Increases	(1.350)		eg. Recruitment to vacancies
Pay Award	(3.800)		Funded
Non recurrent Benefits	5.000		
Total Additional H2 Costs	**(8.657)**	**(13.415)**	
Funding changes:			
Inflationary uplift including pay award	4.148		To support Pay Award and Growth
Efficiency	(3.413)		0.82% general efficiency plus share of System Efficiency target
Capacity Funding	2.180		Additional funding for winter and emergency activity
Total Funding changes	**2.915**	**(10.500)**	
Efficiency Target		6.700	
H2 Planned Deficit		**(3.800)**	

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Covid-19 Costs

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H2 Impact (£)	Division								
Allowable cost type (Direct Costs / Activity Impact)	**Surgery & Anaesthetics**	**Central & Technical**	**Medicine**	**Families & Specialist Services**	**Community**	**Corporate Services**	**Health Informatics**	**Calderdale & Huddersfield Solutions Ltd**	**Grand Total**
Segregation of patient pathways	168,784	0	4,835,340	0					5,004,124
Decontamination		0		0		134,076		0	134,076
PPE - locally procured		120,000		0					120,000
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)		0				361,845			361,845
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly	817,455	0							817,455
Remote management of patients	15,288	0		398,340	149,604		116,631		679,863
Support for stay at home models						34,081			34,081
Existing workforce additional shifts				50,820		88,040		21	138,881
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	973,746			59,046					1,032,792
Backfill for higher sickness absence				222,804					222,804
Enhanced PTS					189,270				189,270
Grand Total	**1,975,273**	**120,000**	**4,835,340**	**731,010**	**338,874**	**618,042**	**116,631**	**21**	**8,735,191**

Main areas of expenditure:

- £3.13m Emergency Department segregation
- £0.82m Critical Care capacity
- £0.66m additional staffing on Respiratory Ward
- £0.61m additional Medical staffing on Acute Floor
- £0.40m CT and MRI mobile capacity

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Recovery Costs

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H2 Impact (£)	Division						
Recovery Categories	Surgery & Anaesthetics	Medicine	Families & Specialist Services	Community	Corporate Services	Health Informatics	Grand Total
Additional staffing - Medical	59,500	867,534					927,034
Additional staffing - Nursing	117,194	139,236	22,316	72,436			351,181
Additional staffing - Other	142,148	94,042	14,820	209,979	106,608	127,664	695,261
Enhanced Payment Model - Medical	-313,284	324,848	0				11,564
Enhanced Payment Model - Nursing	391,434		0				391,434
Independent Sector	3,775,911		154,800				3,930,711
Non Pay	63,480	167,372	423,330	34,398		16,176	704,756
Grand Total	**4,236,382**	**1,593,032**	**615,266**	**316,813**	**106,608**	**143,840**	**7,011,940**

- Reduction of £1m in Independent Sector costs vs previous Recovery plan of £8m approved at October Meeting.
- £3.8m Independent Sector includes Insourcing (Remedy, Ormis, Pioneer) and Outsourcing (BMI, Spire, Optegra) surgical capacity
- Plus £0.15m Radiology Outsourcing (This Is My)
- £0.40m MRI and CT Mobile capacity for recovery
- Additional staffing costs exclude impact of 50% Bank pay enhancement

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Enhanced Bank Rate

50% enhanced Bank rate	H1	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	H2 Total	Total
	£	£	£	£	£	£	£	£	£
Medical Staff	804,229	356,147	267,110	267,110	267,110	178,074	178,074	1,513,625	2,317,854
Non Medical Staff	1,009,915	412,200	309,150	309,150	309,150	206,100	206,100	1,751,850	2,761,765
Total	**1,814,144**	**768,347**	**576,260**	**576,260**	**576,260**	**384,174**	**384,174**	**3,265,475**	**5,079,619**

- 50% Bank Premium paid since mid July 2021.
- £3.27m forecast for H2 assumes some reduction compared to Aug / Sept costs incurred following review of methodology.
- Full year forecast is currently £5.08m for this premium payment.
- Commitment to further review more targeted approach and exit plan

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Targeted Investment Fund (TIF) - Capital

The Trust has submitted a bid for £6.5m for Capital funding from the ICS allocation of £32m of the Targeted Investment Fund to support Elective Recovery, out come of the bid is still to be confirmed.

Planned area of Spend	£k
Digital Schemes	2,416
Outpatients	1,800
Theatre and Diagnostic Equipment	1,157
Release of Estate to create capacity	610
Outpatient Equipment	372
COVID Testing Equipment	157
Grand Total	**6,511**

- Bids were required with very short turnaround of 1-2 weeks
- £6.4m CHFT share of ICS allocation of which 1/3 is expected to be Digital
- £0.1m additional bid linked to shortfall in Digital bids in other regions
- Expenditure to be made in 2021/22

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Cash

- **Opening Cash Balance of £46.05m**
- Planned Deficit of £3.8m would reduce cash balance by year end
- Cash reserves sufficient to avoid any requirement for revenue support in this financial year
- High level of accrued expenditure will result in cash payments over the next 12-18 months (e.g. Annual Leave accrual). Working Capital is expected to reduce by at least £11m over this period.

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Recommendations

- To approve H2 Financial Plan comprising:
  - £6.7m efficiency target
  - H2 Recovery costs of £7.1m
  - H2 Covid-19 costs of £8.7m
  - Enhanced Bank rate impact of £3.2m (subject to further review)

Driving a residual financial gap of £3.8m*

  - Further mitigation offered, *subject to final agreement with System partners*: £2.1m additional ICS funding allocation in recognition of current challenges.

Will reduce financial gap to £1.7m.

  - against which opportunities are being pursued to secure additional funding through either ERF, flexibilities within 'place' or through the ICS risk management protocol.

- Options:

  - to submit a balanced plan at risk
  - or declare a £1.7m deficit

- **Recommendation of Finance & Performance Committee is to submit a balanced plan at risk***
- To note the Targeted Investment Fund capital bids of £6.5m

* Excludes £5m non recurrent technical accounting adjustment relating to Project Echo, that is dependent on NHSI approving the transaction in this financial year.

A Workforce for the Future

14. West Yorkshire and Harrogate and Health and Social Care Partnership Root Out Racism Campaign

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title of report:	West Yorkshire and Harrogate Health and Care Partnership Root Out Racism Campaign
Authors:	Nikki Hosty, Assistant Director of Human Resources Tahliah Kelly Martin, BAME Community Engagement Advisor
Sponsor:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 30 September 2021

Purpose of the Report

This paper allows the Board to publicly register its support for the West Yorkshire and Harrogate Root Out Racism campaign.

Key Points to Note

- The Root Out Racism movement aims to tackle structural and institutionalised racism, as well as addressing health and social inequalities across the area. This sits squarely with our own equality, diversity and inclusion agenda. While we are proud of the developments we have made within the Trust, we recognise there is still so much left to be done. Our aim is to create an inclusive environment with a sense of belonging for everyone. Everyone has the right to feel safe, valued and supported in our community. The Root out Racism campaign will be an enabler for change, and we intend to promote this far and wide within the Trust and our communities.
- Following its review in 2020 into the impact of COVID-19 on health inequalities and the disproportionate effect on ethnic minority communities and staff, West Yorkshire and Harrogate Health and Care Partnership launched an anti-racism movement in August 2020 in partnership with the West Yorkshire Violence Reduction Unit.
- Through educational resources, real-life images and stories the Root Out Racism movement has set about encouraging people to better inform themselves on anti-racist behaviours and practices.
- In the planning of this movement, over 100 ethnic minority colleagues from across the Partnership come forward to share their experiences of racism and help their colleagues and other organisations to take action. Visit West Yorkshire and Harrogate's Root Out Racism campaign page to learn more and or get involved
- CHFT leaders have come together to launch our Root Out Racism pledge. Individually, they have signed pledges and shared their thoughts about how they plan on playing their part.
- Our aim is to deliver a campaign where colleagues can sign a pledge that signifies their support and commitment to the campaign.

EQIA – Equality Impact Assessment

All equality groups have been consulted about the campaign and will work together to encourage support.

Recommendation

The Board is asked to **NOTE** the content of the paper and to commit and support the Root Out Racism campaign.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

4 NOVEMBER 2021

WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP ROOT OUT RACISM CAMPAIGN

1. PURPOSE

This paper allows the Board to publicly register its support for the West Yorkshire and Harrogate Root Out Racism campaign.

2. BACKGROUND

Following their review in 2020 into the impact of COVID-19 on health inequalities and the disproportionate effect on ethnic minority communities and staff, in August of this year West Yorkshire Health and Care Partnership launched an anti-racism movement with their partners at West Yorkshire Violence Reduction Unit.

The Root Out Racism movement aims to tackle structural and institutionalised racism, as well as addressing health and social inequalities across the area. This sits squarely with our own equality, diversity and inclusion agenda. While we are proud of the developments we have made within the Trust, we recognise there is still so much left to be done. Our aim is to create an inclusive environment with a sense of belonging for everyone. Everyone has the right to feel safe, valued and supported in our community. The Root out Racism campaign will be an enabler for change, and we intend to promote this far and wide within the Trust and our communities.

3. LOCAL DEPLOYMENT

Working in collaboration with with the West Yorkshire and Harrogate Health and Care partnership and several other organisations throughout the region, Calderdale and Huddersfield NHS Foundation Trust pledged its support to the campaign, standing alongside our colleagues to root out racism. Our leaders have come together to launch our Root Out Racism pledge. They've signed pledges and shared their thoughts about how they plan on playing their part as we bid to do what we can to fight racism in our workplace and in our communities.

4. ACTION PLAN TO PROMOTE THE CAMPAIGN

We pledge to act and show there is no place for racism across our region. We are proud to stand alongside our colleagues and partners and root out racism. No barriers, no excuses and only one commitment.

Through promotion and engagement via the equality groups we will develop a pledge, design a social media campaign, utilise a root out racism pin badge as a visible symbol of support and develop a range of education and awareness resources to build the courage to speak up against racist behaviours,

5. RESPONSE

Engagement with colleagues through our equality network groups and beyond will take place from November 2021.

6. CONCLUSION

The Board is asked to **NOTE** the content of the paper and to commit and support the Root Out Racism campaign.

Nicola Hosty
Assistant Director of Human Resources

Tahliah Kelly Martin
BAME Community Engagement Advisor

October 2021

15. Freedom to Speak Up Self-Assessment

To Approve

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title of report:	Freedom to Speak Up Board Self-Assessment
Authors:	Andrea Gillespie, Freedom to Speak Up Guardian Nikki Hosty, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsor:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 9 August 2021

Purpose of the Report

This report provides a summary of the responses submitted by individual members of the Board of Directors to a questionnaire based on an NHS England/NHS Improvement (NHSE/I) Freedom to Speak Up (FTSU) self-assessment tool designed specifically for NHS Boards to use to assess progress in the development of a positive freedom to speak up culture.

Key Points to Note

- Effective speaking up arrangements help protect patients and improve the experience of our colleagues. The opportunity to speak up is a measure of a Trust's openness and transparency and is a feature of well-led NHS organisations
- NHSE/I published a 'Freedom to Speak Up review tool for NHS trusts and foundations trusts' in July 2019
- The tool is for a Board to deploy to facilitate an assessment of its role and the progress made in developing and supporting a positive work environment in which colleagues are able to raise concerns which are acted upon
- The tool covers 11 aspects of an FTSU approach
- A questionnaire based on the tool was designed and shared with Board members in June 2021 with responses received in July 2021
- Board members were asked to evaluate and determine their view on whether the Trust is compliant with statements set out in the tool, what evidence is available to substantiate their assessed view and what more the Trust should/can do to encourage an effective speaking up approach
- Responses have been collated and anonymised
- Recommendations for action are identified
- Engagement with colleagues through our equality network groups and beyond will take place from November 2021.

EQIA – Equality Impact Assessment

The equality impact for specific actions arising following consideration of the responses to the Board assessment will be assessed, considered and mitigated as appropriate.

Recommendation

The Board is asked to **NOTE** the content of the paper and **APPROVE** the associated action plan.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

4 NOVEMBER 2021

FREEDOM TO SPEAK UP BOARD SELF-ASSESSMENT

1. PURPOSE

This report provides a summary of the responses submitted by individual members of the Board of Directors to a questionnaire based on an NHS England/NHS Improvement (NHSE/I) Freedom to Speak Up (FTSU) self-assessment tool designed specifically for NHS Boards to use to assess progress in the development of a positive freedom to speak up culture.

2. BACKGROUND

Effective speaking up arrangements help protect patients and improve the experience of our colleagues. The opportunity to speak up is a measure of a Trust's openness and transparency and is a feature of well-led NHS organisations. NHS England/Improvement published a 'Freedom to Speak Up review tool for NHS trusts and foundations trusts' in July 2019. The tool is for a Board to deploy to facilitate an assessment of its role and the progress made in developing and supporting a positive work environment in which colleagues are able to raise concerns which are acted upon. The tool covers 11 aspects of an FTSU approach.

3. LOCAL DEPLOYMENT

A questionnaire based on the NHSE/I tool was designed and shared with Board members in June 2021 with responses received in July 2021.

Board members were asked to evaluate and determine their view on whether the Trust is compliant with statements set out in the tool, what evidence is available to substantiate their assessed view and what more the Trust should/can do to encourage an effective speaking up approach.

4. BOARD FEEDBACK

The responses from individual Board members have been collated and anonymised. Feedback/responses cover the following themes:-

- Executive and Non-Executive Directors can evidence that they behave in a way that encourages workers to speak up
- The Board can evidence their commitment to creating an open and honest culture
- The Board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture
- The executive team can evidence they actively support their FTSU Guardian
- Evidence that the Trust has a speaking up policy that reflects the minimum standards set out by NHS Improvement
- Evidence that the Board receives assurance to demonstrate that the speaking up culture is healthy and effective
- The Board can evidence the FTSU Guardian attends Board meetings, at least every six months, and presents a comprehensive report

- The Board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- The Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian
- The Trust can evidence how it has been open and transparent in relation to concerns raised by its employees
- The Chair, Chief Executive, executive lead for FTSU, non-executive lead for FTSU, Director of Workforce and Organisational Development, Medical Director and Director of Nursing should evidence that they have considered how they meet the responsibilities associated with their role as part of their appraisal.

The full results are detailed in Appendix 1.

5. RESPONSE

In response to the Board feedback the following actions have been identified:-

THEME: PROMOTION

- FTSU Guardian to develop a communication plan (with Communications team assistance) which ensures regular communication and messaging. There will be an emphasis on positive stories that illustrate FTSU effectiveness and improvements
- Update and expand existing promotional materials
- Analyse local FTSU data to identify wards, departments, divisions, staff groups et al where targeted promotion is required
- Work with internal CQC Compliance lead to gain intelligence in relation to staff FTSU knowledge from Journey to Outstanding Reviews and support targeted promotion
- Introduce National Guardian's Office (NGO) developed e-learning modules to Essential Safety Training (Speak Up for all colleagues, Listen Up for managers and Follow Up for senior leaders).

THEME: GROW CONFIDENCE IN FTSU PROCESSES

- All communications (verbal and written) to provide a clear message to colleagues that it is safe to raise a concern
- Communication to notify colleagues that concerns raised anonymously will always be investigated
- Use intelligence provided by the NGO Annual Index Report to understand what colleagues are saying in relation to Speak Up and reporting unsafe clinical practice
- Raise colleague awareness of the support available to them throughout the FTSU process
- FTSU Guardian and Ambassadors to be visible to colleagues in the Trust through the design of robust engagement plans.

THEME: FTSU IS DELIVERED IN LINE WITH NATIONAL GUIDANCE

- FTSU Guardian to regularly attend FTSU regional meetings and cascade the information including case reviews published by NGO
- FTSU Guardian to use the NGO for support and guidance as and when required
- Ensure our webpages, FTSU portal and policy remains consistent with nationally published guidance
- FTSU Guardian to work with buddy Trust to share thoughts and ideas and secure professional support and guidance.

THEME: SHARING THE RESPONSIBILITY SO FTSU IS PART OF BUSINESS AS USUAL

- FTSU Guardian to agree a plan with each Divisions to raise the profile of FTSU ensuring participation and co-operation with enquiries and cascading learning
- FTSU Guardian to develop an education process to enable managers and leaders to understand their roles in the FTSU process.

All actions will be led by the FTSU Guardian. An assessment of action delivery will be included in the 2021/2022 FTSU Annual Report.

Engagement with colleagues through our equality network groups and beyond will take place from November 2021.

6. CONCLUSION

The Board is asked to note the content of the paper and approve the associated action plan.

Andrea Gillespie
Freedom to Speak Up Guardian

Nicola Hosty
Assistant Director of Human Resources

Jason Eddleston
Deputy Director of Workforce and Organisational Development

October 2021

Freedom to Speak Up

Board Self-Assessment

September 2021

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Background

Effective speaking up arrangements help protect patients and improve the experience of our colleagues. The opportunity to speak up is a measure of a Trust's openness and transparency and is a feature of well-led NHS organisations.

NHS England/NHS Improvement has developed a Freedom to Speak Up (FTSU) self-assessment tool for NHS Boards to use to assess progress. It has advocated completion of the assessment by Boards.

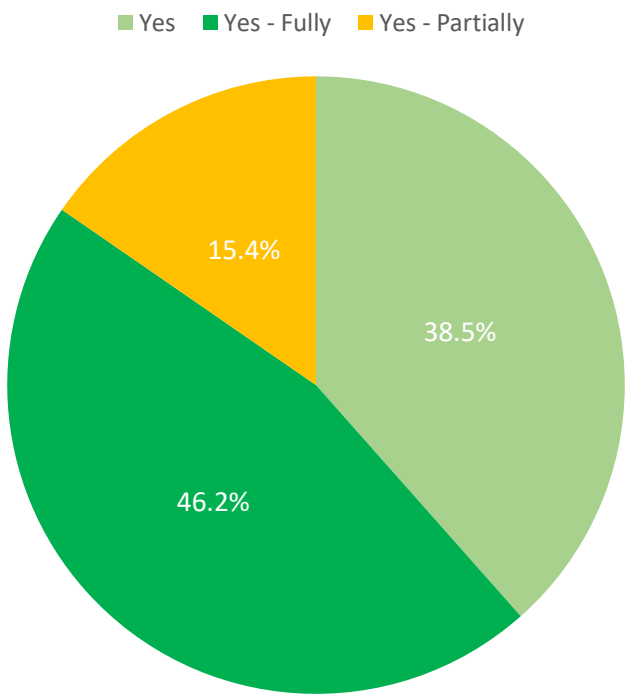
Board members were asked to individually complete the Board self-assessment via a spreadsheet questionnaire.

The assessment sets out 11 aspects of an FTSU approach that Board members were asked to evaluate and determine their view on whether the Trust is compliant with statements set out in the tool, what evidence is available to substantiate their assessed view and what more the Trust should/can do to encourage an effective speaking up approach.

Behave in a way that encourages workers to speak up

Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they:
- understand the impact their behaviour can have on a trust's culture
- know what behaviours encourage and inhibit workers from speaking up
- test their beliefs about their behaviours using a wide range of feedback
- reflect on the feedback and make changes as necessary
- constructively and compassionately challenge each other when appropriate behaviour is not displayed

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- FTSU Policy and supporting information on the Trust website and intranet.
- FTSU Guardian and Ambassadors
- Actively lead WTGR 3Rs workshops where colleagues are encouraged to speak up about the reality without challenge
- Actively championed the development of values and behaviours that enable a culture where colleagues feel confident and able to speak out safely
- Established and promoted inclusivity groups to listen and learn from colleagues
- EQIA
- Reports and presentations into public sessions
- Staff survey results and taken seriously and monitored at board and relevant sub-committees
- Ask Owen
- The leadership development programme also provides tools and techniques for leaders with opportunity to seek feedback

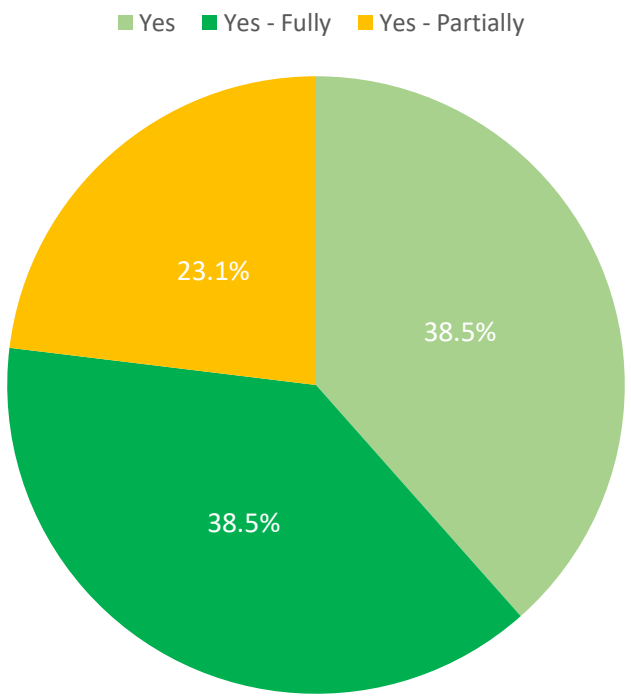
What else should we be doing?

- More structured approach to 360 so all colleagues in leadership roles have this opportunity
- Looking at ways of reducing the number of anonymous submissions
- There could be more done around challenge at Board on this issue and we might benefit from spending time as a Board thinking about the metrics we can use to assess the impact of the FTSU approach.
- Increasing visibility and opportunity to ask questions of staff post pandemic
- Not sure if we have freedom to speak weeks / initiatives but would be worthwhile and to raise awareness. We may well have them but I have not noticed. E-learning modules ?
- Implementing the feedback from AquA
- Sharing learning from what behaviours have been successful to encourage people to speak up in the Trust and best practice comparators
- Continue to challenge constructively. Especially as we move into the next period of the pandemic

Demonstrate commitment to FTSU

The board can evidence their commitment to creating an open and honest culture by demonstrating:
- there are named executive and non-executive leads responsible for speaking up
- speaking up and other cultural issues are included in the board development programme
- they welcome workers to speak about their experiences in person at board meetings
- the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility
- there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made
- the trust continually invests in leadership development
- the trust regularly evaluates how effective its FTSU Guardian and champion model is
- the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- FTSU Guardian and Ambassadors
- FTSU Policy
- Named Executive and Non-Executive Lead
- Evidence of focus on specific scores in the staff survey
- Patient/colleague stories
- Inclusivity groups established
- Board frequently includes main agenda topics related to inequalities
- Strengthened its EQIA processes and all issues presented to Board
- Regular communication about FTSU on screensavers and in CHFT News
- Through OCOC the Trust has a sustained an ongoing focus on the reduction of bullying, harassment and incivility
- Different forums aimed to maximise peoples ability to comfortably engage and these are led by colleagues not managers

What else should we be doing?

- Prioritise the development of leaders and importantly create the capacity to do this
- Ensure the processes we have in place are all inclusive and people feel supported. Maybe more comms on where people might get that support
- Hold a Board workshop on FTSU to support training and update of our learning of what has worked and what else we could do compared to best practice models
- Review of the FTSU role
- Add further information to the website and bulletins as a reminder
- Depends on the pulse surveys
- e-learning modules. They may well exist but regular updates / renewals would be helpful
- Promote FTSU Guardian and other channels for disclosure via intranet and other Trust media

Demonstrate commitment to FTSU

The board can evidence their commitment to creating an open and honest culture by demonstrating:
• there are a named executive and non-executive leads responsible for speaking up
• speaking up and other cultural issues are included in the board development programme
• they welcome workers to speak about their experiences in person at board meetings
• the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility
• there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made
• the trust continually invests in leadership development
• the trust regularly evaluates how effective its FTSU Guardian and champion model is
• the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.

What else should we be doing (continued)?

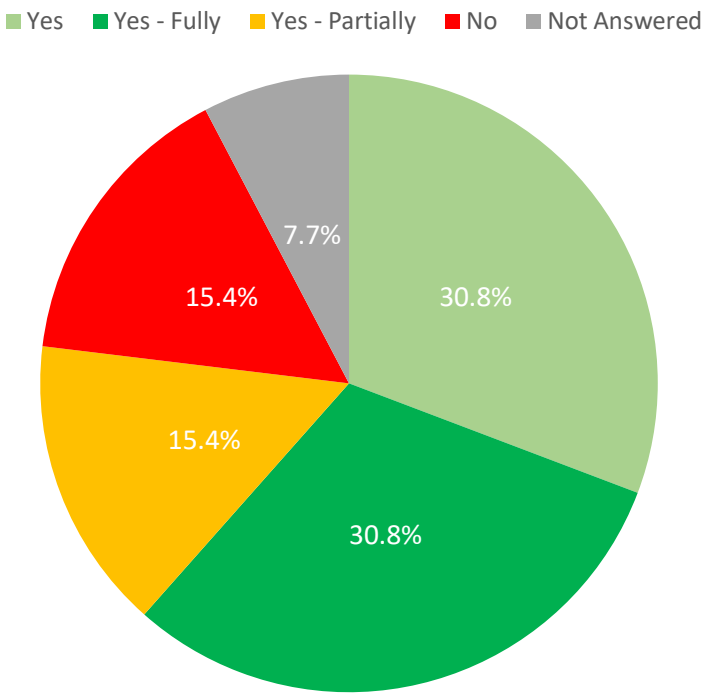
- There is more that could be done in developing a creative and engaging communication strategy to tell positive stories about speaking up
- We might benefit from spending time as a Board thinking about the metrics we can use to assess the impact of the FTSU approach
- More emphasis on inclusive leadership
- More to do advertise the FTSU role as per the Guardian's report in January to the Board plus show more evidence of what has happened as a result of concerns being raised

Have a strategy to improve your FTSU culture

The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate:

- as a minimum – the draft strategy was shared with key stakeholders
- the strategy has been discussed and agreed by the board
- the strategy is linked to or embedded within other relevant strategies
- the board is regularly updated by the executive lead on the progress against the strategy as a whole
- the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- FTSU Strategy discussed at Board following consultation
- Reports to Board and conversations with FTSU Lead
- Part of Workforce and OD Strategy / The Cupboard – shared with stakeholders
- The strategy is linked to the ambition around OCOC. The Board is regularly updated by the executive lead on the progress against the strategy as a whole
- Regular reports to Workforce Committee supported by an Annual Report which is also presented at Board
- The Trust has a clear strategy and lives by this as can be evidenced in updates to Board and various committees that are an amalgamation of Executive level oversight and champions inputs
- Not aware of a strategy but we have good links with the Integrated Care System
- Not aware that we have a strategy that we report against

What else should we be doing?

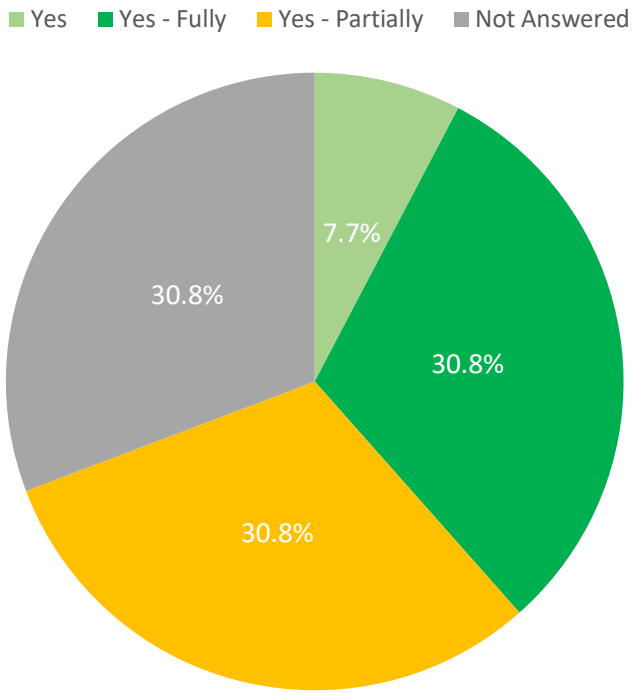
- Develop a strategy - or if we do have one already promote and communicate about this. Hold a Board workshop about the strategy
- As necessary develop a strategy with KPIs that links speaking up with patient safety, staff experience and continuous improvement. Link to people strategy
- More general awareness weeks / initiatives?
- Possibly more focus on outcomes including quantitative and qualitative measures
- There may be a recognition of an approach to FTSU rather than an embedded strategy. More could be done to evaluate delivery against the 'so what' of the Trust's approach
- Continually seeking new ways to encourage staff to speak up and to continue to develop a culture where all feel safe to do so
- Develop a strategy

Support your FTSU Guardian

The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate:

- they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively
- the Guardian has been given time and resource to complete training and development
- there is support available to enable the Guardian to reflect on the emotional aspects of their role
- there are regular meetings between the Guardian and key executives as well as the non executive lead.
- individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner
- they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes
- the Guardian is enabled to develop external relationships and attend National Guardian related events.

Does the Trust meet this requirement?



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What is this response based on?

- The FTSU Guardian is well supported
- Supported the creation of the role and recognised time for colleagues to undertake their duties as FTSU Guardian
- Visibility of FTSU Guardian gives me assurance she has supported time to do the job
- Conversations demonstrate she has access to relevant information to do her job
- Regular agenda item with Owen to ensure Executive Team fulfil their responsibilities to FTSU
- FTSU Guardians have the same agreed time to fulfil their role as Governors do
- FTSU Guardian appears to have appropriate level of training and support staff
- There is support available to enable the Guardian and champions to reflect on the emotional aspects of their role
- Regular meetings between the Guardian and key executives as well as the non executive lead
- The Trust has placed a great deal of importance over the past few years on this role and the need to encourage an open and transparent culture

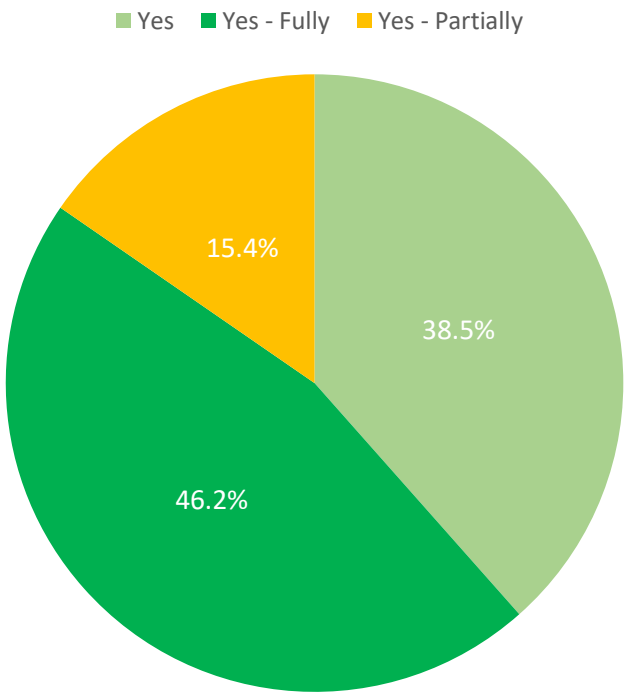
What else should we be doing?

- Provide more information to Board of support given to Guardian
- Annual review of hours required for FTSU Guardian. The Guardian has reported linking and networking locally, regionally/nationally
- Regular reminders to all colleagues and more connections with CHS would be beneficial
- Possibly more 'Go See' opportunities to review bast practice in other Trusts
- It might be timely to review the processes for supporting the Trust lead and local champions
- More could be done to triangulate with safety data
- Reduce the levels of anonymity

Be assured your FTSU culture is healthy and effective - 1

Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:
• that the policy is up to date and has been reviewed at least every two years
• reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.

Does the Trust meet this requirement?



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What is this response based on?

- The policy is reviewed regularly and is informed by feedback
- Board reports, but reliant on FTSU expert to advise
- My gauge around all this is am I aware of the strategy and activity and I believe I am
- The Trust has established a dedicated role that has been promoted and supported. The Trust policy is up to date and promoted. The Guardian has visibility and is regularly invited to Board meetings
- Annual FTSU report
- The policy is available on the intranet and is regularly drawn to the attention of work colleagues via the twice weekly newsletter and also features from time to time on the screensaver
- Board meetings and Committee meetings and a culture that is evident and clear to see
- The policy has been reviewed and we continuously increase the numbers reporting concerns

What else should we be doing?

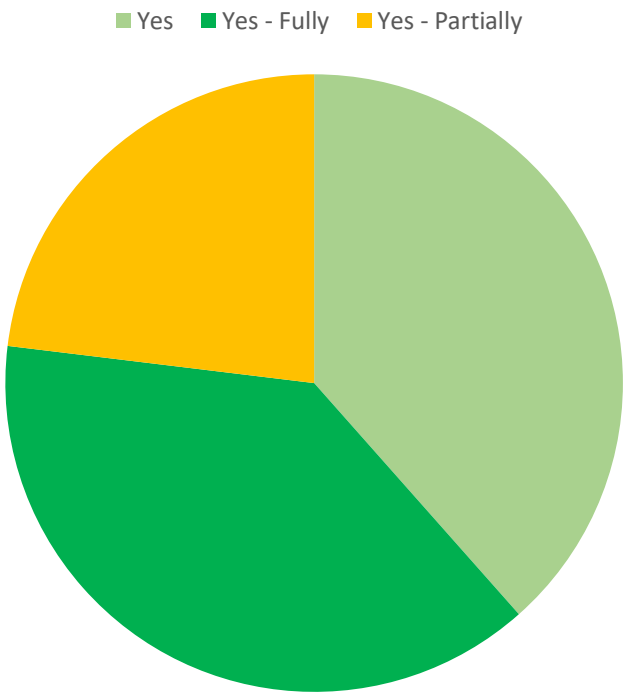
- I am not sure how wide the strategy and events are known maybe we should test this
- Audit / peer review of FTSU service
- Possibly specific confirmation about compliance with NHSI standards
- Reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian. This is an area where there us some scope for improvement in terms of loop closure around ongoing audit
- Ensure policy is regularly updated and that there is wide staff involvement in that update process as per this requirement

Be assured your FTSU culture is healthy and effective - 2

Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate:

- you receive a variety of assurance
- assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience.
- you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances
- you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection
- you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.

Does the Trust meet this requirement?



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What is this response based on?

- FTSU Annual Report to Board provides this assurance
- Guardian of Safe Working Hours regularly reports to the Board. Evidence from complaints and compliments, Datix, incidents
- Board meetings and Committee meetings and a culture that is evident and clear to see
- FTSU Guardian feedback and reports as noted above. Staff survey results and resultant 'deep dives'
- CHFT has a recognised process for support wrap around at times of stress based on need at the time
- Regular reporting demonstrates that the culture is moving in the right direction – the numbers speaking up are increasing
- The risk register is reviewed very regularly alongside the BAF. The relevant Board committee reviews risks covering their own areas of responsibility
- Through change we undertaken 'Go See's' and put in place active listening events to ensure we hear from a wide range of colleagues
- Implemented more structured visible leadership processes which includes listening to colleagues with particular focus on Out of Hours and community
- FTSU reports show this but more to be done to triangulate that with other feedback channels such as Ask Owen, staff survey and divisional meetings

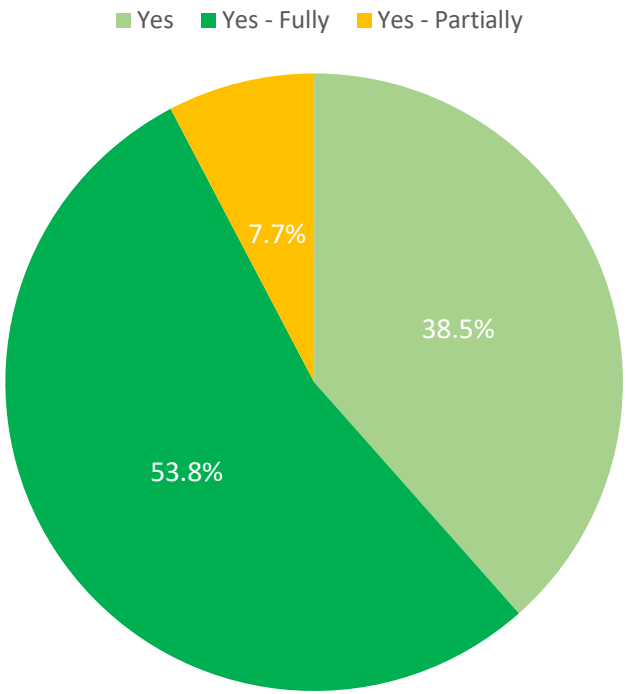
What else should we be doing?

- How is information from exit interviews being used?
- If not in place the Trust should provide access to appropriately trained colleagues to undertake exit interviews with those individuals who want to talk confidentially about their experience
- There is a gap in terms of triangulating FTSU activity to safety metrics
- More overtly link patient concerns, complaints, staff concerns to improvements
- More of the same

Be assured your FTSU culture is healthy and effective - 3

The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- The Guardian regularly attends Board meetings
- Due to Covid this may not have been as frequent
- Guardian presents FTSU reports at the Board and this is minuted
- Board meetings and Committee meetings and a culture that is evident and clear to see
- Workforce Committee
- A combination of Trust Guardian and trainee medical staff Guardian attend and present directly to Board. Board only meets bi -monthly with clear governance in sub committees that report into Board so some of the papers/discussions take place more frequently in these forums. This is locked into our governance arrangements
- Reports on Board workplan for every 6 months; last report in January was clear and comprehensive

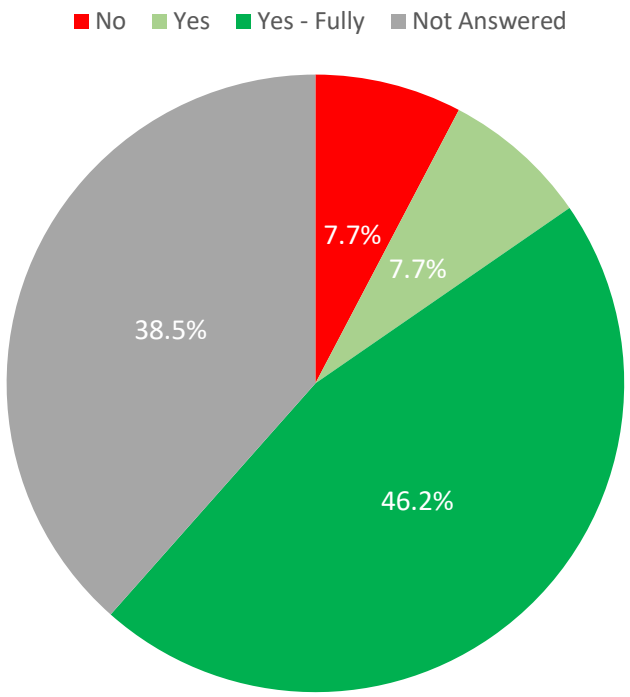
What else should we be doing?

- Share an anonymised CHFT FTSU case study with Board to aid learning
- As Chair of the Council of Governors, I should be bringing this to the attention of the governors as a yearly item on their agenda

Be assured your FTSU culture is healthy and effective - 4

The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- I believe so
- The presence of a very capable guardian would indicate that appropriate recruitment processes have been used. I have not read the job description or other national guidance
- Assurance from Workforce and OD Director and Workforce Committee
- Workforce and OD reports
- Fair recruitment process for all posts and therefore make the link that this recruitment will be compliant but don't have a personal evidence base
- Not seen evidence of how the current Guardian was appointed

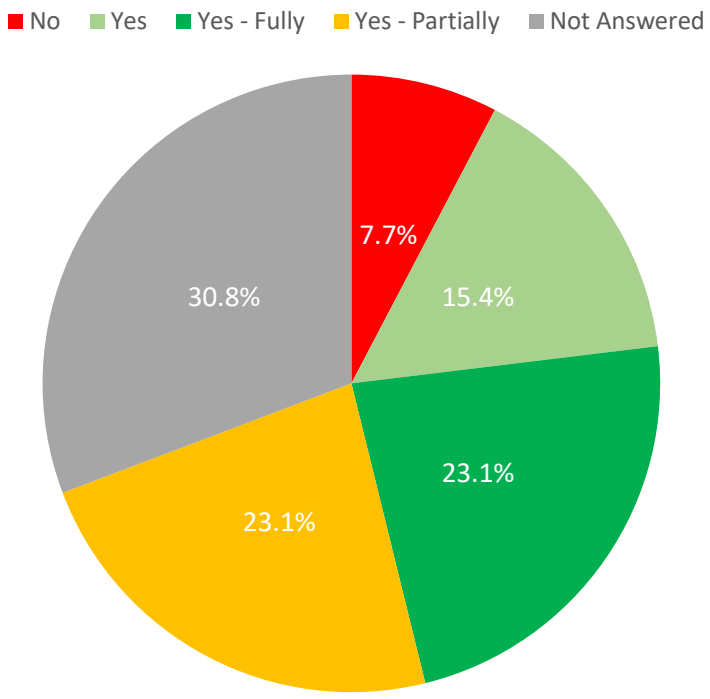
What else should we be doing?

- Is this something all Directors need to know and do if so maybe it should be part of the appraisal process?

Be assured your FTSU culture is healthy and effective - 5

The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- This forms part of the FTSU report to the Board
- NGO case studies not currently covered in detail in Board Report
- This should be part of the information that falls from the Quality and Workforce Committee
- Feedback from sub committees
- No evidence seen

What else should we be doing?

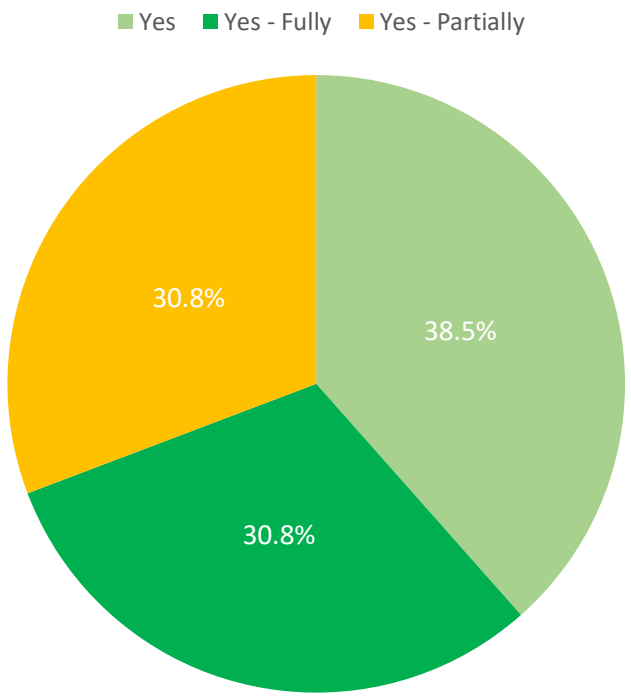
- This prompts the question around all Directors and what they should or need to know around national guidance
- Board to be made aware of NGO guidance and any learning for the Trust
- Possibly use of Internal Audit to confirm follow up processes
- I am unaware of whether we could demonstrate a gap analysis when the national team produce any reports / data etc, this may be just that I am personally not sighted on it.

Be open and transparent

The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate:

- discussion with relevant oversight organisation
- discussion within relevant peer networks
- content in the trust's annual report
- content on the trust's website
- discussion at the public board
- welcoming engagement with the National Guardian and her staff.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- Engagement on the policy and publicity/encouragement to speak up
- The tools we have in place promotes this, well being and risk assessments, Ask Owen , The Cupboard, One Culture of Care, embedding EQIA, staff survey results, the various groups that are set up around the protected characteristics
- Information on website. Trust has several inclusivity groups that it supports and encourages discussion and peer review
- FTSU content in the annual report. Board updated and cited on developments for FTSU. FTSU reports discussed in Public Board meetings
- We have a further fail safe mechanism through 'Ask Owen'
- A culture that is evident and clear to see
- Openness with CQC in engagement meetings
- Ties into local regional and national networks
- Concerns are raised with other bodies as relevant and the Trust takes a open and transparent approach with its stakeholders and partners
- Regular touchpoints with regulators including NHSE/I, CQC etc with minutes that can evidence transparency
- Minimal business goes through private board with the majority going to the Board held in public
- System Quality Board and ICS led discussions also evidence transparency
- Little info on what happens to concerns that have been raised

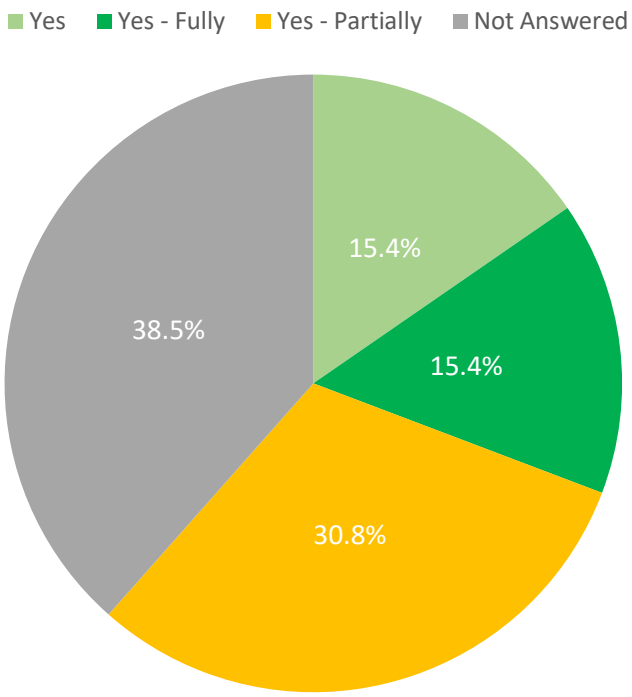
What else should we be doing?

- Regular 'publicity drive' within the trust for FTSU

Individual responsibilities

The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.

Does the Trust meet this requirement?



Please note, some colleagues used a different template for responding and stated 'Yes' rather than 'Fully' or 'Partially'.

What is this response based on?

- I am not personally sighted on these specific individual objectives
- Evidence of this through the behaviour of the members listed in the question. The trust appraisal and documentation does allow discussion on Well-being , Equality and diversity and FTSU
- The Chair's appraisal follows national guidelines
- Board meetings and Committee meetings and a culture that is evident and clear to see
- Although not directly involved in the appraisal processes other than that of the Chair, I believe that this is taking place
- OCoC a key element of all appraisals
- Discussions with colleagues on priorities and objectives
- I believe this is done but have not seen the evidence

What else should we be doing?

- Possibly formal confirmation that this has been documented as part of Board Report
- Job descriptions should make this more specific

Next steps….

Activity timeline for the review of the FTSU self-assessment response analysis:

- 9 August 2021 Workforce Committee
- 2 September 2021 Private Board of Directors
- 4 November 2021 Public Board of Directors
- Post-November 2021 Engage with colleagues through our equality network groups and beyond.

COMFORT BREAK – 5 MINUTES

Keeping the Base Safe

16. Winter Vaccination Plan

To Note

Presented by David Birkenhead

Date of Meeting:	Thursday 4 November
Meeting:	Public Board of Directors
Title:	Staff Winter Vaccinations Campaign 2021-22
Author:	Christine Bouckley & Rebecca Sharpe
Sponsoring Director:	David Birkenhead, Medical Director

Purpose of the Report

This paper sets out the approach for delivering the seasonal influenza vaccine alongside the booster (3rd dose) Cominarty (Pfizer) injections to all staff working at Calderdale and Huddersfield NHS Foundation Trust (CHFT) which includes CHFT, CHS, THIS, Flexible workforce volunteers, agency and students. The booster vaccination follows on from the National Campaign which delivered dose 1 and 2 of the Pfizer vaccine.

Key Points to Note

- The 2021-2022 clinics commenced from 27th September 2021 and provide 100% offer to all staff, and as near to 100% uptake as possible (internal target for flu 85%).
- Vaccine clinics held to offer vaccines by booked appointments in a covid secure environment. These clinics run 7 days per week with evening appointments available.
- Appointments available for all CHFT colleagues
- Winter Vaccinations Steering Group meets twice a week
- Uptake data will be reported weekly from mid-October to the Exec Board, and published with campaign news and publicity weekly to all colleagues
- Monthly reporting to DH via ImmForm will be made through the clinical data and OH teams. To commence from 1st November.
- The Steering Group envisage the Vaccination Clinics will continue for a period of 8 weeks from commencement date and alongside analysis of uptake data the campaign strategy will move towards increased drop-in clinics and mobilisation of peer immunisers within clinical settings.

EQIA – Equality Impact Assessment

There is no evident disadvantage for colleagues in accessing a flu or covid vaccine due to any protected characteristic. Effort is made to actively encourage vaccination uptake for staff with health problems, or who are over 65 or who have other factors which increase their risks from infection. For those colleagues without access to a computer or have limited computer literacy then a booking solution with management teams has been developed. This same booking solution is also available for CHS, ISS, Engie and other colleagues who don't have a CHFT employee number

Recommendation

It is recommended that Board of Directors **NOTE** the contents of the report and to consider incentives for the 2021 winter vaccine campaign to encourage maximum participation and to recognise and reward colleagues and immunisers.

Staff Flu Vaccination and Covid-19 dose 3 Campaign 2021

Summary

This paper sets out the approach for delivering the seasonal influenza vaccine alongside the booster (3rd dose) Cominarty (Pfizer) injections to all staff working at CHFT which includes CHFT, CHS, THIS, Flexible workforce volunteers, agency and students. The booster vaccination follows on from the National Campaign which delivered dose 1 and 2 of the Pfizer vaccine.

Result

Covid vaccines will be administered a minimum of 182 days following from the date of the 2nd dose alongside or (if preferred) separate from the Flu Vaccine within a covid secure environment in accordance with briefing Letter Publication approval reference: C1410 dated 15 September 2021. Delivery methods will be by appointment-based clinics, operating 7 days a week, with availability of appointments at both Calderdale Royal Hospital and Huddersfield Royal infirmary.

The Flu campaign will follow the remit of the National Flu Immunisation programme 2021-2022 (gateway ref 2020153) and will focus on achieving a maximum uptake of vaccine, with 100% targeted offer. Local target 85% uptake. *Public Assurance Checklist is available in Appendix 1.*

Responsibility for ensuring vaccine uptake will be devolved to line managers and divisional leads. Central data collection will be through knowledge portal data entry for immunisers / date teams and self-declarations, which is embedded in the trust intranet.

Training for immunisers will be delivered to the PHE Core standards by e-learning modules in ESR and practice-based assessments in the clinics.

The communication plan will ensure all colleagues are aware of when and how they can receive their vaccine by a variety of sources including letters, emails, and Trust communications. All multimedia approaches are fully utilised, which engages all colleagues in the campaign.

Uptake data will be reported weekly from mid-October to the Exec Board, through the weekly performance report and published with campaign news and publicity weekly to all colleagues as part of the communications plan.

Monthly reporting for Flu to DH via ImmForm will be made through the clinical data and OH teams. Reporting will commence in November. Awaiting confirmation of reporting requirements for Covid via ImmForm from DH.

Vaccine Supply

Flu vaccines have been procured in accordance with the WHO and DH recommended guidance; QIVe for healthcare workers (5700 doses), and QIVc (300 doses) for staff of 65 years or over or who also meet specific higher risk criteria.

Covid vaccine is allocated regionally based on the total number of Trust staff/ predicted uptake of vaccinations. Pharmacy procurement staff draw down the required number of vaccine outers (195 vials/ 1170 doses per box) based on current stock levels and predicted number of appointments booked. Orders are placed via the ImmForm portal. Orders placed on ImmForm portal before 11:55am Monday to Friday will receive next day delivery (Tuesday to Saturday respectively).

The vaccine is received frozen and is removed into the central pharmacy fridge at which point it is given a 31-day expiry.

Effective Leadership

A “winter vaccine” Steering Group including strategic and operational leads, professional expert leads and communications lead meet fortnightly as a minimum from Sept 2021– January 2022. The frequency of meetings has increased to 2 or 3 meetings a week operationally during the peak period of activity.

The Steering Group will monitor vaccine supply and uptake weekly and consider additional and alternative models of administration to encourage maximum availability and uptake.

Please see Appendix 2 for membership.

Reality

Planning and delivering a vaccine campaign within the contact of the Coronavirus outbreak is a now familiar challenge and influences the processes by which a safe programme can be presented.

During this pandemic we continue to have a significant number of staff working from home and it will therefore not be as easy for them to access the vaccine and consideration needs to be given as to how this is going to be done.

Community provision of vaccines remains good – and home working colleagues are able to access vaccines for Flu and Covid at multiple community sites operated by the local CCGs for those who are eligible.

Staffing levels in the NHS are low and there are concerns about resourcing sufficiently trained immunisers without compromising clinical areas. A project lead and clinical lead were appointed and clinics resources as far as able by bank staff trained for immunising last season or at community covid vaccine clinics.

Response

A review of the Flu and Covid 2020-21 campaigns was undertaken and areas of good practice and areas for development embedded into this year’s programme as detailed in Appendix 3.

Joint covid / flu vaccine clinics 2021

The 2021-2022 clinics commenced 27th September 2021 and provide 100% offer to all staff, and as near to 100% uptake as possible (internal target for flu 85%).

Key Covid-safe Principles for immunisation clinics

- Minimisation of staff movement between areas
- Appropriate use of PPE for Immunisers and colleagues being immunised clinics signed off by IPC team and assessed as “Amber” for PPE
- Appropriate venues for immunisation with managed people flow and timed appointments to avoid groups / queues forming.

Committed Leadership

The Board will have oversight of the Covid and Flu campaign, appointment of a clinical flu lead (Exec medical director) who reports to GOLD command on a weekly basis and provides links with the CCG leads for the national immunisation campaign leadership.

Divisions will be responsible for the uptake of the winter vaccination campaign in their areas including interrogation of uptake performance data from the clinics and self-declaration data on KP+ quality.

The Steering Group will ensure effective use of clinic resource and cost-effective use of clinic staff, the appointment of a clinic shift manager and project leads to oversee the programme and use of bank immunisers to minimise pulling staff from ward or other clinical areas to staff the clinic.

Occupational Health will pay a key role in clinical and operational support of the immunisation campaign which includes

- Provide an operational leadership for the campaign and act as support for clinic shift lead and project manager.
- training and supporting immunisers
- Taking a clinical lead on flu and covid general advice
- Facilitation flu appointment sessions for colleagues of 65 years and over or with underlying health needs (who required QIVc vaccine)
- Support with monitoring data, vaccine uptake and vaccine supply on a weekly basis, and reviewing the campaign plan where needed.
- Supporting the data team to report uptake figures to DH through ImmForm portal on a monthly basis
- Provide assessment and advice for those who cannot be vaccinated in the clinic for medical reasons and those with an allergy.

Vaccine Availability

We've already received supplies of vaccines and don't anticipate any delays to further supplies.

The pharmacy lead takes an active role in the Steering Group and supporting clinics with pharmacy staff to support stock control and draw up vaccines for immunisers at busy periods

Communications Plan

A multimedia campaign communication strategy, using all available channels, will ensure all colleagues are informed about flu and covid vaccine facts, the value of immunisation, and clear instruction as to how and where to access a vaccine or report a vaccine has been given externally to the trust campaign.

The winter vaccine plan is communicated throughout the Trust, and published in executive board and public board papers

Flexible accessibility

Vaccine clinics will be held to offer vaccines by booked appointments in a covid secure environment. These clinics alternate weekly between CRH and HRI to offer flexible accessibility to colleagues. These clinics cover a 7-day week and later appointment slots weekly. Managers of teams without easy access to the online booking form are allocated block sessions for their team to access appointments (inc. ISS/Engie/White Knight Blood Bike Riders)

Healthcare workers are also eligible to access vaccines from their GP or community pharmacy providers and self-declare their uptake of the vaccine outside of the CHFT campaign through the staff intranet.

Clinics are currently planned to run until end of November and alongside analysis of uptake data the campaign strategy will move towards increased drop-in clinics and mobilisation of peer immunisers within clinical settings.

The Steering Group are exploring the capacity to develop a booking telephone line to support staff engagement and uptake with the campaign.

Clinical Records

Paper records are generated on entry to the vaccine clinic which details personal information, assessment of fitness to vaccinate and vaccine administration data. This data is transferred in clinic at the time of the appointment into NIVs and CHFT data KP+. The paper consent form will be stored in the scanning bureau as per retention of records. GDPR statement can be viewed on the CHFT intranet or on application.

Equality Impact review

There is no evident disadvantage for colleagues in accessing a flu or covid vaccine due to any protected characteristic. Effort is made to actively encourage vaccination uptake for staff with health problems, or who are over 65 or who have other factors which increase their risks from infection. For those colleagues without access to a computer or have limited computer literacy then a booking solution with management teams has been developed. This same booking solution is also available for CHS, ISS, Engie and other colleagues who don't have a CHFT employee number.

Uptake Data Reporting

The Clinical data team will provide a weekly trust report to Exec Board, cascaded to divisions and shared in Trust communications.

All colleagues are encouraged through CHFT Comms to self-declare immunisations for Flu or covid doses (1, 2 or 3) into the KP+ portal vis an e-form link.

A dashboard of vaccine uptake data will be available to managers on KP+ Quality

Please see Appendix 4 for current uptake data (to 21st October 2021)

National Reporting

Vaccine administration is recorded at the time of immunisation to the NIVs portal.

Reasons for declined vaccines will be collated and forwarded to the Occupational Health Department from Divisional leads.

Vaccine responses are reported to DH via Public Health England through ImmForm, which is submitted by the OH and Data Services.

Incentives

The Exec Board is requested to consider incentives for the 2021 winter vaccine campaign to encourage maximum participation and to recognise and reward colleagues and immunisers.

Response

By 31 August

- Steering group meeting schedule, membership and Terms of reference will be established (Appendix 1)

By 10 September

- Immunisers must be booked into a training session – via teams
- Identification of suitable location of the clinics at HRI and CRH
- Detailed booking plan for clinics, revision of key protocols and consent documentation
- Identify and update / train immunisers

By 24 September

- Communications plan will be ready and presented to colleagues with clear guidance of the booking process of obtaining a vaccine

- Preparation of clinic at HRI

From 27 September

- Main campaign launches with clinic at HRI for 7 days
- Preparation of clinic at CRH
- OH will take bookings for colleagues who have pre-existing health conditions / over 65 years of age or egg allergy
- Trust Board will provide Public assurance of Best practice in Healthcare Worker Flu immunisation by December 2021 (Appendix 2)

From 25 October

- Weekly performance reporting to WEB and through Performance Report

From 1 November

- Monthly flu reporting to ImmForm
- Create drop in capacity to clinics
- Engage and train peer immunisers

Future Planning Considerations

- The Steering Group envisage the Vaccination Clinics will continue for a period of 8 weeks from commencement date. This should allow our 6,000 workforce to book into the available clinics assigned providing we have the appropriate staffing at each session. The Steering Group will monitor the uptake on a weekly basis which will in turn determine what future planning is required for CHFT to continue to deliver a vaccination programme.
- Clinics are currently planned to run until end of November and alongside analysis of uptake data the campaign strategy will move towards increased drop-in clinics and mobilisation of peer immunisers within clinical settings.
- Alongside the CHFT Winter Vaccination campaign colleagues also have access to alternative vaccine providers commissioned as wider CCG led winter campaigns (GP, Pharmacies, Community drop-in centres etc.). Staff are asked to complete self-declarations where they have used alternative services.
- For colleagues with assessed specific allergies to the vaccines referrals to specialist services will be made through OH.

Data recording

Clinical records

- Each immuniser has the professional duty to ensure they record accurately the vaccination batch number, expiry, dose, route, time and immuniser. This should be done in paper format for the admin team to upload to the flu app.

Campaign data records

- Ward and department managers should be encouraged to keep a record of their direct reports which will include:
    - who has been vaccinated including those staff vaccinated elsewhere
    - who have declined the vaccine with the reason also recorded where declared.

Clinical Information team will liaise with the divisional admin leads to validate the campaign data, triangulate with immuniser information (via the intranet portal link) and provide a weekly report to Exec Board and divisions.

The OH team will report monthly totals by broad staff groups to the DH via ImmForm to demonstrate CHFT compliance to the national campaign.

Appendix 1. Public Assurance Checklist
(for public assurance via Trust Boards by December 2021)

Source: National flu immunisation programme plan – gov.uk

A	**Committed leadership**	**Trust self- assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	✓
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	✓
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	✓
A4	Agree on a board champion for flu campaign	✓
A5	All board members receive flu vaccination and publicise this	**X** All Board members will be offered the flu vaccine and the programme has the support of the Board.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	✓
A7	Flu team to meet regularly from September 2021	✓
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	✓
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Clinics currently taking bookings. As demand reduces drop-in clinics will be advertised and mobile immunisers utilised
B3	Board and senior managers having their vaccinations to be publicised	✓
B4	Flu vaccination programme and access to vaccination on induction programmes	Inductions are currently virtual. Information on vaccines will be provided
B5	Programme to be publicised on screensavers, posters and social media	✓
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	✓
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Planning to commence from mid-November
C2	Schedule for easy access drop-in clinics agreed	Clinics currently taking bookings. As demand reduces drop-in clinics will be advertised and mobile immunisers utilised
C3	Schedule for 24-hour mobile vaccinations to be agreed	Planning to commence from mid-November
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Review of previous campaigns taking place. (Cash prize / annual leave/ high street vouchers / matched support for local charity/UNICEF) To be discussed at Board on 4th November
D2	Success to be celebrated weekly	✓

Appendix 2. Membership of Winter Vaccine Campaign 2021 Steering Group

(based upon “Balanced Flu team” – membership)

Core Membership		
Board level Clinical Lead/Chair	David Birkenhead	
Project Lead	Carol Gregson	
Project Manager	Lisa Cooper	
PMO Manager	Rebecca Sharpe	
Occupational Health Lead	Christine Bouckley	
Infection Prevention Lead	Rachel Tomlinson	
Clinical Information Lead	Charlotte Anderson	
Pharmacy Lead	Elisabeth Street	
Communications Lead	Jacqui Booth	
HR BPS	Azizen Khan	
Staff Side Representation	Chris Burton	
BAME Group Representation	Errol Brown	
Divisional Strategic Leads / General Manager / CD /Matrons		
Community	Liz Morley / Caroline Lane	
Medical	Liane King	
Surgery	Karen Farrar	
FSS	Kate Heighway	
Corporate/estates	Janette Cockroft	
Patient Pathways/OPs	Karen Spencer	
Co-opting specialists		
E-Roster	Rose Hagreen	

Appendix 3. Review of the 2020-2021 campaigns and lessons learned

- During 2019-20 the use of the digital Flu app to record vaccines administration had enabled a "real time" picture of the campaign activity and enabled rich data for immunisers to target areas of low uptake. At "drop in" sessions, the use of digital forms was slow, and a non-clinical support team (Flu buddies) were deployed and trained to assist. This was very well received by peer immunisers and helped in managing "walk abouts" and "drop in" sessions. In 2020, peer immunisers were required to complete the data upload in their own clinical areas using an e-form which provided data to the CHFT dashboard through Knowledge portal. This assisted with real time data on vaccine uptake from each area, and enabled support and prompts to lower uptake areas. For 2021, additional requirement to report the Flu data to NIVS creates a challenge for administration of the campaign and limits the scope for real time input of data by clinical immunisers in their workplaces. The covid / flu clinics however were resourced with an admin team to help facilitate data inputting and vaccine record keeping. This model was adopted for the 2021-2022 campaign.
- The communication plan worked well and used a variety of media platforms. Towards the end of the campaign more thought was given to engaging harder to reach and lower uptake groups, and comms specifically targeted to inform and engage these groups
- The uptake target of was achieved and supported by the climate of anxiety of winter infection risks and pending covid vaccination due to begin at the end of the year. Comms messages encouraged early uptake of flu vaccine before the covid vaccines were available. A mop up message and follow up emails to ensure non uptake was noted and self-declarations made where vaccines had been given outside of the CHFT campaign.

Lessons from Covid vaccine clinics Dec – May 2021

- Covid Vaccine clinics were established to provide primary immunisation (dose one and two) to the healthcare providing workforce across Calderdale and Kirklees, including NHS Trusts and community, local government, voluntary organisations and private sector providers. Additional clinics were held to support administration of vaccine to those with higher allergy risk, and those with added needs such as learning disabilities. These clinics were supported by additional specialist staff to ensure a safe and supportive environment.
- The clinics ran simultaneously at HRI and CRH and clinic bookings were managed and driven by the volume of vaccines which needed to be administered within the set timeframe of shelf-life. A pharmacist was allocated to each clinic to support vaccine handling, storage, stock control and security.
- Immunisers were trained through-learning modules, and by leader or experienced peer supervision and assessment in the clinics. A medic was on shift at all clinics to support advice and/or prescription for any attendees with health queries falling outside of the national Protocol.
- Immuniser training records and protocol sign up documents were kept and stored with the clinic consent documents in the Medical records department as per record keeping guidelines.
- Appointments were booked by colleagues through the use of an on-line booking tool; or by block allocation to team managers where teams had no access to the booking tool. An administrative team was established to support bookings and follow up enquiries for the duration of the programme.
- Data was collated in the clinics by a team of administrative assistants, who transferred data from paper consent vaccine records onto CHFT electronic data records (KP+) and to NIVS
- A daily report to NIVS was made to verify doses given, vaccine wastage and any additional required information of incidents during the shift.
- Initially the clinics required a high level of management, balancing the flow of attendees to the daily vaccine supply, and supporting learning of new immunisers. After the initial weeks the clinics developed a rhythm and settled to a routine. The staffing of clinics was high and used senior staff in immuniser roles which whilst providing a safe clinic, was an expensive resource.
- A good level of vaccine uptake was achieved, with CHFT staff uptake of dose 1 reported at around 91% and 89% dose 2 (data published October 2021.

Appendix 4 – Current Uptake Data (27th September to 21st October 2021)

Campaign Summary

Campaign Start: 27th September 2021

Total Covid Boosters Given to CHFT Staff	Total Flu Given to CHFT Staff	Vaccines Given to Non CHFT Staff (ISS, Engie etc)	Total Vaccines Given
1625	1,485	213	3,323

Campign Days	Average Vaccinations Per Day
24	138

Slots

Total Slots (available between 22/10/21 and 4/11/21	Booked Slots	Blocked Slots	Vacant Slots (All currently bookable)
1224	714	337	173

Number of vaccinations left to give

assuming we vaccinated 100% of eliagble staff for COVID booster and 80% of staff for Flu

Number of vaccinations left to give	Clinic Days Required	Clinics Week Required
6,209	45	6

*Note this is worst case scenario as hopefully people will have both vaccines in the same appointment

COVID Booster Performance

Division	Total Number of Staff	Total Number of Staff Eligble for Booster (recorded as having 1st and 2nd dose)	Total vaccinated at CHFT	Total vaccinated elsewhere	Total Declined	Total left to vaccinate (all)	Total left to vaccinate (eligible staff)
Calderdale & Huddersfield Solutions Ltd	479	303	114	2	0	363	187
Central & Technical	94	27	4	0	0	90	23
CHFT Staff Bank	0	0	0	0	0	0	0
Community	821	514	211	19	1	590	283
Corporate	492	269	122	12	0	358	135
Families & Specialist Services	1460	1030	411	30	1	1,018	588
Health Informatics	229	138	54	5	0	170	79
Medical	1658	1023	341	28	0	1,289	654
Pharmacy Manufacturing Unit	70	49	26	0	0	44	23
Surgery & Anaesthetics	1320	885	342	26	2	950	515
Trust Total	**6623**	**4238**	**1,625**	**122**	**4**	**4,872**	**2,487**

Flu Performance

Division	Total Number of Staff	Number of Staff to Vaccinate to reach 80%	Total vaccinated at CHFT	Total vaccinated elsewhere	Total Declined	Total left to vaccinate (all)	Total left to vaccinate (80% of staff)
Calderdale & Huddersfield Solutions Ltd	479	383.2	100	1	1	377	281
Central & Technical	94	75.2	3	0	0	91	72
Community	821	656.8	189	16	0	616	452
Corporate	492	393.6	116	8	0	368	270
Families & Specialist Services	1460	1168	384	23	3	1,050	758
Health Informatics	229	183.2	48	6	0	175	129
Medical	1658	1326.4	310	14	1	1,333	1,001
Pharmacy Manufacturing Unit	70	56	22	1	0	47	33
Surgery & Anaesthetics	1320	1056	313	15	1	991	727
Totals	**6623**	**5298.4**	**1,485**	**84**	**7**	**5,047**	**3,722**

17. Director of Infection Prevention and Control Q2 Report

To Approve

Presented by David Birkenhead

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Director of Infection Prevention and Control (DIPC) report Q2 – 1st July 2021 to 30th September 2021
Authors:	Gillian Manojlovic, Senior IPC Nurse Lindsay Rudge, Deputy Director of Nursing / Assistant DIPC
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	Quality Committee

Purpose of the Report

To provide the Board a report on the position of Healthcare Associated Infections (HCAIs) in Q2 from 1st July to 30th September 2021.

Key Points to Note

The revised version of the Board Assurance Framework (BAF) last updated on 30 June 2021 is awaited.

Covid-19 outbreaks in September have resulted in a significant increase of healthcare associated Covid-19 cases (HOCI's).

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. Information on flu uptake has been analysed by ethnic group and reportedly separately.

Recommendation

The Committee is asked to **NOTE** the performance against key IPC targets and **APPROVE** the report.

Director of Infection Prevention and Control (DIPC) report - Q2 1st July to 30th September 2021

1. Introduction

This report covers the period from 1st July – 30th September 2021. 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.

2. Performance

Indicator	End of year ceiling 2021/2022	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	0	
C.difficile (trust assigned)	Objective = 22	13	8 HOHA = 2 preventable, 5 unpreventable, 1 pending 5 COHA = 4 unpreventable, 1 pending
MSSA bacteraemia (post admission)	None set	9	
E. coli bacteraemia (post admission)	Objective = 91	43	19 post admission cases 24 COHA cases.
MRSA screening (electives)	95%	70%	Data quality issues possible. FSS data having a significant effect.
ANTT Competency assessments (doctors)	90%	60%	Deterioration in both staff groups this quarter.
ANTT Competency assessments (nursing and AHP)	90%	90%	
Hand hygiene	95%	99.8%	
Level 2 IPC training (Doctors	90%	83%	This continues as an e-learning package
Level 2 IPC training (nursing and AHP)	90%	90%	

COHA = community onset, healthcare associated
HOHA = hospital onset, healthcare associated

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	94%	
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients continue to take priority for side room isolation
Cleanliness	Non set	97.8%	

4. MRSA bacteraemia:

No cases to report during the current reporting period.

5. MSSA bacteraemia:

There have been 9 post-admission MSSA bacteraemia cases during the current reporting period. The IPC team will continue to review cases monthly.

6. Clostridium difficile:

The objective for 2021-22 is 22 cases, a reduction of 1 case on the 2019 data (calendar year). The current number of cases is 13: (8 HOHA and 5 COHA). At the current rate there is a risk the objective will be breached.

All cases are subject to an investigation of which:

- 2 deemed as preventable
- 9 unpreventable
- 2 pending

7. E. coli bacteraemia:

There have been 19 post-admission *E. coli* bacteraemia cases plus 24 COHA cases during the reporting period. Given an objective of 91 cases, at the current rate there is a risk the objective will be breached.

8. Outbreaks & Incidents:

8.1 Outbreaks

There have been 6 COVID-19 outbreaks during the reporting period; 2 staff outbreaks (ophthalmology clinic and audiology clinic) both of which are now closed, plus 4 ward outbreaks (H5, H11, H12 and H19). All outbreaks are managed in line with COVID-19 outbreak management guidelines and are monitored for 28 days. H11 and H12 remain open at present. Issues identified included:

- Environmental issues especially difficult with maintaining social distancing for both patients and staff
- Mobile patients with cognitive impairment
- Staff attending work with symptoms
- Timely retesting and isolation where results returned inconclusive.

8.2 Healthcare associated COVID-19 Infections (HOCI's)

All probable and definite HOCIs are investigated at CHFT following a process agreed with the divisions and the risk team. Any immediate learning is also discussed at the IPC gold meeting and communicated where relevant.

For this reporting period there have been 23 HOCI cases (5 definite, 18 probable). The outbreaks seen on wards 11, 12 and 19 have contributed to 14 of these patients HOCIs.

8.3 Staff Covid test and trace

System in place to manage staff who are deemed essential to safe service delivery but would otherwise need to isolate. Further options being explored to make best use of staff with household contacts. Staff testing and vaccine update is outlined in the Occupational Health report.

9. FFP3 FIT testing

The National programme to build resilience in the supply chain and reduce reliance on 3M as a manufacturer requires staff to be fit tested to at least 2 masks. In addition, further changes have been proposed by DH including repeat fit testing every 2 years and the exclusion of valved masks from surgical fields. These changes are being implemented.

The external fit testers should have finished in September, but it has been confirmed that this will be extended though no clarity as to how long. Longer term planning for the ongoing provision to be agreed.

10. Audits

COVID Assurance audits including:

- IPC BAF framework self assessment – new framework is awaited
- Daily must do compliance by ward managers
- Weekly leadership walkround every Wednesday
- Weekly IPC Covid-19 assurance – completed by the Matrons
- 2 weekly FLO audits
- Night matron's assurance audit to monitor compliance out of hours (OOH) to IPC and social distancing recommendations
- 7 day on site Senior Leadership rota

Quality Improvement Audits

The programme was once again put on hold during the reporting period, this has been reviewed and it is proposed that this recommences in January 2022.

Quality Priorities

The focussed Quality Priorities identified in 21/22 for reducing Hospital Acquired Infections including COVID-19. Our focus for this quality priority and actions to date are:

- **Implement patient testing strategies aligned to national guidance.** Elective testing pre-admission process in place; regular in-patient testing protocol implemented. Monitoring of staff LFD uptake made difficult due to reporting moving to the national platform.
- **Support a system wide approach to the vaccination programme.** No update
- **Review and implement the CPE screening toolkit**: policy under review against the toolkit and feasibility of implementation of each element under discussion.
- **Reduce the number of preventable Clostridium Difficile infections**: deep dive completed, antimicrobial prescribing noted as the key issue in the increased incidence as well as timely sampling and isolation as areas for improvement. Divisions have been tasked with actioning the recommendations from the review.
- **Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection:** patient placement protocols and social distancing additional measures in place including masks for patients; regular in-patient testing protocol implemented; compliance monitoring in place.

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. Current audit results are scoring 90%.

11. Recommendations

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

18. Learning from Deaths Q2 Report

To Note

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Learning from Deaths Q2 Report
Authors:	Cornelle Parker, Deputy Medical Director Mandy Hurley, Clinical Governance Support Manager
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Purpose of the Report

To provide Board with assurance of the Learning from Deaths (LfD) mortality review process.

To provide an update against agreed recommendations in relation to LfD approved in the annual report July 2021.

Key Points to Note

In Quarter 2 (July – Sept 2021), there were 344 adult inpatient deaths.

For Quarter 1 the completion rate using the initial screening tool (ISR) was 32% against a target of 50%. 8% of all in-hospital deaths have been reviewed in Quarter 2 thus far. However, there is a time lag within the process from allocation to completion by reviewers.

Recovery plans are being agreed to achieve the 50% standard with Acute Medicine, Respiratory Medicine and Elderly Medicine Mortality Leads as these are the specialities with the greatest number of deaths, but these areas are also subject to some of the greatest clinical pressures.

The Medical Examiner's Office is now reviewing 100% of in-patient deaths. This provides early senior clinical scrutiny of all deaths. Approximately 5% of all deaths are being referred for Structured Judgement Review through this route.

A total of 46 Structured Judgement Reviews were requested in the 1st Quarter of 2021/22 of which 46 (100%) have been completed.

A Structured Judgement Review undertaken in June was given a care score of 2 (poor care). This will be escalated through Division. The Quality Governance Lead and Clinical Director for Surgery have been informed.

EQIA – Equality Impact Assessment

Equality impact in relation to the impact of 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 **NOTE** the Learning from Deaths Q2 Report.

Learning from Deaths Report Quarter 2 2021/2022

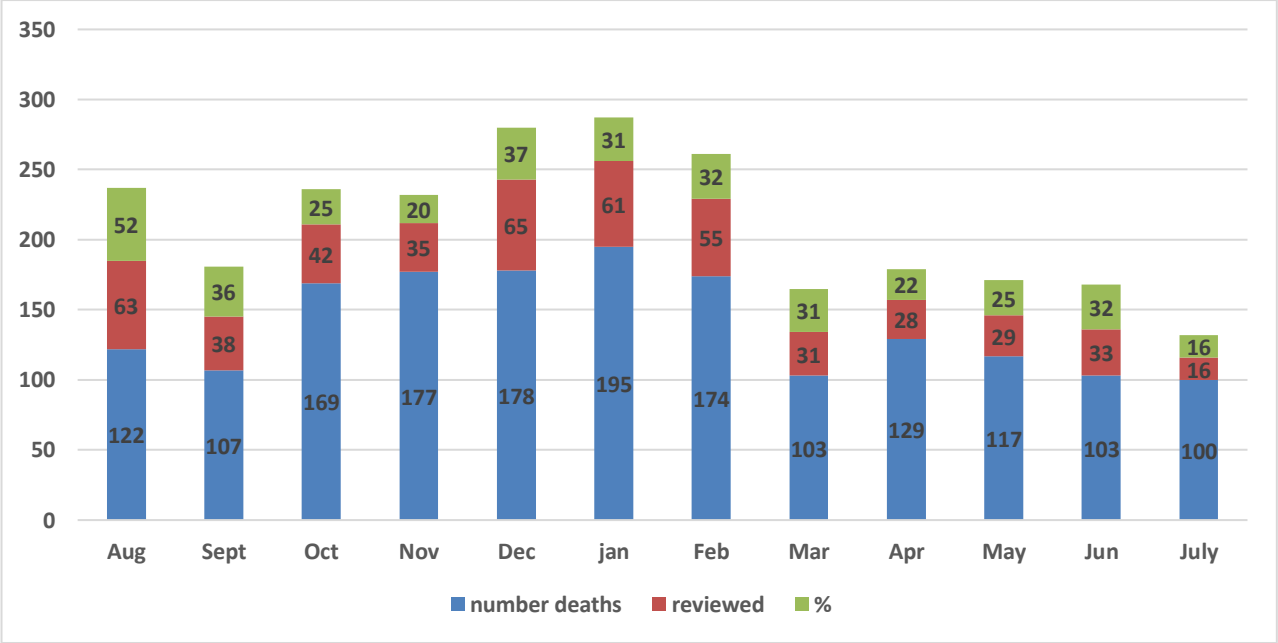
In Quarter 2 (July – Sept 2021), there were 344 adult inpatient deaths at CHFT recorded on Knowledge Portal. This report was generated on 23rd September.

Initial Screening Reviews (ISR)

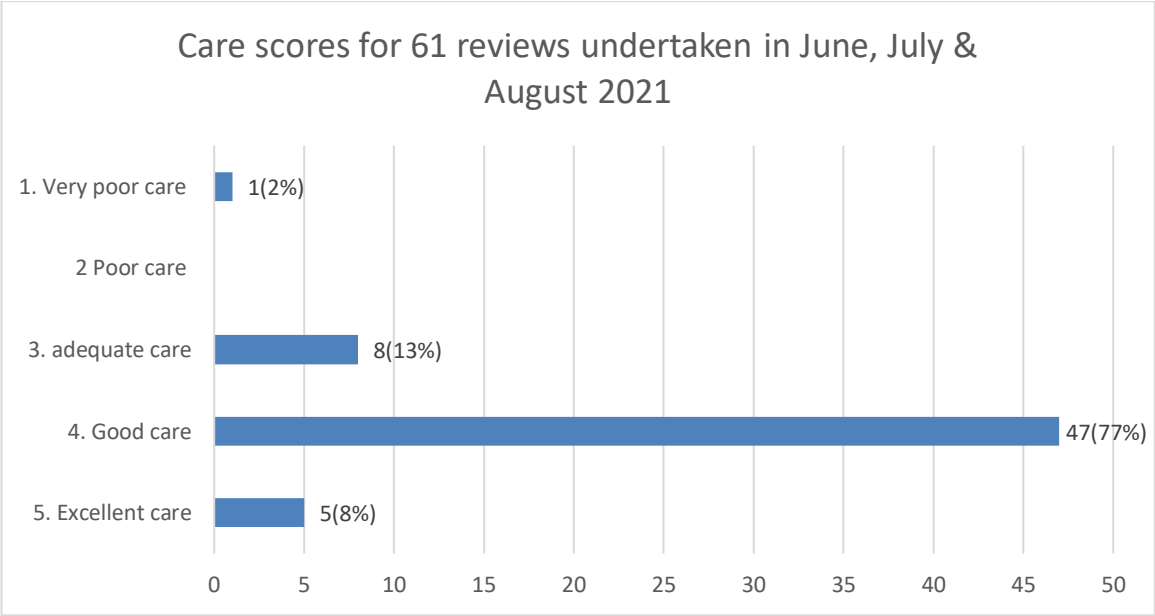
The online initial screening review tool focuses primarily on initial assessment, ongoing care and end of life care. Reviewers are asked to provide their judgement on the overall quality of care. Specialities have been given the opportunity to identify additional specific questions to enhance the information they have around death. The tool now includes speciality specific questions for Gastroenterology, Critical Care, Haematology, Oncology and Respiratory Medicine.

Of the **344** adult inpatient deaths recorded in Quarter 2 of 2021/2022, **28** (8%) have been reviewed using the initial screening tool. This falls short of the 50% target. The committee is reminded of the lag between issuing cases for review and completion of the reports. By comparison in the Q1 report, June mortalities demonstrated a review rate of 17%. The chart below demonstrates that this figure has now risen to a 32% completion rate.

An ISR recovery plan has been agreed with Acute Medicine and is under discussion with Respiratory and Elderly Medicine Mortality Leads, these are the specialities with the greatest number of deaths. We recognise these are clinical areas with some of the greatest operational pressure currently and we are conscious of the time pressures this scrutiny creates.



Quality of care was assessed as follows



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

Structured Judgement Reviews

Structured Judgement Reviews (SJR's) have continued throughout the Covid pandemic response.

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Total
Escalated from ISR	3	0	3	2	3	0	1	0	0	2	1	1	**16**
Escalated by ME	-	-	-	1	0	2	6	0	2	10	3	8	**32**
Complaint	1	0	0	0	1	0	1	0	0	0	0	0	**3**
SI Panel	0	0	2	0	0	0	0	0	0	0	0	0	**2**
Elective	1	0	0	1	0	0	0	0	0	0	2	0	**4**
LD	1	0	3	0	3	2	2	0	1	1	0	0	**13**
2nd Opinion SJR	2	0	1	2	2	0	3	2	3	4	0	2	**21**
Coroner	2	0	0	0	0	0	0	0	1	0	0	0	**3**
Other	8	0	1	0	0	6	1	18	0	2	0	0	**36**
Total Requested	**18**	**0**	**10**	**6**	**9**	**10**	**14**	**20**	**7**	19	**6**	**11**	**130**

130 SJRs were requested in the last 12 months. A rising proportion of SJR's have been requested through the Medical Examiner's Office. This is to be expected and is a positive development. Early case review by an experienced medical practitioner which is intrinsic to the process, flags clinical concerns more promptly.

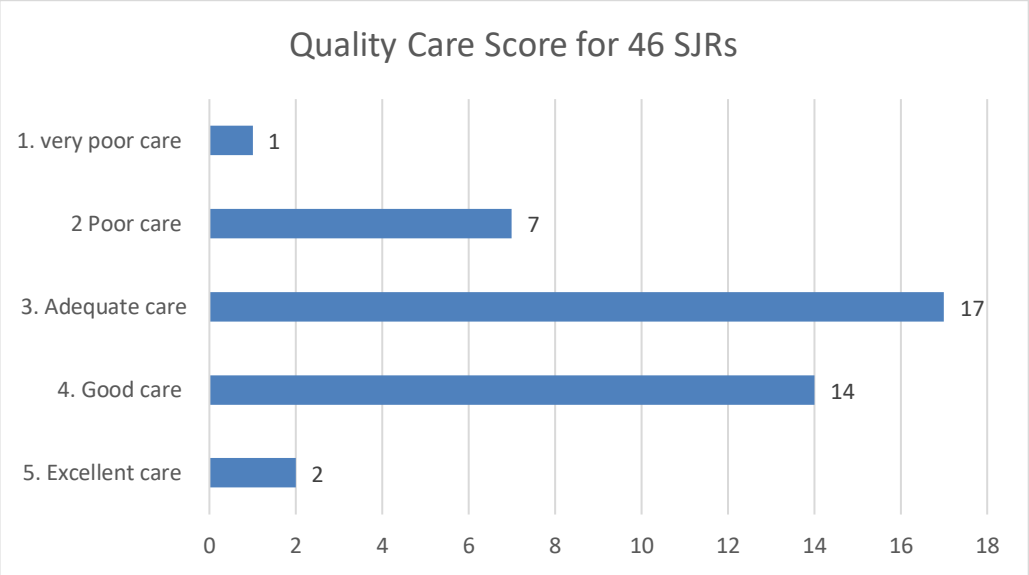
A total of 46 SJRs were requested in the 1st Quarter of 2021/22 of which 46 have been completed. The findings from SJRs are shared with the speciality mortality lead and appropriate Clinical Director.

One Structured Judgement Review undertaken in June was given a care score of 2. The 2nd opinion reviewer also gave a care score of 2. This is reported onto Datix and the surgical division will review at orange panel and agree whether this requires further escalation. The Quality Governance Lead and Clinical Director for Surgery have been made aware.

Quality of care issues for the case with care score of 2

- Delay in giving antibiotics i.e., recognition and management of sepsis
- Patient waited 72 hours before being taken to theatre through delay in decision making
- Despite patient's deterioration, and suggestion from Learning Disability matron, a palliative care opinion was not sought.

Quality of Care score distribution for 46 completed SJRs



From the 46 SJRs completed in Quarter 1 2021/2022 the following learning themes and concerns were identified:

- Several failures to correctly implement the Mental Capacity Act – these examples have been highlighted with the Safeguarding Team
- Incorrect VTE prophylaxis
- Missed doses of prescribed medications in a patient with deteriorating heart failure
- Poor documentation around an invasive procedure
- Delayed recognition of a deteriorating patient and lack of prompt intervention

The following good practice was identified:

- Excellent MDT working and communication in the critical care setting despite pressures on resource and COVID-19 restrictions
- Good senior decision making from consultants & Heart Failure nurse with evidence of good liaison with next of kin

- Good documentation of conversations with family regarding patient's religious beliefs
- Evidence of good skin care undertaken by tissue viability nursing staff
- Evidence of excellent nursing care eg mouth care, positioning, skin care
- Good documentation at end of life
- Timely review of patients with escalation to senior colleagues appropriately communicated

Recommendations in relation to LfD for 2021/22 proposed in 2020/21 annual report

- **50% of all in-patient deaths to be reviewed by June 2021:**
  - SJR's reviews are completed to target. As described above, the pandemic still presents challenges with regards to ISR capacity.

- **Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities:**
  - Aligning SJR themes with improving quality in Care of the Acutely Ill Programme
  - SJR findings are shared with speciality mortality leads and clinical directors
  - The next step is to develop a process for the specialities to feedback their responses to SJR findings in their annual updates to the Mortality Surveillance Group.

- **To work alongside the new Medical Examiner (ME) team and align the LfD processes:**
  - Lead Medical Examiner now attends the Mortality Surveillance Group
  - The Medical Examiner team is scrutinising all medical certificates of cause of death and identifying certification errors. This will result in an improvement in completing the medical certificate of cause of death. The Medical Examiner Office is now escalating quality of care issues identified on initial review for SJR. The Medical Examiner's Office is reviewing 100% of in-patient deaths providing early senior clinical scrutiny of all deaths. Approximately 5% of all deaths are being referred for Structured Judgement Review through this route.

Recommendation to Quality Committee

Quality Committee is asked to note the Learning from Deaths Quarter 2 report.

19. Guardian of Safe Working Hours Q2 Report

Presented by Devina Gogi, Guardian of Safe Working Hours

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Board of Directors
Title:	Quarter 2 report (1st July 2021- 30th September 2021) from the Guardian of Safe Working Hours, CHFT
Author:	Ms Devina Gogi, Guardian of Safe Working Hours
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None

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. Slight increase in exception reports in this quarter.
2. Efficient filling the of rota gaps in this quarter.
3. Delivery of Exception report Teaching in Trust Induction
4. Successful hosting of first junior doctor's forum for the new cohort of junior doctors

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 acknowledge the need for extra support & flexibility with training and rota for junior doctors in the training recovery phase.

Q2 report: (1st July 2021 to 30th Sept 2021)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

This quarter shows a slight increase in the number of exception reports which could be reflective of improved engagement & the successful delivery of the presentation about Exception reporting at the junior doctor induction in August 2021.

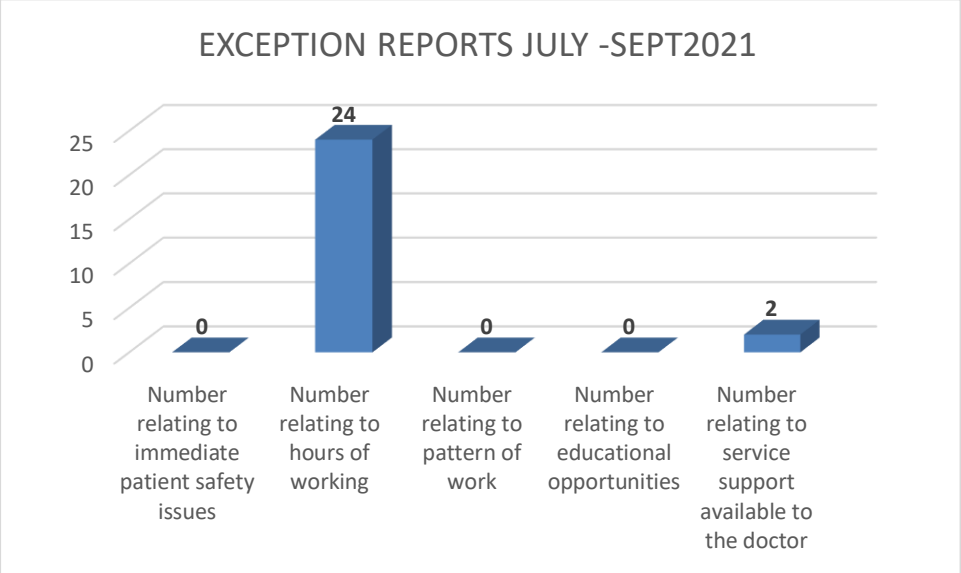
Most exception reports were related to extra hours of working and were resolved by overtime payments or Time off in Lieu (TOIL).

Gaps in rotas from vacancies, sickness absence, and other unplanned absence were filled efficiently by agency staff and internal bank locums, with a fill rate of 10% of the junior doctor's posts across the trust.

We received a lot of interest and several volunteers to be Junior Doctor Representatives following its advertisement in the junior doctor trust induction by GOSWH. The first Junior Doctor Forum (JDF) was chaired successfully on 30th Sept 2021 and methods to improve junior doctor engagement were discussed.

a) Exception reports and trends

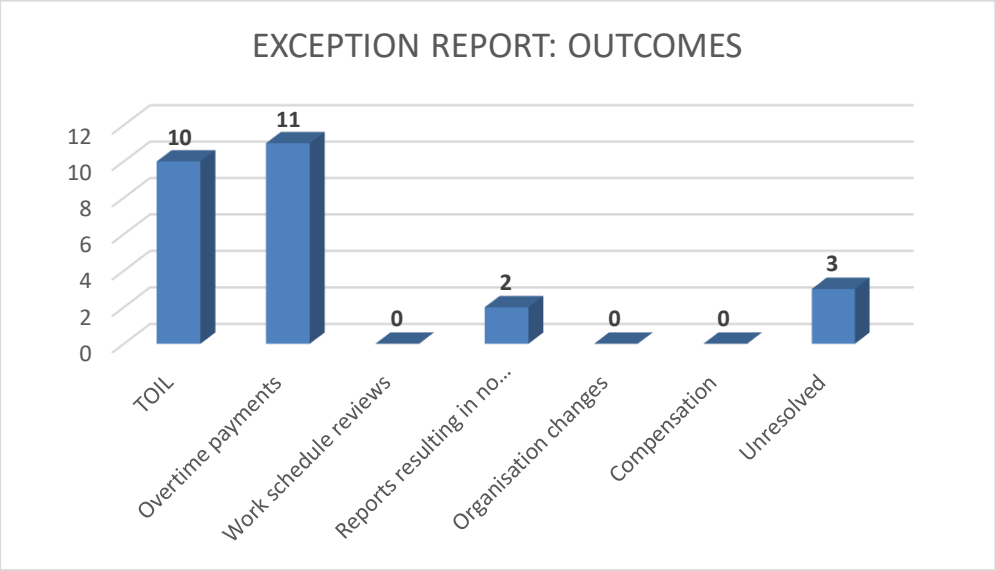
There have been 26 Exception Reports (ER) this quarter. This is slightly more than the last quarter which could highlight better understanding and reporting by the new cohort of junior doctors due to active inclusion & presentation of key points of exception reporting in trust induction.



24 ER were related to hours of working while 2 were due to issues with service support. There were no ER related to immediate patient safety issues or educational opportunities.

Regarding the ER related to service support, the first was by a CT3 trainee who was posted to the gastroenterology ward. The trainee highlighted that the ward was short staffed which

led to him missing his weekly teaching. The second ER was by a ST4 in Paediatrics, as a locum doctor did not turn up for the night shift, without any warning. This led to the workload of the trainee being increased that night. This matter has been raised in the Paediatrics medical staffing meeting with the Clinical Director Dr Thiyagesh, the departmental manager Elena Gelsthorpe-Hill and rota coordinator Hannah Spencer. A complaint has been made to the locum agency.

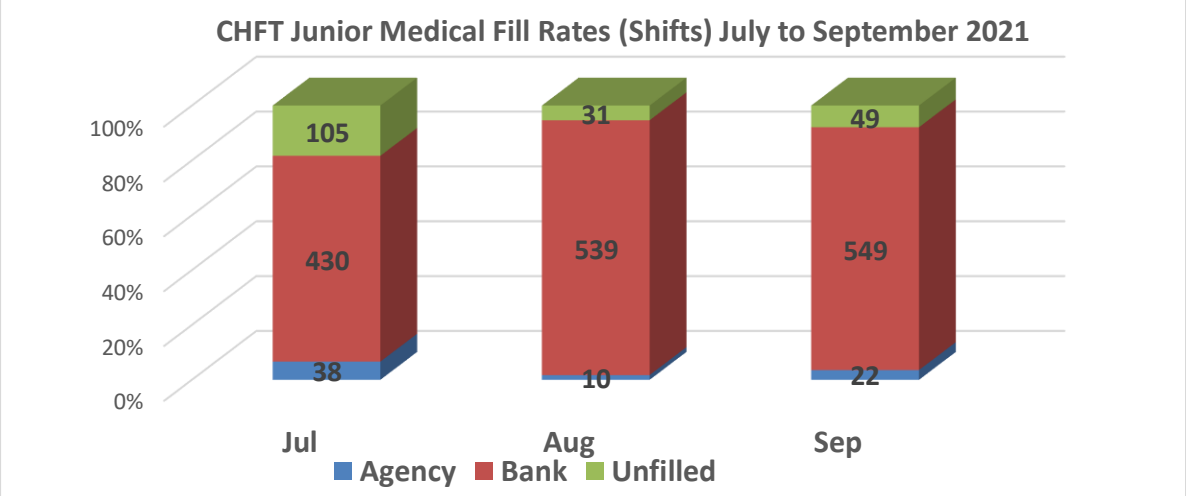


The ER were closed by overtime payments & TOIL & 3 were unresolved due to no response to the agreed outcome by the concerned doctor. 2 reports are still waiting initial meeting with the supervisor.

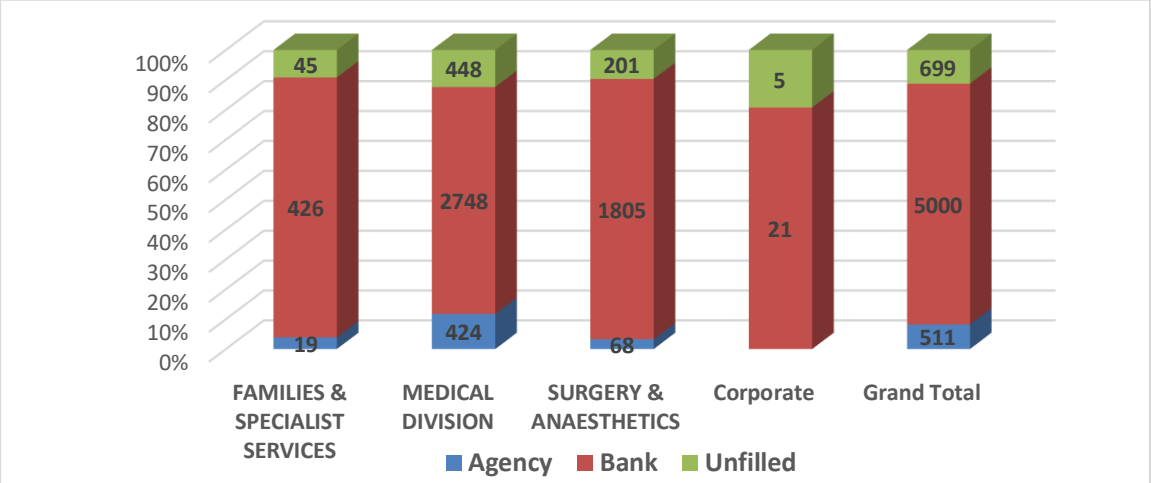
No guardian fines have been levied this quarter.

b) Rota Gaps between June to September 2021

There were some rota gaps from July to September 2021, but they were filled by agency & bank locum.



The gaps were maximum in medical division but using the bank & agency locum the total unfulfilled posts were around 10%.



c) Appointment of New Junior Doctor Lead for Training Recovery

Dr Louise Finn has been appointed as a junior doctor lead for Training recovery. Her appointment is a positive step towards active involvement of the junior doctors in the training recovery programme that has started in the trust.

d) Active Participation in Trust Induction

The GOSWH was ardently involved in trust induction in August and advocated the importance of junior doctors' participation as representatives in junior doctor forums so that we can strive to learn about and resolve issues, creating a better work environment for them. The process and importance of Exception Reporting was also highlighted in the trust induction.

d) Junior doctor forum (JDF)

The JDF was held on 30th September 2021 and was chaired by the GOSWH. Whilst there were some junior doctor representatives that attended, there were fewer than expected in attendance at the forum. The GOSWH highlighted the importance of better engagement by junior doctors in this forum.

The junior doctors emphasised updating the "DOCTOR TOOLBOX" with important information so that it can be a useful resource by junior doctors to carry out their routine clinical activities properly. The lack of availability of rooms for junior doctors to attend meetings due to the closure of the postgraduate centre in HRI, was expressed and various possible solutions were explored. Reconfiguration plans will be discussed at the next JDF, so that trainees gain a greater awareness of the planned changes and how these will affect the Medical Education centre and the availability of meeting rooms.

e) Recommendation

At CHFT, this quarter saw the recruitment of a new cohort of junior doctors who have been actively informed about the importance and process of exception reporting.

The training recovery programme has started in the trust and the appointment of a Junior Doctor Lead for Training Recovery will improve active participation by the junior doctors.

Extra support, flexibility, and access to training and educational facilities would be welcomed to ensure that the trust provides the best training experience possible for our trainees.

The Trust Board is asked to receive and note the Guardian of Safe Working Hour's Report.

Devina Gogi
Guardian of Safe Working Hours
October 2021

20. Quality Report

- Maternity Services Update

To Note

Presented by Ellen Armistead

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period August to September 2021)
Author:	Enzani Nyatoro, Interim Assistant Director for Quality and Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee October 2021

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues for consideration.

It is to ensure that the Board of Directors is provided with a level of assurance around key quality and patient experience outcomes. The report provides confirmation that during the COVID pandemic and as the Trusts implements its recovery programme in response to the pandemic, the processes, and systems within the Trust to ensure quality and safety are fit for purpose.

To provide high level updates on the Trust's preparedness for relevant regulatory scrutiny.

Key Points to Note

The Quality Report aims to provide further detail on areas of key focus and complements the Integrated Performance and Quality Priorities Report.

Care Quality Commission (CQC)

- During August and September 2021, the CQC workstreams have been guided by maintaining continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, national guidance and CQCs Emergency Support Framework.
- 2020/21 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions from the 2018 CQC inspection: one action remains outstanding (Quality and financial position of the Trust)
- CQC Engagement Meetings – CHFT, Acute and Community Healthcare Services have maintained monthly regular review meetings between the CQC have continued throughout the COVID-19 pandemic. The last full engagement meeting took place on 17th September 2021.
- The Journey 2 Outstanding Reviews (J2O) continue wards across the 2 sites. Compliance levels were between 72% and 92%

Central Alert System

To note the current position and actions being undertaken for the Central Alert System (CAS). There are 2 overdue alerts (2 of the previous reports from the 4 overdue alerts were closed) 3 alerts are in progress and all within timescale (an increase of 1 from previous reporting period) 3 alerts have been closed during the reporting period.

Dementia Screening

- The Trust is exceeding the key performance indicator (KPI) for dementia training with 97.22%, against a KPI of 95%. Dementia screening remains below the target with a

Trust average of 42.67%, however this is an improvement. The Dementia Lead continues to focus on dementia screening working closely with medical teams to increase compliance on acute floor and assessment units, including frailty. Various strategies to improve compliance are underway and these include increased communication with teams as well as the development of a standard operating procedure on how to complete screen. The development of the whiteboard on EPR is ongoing.

- There is limited assurance in person centred dementia care training and further improvement work is underway. Current staffing challenges within the Enhanced Care Team have slowed down the delivery of the dementia training which is done face to face. New ways of delivering this training are being considered.
- There is a new indicator for Depression and Delirium screening with a target of 90%. The Trust average for depression/delirium needs improvement with a focus to increase Dementia screening and then progress to an improvement for the Depression and Delirium screen.

Experience, Participation, Equalities

- Improving the experience of patients with visual impairment held their second meeting to review the feedback from the service user engagement events focusing on signage/ orientation and staff awareness.
- Observe and Act (O&A) programme which was paused for 5 weeks due to the clinical pressures is back in place and has had excellent engagement.
- Patient Experience and Transformation team have been involved in engagement activities: working together to maintain connections with several stakeholders.
- Trust BAME Community Engagement Advisor is creating engagement opportunities with the local BAME communities from various groups.
- There has been progress with the Friends and Family Test is progress with revised targets introduced based on national averages – these have been built into the IPR and KP+
- Learning lessons to improve patient experience: An impact story per month has been produced, along with a 'You Said, We Did' version for IPR.
- Visiting: The visiting work stream established a task and finish group to progress a review of current restrictions to enable increased visiting whilst maintaining patient safety.

Legal

- The legal service benchmarking against the GIRFT/NHSR "Learning from Litigation Claims" best practice guide will be reviewed by the Head of Legal Services and will assist in reviewing the current service provision. This will build upon the existing improvement programme detailed within the report.

Incidents

- Work continues across divisions to manage outstanding actions. There is a recognition of the operational pressures and the impact this is having on the management of closing actions however the number of outstanding actions has improved.

- A total of 6 StEIS (Strategic Executive Information System) incidents were reported; 2 for August and 4 in September.

Medicine Safety

- Areas of Limited Assurance include non-compliance of the medicines management 'must do's, which are ongoing objectives requiring continual monitoring; and Medical gas training to ensure compliance with Health Technical Memorandum (HTM) requirements.
- To note lack of quoracy at the Medicine Safety and Compliance Group.

Maternity Services

- Ockenden report
  - The site visits by the Regional Chief Midwife and her team proposed for the end of July 2021 have been suspended due to operational pressures across health care.
  - The Perinatal Quality Surveillance Meetings continue to be held monthly with CHFT maternity safety champions CCG and LMS colleagues and with a revised agenda for the meetings as the meeting develops.
  - NHSEI's workforce department have released the first allocation of funds to support the additional 10.9 wte midwives received by CHFT as part of the national additional funding to support improvement in maternity services. The additional posts have been advertised, but no one has applied yet.
  - Maternity services nationally have also each received an additional £50 000 non-recurrently specifically to support the recently appointed newly qualified midwives in their first year of professional practice
- Better Births – Continuity of Carer (COC)
- Maternity services are continuing to work towards the ambition that all women will be placed on a COC pathway by March 2023. We currently have four teams and approximately 24% of all women booked on a Continuity of Care Pathway and in August approximately 48% of all BAME background. In September the overall was 24% with 56% BAME. placed on a COC pathway.

- NHS Resolution Maternity Incentive Scheme
  - The requirements for Year 4 of the scheme were released in August 2021 with a planned submission date of June 2022. Maternity providers are awaiting an update to the requirements considering the ongoing challenging operational pressures. A task and finish group has been instigated to monitor completion of the elements of all 10 safety actions as they are currently described.
- Maternity incidents
  - Maternity incidents reviewed at weekly maternity governance MDT meeting: 50 incidents reported during the reporting period.
- Healthcare Safety Investigation Branch (HSIB):
  - 28 referrals to date with 7 current Active cases
- Maternity Staffing
  - In 2015 NICE produced its guidance on safe midwifery staffing and the provision of 1:1 care in labour is for August is 98.9%
- User feedback
  - The current visiting restrictions in maternity services are being reviewed as part of the trust wide review of visiting at CHFT.

- **Quality Priorities**
  - To note the updates to the Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022:

    <u>Quality Account priorities</u>
    - Recognition and timely treatment of Sepsis
    - Reduce number of Hospital Acquired Infections including Covid 19
    - Reduce waiting times for individuals attending the ED

    <u>Focussed Quality Priorities</u>
    - Falls
    - End of Life

- Clinical Documentation
- Nutrition and Hydration
- Pressure Ulcers
- Making Complaints Count

All Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022 have discussed at Divisional Performance Review meetings (PRMs) with the focus that the quality priorities form an integral part of the divisional quality agenda and strategy. Further work is being undertaken to ensure areas of focus for each priority are linked to actions at division level

EQIA – Equality Impact Assessment

In undertaking the Equality Impact Assessment this ensures that the Trust is sited on all aspect of our care delivery and the impact this can have on the diverse patient group. This in turn demonstrates that as a Trust we are considering the needs of all in our care and ensures that services we provide do not have a disproportionate impact on individuals or groups that share a protected characteristic under the Equality Act 2010.

This report considers the impact on all 'protected` groups under the Equality Act 2010 including parents/carers and/or socio-economic groups.

It is not anticipated that the contents within this report will have a detrimental impact on any of the protected characteristics but seeks to give the assurances that as a Trust we are doing everything in our power to reduce risk and ensure high quality and safe care for all to include improvements for dementia screening for our patients aged 75 and over.

The Equality Impact Assessment is an ongoing process, and every effort is made to ensure it is an integral part of service delivery and enable us to demonstrate 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.

In ensuring the above as a Trust we well be well placed to respond positively to external scrutiny from the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.

Recommendations

- The Board of Directors is asked to **NOTE** the content of the report and the ongoing activities across the Trust to improve the quality and safety of patient care.
- The Board is asked to **NOTE** the Maternity Quality report update.

Contents

Bi-monthly reports

1. 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 Trust Quality Board paper seeks to brief the Board on the developments and progress against the Quality Strategy and improvement work underway.

This report provides assurances that as a Trust we are working towards the Outstanding CQC rating, the question for any Trust committee should be one of 'Am I assured and am I confident that we know where the risks lie'. Through the transparent reporting and the robustness of the reports we seek to give the Board the clarity and assurance required.

This report provides an update on assurances against several quality measures for the last quarter the progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2021/2022.

The Quality Committee continues to provide the scrutiny, monitoring and assurance on the quality programmes that are in place within the Trust. The Committee has and continues to recognise the challenges that has been placed upon the Trust during the COVID -19 Pandemic and continues to acknowledge the hard work from all colleagues to continue to provide one culture of care for patients and colleagues. As we implement the recovery programme it is more than ever important that as a Trust, we are sighted on the quality agenda and any associated risks.

2. Care Quality Commission (CQC) workstreams

During August and September 2021, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, national guidance and CQCs Emergency Support Framework.

2020 / 2021 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust now has one action to complete which is rated GREEN Substantial Assurance

- MD1 - *The trust must improve its financial performance to ensure services are sustainable in the future* remains rated green (substantial assurance) pending further consideration of the quality and financial position of the Trust.

Table 1

Compliance	Current Position	Further Actions	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	The Trust's submitted draft financial plan for 20/21 was in line with the required five-year Financial Improvement Trajectory, this plan was overridden subsequently due to Covid-19. The Month 5 reported position was break-even, based upon the temporary financial regime in place to support Covid pressures. Very long-term strategic recommendation, the plans linked to this were around reconfiguration. We continue to progress but due to current environment we are breaking even on a	This action is a long-term action which continues to progress a further update is scheduled to be received at the April 2021 CQC & Compliance Group.	**Substantial Assurance**

	month-on-month basis to support Covid activity. Planning for the next financial year is taking place		

CQC Engagement Meetings

Regular review meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services. These meetings are scheduled to continue monthly with the last full engagement meeting taking place on 17th September 2021.

Updates were shared regarding current position with all open enquiries as set out below:

- 10 New Enquiries Opened since June 2021
- 2 Enquiries have been closed since June 2021
- 7 Enquiries pending CQC approval for closure
- Currently 19 Open Enquiries.

- 4 x Serious Incident
- 7 x Orange level Investigations
- 2 x Concerns/Complaint
- 3 x Safeguarding Concerns
- 2 x HSIB Reportable Incidents

The next planned engagement meeting will take place on 10th December 2021.

Journey 2 Outstanding Review

The Journey 2 Outstanding Reviews (J2O) were re-established from w/c 20th September 2021 a full schedule of reviews is now in place until the end of 2021.

A team of CHFT Colleagues form the review teams to undertake the inspections, the current schedule allows for 2 reviews to be completed per month.

Reviews to Date

Four Journey 2 Outstanding Reviews have taken place to date on Ward 8B at CRH, Ward 5 at HRI and Ward 17 at HRI, Ward 20 at HRI. Below sets out the overall compliance on each Ward visited:

Traffic Light Score	
	GREEN - 95%
	AMBER - 80- 94%
	RED - 79% and under

	Ward 8B CRH	Ward 5 HRI	Ward 17 HRI	Ward 20 HRI
	Surgical Head & Neck	Medicine Elderly Care	Medicine Gastro	Medicine Elderly Care
	Date: 17th to 21st May	Date of J20: 14th to 18th June	Date of J20: 5th to 9th July	Date of J20: 27th Sep to 1st Oct
Pre-Inspection Data Review	N/A	N/A	N/A	N/A
Onsite Observations	87%	77%	70%	96%
Night Matron Observations	N/A	N/A	N/A	N/A
Medicine Management Audit	88%	75%	94%	97%
Ward Manager Engagement	73%	89%	91%	89%
Medic Engagament	58%	73%	77%	N/A
Staff Engagement 1	84%	77%	71%	93%
Staff Engagement 2	N/A	97%	65%	94%
Patient Record Audit	91%	80%	72%	83%
Observe & Act	N/A	N/A	N/A	N/A
Overall Compliance Score	80%	81%	77%	92%

All visted wards have action plans in place to ensure progress is made against any non-compliance. Monthly meetings have been initiated within the division of Medicine to ensure Ward Managers and Ward Matrons are held accountable for all action plans.

All visited ward areas are due to give a full update regarding their position against compliance at the October CQC & Compliance Group.

CQC Insight Report

The most recent CQC Insight Report was published in September 2021 with the previous report been published in July 2021. The insight report indicators and outliers continue to be monitored via the CQC and Compliance Group.

CHFT Performance Summary:

Trust level rating:	Safe	Effective	Caring	Responsive	Well led	Overall
Date of last inspection: 03/04/2018	RI 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018

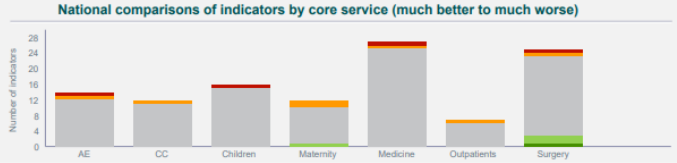
Outliers, trust wide and core service indicators

• There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 72 trust wide indicators, 4 (6%) are categorised as much better, 0 (0%) as better, 5 (7%) as worse and 4 (6%) as much worse. 57 indicators have been compared to data from 12 months previous, of which 6 (11%) have shown an improvement and 1 (2%) have shown a decline

Much better compared nationally	Much worse compared nationally	Improved	Declined
• Hospital Standardised Mortality Ratio (HSMR) • Stability of non clinical staff • Sick days for medical and dental staff-[set target 3.5%] (%) • Hospital Standardised Mortality Ratio (Weekday)	• CAS alerts closed late in preceding 12 months • CAS alerts not closed by the trust more than 12 months before • Whistleblowing alerts • CAS alerts not closed by the trust in the preceding 12 months	• Never events (total events with statistical comparison to bed days) • Health & wellbeing • Never events (total events with rule-based risk assessment) • Morale • Safety Culture • Stability of non clinical staff	• Stability of other clinical staff

For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:



Central Alert Systems (CAS) Alerts

CHFT continue to be performing much worse compared nationally in relation to actioning and completing CAS Alerts, this continues to be monitored monthly via the CQC & Compliance Group.

Below sets out the Trusts position as of 13th September 2021:

Alerts	
2	Overdue
3	Open and within timescale
3	Closed

The following patient safety alerts are currently overdue:

Issued	Completion Due Date	Alert Title	Current Status	Progress
3 March 2020	5 March and 3 June 2020	NatPSA/2020/001/NHSPS Ligature and ligature point risk assessment tools and policies	OVERDUE – Anticipated closure for October 2021	**Lead:** Janet Youd **September 2021 update**: The ligature rescue packs have now been delivered, and yet to be placed on resuscitation crash trollies - this is being followed up. The ligature policy went to the Health and Safety Committee on 18 August 2021 and work still needed on risk assessment tools / audits. This cannot be submitted to the Weekly Executive Board (WEB) until all elements are complete.
13 Aug 2020	13 May 2021	NatPSA-2020-005-NHSPS Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	OVERDUE	**Lead:** Dr Julie Kyaw-Tun **September 2021 Update**: Draft standard operating procedure and draft risk register entry produced and circulated to task and finish group, and also forwarded to Divisional Directors and Associate

				Directors of Nursing on 13 August 2021 for support and review of implications in their areas, and to identify any additional areas who may need a supply of cards available. Final agreed draft to be submitted to the Medicines Management Committee (MMC) in September 2021. Screen savers to be established and rolled out following approval from MMC. Further task and finish group to be convened with divisions to assess relevant specialties for prescribing

The following patient safety alerts are currently within deadline date:

16 June 2021	16 November 2021	**NatPSA-2021-003/NHSPS** Eliminating the risk of inadvertent connection to a medical air via a flowmeter	**Action underway**	**Lead**: Medical Engineering and Medical Gases and Non-invasive Ventilation (NIV) Group **Update:** Work underway
25 August 2021	25 November 2021	**NatPSA-2021-009-NHSPS** Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures	**Action underway**	**Update:** discussed at Trust PSQB on Thursday, 2 September 2021, with actions being led by the Infection Control Team
25 August 2021	25 February 2022	**NatPSA-2021-008-NHSPS** Elimination of bottles of liquefied phenol 80%	**Action underway**	**Update:** discussed at Trust PSQB on Thursday, 2 September 2021. Alert forwarded to Pharmacy, Podiatry, Orthopaedics and Anaesthetics for responses.

Patient safety alerts which have now closed, with evidence reviewed at the Trust Patient Safety and Quality Board:

Issued	Completion Due Date	Alert Title	Current Status	Progress
18 August 2021	20 August 2021	**NatPSA -2021-007-PHE** Potent Synthetic Opioids Implicated In Increase In Drug Overdoses	**Closed**	Alert closed on Datix, as actions of alert fulfilled. Some internal actions are yet to be completed, outside of the remit of the alert.
25 June 2021	17 December 2021	**NatPSA-2021-005-MHRA** Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds	**Closed**	No affected devices at CHFT.
1 Sept 2020	1 June 2021	**NatPSA-2020-006-NHSPS** Foreign body aspiration during intubation, advanced airway management or ventilation	**Closed**	Alert closed on Datix, as actions of alert now fulfilled.

3. Dementia Screening

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
National Driver Dementia screen Target 90%	**September 2021 performance** Medicine 46.28% Surgery 29.23% FSS N/A Trust 42.67%	Dementia screening compliance has been low; however, this is improving with new controls in place. Risk of Dementia Screening compliance declining when new rotational medics start.	▪ The Dementia Lead will continue to focus on dementia screening and will work closely with the medical teams to increase compliance on acute floor and assessment units, including frailty. ▪ Daily email sent for overdue screens to Consultants, Ward Managers and Matrons in these focussed areas. ▪ Surgical division has re-introduced wristbands to highlight patients requiring a screen. ▪ Development of the whiteboard on EPR is ongoing ▪ Increased compliance for doctors undertaking Dementia Screening via the EPR – daily emails sent re incomplete screen ▪ Weekly performance reviewed by Dementia Lead ▪ SOP developed on how to complete screen ▪ Training being developed to be delivered in induction for new rotational medics	**Reasonable Assurance**

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
National Driver - Dementia training Target 95%	Overall compliance for Dementia training across the Trust is **97.22**%.	Not applicable	A full review of how person-centred dementia training can take place across the Trust.	**Substantial assurance**
Local Driver - Person centred dementia care training	This training has always been delivered face to face in small groups of up to 10 people. During the COVID pandemic this training stopped and has now been evaluated so the training can now be re-established in small groups socially distanced	Face to Face training is only in small groups which will take longer to implement due to the numbers in each session. Staffing challenges within the Enhanced Care Team has slowed down the delivery of Person-Centred Care Training.	▪ Training to be arranged for small socially distanced groups once staffing levels in Enhanced Care Team has improved. ▪ Training programme under review to facilitate ease of access ▪ Bite size training under development to support education in practice	**Limited Assurance**
Local Driver - Delirium and Depression screening Target 90%	This is a new indicator: Sept 2021 performance **Depression** / **Delirium** Medicine 3.4% 3.56% Surgery 4.5% 3.82% FSS 14.8% 8.96% Trust 4.4% 3.76%	A more focussed improvement will commence once the dementia screening improvement is sustained	The development of the quality project for delirium Depression, delirium, and dementia to be accessed on EPR.	**Limited Assurance**

4. Patient Experience, Participation and Equalities Programme

Experience, Participation, Equalities – Bi-monthly highlight report Aug / Sept 2021

Workstream	Progress this period	RAG	Next Period
Strategy, Policy & Programme	• Second meeting of the Patient Experience & Caring Group (PE&CG) held 2.8.21. This had a focus on the corporate programme reporting in line with the revised structure of the meeting alternating between Corporate and Divisional reporting. • September meeting was stood down due to clinical pressures		• First versions of Divisional reports to be received at the November meeting based on revised reporting format, covering Experience, Participation, Equalities • Further work required to finalise the Strategy
Equality	• **Ethnic Diversity Index (EDI):** Position remains the same - Initial indications is that there appears to be a higher level of advocacy amongst the BAME community than the non-BAME when it comes to making complaints; Maternity specific complaints –are too few complaints to draw any conclusions around IMD or ethnicity • **Equality Delivery System (EDS):** Planning underway for the EDS community events. Dates for these have been agreed - Kirklees: Tuesday 11th January p.m. Calderdale: Tuesday 7th Dec a.m. • **Impact Assessments:** PMO continue to monitor usage and receive feedback reporting via the quarter report to quality committee		• **Ethnic Diversity Index (EDI):** This remains on the agenda for the Health Inequalities group, however it is on hold awaiting for a new appointment to the senior manager in the Quality and Safety team • **Equality Delivery System (EDS):** Sessions will be themed around Reset and Recovery after the Pandemic • **Impact Assessments:** Being undertaken regarding the proposed building work for the new A&E at HRI which will impact on access to a number of services on South Drive
Experience	• **Commitment to carers (unpaid):** First meeting of the group held 26.8.21. Agreed proposal for a 2 phased approach • **Making complaints count:** Due to changes to the operational lead for the programme the plan has been reviewed and some slight amendments made. This also reflects the output from a 3Rs stocktake • **Winter and Covid Volunteering programme:** Ward volunteer helper role now in SAU & 17 at HRI and 6AB & 3 (Paediatrics) at CRH. Induction of volunteers to commence on ward 20 HRI		• **Commitment to carers (unpaid)**: First meeting generated a lot of discussion and points for consideration; second meeting will include attendance from NHSEI North East and regional carers team • **Making complaints count:** Plan has been revised with Lead Nurse, Quality Directorate and Head of Complaints. Next steps is to outline how Divisions can support the plan • **Winter and Covid Volunteering programme:** Focus on exit strategy with Workforce & OD ahead of the project completing at the end of November

Experience, Participation, Equalities – Bi-monthly highlight report Aug / Sept 2021

Workstream	Progress this period	RAG	Next Period
Experience / Participation	• **Improving the experience of patients with visual impairment:** Four organisations (Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network) held their second meeting to review the feedback from the service user engagement events, current focus is signage / orientation and staff awareness • **Observe and Act (O&A):** The programme was paused for 5 weeks due to the clinical pressures and is now back in place; Excellent engagement from the virtual observers, with positive feedback regarding the valuable insight into patient /staff interactions ,patient experiences and team working in these challenging times.		• **Improving the experience of patients with visual impairment:** Signage within CRH has been recorded on video and will be shared with a group of services users for their views / feedback • **Observe and Act:** Programme revised to enable alternate visits across medical and surgical wards; Continue to pull any themes from the feedback (information regarding Nutrition has been shared with Nutritional steering group and informed a need to support preparation for and assistant with mealtimes)
Participation	• **Engagement activities:** Patient Experience and Transformation team working together to maintain connections with Calderdale CCG Engagement Co-ordinator and Involving People Network; Developed an outline document to create a better understanding of Engagement and Participation and a suggested style for capturing activities • **BAME:** Trust BAME Community Engagement Advisor is creating engagement opportunities with the local BAME communities, e.g. Community centres in Huddersfield and Calderdale such as Women's Activity Centre (organisation which supports women from South Asian backgrounds exposed to social isolation and deprivation)		• **Engagement:** Captured a list of engagement activities, these need to be reviewed and detailed within a central reporting system • **BAME:** Agree a reporting route for patient experience insight gathered by the BAME engagement officer through these engagement opportunities

Experience, Participation, Equalities – Highlight Report Aug / Sept 2021

Workstream	Progress this period	RAG	Next Period
Continuous quality improvement	• **Friends and Family Test:** Continued month on month progress with number of responses for each service; Revised targets introduced based on national averages – these have been built into the IPR and also KP+ • **Chaplaincy:** Band 7 Chaplaincy lead recruited • **Every story matters:** Changes to the senior staff who were taking this project forward has resulted in delays to the introduction of this process (receiving 'stories' in the organisation and identifying organisational learning) • **Learning lessons to improve patient experience:** An impact story per month has been produced, along with a 'You Said, We Did' version for IPR. These are being captured in the Sharing Learning Improving Care pages on the intranet. Other elements of the learning lessons activities are paused due to current staffing pressures in the team • **Visiting:** Task and Finish group set up to see how we can progress with opening up visiting safely • **Relatives' Line:** -. As part of Business Better Than usual quarterly review graded as amber purely based on the staffing levels which are not reflective of what was agreed at CISG when the business case was approved		• **Friends and Family Test:** Promote understanding of the revised targets • **Chaplaincy:** Recently appointed Lead Chaplain to commence a review of the NHS Chaplaincy guidelines 2015 • **Every story matters:** Pilot of a slightly revised process, along with the first story to be shared at the next Patient Experience and Caring Group • **Learning lessons to improve patient experience:** Production of themed Newsletters remains paused. Continue with impact stories monthly; A relaunch of 'learning' to be planned, for later in the year, including building capacity & capability • **Visiting:** Work closely with Divisions to plan an equitable way forward • **Relatives' Line:** Exploring ways in which the Relatives' Line can be supported with redeployed staff from the divisions as currently operating on 50% Workforce model

RAG rating (progress against next period actions) : None of the actions delivered, no plan in place, Some actions delivered, with plan for others, All actions delivered, Project complete

Risk/ Issue	Risk Owner	Action	Progress
Due to work on Covid 19 and limited capacity, certain projects have had to be paused	Lindsay Rudge	The programme plans remain under review / prioritisation by the Patient Experience & Caring Group	A revised programme plan is in progress. But further adjustments can be expected

5. Patient Advice and Complaints Service (PACS)

CHFT views any complaint as an extension of our service user's care and the Trust is committed to moving towards a user centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints is pivotal to organisational learning success.

Key Objectives

The Patient Advice and Complaint team's main objectives are:

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance and user centric service	**REASONABLE Assurance**	Progress continues and implementation of new processes is underway with a continued improvement in performance which has resulted in an increase from red to amber in the assurance rating
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/ quality priority	**REASONABLE Assurance**	Good progress.

Progress against key objectives

Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	August	September
Complaints received	41	44
Complaints closed	49	29
Complaints closed outside of target timeframe	24	9
% of complaints closed within target timeframe	51%	69%
Complaints reopened *[1]	10	11
*[1] Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	145	169
Compliments received	62	49
PHSO complaints received	0	1
PHSO complaints closed	0	0
Complaints under investigation with PHSO	1	1

Making Complaints Count Collaborative

The Making Complaints Count (MCC) steering and operational groups are currently being reviewed to ensure effective use of colleague input across both groups. Implementation of focussed process improvements continues. Please refer to the quality priority update for further detail.

6. Legal Services

Introduction

Calderdale and Huddersfield NHS Foundation Trust is committed to:

1. Promoting the highest possible standards of care for patients in an environment that is safe and effective for staff and visitors.
2. Dealing with claims that arise in a competent and consistent manner, in a culture of openness between the parties to facilitate early resolution, and thereby minimise the financial loss to the Trust / NHS Resolution (NHSR)
3. Using learning arising from claims and inquest investigations to promote improvements to the quality of care provided to patients.

Recent Data

This report covers the period **1 August – 30 September 2021**.

Clinical Negligence

- 174 active clinical negligence claims
- 7 new clinical negligence claims were received
- 8 clinical negligence claims were concluded
- Damages totalled £250,822

Employers' and Public Liability (EL/PL) Claims

- 21 active EL/PL claims
- 0 new EL/PL claims were received
- 2 EL/PL claims were concluded
- Damages totalled £2,500

Inquests

- 166 active inquests
- 14 inquest files were opened
- 10 inquest files were closed

Forward plan

Previous work, including benchmarking against the GIRFT/NHSR "Learning from Litigation Claims" best practice guide, has been shared with the new Head of Legal Services and will assist in looking at the current service provision, aiming to develop towards good practice standards and, thereafter, best practice. This will build upon the existing improvement programme as detailed below.

Assurance

Appendix A: Legal services improvement programme

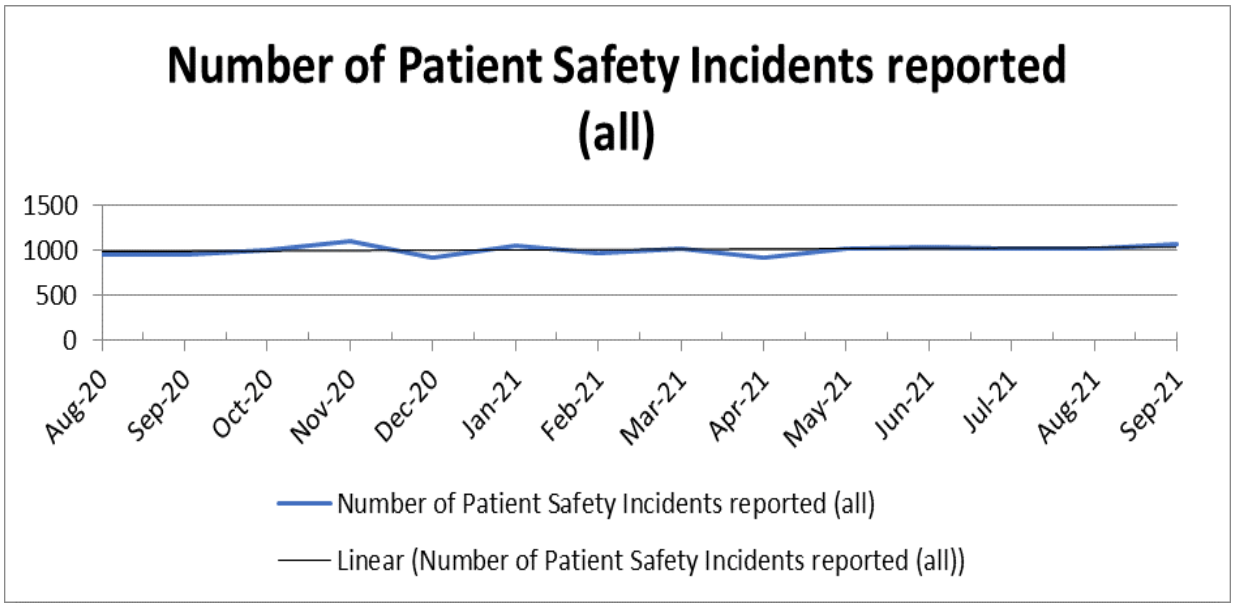
Objective	Comment	Progress	Assurance
Improve communication and response times between legal team and third parties / external partners	0.6 WTE Band 3 commenced 1.6.21, induction carried out and some early progress made.	Effectiveness increased in the 3 days per week in question.	Limited assurance
Improve response time in dealing with request for disclosure of patient records, reduce complaints and missing records	Induction and training required for colleagues who join the department on a temporary basis has been reviewed.	Refresher sessions commenced for all staff handling disclosure issues, in conjunction with and thanks to the Access To Data team.	Limited assurance
Ensure consistent use of Datix for case handling and document storage	Encouraging greater attention to detail and recording of routine correspondence. Assistance with objectives above will allow more time to be spent ensuring files are up to date.	With assistance of 1 above, now showing consistent signs of improvement.	Limited assurance
Ensure learning for legal activity is captured	Meeting with executive team and key partners to share best practice. Case management system needs more robust use in first instance to identify learning to be conveyed.	More robust use of case management system commenced.	Limited assurance

7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year August 2020 to September 2021, and number of serious incidents (SIs) reported by month.

Following review, the number of incidents resulting in severe harm or death during the period reported has been amended to reflect the current position, post investigation.

Month reported	Number of Patient Safety Incidents reported (all)	Number of Patient Safety Incidents of severe harm or death	Serious Incidents by the month externally reported on StEIS
Aug 2020	958	2	2
Sept 2020	958	5	4
Oct 2020	997	6	2
Nov 2020	1102	25	1
Dec 2020	911	13	3
Jan 2021	1045	31	5
Feb 2021	971	18	2
Mar 2021	1024	5	2
April 2021	917	5	4
May 2021	1015	6	2
June 2021	1033	8	6
July 2021	1017	4	3
Aug 2021	1010	7	2
Sept 2021	1068	13	4



Never Events

No further Never Events have been reported during August and September. The Never Event related to the delay in identifying a retained guide wire was highlighted in the last report.

Summary of Progress with Serious Incident Actions

- Work continues across divisions to manage outstanding actions. There is a recognition of the operational pressures and the impact this is having on the management of serious incidents. The risk team are providing support to clinical teams. There are plans to work closely with the divisions to ensure a consistent process across the trust and ensure all actions are responded to in a timely manner, with robust evidence.
- A total of 6 StEIS (Strategic Executive Information System) incidents were reported; 2 for August and 4 in September.

Learning from Serious Incidents

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in August 2021 and September 2021 are as follows:

Incident Summary	Learning Need and Organisational Learning
A failure to escalate high NEWS and recognise deterioration due to infrequent observations.	Prompt escalation of the deteriorating patient as per the policy enables the relevant specialist to assess the patient and implement treatment or interventions in a timely way to maximise the potential benefits to the patient. Comprehensive and timely documentation of your decision-making is essential to support effective communication with your colleagues and other teams and to retrospectively understand decision-making
A failure to report the neck component (section of the scan) therefore missing neck lymphadenopathy which could be an indication of cancer.	The Radiology reporter should ensure the full imaging is reported. The requester of the diagnostic test/scan should ensure they receive everything that they have asked for.
A failure to review medication history and stop anticoagulant medication.	Take care to ensure the most recent scan results are reviewed. Discuss with colleagues where an error has been made to agree an appropriate plan. Patient safety is the key factor, and time of night should not influence appropriate action being taken.
HSIB Maternity investigation: Shortness of breath and collapsed post-emergency caesarean section. Cause of death Pulmonary Embolism.	HSIB did not make any safety recommendations in respect of this investigation. CHFT have updated the anticoagulant (Fragmin) policy and timing of prescribing post-operatively and added to the WHO checklist. Audit is planned. The conclusion is however this change in practice would not have prevented the fatal PE in this case.
Methicillin-Susceptible Staphyloccus Aureus (MSSA) Catheter-Related Blood Stream Infection (CRBSI)	It is important to document the verbal and written information given prior to PICC line insertion has been given to the patient and that the information was understood Early involvement of the multi-disciplinary team for advice particularly in rare conditions.

8. Medicines Safety

The Medication Safety and Compliance Group (MSCG) continues to raise awareness of the importance of safe storage, prescribing and administration of medication.

The priority MSCG work streams are:

- Development of an electronic recording solution for controlled drug (CD) registers to improve our CD documentation and compliance with legislative requirements. Planned for completion November 2021
- Phase one of installation of electronic medication storage cabinets. This first phase is for installing the required cabinets in our Emergency Departments (ED) to ensure we have robust storage facilities, reduce risk of medication error selection, reduce risk of medication diversion and free up nursing time to care. Installation planned for HRI ED November 2021.
- Go-live for active temperature monitoring for medication stored in fridges and then expansion of system to include ambient temperature monitoring

Main concerns / escalations:

- Lack of quoracy at MSCG due to gaps of divisional / cancellation of last meeting due to operational pressures. Pharmacy leading on all current medication safety work streams. Refresh needed to ensure medicines safety priorities are viewed as a multidisciplinary responsibility
- Training requirements of ward staff for use of electronic CD registers and Active temperature systems. Both systems due to go live in the next three months and will require release of ward staff to complete training.
- Escalation process for receipt and action of fridge temperature deviations out of hours to be agreed. Nursing staff struggling to take on this responsibility. To action alerts requires an on-site presence i.e., to check fridge door closed. Medical Engineering and Pharmacy not on-site out of hours.

Medication incidents

Reporting of medicine incidents continues to fluctuate. Peak in June 2021 (112) with incidents linked to administration or nursing tasks.

Incidents where medication was involved from last financial year to date by Level of harm and Reported date (Month and year)

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Total
No Harm	54	84	94	94	117	102	73	97	95	68	59	85	100	85	105	88	77	62	1539
Minor Harm	4	9	8	6	7	4	8	10	9	3	8	7	10	8	7	14	5	4	131
Moderate harm	0	1	0	1	1	1	0	2	1	0	3	1	1	0	0	2	2	0	16
Severe harm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Catastrophic or Death	0	0	0	0	0	0	0	0	1	2	1	0	0	0	0	0	0	1	5
Death - not caused/related to incident	0	0	0	0	0	0	0	0	1	0	0	0	0	2	0	0	1	0	4
Total	58	94	102	101	125	107	81	109	107	73	71	93	111	95	112	104	85	68	1696

Issue	Update	Risks	Mitigations	Next steps	Assurance
Non-compliance of the medicines management 'must do's **Ongoing objective requiring continual monitoring**	Bi-annual pharmacy audits continue to be completed and highlight both areas of good and poor practice. Electronic medication management audit tool development now complete and tested. ADNs asked if appropriate to commence audit in Oct 21 or, due to current pressures, delay until April 22. FSS support to commence now. Response from meds and surgery awaited (at time of report) Spot checks have reported a mixed level of compliance and some historic issues (previously highlighted by CQC) emerging i.e Ward 21 - TTO's left out in the clinic room, date of opening / expiry not documented on liquid morphine, alarm had been switched off on the temperature monitor as the min/max temperatures were incorrect, trolley not locked, loose strips of medications, out of date tranexamic acid and cyclizine.	Audits only give a snapshot of routine practice	Ad hoc spot checks by pharmacy team and senior nurses to ensure required standards are consistently met The Journey to Outstanding (J2O) has commenced, with checks being undertaken in clinical areas.	ADNs to confirm whether to commence audit Oct 21 or delay until April 22. Next steps depend on response to above. Where spot checks have highlighted issues / concerns, reported to ward manager and action plan agreed. Results of medicines management section of J20 reports to be fed into MSCG	**LIMITED ASSURANCE**

Issue	Update	Risks	Mitigations	Next steps	Assurance
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance. **Go live for Active temperature monitoring system- target completion date delated from Aug to Nov 21**	Temperature assets placed in clinical areas for monitoring ambient temperatures to identify any potential areas of noncompliance before system go live. SOP for how to access and update active temp system shared with Digital Ops board and Nursing and Midwifery Committee for approval Staff identified who need training. Training module being developed and tested. Quote (£10,000) received from Stanley Healthcare to integrate the alerts to Cisco phones.	Staff may tamper with new temperature devices as they may not know what they are Staff have turned off current' traditional' fridge thermometer alarms (reliant on for manual monitoring of fridges until the active system go live). This results in no audible alarm i.e., when fridge door left Once we go live with ambient temperature monitoring there is a financial risk for any areas whose temperature is consistently above 25 degrees Celsius as they may need air con installing	Screensaver and comms issued to clinical staff showing pictures of monitoring devices including instruction stating not to tamper with devices Daily manual recording of fridge temperatures continues until active system Go Live Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded For any areas storing meds at higher than recommended temperatures, there is a pharmacy led process of reducing expiring dates (depending on exposure length and temp reached). This carries the added risk of increased waste of medication/ cost	Not all areas have Zebra devices, (used to receive temperature alerts) options for those areas to be reviewed including potential to send alerts to CISCO phones. To discuss if funding available from Scan4safety to support integration of alerts to CISCO phones. Out of hours process (for receipt and action of alerts) still not agreed. Nursing teams suggest they don't have capacity, medical engineering not available OOH and suggestion that should be on call pharmacist responsibility (but they are not on site and so would still need on-site staff to check fridge i.e., is door closed properly etc Requirement for clear process and escalation to be agreed.	**REASONABLE ASSURANCE**
To improve medical gas training to ensure compliant with HTM requirements	SWAY oxygen training completed. New Oxygen HSIB report received which includes recommendations to update the Medical gas HTM and also the national template for Medical gas group ToR DNO virtual group formed – holding bi-annual meeting at which updates on relevant oxygen and	Not all clinical staff may be up to date with training	Completion of Datix reports when any incidents relating to medical gases including poor practice occur	Next steps to take training package to the Nursing and Midwifery Practice Education Group for approval. The training will be via the internet, with completion of the embedded questions as proof of training. Managers would then submit a declaration to ESR for monitoring. Promotion of the training would include posters, bite size info on the monthly newsletters, block emails to managers, etc, and their ESR would be put on red until it completed Await national updates to HTM and Medical Gas Group ToR (as per HSIB	**LIMITED ASSURANCE**

Issue	Update	Risks	Mitigations	Next steps	Assurance
	medical gas information shared Oxygen incidents continue to be recorded on Datix			report recommendations)	
Requirements for areas administering Entonox and nitrous oxide to complete annual occupational exposure checks	Site visits completed by Peritus. Compliance report produced for HRI and CRH. HRI report showed no major concerns. CRH reported one area of high exposure. EQUANs asked to check for leaking pipes and then arranged for repeat testing by Peritus, Initial report showed nitrous oxide levels to be higher (23%) than recommended levels (10%).	Not all staff using gas were tested (just a sample) and exposure levels were dependent on amount of Nitrous oxide/ Entonox being used during the clinical session. The test may have been completed on a day of 'light' exposure/ low gas use	Good ventilation in NO/ Entonox areas Repeat testing in 12 months	Awaiting results of repeat test in maternity area.	**SUBSTANTIAL ASSURANCE**

9. Maternity Services

Ockenden report

The site visits by the Regional Chief Midwife and her team proposed for the end of July 2021 have been temporarily suspended in response to the continuing operational pressures across health care.

The Perinatal Quality Surveillance Meetings continue to be held monthly with attendance from CHFT maternity safety champions CCG and LMS colleagues. The agenda for the meetings is continuing to be revised and developed following each meeting.

NHSEI's workforce department have released the first allocation of funds to support the additional 10.9 wte midwives received by CHFT as part of the national additional funding to support improvement in maternity services. These additional posts have now been advertised, however, to date we have received no applicants for the posts. The advertisement remains in the public domain.

Maternity services nationally have also each received an additional £50 000 non-recurrently specifically to support the recently appointed newly qualified midwives in their first year of professional practice. This is in recognition that these staff experienced severe disruption to the final year of their undergraduate training programme as a result of the Covid- 19 pandemic. CHFT maternity services will use the funding to recruit 40 hours of Band 6 midwifery practice educators to work alongside the new registrants.

Better Births – Continuity of Carer (COC)

Maternity services are continuing to work towards the ambition that all women will be placed on a COC pathway by March 2023. We currently have four teams with approximately 24% of women and approximately 48% of women from a BAME background placed on a COC pathway each month. Whilst committed to COC there are well recognised difficulties in implementing the vision associated with the fulfilment of the required staffing levels, staff engagement and the education and training of midwives; issues which have been recognised in the Health and Social Care Committee's "Inquiry into Safety of Maternity Services in England" published in July 2021. With this in mind maternity services would plan, with Board approval, to implement continuity in the antenatal and postnatal period to all women in the first instance and move towards intrapartum continuity when all midwives are skilled to care for women in all care settings.

NHS Resolution Maternity Incentive Scheme

The requirements for Year 4 of the scheme were released in August 2021 with a planned submission date of June 2022; however maternity providers are awaiting an update to the requirements in light of the ongoing challenging operational pressures. Maternity services have however instigated a task and finish group to monitor completion of the elements of all 10 safety actions as they are currently described.

Healthcare Safety Investigation Branch (HSIB)

As of 10th October, the maternity services position is:

Cases to date	
Total referrals	28
Referrals / cases rejected	5
Total investigations to date	22
Total investigations completed	16
Current active cases	7 (1 x on hold, 1 await family contact and consent)

Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents.

	Total
PPH- no adverse outcome	13
Shoulder Dystocia	10
Unexpected admission to the Neonatal Unit	18
2nd Theatre opened	1
3rd or 4th Degree perineal tear	5
Delay in Emergency Caesarean Section	3
Total	50

Maternity Complaints

Maternity services currently have 10 open complaints as of 5th October 2021 under investigation all of these within timescale.

Maternity Staffing

In 2015 NICE produced it's guidance on safe midwifery staffing and the provision of 1:1 care is a recognised recommendation within the guidance and as such is reported on the maternity services dashboard.

	Dec 2021	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021	July 2021	Aug 2021	YTD
1:1 Care in labour	100%	100%	99.7%	99.7%	98.9%	100%	99.5%	98.2%	98.9%	99.2%

Unfortunately, this metric is not recorded on the regional dashboard, so it is not possible to benchmark CHFT against other services.

Midwifery has recruited 13 wte newly qualified midwives as part of the Local Maternity System (LMS) wide recruitment that is coming into post in the current month. Midwifery staffing remains challenging due to increase levels of staff absence. This is being recognised across the LMS and a daily maternity sit rep has been devised to monitor activity and acuity across maternity units within the LMS.

User feedback

Following the 12th April mandate from the Secretary of State for Health for the full introduction of support for pregnant women accessing maternity services maternity services are able to report that birth partners can support women at all contacts throughout their

pregnancy journey both in the hospital and community environments. The current visiting restrictions in maternity services are being reviewed as part of the trust wide review of visiting at CHFT.

The MVP is currently reviewing the maternity services page on the external trust internet site. The review is in response to an action from the Ockenden Report, for a benchmarking of maternity services web pages against those of the Chelsea and Westminster Hospital.

10. Quality Priority updates

Set out below is the first report in relation to the Quality Account Priorities for 2021/2022. The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

Quality Account Priorities

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Experience
Recognition and timely treatment of Sepsis 	**Reduce the number of Hospital Acquired Infections including COVID-19** 	**Reduce waiting times for individuals in the Emergency Department (ED)** 

Focussed Quality Priorities

CQC Domain: Caring	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Responsive	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Effective
Reducing the number of Falls resulting in harm 	**End of Life Care** 	**Increase the quality of clinical documentation across CHFT** 	**Clinical Prioritisation (Deferred care pathways)** 	**Nutrition and Hydration for in-patient adult and paediatric patients** 	**Reduction in the number of CHFT acquired pressure ulcers** 	**Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)** 

10.1 **Recognition and timely treatment of Sepsis** (Quality Account Priority)

Operational Leads – Dr Rob Moisey and Paula McDonagh

We will this year undertake quality improvements to - Improve the recognition and timely treatment of Sepsis.

What do we aim to achieve?		Update	Progress rating
QP1.	Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60minutes of recognition of sepsis to 80% for the severely septic patient. This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system.	**August 2021 67.5%** **September 2021 68.6%** *(may change as coding data still being pulled through)* The above percentages are based on all patients with suspected sepsis in the Emergency Department (ED) at both sites. Red flag data collection requiring further work to ensure accuracy. **Update** ▪ Collaborative members agreed that red flag data requires qualitative input, ED consultant will audit patients monthly for accuracy. Informatics will add table to input findings. ▪ (ED) consultant monitoring non-compliant patients and feeding back issues at the ED handovers for learning and action. Compliance from this clinical audit indicates ED performance at 85-90% ▪ Consultant also updating ED specific sepsis training presentation for clinicians. ▪ Sepsis nurse liaising with ED matrons regarding progress work. ▪ Sepsis trollies purchased and in use at both sites. ▪ Macoset device being trialled in HRI ED to assist speed in mixing Pip Tazocin, improvements in reducing time noted so agreed to try device in front end areas (SAU and both Acute floors) ▪ Sepsis nurse training the ED health care assistants about NEWS 2/sepsis. ▪ ED clinical educator addressing sepsis on Registered Nurse (RN) induction. **Risks identified** ▪ Flow issues through the EDs have been noted to effect administering of intra venous antibiotics within 60 minutes. ▪ Consistent use of sepsis trollies and storage space when not in use so are now using trolley in Red resuscitation where the sickest sepsis patients are treated. **Actions** ▪ (ED consultant) to monitor that suspected sepsis patients are categorised as level 2 and seen in rapid assessment where appropriate. ▪ ED Consultant to report results of noncompliant patients in ED monthly plus feedback issues to ED clinicians. ▪ Lead Sepsis Nurse to oversee and support consistent use of sepsis trollies. ▪ Lead Sepsis Nurse to meet with clinical commanders to discuss flow issues	**Reasonable Assurance**

What do we aim to achieve?		Update – June 2021		Progress rating
QP2.	Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50% **single elements to be improved to 90%**	**August 2021**	**September 2021**	
	Blood cultures	79.4%	78.3%	**Reasonable**
	Urine output	54.2%.	78.3%	**Reasonable**
	Fluids	94.4%.	100%	**Substantial**
	Antibiotics	98.1%.	100%	**Substantial**
	Lactate	Unable to add Lactate to EPR		
	Oxygen	85%.	93.5%	**Substantial**
	Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Update** ▪ Oxygen data now being reported on compliance if received oxygen or the patient's oxygen saturation is between the target of 92-98% or 88-92% (risk of hypercapnic respiratory failure). Some improvement noted, agreed to wait for next month's data results and audit 20 non-compliant patients to check if any issues/learning points within the data pull from EPR. ▪ Sepsis care bundle addressed on training and through communication channels (Trust News, Sepsis Press, Sepsis Teams Channel, Training, poster drops, ward meetings). ▪ Business case completed for Point of care testing (Lactate), Rob Moisey and Luke Stockdale to deliver presentation for funding application, cost £80K ▪ Sepsis nurse working to improve recording of blood cultures as compliance variable- focussing on the front-end areas. 20 non-compliant patient audit completed. ▪ Sepsis nurse attended Chief Nurse band 7 forum to deliver information about 3 sepsis QP and how ward and department managers can influence clinicians using the sepsis screening tool and prompt their staff to complete their sepsis essential training when on ESR. **Risks identified** ▪ Blood cultures not always taken or consistently recorded on EPR. ▪ Urine output pulling through to Nerve centre. ▪ Awaiting Lactate to be added to EPR. **Actions** ▪ Application presentation for funding- Point of care testing. ▪ Sepsis nurse to further highlight that patients with suspected sepsis require blood culture sampling. ▪ Lead Sepsis Nurse to continue working with front end areas regarding improving the recording of blood cultures on EPR. ▪ Urine output being addressed by separate working group.	

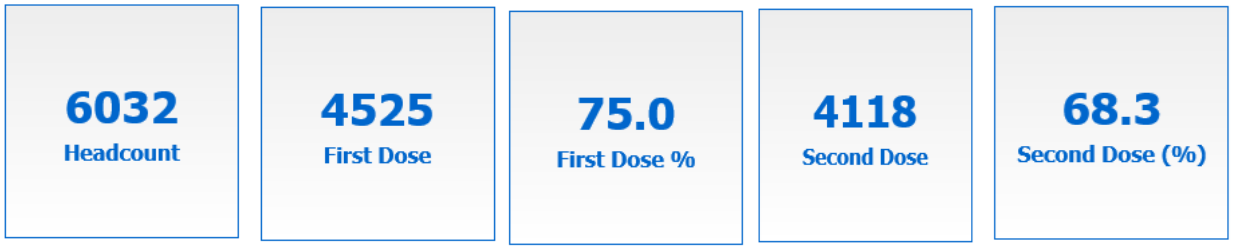
What do we aim to achieve?	Update – June 2021	Progress rating
QP3. Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations.	**Update** ▪ Training application form for ESR and combined sepsis presentation for clinicians/registered nurses approved by Sepsis Collaborative Members. 250 RN have received sepsis training, there are currently 9 clinician sepsis champions and 45 RN champions. Sepsis nurse meeting with Divisional Matrons to deliver sepsis updates. ▪ Junior doctor induction- EPR sepsis power plan is in the handbook with video link to training presentation. EPR team asked to raise the importance of viewing the slides during the Induction programme. ▪ Business intelligence have now provided the training numbers: - Consultants (except Obstetrics and Gynaecology) 250 - Foundation years (except Obstetrics and Gynaecology) 82 - CT (except Obstetrics and Gynaecology) 31 - ST (except Obstetrics and Gynaecology) 69 - Clinician Total **432** - Registered Nursing Total **672** **Risks identified** ▪ Sepsis recognition and treatment not currently part of essential safety training. ▪ Delay due to EST upgrade, decision to separate clinician and RN sepsis training at August Collaborative meeting so further work required to action, sepsis nurse will aim to complete before EST upgrade finishes in 4 weeks. **Action** ▪ Lead sepsis nurse to complete separate clinician and RN training presentations ▪ Lead Sepsis Nurse to continue delivering face to face and Teams sepsis training.	**Limited assurance**

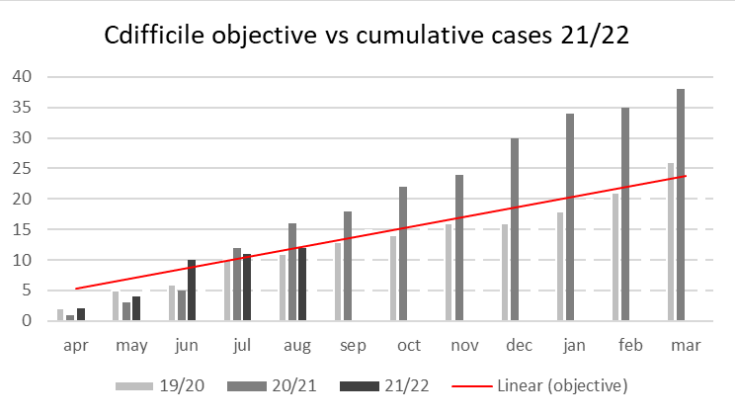
10.2 Reduce number of Hospital Acquired Infections including COVID-19 (Quality Account Priority)

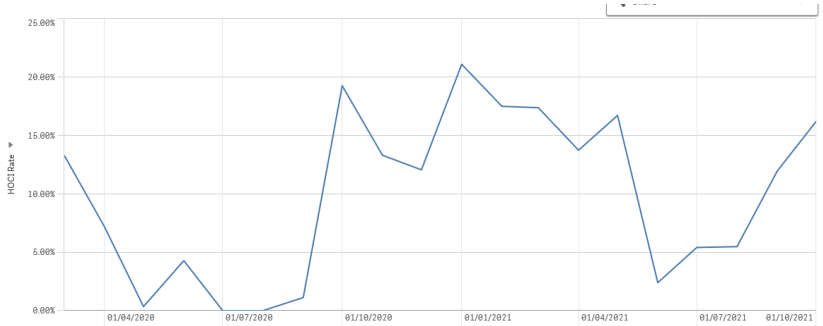
Operational Leads – Lindsay Rudge, Dr Vivek Nayak and Gillian Manojlovic

We will this year undertake quality improvements to - Reduce the number of Hospital Acquired Infections including COVID-19

What do we aim to achieve?	Update	Progress rating
QP1. Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes.	CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of our local guidance	**Full assurance**
	Lateral Flow Device (LFD) testing is in place as per national guidance for staff. This is to be encouraged with staff but is not mandated. The last data reported identified a decreasing trend for LFD. We are no longer able to track this data due to staff being instructed to upload results onto the National portal. Continuing actions taken to promote LFD uptake include communication via leadership briefings and the MUST Do messages.	**Reasonable Assurance**
QP2. Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme.	The trust continues to plan for its vaccine programme and will implement this alongside national guidance. Staff vaccination booster clinics have been opened (27/09/21)	**Substantial assurance**
2a Establish specialised vaccine clinics for people with Learning Disabilities (LD)	Specialised clinics have been established to support people with a learning disability to receive their vaccines and will be included in future planning	**Substantial assurance**

What do we aim to achieve?	Update	Progress rating
2b Establish clinics for people with allergies	Specialised clinics for patients with multiple allergies and/or previous anaphylaxis were undertaken, again outside of the routine clinics, supported by a Consultant Anaesthetist, senior nursing, and administration staff. A total of 17 allergy patients have been through the clinics. The final allergy clinic session was on the 28 June 2021 for the administration of second doses. All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital.	**Full Assurance**
2c Through our community teams support the vaccine programme across Calderdale	The community healthcare division has proactively supported the vaccination programmes across Calderdale place and has included this in the system wide winter planning.	**Substantial assurance**
2d Through our partnerships support the vaccine programme across Kirklees	CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme	**Substantial assurance**
This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available.		

What do we aim to achieve?	Update	Progress rating
QP3. Reduce the number of preventable Clostridium Difficile infections This will be measured by ensuring we do not exceed the threshold of 22 cases set in 20/21	A 'deep dive' of the 49 C-diff cases from 2020/2021 was undertaken in May 2021; key learning was identified, and an action plan has been developed which is being led by the Infection Control Doctor/Consultant Microbiologist. The targets have now been published with a C.difficile objective of 22 cases which is a reduction of one case based on the 2019 data of 18 HOHA cases plus 5 COHA cases. These will be monitored in the Integrated Performance Report (IPR) 	**Substantial assurance**

What do we aim to achieve?	Update	Progress rating
QP4. Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI) This will be measured by the rate of HOCI each month.	COVID patient pathways are in place to minimise the risk. Any HOCIs identified are reported immediately and a rapid RCA completed. HOCIs are currently reported weekly to Infection Prevention and Control (IPC) Gold and monthly to IPC Performance Board. Every action count tools are being used to support alongside the updated IPC guidance Lessons learnt from HOCI are shared to support organisational learning. The IPC Board Assurance Framework (BAF) is reviewed within the governance structures. 	**Reasonable Assurance**

10.3 **Reduce waiting times for individuals in the Emergency Department** (Quality Account Priority)

Operational Leads – Jason Bushby, Dr Amjid Mohammed and Jayne Robinson

We will this year undertake quality improvements to - Reduce waiting times for individuals attending the Emergency Department

What do we aim to achieve?	Update – August to September 2021	Progress rating
QP1. Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the ED department This will be measured by: • Number of (NHSE/I) reportable 12-hour breaches	Presented to Data Quality Board in June 2021 that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately. **No change still capturing any LoS >12 hours process is working no patients missed**	**Reasonable Assurance**
• Internal standard: Number of patients who waited >12 hour within the department from time of arrival	Zero tolerance as reportable. There were two patients over 12-hour breaches last month discharged home non-reportable. **All LoS over 720 mins are now captured and reported daily and validated daily to ascertain patient status i.e. admitted/non-admitted no patients with a LoS over 720 mins have been missed/not reported since reporting at point of discharge**	**Limited assurance**
• Training delivered for on-call teams to support implementation of the SOP	Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads. **Update Sept - full ED internal OPEL escalation process developed and now live on EmBeds. Distribution increased to all clinical flow teams next step to include on-call management teams**	**Limited assurance**
QP2. To align reporting systems with Cerner and the DATIX incident reporting system. This will be measured by: • Establishment of >12hr DTA breach report from Cerner that matches incident reporting	New datix format for 12-hour LOS implemented by risk	**Substantial assurance**

What do we aim to achieve?	Update – August to September 2021	Progress rating
QP3. Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration. This will be measured through: • Number of colleagues who undertake training for intentional care rounds	Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success. **Ongoing**	**Reasonable Assurance**
• Monthly audit of patient cases to review compliance with clinical documentation	Care is reviewed via datix	**Reasonable Assurance**

10.4 **Reducing the number of falls resulting in harm** (Focused Quality Priority)

Operational Leads – Dr Abhijit Chakraborty, Helen Hodgson and Charlotte Anderson

We will this year undertake quality improvements to - Reduce the number of inpatient falls and those resulting in harm by 10%, by the end of 2021 / 2022

What do we aim to achieve?	Current update	Progress rating
Reduce the total number of falls. Reduced number of harms falls by 10%.	Developing Falls Link Practitioner (FLP) role for each ward area and in process of developing education programme and contract for FLPs. Call, don't fall posters in use on CRH acute floor as this reduced the number of falls on the ward. Plan to roll this out to HRI acute floor. Plan to implement audits to monitor progress with Lying and Standing blood pressure, medication reviews and mobility assessments. In line with the EPR documentation falls assessment tool workstream, education will be developed and cascaded to staff around how to use the falls assessment tool effectively. This is in the process of being developed. Gathering data from other trusts with inpatient falls teams to develop business case for CHFT inpatient falls team. Liaising with the Therapy Lead re red zimmer frames for patients with a cognitive/visual impairment, awaiting update.	**Reasonable Assurance**
Slip trip policy to include measurable falls assessment risk target	Slip, Trip and Falls Policy is in the process of being reviewed and will include a measurable falls risk assessment target. This will be in line with the EPR falls assessment documentation workstream. Plan to review with Falls Collaborative in November	**Limited Assurance**
Implement audits to check progress against targets	Audits on lying and standing blood pressures, mobility assessments and medication reviews currently being collected on W6, this will be rolled out across the trust once fully established. It's currently difficult to fully audit due to staff documenting in different areas on EPR. This will improve in line with the EPR documentation workstream.	**Reasonable Assurance**

10.5 **End of Life Care** (Focused Quality Priority)

Operational Leads – Mary Kiely, Christopher Roberts and Christopher Button

We will this year undertake quality improvements to:

- Ensure the needs of both the patient and their families/carers does not vary in quality because of an individual's characteristics by ensuring care provision is individualised, timely and relevant.
- Ensure improved resources for relatives and carers relating to breaking bad news relating to End of Life (EoL) care

What do we aim to achieve?	Current update	Progress rating
QP1. Implement a 7-day service across community services Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	7-day service commenced within Calderdale community specialist palliative care (SPCT) in April/May this year. Dashboard to be approved. A prospective audit was undertaken during the months of April and May 2020 at the height of the COVID 19 outbreak at CHFT. The audit was undertaken to determine numerically how many patients benefitted from the 7-day service the team provided at that time, and to capture our work at weekends / bank holidays to showcase the difference the service made to patients, families and colleagues.	**Reasonable Assurance**
QP2. Implement a 7-day service within the in-patient areas Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	Due to current sickness levels in palliative care the move to a 7-day SPCT service has been paused. Modelling has suggested that the current workforce could support a 7-day service, however, due to documented and evidenced concerns a business case for an enhanced SPCT model has been developed and will be submitted in July 2021. September 2021: current workforce still not able to support a 7-day service; further team expansion required and recruitment process continues. Dashboard exists for hospital team performance indicators and data collection, but not yet regularly shared/circulated.	**Limited Assurance**

What do we aim to achieve?	Current update	Progress rating
QP3. Improve access to ePaCCs for patients within Frailty service This will be measured through an audit of records every quarter	ePaCCs is accessible to the frailty team and work is ongoing to make this accessible to clinical staff. Ward 6 and SDEC areas have gained access and teaching provided. The plan will then be to roll this out across elderly care	**Reasonable Assurance**
QP4. Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams This will be measured by qualitative narrative quarterly by EoL care facilitator.	The bereavement service as highlighted in QP5 will act on negative and positive person's experience gained from the bereavement telephone service. Currently the Educational Facilitator and assistant work with wards and groups to improve overall care but specific areas are targeted based on feedback from the bereavement service where necessary. A business case has been prepared and will be submitted to support the maintenance of the bereavement service as 'business better than usual' moving forward. The bereavement service will feed back person narrative and improvements to the End-of-Life Care Steering Group quarterly in a 'you said, we did' style report.	**Reasonable Assurance**
QP5. Review the Bereaved relatives telephone support service This will be measured by a qualitative and quantitative review of the service established during the pandemic	Ongoing review of the bereavement support service. We now have the bereavement service as part of the Datix reporting to enable us to look at trends and implement changes. Writing a business case to look for substantive funding for this service – building back better than usual. Overwhelming positive feedback from the relatives we speak to. Q2 will establish data capture of number of calls undertaken as a percentage of people who died within in-patient areas.	**Reasonable Assurance**
QP6. Review Visitors guidance in line with national guidance and monitor compliance This will be measured by a Quarterly audit of the guidance in relation to EoL patients	Visiting adhered to national guidance. Further local safety issues were taken into consideration when needed. Two general visiting audits were completed in the last quarter 20/21 which highlighted improvements in compliance. From an end-of-life point of view regular audits are completed as part of the bereavement telephone service. Improvements and complements are fed back into the system through the actions resulting from QP4 above.	**Substantial assurance**

10.6 **Clinical Documentation** (Focused Quality Priority)

Operational Leads – Lindsay Rudge, Louise Croxall and Mr Graham Walsh

We will this year undertake quality improvements to: Measure this piece of work is to ensure that the clinical record gives an accurate picture of the patients diagnoses, the care provided to that individual, that it reflects the standards laid down by the Trust and that information is recorded consistently.

What do we aim to achieve?	Current Update	Progress rating
QP1. Optimise the Clinical Record: 1a. Complete the in-depth analysis	Company identified – stuck in the procurement process at the moment. July 2021 – Meeting arranged with company 20.07.21 Sept 2021 – Meeting took place with the company new Chief Nurse Informatics Officer (CNIO), who needs to become up to date with background and then drive this forward to bring a plan back to next meeting.	**Reasonable Assurance**
1b. Benchmark	Subject to the outcome of the in-depth analysis	**Reasonable Assurance**
1c. Set local standards	Subject to the outcome of the benchmarking	**Reasonable Assurance**
QP2. Trial the use of the Digital White Board Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning.	Trial period commenced – end date 15th June 21. July 2021 – evaluation of the trial underway. Sept 2021 – trial completed and Chief Nurse Information Officer (CNIO) and Chief Clinical Informatics Officer (CCIO) to meet to review feedback and discuss future innovations with Cerner.	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
QP3. Carry out a full review of the Ward Assurance within the KP+. 3a. Look at current data captured with service users	This will be reviewed by the SME's and Ward Managers following the Work Together Get Results (WTGR) piece. Work to commence July 2021. July 2021 – Task and Finish Groups to be formed now WTGR completed to look at data capture. Sept 2021- Task and finish groups under way. All first ones undertaken and SME's reviewing the documentation to bring back to next meeting.	**Reasonable Assurance**
3b. Assess whether data relevant	Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls. July 2021 – Task and Finish Groups to be formed now WTGR completed to assess whether data relevant. Sept 2021 – SME's reviewing documentation bring back to task and finish groups.	**Reasonable Assurance**
3c. Agree metrics for collection	Metrics already agreed upon – review of data being extracted. Sept 2021- Metrics may change according to task and finish group decisions. R Cox present at meetings.	**Substantial assurance**
QP4. Ensure Ward Managers and Matrons own their own ward data using KP+ 4a. Ensure that all Ward Managers and Matrons have access to KP+	Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021. July 2021 – engaged with Matrons and Managers – access arranged for those who did not have access. Sept 2021- This has been put on hold until task and finish groups complete there woke to train all staff the correct way.	**Reasonable Assurance**
4b. Provide training in the use of KP+ for Ward Managers and Matrons	This was carried out in November 2020 – further engagement with staff on the 6th August 2021 through Ellen's briefing. Sept 2021- All ward managers have been asked to make sure they have access to KP+	**Substantial assurance**

What do we aim to achieve?	Current Update	Progress rating
4c. Embed review of KP+ into daily practice	This will be an action from the WTGR – start end of July 2021. July 2021 – further training 6th August 2021 at Ellen's briefing. Sept 2021- Once task and finish groups completed this will be a session on Ellen's briefing.	**Reasonable Assurance**
QP5. Audit clinical records using an audit tool. Audit 5 sets of records per week by Ward Manager reporting and act upon findings.	Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021. July 2021 – roll out delayed due to delay in completion of WTGR Sept 2021- As above.	**Reasonable Assurance**
QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust. 6a. Identify the team	This will include Associate Director of Nursing, Matron and Ward Managers across the Trust.	**Substantial assurance**
6b. Identify outcomes wanting to achieve	Working Together Get Results completed at the end of July, face to face to ensure optimum engagement obtained. Action Plan to be completed from the results of the WTGR. Sept 21- Task and finish groups have been established. Which are being led by the subject matter experts	**Reasonable Assurance**
6c. Agree defined goals and action plan that reflects this	Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021. July 21 - Sessions completed end of July – working towards action plan middle of August 2021. Sept 21-. Subject matter experts leading the review of assessment documentation within EPR. Amendments can then be made to extract data at the backend of EPR	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff 7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities	Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and HCA groups as a priority. Some representation from nursing but not medical teams – seeking support from them. July 2021 - Progressing well with projected completion by the end of August 2021. Sept 2021- Training team for digital health are attending ward areas also with set goals to achieve. CNIO working with Matrons and ward manager for the area to make sure correct goals are set. Ward 5 identified as first ward.	**Reasonable Assurance**
7b. Encourage Training Team to explore ways in which service users can be supported e.g., online, face to face, digitally	This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021. July 2021 – E Learning Developer now in post and e learning sessions already underway. Sept 2021- Training team attending ward areas for 3 weeks at a time working with nurses on the ward making sure EPR is being used to its most effective and documentation is all in the correct place.	**Reasonable Assurance**

10.7 Nutrition and Hydration for in-patient adult and paediatric patients

Operational Leads – Vanessa Dickinson, Jonathan Wood, and Dr Mohamed Yousif

We will this year undertake quality improvements to: Deliver safe and high-quality nutrition and hydration care for all in-patients at CHFT.

What do we aim to achieve?	Current update	Progress rating
1. A minimum of 90% of staff required to complete Malnutrition Universal Screening Tool (MUST) training will be compliant	Sep 2021 = 89.5% compliance. Slight month on month reduction	**Reasonable assurance**
2. A minimum of 90% of staff required to complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training will be compliant	Sep 2021 = 80 % static position June 2021 = 73.6%.	**Reasonable assurance**
3. 100% of adult in-patients will have a MUST assessment within 24 hours of admission & weekly thereafter	Sep 2021 = 14.7 % Slight month on month reduction **Mitigation** ▪ Safety huddle inclusion within clinical areas as prompt for completion for clinical staff. ▪ Inclusion within Journey to Outstanding clinical area reviews. **Actions** ▪ The nutritional specialist nurses and dieticians have undertaken some partnership working with Bradford colleagues to review the mandated fields within the MUST assessment to aid with automated calculation of the MUST following completion of 3 mandated fields. The aim is that this will help to improve compliance. ▪ Changes are live and staff are being reminded during other training sessions ▪ WTGR improvement work planned for clinical documentation to include work on nutrition and hydration risk assessment and compliance monitoring. ▪ Task and finish group convened 1/10/21 to address lack of completion of documentation. Further meetings arranged	**Limited assurance**

What do we aim to achieve?	Current update	Progress rating
4. Trust aspiration to achieve 100% of paediatric in-patients having a STAMP assessment within 24 hours of admission & weekly thereafter	Data collated on nutritional dashboard. This data isn't currently available on the ward assurance dashboard on K+, a request was made on 03 June 2021 to include this	**Reasonable assurance**
5. 100% of adult in-patients with a MUST score of 2 or above will be referred to the dietetic service	**Sep 2021 = 2.6% minimal decrease on July 2021 3.1 % compliance** Again, in partnership with Bradford colleagues, if the MUST calculated score is of 2 or above an automatic referral will be populated to the dietetic team who will screen the patients records and determine appropriate action linking with ward areas appropriately. The above figures don't reflect the current position. The automated system has resulted in an increase in referrals daily. Jonathan Wood will investigate this further. This aims to capture a more accurate number of our patients requiring nutritional support from the dietetic team and not be reliant on a separate referral process, as is the system at the current time. This proposed work will be shared with the Digital health group soon. Unsure as to where this data is collated from as it does not match the dietetic workload. Definite increase in referrals noted by dietetic team since auto referral system in place. As part of task and finish group this is being addressed	**Limited assurance**
6. 100% of paediatric in-patients with a STAMP score of 4 or above will be referred for nutritional support (i.e., dietician, nutritional support team or consultant)	This data is not currently available on the ward assurance dashboard on K+, a request was made on 3 June 2021 to include this.	**Limited assurance**

<table>
<tr><th>What do we aim to achieve?</th><th>Current update</th><th>Progress rating</th></tr>
<tr><td>7. A minimum of 90% of staff from wards that are regular users or high users of nasogastric tube feeds will be compliant with nasogastric training</td><td>
June 2021
<table>
<tr><th colspan="5">High Users</th><th colspan="4">Regular Users</th></tr>
<tr><td>17</td><td>ICU</td><td>Paeds</td><td>Comm Paeds</td><td>HOOP</td><td>5A-D</td><td>6AB</td><td>8C</td><td>7AD</td></tr>
<tr><td>93.7%</td><td>56.4%</td><td>75.0%</td><td>91.7%</td><td>83.3%</td><td>68.5%</td><td>21.0%</td><td>53.8%</td><td>71.0%</td></tr>
</table>
Sep 2021
<table>
<tr><th colspan="5">High Users</th><th colspan="5">Regular Users</th></tr>
<tr><td>17</td><td>ICU</td><td>Paeds</td><td>Comm Paeds</td><td>HOOP</td><td>5A-D</td><td>6AB</td><td>8C</td><td>7AD</td><td>20</td></tr>
<tr><td>88.5%</td><td>56.2%</td><td>71.4%</td><td>91.7%</td><td>83.3%</td><td>78.4%</td><td>21.0%</td><td>57.1%</td><td>80.9%</td><td>67.7%</td></tr>
</table>
There has been a reduction on ward 17 due to new starters. Nutritional specialist nurses has started to train these and expects numbers to increase shortly

Improvement has been seen on respiratory floor and stroke floor , other areas remain static

Nutritional specialist nurses has undertaken a period of intense training with staff on ward 20 & 15 and have now reached 67.7%

Divisional reporting via dashboard and monitoring monthly compliance.
Initial training and ongoing management undertaken by Nutritional specialist nurses via simulation session.
Update training undertaken every 3 years is undertaken through online training package and self-assessment and verification sign off by ward leader and confirming e mail sent through to nutritional specialist nurse (NSN) who collates the data.

Areas with lower than 80% offered in reach training/support by NSN
</td><td>Reasonable assurance</td></tr>
<tr><td>8. Nasogastric and STAMP training will be added to the ESR platform to enable monitoring by ward managers & matrons</td><td>Nasogastric tube training data is available via education and learning dashboard of Business Intelligence spine of ESR

3.6.21 update - ESR compliance is based on the target audiences on position not on an individual level. It must be everyone in that position as they do the same job.</td><td>Limited assurance</td></tr>
</table>

What do we aim to achieve?	Current update	Progress rating
	Option: To put through the EST proforma and ask it to be set up as an EST role specific course. 3.6.21 update - STAMP training has been requested via EST process to be reported.	
9. Meal service will be safe, organised, and well led on all wards at CHFT	Divisional actions plan and observation of service delivery in ward areas. Patient feedback collated by ISS and CHS catering depts. Feedback through patient discussions and complaints/incidents Observation of mealtimes during Observe and Act framework, practice will be monitored through this process and shared at ward level. Leadership observations at ward level	**Reasonable assurance**
10. The red tray/lid and jug lid alert system will be used consistently and appropriately on all adult in-patient wards	Trust wide initiative not consistently utilised in all ward areas. HRI site A recent review of red trays has resulted in catering dept purchasing further trays and reviewing condition of existing supply. CRH site utilise a red plate lid system for alert due to the meal delivery system, this is reliant on ward staff identifying a requirement for the lid when ordering the meals. Question included within Observe and Act observation tool to monitor local compliance (Theme D. Food and drink) Key themes to date (3 wards)-preparation and assistance at mealtimes and utilisation of red trays and red jugs lids	**Reasonable assurance**
11. CHFT guidelines, policies, strategies, pathways, decision making tools will reflect current NHS guidelines & NICE guidance	CHFT Policies and guidance is reviewed against current NHS guidelines & NICE guidance via the nutrition operational meeting. Includes: • Nutrition and hydration policy (including allergen management) • Food hygiene policy	**Substantial assurance**

What do we aim to achieve?	Current update	Progress rating
	• Parenteral nutrition policy Reviews undertaken as new guidance released and via CHFT policy review process.	
12. The ward assurance indicators for nutrition and hydration will be reviewed for appropriateness and accurate affiliation with CHFT's nutritional policies, guideline etc.	Ward assurance documentation indicators reflect the current guidance within the current Nutrition and hydration policy. Further actions-for discussion of ward assurance indicators at WTGR	**Reasonable assurance**
13. A staff education plan to be developed and actioned to ensure staff know when a fluid balance chart is indicated and understand the importance of monitoring and recording correctly within EPR	No generic education plan No existing CHFT HCA competencies for nutrition and hydration. Nutritional specialist nurse undertaking training package development with Respiratory specialist nurse as she has similar package for HCA's on respiratory floor Trust compliance with clinical recording of fluid balance on EPR **Sep =20.4% July 2021 = 19.4% June 2021 = 20.3%** **This is part of the task and finish group agenda** <u>Risks</u> Inaccurate monitoring and recording of fluid balance chart on EPR impacting on patient's clinical outcome and patient experience. <u>Mitigation of risks</u> Clinical based actions-requests via medical team with clear guidance as to rationale for FBC. Accuracy of monitoring/compliance through ward assurance documentation <u>Further Actions</u> Lead to be identified to develop an education plan. NVQ team to devise HCA competencies. Review process of indication/recording/monitoring requirement through WTGR workshop.	**Limited assurance**
14. Theme D (Food & Drink) of Observe & Act reports to be monitored at monthly Nutrition Operational group meetings for information, discussion, and	Pilot areas completed utilising Observe and Act framework completed. <u>Further actions</u> Monthly agenda item for discussion and shared learning at nutrition operational meeting.	**Substantial assurance**

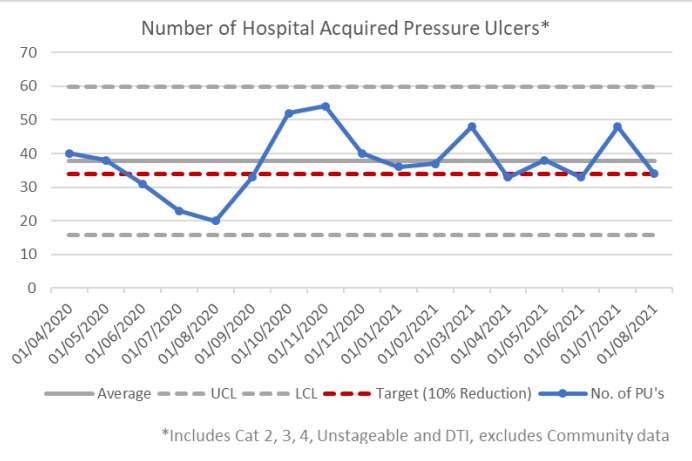
What do we aim to achieve?	Current update	Progress rating
potential shared learning		
15. A CHFT Food & Drink strategy to be developed to sit alongside the comprehensive CHFT Nutrition and Hydration policy (recommendation of the 2014 Hospital Food Standard panel report DoH)	Strategy to be developed with identified lead- New Lead identified work will now commence of developing a CHFT Food & Drink strategy	**Reasonable assurance**

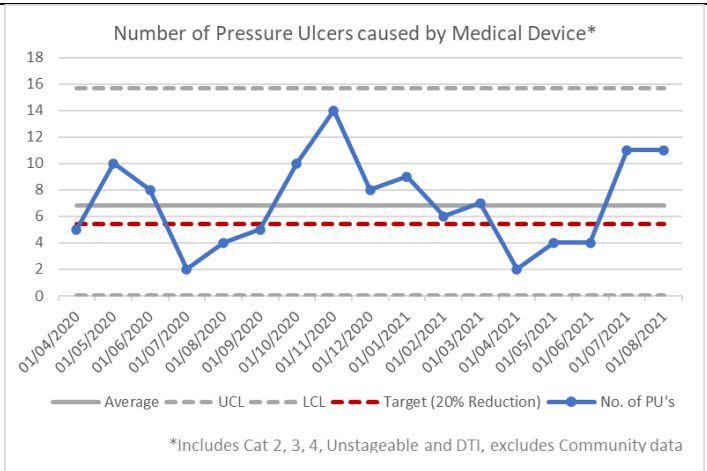
10.8 Reduction in the number of CHFT acquired pressure ulcers (Focused Quality Priority)

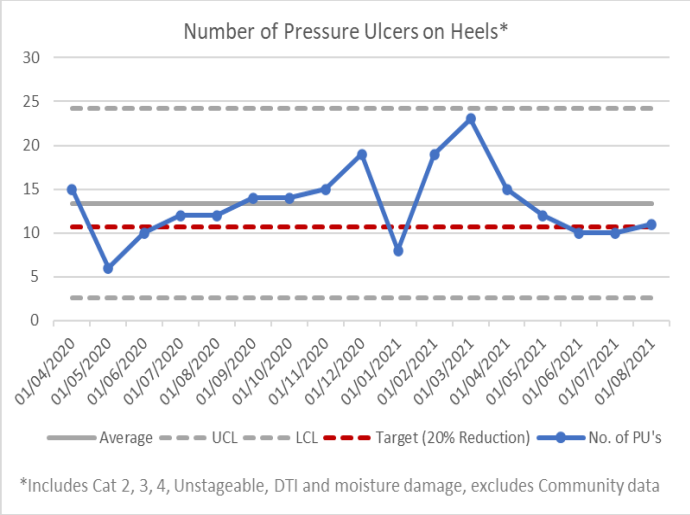
Operational Lead – Judy Harker

We will this year undertake quality improvements to:

- Reduce the occurrence of pressure ulcers and improve healing rates for existing pressure ulcers. In doing so we can reduce harm and spend, while improving the quality of healthcare experience of our most vulnerable patients.

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data	 There has been a reduction in incidence of hospital acquired pressure ulcers from July to August 2021. **Risk** Delay in quality improvement work within the Tissue Viability service due to clinical workload. **Mitigation** This risk will be reduced once the capacity in the service is increased following recruitment of additional specialist nurses. 3	**Reasonable assurance**	Continue to monitor and validate September data

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
	specialist nurse posts have been recruited to and are awaiting start dates. Work with divisional pressure ulcer quality champions is gaining momentum. Worry Area Dashboard now being published which highlights wards which are outliers against staffing and nursing quality indicators. Pressure ulcers feature as one of the quality indicators.		
Reduction in the incidence* of hospital-acquired medical device related pressure ulcers by 20%. This will be measured by incident data	 There has been has increase in incidence of pressure ulcers from June to July 2021. However, July and August data would suggest a constant position. Increased incidence which aligns with upward trend in covid admissions requiring respiratory / ICU care. These patients are managed with many medical devices, especially to the face, where the skin is vulnerable.	**Reasonable assurance**	Continue to monitor and validate September data. Relaunch medical device pressure ulcer resource packs. Collaborate with other Trusts to share learning. Ensure good attendance at upcoming seminar on medical device pressure ulcers hosted by Leeds Teaching Hospitals Trust Critical Care Team

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data	 Hospital acquired heel pressure ulcers remain with within target. Need for reduction in numbers of pressure ulcers to heels in community setting. September data being validated. Working Together Get Results meetings to address heel pressure ulcer reduction have started. Action plan to follow from meetings.	**Reasonable assurance**	Continue to monitor and validate September data Remainder of inpatient areas will receive Off-loading devices on top up via Materials Management
Reduction in the number of Orange harm pressure ulcers by 50%	There was a reduction in Orange pressure ulcer harms from 10 in March to 7 in September 2021. SPC charts to follow in next report. Note: Level of harm and investigation can change depending on outcome of validation at Orange Panel. Data can therefore change over time. Joint working between Tissue Viability Service and Divisional Governance Leads to support Orange Panel processes.	**Reasonable assurance**	Actions in place to address lapses in care identified in RCAs. Work to commence on reviewing Datix build and have capability to extract pressure ulcer contributory factors to support system wide learning.

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
No Red serious pressure ulcer incidents	No red incidents from April to September 2021.	**Substantial assurance**	
95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance	31% of patients received a risk assessment within 6 hours of admission/transfer. **Risk** Failure to implement or delayed implementation of preventative interventions. **Mitigation** Record Keeping / Documentation Quality Priority improvement work is now underway with pressure ulcers identified as a workstream. Task and finish group now meeting to agree short- and long-term actions required to obtain correct pressure ulcer outcome data. Record keeping 'must do's' identified. Collaboration with Informatics to ensure data is extracted from correct location within EPR.	**Limited assurance**	Complete actions within Task and Finish Group. Screensaver to be shared with staff to increase awareness of risk assessment expectations.
95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured by ward assurance	Data incomplete. **Risk** Gaps in skin bundles poses risk for pressure ulcer development. **Mitigation** As above. Record keeping / Documentation Quality Priority improvement work will include sskin bundle on EPR.	**Limited assurance**	Skin bundle fields on EPR being reviewed jointly with BHFT. Changes to EPR to require ED to initiate skin bundles. Meeting with ED staff to understand how sskin bundles will fit with patient pathways on EPR.

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated. Joint work underway with BHFT in developing a new suite of pressure ulcer care plans. Pressure ulcer care plans feature in the WTGR documentation project. The group is seeking to eradicate inconsistency in the use of care plans across the Trust. Task and finish group now meeting to agree short- and long-term actions required to obtain correct pressure ulcer outcome data.	**Substantial assurance**	The Digital / EPR team are in process of updating and relaunching the SOP for completing pressure ulcer care plans for Powerchart. Finalise revisions to BHT / CHFT care plan. Task and finish group to complete objectives.
95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit.	Significant frontline pressures in community have prevented any progress being made with this measure. The division continue to understand the data to allow for robust reporting going forward. **Risk** More than half of the pressure ulcers developing in the Trust, occur in the community. Community nursing is experiencing significant challenges with high levels of pressure ulcer occurrence and pressure ulcer deterioration. Lack of data escalated to community division and Informatics.	**Not applicable**	
95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	81% of staff have completed React To Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff. Improved traction with divisional quality improvement pressure ulcer leads to address non-compliance of staff with regards to training.	**Reasonable assurance**	Divisions to continue to address non-compliance Meet with Workforce team to implement new national e learning tool. Screensaver to raise

What do we aim to achieve?	Current Update – July / August 2021	Progress rating	Next period
	National pressure ulcer e learning tool in development which will replace React To Red. This forms part of the wider National Wound Care Strategy which CHFT is following closely.		awareness of training.

10.9 Making complaints count: Implementation of the national regulations and Parliamentary and Health Service Ombudsman (PHSO) standards (phased introduction)

Operational Leads – Head of Complaints and Associate Director for Patient Experience (vacant)

Our focus for this quality priority is to: Demonstrate an incremental improvement / compliance over the year against the national regulations and standards. Our implementation success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting and within this bi-monthly report.

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
QP1: Through the Making Complaints Collaborative support the delivery of the national complaints regulations and the emergent pilot Parliamentary and Health Service Ombudsman (PHSO) standards.			
QP1. Robust performance reporting against the national regulations	• Due to recent staffing changes and a review of the Making Complaints Collaborative performance reporting is under review	**Reasonable Assurance**	• Weekly reviews are taking place to determine performance levels and actions and support are identified to improve performance, with regular team meetings and liaison with Divisions
QP2. Align the work of the Making Complaints Collaborative to support the delivery of the national complaints regulations and the pilot Parliamentary and Health Service Ombudsman (PHSO) standards.			
1.1. Senior staff make sure every member of staff knows how they can create and deliver a just and learning culture in their role. Staff can demonstrate how they meet these objectives through practical examples.	• There has been a focus on closing actions across Divisions with some success. • Learning / impact stories are being captured as part of the Trust's reporting arrangements - 1 per month on a rolling programme across the Divisions. A summary 'you said, we did' style version is included in the monthly IPR • A page has been developed within the Datix complaint module to support the front end of the complaints process • A triage process has been built into Datix, which enables each complaint to be assessed (by the Head of Complaints) as standard or high and actions required. This is based on the consequence of the issues raised • A revised response template has been designed and introduced which is in the style of a letter rather than a report	**Reasonable Assurance**	• Some old actions remain open and will be reviewed to bring together as themed learning where possible • Going forward action plans will contain SMART actions and be monitored more efficiently to prevent delays in progress • Continue to revise the SOP to reflect revised arrangements (triage process, response template etc)

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
1.5. Organisations put measures in place to capture feedback from those who make complaints (as well as the staff involved) on their experience. They use this to demonstrate how the organisation has performed towards meeting the Complaint Standards and what users expect to see, as set out in My Expectations	• Service user survey ready for use, but not started to issue this • Output from the MCC 3Rs session has been used to direct the future approach to managing the Making Complaints Count project - there has been a change in senior complaints staff, therefore this is useful background to the project	**Reasonable Assurance**	• Agree the approach for issuing the service user survey • Use the findings from 3Rs stocktake to direct the project, the findings recommend a 2 phased approach: - Phase 1: process improvements, to bring about the rapid improvement in performance. - Phase 2: the remaining improvements that are needed against the PHSO standards
2.6 Each stage in the complaints procedure is responsive to the needs of each individual. Every stage meets the needs of minority and vulnerable groups and makes reasonable adjustments where required	• As part of the CHFT Health inequalities task and finish project (IMD data / analysis), some analysis of complaints has been undertaken. Using the Ethnic Diversity Index (EDI), the indication is that BAME communities are accessing the service above the current %population figures. Maternity specific complaints have also been reviewed but there are too few too complaints to draw any conclusions around IMD or ethnicity • Equality monitoring data is now captured as part of the service user survey and at the point of access into the service • Access to reasonable adjustment services are in place e.g., interpreting for the spoken language and BSL • Support is also available via Healthwatch for anyone requiring support to submit a complaints	**Reasonable Assurance**	• Ethnic Diversity Index (EDI): This remains on the agenda for the Health Inequalities group, however it is on hold awaiting for a new appointment to the senior manager in the Quality and Safety team • Look at more effective ways of capturing equality monitoring data to enable complainants to record this information themselves rather than being asked the questions by the PALS and complaints team • Agree a process for distribution of the complaints survey – the feedback will be used on an ongoing basis to monitor views of complainants
2.8 Staff make sure they respond to complaints at the earliest opportunity. Staff consistently meet expected timescales for acknowledging a complaint. They give clear timeframes for how long it will take to look into the issues, taking into account the complexity of the matter.	• Service has moved to negotiated timelines in partnership with families – Datix is updated to reflect any revised timelines *(Process is that the complaint handler calls the complainant and negotiates the timeline. Currently take the opportunity to highlight current staffing challenges and therefore may take longer; Aim to deal with the majority of complaints within 40 working days and the more complex at 60 working days - this can be extended up to 6 months)*	**Reasonable Assurance**	• Review the process re negotiated timelines with Divisional Colleagues (Use PDSA cycle approach to ensure that revised process is working effectively)

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
3.2 Organisations make sure all staff who look at complaints have the appropriate resources, support and protected time to do so in order to meet these expectations consistently.	• The role of Patient experience and quality support leads has been revised to increase the 'improvement' element of the role – an action learning set approach is in place for these staff members with Head of Complaints • An investigation training programme is ongoing - the focus for this is serious incident investigation, but the theory is transferable to a complaint investigation • Complaint Electronic Staff Record (ESR) learning module in place	**Reasonable Assurance**	• Conclude the work to build a 'complaints' element into the CD programme – look into this (was being led by ADD) • Conduct scoping / mapping of current investigators • Review the 'Quality check' of draft complaint responses tool previously used by Divisional managers. This will support identification of which staff require additional / focussed support
3.2 Organisations make sure all staff who look at complaints have the appropriate resources, support and protected time to do so in order to meet these expectations consistently	• There have been a number of staffing changes, with 2 interim Head of Complaints prior to the appointment to the substantive post. • The role of PALS Team Leader has also been recruited to with an interim covering ahead of him starting in post. The Interim Team Leader staying until end of December to support current increase in complaints • A business case has been submitted via the Director of Nursing to increase the substantive resources within the Corporate Team • Surgical division has introduced an additional complaints support staff position		• Divisions continue to feel challenged to respond to complaints, particularly at the current time when staffing levels are extremely challenged • Consider what short term measures can be built in to support hot spots
3.3 All staff who handle complaints do so fairly. Where possible, organisations make sure they assign complaints to staff who have had no prior involvement or who have no actual or perceived conflict of interest. Where this is not possible, staff take clear steps to demonstrate how they have looked at the issues fairly.	• Assigning complaints to staff who have had no prior involvement / conflict of interest is not currently happening – they are ***usually*** assigned to a more senior member of staff within the same team. • All complaint responses are reviewed by a senior member of the Trust and therefore would be assessed to ensure a fair and just response has been made	**Reasonable Assurance**	• Recommend that responding to this standard is transferred to phase 2 of the project

Risk/ Issue	Owner	Action	Progress
Ongoing workforce challenges and increases in complaint numbers continue to create delivery capacity concerns	Lindsay Rudge	• Team structures are currently being reviewed by senior members of the wider team to ensure a resilient workforce is in place	Substantive head of PACS is now in post and the substantive Complaints Team leader commenced in post at the end of September

<u>Appendix 1</u> – Report BRAG rating assurance table

RAG RATING	Evidence of fulfilling RAG rating
WHITE	• Not yet started
Substantial assurance	• Progressing to time, evidence of progress • Full assurance provided over the effectiveness of controls. • No action required • This would normally be triggered when performance is currently meeting the target or on track to meet the target. • No significant issues are being flagged up and actions to progress performance are in place.
Reasonable Assurance	• Evidence available at the time of assessment shows that the outcome is mostly met or there is insufficient evidence to demonstrate the outcome is met. • Impact on people who use services, visitors or staff is low. • Action required is minimal • Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve. • There are a set of actions in place that is expected to result in performance coming closer to meeting the target by the end of the target or reporting period. • Delayed, with evidence of actions to get back on track.
Limited assurance	• Evidence available at the time shows that the outcome is not being met or there is no available evidence that the outcome is met. Impact on people who use services, visitors or staff is high/significant. Action is required quickly • Cause for concern. No progress towards completion. Needs evidence of action being taken • Close monitoring or significant action required. This would normally be triggered by any combination of the following: • Performance is currently not meeting the target or set to miss the target by a significant amount. • Actions in place are not believed to be enough to bring performance fully back on track before the end of the target or reporting period. • The issue requires further attention or action
Full assurance	• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.

21. Integrated Performance Report – September 2021

Presented by Bev Walker, Acting Chief Operating Officer

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Authors:	Peter Keogh, Assistant Director of Performance Philippa Russell Acting Deputy Director of Finance Cornelle Parker Deputy Medical Director Lindsay Rudge Deputy Chief Nurse Jason Eddleston Deputy Director of Workforce and OD Bev Walker Acting Chief Operating Officer
Sponsoring Director:	Bev Walker, Acting Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of September 2021.

Key Points to Note

Trust performance for September 2021 was 66.4% which is a significant deterioration on the August position with the key changes being in Complaints, SHMI and Stroke. Despite the overall position the Trust still has 4 green domains.

The **SAFE** domain remains green. The **CARING** domain remains green but maintaining performance in Complaints is still a challenge. Dementia screening has continued to improve but is still some way short of target. The **EFFECTIVE** domain remains green although SHMI has risen above 100 again and #Neck of Femur access is still the main challenge but is improving. The **RESPONSIVE** domain is the most volatile during this period of operational challenge and is just about managing to remain amber with deterioration in the Stroke indicators alongside the underperformance in the main planned access indicators and ED. **WORKFORCE** remains amber with short-term sickness now amber and highest rate since November 2020. Return to Work Interviews have improved slightly in month. **FINANCE** remains green.

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 of Directors is asked to **NOTE** the narrative and contents of the report and the overall performance score for September 2021.

Calderdale and Huddersfield NHS Foundation Trust

Performance
September 2021

Quality, Workforce and Finance

We have looked at our main headlines from a Trust overview perspective and considered the impact that these areas are having on service performance.

We continue to see unprecedented levels of attendances at both hospital sites during the last few months although these are not always translating into admissions at the same rate, however the acuity/dependency is significantly higher. We are now seeing an impact on our 4-hour ECS performance although still often better than other Trusts in West Yorkshire. However we are seeing long waits in both emergency departments which is an extremely poor patient experience.

The demand for our services including the beds required for Covid patients means that we have seen some deterioration in performance in September although we have still managed to maintain key cancer metrics whilst in strategic gold command and control. Mitigations are in place to keep the organisation safe for patients.

Although the Trust did achieve its financial plan of a break-even position for H1 (April -September 2021), this was primarily due to the £3.6m additional support received via the Elective Recovery Fund (ERF) for Quarter 1 activity. Quarter 2 Elective activity has been very close to the planned level, but a change in the threshold required to access ERF funding has impacted across the Integrated Care System (ICS). Elective activity has not recovered to the required 95% of 2019/20 levels and no further funding has been available to support the additional pay and Independent sector costs incurred. From a financial perspective this has meant that the surplus position reported at the end of Quarter 1 has been fully eroded and the monthly position over the last two months is running at circa £2m a month deficit.

It is pay expenditure that is driving the Quarter 2 deficit and this is driven by the ongoing impact of Covid and recovery and the actions taken to mitigate the severe staffing shortages seen over the last 3 months. Demand for additional staffing continues to increase due to the additional capacity requirements for Covid segregation (particularly in the Emergency Department, Respiratory and in Critical Care) and the demands of Elective recovery. It is also exacerbated by increased levels of absence that have peaked over the last two months. It was to try and mitigate these pressures that enhanced rates of pay for bank shifts were introduced in mid-July. The additional cost due to these enhanced rates in Quarter 2 was £1.8m and has contributed significantly to the in-month deficits reported in August and September. Whilst the number of Bank shifts filled has increased as a result of the premium payment, demand continues to outstrip supply and the Trust has also looked to reintroduce higher cost agencies for qualified Nursing staff and has also used agencies to fill HCA gaps for the first time since 2019/20.

Colleagues are feeling fatigued which creates a physical/emotional/psychological challenge especially as we are asking colleagues to commit to do more due to the increased operational pressures and need for Recovery. We are focusing in on the ‘here and now’, so ensuring that some basic requirements are available to colleagues is essential – nutrition and hydration (food and water) is a focus as are clear communications about what we reasonably expect from colleagues together with demonstrable commitments to be ‘leader visible and accessible’ with reassurance about what activity can be paused/dropped and an overriding statement that ‘we have your back’.

A large majority of clinical areas have seen the actual care hours per patient day (CHPPD planned vs actual) hours less than those that were planned and this has deteriorated from the previous month.
There has been an increase in harm falls across the surgical and medical services with a rise in

pressure ulcers across surgical areas. Skill mix remains an area of concern within the context of the current workforce issues described, with this being the highest reported safety red flag recorded within the health roster system. The evidence related to reduced RN levels and the impact upon nurse sensitive indicators is an area of concern in the context of the current operational activity where we are also seeing a sustained increase in patients on the transfer of care list due to capacity issues in social care packages of care and discharge to assess beds. This is partly driving an increase in occupancy levels and opening of some escalation beds. This position whilst escalated is not resolving, and a date for the previously described 'Risk Summit' for system leaders to discuss the quality and safety impacts related to the current position has now been confirmed.

The number of complaints and PALS contacts continue to increase.

The number of CAMHS patients requiring a Tier 4 bed has increased with extensive waits within inpatient services and this has been escalated within the system regarding the current position within the Trust.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

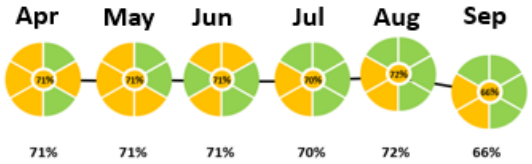
September 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

September 2021



OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
FFT Community FFT A&E	FFT Maternity FFT Inpatients FFT Outpatients
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

September's Performance Score is at **66.4%** which is a significant deterioration on the August position with the key changes being in Complaints, SHMI and Stroke. Despite the overall position the Trust still has 4 green domains.

The **SAFE** domain remains green. The **CARING** domain remains green but maintaining performance in Complaints is still a challenge. Dementia screening has continued to improve but is still some way short of target. The **EFFECTIVE** domain remains green although SHMI has risen above 100 again and #Neck of Femur access is still the main challenge but is improving. The **RESPONSIVE** domain is the most volatile during this period of operational challenge and is just about managing to remain amber with deterioration in the Stroke indicators alongside the underperformance in the main planned access indicators and ED. **WORKFORCE** remains amber with short-term sickness now amber and highest rate since November 2020. Return to Work Interviews have improved slightly in month. **FINANCE** remains green.

Key Indicators

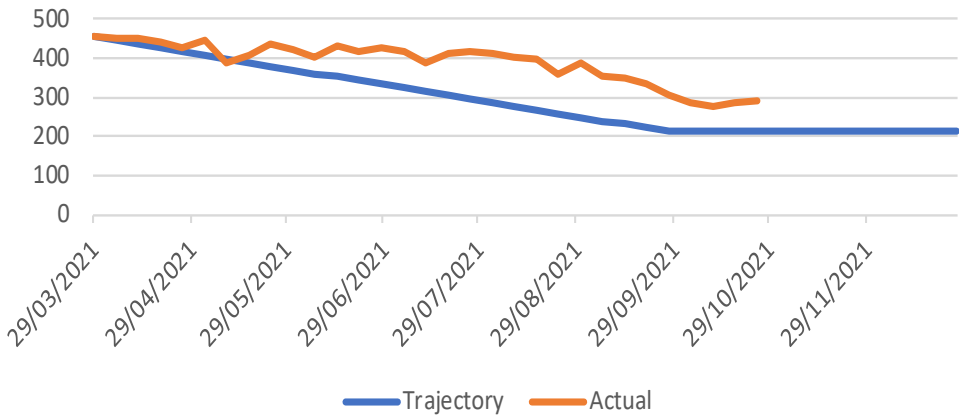
	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	YTD	Performance Range		
SAFE																					Green	Amber	Red
Never Events	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0		>=1
CARING																					Green	Amber	Red
% Complaints closed within target timeframe	60.07%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	60.00%	100.00%	87.50%	100.00%	69.44%	55.10%	in arrears	74.64%	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	91.09%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	96.82%	96.75%	95.62%	97.00%	96.38%	96.61%	in arrears	96.60%	>=90%	80% - 89%	<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	93.27%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	92.38%	92.45%	92.20%	92.29%	91.88%	91.77%	in arrears	92.00%	>=90%	80% - 89%	<=79%
Friends and Family Test A & E Survey - % Positive Responses	90.16%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	90.48%	85.13%	85.90%	82.98%	78.53%	81.33%	in arrears	82.83%	>=80%	70% - 79%	<=69%
Friends & Family Test (Maternity) - % Positive Responses	98.86%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	91.89%	85.71%	90.00%	91.23%	97.53%	95.19%	in arrears	95.40%	>=90%	80% - 89%	<=79%
Friends and Family Test Community Survey - % Positive Responses	100.00%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	100.00%	99.50%	93.80%	93.37%	87.74%	92.52%	in arrears	91.69%	>=90%	80% - 89%	<=79%
EFFECTIVE																					Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		>=0
Preventable number of Clostridium Difficile Cases	6	1	1	2	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	104.11	103.15	102.26	99.91	101.91					101.91	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	90.49	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	90.76	89.46	88.24	88.99	90.00				90.00	<=100	101 - 109	>=111
RESPONSIVE																					Green	Amber	Red
Emergency Care Standard 4 hours	88.81%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	87.83%	88.22%	86.70%	86.16%	78.59%	79.57%	78.29%	82.83%	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	65.30%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	38.60%	61.02%	49.06%	54.90%	42.29%	43.14%	42.00%	48.66%	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.74%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	98.76%	98.31%	99.02%	97.84%	97.87%	98.46%	98.62%	98.34%	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.86%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	97.34%	98.28%	98.04%	100.00%	98.68%	100.00%	98.64%	98.91%	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.08%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	99.22%	99.46%	99.41%	97.62%	98.92%	97.85%	96.03%	98.25%	>=96%		<=95%
31 Day Subsequent Surgery Treatment	90.99%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	100.00%	97.14%	100.00%	100.00%	97.78%	94.44%	85.37%	95.54%	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.15%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	98.04%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=98%		<=97%
38 Day Referral to Tertiary	54.64%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	91.67%	50.00%	63.16%	50.00%	66.67%	35.00%	53.33%	52.08%	>=85%		<=84%
62 Day GP Referral to Treatment	91.47%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	95.65%	93.14%	90.09%	91.97%	91.38%	91.24%	89.50%	91.25%	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	63.98%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	100.00%	72.22%	57.89%	48.48%	32.14%	55.26%	25.00%	50.57%	>=90%		<=89%
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	79.84%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	80.21%	73.09%	67.36%	68.97%	73.40%	69.70%	72.53%	70.80%	>=75%		<=70%
WORKFORCE																					Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	4.52%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	4.37%	4.35%	4.44%	4.61%	4.76%	4.89%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	3.07%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	3.01%	2.99%	3.07%	3.17%	3.29%	3.36%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.45%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	1.36%	1.35%	1.38%	1.44%	1.48%	1.53%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.90%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	93.93%	93.81%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	95.15%									95.15%	95.15%	95.15%	95.15%							-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	41.05%																			-	>=95%	>=90%	<90%
FINANCE																					Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	1.18	0.55	2.39	0.28	-0.22	-1.40	-1.62	0.00			

SWOT Analysis

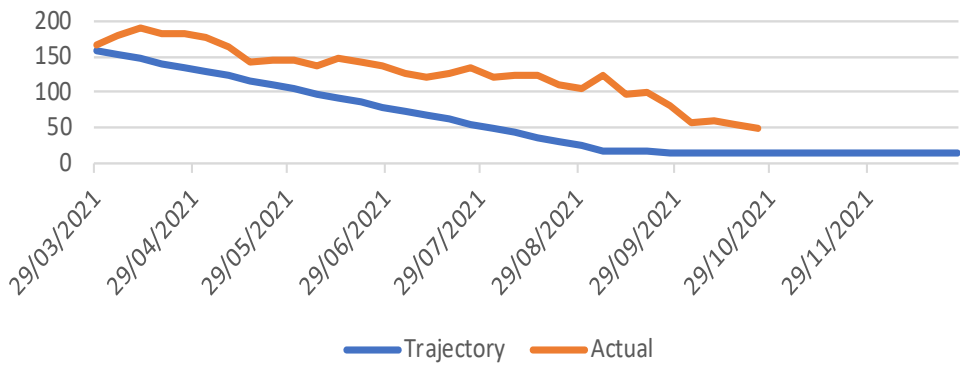
Strengths	• Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks). • Ongoing comprehensive theatre staff engagement and workforce development programme – starting to receive positive feedback from staff. • Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management. • Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for breast and lung cancer and we are also now providing some in-reach support to Bradford. • The Tytocare trial has now commenced for a period of 6 weeks in the Emergency Department following clinical safety sign-off and sign-off by the Divisional senior management team. The aim of the trial is to utilise new technology to enable virtual consultant presence in the emergency department; this should reduce the overall length of stay in the department and increase the number of patients who have a decision within one hour. • Focus on recruitment in both clinical and admin roles to support winter planning and recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend. • Ongoing focus on clinical validation and prioritisation. • Agreed Recovery Framework.
Weaknesses	• High volumes of attendances through Accident and Emergency. Bed pressures continue to be significant. • The staffing position continues to be extremely challenging across all divisions in particular among nursing teams and is being closely monitored and managed on a daily basis through the Gold meetings. • High levels of staff having to isolate leading to low levels of staffing across clinical areas. • Staffing shortages in theatres leading to continued reduced capacity to operate on patients and short notice cancellation of remaining lists. • The additional demand for school age (12-15 yr old) Covid vaccinations has highlighted the limited capacity within the school age immunisations team and the absence of a pool of suitable competencies outside of this team do deal with additional demand and/or short and long-term gaps in team capacity. • Ability to respond to initial specification for 12-15yr old vaccinations complicated by new requirements for out of school vaccination channels. • Trust Estate and dual site configuration reduces flexibility.
Opportunities	• The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period. • The Plan for Every Patient roll out programme is underway with further resource allocated to increase pace and buy in. • Opportunities for acceleration of community based Early Supported Discharge and urgent response function for winter/surge plans plus maintaining elective recovery through control on non-elective demand i.e. increasing in-reach of Respiratory team and support for earlier discharge for oxygen weaning via CVW. • Medicine is enacting plans to effectively use allocated face to face clinic capacity to ensure this is used effectively across all specialties to ensure patients with the highest priority are seen. • Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Mon-Fri 08.00-18.00 with the service reverting to Local Care Direct outside of these hours. The pilots have been extended until the end of December and a joint business case with the CCGs is now in draft format. We have managed to secure a significant increase with GP shifts in the hubs. • Discussions with additional insourcing and outsourcing organisations to support with our surgical and outpatient backlogs in ENT, Ophthalmology and Orthopaedics. • A revised/simplified enhanced payments model for additionality could help unlock weekend theatre capacity to support recovery. • Approval for proposal with "Healthcomms" to support waiting list validation across outpatients and inpatient elective waiting lists. • Development of theatre workforce plan including ODP apprentices, Nurse Associate role. • Community Division and development of Integrated Care Provider partnerships.
Threats	• We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing. • Staff being stretched due to increased number of Delayed Transfers of Care and increased Covid bed base. • Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management. • Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community. • Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads. • Cost pressures within division linked increasing dependencies on overtime and bank. • Potential stopping of some elective services to move RNs to support medical wards - significant health and wellbeing implications to these staff as well as the risk they resign from CHFT. • Expected Paediatric medical surge which would impact elective activity. • Increasing numbers of Covid patients being admitted with resulting pressure on ITU admissions. • Winter pressures. • Limited uptake to date of enhanced payments scheme to support recovery. • Increasing number of complaints due to prolonged waits and poor patient experience. • Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.

INPATIENT WAITING LIST - P2

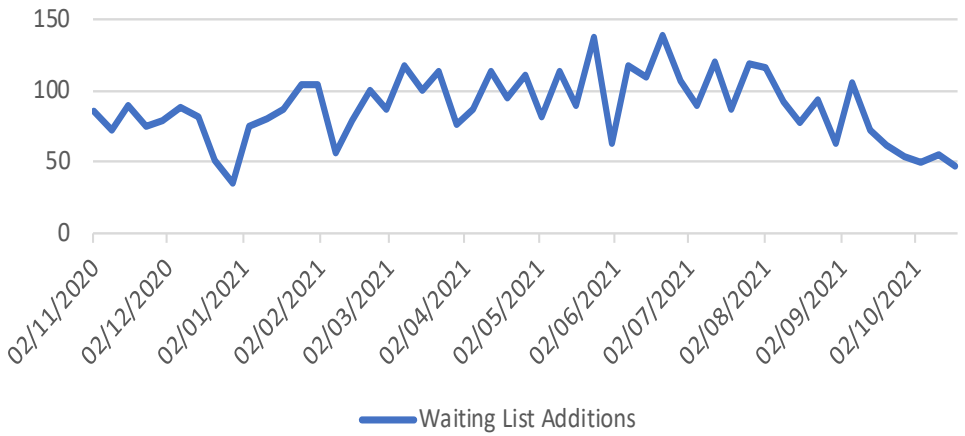
Trajectory vs Actual - Total P2s on Waiting List



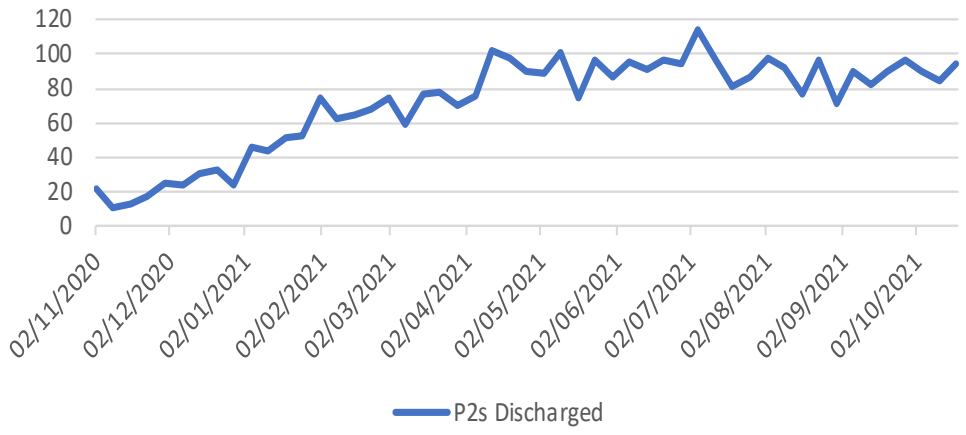
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

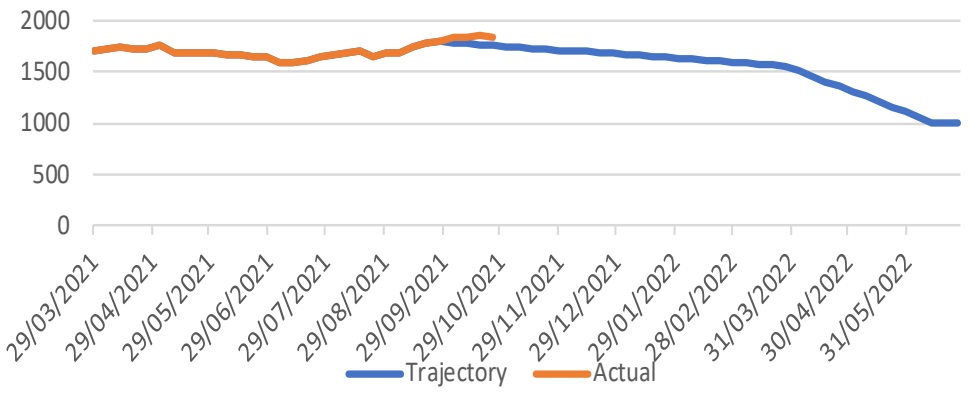


P2 Surgery done in the week

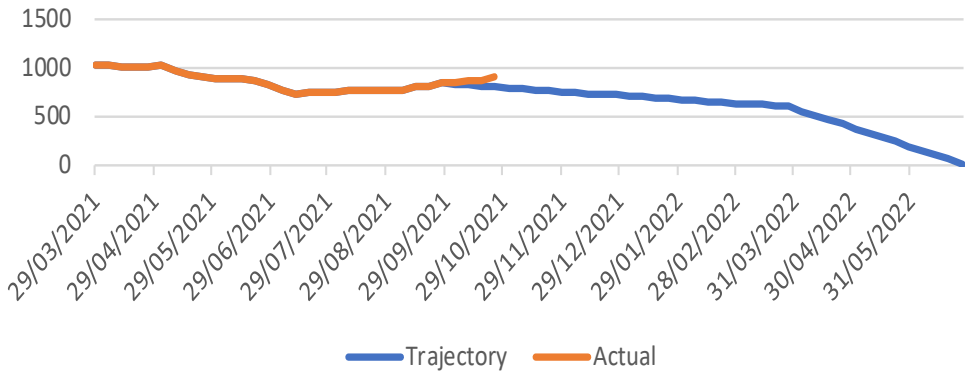


INPATIENT WAITING LIST - P3

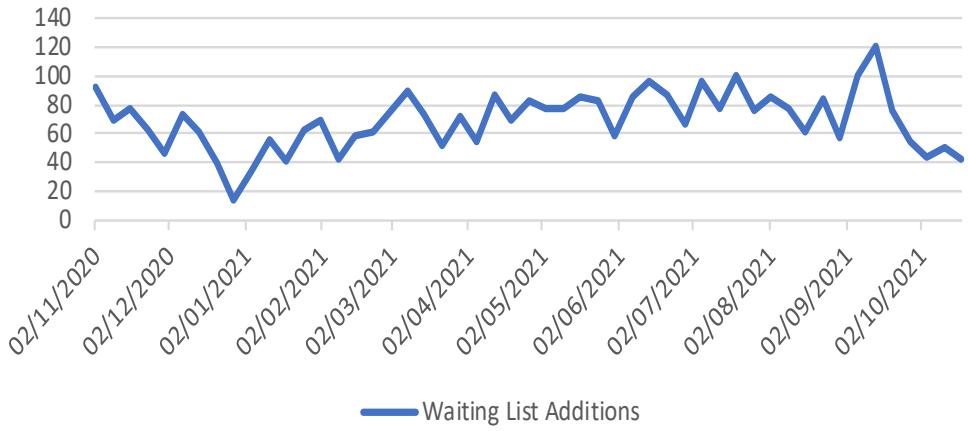
Trajectory vs Actual - Total P3s on Waiting List



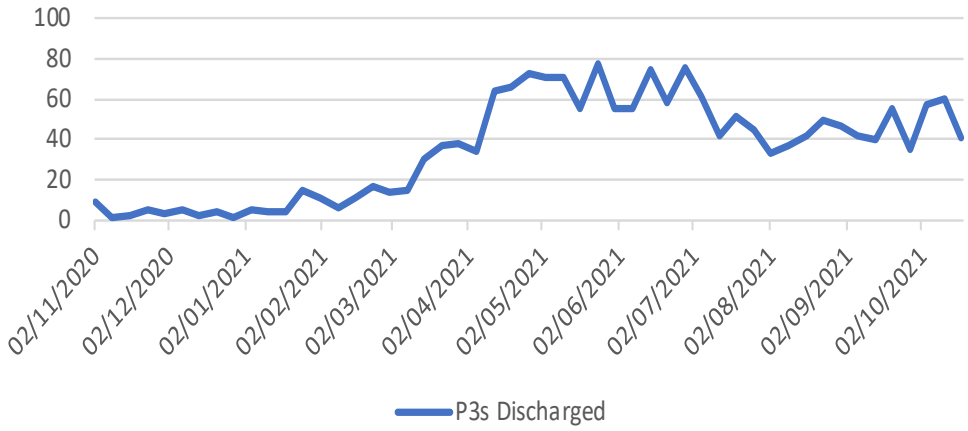
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



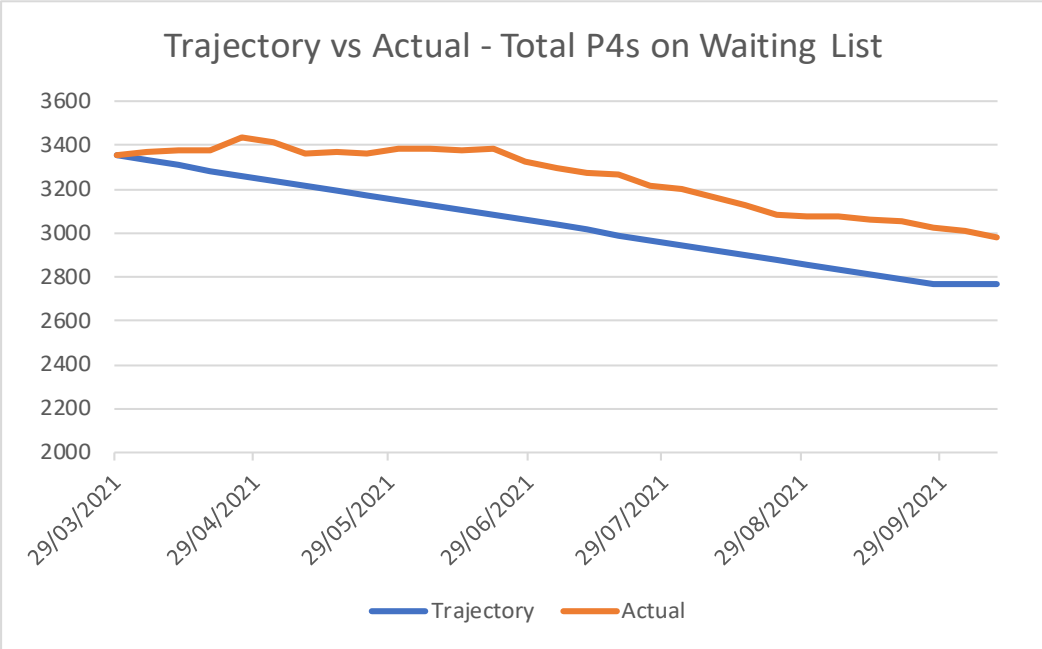
P3 waiting List Additions

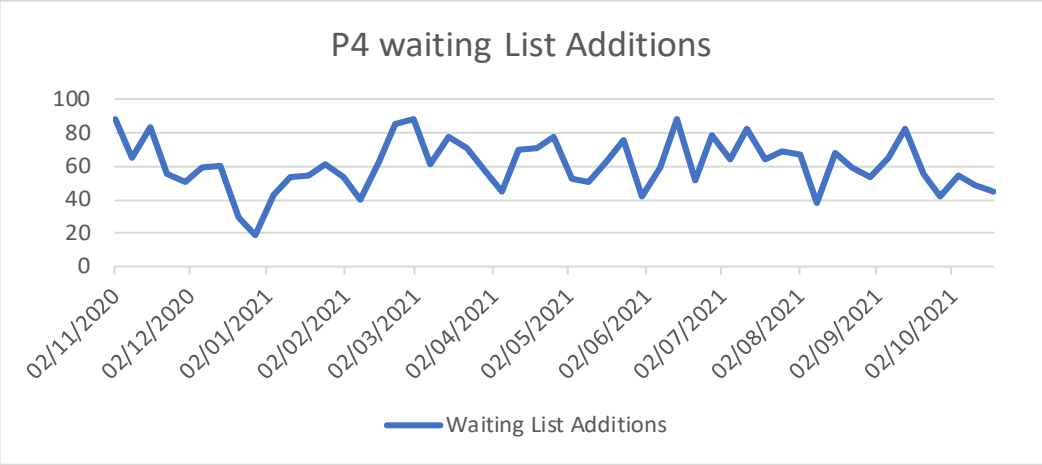


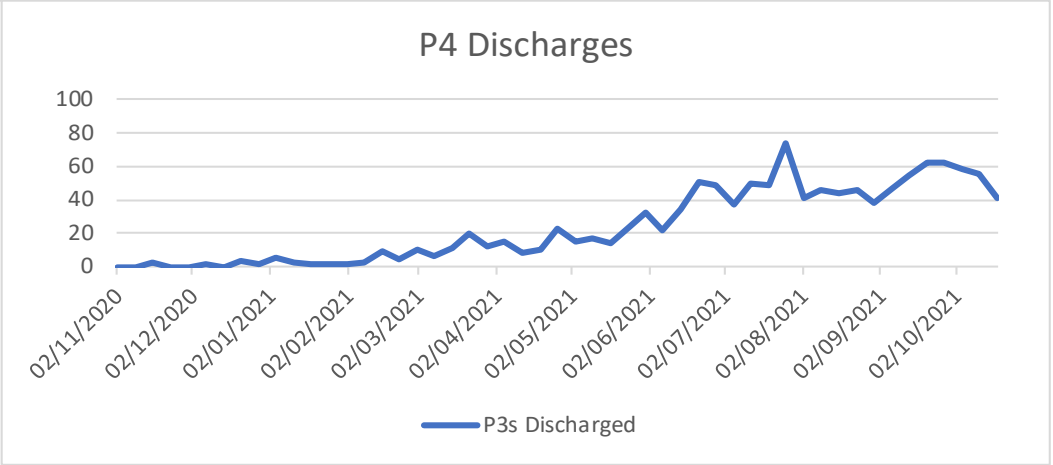
P3 Discharges



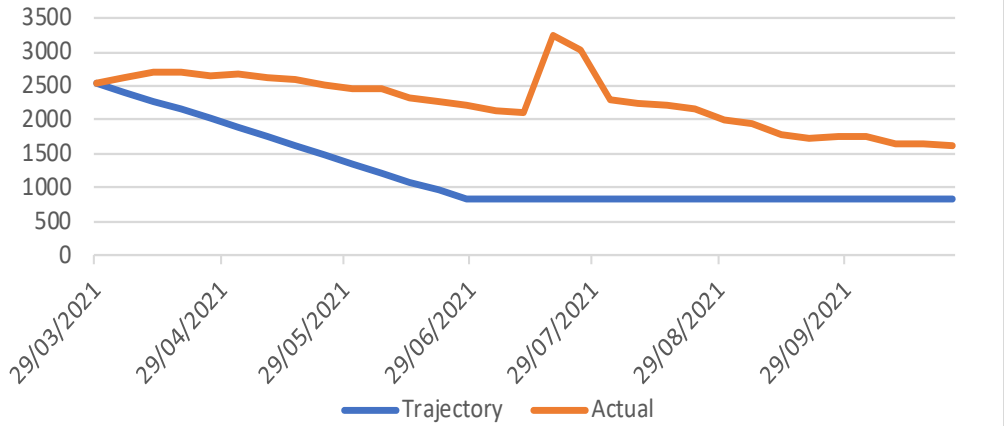
INPATIENT WAITING LIST - P4

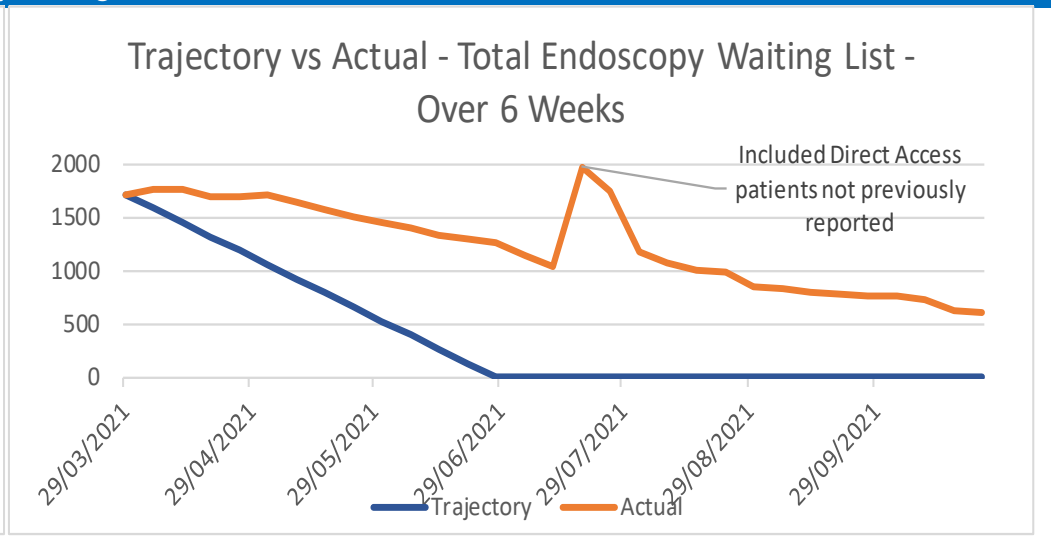


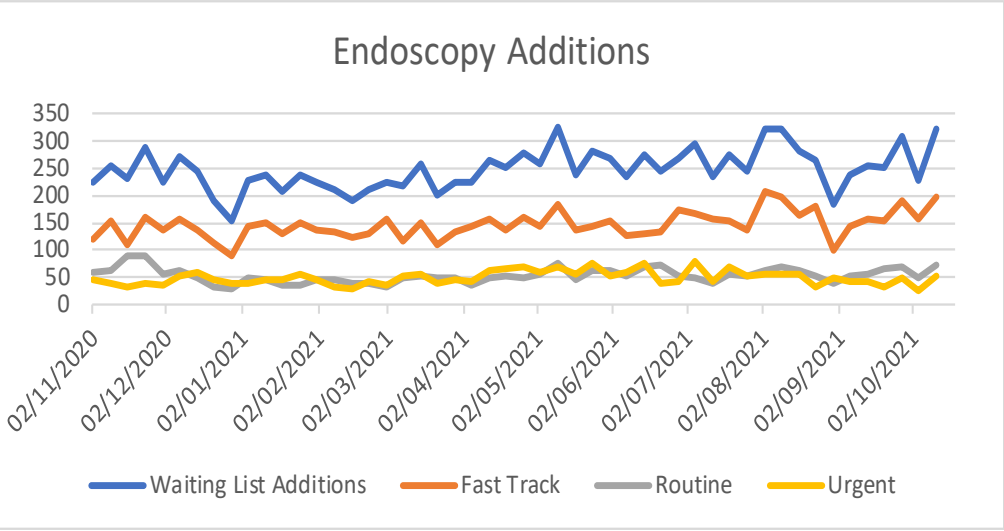


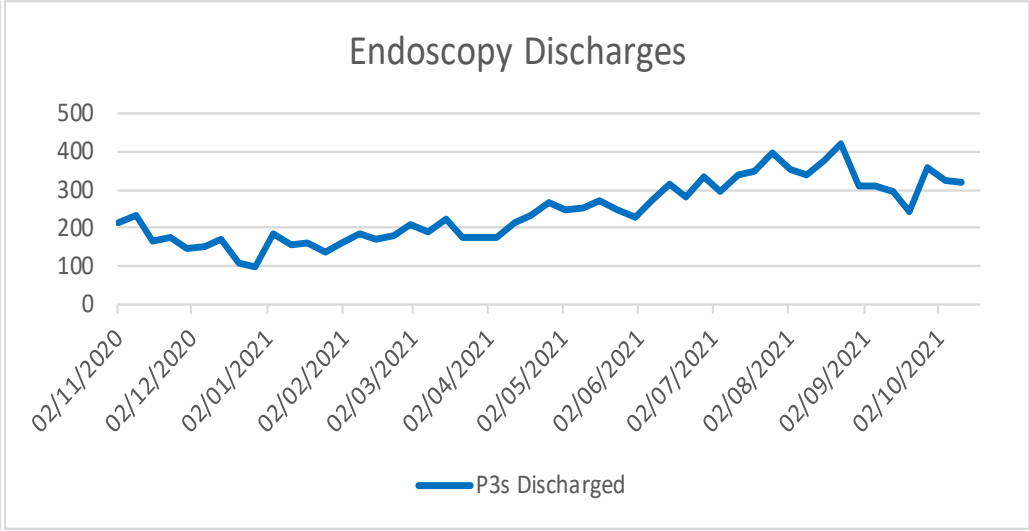


Endoscopy Waiting List

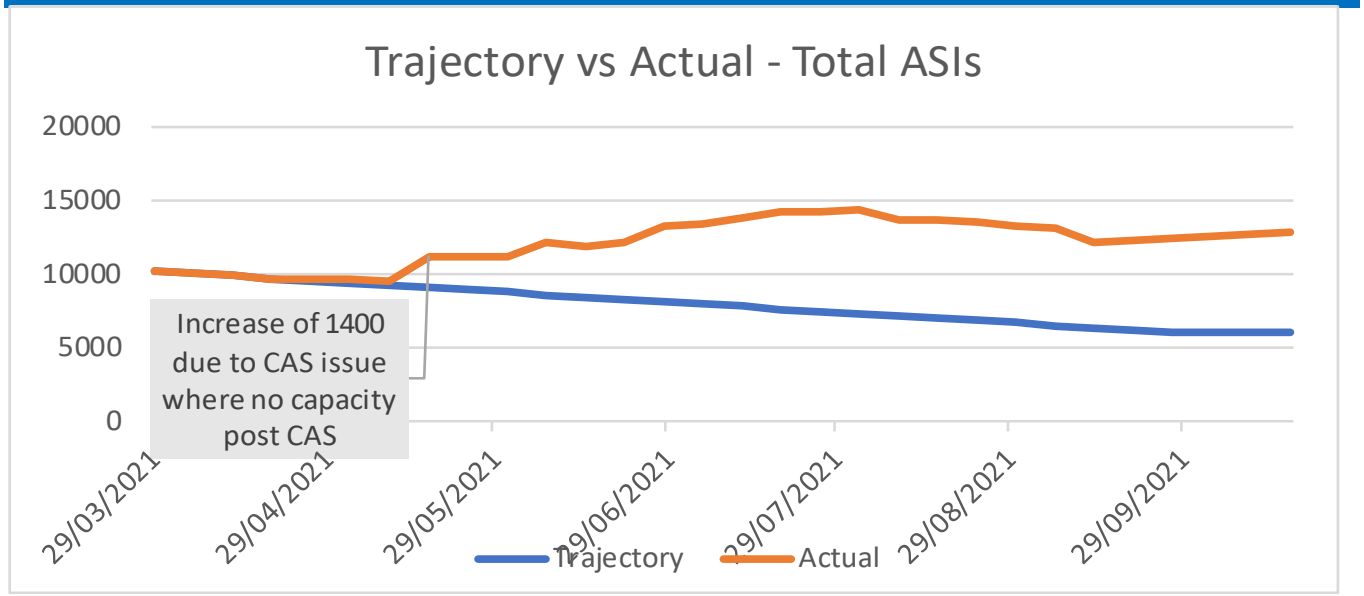


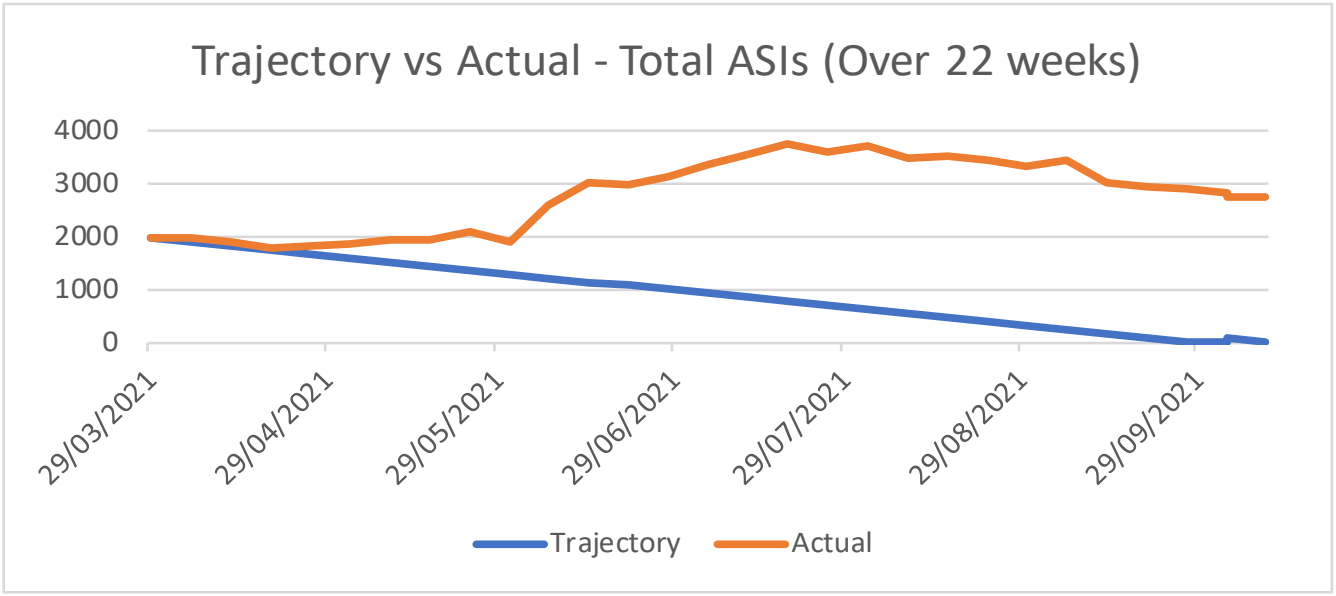






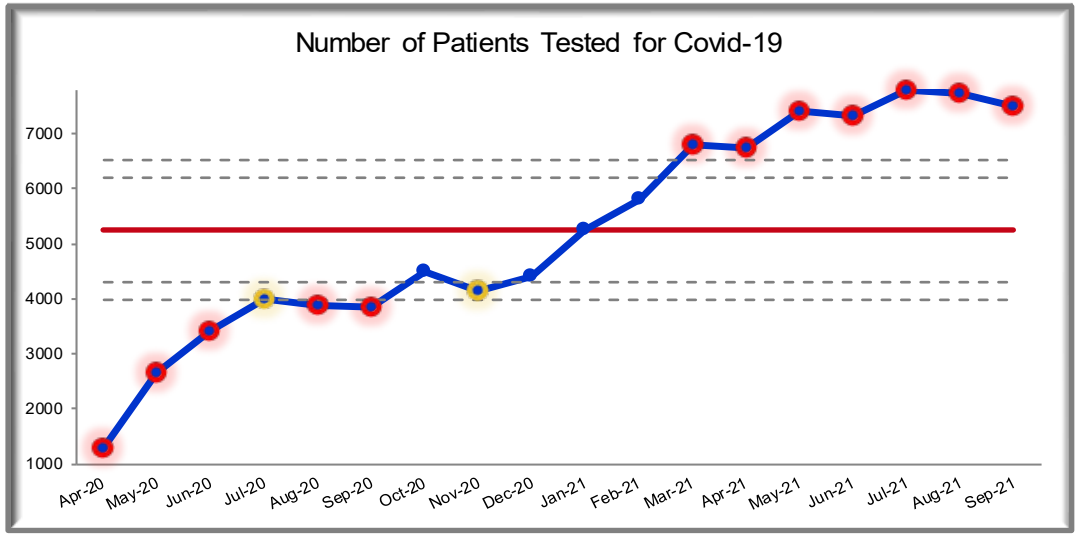
ASIs

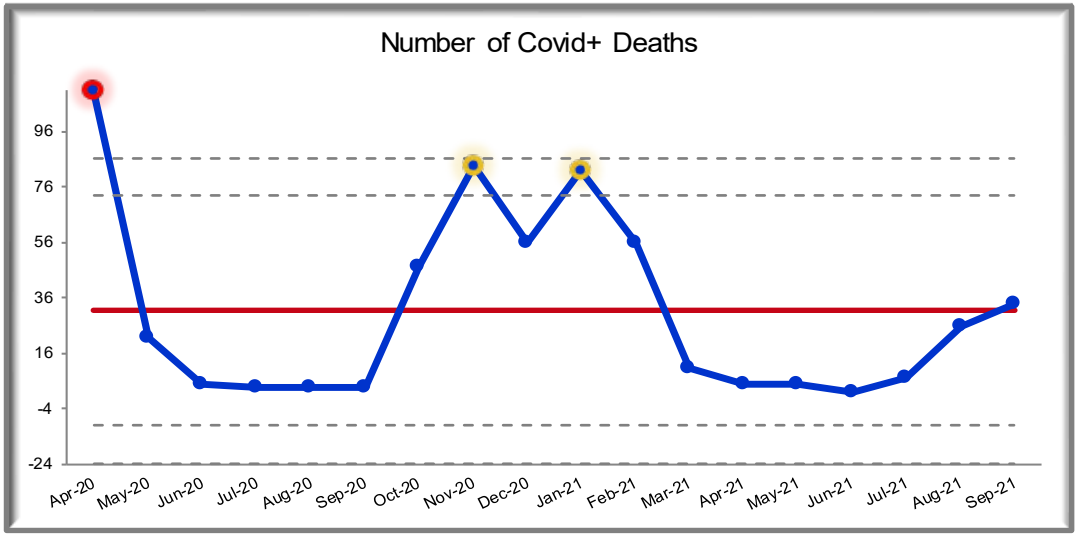

Trajectory vs Actual - Total ASIs
20000
15000
10000
5000
0
Increase of 1400 due to CAS issue where no capacity post CAS
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
Trajectory
Actual

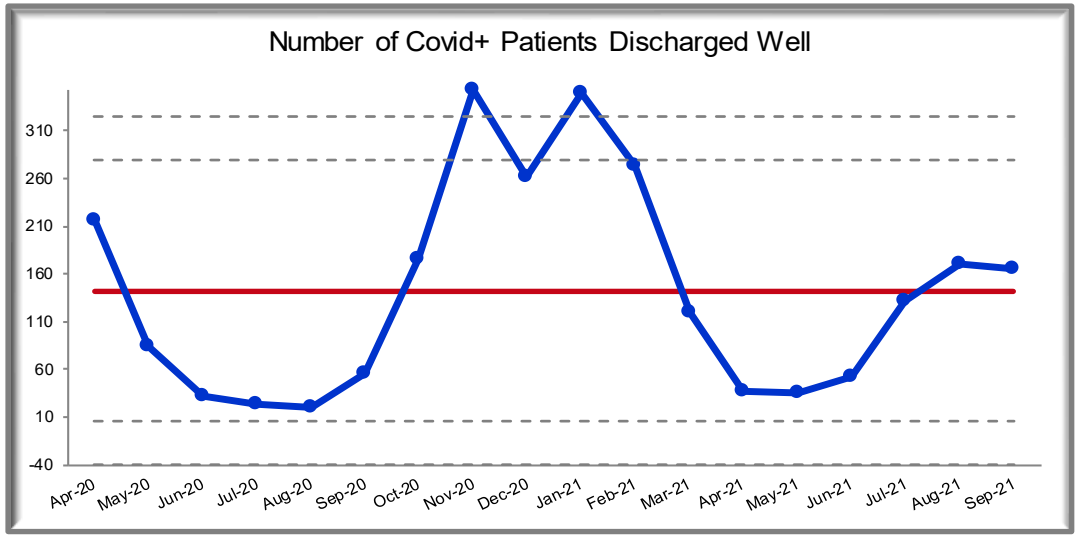

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
Trajectory
Actual

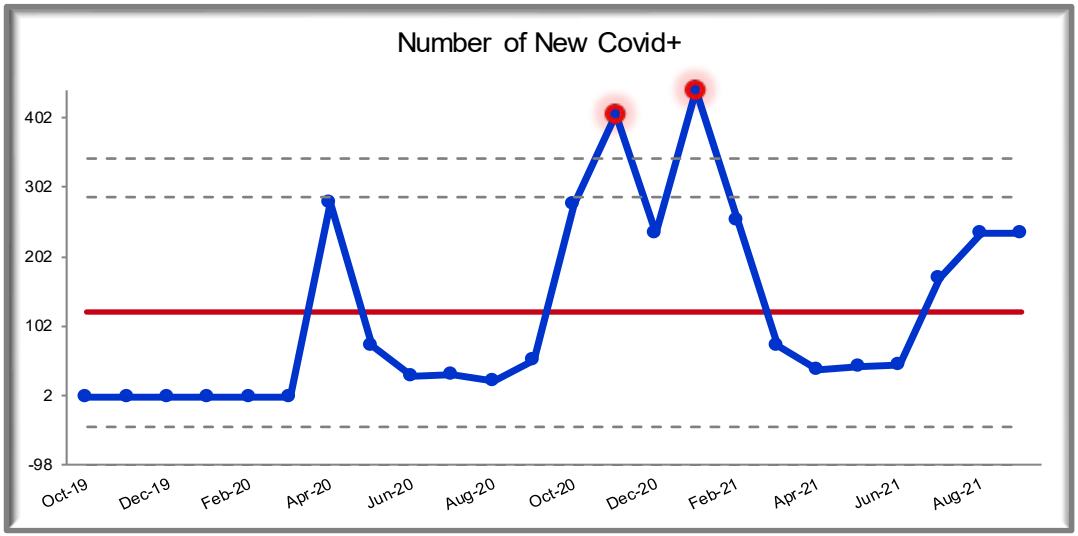
Covid-19 - SPC Charts

Average | Values | Target | Control Limits | Warning | Critical | Trend | Good Over Target / Good Below Target



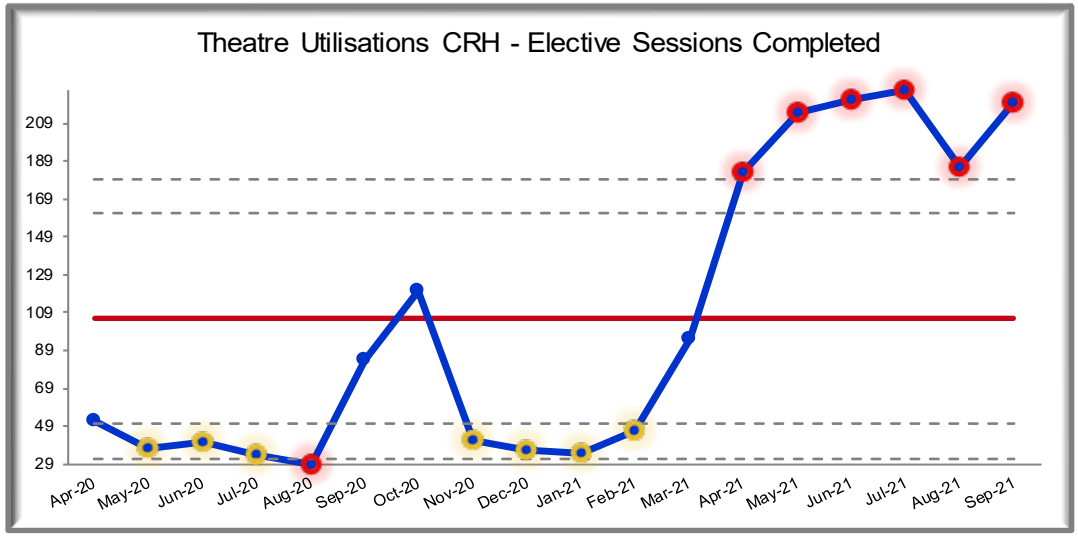


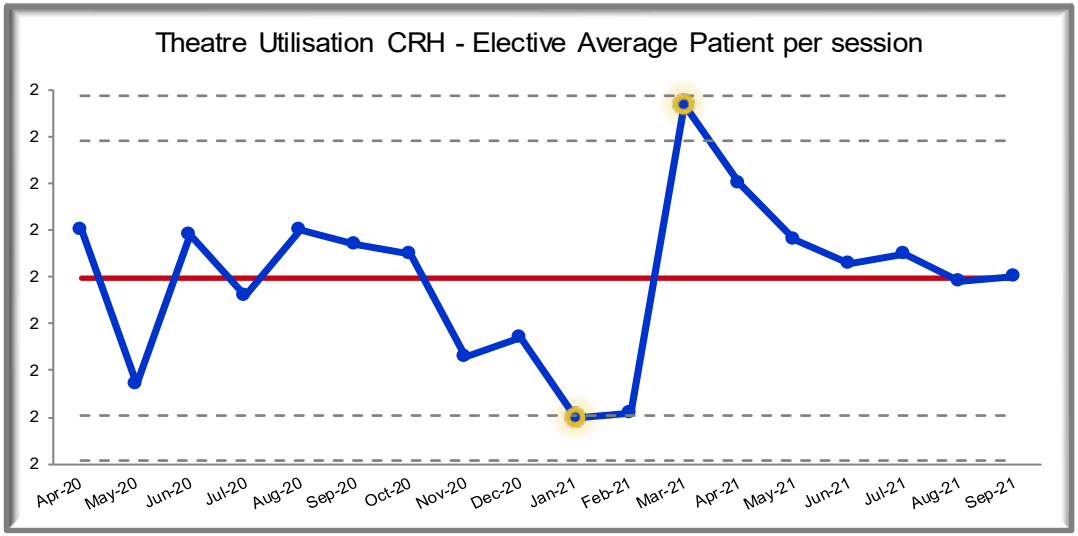


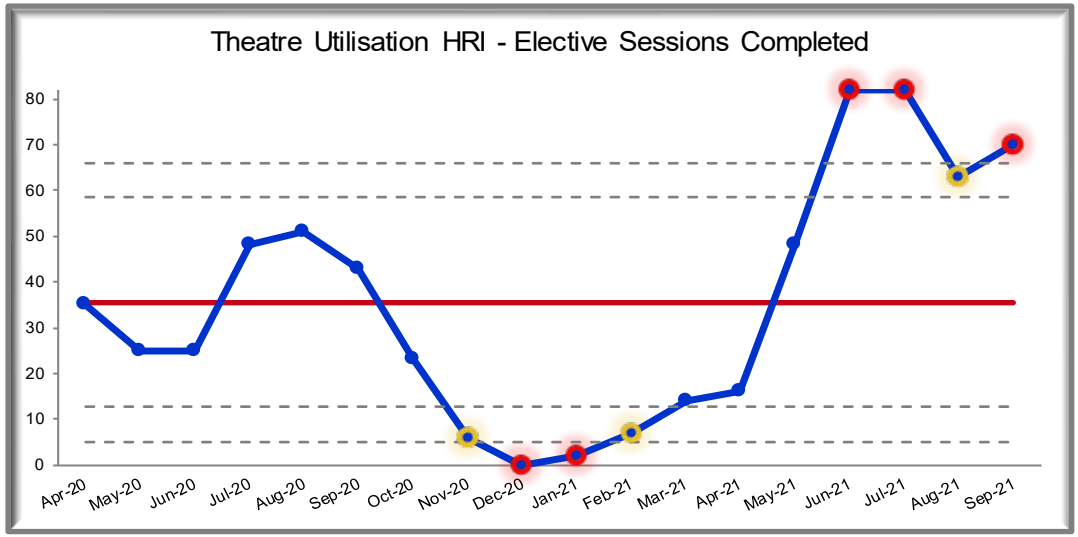


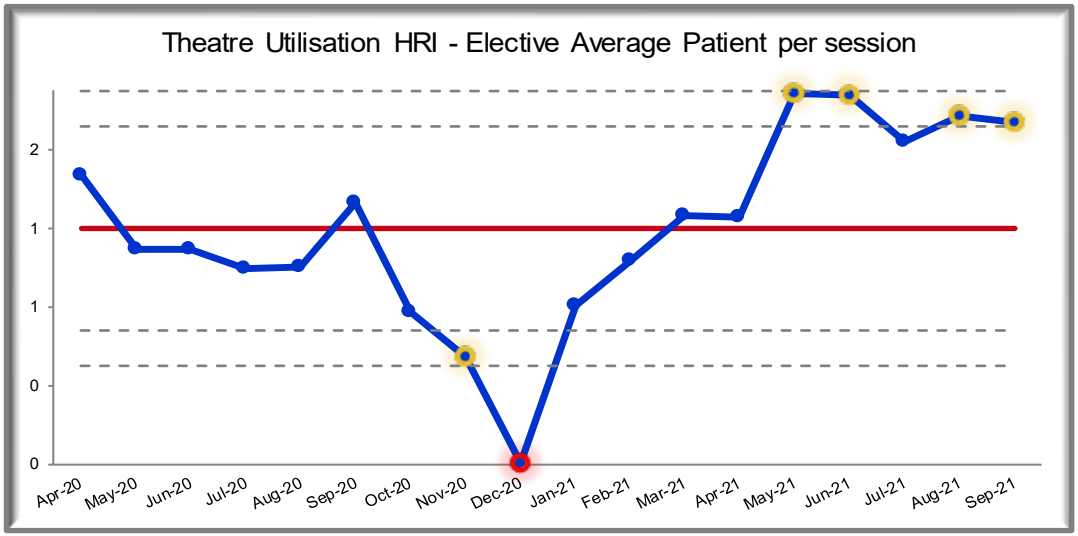
Theatres - SPC Charts

Average | Values | Target | Control Limits | Warning | Critical | Trend | Good Over Target / Good Below Target

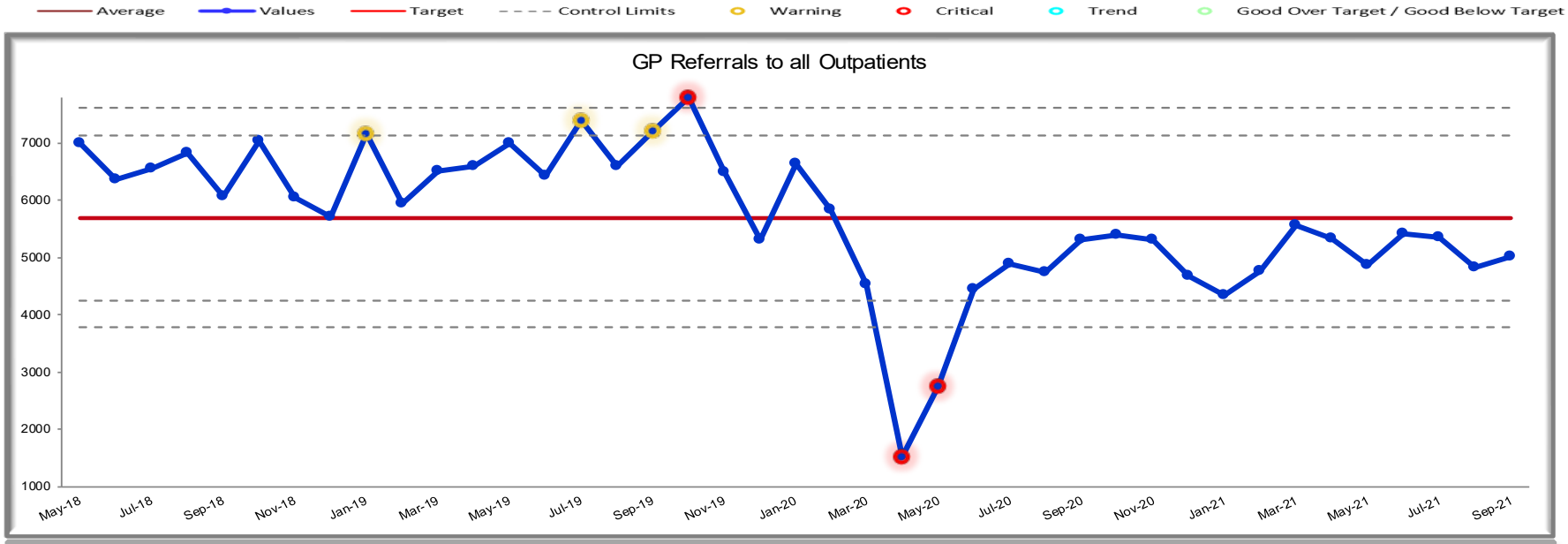


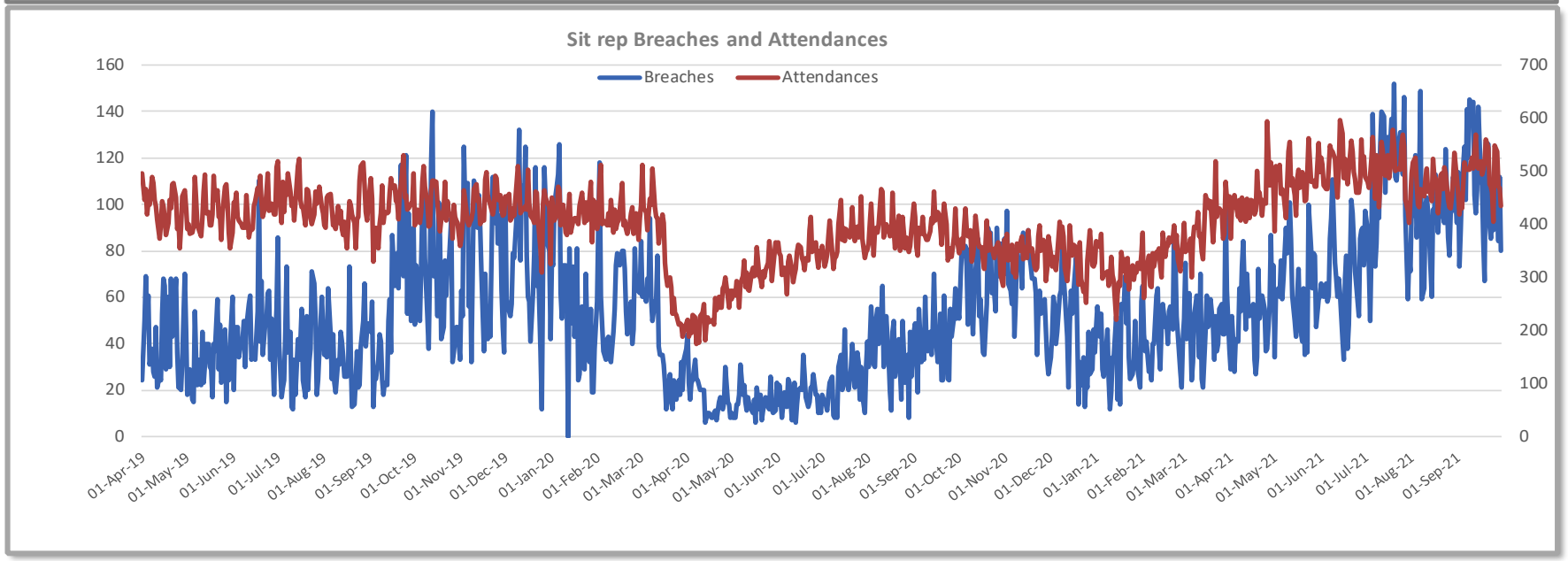






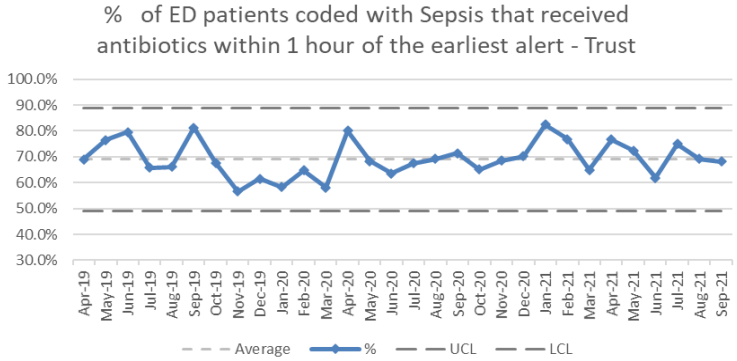
Capacity and Demand

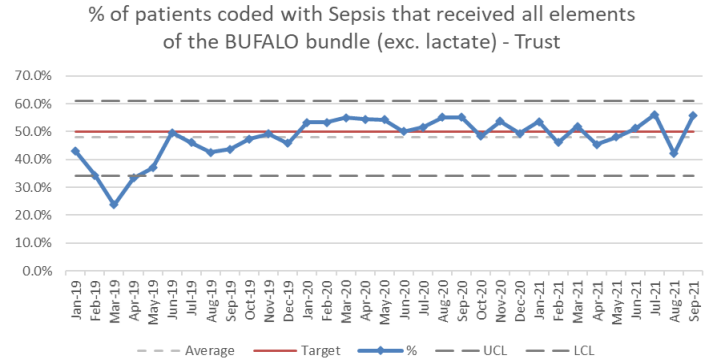




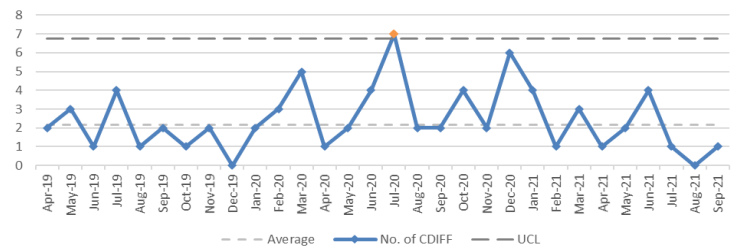
Quality Priorities - Quality Account Priorities

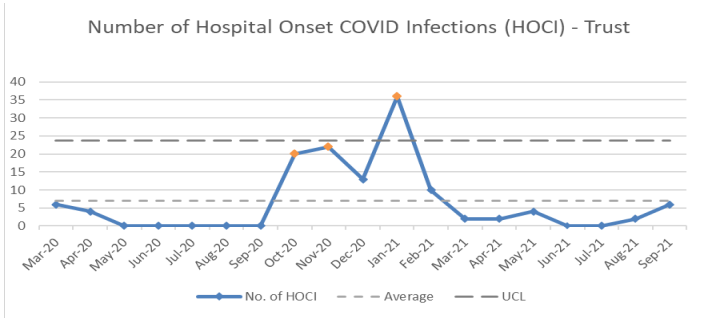
1. Recognition and timely treatment of Sepsis



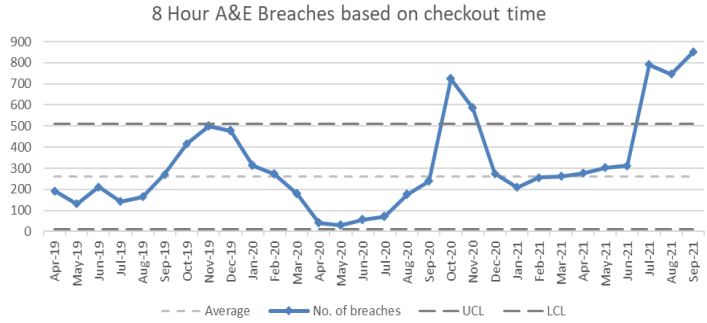


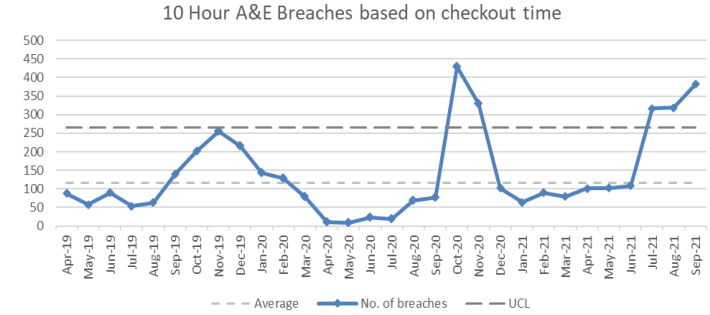
2. Reduce number of Hospital Acquired Infections including Covid 19





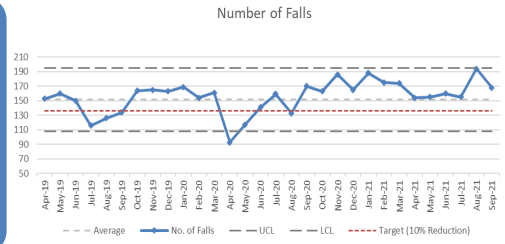
3. Reduce waiting times for individuals attending the ED



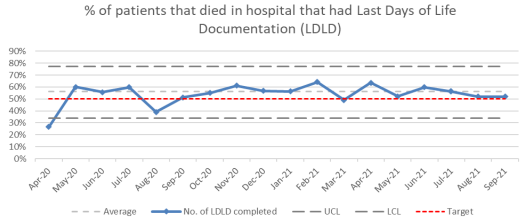


Quality Priorities - Focussed Quality Priorities

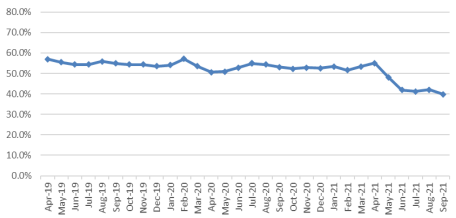
1. Falls Resulting in Harm



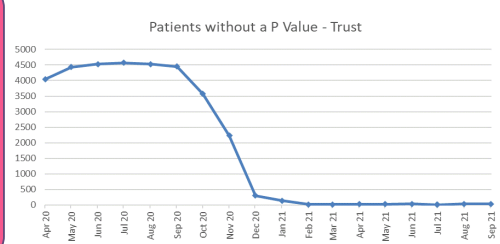
2. End of Life Care



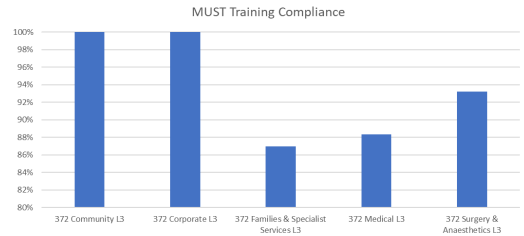
3. Clinical Documentation

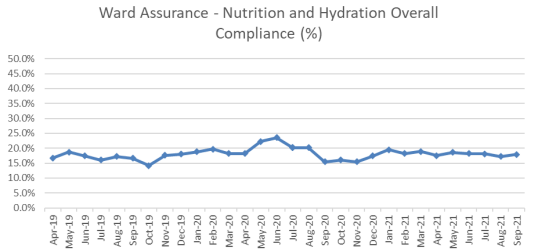


4. Clinical Prioritisation (Deferred care pathways)



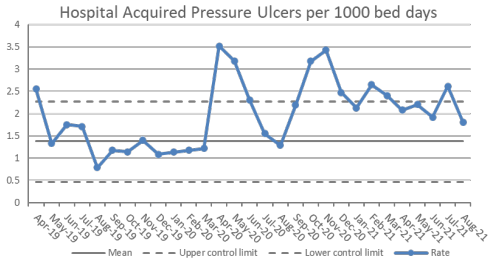
5. Nutrition and Hydration

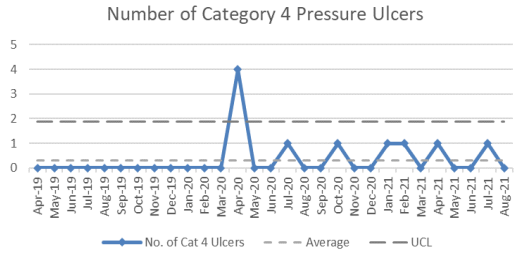




6. Pressure Ulcers

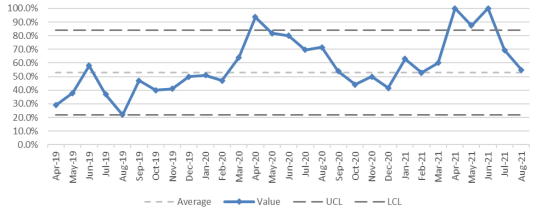
(Reported a month in areas)





7. Making Complaints Count

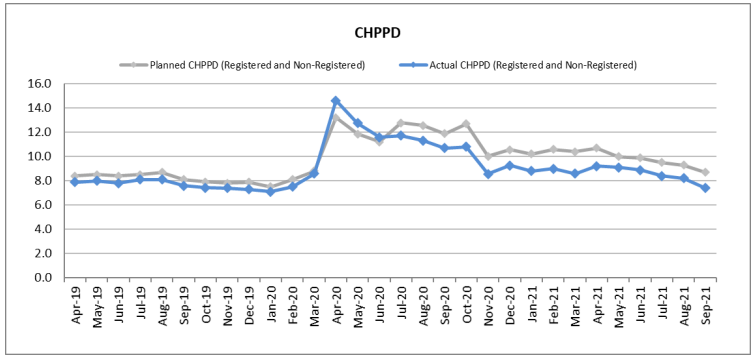
(Reported a month in areas)



Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

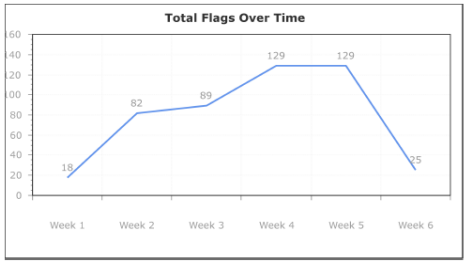
	Jul-21	Aug-21	Sep-21
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	90.4%	90.7%	86.5%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	90.6%	91.4%	89.6%
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	9.5	9.3	8.7
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.4	8.2	7.4

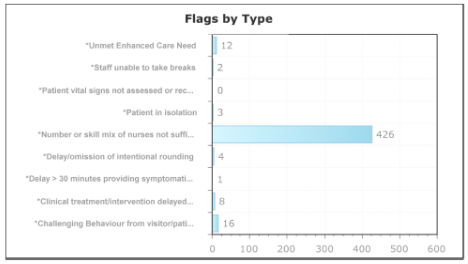


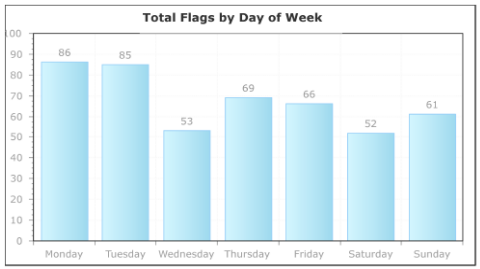
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

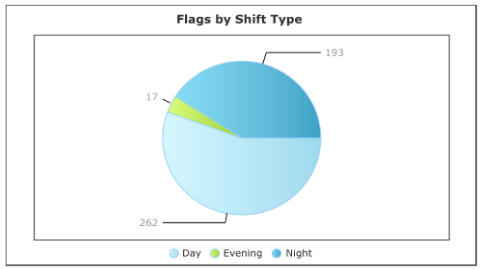
A review of September 2021 data indicates that the combined RN and non registered clinical staff metrics resulted in 23 of the 27 clinical areas having fewer CHPPD than the planned, this is coupled with a reduction in the percentage of shift fill-rates. The September position shows a further deterioration on the August position which is reflective of increased staff absence due to both Covid and non-Covid sickness. Professional judgement is used daily to establish safe staffing in these areas. Areas with CHPPD greater than planned is attributable to 1:1 enhanced care requirements or inclusion of therapists in the care hours where these are single ward based.
A review of the nurse sensitive indicators show falls in both the medical and surgical division are of concern as are the increased prevalence of pressure ulcers in the surgical division.

STAFFING RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required.

Hard Truths: Safe Staffing Levels (2)

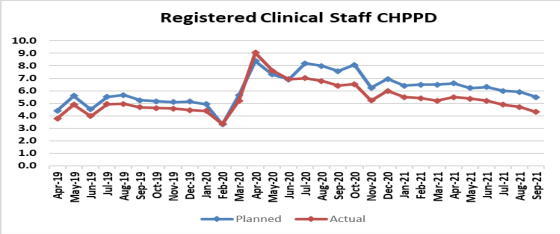
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 5.5 for planned and 4.3 For actual for Registered Clinical Staff.

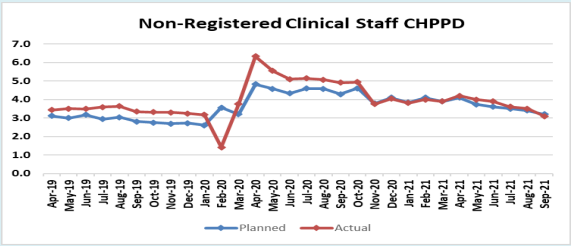


Overall there is a shortfall of 1.2 CHPPD against an overall requirement of 5.5. CHPPD. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations. For those indicators reported against there has been an increase in the number of falls, but a slight decrease in the number of pressure ulcers in month, though these still remain high but within normal variance.

Non Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.2 for planned and 3.1 for actual for Non-Registered Clinical Staff.



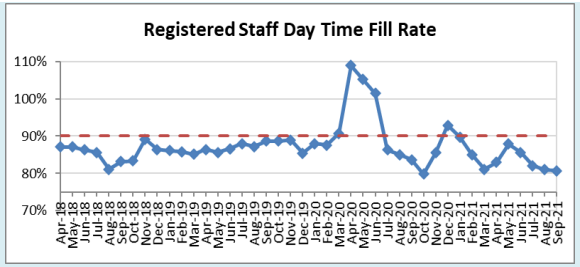
Overall there is an increase in the CHPPD of 0.1 for non-registered clinical staff, which is reflective of the successful recruitment to this workforce group. It is also reflective of the response to mitigate the clinical risk to patients due to the shortfall in Registered Clinical Staff CHPPD.

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

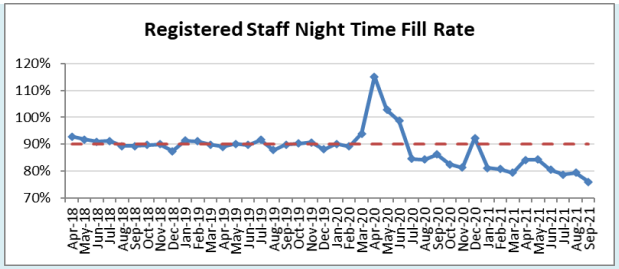
80.69% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

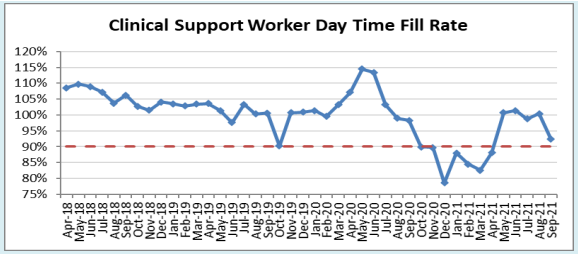
75.98% of expected Registered Clinical Staff hours were achieved for night shifts.



Non Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

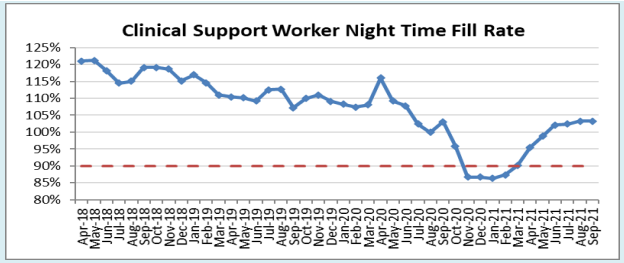
92.37% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non-Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

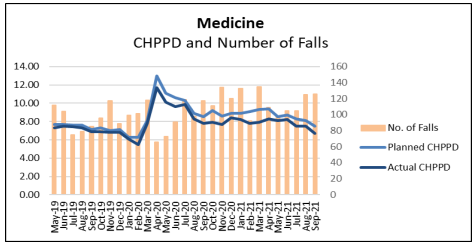
103.26% of expected Non-Registered Clinical Staff hours were achieved for night shifts.

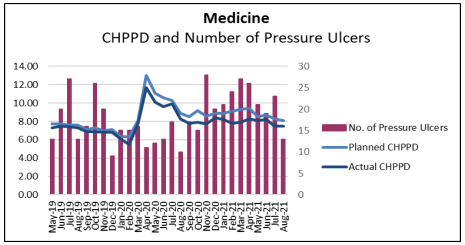


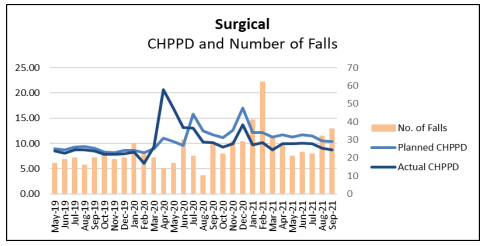
Hard Truths: Safe Staffing Levels (3)

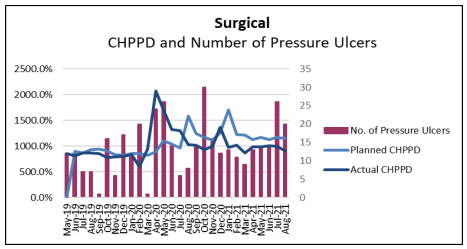
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				Care Hours Per Patient Day		Nursing Quality Indicators					Safecare	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month in Areas)	Falls	Staffing Red Flags	Ward Assurance	Number of red shifts	Number of amber shifts
Medicine	**83.4%**	**95.7%**	**76.3%**	**108.0%**	**7.5**	**6.7**	**0**	**16**	**123**	**294**	**46%**	**773**	**59**
CRH ACUTE FLOOR	96.8%	99.7%	90.7%	107.2%	6.7	6.5		3	17	20	53.5%	59	5
HRI ACUTE FLOOR	81.9%	84.7%	85.6%	82.9%	7.7	6.5		8	15	26	45.6%	61	7
RESPIRATORY FLOOR	65.0%	76.6%	71.3%	81.2%	9.8	7.1			17	30	41.1%	60	11
WARD 5	67.2%	112.9%	68.9%	140.5%	6.6	6.3			7	38	41.4%	66	5
WARD 6	78.2%	75.1%	101.7%	99.8%	4.1	3.5		1	12	7	49.7%	49	3
WARD 6C	85.7%	149.0%	87.1%	155.6%	10.2	11.8			2	3	42.8%	40	3
WARD 6AB	85.7%	149.0%	87.1%	155.6%	4.9	5.7			12	36	47.3%	66	7
WARD CCU	66.7%	87.7%	71.7%		8.2	6.4			1	12	51.7%	36	3
STROKE FLOOR	163.4%	109.5%	80.8%	97.6%	7.8	9.1			8	47	50.3%	25	3
WARD 12	87.6%	90.6%	100.0%	110.0%	6.8	6.4			10	2	34.3%	28	1
WARD 15	68.2%	87.1%	57.5%	112.2%	7.2	5.8			11	46	43.0%	83	3
WARD 17	81.0%	83.1%	67.1%	132.0%	6.7	5.7			4	5	40.7%	61	1
WARD 18	50.4%	82.2%	50.0%	88.9%	13.4	9.0		3		3	55.7%	55	6
WARD 20	68.0%	85.8%	57.8%	110.7%	7.0	5.6		1	7	19	44.7%	84	1
Surgical	**79.0%**	**90.1%**	**74.1%**	**101.8%**	**10.4**	**8.7**		**17**	**33**	**59**	**49.8%**	**253**	**51**
WARD 21	69.9%	91.6%	63.4%	125.9%	7.9	6.8		1	4	4	50.2%	30	6
WARD 22	91.3%	101.3%	71.5%	119.0%	6.7	6.2			3	4	46.1%	51	8
ICU	75.2%	65.9%	76.9%	55.5%	35.4	25.8		12		1	58.4%		
WARD 8A	83.6%	58.0%	68.3%	104.3%	18.2	13.5			2	1	60.4%	9	3
WARD 8B	100.1%	72.5%	100.0%	80.4%	6.8	6.1			2		45.0%	29	6
WARD 8D	59.2%	76.7%	35.0%		24.1	13.6					52.4%	9	1
WARD 10	70.1%	102.6%	67.8%	101.2%	11.4	9.3			1	1	52.4%	21	3
WARD 11	80.3%	119.7%	98.1%	113.9%	6.6	6.8			5	16	53.8%	28	6
WARD 19	85.8%	105.3%	71.1%	121.3%	7.6	7.3		2	11	3	39.4%	15	9
SAU HRI	84.2%	96.5%	77.4%	95.6%	6.8	5.9		2	5	29	39.9%	61	9
FSS	**78.3%**	**85.0%**	**79.0%**	**86.7%**	**11.2**	**8.9**	**0**	**0**	**0**	**5**	**12.3%**	**38**	**6**
WARD LDRP	76.2%	73.2%	76.4%	71.1%	22.5	17.0				2	12.7%		
WARD NICU	80.1%	71.7%	84.4%	94.2%	13.9	11.4					10.6%		
WARD 3ABCD	73.5%	89.3%	75.2%	83.2%	14.0	10.7				1	14.1%		
WARD 4ABC	87.4%	103.0%	85.9%	101.4%	4.7	4.3				2	11.9%	38	6
TRUST	**80.69%**	**92.37%**	**75.98%**	**103.26%**	**8.7**	**7.4**							









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments.

On-going activity:
1. A revised 'worryward' dashboard has been approved as part of the Hard Truths section of the IPR which closely aligns the workforce position to an agreed suite of nurse sensitive indicators. This is monitored weekly as part of the senior staffing group.
2. The Nursing and Midwifery Workforce Steering Group is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI.
3. A section on Knowledge Portal Plus has been developed to support triangulation of the workforce position to the agreed suite of nurse sensitive indicators and has been supported with a staff engagement and training exercise.
4. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment.
6. International recruitment project continue to progress well with 46 recruits of the planned 70 resident in the UK at the end of September. A further 10 are in place for October arrival, with the remaining 14 due to arrive in November and December.
7. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy, with cohort 4 of the TNAs due to register in January 2022 providing a further 13 registrants for the New Year.

22. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Board Assurance Framework – Update 2 2021/22
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 12 October 2021

Purpose of the Report

The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year.

This report presents the second update of the Board Assurance Framework (BAF) for 2021/22 for approval and is recommended to the Board for approval following review by the Audit and Risk Committee on 12 October 2021.

Key Points to Note

Risk Profile
The Trust has the following risk profile for its strategic risks as at 22 October 2021:

BAF Risks	Total Number of Risks	Change
Red Risks (15 - 25)	13	+ 1
Amber Risks	8	None
Green Risks	1	-1
Total	22	0

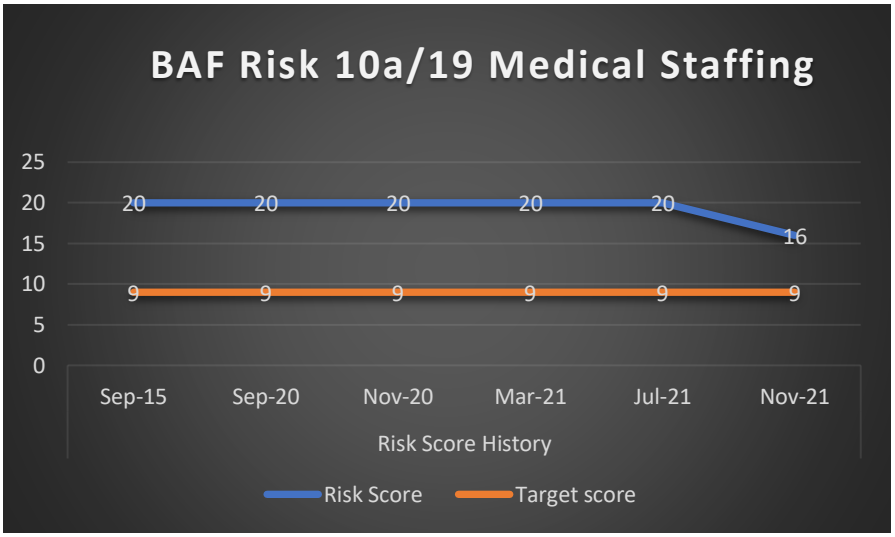
There have been no new risks added to the Board Assurance Framework (BAF) since the last report presented to the Board on 1 July 2021.

All BAF risks have been reviewed and updated by the lead Director with updates shown in red font for ease of reference in the enclosed full BAF document.

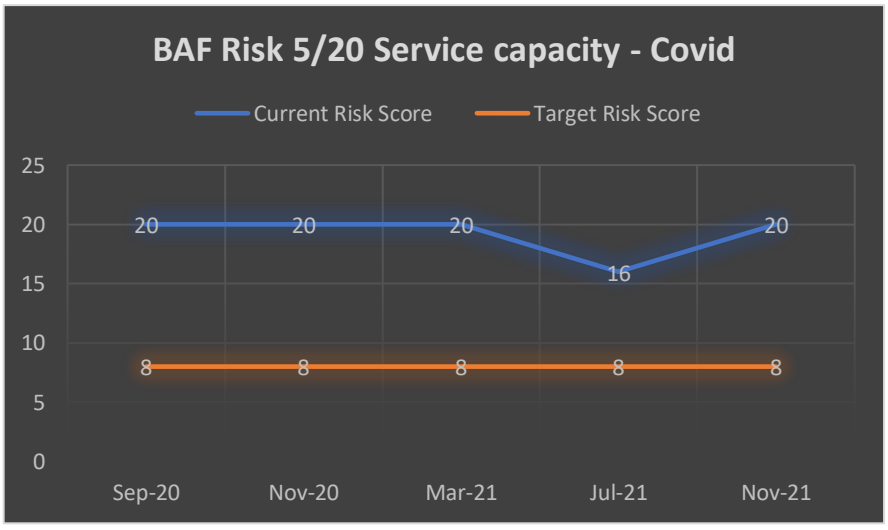
Risk Score Movement
There have been reductions in one risk score and an increase in four risk scores shown below. Rationale for this movement in risk score is given below.

Risk score movement	Risk reference and score
↓ 20 to 16	10a/19 Medical Staffing

16 to 20	5/20 Service capacity due to Covid response
6 to 9	3/19 Seven Day Services
12 to 15	6/19 Quality and Safety
9 to 12	12/19 Colleague engagement



- *10a/19 medical staffing* - reduced risk score from 20 to 16 due to an overall improving picture, net recruitment gain of 35 medical and dental posts (from July 2020 to July 2021), 9 Radiology posts recruited to (6 Consultant, 3 Global Fellows). Emergency Department medical staffing position remains an ongoing issue therefore risk not reduced further than 16.



- *5/20 capacity* - Having reduced in risk score from 20 to 16 in July 2021, this risk has been increased in score back to 20 reflecting that the Covid position is not improving, CHFT seems to be more impacted by ongoing Covid demand than neighbouring organisations and issues with nurse staffing availability.

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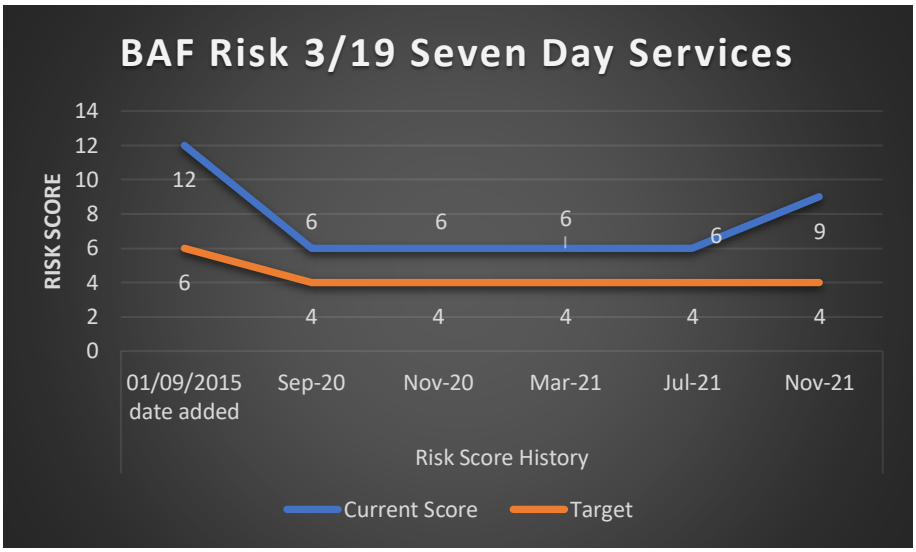
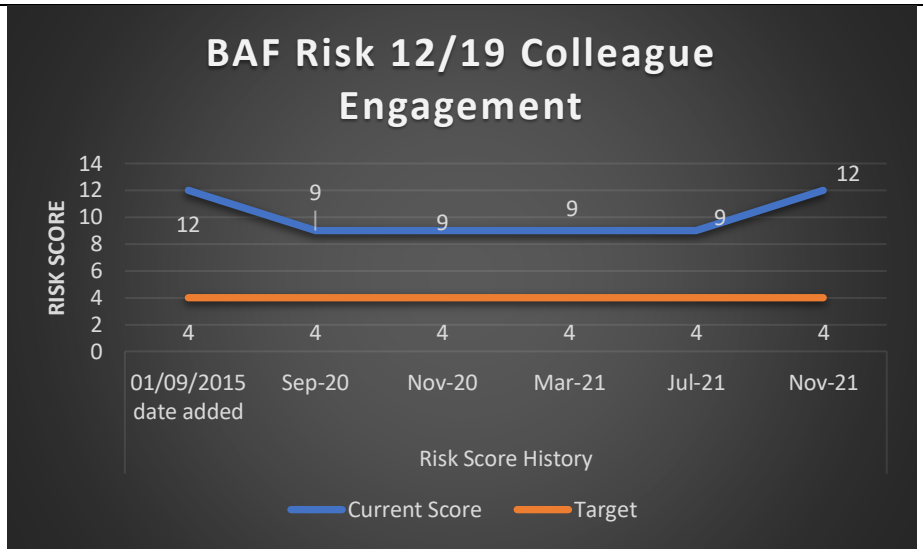


- *3/19 Seven day services* increased risk score from 6 to 9, with increased likelihood from 2 to 3 due to rapidly changing rotas to manage continually changing Covid activity.

- 6/19 Quality and Safety - increased score from 12 to 15 due to increase of likelihood from 4 to 5 due to general operational pressures, which have meant that we have seen an increase in non-elective activity, with the Elective Recovery programme adding to operational demands, with the number of Covid patients increasing and staff availability reducing.



- *12/19 Colleague engagement* - increased score from 9 to 12 reflecting increasing difficulties in engaging with colleagues who have lower morale than 12 months ago. The Trust is reliant on colleagues telling us how we can help our fatigued colleagues.

  To note the score for risk 11/19 re recruitment and retention was reviewed however there has been no score increase as at present we have only seen minimal impact on retention.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate or low) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 22 October 2021 the Trust has ten areas of risk exposure summarised below, an increase of two since July 2021:

Strategic Goal: Transforming and Improving Care	Risk Score	Risk Appetite category	Risk Appetite
4/19 Patient and Public Involvement	16	Regulation	Moderate
7/20 Reducing health inequalities	16	Harm and safety	Low
Strategic Goal: Keeping the Base Safe			
6/19 Quality and Safety (newly added)	15 ↑	Regulation	Moderate
4/20 CQC rating	16	Regulation	Moderate
7/19 NHS Improvement Compliance	20	Regulation	Moderate
8/19 Performance targets	16	Regulation	Moderate
5/20 Service capacity due to Covid-19	20 ↑	Harm and safety	Low
Strategic Goal: Workforce			

12/19 Colleague engagement (newly added)	12↑	Workforce	Low
Strategic Goal: Sustainability			
14/19 Capital funding	16=	Financial/Assets	Moderate
18/19 Long term financial sustainability	16=	Financial/Assets	Moderate

These areas of risk exposure are shaded in grey in the summary sheet of risks in the enclosed BAF.

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust making slow progress addressing health inequalities in the 20% of the most deprived patients in our communities.

The Trust has a regular report on progress with health inequalities actions at Board meetings.

In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.

Recommendation

The Board is asked to **APPROVE** the updated Board Assurance Framework as at 22 October 2021, noting the movement in risk scores and areas of risk exposure.

Update 2 - 4 October 2021
2021/22

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2021/22

Contents:

compassionate care

CHFT RISK APPETITE STATEMENT - Revised September 2021

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We will always explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming and Improving Patient Care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	15 =	10	AB	2827, 5806,7413,7414	Strategic/ Organisational	Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	9 ↑	4	DB	None	Regulation	Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient recommendations	12	16 =	4	EA	None	Regulation	Moderate
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce	15	12 =	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	12	12 =	9	MG	7,617	Innovation/ Technology	High
03/20	Risk the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation, resulting in the Trust not being able to stabilise the future delivery of services and missing opportunities for improvement in the quality, experience and efficency of service delivery.	12	12=	8	AB	None	Strategic/ Organisational	Significant
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete data, mismatch between service and deprivation, lack of quality priorites to advance health equity and health prevention, ineffective partnership working a resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	16=	8	EA	None	Harm and safety	Low
Keeping the base safe								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	15 ↑	10	EA	see individual sheet	Regulation	Moderate
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement resulting in enforcement action	25	20 =	10	OW	None	Regulation	Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	16 =	12	BW/JF	7615	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	15 =	8	GB	5806	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	9	9 =	4	SD	7413, 7414 , 7474	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation	12	16=	6	EA	None	Regulation	Moderate
05/20	Risk that services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand and non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality.	20	20 ↑	8	OW	7689, 7683, 7809, 7834, 7634	Harm and safety	Low

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

A workforce fit for the future								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16** ↓	9	DB	2827,7078, 5747	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	EA	6345, 7557, 8079	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms	12	**12** ↑	4	SD	None	Workforce	Low
Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**16 =**	12	GB	None	Financial/Assets	Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution..	**9 =**	6	6	GB	None	Commercial	High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16=**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure resulting in adverse impacts on public health, patients, natural environment and reputation denotes risk with risk exposure	16	**12=**	9	SS	None	Strategic/ Organisational	Significant

HEAT MAP

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)			6/19 Compliance with quality standards ↑	05/20 Service Capacity due to Covid-19 response ↑	
Likely (4)			02/20 Digital Strategy = 12/19 Staff engagement ↑	14/19 Capital = 07/20 Health Inequalities = 04/20 CQC rating = 4/19 Public involvement = 18/19 Long term financial sustainability = 8/19 National and local performance targets = 10a /19 Medical Staffing levels ↓	10b/19 Nurse Staffing levels = 7/19 Compliance with NHS Improvement =
Possible (3)		15/19 Commercial growth	16/19 Health & Safety = 3/19 Seven day services ↑	11/19 Clinical leadership = 03/20 Business Better Than Usual service transformation = 01/20 Clinical Strategy = 06/20 Climate Action Failure =	1/19 Approval of hospital reconfiguration strategic outline case, outline business case and full business case = 9/19 HRI Estate fit for purpose =
Unlikely (2)					
Rare (1)					

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021** **Risk category: Strategic** **Risk appetite: Significant**		
								Initial	**Current**	**Target**
1/19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire & Harrogate Health & Care Partnership and commissioners to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and CCGs ability to provide formal letters of support for the business cases. A local system Partnership Transformation Board that has members from CCGs, ICS, YAS, and the Trust meets monthly to ensure system alignment and support for business case planning assumptions and development.	<u>First line</u> Transformation Programme Board- oversight of governance and content of business case development including relationship management with Stakeholders and NHSE/NHSI, DHSC <u>Second line</u> Trust Board approval of business cases (SOC approved, March 2019).OBC for CRH and FBC for HRI scheduled for approval by October 2021. <u>Third line</u> ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019	• See below for further detail. 1. Clinical protocols to be agreed with Yorkshire Ambulance Services 2. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 3. Agreement for development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	Moving forward, subject to approval of OBC, the Trust will need to review the technical and other skills capacity and capabiltity to progress the next stages of the programme to FBC.	5x5 = 25	3x5 = 15	2x5 = 10

Gaps in Control	**Timescales**	**Lead**
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	1. Discussions are taking place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion. 4. The Trust has submitted a planning application for the mutli-storey car park to Calderdale Council in July 2021. The Trust's Travel Plan and Green Plan have been developed. The Travel Plan has been approved by the TPB and the Green Plan by the Trust Board.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A&E - workforce standards, A&E and critical care
5806 - urgent estate work not completed
7413 - fire compartmentation risk HRI
7414 - building safety risk, HRI

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021 Risk category: Regulation Risk appetite: Moderate**		
3/19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place, Learning from Deaths group and Care of the Acutely Ill Programme re-established, reports to Clinical Outcomes Group and Quality Committee. Quality Comittee oversight of SHMI / HSMR. • Rosters focussed on managing Covid-19 providng extended cover • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology, gastro, stroke, haematology, acute medicine, diabetes with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR better than expected, SHMI increasing though remains within expected range largely as a result of out of hospital mortality. Second line Deep dive report on this risk to Quality Committee 30.12.20. minor amend to risk description Integrated Board report with SHMI/HSMR reporting. Annual Learning from Deaths report to Board July 2021. Quarterly Learning from Deaths report to Board (4 March 2021, 1 July 2021) Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme Benchmarking exercise against remaining 6 non-priority standards to report to WEB	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant -directed interventions - expect this to improve once newly appointed Radiologists in post. Improved staffing in Accident and Emergency, however remains insufficient to deliver extended Consultant presence in accordance with National Guidance. Challenging to meet this standard until reconfigured service in place. Diagnsotic capacity in Radiology and Endoscopy limited by requirements of Covid-19 IPC. Endoscopy waiting lists are challenging - action: plan additional internal activity as part of Recovery response; in -sourcing and outsourcing under consideration : COO. Resource to audit 4 standards to be confirmed, impacted by covid. Audit to assess impact of expanded 7 day working on outcomes: Working Together to Get Results session held June 2021 on Quality Directorate capacity to identify resource- Quality Directorate structure reviewed to identify additional support for the work.	• Scope for futher implementation limited without service reconfiguration or additional investment NHS I suspended collection of reports on seven day service standards due to Covid-19 in March 2020 Action: Explore local audit measures - EL Lead: Deputy Medical Director Future response to Covid-19 may impact delivery of 7 days services in some specialities as a result of changes to both medical and nursing rotas. In principle aim to meet seven day standards(7DS) but these have not been measured; position variable depending on Covid situation and escalation and impact Action: Associate Medical Director (EL) looking at how to start gathering data on 7DS impacted by changes to manage covid so 4 key standards not been measured.	**Initial** 5x3 = 15	**Current** 3x3= 9 ↑	**Target** 2x2 = 4

Action	**Timescales**	**Lead**
Ongoing review of staffing pressures A&E	Ongoing	DB/CP
Explore undertaking local audit of seven day standards	April 2022	EL

Links to risk register:
No high level risks with score >15

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021 Risk category: Regulation Risk appetite: Moderate**		
4/19	Quality Committee	Executive Director of Nursing / Deputy Chief Executive	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) in place which mandates the workplan and oversees progress and audit activity for public invovlement and patient experience Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs Patient and Service User Engagement Strategy approved by Quality Committee • Patient engagement in Outpatient Transformation Programme • Patient Engagement champions in clinical areas to support staff in engaging with patients and service users • Nursing and Midwifery Strategy which enables staff time to care for patients • Health Inequalities group established and developed workplan with a focus on the experience of BAME services users and people living with learning disabilities BAME Community Engagement Advisor Engagement appointed to work alongside the CHFT BAME network group and create engagement opportunities with local BAME communities • Matron assigned to Reconfiguration Team to lead on patient experience	First line Patient Experience Group, areas of good practice with service users identified eg co design and development of children's community hub, continuity of carer maternity teams supporting greater engagement in decisions about personal care (BAME / areas of deprivation), engagement on relocation of Rainbow Child Development Service, project to improve access to healthcare for disadvantaged groups focused in ED, new Clinical Nurse Specialist post for transition of young people with neruo-disability. Introduced Observe and Act observation tool initiative to "see through the patient eyes" .Regular review by Quality Committee Second line Patient Story to Board meetings Governor attends PEG PEG reporting to Quality Committee quarterly, CCG membership at Quality Commitee. Board quality report inlcudes a section in relation to service users involvement Third line Quality Account to NHS Improvement, CCGs and other stakeholders, CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead Assistant Director for Patient Experience, March 2022 Lack of mechanism for systematic involvement of members of BAME communities. Action: Implementation of Patient and Service User Engagement Strategy , Assistant Director Patient Experience, review March 2022 Current operational pressures are impacting on the pace of progression of some workstreams.	Well-led developmental review identifies actions to improve patient involvement and Equality & Diversity - action delayed due to repsonse to Covid-19 pandemic. Action to pick up as Business Better Than Usuual, lead: Director of Nursing and Associate Director of Patient Experience - this was delayed as a result of pandemic response, to be picked up in Q1 2022	**Initial** 3x4 = 12	**Current** 4x4 = 16 =	**Target** 1x4 = 4
Action					**Timescales**			**Lead**		
Implementation of Patient and Service User Engagement Strategy					March 2022			Quality Directorate / L Rudge		
Links to risk register: No risks on the high level risk register										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk and 3/20 Business Better Than Usual risk .	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved Board Business Better Than Usual report to 2 July 2020 Board describing learning from Covid-19 will help to inform any necessary adaptation of the Clinical Strategy ICS clinical forum 7 July 2020 discussed Planned Preventative Care post Covid-19 Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Common LIMS procured now being rolled out	Non-Surgical Oncology - acute system pressures across West Yorkshire require additional support from CHFT. Action: Working with LTHT, MYHT to ensure short term service support in place, contributing to ongoing work to identify a sustainable solution across West Yorkshire - report Autumn 2021 West Yorkshire and Harrogate Clinical Strategy under development WYAAT and ICS system-wide approaches to reset Performance of CHFT in relation to Covid recovery programme may reduce ability to deliver new services Consideration to be given to primacy of PLACE v system.	None at present	**3x5=15**	**3x4=12**	**2x5=10**
Action					**Timescales**			**Lead**		
WYAAT - agreement of West Yorkshire Clinical Strategy					Clinical Lead WYAAT			David Birkenhead, Medical Director WYAAT Chief Executives		
Links to risk register: None See 1/19 reconfiguration BAF risk and 3/20 BBTU risk										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
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								Initial	**Current**	**Target**
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the 10 year digital strategy Digital Aspirant and Scan for Safety funding for next 2 years to March 2023 and committed capital funding from the Trust which will enable progression along the national Digital Aspirant Programme Dedicated Digital Transformation Director co-ordinating digital programmes and providing leadership Governance via Digital Health Forum and Digital Operations Board. Digital Operations Board chaired by Managing Director Digital Health, with reviewed terms of reference Monthly meetings with Managing Director Digital Health and Director of Finance reviewing progress with digital investment strategy - Divisional Digital Boards which report into the Digital Operations Board with revised terms of reference which will ensure clarity of purpose of group and consistent approach	**First Line:** Digital Health Forum meeting bi-monthly, programme of work and progress presenned at each meeting **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2021/22 secured as part of capital planning meeting November 2020. Progress update on paper reduction to WEB 18.2.21. Annual review of 5 year Digital Strategy Board 1 July 2021, Finance and Performance Committee 28th June 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS **Third Line:** Digital Aspirant Trust Scan for Safety Programme in progress.	Lack of consistent attendance at Digital Operational Board meetings - Action: Divisional Directors and Chief Operating Officer to ensure appropriate resource identified to attend divisional digital Board meetings - still inconsistent but improving - new TOR and governance from October 2021 Lack of prioritisation process for digital projects: Action: Create formal prioritsation process at Capital Investment Strategy Group Lead: Managing Director - Digital Health Timescale: In place for March 2022 Review of digital health team capacity and capability Action: Redefine scope of digital health programme in line with EPR optimisation, reconfiguration and cross - organisational partnerships Lead: Managing Director - Digital Health Timescale: October 2022	Managing Director Digital Health to launch revised governance with Divisional Digital Boards	**4x3 = 12**	**4x3 = 12**	**3x3=9**

Action	**Timescales**	**Lead**
Lack of prioritisation process for digital projects	Create formal prioritsation process at Capital Investment Strategy Group	Jim Rea, MD - Digital Health
Review of digital health team capacity and capability	Redefine scope of digital health programme in line with EPR optimisation, reconfiguration and cross - organisational partnerships	Jim Rea, MD - Digital Health
Ongoing monitoring via Finance and Performance Committeee		Kirsty Archer /Gary Boothby

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
03/20 July 2020	Transformation Programme Board	Director of Transformations and Partnerships	**Business Better Than Usual (BBTU)** There is a risk that the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation. As a result the Trust may not be able to stabilise the future delivery of services and will miss opportunities for improvement in the quality, experience and efficency of service delivery.	CHFT has engaged colleagues, patients and partners across the Calderdale and Greater Huddersfield health and social care system to capture learning from experience of their responses to the COVID -19 pandemic. The findings from this were presented to the Trust Board on 2nd July 2020 and 12 key learning themes of transformational changes that should be sustained and amplified were agreed by the Board. Governance and management arrangements to provide assurance on the implementation of this have been agreed by the Trust Board and have been implemented. This includes: - appointment of theme leads - establishment of BBTU Delivery Group - oversight by Transformation Programme Board	**First Line** - A BBTU Delivery Group chaired by the CEO has been established and includes membership of a named Lead for each learning theme. The Delivery Group will lead implementation and provide progress reports to the Transformation Programme Board. (8.7.21.) **Second Line** - the Transformation Programme Board will provide oversight of the BBTU programme of delivery and and provide updates on progress to the Trust Board. **Third Line**. External - the Trust will collaborate and work with external stakeholders (e.g.CCGs, acute and mental health Trusts, community providers, hospices, voluntary sector, social care, the West Yorkshire ICS, and NHSE) to progress and provide regular updates on actions to respond to learning from the pandemic.	Impact Assessments to be completed: Additional work is required to ensure and demonstrate that implementation of BBTU includes assurance of robust EQIA, QIA, digital impact assessment and patient involvement and to provide reports on this to the Workforce and Quality Committees. As the plans for implementation of each theme develops further work will be needed to assess the financial impacts of BBTU and provide reports on this to the Finance and Performance Committee. Regular quarterly updates are being provided to the TPB, Quality, WOD and F&P Committees. Lead: Anna Basford Timeframe: ongoing every quarter -	The work to implement BBTU is progressing and update on key milestones is being reported at quarterly intervals to Board sub-committees. Review meetings with each theme lead are being scheduled with regular fortnightly briefing update provided to the CEO. BBTU is one of the programmes of transformation and efficiencies that will contribute to the Trust H2 plans being submitted to Trust Board in November 2021.	**3x4=12**	**3x4=12**	**2x4=8**
Action					**Timescales**			**Lead**		
Work to clarify the impact of BBTU on operating costs and efficiency is on-going.					Work to clarify the impact of BBTU on operating costs and efficiency is on-going.			AB/KA		
Links to risk register:None										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Director of Nursing / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Actively addressing the urgent actions for health inequalities set out by NHS E/I. Health Inequalities Group, chaired by NED, ensures oversight of all Trust workstreams in relation to health inequalities. Equality impact assessment (EQIA) process for service and policy changes. Health Inequalities is reported formally into Trust Board. Board development sessions include deep dives on issues relating to health inequalities to increase knowledge of Board members on why addressing health inequalities is important and provide insight to local health inequality issues Diversity - 1 Executive and 1 Non-Executive BAME members of the Board brings lived experience to help tackle health inequalities. Trust Diversity and inclusion networks and 5 year plan for inclusion (Staff).The ethnicity of the Trust Board reflects its workforce and local communities. West Yorkshire and Harrogate Healthcare Partnership (ICS) - Trust plays a full part in Health and Well-Being Boards and place-based partnerships, where reducing inequality is an ICS goal and exemplified in the Professor Dame Donna Kinnair DBE review. CHFT part of the Health Inequalities Academy to share best practice and agree workstreams. Nominations and Remuneration Committee (Board of Directors) agreed actions to improve Board diversity as part of succession planning and Inclusive Recruitment Strategy for Director vacancies 12.2.21.	**First Line** - developing data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. Project in Maternity Services underway to look at outcomes and experiences of those from most deprived areas in the community. **Second Line** - Board development session 3 June 2021 re health inequalities locally and the imapct of becoming an anchor organsiation. Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties: Regular updates to Board by Health Inequalities Group leads (6.5.21., 1.7.21. 2.9.21) with workstream updates. A Board succession plan has been approved which seeks to ensure that there are clear talent pipelines for each Executive and non Executive role in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** WYAAT Committee in Common report by Trusts on impact of inequalities on patients, elective recovery and waiting times.27.7.21	Health Inequalities Academy workstreams yet to be defined Leadership - Reflect our diverse community through a 5 year Board action plan for Board and senior staffing to match the BAME workforce by 2025.	There are no expectations on reporting externally, however Trust working with and reporting to the ICS and WYAAT.	4x4=16	4x4=16	2x4=8
Action					**Timescales**			**Lead**		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2021 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
06/19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety Quality and Safety Strategy - each clinical division reports into performance review meetings on delivery of the ambitions of the strategy • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers Strengthened quality section within performance review meetings more in depth analysis of quality and safety priorities • Programme of ward assurance visits in place - clinical area quality dashboard in place reviewed at Gold Command (weekly) and weekly at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry • Consistent mandatory and essential training compliance Care of the Acutely Ill Patient programme in place to improve mortality outcomes • Risk management strategy. • Learning and Improving: Quality and Safety Strategy agreed and rolled out	<u>First line</u> Assessment of compliance with NICE guidance Ward accreditation - J2O Jouney to outstanding in early phases of roll out. Performance against saferty must dos reviewed at ward / matron level HSMR & SHMI Mandatory training compliance Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group <u>Second line</u> Clinical audit plan reviewed Bi-monthly Quality Report to Quality Committee and Board KPIs in Integrated Performance Report PSQB reports to Quality Committee Infection Prevention and Control report to Board IPC Board Assurance Framework approved at Board 2 July 2020, progress with IPC BAF recommendations regularly report to Board via Quality report and reviewed through governance structures Serious incident report to Quality Committee Safer Staffing Hard Truths report to Board 4.11.21. <u>Third line</u> CQC rating of Good Quality Account reviewed by stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies CQC TMA visits have taken place in ED, Maternity and Vaccinaition centre. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports	• Investigator capacity to support Si investigations and standard of serious incident investigations needs further improvement Alternative model for investigators to Quality Committee • Safety "must do's" to be embedded on wards - • Quality and Safety Strategy to be rolled out Q4 2020/21 and Q1 2021/22, Divisions need to adapt the strategy to their local needs	• CQC assessed the Trust as requires improvement for safe domain • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements - see 10a/19 (Allocate) • There has been a move away from non essential activity by relevant regulators in response to the pandemic. • Regular leadership assurance visits not being undertaken regularly due to operational pressures.	3x5 = 15	3x5= 15 ↑	2x5 = 10

Action	Timescales	Lead
Develop alternative model for serious incident investigtaors and present to Quality Committee Quality and Safety Strategy to be adapted divisonal needs	March 2022	EA AD Quality & Safety

Links to risk register:
Risk Opthalomology (7930 glaucoma. 7809, clinical capacity, 7689 waits for diagnostics, operations and outpatients, 7683 isolation capacity, 7474 Medical devices, 7809 theatre and clinic capacity, 7834 Elective orthopaedic inpatient theatre capacity, 6453 delay of surgical repair of #NOF, 7527 maxillofacial follow up appointment, 2827 ED middle grade medical staffing capacity, 7615 emergency care delays not meeting the 4 hour emergency care standard, 6715 inconsistent completion EPR documentation

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2021 Risk category: Regulation Risk appetite: Moderate
7/19	Finance and Performance Committee	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Board approved 10 Year Strategic Plan • Board member participation in Place based system meetings with NHS E/I(1 Kirklees, 1 Calderdale) with ICS feedback letter • ICS system financial regime • Standing Financial Instructions and budget management • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources work steered by Finance and Performance Committee • Executive leads assigned for 5 Use of resources areas with working groups reporting to Executive leads • Post project evaluation reported at Capital Management Group for capital schemes and Commercial Investment Strategy group for revenue investment	<u>First line</u> Transformation project support Monthly monitoring of performance and Covid spend Minutes from Capital Management Group and Commercial Investment Strategy Group, reporting into Finance and Performance Committee. <u>Second line</u> Integrated Board report monitoring of key regulatory standards to every Board public meeting and Finance and Performance Committee, most recent F&P discussion UoR update provided to F&P on 1.6.21 that detailed actions taken from last inspection and provided evidence of where discussions take place and where further improvement remains in focus. A repository of information is available with evidence of discussions and actions along with updated metrics. On a control total basis the Trust has delivered a surplus financial position (£360k) for the 2nd year running and this has also resulted in a revised external audit VFM assessment that reflects the progress made. <u>Third line</u> Current use of resource score was a 2 from April to August 2020 which was an improvement from 3. However, due to loan repayments in September 2020 the capital service cover element of the score became a 4, and overall rating defaulted to a 3. This was a technical anomaly and was discussed in detail at Finance and Performance Committee and with NHS E/I. A decision was taken to adjust the score to report a score more reflective of current performance. This improved the score to a 2. The Trust closed 20/21 with a score of 2. Further autonomy granted from NHS E/I as result of performance and delivery of the 2019/20 control total from NHSE/I.	Efficiency methodolgy is being developed Funding settlement for H2 issued 30 September 2021 and revised financial plan to Board for approval 4.11.21.	• Performance against key targets • Use of Resources rating of requires improvement. Use of Resources external assessment has not been completed as benchmarking data is not available and no external capacity to provide a valued assesment.	Initial: 5x5 = 25 Current: 4x5 =20 = Target: 2x5 = 10

Action	Timescales	Lead
Implications of H2 planning guidance being considered for Trust and ICS - paper to Board 4.11.21.	4.11.21	Acting Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
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8/19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets due to a needs-based stabilisation and reset plan **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders Clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need Increased number of outcome metrics within performance reporting monitored through performance framework Performance Management and Accountability Framework to support delivery of national standards and Trust quality,financial and operational objectives. Current Covid-19 management and governance arrangements in place to oversee the delivery of needs-based care. Daily escalation of performance issues from divisional hubs into Covid-19 tactical (daily meetings) with daily Gold reflecting increased pressures. Weekly review of KPIs with Directors of Operations (D Ops), Assistant Directors of Nursing, plus 1:1 with COO and D Ops. Local triggers for wave 4 agreed by Recovery oversight group - working well and used for wave 3 monitoring Daily touchpoint meeting with Divisional teams for timely escalation, action and joint visibility Planned care backlogs collated & presented to Finance & Performance Committee Trajectories and tracking included in IPR Acute Respiratory Care Unit (ARCU) business case approved to build in greater resilience for managing pressures without the requirement to redeploy theatre and endoscopy staff; the provision of an ARCU will aid recruitment & retention. Clinical Reference Groups for Modelling and Health Inequalities supporting the shaping of capacity. Developing a clinical prioritisation/holistics needs assessment matrix. Waiting time modelling completed,with parameters, and shared with regulators along with needs based focus; this has been accepted Continue to utilise external capacity for backlogs, internal enhancement scheme being tested to try and secure further additionality and joint deployment team in place with CCGs to ensure opportunities managed at pace.	First line Daily Gold meetings including escalation of risks, incidents, complaints and staff concerns. Gold attended by CCG colleagues and system silver in place with wider engagement. Risk registers reviewed at Divisional PSQBs & PRMs. Weekly review of KPIs by COO and senior divisional teams Integrated Performance report focus of one WEB each month for detailed scrutiny with wider representation from divisions. Regular monitoring of waiting time past due date for clinically prioritised Second line Board sub committee detailed appraisals of position & actions. Integrated Board Report discussed at each Board sub committee and Board of Directors. Clinical Prioritisation agreed as a key Quality Indicator, led by Medicl Director reporting via PRMs and into Quality Committee Detailed review of backlog position across planned care through Finance & Performance Committee. Third line New modelling for wave 3 and scenario planning complete	Performance monitoring currently in divisional silos, Action: review current divisional performance review process and opportunity to undertake more thematic reviews: Lead: COO Timescale: commence September 2020, complete by March 2021 • Potential requirement for system focussed incident room for winter. Action: Scoping theform and function of a systemincident room. Timescale: Proposal presented to Gold in September 2021.	Developing outcome metrics however a recognised time lag for outcome to be evident. Under constant review and incorporated into IPR	**Initial** 4x5 = 20	**Current** 4x4 = 16 =	**Target** 4 x 3 = 12
Actions					**Timescales**			**Lead**		
Developing outcome metrics					Ongoing			Interim Chief Operating Officer		
Links to risk register: 7615 4 hour Emergency Care standard										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE											
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9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies &procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish nurses home, Learning Centre, DATs building and Saville Court to reduce backlog maintenance.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Review of CHS SLAs (Quantitive KPIs & Qualitative Performance) carried out Q4 2020 Audits of routine checks, estates * Newly appointed Trust Health & Safety Manager with oversight of H&S across Trust & between partners Second line Estates strategy (revised) approved at Board 2.9.21.H&S Update to Board: January 2021. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports Assurance provided by HTM Compliance reports via external Authroised Engineers inspections against HTM standars. WEB reports on medical devices July 2019 H&S Training 95% target achieved, 97% as at 10.11.21. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments *1 CQC Compliance report Premises Assurance Model (PAMs) now available and illustratesto patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Familiarisation visits by local operational Fire and Rescue teams External assurance from authorising engineers for high voltage/ low voltage systems,	* HRI investment (£20M) full business case to be agreed by regulators, however current funding for early drawdown has been supported, overseen by Transformation Programme Board • Funding for prioritised HRI work but does not cover all backlog maintenance. Discusssions ongoing with regulator and ICS on resolution to shortfall. 2021/22 is resolved but not resolved recurrently with longer term shortfall No agreed solution for cladding lead Director of Finance	There are 44 Estate Risks held on the CHS Risk Register and differences in some of risk scores between the CHS Risk Register and the Trust Risk Register. Chris Davies to attend the Risk Group to ensure a common view. Action Tom Donaghey *1 PLACE inspections not take place since 2020	**Initial** 4x4 = 16	**Current** 5x3= 15	**Target** 2x4 = 8

Action	**Timescales**	**Lead**
Ongoing discussions regarding funding CHS to attend the Risk Group to align Risk Register	Ongoing December 2021	Acting Director of Finance Acting Director of Finance/CHS

Links to risk register:
Risk 5806 - Urgent estate schemes not undertaken
Risk 7414 - Building safety risk, HRI
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
16/19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	•Board approved 5 year H&S strategy with 6 key elements, NHS Workplace Safety Standards provides framework for H&S activity. •Health and Safety Policy clearly highlights the overarching roles and responsibilities from Director level right to front-line colleagues. The roles and responsibilities clearly set-out expectations so that CHFT can be confident of meeting its legal obligations • Process and document describing process for monitoring 12 H&S specific regulatory policies (eg slips, trips and falls, absbetos) with lead per policy developed and being implemented • SLA in place for CHS to provde Health and Safety Induction Training for CHFT colleagues • Director and Non-Executive Director Health and Safety Champion identified as well as Director responsible for Fire Safety Operational responsibility for H&S across sites sits with CHS for HRI and our PFI partners at CRH - recently appointed interim technical advisor in CHS. • Proactive Health & Safety Committee. • Head of Health and Safety involved in all new sub committees to H&S committee. • Health & Safety action plan in porgress • Annual report on Health and Safety to Board, • Health and Safety action plan with updates to Board, Audit and risk Committee oversight. • Health and Safety mandatory training for staff (3 years). • Health and Safety training on staff induction.	<u>First line</u> Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . <u>Second line</u> Board joint responsibility for risk understood. WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 and 2020/21 Annual Health and Safety action plan to Board - January 2021 and 1 July 2021 • Health and Safety Strategy approved by Board 1 July 2021 • Lead Persons nominated and appointed as chairpersons of health and safety sub-groups. Updates to Board on H&S 3 September 2020, 14 January 2021 and 1 July 2021 <u>Third line</u> External health and safety review (Quadriga) 2019. Progress monitored at Health and Safety Committee. Audit and Risk Committee and Board.	Implementation of policy monitoring document and process for 12 regulatory policies, including policy revision and detailed review of individual roles and responsibilities working with sub groups (Stage 1). Lead: Head of H&S Timescale: March 2021 Stage 2:Monitoring of 12 regulatory policies compliance via auditing and dashboard reporting to H&S Committee Lead: Head of H&S Timescale: December 2022	Lead for COSHH to be established to chair COSHH sub committee.Exploring nominated representative from CHS to take on the responsibilities for COSHH lead.	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Stage 1 Implementation of H&S Policy Monitoring Document for 12 key regulatory policies	March 2022	Head of H&S
Stage 2: Monitoring of Compliance of H&S Policy Monitoring Document	December 2021	Head of H&S
Plan to identify nominated representative for COSHH through joint working with CHS	January 2022	Ian Rawson, Corporate

Links to risk register:
7413 fire compartmentation, 7414 building safety, 7474 medical devices

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
04/20 July 2020	Quality Committee	Director of Nursing / Deputy Chief Executive	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC & Compliance group meets monthly, oversses divisional compliance with regulatory standards/ compliance registers and reports to Quality Committee and Audit and Risk Committee for compliance. Regular engagement meetings with CQC Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reveiwed and updated, piloted and being rolled out	**First Line:** Reports to CQC & Compliance Group from divisions Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group **Second Line:** Quality Committee reports from CQC Group Quality update report to each Board 6 May, 1st July 2021 Review by Quality Committee and Board of progress with CQC action plan . Quality report to January, March and July Board . CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. **Third Line:** Quarterly formal engagement meetings with CQC Current CQC rating of "good" including well-led governance	CQC preparation visits had been scaled back in response to Covid priorities, Uncertainty of direction of future CQC inspection and rating regime. Developments identified from well-led governance review deferred due to operational pressures. Lead: Ellen Armistead/ Suzanne Dunkley	Journey to Outstanding in early phases of implementaion, as such there is little available data to assure. CQC new regulatory framework not yet implemented nationally.	4x3=12	4x4=16	3x2=6

Action	Timescales	Lead
Journey to Outstanding implementation underway via rolling programme	Ongoing	ADN Quality and Safety and Deputy Director of Nursing
Repeat audit of 2 recently closed CQC actions (Critical Care Anaesthetic cover, ED Consultant cover)	Q2 2022	Director of Nursing

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
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								Initial	**Current**	**Target**
05/20 July 2020	Finance and Performance Committee	Chief Executive	Risk that: - services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand. - non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	New surge plan developed and agreed across Divisions to support recovery whilst maintaining capacity and triggers for future surges. Bed plans and flow arrangements reflect the risk of increased non elective demand. IPC pathways amended to reflect national guidance, cross checked with Board of Directors principles on patient and staff safety. Maintaining separation of elective and non elective bed capacity Continuing to utilise the Independnent sector, commissooining activity for H1 and considering H2. Retained additonal diagnostic capacity to supplement reduced internal capcaity or provide additional capacity for backlog clearance and non elective demand increases All inpatient waiting lists clinically reviewed and priority status identified. Criteria for outpatients agreed and clinical review ongoing. Reviewing waiting lists and cross referencing with deprivation index. Working with system partners on referral pathways Health & Well-Being risk assessment of staff Scenarios modelled for various configurations of covid activity including a Wave 4. Covid risk register closed and outstanding risks moved to Divisional registers reflecting wider spread of risks and differences at specilaty level. Overseen by Divisoinal PSQB and PRMs	**First Line:** Daily review of Covid-19 activity and weekly review of all other waiting list data Submission of national data sets. Daily tactical meetings chaired by senior Operational manager monitoring demand and bed capacity All admitted waiting lists clnically prioritised with consistency checking process in place and monitoring of waiting time against priority score **Second Line** Finance & Performance Committee oversight of activity and backlogs with new IPR that includes a Recovery section Performance reports to relevant Board Sub-Committees (Finance and Performance, Quality Committee, Workforce Committee)	1. Reset plans have interdependency risks on workforce that will limit capacity and connected triggers not yet in place -Triggers for Priority 2 restart agreed cross divisionally, Triggers for recovery post wave 3 to be developed 2.Health inequalities deprivation data and how to assimilate with clinical data for holistic needs assessment	Clinically prioritised waiting list at IMD level in place, need to develop a mechanism for wider holistic scoring of patients to reflect Health Inequalities that will support decision making for scheduling Lead: Chief Operating Officer,	4 x 5 - 20	4 x5= 20 ↑	2x4=8
Action:					**Timescales**			**Lead**		
1. Clinical review for out patient activity					Ongoing			Medical Director David Birkenhead		
Links to risk register: 7689 out patient waits, 7683, isolation capacity, 7809 theatre and clinical capacity, 7834 elective orthopaedic in patient theatre capacity, 7634 theatre list cancellation										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE (*Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2021 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant Succession planning -divisional workforce planning including discussions with Consultants over age of 55 and "Grow our own" approach • CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention. Global fellows in Radiology Scenario planning for Covid wave 3, Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for all Consusltants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity • Revisions to rotas for Consultants, registrars,trainees with clincians & medical HR to support training, staff and activity backlog • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non- Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology • ED business continuity plan in place; ED Clinical Fellows with 30% education time to provide succession planning • Ongoing recruitment -segmentation approach & vacancy tracker (maps medical workforce to establishment, tacks vacancies, pipeline, retention) ensures focus on clinically high risk and likelihood of appointment. Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme Steering Group meetings provides overview of the programme. Meeting monthly with highlight reports from workstream leads. Recruitment through external agencies for posts which are difficult to recruit to (eg Interventional Radiology) New national contract launched for specialty doctors and specialist doctors enbaling appointments at specialist level with more independence. Junior doctor awards.Adopted SAS (Staff and Associat Specialists) doctor charter , recruitment udnerway for SAS advocate role	First line Staffing levels, training & education compliance and development reported to WEB, Divisional business meetings and PSQBs consider staffing levels as part of standard agenda, IPR with key KPIs shows slight decrease in sickness levels, and reduction in agency spend Aim to keep agency expenditure under control though for patient safety may need to breach agency cap where necessary with Executive Direcor sign off. Weekly meeting on agency spend. Additional PA posts recruited to, work with Deanery to develop those in post, additional 6 PAs, some of which are in ED. Improvements in mortality (HSMR / SHMI). Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - reduction in medical agency spend based on forecast. Vacancy tracker broadly shows improvement in some medical specialties. Turnover reduced from 12% in June 202 to 6% in 2021. Medical workforce programme steering group meetings reinstated monthly. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 35 medical and dental posts from July 2020 to June 2021. Recruited to 9 Radiology posts (6 Consultant, 3 Global Fellows. Emergency Department middle grade remains challenging. Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working annual and quartetly report (2.9.21., 7.12.21.) on working hours to Board - investing in improved facilities for trainees PSQB reports to Quality Committee 9 August 2021 Deep dive review of risk by Workforce Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies, GMC Report on Junior Doctor Experience	Medical E-rostering only partially implemented for doctors -Implementation of NHSE/I Medical Deployment systems project 2023 – Phase 1 completion. Pensions rules remain a concern and affect willingness of medical staff to deliver additional work, thouhg Dependence on HEE allocation of trainees across the patch. Sickness absences are unpredictable and contribute to rota gaps. Unknown impact of Covid on existing medical staff who may take early retirement or reduce job plans as a result of pressures of having worked through Covid-19 Accumulated annual leave from Covid-19 may pressure clinical service delivery.	Short term sickness absence may be under-reported by medical staff. Action: Implementation of e-rostering to record sickness absence (2023)	Initial: 4 x 4= 16 Current: 4 x4=16 → Target: 3 x 3 = 9

Action	Timescales	Lead
E-rostering being rolled out to medics- implementation expected 2023,subject to change depending on Covid operational pressures. Objectives 100% Consutlant & SAS doctors have electronic job plans/85% junior doctors electronically rostered,55% Consultants electronically rostered Explore Global fellowships in other areas difficult to recruit	2023 (may slip due to Covid-19 priorities) Lisa Cooper, Medical Workforce with Claire Wilson and Pauline North /procurement team Lisa Cooper / Dr S Tumula Dr S Tumula, Associate Medical Director with Pauline North	Associate Medical Director Workforce Associate Medical Director Workforce

Links to risk register:
Risk 2827 - Over reliance on middle grade doctors in A&E
Risk 7078 - medical staffing risk
Risk 5747 - Vascular / interventional radiology staffing

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about*	RATING OCTOBER 2021 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant
10b/19 2021/22	Workforce Committee	Executive Director of Nursing	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Twice daily staffing meetings, Workforce meetings increased in areas of greatest need - senior nurse staffing meetings twice a week •Daily and weekly nurse staffing escalation reports • Gold Command meeting routinely reviews staffing pressures with monitoring via staffing dashboard identifying areas of concern and MOSCOW exercise to identify any further risk mitigation actions required. • Nursing and Midwifery Strategy- implementation of "Time to Care" - relaunch 8 October 2021 • Ongoing recruitment programme in place, including international recruitment • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure with bank enhancements introduced to encourage uptake of shifts • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes • Risk assessments in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	First line Gold Command meetings review of nurse staffing shortages Divisional business meetings and PSQBs consider staffing levels as part of standard agenda Bi-annual review of ward nursing levels Trust recruting to fill all HCSW vacancies Embarking on international recruitment programme Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues., Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board Septemner 2020 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Review of impact of bank pay enhancements in addressing shortages at WEB (23.9..21) Third Line Performance reported into NHSE/I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Despite the controls in place and increased scrutiny there are occasions where capacity does not meet demand , eg managing staff sickness, managing covid positive and negative patients, increase in non elective, elective recovery and a decrease in staff undertaking bank shifts is significantly impacting on safe staffing levels. Pace of embedding all elements of the Nursing and Midwifery Strategy has been impacted by Covid response **Action:** To refocus nursing workforce on key deliverables of Time to Care **Lead:** Andrea Dauris **Timescale: Ongoing - Q4 2021/22**	Filling shifts is significantly challenging. Ward accreditation process updated Journey to Outstanding) which will include an assessment of staffing leveles. Rolling out across all clinical areas over next 12 months. Plan to discusse safe staffing at the Quality Committee and dashboard in development. lead:Andrea Dauris, Associte Direcotr of Nursing (Corporate)Q3 2021/22 Timescale	Initial: 4x4 = 16 Current: 4x5 = 20 Target: 3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	Q3 2021	Andrea Dauris

Links to risk register:
Risk 6345 - nurse staffing risk , 7557 ED staffing (nursing), 8079 community nursing

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/*	RATING OCTOBER 2021 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Board agreed Succession Planning approach in place for Board, being rolled out by division which links to co-ordinated talent management pipeline programme including Empower programme and Enhance alent approach • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • New recruitment website now in place • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Clinical Director review complete with induction proramme developed and now in place • Development of new roles across professional groups, eg physicians associates., and widenining access programme rolled out July 2021 development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Development of specific behavipours to support 4 pillars by BAME network Development of 24/7 helpline for colleagues to receive support with their mental health including specialist psychological help if required Well being hour and appointment of 150 well being Ambassadors • Health and Well Being assistance in place for staff via bespoke psychological and mental health support	First line Clinicians leading of transformation programmes Recruitment to key Consultant roles across the Trust - see BAF risk 10a Second line Integrated Performance Report and Workforce Committee reports show turnover of 7.98% Revalidation report to Board Workforce Committee approval of Enhance (Talent Management Pipeline) 30.9.21. Third line Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Very positive feedback from reviewer in June 2021. GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT trusts. Annual staff survey saw an increase in response rate to 50.1% and a 1% increase in our overall score.		Review medical colleague turnover following issue of annual pension statement in October 2021 Lead SD Action survey of Consultants early November to assess impact	Initial: 4x4 = 16 Current: 3x4 =12 Target: 3x3 = 9

Actions	Action, Lead, Timescales	Lead
Consultant survey re: impact of pension statements	Dec-21	Suzanne Dunkley

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2021 Risk Category: Workforce Risk appetite: Low
12/19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Engagement re: health and well being and planning events •Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult last 18 months. • Facilitated teams events taken place • Trust appointed 150 HWB ambassadors to engage with colleagues across all services areas. • Engagement events carried out by divisions focused on services and coping with enormous challenges related to elective recovery and increasing volume and activity across the Trust. • Leadership visibility / walkarounds carried out by senior colleagues who have moved to 7/7 day working • Freedom to Speak Up (F2SU) resource - appointed clinical F2SU guardian so that colleagues who want to raise safety concerns feel more able to do so • Medical CHFT's Got Talent Awards • CHuFT awards (late September 2021) began month celebration of everything CHFT colleagues have achieved over the last year • Colleague engagement groups, now expanded to include Women's netowrk in addition to BAME network, Colleague Disability Action Group, LGBTQ+. Network chairs meet regularly to share best practice. • Community engagement post in engagement team works with patients and communities and links to BAME network, balancing colleague and patient experience	<u>First line</u> Monthly workforce monitoring meeting reviews all workfroce data sets and IPR. <u>Second line</u> Workforce Committee reviews progress with colleague engagte,ent with health and well being activities / programmes. PRMs monitoring roll out of staff survey actions. <u>Third line</u> Staff FFT / staff survey provides some positive feedback, 2020 survey increased response rate to 51% Investors in People accreditation - Silver award to 2021. CQC rating of Good	Hot House events temporarily paused due to colleague unavailability (September 2021) Action: Review depending om operational pressures: Lead: SD	NHS Quarterly Staff Survey results (Q1 2021/22) awaited. 2021 Annual Staff survey underway. Results will be presented to Board in March 2022.	Initial: 3x4 = 12 Current: 3x4 =12 ↑ Target: 1x4 = 4

Action to address gap in control	Action and timescale	Lead

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021** Risk Category: Financial / Assets Risk appetite: Moderate		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Historic delivery of the plan. Contingency set within annual plan Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	First line Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes Second line Business case for reconfiguration continues to progress through NHS E/I approval process Third Line Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. However, the business case is yet to be approved. Strategic Outline Case flagged that additional resources woud be required above the SOC value for HRI. Funding for the Cladding at HRI and multi storey car park (MSCP) at CRH are reliant on ICS financial prioritisation Actual costs for cladding are not yet confirmed Meeting scheduled with ICS lead to agree value to be included in OBC Lead: Director of Finance	Ongoing discussions and clarity required relating to shortfall of capital monies. Approach agreed with regulators and recognised as a requirement against the system allocated capital total in future years. Agreed to leave a residual unidentified funding gap in the HRI OBC. Lead: Director of Finance, awaiting national guidance on capital Backlog maintenance costs will remain in excess of planned capital spend. No firm agreement reached with ICS for prioritisation of funds to cover cladding or multi storey ar park after 2021/22	4x5 = 20	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board Continued pursuit of agreed ICS prioritisation of cladding and MSCP for 2022/23	Ongoing Ongoing	Director of Finance
Links to risk register: None		

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2021 Risk Category: Commercial Risk appetite: Moderate**		
								Initial	**Current**	**Target**
15/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Second Line** Successful bid for digital aspirant funds to support both digital development and ongoing capital requirements.	HPS requires further capital investment to continue to grow. Exploring future commercial options. Director of Finance has written to national Director of Finance to highlight the challenge. Lead: Director of Finance The 2021/22 financial plans for THIS and HPS are reliant on lower contributions than previous years based on known reductions in activity and trading.	HPS requires capital investment to meet its ambitious growth plans. This was discussed in Private Board workshop in December 2020. Recognised that investment is needed to deliver the commercial strategy and increased revenue returns. Further work agreed with a review at Board in 2021. External advisers appointed and report received. Awaiting decision on national funding. Lead: Director of Finance	**3x3 = 9**	**3x2 = 6**	**3*2= 6**
Action								**Lead**		
Ongoing monitoring of financial position through F&P and Board Explore future commercial options					Ongoing Ongoing			Director of Finance Director of Finance		
Links to high level risk register: None										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2021** Risk Category: Financial / Assets Risk appetite: Moderate		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Budgetary control process with increased profile and ownership Business better than usual forum established to support more efficient pathways. Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting ICS have a balanced H1 plan for 2021/22 <u>Third line</u> Monthly return to NHS E/ I Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019. H1 Financial plan agreed by Board and ICS. Minimum income for H1 is agreed.	No clear financial framweork agreed for H2 2021/22. Efficiency process for 2021/22 is still being developed Competing ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Limited additional revenue costs have been included for the development of the Reconfiguration Business Case.	H1 identifies a £3m efficiency challenge which is low risk but current plans show a significant challenge from H2 onwards. This will be clarified at Board on 4.11.21. once the implications of H2 planning guidance issued 30.9.21. are worked through. Efficiency process being developed.	5x5 = 25	4x4 = 16	3x4=12

Action	Timescales	Lead
2021/22 Financial Plan	31/03/2021	K Archer
Development of financial modelling for reconfiguration Outline Businss Case	31/12/2021	K Archer

Links to high level risk register risks: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2021 Risk Category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	**Risk** Risk of climate action failure including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	CHS is rolling out Carbon Literacy Training for its senior management team and this will be cascaded to all colleague by the Environment Manager. Energy - 100% energy bought from green sources and installation of LED lighting to reduce energy consumption Signed up to NHS pledge to reduce plastic usage in hospital Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Green Planning Committee chaired by a NED within CHFT has been established to oversee delivery of sustainbility action plan which will report to Transformation Programme Board on quarterly basis. The Committee is attended by a range of internal and external partners and we continue to expand the membership. Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. The Green Planning Committee meets quarterly, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items. External controls - Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYATT, Kirklees & Calderdale Councils. QIA procedure to be reviewed along with business case applications to ensure that a standing section for sustainability is featured and addressed in Board paper submissions.	<u>First line</u> Monthly monitoring of the Trusts energy consumption <u>Second line</u> 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at May 2021 Board meeting. 2. Annual Board paper on sustainability/climate change Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 <u>Third line</u> Working towards ISO14001 accreditation as a means of assuring environmental management systems across the CHFT	A Sustainable Development Management Plan and Action Plan is already in place and this has now been transposed into a Green Plan Green Plan was approved by the CHFT Board, including interventions to address carbon emissions and to further promote climate resiliance, reviewed by Transformation Programme Board 8 March 2021, and Trust Board 6 May 2021. Green Planning Committee Terms of Reference approved by Transformation Programme Board on 8 March 2021.	CHS MD will produce an annual report to Board on climate change and progress with actions based on the action plan contained in the Green Plan.	**4x4 = 16**	**4x3 = 12**	**3x3=9**
Action					**Timescales**			**Lead**		
								Stuart Sugarman		
No related risks on high level risk register										

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CHS	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
ASSURAN	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan
ICS	Integrated Care System
DH	Department of Health
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JF	Jo Fawcus, Chief Operating Officer
JR	Jim Rea, Managing Director of Digital Health
BW	Bev Walker, Interim Chief Operating Officer
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director (Seven day service lead)
SS	Stuart Sugarman, Managing Director CHS
OW	Owen Williams, Chief Executive
EA	Ellen Armistead, Director of Nursing / Deputy Chief Executive
KA	Kirsty Archer, Acting Director of Finance
ALL	All Board members

23. Revised Governance Arrangements

a) Effective Use of Resources

b) Service Reconfiguration - Appointment of Interim Senior Responsible Owner (SRO)

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title of report:	Effective Use of Resources
Author:	Kirsty Archer, Acting Director of Finance Anna Basford, Director of Transformation and Partnerships
Sponsor:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive *(Interim Chief Executive from 7th November until Permanent new Chief Executive in role)*
Previous Forums:	Finance and Performance Committee 1st November 2021

Purpose of the Report

To describe an updated approach to manage the effective use of resources that will be implemented from 1st November 2021.

Key Points to Note

In 2020 CHFT suspended previous mechanisms of cost improvement planning to release colleague time to focus on operational management of the pandemic. This aligned with national expectations as the requirement to deliver cost improvement programmes was suspended in 2020/21 and supported by the funding mechanisms in place.

The Trust now needs to ensure there are strong mechanisms of governance to develop financial efficiency savings to support delivery of the Trust's financial plans. The systems previously in place prior to the pandemic are no longer appropriate.

The report describes that a new group (called the Effective Resources Group – ERG) will be established and meet weekly, chaired by the CEO from the 1st November. The ERG will report to the Finance and Performance Committee.

EQIA – Equality Impact Assessment

Agreement of savings and transformation plans developed by the Effective Resources Group will be subject to demonstrating that an EQIA and QIA assessment has been undertaken and that any negative impacts have been mitigated.

Recommendation

The Board is asked to **NOTE** the updated approach to manage the effective use of resources that will be implemented from 1st November 2021.

Effective Use of Resources at CHFT

Proposed Future Approach at CHFT

November 2021

1. Purpose

The purpose of this report is to request that the Trust Board notes an updated approach to manage the effective use of resources that will be implemented from 1st November 2021. This will replace the Trust's previous arrangements for Cost Improvement Planning methods (Turn-around Executive) that were suspended in response to the Pandemic in March 2020.

2. Background

Since 2014/15 the Trust has had strong governance processes for the planning, monitoring and delivery of efficiency savings. In the consecutive 5 years to 2019/20 the Trust achieved its annual cost improvement plans.

In 2020 the Covid-19 Pandemic required new ways of working and management across the health and social care system to respond to the immediate operational, patient safety and resource issues. Financial systems of governance and funding allocation methods have changed across the NHS since 2020. At CHFT the decision was made in 2020 to suspend the previous mechanisms of cost improvement planning to release colleague time to focus on operational management of the pandemic. This aligned with national expectations as the requirement to deliver cost improvement programmes was suspended in 2020/21 and supported by the funding mechanisms in place.

3. Current Position November 2021

As the Trust now moves forward to manage the response to the Pandemic and Elective Recovery the financial position is more challenging and requires an increased focus on effective financial management. In the second half of 2021/22 (H2) the Trust has the challenge to achieve a financial break even that will require delivery of efficiencies. Forward planning is also required for 2022/23 and beyond as the national funding mechanisms will continue to expect the delivery of efficiencies.

4. Proposed Approach Going Forward

The Trust needs to ensure there are strong mechanisms of governance to develop and deliver financial efficiencies to support delivery of the Trust's financial plans. The systems previously in place prior to the pandemic are no longer appropriate. Learning from the Pandemic has emphasised the need for a new collaborative and inclusive approach going forward.

In addition to the development of annual financial savings plans the Trust also needs to ensure there are robust arrangements to monitor and measure the planned benefits from transformation projects that are in progress and the impact of this on the Trust's long term financial plans. The Trust has strong examples of leading and delivering transformation and improvement (with national recognition for several of these) e.g.:

- Digital Innovation
- Out-Patient service delivery – new models;
- Reducing Health Inequalities
- "Getting it Right First Time"
- Collaboration with providers to deliver new service models e.g., across West

Yorkshire Association of Acute Trusts (WYAAT);
- Workforce Organisational Development - “One Culture of Care”
- Embedding learning from the Pandemic (“Business Better than Usual”)
- Climate change and sustainability
- Improving Patient Experience

Following recent discussions with Executive Directors and Divisional operational and finance colleagues it is proposed that from 1st November:

- A forum (called the **Effective Resources Group – ERG)** will be established and meet weekly, chaired by the CEO. The forum will include representation from clinical colleagues in all divisions, Directors of Operations and all Executive Directors. Non-Executive Directors will be welcome to attend meetings and in particular the Chairs of the Finance and Performance Committee and the Transformation Programme Board may wish to attend some meetings.

- The **ERG** will have an agreed Terms of Reference describing responsibilities and arrangements to plan and deliver effective resource use to support delivery of the Trust’s financial plans (draft at appendix 1).

- The **ERG** will be accountable to the Finance and Performance Committee (F&P) and provide monthly updates to F&P. The F&P is a formal sub-committee of the Trust Board. The F&P is responsible for providing assurance to the Trust Board on financial management and effective use of resources.

- The above proposed new systems of managing, reporting and accountability arrangements will supersede the Trust’s pre-pandemic mechanisms and governance including the previous weekly Turnaround Executive.

5. Recommendation

The Board of Directors is asked to:

- **NOTE** - that a new forum is established called the **Effective Resources Group – “ERG”** to plan and deliver effective resource use to support delivery of the Trust’s financial plans – this will supersede the Trust’s pre-pandemic mechanisms and governance including the previous weekly Turnaround Executive.
- **NOTE -** the draft Terms of Reference for the **ERG**
- **NOTE** - the **ERG** will be accountable to the Finance and Performance Committee (F&P) and will provide monthly updates to F&P.

Effective Use of Resources Group (ERG) Terms of Reference November 2021

Purpose: To provide assurance on the effective use of resources at CHFT

A weekly meeting, chaired by the CHFT CEO to plan and deliver effective resource use to support delivery of the Trust's financial plans.

Agenda

- Implement mechanisms and governance for effective use of resources to support delivery of the Trust financial plans.
- Identify specific efficiency benefits/savings plans and opportunities for revenue generation providing oversight and leadership to deliver the plans.
- To monitor and measure the planned benefits from transformation projects that are in progress and the impact of this on the Trust's long term financial plans
- Ensure EQIA & QIA impact assessment of plans and that mitigations if needed are implemented.
- Responsibility for oversight of the Trust's progress against CQC / NHSE Use of Resources rating.

People

- Chief Executive
- Chief Operating Officer
- Director of Transformation & Partnerships
- Director of Finance
- Medical Director
- Chief Nurse
- Director of Workforce & OD
- Directors of Operations (x4)
- Assistant Director of Transformation & Partnerships
- Divisional Clinical Representation (nominated per Division)
- Managing Director for Digital Health
- Managing Director of CHS

Chair – Chief Executive
Vice Chair – Director of Finance

Other colleagues may be co-opted onto the group as agenda requires

Quorum

- Minimum of 5 members, including 3 Board Directors & 2 Divisional Colleagues
- Attendees must be present at a minimum of 75% of meetings
- Nominated Deputies, with delegated authority for decision-making will be accepted on a meeting by meeting basis.

Design

Frequency
- Weekly

Decision-making
- Full decision making in line with Standard Financial Instructions (SFI)
- Items for escalation to Finance and Performance Committee

Authority
- Approval of plans by F&P.

Reporting Strategy
- Reports into Finance and Performance Committee.

Support from
- Finance Teams and PMO for minutes, agenda setting etc.

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th November 2021
Meeting:	Public Board of Directors
Title of report:	Calderdale and Huddersfield Programme of Service Reconfiguration - Appointment of Programme Senior Responsible Owner
Author:	Anna Basford, Director of Transformation and Partnerships
Sponsor:	Peter Wilkinson, Non-Executive Director
Previous Forums:	None

Purpose of the Report

To request that the Trust Board approve the appointment of the Interim Chief Executive at CHFT as the 'Senior Responsible Owner' for the Programme of Service Reconfiguration for the period from 7th November 2021 until a permanent new Chief Executive commences in role at CHFT.

Key Points to Note

The Senior Responsible Owner (SRO) for the Reconfiguration Programme is the 'owner' of the programme and associated business cases - accountable for all aspects of governance. The Trust is required by DHSC and Government to have an appointed 'Senior Responsible Owner' for this programme.

The CHFT Chief Executive is the current SRO reporting to the Trust Board.

This report seeks approval that the CHFT Director of Nursing & Deputy CEO whilst undertaking the role of Interim Chief Executive from 7th November 2021 (and until a new permanent CEO is in role) is appointed as the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT.

EQIA – Equality Impact Assessment

In 2016, an Equality Analysis Report was completed in relation to the protected groups likely to be affected by the Reconfiguration proposals. The Midlands and Lancashire Commissioning Support Unit undertook a comprehensive equality and health inequalities impact assessment of the proposals for the consolidation of planned and unplanned hospital services. This concluded that there was no indication of differential impact that would lead to unlawful discrimination linked to the proposals and that the proposals set out health services to address the needs of the whole population, including those who currently experience disadvantage and the plans are intended to help improve access, experience and outcomes for all.

In July 2018 CHFT undertook further quality and equality impact assessment of the proposed model. The findings were presented to CHFT Quality Committee on the 20th July 2018 and to the Board of Directors on the 2nd August 2018. The conclusion of this assessment was that the proposed changes do not generate differential discriminatory equality or health inequality impacts. At a meeting of the Trust Board on 22nd March 2019 the Trust Board approved the Strategic Outline Business for Service Reconfiguration and confirmed in making this decision that the findings of the EQIA and QIA assessment undertaken had been fully taken into account and concluded the proposed changes do not generate differential discriminatory equality or health inequality impacts.

During 2020-21 as part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty a refreshed assessment of the EQIA and QIA impact of the proposed service changes was undertaken. This used the new and strengthened process to assess the EQIA and QIA impact and included meeting with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required. The refreshed assessment was submitted to the Quality Committee in May 2021 for review and comment. The Quality Committee recommended approval of the EQIA and QIA and this was subsequently presented to the Transformation Programme Board in June 2021 and was approved.

The conclusion of this work is that the overall impact of the Reconfiguration in relation to EQIA and QIA is positive, there is no differential discriminatory impact, and appropriate mitigating actions have been identified. Engagement will continue and expand further into community groups throughout the development of the building proposals and changes to care pathways.

Recommendation

The Board is asked to **APPROVE** that the CHFT Director of Nursing & Deputy CEO whilst undertaking the role of Interim Chief Executive from 7th November 2021 (and until a new permanent CEO is in role) is appointed as the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT.

Calderdale and Huddersfield Programme of Service Reconfiguration

Appointment of Programme Senior Responsible Owner

November 2021

1. Purpose

The purpose of this report is to request that the Trust Board approve the appointment of the Interim Chief Executive at CHFT as the 'Senior Responsible Owner' for the Programme of Service Reconfiguration for the period from 7th November 2021 until a permanent new Chief Executive commences in role at CHFT.

2. Background

Calderdale and Huddersfield NHS Foundation Trust (CHFT) has ambitious plans to invest in new healthcare facilities at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI). The plans will support the longer-term resilience of service provision across Calderdale, Huddersfield and West Yorkshire.

In 2018 to enable implementation of CHFT plans DHSC and Government confirmed allocation of public dividend capital (PDC) for investment at CHFT as part of Wave 4 of the Government's major multi-year funding package of additional capital investment in the NHS to provide better service models for patients, integrate care services and renew aging facilities.

The plan is to invest at CRH to expand the hospital providing additional wards, theatres and a new Accident and Emergency (A&E) Department including a specialist paediatric Accident and Emergency Department. At HRI investment will enable the build of a new Accident and Emergency Department and the adaptation of existing buildings to address estate safety and maintenance requirements.

The Trust is required by DHSC and Government to have an appointed 'Senior Responsible Owner' for this programme.

In 2019 the Trust Board approved Governance arrangements for the Programme through the establishment of the Transformation Programme Board (TPB). The Terms of Reference for this confirm the CEO as the SRO and the key deliverables of the programme the SRO leads. The overall governance arrangements for the programme are:

- CHFT Trust Board is responsible and accountable for delivery of the Programme of reconfiguration.
- The Trust Board has established a Standing Formal Committee known as the Transformation Programme Board (TPB) to oversee delivery of the Programme and provide assurance to the Trust Board.
- The Trust Board will seek assurance from the Transformation Programme Board on any aspect of the programme that may pose a risk to achieving the investment objectives and realisation of benefits.
- The Chief Executive is the Senior Responsible Owner (SRO) reporting to the Trust Board.
- The Director of Transformation and Partnerships is the Programme Director reporting to the SRO.
- A Project Director with the necessary experience and skills in delivery of major healthcare capital projects has been appointed from Turner and Townsend and a Programme Manager has been appointed and reports to the Programme Director.

- The responsibilities of the Transformation Programme Board are set out in Terms of Reference approved by the Trust Board and confirm the CEO as the SRO.

The SRO is a the 'owner' of the programme and associated business cases - accountable for all aspects of governance. The SRO responsibilities include:

- defining and communicating the vision and business objectives
- ensuring a real business need is being addressed
- assuring ongoing viability, and if necessary, taking the decision to stop the project
- engaging key stakeholders
- providing the team with leadership, decisions and direction
- ensuring the delivered solution meets the needs of the business
- ensuring that the project has in place a governance and assurance regime that is effective, proportionate and appropriate
- ensure that, if appropriate, the programme is subject to Gateway Review at key decision points and make certain any recommendations or concerns from Gateway reviews are met or addressed before progressing to the next stage.

CHFT is currently managing the transition to a new CEO. During the interim period and until a permanent Chief Executive is appointed the Director of Nursing & Deputy Chief Executive will be the Trusts' Interim Chief Executive. This report requests Trust Board approval / confirmation that the responsibilities of the Interim CEO includes the SRO role for the programme of estate development and reconfiguration at CHFT.

3. Recommendation

The Trust Board is requested to:

- **APPROVE** that the CHFT Director of Nursing & Deputy CEO whilst undertaking the role of Interim Chief Executive from 7th November 2021 (and until a new permanent CEO is in role) is the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT;

- **CONFIRM** that when the new permanent CEO commences in roles their responsibilities will include the role of SRO for the programme.

24. Governance Report

a) Updated Governance Structure v26

b) Update on Associate Non-Executive Director Appointments

c) Board of Directors Workplan

d) Use of Trust Seal

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

This report brings together a number of governance items for the Board in November 2021.

Key Points to Note

a) Updated Governance Structure

The updated governance structure is attached at Appendix R2 for the Board to approve.

RECOMMENDATION: The Board is asked to **APPROVE** the updated Governance Structure.

b) Update on Associate Non-Executive Director Appointments

The Nominations and Remuneration Committee of the Council of Governors approved the pilot of two Associate Non-Executive Director roles on 9 August 2021 supplementary to the existing Non-Executive Directors. Recruitment processes are currently underway for an Associate Non-Executive Director (NED) for CHS and one for CHFT, with a quality focus. A verbal update will be provided at the meeting on the Associate Non-Executive Director recruitment and next steps including the Council of Governors Nominations and Remuneration Committee approval of the appointments.

RECOMMENDATION: The Board is asked to **NOTE** the update on the Associate Non-Executive Director appointments.

c) Board Workplan

The business cycle for the Board for the financial years 2021/22 and 2022/23 are attached at Appendix R3 and R4. The Board workplan provides the basis for the preparation of Board agendas for the financial year 2022/23. Ad hoc items will be included on Board agendas as need arises following discussion with the Chair and Chief Executive.

RECOMMENDATION: The Board is asked to **NOTE** the Board Workplan for the financial years 2021/22 and 2022/23 and advise the Corporate Governance Manager should there be any further items or amendments to the workplan.

d) Use of Trust Seal

The Trust Seal has been used once during July and September 2021 and since the last report to the Board on 1 July 2021. The details are available at Appendix R5.

RECOMMENDATION: The Board is asked to **NOTE** the use of the Trust Seal during Q2, 2021/22.

Recommendation

The Board is asked to:

- **APPROVE** the update governance structure
- **NOTE** the update on the Associate Non-Executive Director appointments
- **NOTE** the Board workplans for the financial years 2021/22 and 2022/23
- **NOTE** the use of the Trust seal during Q2, 2021/22.

GOVERNANCE STRUCTURE
NOVEMBER 2021

CHFT & BTHFT Transformation Board

Partnership Transformation Board (CCGs)

WYAAT Committee in Common West Yorkshire & Harrogate ICS

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Philip Lewer / Frequency: Quarterly

Organ Donation Committee
Chair: Philip Lewer / Frequency: Bi-annual

Council of Governors
Chair: Philip Lewer / Frequency: Quarterly

Nominations & Remuneration Committee (Sub Committee to the Council of Governors)
Chair: Philip Lewer / Frequency: Ad hoc

Audit and Risk Committee
Chair: Andy Nelson
Frequency: Quarterly

- **Risk Group** Chair: AD for Patient Safety Frequency: Monthly
- **Information Governance & Risk Strategy Committee** Chair: CIO Frequency: Quarterly
  - **Clinical Records Group**
- **Data Quality Board** Chair: COO Frequency: Monthly
- **Health & Safety Committee** Chair: ED Workforce & OD Frequency: Monthly
  - **Security & Resilience Group**

Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Monthly

- **Business Better Than Usual (BBTU) Delivery Group** Chair: Chief Executive Frequency: Weekly

Finance & Performance Committee
Chair: Richard Hopkin
Frequency: Monthly

- **Efficiency and use of Resources Group**
- **Capital Management Group**
- **Commercial Investment & Strategy Committee**
- **The Health Informatics Service Board**
- **Huddersfield Pharmacy Specials Board**
- **Divisional Performance Reviews Executive Lead &** Chair: **COO** Frequency: Determined by position e.g. monthly, bi-monthly or quarterly
- **CHS & CHFT Joint Liaison Committee**
- **CHFT/PFI Quarterly Contract Meeting**
- **CHFT/Pennine Property Partnership Board**
- **A&E Board (System Resilience Group)**

Nominations & Remuneration Committee (Board of Directors)
Chair: Philip Lewer
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

- **Education Committee** Chair: ED Workforce & OD Frequency: Bi-monthly from April 2021

Quality Committee
Chair: Denise Sterling
Frequency: Monthly

- **Research and Innovation Group** Chair: Deputy Medical Director Reporting: Annually
- **Clinical Ethics Group** Chair: Associate Medical Director Reporting: Quarterly
- **Infection Prevention and Control Committee**
- **Antimicrobial Strategy Group**
  - **Infection Prevention and Control Board** Chair: Medical Director Reporting: Quarterly
- **Safeguarding Committee** Chair: Deputy Chief Nurse Reporting: 6-monthly
- **Trust Patient and Safety Quality Board*** Chair: AD Patient Safety Reporting: Monthly
- **Cancer Board** Chair: Chief Operating Officer Reporting: Quarterly (minutes only)
- **Consent Working Group**
  - **Clinical Effectiveness and Audit Group** Chair: Associate Medical Director Reporting: Quarterly
- **Patient Experience and Caring Group** Chair: Andy Nelson Frequency: Monthly
- **Clinical Improvement Group*** Chair: Medical Director Reporting: Monthly
- **Antimicrobial Strategy Group** (formulary / policy updates)
  - **Medicines Management Committee** Chair: Consultant Oncologist Reporting: 6 monthly
- **Medical Gases Group** Chair: Acute Consultant Reporting: 6 monthly
- **CQC & Compliance Group** Chair: Chief Nurse Reporting: Bi-Monthly

Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly
One meeting per month focused on quality and performance, one on Digital Health

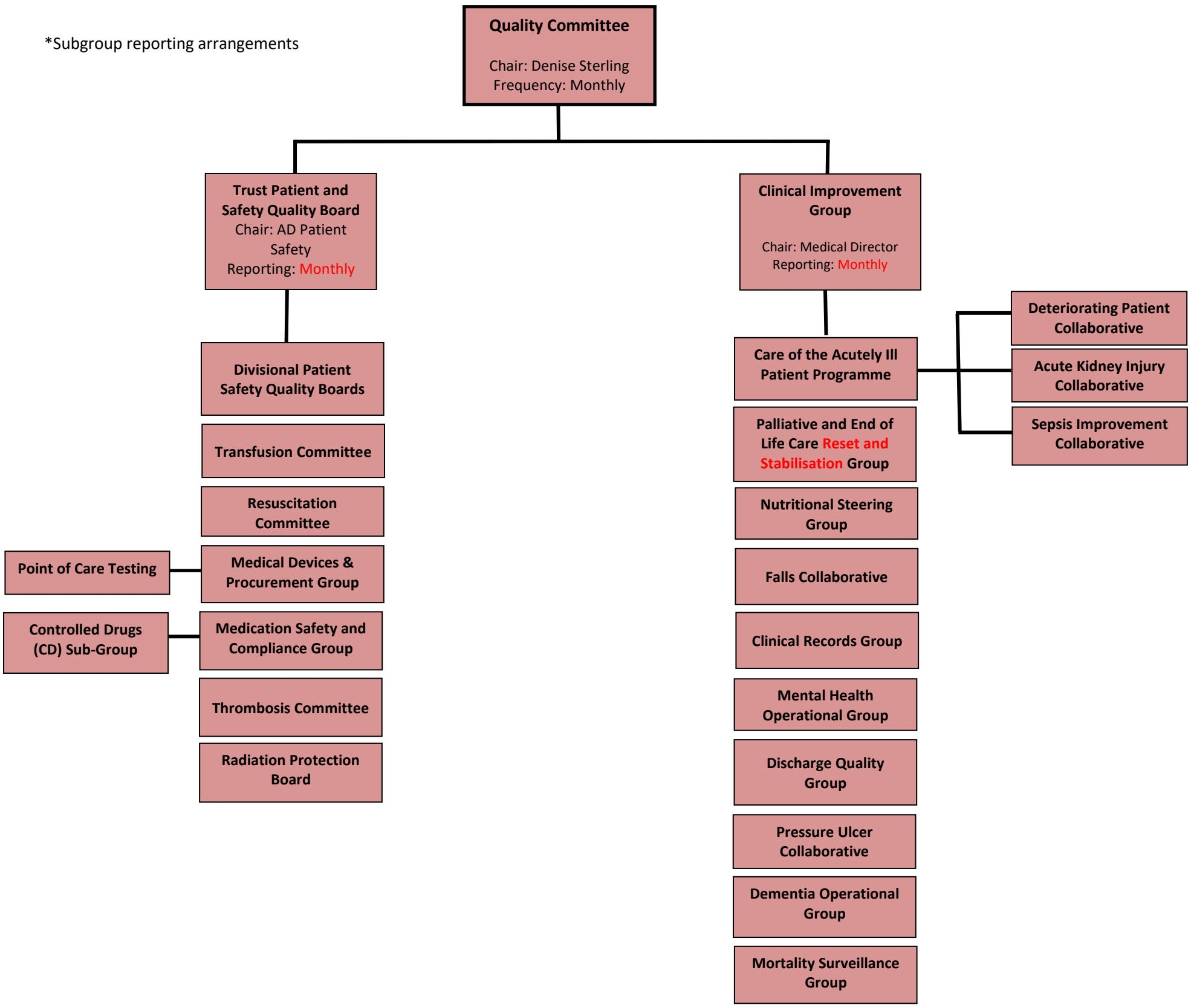
Digital Operational Board
Frequency: Monthly

- **EPR Partners** Frequency: Quarterly
- **Divisional Digital Boards** Frequency: Monthly

Compliance Reporting only

November 2021

*Subgroup reporting arrangements



PUBLIC BOARD WORKPLAN 2021-2022

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Date of agenda setting/Feedback to Execs	7 December 2020	1 February 2021	7 April 2021	27 May 2021	2 August 2021	7 October 2021	8 December 2021	31 January 2022
Date final reports required	31 December 2020	19 February 2021	23 April 2021	18 June 2021	20 August 2021	22 October 2021	31 December 2022	18 February 2022
STANDING AGENDA ITEMS								
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓	✓	✓
Recovery Update							✓	✓
Financial Update	✓	✓	✓	✓	✓	✓	✓	✓
Health Inequalities	✓ **Defer to March**	✓	✓	✓	✓	✓	✓	✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓	✓

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓	✓	✓
COVID-19 Oversight Committee Minutes	✓	✓	✓					
Council of Governors Meeting Minutes		✓	✓		✓	✓		✓
STRATEGY AND PLANNING								
Strategic Objectives – 1 year plan / 10 year strategy		✓		✓ *- 2020/21 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy				✓				
Workforce OD Strategy		**Defer to May**	✓					✓
Risk Management Strategy		✓					✓	
Service Reconfiguration Outline Business Case					✓* additional Board meeting may be required in later July TBC			
Annual Plan		✓	✓	✓				✓
Capital Plan	✓						✓	
Winter Plan					✓			
Green Plan (Climate Change)			✓					
QUALITY								
Quality Board update	✓	✓	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓ Q2, Q3 2020/21		✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report				✓				

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Learning from Deaths Quarterly Report		✓ Q3		✓Q4	✓Q1	✓Q2		✓ Q3
Safeguarding update – Adults & Children		✓			✓ (Annual report)			✓
Complaints Annual Report					✓			
WORKFORCE								
Staff Survey Results and Action Plan			✓	✓				✓
Health and Well-Being			Deferred to September		✓			
Nursing and Midwifery Staffing Hard Truths Requirement (Bi-Annual report due annually in Sep; however, it will be Nov this year)		✓ (Bi-annual)				✓ (Bi-annual)		✓ (Bi-annual)
Guardian of Safe Working Hours (quarterly)	✓Q3		✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report			✓					
Diversity		✓						
Medical revalidation & appraisal Annual Report					✓			
Freedom to Speak Up Annual Report	✓ 6 month report FTSU themes				✓ Annual Report			
Workforce Committee Annual Report	✓ 2019/2020			✓ 2020/21				
Public Sector Equality Duty (PSED) Annual Report		✓						✓
GOVERNANCE & ASSURANCE								
Health and Safety Update	✓		✓	✓			✓	
Health and Safety Policy			✓					

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Health and Safety Annual Report	✓						✓	
Board Assurance Framework		✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement					✓ with BAF			
High Level Risk Register	✓		✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review			✓					
Non-Executive appointments		✓				✓		✓
Annual review of NED roles					✓			
Board workplan	✓	✓	✓	✓	✓	✓	✓	✓
Board meeting dates				✓				
Use of Trust Seal			✓	✓		✓		
Council of Governor elections		✓ timetable						✓ timetable
Declaration of Interests – Board of Directors (annually)		✓						✓
Attendance Register – (annually)			✓					
Fit and Proper Person Self-Declaration Register		✓						✓
Seek delegation from Board to ARC for the annual report and accounts 2020/21			✓					
BOD Terms of Reference		✓						✓
Sub Committees Terms of Reference	✓ Workforce ✓NRC BOD	✓QC	✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓ QC NRC BOD
Constitutional changes (+as required)		✓	✓					
Compliance with Licence Conditions			✓					

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Huddersfield Pharmaceuticals Specials Annual Report						✓		
Fire Safety Annual Report				✓				
Fire Strategy 2021-2026 and Fire Policy Update		✓						
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)					✓			
Charitable Funds Report 2019-20 and Accounts (Audit Highlights Memorandum)	✓							
Committee review and annual reports				✓	✓	✓		
Audit & Risk Committee Annual Report 2020/2021					✓ 2020/21			
Finance & Performance Committee Annual Report 2020/2021				✓				
Quality Committee Annual Report 2020/21						✓ 2020/21		
WYAAT/WY&H Partnership Reports	✓	✓	✓	✓	✓	✓	✓	✓
WYAAT Annual Report and Summary Annual Report	✓						✓	

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

PUBLIC BOARD WORKPLAN 2022-2023

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Date of agenda setting/Feedback to Execs	TBC	TBC	TBC	TBC	TBC	TBC
Date final reports required	22 April 2022	24 June 2022	19 August 2022	21 October 2022	30 December 2022	17 February 2023
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
Recovery Update	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓
Health Inequalities	✓	✓	✓	✓	✓	✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
Council of Governors Meeting Minutes		✓	✓		✓	
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 10 year strategy		✓ *- 2021-2023 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy		✓				

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Workforce OD Strategy	✓					
Risk Management Strategy					✓	
Annual Plan	✓	✓				✓
Capital Plan					✓	
Winter Plan			✓			
Green Plan (Climate Change)	✓					
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓Q4	✓Q1	✓Q2		✓ Q3
Safeguarding update – Adults & Children						✓
Safeguarding Adults and Children Annual Report			✓			
Complaints Annual Report			✓			
WORKFORCE						
Staff Survey Results and Action Plan	✓	✓				✓
Health and Well-Being			✓			
Nursing and Midwifery Staffing Hard Truths Requirement			✓ Bi-Annual			
Guardian of Safe Working Hours (quarterly)	✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity						✓
Medical Revalidation and Appraisal Annual Report			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report			✓ 6 month report FTSU themes
Workforce Committee Annual Report	✓			✓		

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
	2019/2020			2021/22		
Public Sector Equality Duty (PSED) Annual Report						✓
GOVERNANCE & ASSURANCE						
Health and Safety Update	✓	✓			✓	
Health and Safety Policy	✓					
Health and Safety Annual Report					✓	
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Appetite Statement			✓			
High Level Risk Register	✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments				✓		✓
Annual review of NED roles			✓			
Board workplan	✓	✓	✓	✓	✓	✓
Board meeting dates		✓				
Use of Trust Seal		✓		✓		✓
Council of Governor elections						✓ timetable
Declaration of Interests – Board of Directors (annually)						✓
Attendance Register – (annually)	✓					
Fit and Proper Person Self-Declaration Register						✓
Seek delegation from Board to ARC for the annual report and accounts 2021/22	✓					
BOD Terms of Reference						✓
Sub Committees Terms of Reference	✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓					✓

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Compliance with Licence Conditions	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Safety Annual Report		✓				
Fire Strategy 2021-2026 and Fire Policy Update						✓
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)			✓			
Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum)					✓	
Committee review and annual reports		✓				
Audit & Risk Committee Annual Report 2021/2022		✓				
Finance & Performance Committee Annual Report 2021/2022		✓				
Quality Committee Annual Report 2021/22		✓				
WYAAT/WY&H Partnership Reports	✓	✓	✓	✓	✓	✓
WYAAT Annual Report and Summary Annual Report					✓	

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS JULY – SEPTEMBER 2021

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
02-21	16 July 2021	16 July 2021	2.2.1 a renewal lease of the coffee shop unit between Calderdale Hospital SPC Limited ("Concessionco") (1), the Trust (2) and ISS Mediclean Limited (3), ("Renewal Lease"); and 2.2.2 a deed of amendment confirming the extension of a rental/income sharing agreement between Concessionco (1) and the Trust (2) and which is supplemental to the Renewal Lease ("Deed of Amendment")	NAME: Ellen Armistead TITLE: Deputy Chief Executive NAME: Amber Fox TITLE: Corporate Governance Manager on behalf of the Company Secretary

25. Committee Review Annual Reports 2020/2021

• Quality Committee presented by the Director of Nursing

• Nursing and Midwifery Staffing Hard Truths Requirement Bi-Annual Report presented by Andrea Dauris, Associate Director of Corporate Nursing

For Assurance

Presented by Ellen Armistead

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title of report:	Quality Committee Annual Report 2020/2021
Author:	Lindsay Rudge, Deputy Director of Nursing Michelle Augustine, Quality Governance Administrator
Sponsor:	Denise Sterling, Non-Executive Director and Quality Committee Chair
Previous Forums:	Circulated to Quality Committee members

Purpose of the Report

This annual report describes the activities of the Quality Committee between April 2020 and March 2021, describing how the Committee met the duties within the terms of reference. The report includes:

- Overview of the role of the Quality Committee
- Details of membership and attendance between April 2020 and March 2021
- Information of the work of the Committee in the following areas:

  - quality improvement
  - governance and risk / patient safety
  - audit and assurance
  - quality and safety reporting

- Effectiveness of the Committee – this section summarises the response of the self – assessment by members which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. Ten members completed the assessment, and the summarised findings can be found at the end of the report (appendix 1)

Key Points to Note

This annual report is presented for information and assurance and will be shared with the Board of Directors on 4 November 2021.

Recommendation

The Board is asked to **NOTE** the assurances in the Annual Report that the Committee met its duties for the reporting period of 2020/2021.

Quality Committee Annual Report 2020 / 2021

This Quality Committee annual report for 2020 / 2021 details:

- The role of the Quality Committee, membership and attendance between April 2020 and March 2021 and the terms of reference
- The activities of the Quality Committee between April 2020 and March 2021
- Self- assessment of the effectiveness of the committee

1. Introduction

1.1 Purpose of the Quality Committee

The purpose of the Quality Committee is to provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care; and to ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

The Quality Committee is also responsible for reviewing proposed quality improvement priorities, monitoring performance and improvement against the Trust's quality priorities, the implementation of the Quality Account, and ongoing monitoring of compliance with national standards and local requirements.

The Quality Committee receives assurance from a number of quality sub-groups via an annual work plan structured around the CQC domains.

1.2 Terms of Reference

The Committee approved the terms of reference in place.

The terms of reference were reviewed by the Committee in June 2020, and amended in January 2021, with the Assistant Director of Patient Experience added to the membership.

1.3 COVID-19 Pandemic

The COVID-19 pandemic was declared in March 2020, and significant adjustments were made, including a governance structure being put in place to reflect the needs of the organisation, much of which was around specific quality and safety challenges. The Quality Committee streamlined its functions to ensure ongoing oversight of the quality and safety agenda and continued to undertake its key function of maintaining effective quality governance arrangements.

1.4 Quality Committee Membership and Attendance in 2020/2021

The Quality Committee met eleven times between April 2020 and March 2021. The April 2020 meeting was cancelled due to COVID-19.

The membership and attendance at the Quality Committee between April 2020 and March 2021 is given below, with one member of the Council of Governors invited to attend and observe each meeting.

Name	Role	Number of meetings attended
CORE MEMBERS		
Denise Sterling	Non-Executive Director **(Chair)**	11 / 11
Ellen Armistead	Chief Nurse	9 / 11
Doriann Bailey [1]	Associate Director of Quality and Safety	6 / 11
Dr David Birkenhead	Medical Director	9 / 11
Jason Eddleston	Deputy Director of Workforce & Organisational Development	7 / 11
Karen Heaton	Non-Executive Director **(Vice-Chair)**	10 / 11
Andrea McCourt	Company Secretary	6 / 11
Christine Mills	Council of Governors	10 / 11
Lindsay Rudge	Deputy Chief Nurse	5 / 11
Elisabeth Street	Clinical Director of Pharmacy	8 / 11
Rachel White [2]	Associate Director of Patient Experience	7 / 11

1 Member from 28 September 2020
2 Member from 2 September 2020

Name	Role	Number of meetings attended
DIVISONS (one meeting per quarter)		
Surgery & Anaesthetics	Associate Director of Nursing	4 / 4
Medical	Associate Director of Nursing	4 / 4
Families & Specialist Services	Divisional Director / ADN	4 / 4
Community Healthcare	Associate Director of Nursing	4 / 4

2. Quality Committee Activities 2020 / 2021

The principal activities of the Quality Committee during April 2020 and March 2021 are detailed below within the areas of quality improvement, risk, patient safety, audit and assurance and quality and safety reporting from sub-groups. Joint meetings with the Workforce Committee took place in May and June 2020 due to the COVID-19 pandemic.

2.1 Quality Improvement

The Quality Committee reviewed the following areas during the year to gain assurance regarding service quality and improvement:

- **Learning from Deaths** – the Committee received the two updates on the learning from death mortality review process – the annual report in June 2020 and quarters 1 and 2 reports in October 2020. The annual report provided an early review of mortality during the COVID-19 pandemic, and how working alongside the new Medical Examiner team will align the Learning from Deaths processes.

- **Outpatient Improvement Plan** – the Committee received an update in September 2020, following a deep dive in July 2019, with assurance that actions were reviewed in relation to COVID-19 and any changes to required work or new actions identified. A further update was requested for later in the year.

- **Infection Prevention and Control (IPC) Board Assurance Framework (BAF)** - the IPC BAF was released by NHS England and NHS Improvement in May 2020, as a voluntary assessment to support organisations in providing assurance around processes in place to manage COVID-19 from an infection control perspective. Results of the completed assessment were submitted in June 2020, with an updated action plan provided in December 2020

- **CQC** – the Quality Committee continues to have oversight of improvement work to address CQC recommendations and to ensure essential standards are embedded across the organisation via the CQC and Compliance Group.

- **Impact Assessment Process** – a development paper on the revision of the quality impact assessments (QIA) and equality impact assessments (EqIA) was submitted in December 2020, outlining a more robust review process.

- **Complaints** – An update was received in May 2020, followed by the annual report in September 2020, highlighting the pause on all complaint investigations as a result of COVID-19, following directive received from NHS England and NHS Improvement. A draft 'making complaints count' bundle was received in October 2020 outlining a service review, the annual report and results of the internal audit report. The final documents were received in December 2020.

- **Mental Health Policy** – an update was provided in August 2020, stating that development of the Policy was delayed due to colleague redeployment during the pandemic, and work with partners at South West Yorkshire Partnership NHS Foundation Trust and their mental health act legal team. A further update was received in September 2020 on additional work to be undertaken, prior to approval.

- **Friends and Family Test (FFT) Changes** – a report on the national changes made to the FFT questions, suspension of reporting to NHS England and Improvement, and the reduced activity in response to NHS England guidance, was submitted in June 2020. Advice on restarting submission was due later in the year.

- **Safeguarding** – six-monthly and annual reports were received from the Safeguarding team with an overview of national and local context of safeguarding, assurance on key performance activity and information on how statutory responsibilities are met, and any significant issues of risks and how they are mitigated.

- **Joint workforce meetings** - the following were reported during the joint meetings with the Workforce Committee in May and June 2020:
  - Health and wellbeing offer for colleagues in response to COVID-19
  - Workforce report on sickness, recruitment and staffing levels
  - Staff testing and analysis data

- **COVID-19 related reports** – several updates were provided on COVID-19 issues including reports on COVID-19 inpatients, COVID-19 related deaths, COVID-19 risk register, digital solutions relating to visiting and Personal Protective Equipment (PPE). A further detailed report on the position of PPE was provided in January 2021.

- **12-hour Emergency Department (ED) standard breaches** – a review of 12-hour ED breaches was undertaken during wave 2 of the COVID-19 pandemic, and the results were received by the Committee in January 2021. An update on progress with the action plan was received in March 2021. It was agreed that a verbal monthly update on any further 12-hour breaches would be provided to the Committee, as well as quarterly updates reporting on the key performance indicators, and a formal annual report.

- **Split-site paediatric service** – a report on the risks and mitigations of split-site working was received in February 2021, outlining work undertaken to review pathways for children and young people. A further update on progress was requested for later in the year.

- **Observe and Act Framework** – an update was received in February 2021, outlining a toolkit to be implemented for observing service user experience in a variety of care and hospital settings. Training followed by piloting work will take place in May 2021, with feedback reported into the Quality Committee.

2.2 Risk and Patient Safety

The Committee continued its focus on patient safety and risk management which included receiving updates on:

- *Risks* – Regular reviews of the high-level risk register and board assurance framework to ensure that all risks relating to quality and safety were identified and being managed to mitigate the risks.

- *Serious incidents* – serious incident reports were received on newly reported serious incidents, findings and outcomes from serious incident reports submitted to commissioners, and assurance the robust serious incident investigations are being delivered and actions to mitigate risks are identified.

- *Patient safety alerts* – a paper supporting the use of superabsorbent polymer gels was received in December 2020, following the issue of a patient safety alert. Levels of assurance and risk assessments were provided for the continued use of the polymer gels in permitted areas.

Patient Safety and Quality Board (PSQB) Reporting - Four of the Quality Committee meetings during the year were dedicated to seeking assurance from divisions on the effectiveness of divisional governance via quarterly PSQB reports to the Quality Committee during 2020/2021 from the Medical division, Surgery and Anaesthetics division, Family and Specialist Services division and Community Healthcare division.

Sub-group Reporting - The following groups reported to the Quality Committee by providing progress reports during the year as detailed in the work plan:

- Patient Experience and Caring Group
- Patient Safety Group
- Medication Safety and Compliance Group
- Cancer Board Report
- Safeguarding Report
- Research and Innovation Report

2.3 Audit and Assurance

Board Assurance Framework - The Committee received updates on the risks on the Board Assurance Framework (BAF), which relate to achieving strategic objectives. The Quality Committee led on five of the risks on the BAF, including:

- 3/19 - Seven-day services
- 4/19 - Patient and Public Involvement
- 6/19 - Compliance with quality and safety standards
- 9/19 - HRI estate and equipment (impact quality)

- 4/20 - CQC rating

The Quality Committee proposed an approach in September 2020 to carry out deep dives on the above risks, which began in December 2020, until the end of the financial year.

Invited Service Review – Respiratory – the results and action plan of the invited service review undertaken in March 2019 by the Royal College of Physicians, following never events relating to oxygen outlets, were received in September 2020. All actions were complete or on track to be completed.

Duty of Candour internal audit report – results of the internal audit were received in September 2020, which provided significant assurance with minor and moderate recommendations to further improve that assurance.

Clinical Audit Update – the clinical audit programme for 2020-2021 was received in September 2020, outlining changes to the mandated clinical governance half-days, the continuation of some national audits during COVID-19 and the implementation of the national data opt-out. The findings of the internal audit were also submitted in October 2020, resulting in significant assurance.

2.4 Quality and Safety Reporting

Quality Priorities – A paper was submitted in June 2020 describing the quality priorities set in March 2020. Three priorities chosen by the Council of Governors included:

- Learning lessons to improve patient experience.
- Improving staff handovers to ensure they routinely refer to the psychological and emotional needs of patients, as well as their carers.
- Improving resources for distressed relatives/breaking bad news relating to end-of-life care.

Seven additional focussed quality priorities were also identified:

- Clinical documentation
- Clinical prioritisation
- End of life care
- Falls resulting in harm
- Impact of business better than usual
- Medical devices
- Nosocomial spread

Quality reports – these were received on a bi-monthly basis, following agreement in February 2020 to amend the reporting format and for the inclusion of assurance statements, as well as updates on the three quality account priorities and seven focused quality priorities, as outlined above. The frequency of the report changed from quarterly to bi-monthly report, with the first report in the amended format submitted in September 2020. A section on maternity was added to the report in December 2020, following the Ockenden Review

Quality Account - the requirement to include the quality account within the CHFT annual report was removed for 2020/2021. The first draft of the account was submitted to the Quality Committee in August 2020, with the final account approved by the Committee in October, and formally submitted in December 2020.

Quality and Safety Strategy – the CHFT Quality and Safety Strategy 2020-2022 – One culture of care: learning and improving was submitted in September 2020, which included

amendments to the governance framework and the refreshed quality priorities. The launch took place in October 2020

Maternity Service Safe Improvement Plan – this was received in October 2020 and included a detailed service improvement plan, which received positive feedback from the Healthcare Safety Investigation Branch (HSIB) on the improvements put in place.

3. Effectiveness of Quality Committee

On an annual basis, the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in April 2021 (Appendix 1).

4. Conclusion

As described above, the Quality Committee has received assurance through the course of 2020/2021 from a number of sources.

The Committee therefore confirms that it has fulfilled its role to the Board during 1 April 2020 to 31 March 2010 in its key functions of providing assurance that that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care. In addition to ensuring that the risks associated with the quality of the delivery of patient care are managed appropriately.

The members of the Quality Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

5. Next Steps 2021 / 2022

The Committee will continue to focus its attention on the oversight of the delivery of high quality, safe and clinically effective care for the patients of CHFT. The patient experience and engagement agenda will be monitored for progress against key objectives.

Denise Sterling
Non-Executive Director / Quality Committee Chair
October 2021

Appendix 1

Self – assessment of effectiveness of Quality Committee (1 April 2020 to 21 March 2021)

Ten responses were received, and the findings are below

- ***Committee focus***

  - The Committee has set itself a series of objectives it wants to achieve this year
    - Strongly agreed = **50 %**
    - Agreed = **50 %**

  - The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.
    - Strongly agreed = **60 %**
    - Agreed = **40 %**

  - Committee members contribute regularly across the range of issues discussed.
    - Strongly agreed = **40 %**
    - Agreed = **60 %**

  - Sufficient time is given to both current year and forward planning in relation to activity and performance
    - Strongly agreed = **10 %**
    - Agreed = **90 %**

- ***Team Working***

  - The Committee has the right balance of experience, knowledge and skills.
    - Strongly agreed = **40 %**
    - Agreed = **60 %**

  - The Committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.
    - Strongly agreed = **50 %**
    - Agreed = **50 %**

  - Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'
    - Strongly agreed = **30 %**
    - Agreed = **70 %**

  - The sub-groups report timely and clear information in support of the committee thereby eradicating the potential for 'surprises'.
    - Agreed = **90 %**
    - Disagreed **= 10 %**

  - I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.
    - Strongly agreed = **80 %**
    - Agreed = **20 %**

- Members hold their assurance providers to account for late or missing assurances.
  - Strongly agreed = **10 %**
  - Agreed = **80 %**
  - Disagreed = **10 %**

- When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.
  - Strongly agreed = **30 %**
  - Agreed = **50 %**
  - Disagreed = **10 %**
  - Strongly Disagreed = **10%**

➢ ***Effectiveness***

- The quality of committee papers received allows me to perform my role effectively.
  - Strongly agreed = **20 %**
  - Agreed = **70 %**
  - Disagreed = **10 %**

- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.
  - Strongly agreed = **20 %**
  - Agreed = **70 %**
  - Disagreed = **10 %**

- Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.
  - Strongly agreed = **10 %**
  - Agreed = **90 %**

- Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.
  - Strongly agreed = **20 %**
  - Agreed = **80 %**

- At the end of each meeting, we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc
  - Strongly agreed = **50 %**
  - Agreed = **50 %**

- The Board of Directors challenges and understands the reporting of this Committee
  - Strongly agreed = **30 %**
  - Agreed = **30 %**
  - Unable to Answer = **40 %**

- There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.
  - Strongly agreed = **50 %**
  - Agreed = **40 %**
  - Unable to answer = **10 %**

- ***Committee engagement***

  - The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.
    - Strongly agreed = **20 %**
    - Agreed = **80 %**

  - The committee is clear about the complementary relationship it has with other committees that play a role in relation to clinical governance, quality and risk management.
    - Strongly agreed = **30 %**
    - Agreed = **60 %**
    - Unable to answer = **10 %**

  - I can provide two examples of where we, as a committee, have focused on improvements to the system of internal control as a result of assurance gaps identified.
    - Strongly agreed = **30 %**
    - Agreed = **70 %**

- ***Committee leadership***

  - The committee Chair as a positive impact on the performance of the committee.
    - Strongly agreed = **50 %**
    - Agreed = **50 %**

  - Committee meetings are chaired effectively and with clarity of purpose and outcome.
    - Strongly agreed = **60 %**
    - Agreed = **30 %**

  - The committee Chair is visible within the organisation and is considered approachable.
    - Strongly agreed = **40 %**
    - Agreed = **40 %**
    - Unable to answer = **20 %**

  - The committee Chair allows debate to flow freely and does not assert his/her own views too strongly.
    - Strongly agreed = **70 %**
    - Agreed = **30 %**

  - The committee Chair provides clear and concise information to the Board on the activities of the committee and the implications of all identified gaps in assurance/control.
    - Strongly agreed = **30 %**
    - Agreed = **30 %**
    - Unable to answer = **40 %**

Date of Meeting:	Thursday 4 November 2021
Meeting:	Public Board of Directors
Title:	Nursing and Midwifery Safer Staffing Report
Author:	Andrea Dauris - Associate Director of Nursing – Corporate
Sponsoring Directors:	Ellen Armistead - Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Workforce Committee

Purpose of the Report

The purpose of this report is to provide the Board of Directors with an overview for Nursing and Midwifery staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance.

This report provides an update regarding safer nursing and midwifery staffing and an overview of measures being taken to address risk within Calderdale and Huddersfield NHS Foundation Trust.

Key Points to Note

The following details what are considered the key points to note:

- The current reality, in the context of the ongoing pandemic response and the recovery agenda.
- Nursing and Midwifery workforce recruitment and retention continues to be a challenge; however, the Trust is being proactive and innovative in terms of recruitment solutions.
- The continued focused leadership to support this agenda.
- The actual and planned care hours per patient day (CHPPD) position, in particular the gap in the Registered Nurse (RN) staffing group.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- The current compliance against the Developing Workforce Safeguards (2018) guidance and action plan.

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g., migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care.

Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document.

Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.

Recommendation

The Board of Directors is asked to **NOTE** the content of the report for assurance.

CONTENTS	
1.0	Introduction
2.0	Safer Staffing
3.0	Sickness and Absence levels
4.0	Hard Truths data
5.0	Strengthening the escalation and reporting arrangements for Quality and Safety
6.0	Recruitment and Registered Nurse Trajectory
7.0	Summary
8.0	Recommendations
	Appendix 1 (Developing Workforce Safeguards – gap analysis)
	Appendix 2 (Developing Workforce Safeguards – action plan)

1.0. INTRODUCTION

Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing. The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) in particular set out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.

It is well documented that there is an established relationship between higher Registered Nurse (RN) staffing levels and improved patient outcomes and care quality (Griffiths et al 2020).

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

Given a recent gap analysis against the Developing Workforce Standards (2018) (Appendix 1) and the dynamic position of clinical environments a decision supported by the Executive Director of Nursing was made to not undertake data collection using the Safer Nursing Care Tool (SNCT) – the tool of choice at CHFT in adult inpatient wards.

Within Midwifery Services, a baseline assessment was commissioned using BirthRate Plus. The report was used to inform the bi-annual reviews.

This report describes CHFT's position in response to the national guidance for the reporting period January 2021 to June 2021.

The paper will also review mitigations, recommendations and how this correlates with the Trust priorities.

CHFT's Reality

2.0 SAFER STAFFING

The challenges to the NHS workforce are well recognised and reported on by the government and national bodies. However, within the overall picture, the most urgent challenge is in relation to the nursing workforce where the government has pledged to have an additional 50,000 more nurses working in the NHS by 2024/25. This is in response to a current national shortage of more than 45,000 nursing and midwifery vacancies.

Whilst the vacancy rate at CHFT has remained static over previous years running with circa 150 qualified vacancies, July 2021's vacancy position has reported an improvement with a vacancy position of 115 FTE.

During the reporting period two bi-annual reviews have been undertaken across the four divisional areas, with the latter review undertaken in June 2021. The focus of the June review was progressing the restarting of services as we transition through the recovery phase. This included an appraisal of the proposed workforce models, in additional to identification of the right skills, in the right place at the right time, supporting any divisional training plans. Whilst data from SNCT was not collected, clinical areas were provided with a template (reflective of the Developing Workforce Safeguards 2018 guidance) to ensure considerations was given to other metrics such as: sickness/absence data, nurse sensitive indicators and complaints to inform recommendations. Except for services listed below the main workforce models were approved based upon the pre-pandemic models:

- Ward 18 made up of 15 single bedded rooms – providing a new isolation facility.
- Emergency Departments moved to partial segregation across both sites, involved an enhanced workforce model.
- Enhanced Critical Care model
- Enhanced Respiratory model
- Midwifery services (detailed below)

As indicated BirthRate Plus was commissioned to undertake a full baseline assessment for the period 1st April 2019 – 31st March 2020, which was reported on in November 2020. BirthRate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. A current maternity workforce gap analysis was also a requirement within the 7 immediate and essential actions in response to the Ockenden Report.

The BirthRate Plus workforce review provided richer detail to the complex variables affecting staffing requirements in a maternity service.

The review highlighted a requirement for 226.84 wte clinical and non-clinical staff of which 20.81 wte could be suitable qualified support staff at agenda for change Bands 3 or 4. The current funded establishment for maternity services is 186 wte qualified

midwives (clinical and non-clinical), 11.37 wte band 3 Midwifery Support Workers and 39.58 band 2 Health Care Assistants. To note Birth Rate Plus does not include band 2 support staff within their review.

A gap of 20 wte registered midwives (226.84-20.81= 206.06 vs current establishment 186 wte) and 9.44 wte band 3 support staff (20.81-11.37).

In April 2021 NHSE/I invested a further £95.9 million to support maternity services to meet the 7 immediate and essential actions of the Ockenden Report with organisations submitting bids to fill the staffing gaps evidenced by their workforce gap analysis. CHFT maternity services therefore submitted a bid for 20 wte registered midwives based on the November 2020 Birth Rate Plus report and were allocated funding for 10.9 wte.

In reality there is a finite resource of midwives both locally and nationally and within the West Yorkshire and Harrogate Local Maternity System (LMS) all trusts were allocated maternity workforce funding. Most of the midwifery recruitment arises from the first registration of newly qualified midwives in mid-September each year, which means the maternity service frequently carries a number of vacant posts despite a rolling advert and recruitment process.

This year the LMS took a system wide approach to the recruitment process with the aim of reducing the number of new graduates who applied for posts in multiple organisations within the LMS. Unfortunately, this approach is not being taken with the appointment of the additional posts funded by NHSE/I which brings with it an additional risk that the 10.9 wte posts will not be filled.

CHFT maternity services currently births approximately 4500 women per year and has seen a year on year decrease in the number of births in line with national trends. However, the service has maintained an establishment of 186wte midwives despite the reduction in the birth rate evidencing that the trust recognises that the number of births is not wholly indicative of the workforce requirement. But has taken into account the increasing complexity associated with pregnancy and birth and the enhanced requirement of the Continuity of Care model

3.0 SICKNESS AND ABSENCE LEVELS

Figures 1 - 4 show the sickness level at the Trust during the reporting period. Data has also been included from “Covid-19 related absence” which is coded differently within the electronic staff records, however, is an impact of the pandemic which directly affects the availability of the nursing and midwifery and nursing support workforce.

January to March saw a continued upward trend in total absence peaking in February at 12.84% for nursing and midwifery, and in January at 14.64% for nursing support. For the reporting period April to June sickness absence for all staff groups has seen an overall downward trend.

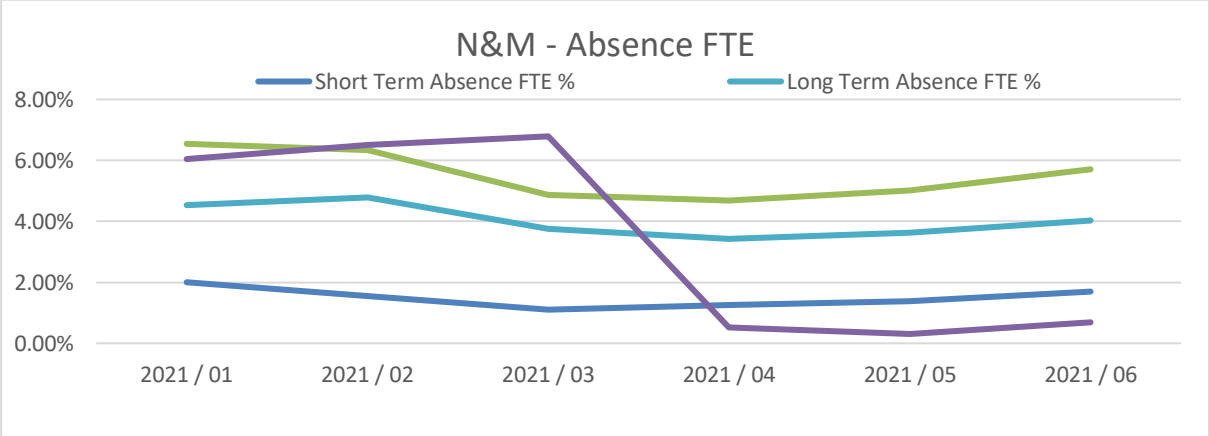
Within both workforce groups anxiety and stress continues to be the highest category recorded against sickness absence.

Whilst these findings are not peculiar to nursing and midwifery, CHFT recognises that support for colleague wellbeing is vital pre, during and post the pandemic. The health and well-being support available at CHFT continues to be refined and tailored to support the diversity of our people and continues to be a critical response to supporting the health and well-being of nursing and midwifery colleagues.

Qualified Nursing & Midwifery

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 01	1,017.88	2,307.82	3,325.70	50,811.94	2.00%	4.54%	6.55%	3,072.34	6.05%	12.59%
2021 / 02	707.37	2,192.86	2,900.23	45,823.93	1.54%	4.79%	6.33%	2,985.82	6.52%	12.84%
2021 / 03	557.60	1,901.55	2,459.16	50,564.31	1.10%	3.76%	4.86%	3,433.45	6.79%	11.65%
2021 / 04	611.29	1,665.85	2,277.13	48,615.09	1.26%	3.43%	4.68%	248.75	0.51%	5.20%
2021 / 05	691.29	1,823.17	2,514.47	50,205.47	1.38%	3.63%	5.01%	153.19	0.31%	5.31%
2021 / 06	819.26	1,948.14	2,767.39	48,391.09	1.69%	4.03%	5.72%	331.43	0.68%	6.40%

(Figure 1)

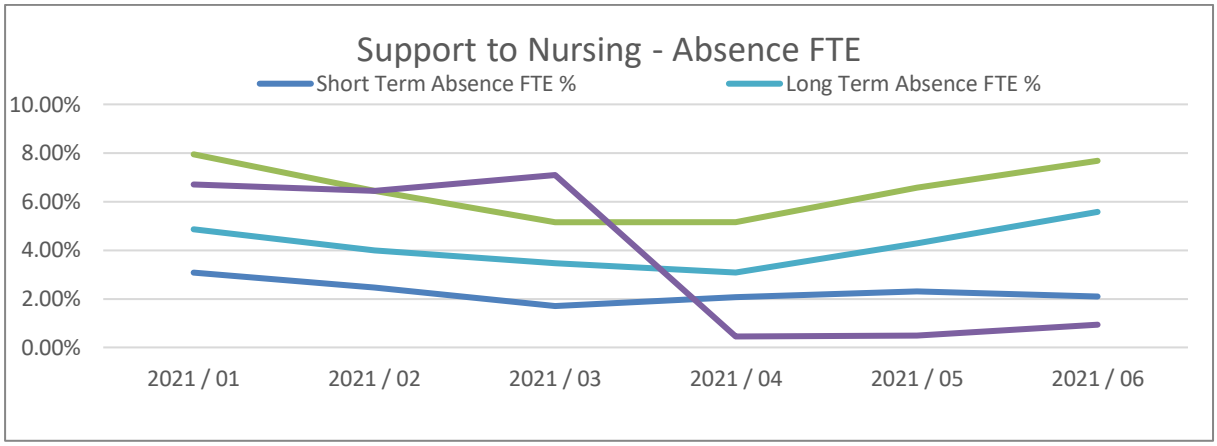


(Figure 2)

Nursing support

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 01	733.77	1,160.05	1,893.83	23,838.97	3.08%	4.87%	7.94%	1,595.23	6.69%	14.64%
2021 / 02	534.71	864.91	1,399.61	21,725.05	2.46%	3.98%	6.44%	1,402.00	6.45%	12.90%
2021 / 03	416.47	845.96	1,262.43	24,460.35	1.70%	3.46%	5.16%	1,734.79	7.09%	12.25%
2021 / 04	517.50	769.17	1,286.67	24,967.60	2.07%	3.08%	5.15%	112.40	0.45%	5.60%
2021 / 05	603.77	1,125.39	1,729.16	26,345.05	2.29%	4.27%	6.56%	127.71	0.48%	7.05%
2021 / 06	533.97	1,423.61	1,957.59	25,535.03	2.09%	5.58%	7.67%	239.46	0.94%	8.60%

(Figure 3)



(Figure 4)

The impact of the combined actual RN wte and average sickness absence position was modelled across three divisions to give context to the workforce challenges.

	Medicine	Surgery	FSS
Budgeted RN wte	501.82	408.58	234.05
Actual RN wte	443.14	368.86	209.67
RN Vacancy wte	67.69	39.72	24.38
Average Absence above budgeted headroom (22%)	10.00%	6.13%	7.24%
Actual Budgeted vs Actual vacancy gap %	23.48%	15.85%	17.65%

*Data source- Healthroster budgeted vs actual position 19/7/21 (***Figure 5)***

4.0 HARD TRUTHS DATA

As indicated earlier safe staffing is one of the essential standards that all health care providers must meet. NHS England and the Care Quality Commission (CQC) issued guidance in 2014 detailing their ongoing commitment to publishing staff data, referred to as “Hard Truths.”

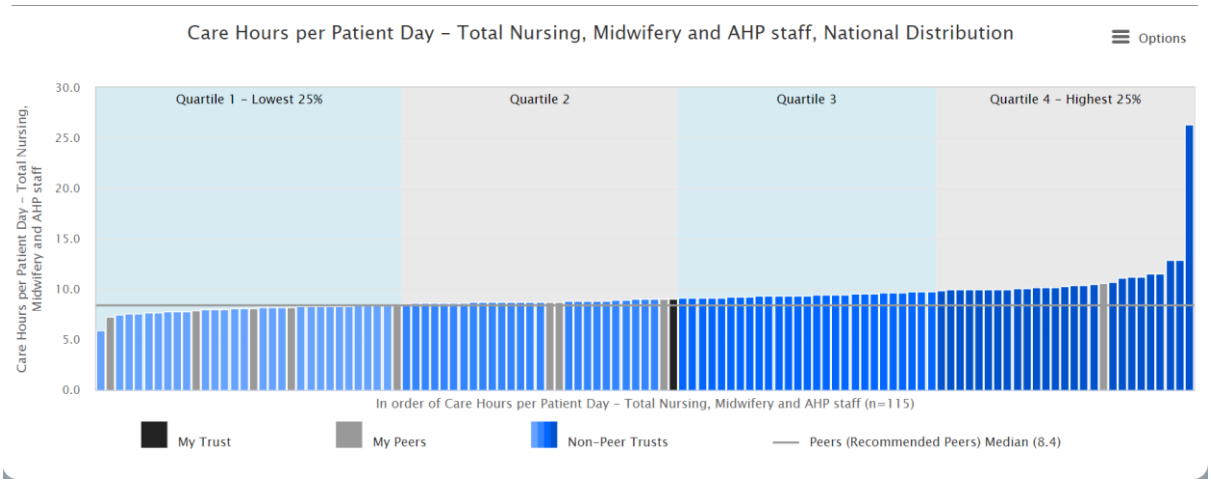
Hard Truths is a commitment to greater openness and transparency and is achieved by publishing staffing data regarding nursing, midwifery and care staff levels.

This is provided through the Trust reporting nursing and midwifery staffing numbers including registered and unregistered to NHS England and Improvement (NHSE/I) via a monthly nursing and midwifery staffing return. The data includes oversight of care hours per patient day (CHPPD) which is now seen as a national measure for safer staffing. NHSE/I began collecting CHPPD formally in 2016 as part of the Carter Programme and data at Trust and ward level for all acute Trusts is now published on NHS Model Hospital.

CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

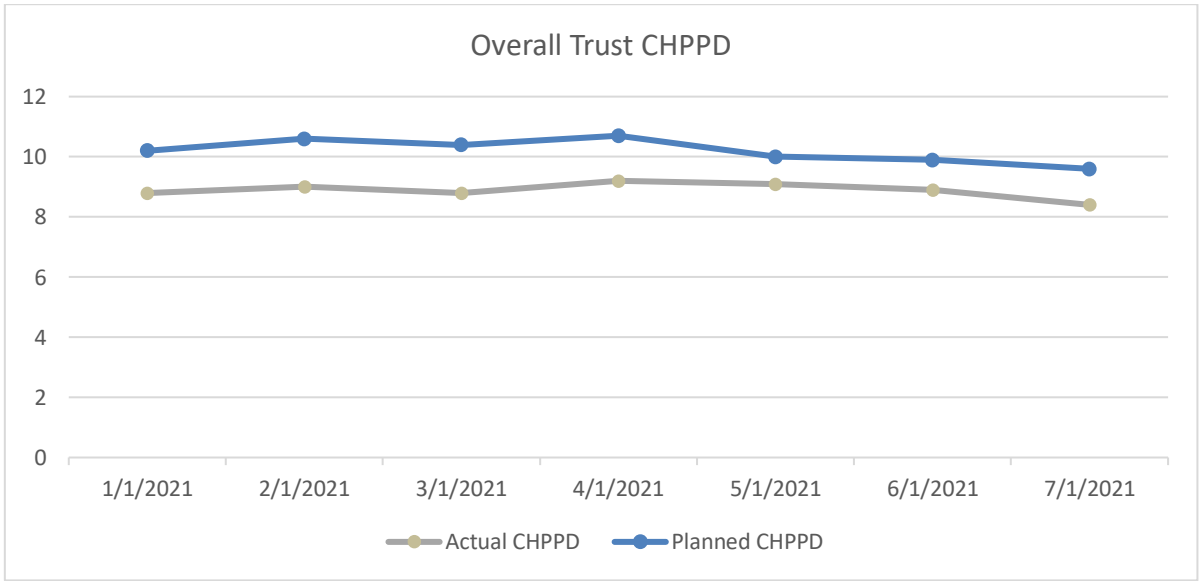
It is calculated by adding together the total number of registered nurse and healthcare assistant hours on each ward and dividing by the number of patients. The aim of this is to enable national benchmarking, reduce variation and increase efficiency.

Figure 6 shows the most up to date position for CHFT on Model Hospital (May 2021) and indicates that for CHPPD nationally, CHFT are in quartile 2 and in line with the national medium of 9.1.



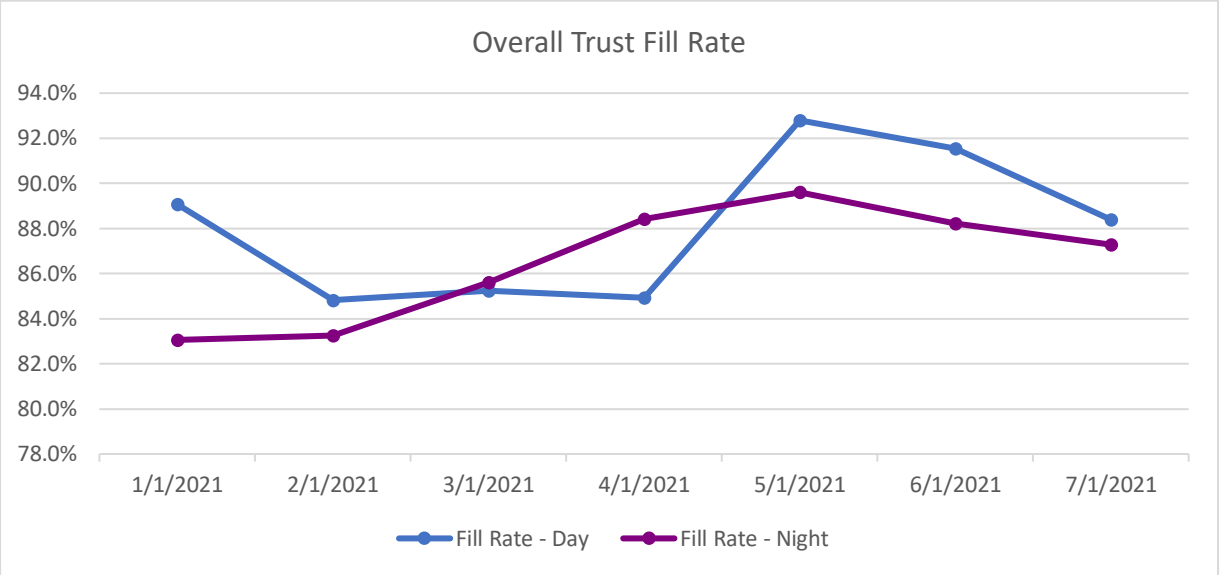
(Figure 6)

CHPPD



(Figure 7)

Fill rates



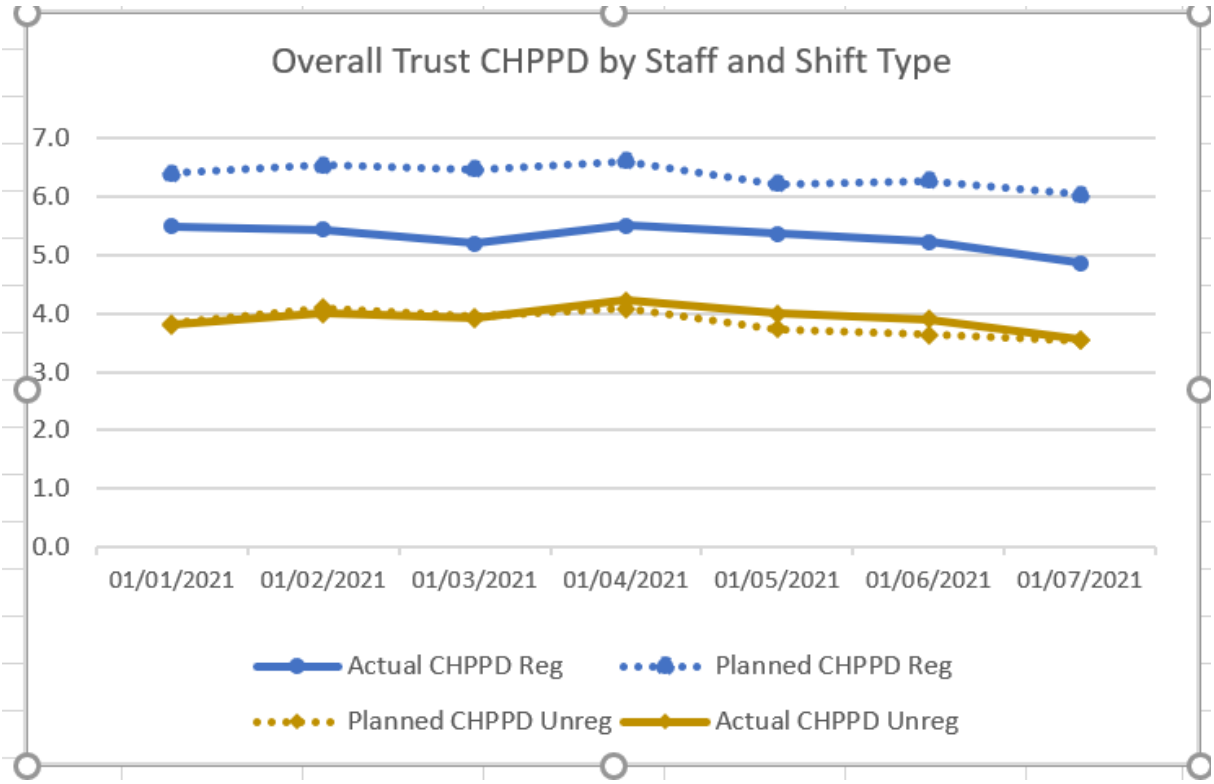
(Figure 8)

Whilst fill rates are no longer a reporting requirement to NHSE/I they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both RN and HCSW. Factors affecting fill rates include:

- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

Trust overall fill rates have not regained the pre pandemic position which trended around the 90-95% position. Fill rate position dipped to 83% during February followed by a period of improvement (Figure 8). These impacts can be seen on the overall trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (Figure 7). This is reflective of the restarting of services to a pre-pandemic position, in addition to supporting enhanced service delivery in some areas.

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), Figure 9 breaks down the CHPPD by staff groups, which highlights the most challenging gap can be seen within the RN workforce.



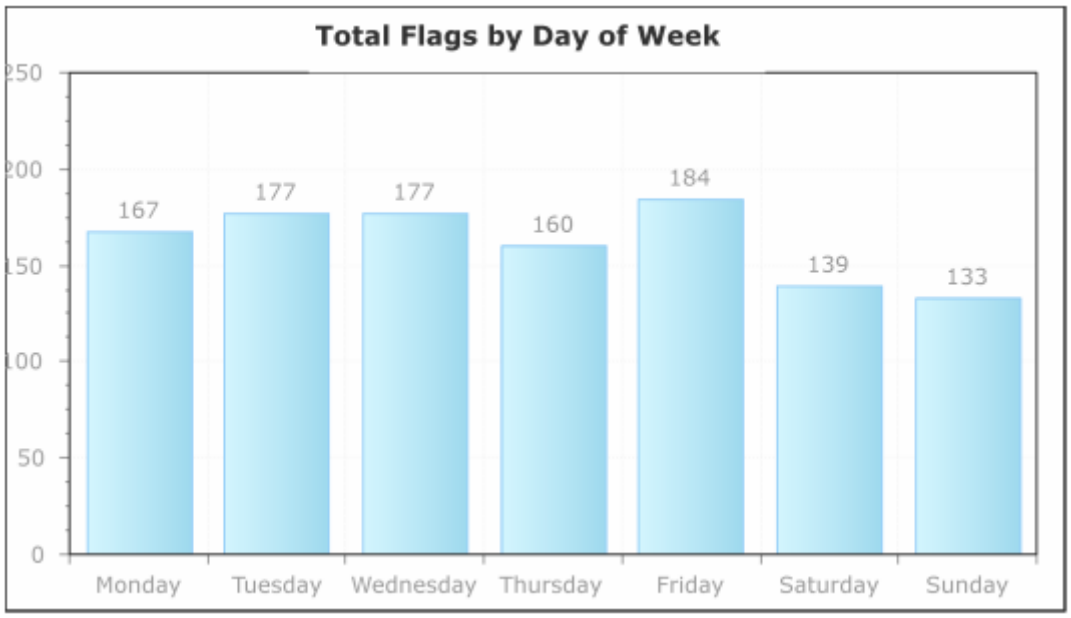
(Figure 9)

4.1 Red Flag Escalation

To supplement the process of rating the status of staffing requirements within the roster system, a system of Red Flag escalation has been developed in line with NICE (2014) guidance. Nursing Red Flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge or a more senior nurse to mitigate patient safety concerns. Nursing Red Flags can be raised at any point during a shift.

During the Covid-19 pandemic given the significant staffing challenges there would be an expectation of escalation via the Red Flag process. Concerns around the lack of reporting led to a Perfect Week event in January 2021 which saw an improvement against this method of staffing escalation.

Figure 10 provides a breakdown of red flags for the reporting period 1st January 2021 – 30th June 2021.



(Figure 10)

Key findings are listed below.

- Red flags are being used as a mechanism to support escalation
- 937/1137 selected “number of skill mix of nurses not sufficient” as the reason for the Red Flag
- 51/1137 selected unmet enhanced care needs
- 48/1137 selected clinical treatments or interventions delayed.
- 37/1137 related to challenging behaviours from patient or visitor
- 30/1137 related to staff unable to take breaks

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients care. Thus, this information should be considered within the context of the CHPPD and fill rate position and the quality agenda in section 4.2 of the report

4.2 Quality

As highlighted earlier there is a well-established correlation between staffing levels, safe care and patient experience.

As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

In addition, since the last report, work has been progressing on the development of an integrated dashboard accessible by clinical teams through Knowledge Portal+. This dashboard provides close alignment of the fill rates, CHPPD and several quality metrics to facilitate professional curiously and initiate deep dives into service areas.

This is further supported by the development of a "Worry Wards" dashboard that will be used to report into the Nursing and Midwifery Safer Staffing meeting and determine additional actions to respond to data triangulation, and mitigation against any impacts.

4.2.1 Friends and Family Test (FFT)

The performance data reported below is a combined rating of any FFT responses submitted between January and June 2021.

The main FFT question asks: ***Thinking about your recent stay in hospital... Overall, how was your experience of our service?*** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens.

All	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know
% of Total	77%	16%	3%	2%	2%	1%
Combined	**Positive:** 93%			**Negative:** 4%		

Supplementary questions are also asked of patients, providing an opportunity to comment on what went well and anything that could be improved.

Below are examples of these messages related to 'staffing/ staffing levels' during the Jan – June 2021 period:

Positive feedback regarding staff:

- Very good treatment by friendly and efficient staff.
- Very good staff, so very helpful, could not do enough for me.
- Very caring staff and understanding to my needs, very busy ward. Nothing too much trouble for staff.
- Very attentive staff and caring. All went that extra mile, a credit to the NHS.
- The time staff took to reassure and care. Never felt rushed even though they were so busy.
- The staff were great, nothing was too much to ask for them, all my needs met.
- The staff were all extremely supportive and I felt safe/cared for.
- The staff went above and beyond what they have to do for me.
- The staff on these wards have been fantastic, they have shown so much care, gone above and beyond, a credit to the NHS!
- The staff are a credit to their profession from top to bottom. Absolutely fantastic care and treatment. No task is too small or trivial, carried out in an impeccable style and manner.
- Great advice given by midwife and did not feel rushed to leave before I wanted to
- Efficient triage procedure. Staff willing to listen even though they were very busy
- Professional and caring staff even though they were very busy

Comments recognising staffing pressures:

- You need more staff 'staff overworked'.
- Well looked after, but need more staff
- Was impressed with the care from the nurses but could do with more staff on.
- Very professional team that gave my care but short staffing on some shifts.
- The staff opened the ward yesterday, are run off their feet, yet they are wonderful angels. Under the stress and strain they are smiling, caring and thoughtful and staff should be recognised for the effort they have put in.
- More staffing might take pressure off the staff on shift and allow a quicker discharge for patients, but I understand why this may not be possible
- Maybe a few more nurses

The comments have been drawn through a manual search involving key words for example: busy, efficient, staffing.

The search has identified several comments related to staffing pressures which are in the main positive but clearly acknowledge the nursing and midwifery staffing challenges.

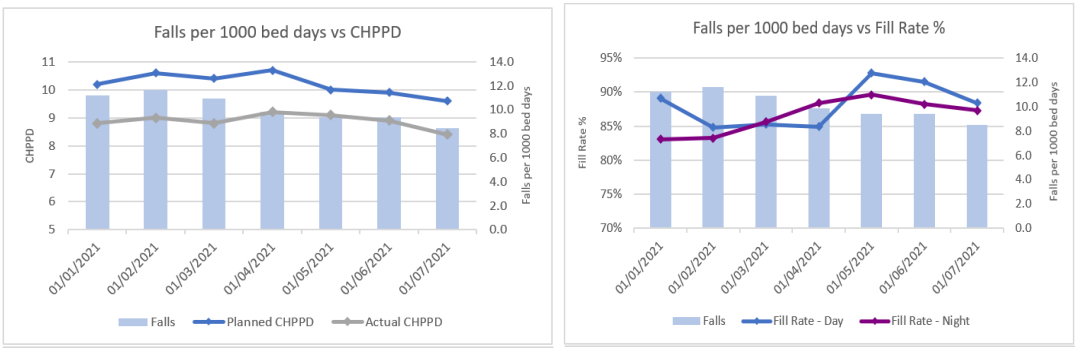
The overall positive FFT score of 96% is a positive position which is against a national position of 95%.

4.2.2 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls per 1000 bed days (Figure 11) and ulcers per 1000 bed days (Figure 12).

<u>Falls</u>

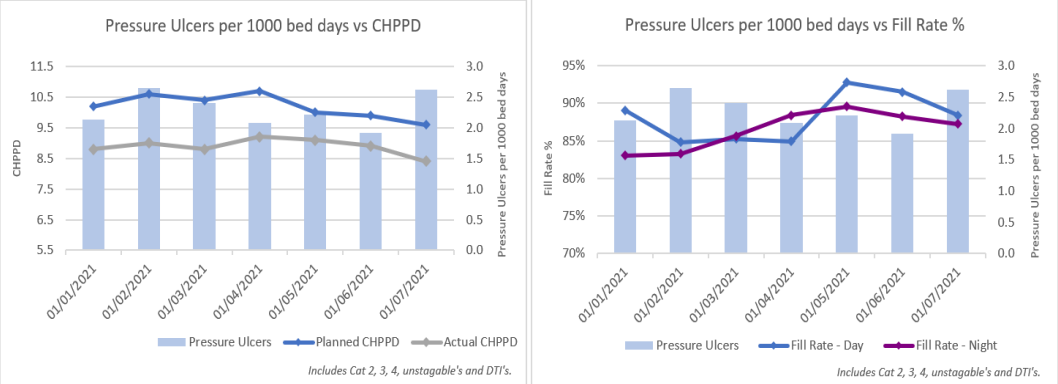
Falls remained at their highest period during the months of January-March 2021 which was also reflective of the lowest period of fill rates. 11.6 falls per 1000 beds days against the lowest fill rates of 83.2% and 84.8 % for night and day respectively. This is consistent again the CHPPD which is at its broadest gap between planned and actual for the same month.



(Figure 11)

Pressure Ulcers

A similar picture is observed for pressure ulcers where a peak in incidence is seen in February against a challenging workforce position, this trend of tracking the gap in fill rates and CHPPD continues, except for July 2021



(Figure 12)

Overall analysis of the data indicates an increasing incidence of the two nurse indicators that coincides with a deteriorating fill rate and CHPPD position.

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), and the gap in CHPPD is identified as the most challenging for the RN workforce (Figure 8).

It is reasonable to suggest the impact of a challenging recovery agenda, ongoing enhanced delivery of some services, current vacancy position and the impact of increasing staff sickness absence has impacted upon the patient experience.

4.2.3 Incident reporting

During the reporting period 143 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. 142 of these incidents were reported as no harm and the appropriate action was taken at the time. One incident was reported as minor harm, this involved three patients deteriorating rapidly within the same time frame. Analysis of the incident indicated that staff responded appropriately, however the rapidity of this situation will have impacted on the patients and staff experience.

4.2.4 Further points for consideration

Whilst red flags and incident reporting are established methods of escalation, it should equally be noted that these approaches may not be fully utilised by a workforce that is challenged by the current staffing position. Under reporting is an ongoing concern and reiterates the importance of ensuring forums are available for concerns to be raised. A recent example included concerns raised by staff side at the Staff Partnership Forum, on behalf of members. These concerns related to the nursing and midwifery staffing position and were principally focused upon: -

- The movement of staff across clinical areas to address shortfalls and how this was being communicated
- Colleagues being asked to work outside of their field of expertise
- Manager visibility

A separate meeting was convened, and these concerns have been responded to.

CHFT'S RESPONSE

Short-term strategies

5.0 STRENGTHENING THE ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

Throughout the pandemic and increasingly so during the second surge Safe Staffing has been a key focus and is one the Trust Must Do priorities. Addressing this has been a key focus of the senior nursing team, and a range of actions put in place to manage risk.

Twice daily nursing and midwifery staffing meetings chaired by the Associate Director of Nursing (Corporate) are now in operation 7 days a week, operating with a revised term of reference.

The purpose of this meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity & dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

The twice daily nursing and midwifery safer staffing meetings have a direct escalation now established to the Nursing and Midwifery Workforce Safer Staffing Group chaired by the Executive Director of Nursing.

A dashboard has been developed in this forum using Knowledge Portal+ to monitor a number of nurse sensitive indicators alongside CHPPD and fill rates. This has been shared through the Executive Director of Nursing's weekly briefing forums with both Matrons and Ward Managers.

A worry ward dashboard is also in development to provide clear visibility on the workforce position and impacts on the patient experience, quality and safety agenda. This dashboard will include a number of metrics that sit across all four divisions, in addition to divisional specific metrics which will enable true triangulation of the datasets.

Given the ongoing critical workforce challenges an additional daily Nursing, Midwifery and Allied Healthcare Professional has been established, supported by Human Resource division business partners to rapidly respond to staffing escalations, in addition to provide ongoing health and well-being support to the frontline workforce.

The 7-day senior nurse leadership rota established earlier this year continues supported by the Executive Director of Nursing, Deputy Director of Nursing and Associate Directors of Nursing to provide ongoing visibility of clinical areas, provide on-going dialogue and support staffing escalations across the 7 days.

5.1 Staff Health and Well-Being

The nursing and midwifery workforce recognise the ongoing impact of the Covid-19 pandemic on NHS staff well-being. This continues to remain an area of significant focus with ongoing support from colleagues within workforce and organisational development departments (WOD). The interventions provided during the peak of the pandemic continue and include:

- Ongoing daily coaching/debrief for critical care staff
- Ensuring staff feel safe and protected
- Ensuring safe spaces for rest and recuperation
- Ongoing health and well-being conversations with managers, WOD colleagues and the senior team
- Psychological support and treatment
- Appraisal of flexible working
- Ongoing promotion and completion of the Trusts health and well-being risk assessment
- Duty Matron rota established 7 days a week
- 7-day senior nurse leadership rota
- Weekly Leadership Assurance audit (including staff health and well-being)
- Listening events (developed into an action plan to inform learning from the first waves of the pandemic)
- CHFT well-being support Autumn/Winter 20/21 programme

Medium-long term strategies

6.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The NHS Long Term Plan has set a target of reducing Nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. This will be addressed by a comprehensive, multi-pronged recruitment strategy with

ongoing alignment to the NHS People Plan and government mandate. This includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

We continue our local approach of 4 rolling adverts out (Staff Nurse Medicine, Staff Nurse Surgery, Return to Practice and Staff nurse student), and maximising opportunities to attract the next cohort of new graduates. Below is further detail surrounding our recruitment strategy:

6.1 International Nurse Recruitment

We are committed to recruiting 70 International Nurses before the end of Dec 2021. To date 38 nurses have arrived in the country. There were some delays from April to June due to travel restrictions of nurses from India. However, we are confident, following successful interviews and a more streamlined recruitment process the remaining 32 nurses will arrive before the year end.

Of the 38 nurses who have arrived, 17 have successfully passed their OSCE exam and are either now registered or awaiting NMC Pin. 21 are in the training programme and will sit the OSCE in either September or October.

All nurses are supported to transition into life within the UK, in addition to a robust training package and wrap around pastoral support that has seen positive results with zero attrition during the 2020-2021 programme.

Pastoral support has been at the centre of this project since its inception and recognised by (Health Education England) HEE and NHSE/I as imperative to making IR recruitment work. CHFT pride themselves on a programme of pastoral support which exceeds the expectation set out by HEE and NHSE/I and includes:

- IR Facebook page for social engagement before and after arrival
- Access to CHF/T's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.
- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support
- Clinical support and orientation

- Welcome packs and meet and greets (we are the first people recruits meet when they arrive)
- Support with NMC registration

During the period 2020-2021 the impact of this approach can be measure against the attrition which represents 0 against 100 international nurse recruits

6.2 Recruitment of Newly Qualified Nurses

Recruitment from the 2020/2021 3rd year student cohort was prioritised as a critical workstream. In the absence of the usual recruitment fairs, the education team in partnership with the Workforce and Organisational Development Teams created promotional materials, suitable for distributing via email, social media and other digital platforms to attract the summer graduates.

The campaign was a success, resulting in 80 nurses receiving an offer, an increase on previous years and reflective of the efforts to enhance the learning environments for this cohort of students despite Covid restrictions.

6.3 Nursing Associate Apprenticeships (TNAs)

13 apprentices successfully registered as Nursing Associates in June. These have been allocated to vacant RN positions across the Trust.

There are 3 active cohorts of Nursing Associate apprentices (37 apprentices in total, of which 14 are due to qualify in Dec 21) with a further cohort of 20 recruited to start Dec 2021.

6.4 Registered Nurse Degree Apprenticeships

2 HCSW's started the full 3-year apprenticeship in January 21 (qualifying in January '24), with a further 7 Registered Nursing Associates joining the 2 year 'top-up' to RN apprenticeship in January 21 (qualifying January '23).

7 Nursing Associates will start the 'top-up' programme in October 21 with a view to qualifying in October 23.

6.5 Return to Practice Nurses:

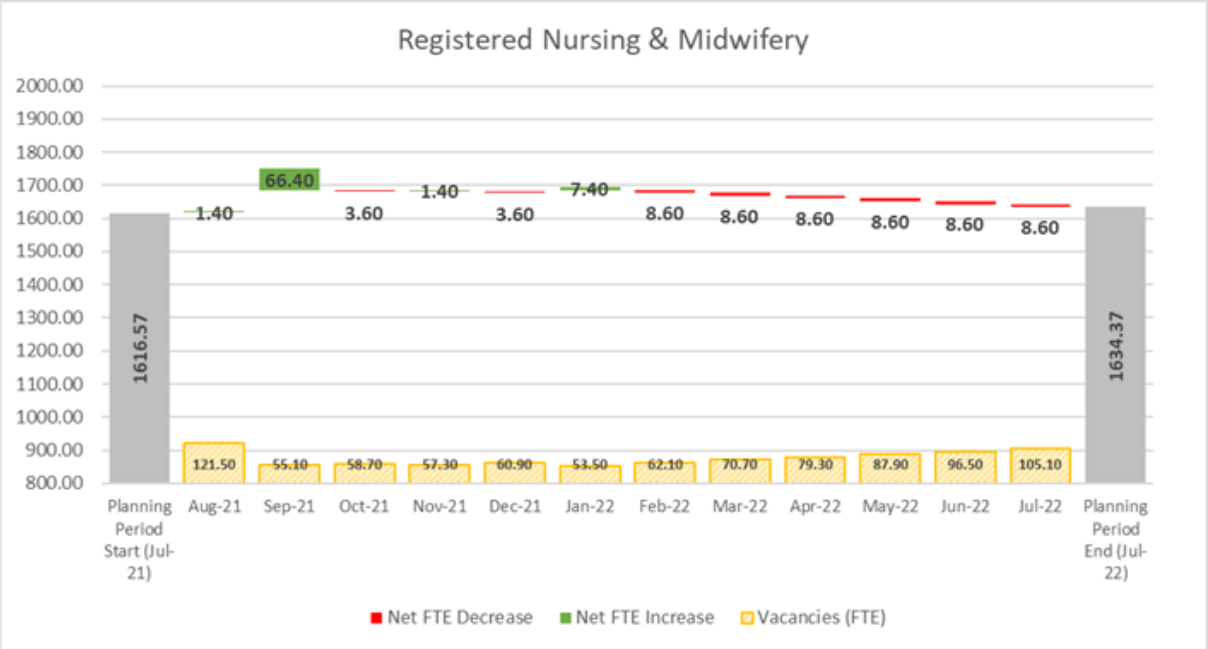
2 nurses returned to Practice in February 21 and are currently awaiting NMC PIN. 1 is planning to join in September 21, with a further 1 in February 22.

6.6 Workforce Modelling

A blended approach to CHFT's nursing and midwifery recruitment strategy provides several opportunities to recruit into the workforce whilst reflecting the commitments set out in the NHS People Plan.

Based on the current recruitment schemes and incorporating modelling assumptions based on the leavers, current projections indicate a vacancy position of 105.10 WTE as of Jul ’22 (Figure 13).

This information is now being used to inform 2022/2023 annual planning cycle and subsequent business cases to further shorten the vacancy position.



(Figure 13)

6.7 Health Care Support Workers (HCSW)

The national ‘Zero HCSW Vacancy’ campaign has been extended in to 2022, the aim of the programme is to meet a zero HCSW vacancies and have procedures in place to ensure this is maintained. An increased funding investment in to welcoming recruits with no prior experience has been pressed as a priority, this is to avoid destabilising existing services and to grow our HCSW workforce nationally in line with demand.

Following on from a recent recruitment campaign, it was identified that there was a need for one streamlined application route for both Healthcare Support Workers (HCSWs) and clinical apprentices. This will enable CHFT to recruit HCSWs as well as clinical Apprentices who may not meet the HCSW criteria at one entry route, the benefit of this new process will allow CHFT to welcome new talent to the trust as well as established and experienced Healthcare Assistants without having to reject promising candidates from the workforce.

In addition to this, the appointment of a HCSW Recruitment Lead into Trust in June 2021 has enabled a focus on employee retainment. This has allowed time investment into the research of improving onboarding and training for Healthcare Support Workers, as well as looking into current policies for internal transfers.

Funding has been secured within the most recent financial term with an expectation this is used towards the following points:

- Build on the success of the 2020-21 Programme to further reduce and maintain HCSW vacancies at minimal levels.
- Support recruitment into new vacancies due to changes in establishment from April 2021.
- Respond to elective demands and ensure adequate provision for winter 2021/22.
- Ensure focused career conversations with all newly recruited HCSWs.
- Provide pastoral care and support and mitigate potential for early attrition.

Below is data submitted to NHSI/E to monitor progress throughout the programme, this shows a zero HCSW vacancy up until the most recent submittal period, however a recruitment campaign for both Band 2 HCSWs and Clinical Apprentices is currently underway.

Organisation Name	Sector	HCSW vacancies M11	HCSW vacancies M12	HCSW vacancies M01	HCSW vacancies M02	HCSW vacancies M03	HCSW vacancies M04
Calderdale and Huddersfield NHS Foundation Trust	Acute	54	12	0	0	0	0

Reviewing employee turnover data has also been a useful tool in supporting both recruitment and retainment of the workforce. It has allowed the measurement of the incoming candidates against the employees leaving CHFT and if the workforce is increasing or maintaining. It is also useful to identify any patterns and trends within certain areas/divisions and allowed us to put together an action plan for targeted recruitment, an example of this is the Enhanced Care Support Worker Team who will be undergoing a recruitment campaign separately.

Turnover / Leaver data – May – June 2021

Trust Name	Sector	Cumulative joiners (WTE)	Joiner rate	NHS leavers (not inc. progression)	NHS rate (not inc. progression)	Leavers May - June (WTE)	Leaver rate	Churn (movement to another Trust)
Calderdale and Huddersfield NHS Foundation Trust	Acute	22	3.0%	- 14	-1.9%	- 27	-3.6%	0

7.0 Summary

- During the reporting period two establishment reviews have been undertaken with the latter focused upon the recovery agenda and returning many services to pre-covid workforce models.

- The impact of the combined actual RN wte and average sickness absence position modelled across the three divisions is creating a deficit and impacting upon the ability to meet the actual CHPPD, which describes an unmet patient need.

- Close monitoring of nurse sensitive indicators and red flag escalations also demonstrates a trend which corresponds to the RN shortfall position.

8.0 Recommendations

The Board is asked to: -

- Note the content of this report and the progress in relation to key work streams.

- Gain insight and assurance regarding the daily processes to monitor and manage nurse and midwifery staffing levels at ward level, including the proposal to refine this approach going forward, which includes tracking of impacts related to the nursing and midwifery workforce position.

Appendix 1

Compliance with the Developing Workforce Safeguards, Nursing and Midwifery

Background

In October 2018, NHSI published the document Developing Workforce Safeguards (https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf), aimed at supporting providers to deliver high quality care through safe and effective staffing.

The publication contains new recommendations to support NHS Providers in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on previous National Quality Board's (NQB) guidance (2013, 2016).

NHSI will assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. It is based on patients' needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

To assess Trusts' compliance with this, NHSI will use information collected through the Single Oversight Framework (SOF) and has asked Trusts to include a specific workforce statement in their annual governance statement.

By implementing this document's recommendations and strong, effective governance, boards can be assured that their workforce decisions will promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, the Use of Resources assessment and the Board's statutory duties.

There is recognition that further work is necessary to develop a consistent approach to safe staffing levels across all clinical workforce groups, particularly the need to develop evidence-based tools for assessing the impact of variations in acuity and dependency on medical, allied health professional (AHP) and other non-nursing clinical staff groups.

Although the guidance applies to all clinical staff; this paper will outline Nursing, Midwifery and Medical compliance with the 14 safeguard recommendations, identifying areas for improvement, including an action plan (appendix 2) will be used to show progress and will be RAG rated accordingly.

WORKFORCE SAFEGUARDS – ASSESSMENT FROM RECOMMENDATIONS / ACTION PLAN

Developing Workforce Safeguards, published in October 2018, was designed to help Trusts manage common workforce problems. It contains new recommendations to support Trusts in making informed, safe, and sustainable workforce decisions, and identifies examples of best practice in the NHS.

There are 5 key themes which are outlined below: -

1 NQB Recommendations
2 Effective workforce planning
3 Deploying staff effectively
4 Governance considerations: redesigning roles and skill mix
5 Responding to unplanned workforce challenges

NHS Improvement's yearly assessment will cover the above 5 themes.

Below is a summary of the recommendations and the current position in respect of compliance relating to Developing Workforce Safeguards for Calderdale and Huddersfield NHS Foundation Trust. Alongside the recommendations are actions needed where gaps have been found:

Each action is RAG rated to show progress against the action.

RAG RATING:

Green – Compliance against action
Amber – Some actions completed; further action(s) needed
Red – Not yet started.

Recommendation 1 **The Trust must formally ensure NQB 2016 guidance is embedded in safe staffing governance**	**AMBER**

Assessment:

Nursing and Midwifery RAG Rating: GREEN
NQB (2016) guidance is well developed in Nursing and Midwifery as part of the safe staffing agenda.
Current compliance is reported in the bi-annual Nursing and Midwifery establishment reviews reported to Trust Board.

Medical RAG Rating AMBER
Safe Hours Guardian in place for Junior Doctors, with regular reports to the Trust Board.
Hours worked is monitored and reported for Bank Workers through the Flexible Workforce Department
Compliant Rota's
Review of working time directive and processes in place.
Work with Model hospital to allow comparison to peers

Recommendation 2 **Trusts must ensure the three components of: evidence-based tools (where available), professional judgement and outcomes are used in safe staffing processes**	**AMBER**

Assessment:

Nursing and Midwifery RAG Rating: AMBER

Tis element of NQB guidance is well developed in Nursing and Midwifery as part of the safe staffing agenda.
Whilst the majority of nursing and midwifery reviews will be undertaken using Safer Nursing Care Tool (SNCT) methodology, this is not appropriate for all clinical areas. The below table (Figure 1) outlines where different methodologies and guidelines are available to inform safe staffing processes.
Community nursing services are currently participating in a pilot project testing the development of SNCT methodology within a community setting.

Area	Methodology
Wards – adult and paediatric	Safer Care Nursing Tool
Out-patient departments	Professional Judgement
Neonatal Unit	British Association of Perinatal Medicine
Critical Care	Intensive Care Society Guidelines for the Provision of Intensive Care Services
Theatres	The Association of Perioperative Practice (AFPP)
Emergency Department	Professional Judgement
Maternity Services	Birthrate+
Endoscopy	Joint Advisory Group for GI Endoscopy/professional judgement
Community Nursing Services	Professional Judgement & Caseload Reviews

(figure 1)

Where SNCT is used to set establishments, The Shelford Group have developed an assessment criterion to address reliability and validity of data collection. CHFT's self-assessment is outlined in Figure 2.

Criteria	Y/N	Evidence required
Have you got a licence to use the SNCT from Imperial Innovations?	Y	License agreement signed by Executive Director of Nursing (04/21)
Do you collect a minimum of 20 days' data twice a year for this?	Y	Processes have now been established to meet this criterion and outlined in the Framework for agreeing Nursing and Midwifery staffing establishment guidance (2021).
Are a maximum of three senior staffing trained and the levels of care recorded?	Y	Training commissioned and provided from The Shelford Group in July 2021. Training database established and in-house training plan to commence.
Is an established external validation of assessments in place?	Y	Process has been established to ensure senior staff with no direct management duties will be allocated to ward for each data collection. Evidence will be provided with the data collection tool
Has inter-rater reliability assessment been completed with these staff	Ongoing	Training has been commissioned and provided by The Shelford Group in July 2021. An in-house training programme is planned to commence as part of the induction/management development of new ward managers/matrons. New staff to be signposted to the Head of Workforce and Education.
Is A&D data collected daily, reflecting the total care provided for the previous 24 hrs as part of a bed-to-bed ward round review	Y	Daily retrospective scoring will be collected during each dataset.
Are enhanced observation patients reported separately?	Y	Enhanced observations are supported by the Enhanced Care Support Worker Team – a separate report will be used to determine individual ward area requirements.
Has the executive Board agreed the process for reviewing and responding to safe staffing recommendations based on the output of SNCT and professional judgement.	Y	

(Figure 2)

The bi-annual review does not include all nursing and midwifery workforce groups for example clinical nurse specialists and nurse consultants.

Medical

Whilst there are established tools and nurse patient ratios to determine safe staffing processes for Nursing and Midwifery, there are no specific standards or framework for medical workforce. This should be explored further.

Recommendation 3 **The Trust will be assessed against annual governance statements which should confirm staffing governance processes are safe and sustainable.**	**GREEN**

Assessment:

Annual governance statement includes a statement around workforce governance. Governance around workforce is through the Workforce Committee and through Divisional Performance Review Meetings.

Recommendation 4 **An annual governance statement will be reviewed through usual regulatory arrangements and performance management processes: namely integrated and complementing quality outcomes, operational and finance performance measures.**	**GREEN**

Assessment:

As referenced already in recommendation 3 in addition to the Trust strengthening the integration of workforce planning with quality, operational and finance performance to produce an overview of workforce information and metrics within the Integrated Performance Report (workforce IPR sample below).

Quality & Performance Report

Recommendation 5 **A Single Oversight Framework (SOF) will be used to provide assurance of the degree of compliance with implementation of new guidance**	**AMBER**

Assessment:

As part of this yearly assessment, NHSI will seek assurance through the SOF, in which a provider's performance is monitored against five themes. The performance data is reported through Integrated Performance Report. The governance and oversight around workforce would be through Divisional PRMs and oversight is through Workforce committee.

Recommendation 6 **The Director of Nursing and Medical Director MUST confirm in a statement to board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.**	**AMBER**

Assessment:

Nursing and Midwifery RAG Rating: AMBER

Nursing and midwifery staffing is reported in the annual and bi-annual Nurse and Midwifery staffing report to the Trust Board.
This report predominantly focuses upon in-patient services and does not currently include all clinical areas (however these are included within the bi-annual review process) and other roles within the nursing and midwifery workforce e.g., nurse consultants and clinical nurse specialists.

Medical

Medical staffing risk deep dive report presented to workforce committee.
Whilst there are established tools and nurse patient ratios to determine safe staffing processes for Nursing and Midwifery, there are no specific standards or framework for medical workforce. This should be explored further.

Recommendation 7 **Trusts MUST have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The board should discuss the plan in a public meeting.**	**AMBER**

Assessment:

Currently workforce planning is in place aligned to the financial, activity and performance plan.

A formal annual workforce plan is required, with NHSI expectations on the workforce planning process to be fully incorporated in order to meet assessments effectively and to clarify workforce risks.

In addition, the six domains highlighted in the NHSI workforce planning toolkit, which differ from previous measures are used in the assessment of annual workforce plans. These domains include future scenario-planning, staff engagement at all levels, use of a workforce planning model, technological and digital systems, evidence of metrics where available, involvement of executive leaders and oversight by external stakeholders.

Nursing and Midwifery RAG Rating: AMBER

Nursing and midwifery staffing are reported in the annual and bi-annual Nursing and Midwifery staffing report to the Trust Board.
This report does not explicitly report against all service areas which are involved in the bi-annual reviews. The bi-annual reviews do not include all clinical areas including those provided by consultant nurses and clinical nurse specialists.

A nursing and midwifery workforce plan has been developed and is reviewed within the Nursing and Midwifery Workforce Steering Group to inform the annual workforce planning cycle.

Medical

The current position for medical workforce numbers, vacancies, recruitment and retention is monitored by the medical workforce programme steering group through Recruitment and Retention, Flexible workforce, Bank and agency and Medical workforce deployment work streams to workforce committee.

Recommendation 8 **Boards must ensure the organisation has an agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency metrics such as Model Hospital. Trusts should report on these metrics to their boards every month with data to be considered as a whole.**	**AMBER**

Assessment:

Nursing and Midwifery

Data is triangulated against several metrics to inform the bi-annual Nursing and Midwifery Safer Staffing Reviews. This is supported by a "Workforce Model Framework" which prompts the use of several data sources, including the recent development of Knowledge Portal+ which has been configured to support reporting against CHPPD, fill rates and several nurse sensitive indicators.

Data is also available within the Quality and Performance Report to Executive Board on a monthly basis, which includes the Hard Truths element of the report which has been revised to include nurse sensitive indicators.

Further consideration needs to be given of how utilisation of the model hospital data is evidenced.

Medical

As above

Recommendation 9 **An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.**	**GREEN**

Assessment:

Currently reported in the bi-annual Nursing and Midwifery report to Trust Board.

Recommendation 10 **There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tools.**	**GREEN**
Assessment: All Nursing and Midwifery staffing tools are implemented as per guidance. Refer also to recommendation 2 for further details.	
Recommendation 11 **Any service changes, including skill-mix changes must have a full quality impact assessment (QIA) review, adapted from the approved NHSI template.**	**GREEN**
Assessment: A QIA process and procedure is in place within the Trust, this has previously focused upon cost improvement programmes **Nursing and Midwifery RAG Rating:** A process has been now been established to include a QIA as part of the bi-annual establishment where any skill mix changes are indicated **Medical** Alternative workforce models have a thorough QIA process before implementation. (PA's, AHP, ACP's Nurse specialists)	

Recommendation 12 **Any redesign or introduction of new and extended roles should be considered as a service change and must have a full QIA.**	**GREEN**

Assessment:

QIA processes and procedures are in place, however these have predominantly focused upon cost improvement programmes.

A new redesign of services template has been designed and implemented recently by Workforce and OD. This has been presented to Divisions and Directorates.

Nursing and Midwifery RAG Rating:

A process has established to include a QIA as part of the bi-annual establishment where any skill mix changes are indicated

Medical

Same as nursing

Recommendation 13 **To support day to day operational challenges, the Trust must carry out dynamic staffing risk assessment including formal escalation processes.**	**GREEN**

Assessment:

Nursing and Midwifery RAG Rating:

Twice daily staffing meetings are in place for Nursing and Midwifery to review the staffing position across a number of clinical areas, supported by the Allocate Safe Care module. These meetings are supported by terms of reference and a set of OPEL safer staffing action cards. Formal escalation of the staffing position is fed into both tactical and the Nursing and Midwifery Safer Staffing Meeting. In addition to local nursing and midwifery escalation guides and action cards.

Medical

As above. Sitreps and well-established escalation routes.
The Trust has an established central flexible workforce department which manages rota gaps (E-Roster, rota co-ordinators for each specialty work closely with Divisional operational teams). Flexible workforce department manages the processes and governance for Bank and Agency and Additional clinical duty payments. This will help to maintain stability, reduce reliance on agency and bank and provide

Recommendation 14 **Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the use (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.**	**GREEN**

Assessment:

Robust systems are currently in place to maintain safety and care quality. There is a need to notify NHSI if services have been closed/curtailed due to staffing issues.

Nursing and Midwifery RAG Rating:

Twice daily staffing meetings are in place for Nursing and Midwifery to review the staffing position across a number of clinical areas, supported by the Allocate Safe Care module. These meetings are supported by terms of reference and a set of OPEL safer staffing action cards. Formal escalation of the staffing position is fed into both tactical and the Nursing and Midwifery Safer Staffing Meeting. In addition to local nursing and midwifery escalation guides.

Medical

Sitreps and well-established escalation routes.
The Trust has an established central flexible workforce department which manages rota gaps (E-Roster, rota co-ordinators for each specialty work closely with Divisional operational teams).

APPENDIX 2

Action Plan

Recommendation	Action(s)	Date
1. The Trust must formally ensure NQB 2016 guidance is embedded in safe staffing governance	• Whilst there are established tools and nurse patient ratios to determine safe staffing processes for Nursing and Midwifery, there are no specific standards or framework for medical workforce. This should be explored further.	
2. Trusts must ensure the three components of: evidence-based tools (where available), professional judgement and outcomes are used in safe staffing processes.	• Extend the scope of N & M clinical roles into the annual and bi-annual Nursing and Midwifery review process • Further embed the use of nurse sensitive indicators and outcome measures to inform the bi-annual Nursing and Midwifery review process • To explore RCP staffing paper and assess if this could be applied across all specialties • CHFT medical establishment – vacancy tracker (recruitment and retention), workforce programme steering group monitoring	Jan 2022 Jan 2022
5. A Single Oversight Framework (SOF) will be used to provide assurance of the degree of compliance with implementation of new guidance.	• Overview is currently through workforce committee. Workforce and HR to work with AMD (workforce) and Associate Director of Nursing for providing SOF.	
6. The Director of Nursing and Medical Director MUST confirm in a statement to board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	• Extend the scope of N & M clinical roles into the annual and bi-annual Nursing and Midwifery review process • Medical – to report biannually similar to N&M • Difficulty with defining ‘safe’ numbers – lack of any tools/standards set by Royal colleges/GMC	Jan 2022

Recommendation	Action(s)	Date
7. Trusts MUST have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the plan in a public meeting.	• Extend the scope of N & M clinical roles into the annual and bi-annual Nursing and Midwifery review process	Jan 2022
8. Boards must ensure the organisation has an agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency metrics such as Model Hospital. Trusts should report on these metrics to their boards every month with data to be considered as a whole.	• Proactive use of NHSI's Model Hospital data. The datasets in model hospital are drawn from provider returns across the UK, and compare productivity, quality and responsiveness data. This gives information on workforce data which can be used for workforce planning, including Care hours per patient per day (CHPPD) and clinical hours to contact (CHtc) data, and cost per contact for non-ward-based settings. • Development of a "worry" dashboard for Nursing and Midwifery Services. • Ongoing refinement of the Hard Truths section of the Integrated Performance Report • Assessment of all KPI's to ensure measures (both qualitative and quantitative) are in place to identify appropriate interventions. • GIRFT sessions, which detail quality metrics associated with productivity. • Model Hospital and GIRFT data to be routinely reviewed at board level and should be embedded in change or improvement methodology. • Review of Job Plans linked to productivity data.	Jan 2022 September 2021 Ongoing
	There is a further action required to extend the assessment to include Allied Healthcare Professionals	TBC

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BOARD OF DIRECTORS

NURSING & MIDWIFERY

SAFER STAFFING REPORT

Reporting period: January to June 2021

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INTRODUCTION

- Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation, Nursing and Midwifery Council (NMC) recommendations and national policy on safe staffing.
- The National Quality Board (2016) guidance and Developing Workforce Safeguards (2018) set out expectations for Nursing and Midwifery staffing levels to assist local Trust Board decisions in ensuring the right staff, with the right skills are in the right place at the right time.
- There is a breath of research that has long demonstrated that staffing levels are linked to the safety of care delivery and that staff shortfalls increase the risks of patient harm and poor-quality care.

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THE REALITY

- The challenges to the NHS workforce are well recognised and reported on by the government and national bodies. However, within the overall picture, the most urgent challenge is in relation to the nursing workforce where the Government has pledged to have an additional 50,000 more nurses working in the NHS by 2024/25. This is in response to a current national shortage of more than 45,000 nursing and midwifery vacancies.

- Whilst the vacancy rate at CHFT has remained static over previous years running with circa 150 qualified vacancies, July 2021's vacancy position has reported an improvement with a vacancy position of 115 FTE.

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THE REALITY

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Sickness / Absence position

Qualified Nursing and Midwifery

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 01	1,017.88	2,307.82	3,325.70	50,811.94	2.00%	4.54%	6.55%	3,072.34	6.05%	12.59%
2021 / 02	707.37	2,192.86	2,900.23	45,823.93	1.54%	4.79%	6.33%	2,985.82	6.52%	12.84%
2021 / 03	557.60	1,901.55	2,459.16	50,564.31	1.10%	3.76%	4.86%	3,433.45	6.79%	11.65%
2021 / 04	611.29	1,665.85	2,277.13	48,615.09	1.26%	3.43%	4.68%	248.75	0.51%	5.20%
2021 / 05	691.29	1,823.17	2,514.47	50,205.47	1.38%	3.63%	5.01%	153.19	0.31%	5.31%
2021 / 06	819.26	1,948.14	2,767.39	48,391.09	1.69%	4.03%	5.72%	331.43	0.68%	6.40%

Nursing Support

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 01	733.77	1,160.05	1,893.83	23,838.97	3.08%	4.87%	7.94%	1,595.23	6.69%	14.64%
2021 / 02	534.71	864.91	1,399.61	21,725.05	2.46%	3.98%	6.44%	1,402.00	6.45%	12.90%
2021 / 03	416.47	845.96	1,262.43	24,460.35	1.70%	3.46%	5.16%	1,734.79	7.09%	12.25%
2021 / 04	517.50	769.17	1,286.67	24,967.60	2.07%	3.08%	5.15%	112.40	0.45%	5.60%
2021 / 05	603.77	1,125.39	1,729.16	26,345.05	2.29%	4.27%	6.56%	127.71	0.48%	7.05%
2021 / 06	533.97	1,423.61	1,957.59	25,535.03	2.09%	5.58%	7.67%	239.46	0.94%	8.60%

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THE IMPACT

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	Medicine	Surgery	FSS
Budgeted RN wte	501.82	408.58	234.05
Actual RN wte	443.14	368.86	209.67
RN Vacancy wte	67.69	39.72	24.38
Average Absence above budgeted headroom (22%)	10.00%	6.13%	7.24%
Actual Budgeted vs Actual vacancy gap %	23.48%	15.85%	17.65%

*Data source - Healthroster budgeted vs actual position 19/7/21

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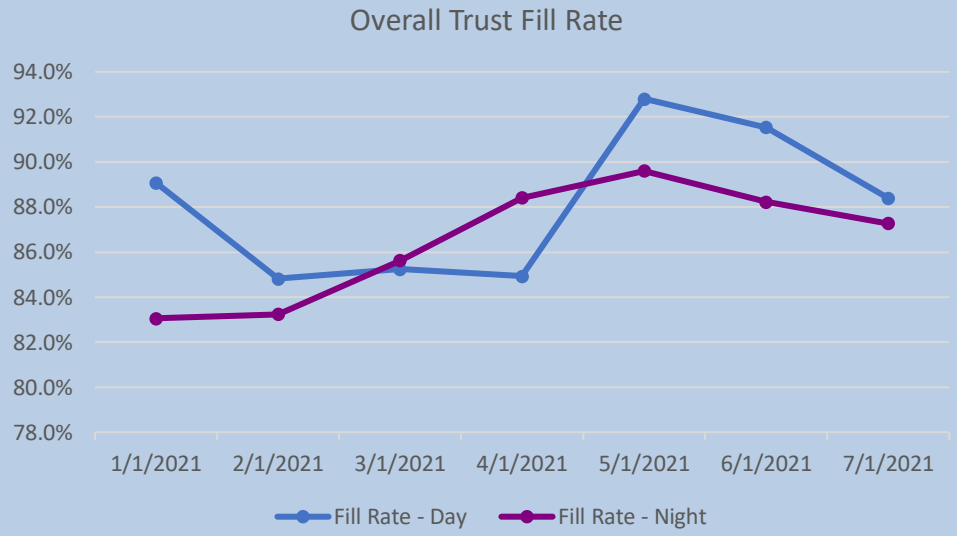
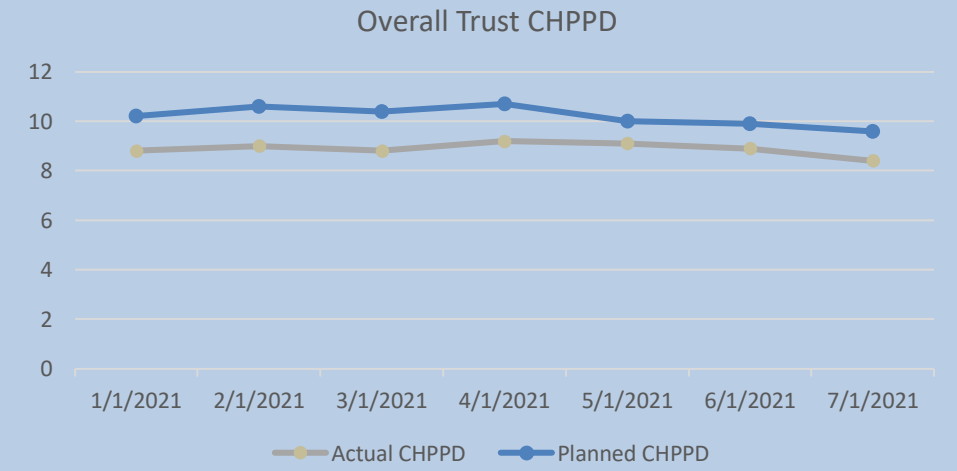
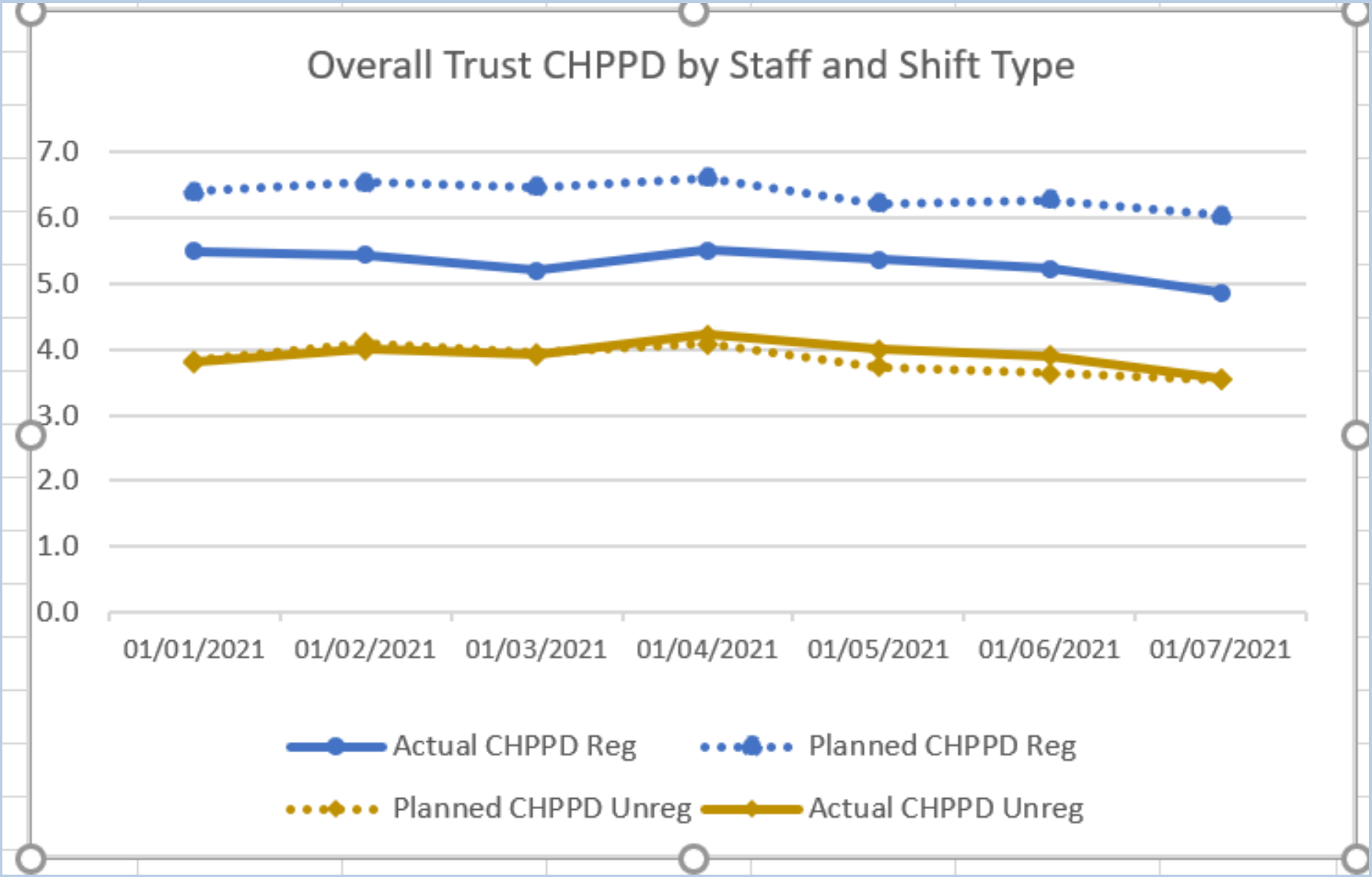
Hard Truths Data





- **Fill Rates:-**Trust overall fill rates have not regained the pre-pandemic position which trended around the 90-95% position. Fill rate position dipped to 83% during February followed by a period of improvement.
- **CHPPD:-** These impacts can be seen on the overall Trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period. This is reflective of the restarting of services to a pre-pandemic position, in addition to supporting enhanced service delivery in some areas.


Overall Trust CHPPD by Staff and Shift Type
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
01/01/2021
01/02/2021
01/03/2021
01/04/2021
01/05/2021
01/06/2021
01/07/2021
Actual CHPPD Reg
Planned CHPPD Reg
Planned CHPPD Unreg
Actual CHPPD Unreg

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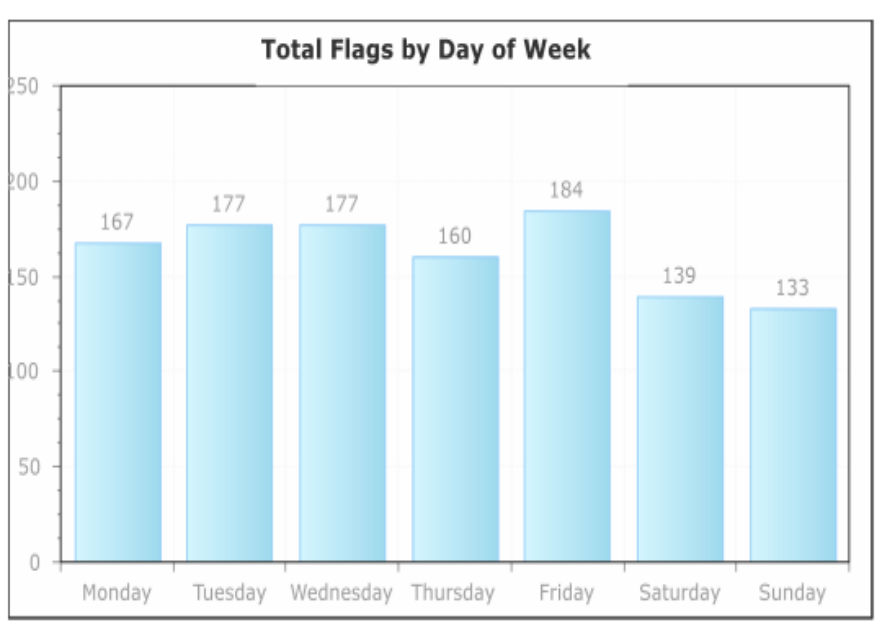
Red Flag escalation



Key findings are listed below:

- Red flags are being used as a mechanism to support escalation.
- 937/1137 selected “number of skill mix of nurses not sufficient” as the reason for the Red Flag.
- 51/1137 selected unmet enhanced care needs.
- 48/1137 selected clinical treatments or interventions delayed.
- 37/1137 related to challenging behaviours from patient or visitor.
- 30/1137 related to staff unable to take breaks.

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Quality

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

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Friends and Family Test

The performance data reported below is a combined rating of any FFT responses submitted between January and June 2021.

The main FFT question asks: ***Thinking about your recent stay in hospital... Overall, how was your experience of our service?*** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens.

All	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know
% of Total	77%	16%	3%	2%	2%	1%
Combined	Positive: 93%			Negative: 4%		

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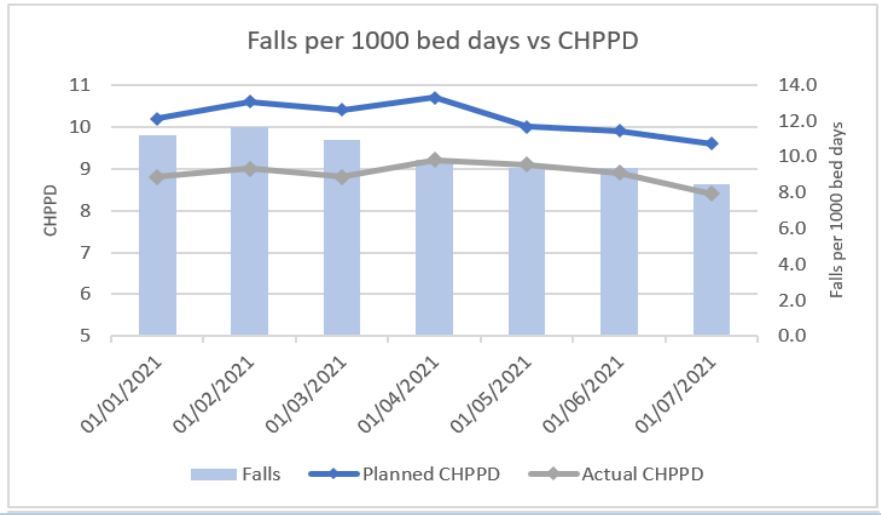
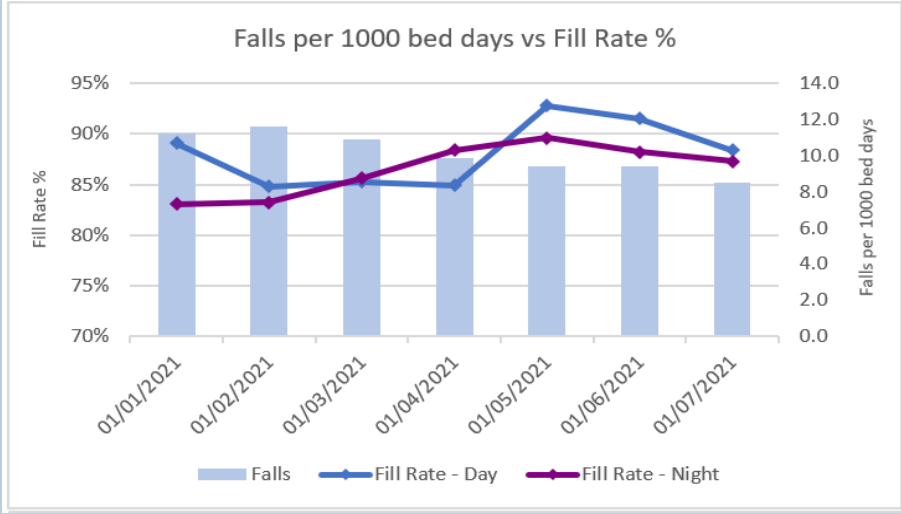
Falls

- Falls remained at their highest period during the months of January-March 2021 which was also reflective of the lowest period of fill rates. 11.6 falls per 1000 bed days against the lowest fill rates of 83.2% and 84.8% for night and day respectively. This is consistent again the CHPPD which is at its broadest gap between planned and actual for the same month.





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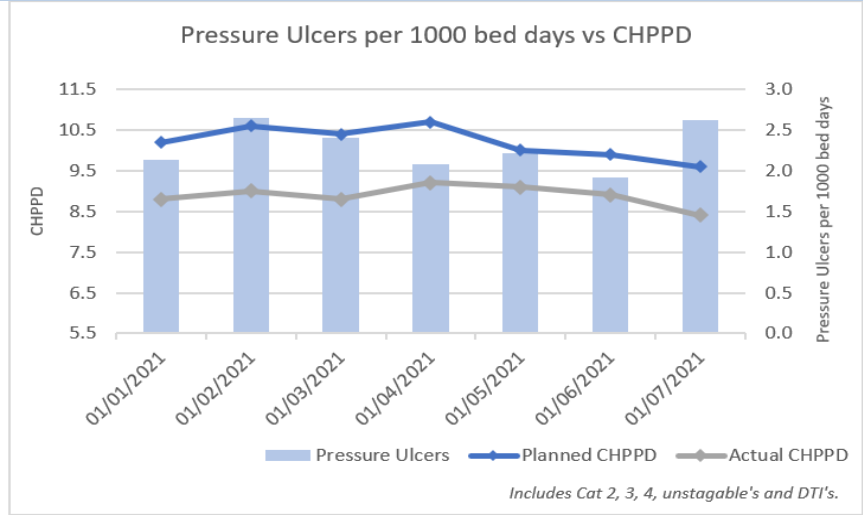
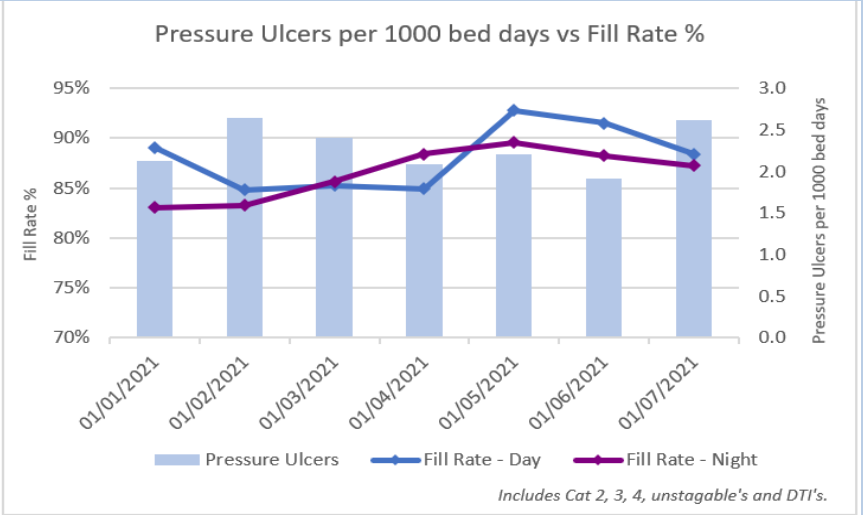
Pressure Ulcers

A similar picture is observed for pressure ulcers where a peak in incidence is seen in February against a challenging workforce position, this trend of tracking the gap in fill rates and CHPPD continues, except for July 2021





Overall analysis of the data indicates an increasing incidence of the two nurse indicators that coincides with a deteriorating fill rate and CHPPD position.

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), and the gap in CHPPD is identified as the most challenging for the RN workforce. It is reasonable to suggest the impact of a challenging recovery agenda, ongoing enhanced delivery of some services, current vacancy position and the impact of increasing staff sickness absence has impacted upon the patient experience.

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Points for consideration

- During the reporting period 143 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. 142 of these incidents were reported as no harm and the appropriate action was taken at the time. One incident was reported as minor harm, this involved three patients deteriorating rapidly within the same time frame. Analysis of the incident indicated that staff responded appropriately, however the rapidity of this situation will have impacted on the patients and staff experience.

- Whilst red flags and incident reporting are established methods of escalation, it should equally be noted that these approaches may not be fully utilised by a workforce that is challenged by the current staffing position. Under reporting is an ongoing concern and reiterates the importance of ensuring forums are available for concerns to be raised. A recent example included concerns raised by staff side at the Staff Partnership Forum, on behalf of members. These concerns related to the nursing and midwifery staffing position and were principally focused upon: -

➢ The movement of staff across clinical areas to address shortfalls and how this was being communicated.
➢ Colleagues being asked to work outside of their field of expertise.
➢ Manager visibility.

A separate meeting was convened, and these concerns have been responded to.

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CHFT RESPONSE SHORT TERM

- Strengthening the escalation and reporting arrangements for quality and safety.
- Twice daily staffing meetings chaired by Associate Directors of Nursing across 7 days.
- Safe care – real time monitoring of staffing position to inform decision making position.
- 7 day senior nurse leadership rota.
- Nursing and Midwifery Safer Staffing Group chaired by the Executive Director of Nursing
- Staff Health and Well-being interventions, in addition to a rapid response initiated through the daily staffing escalations.

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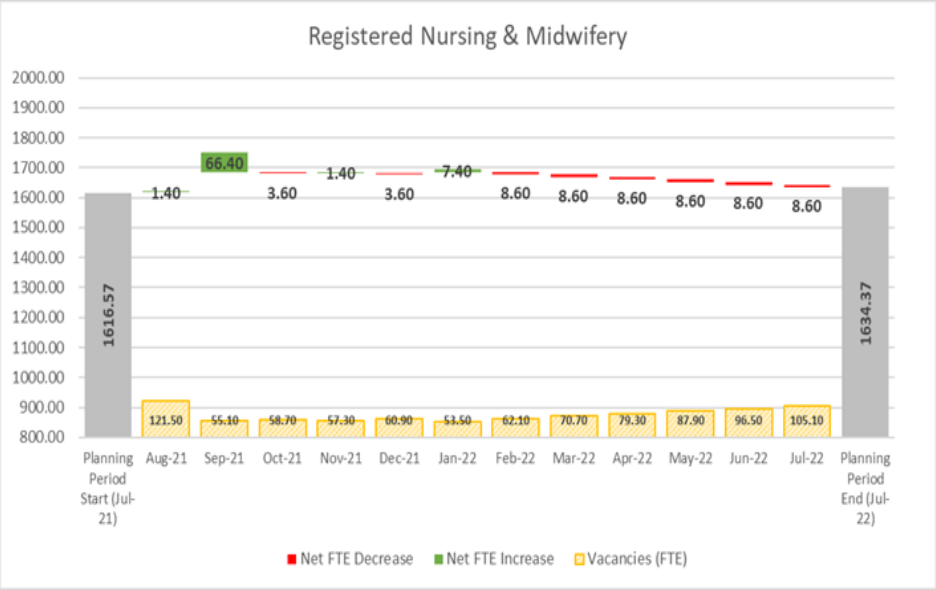
CHFT RESPONSE MEDIUM-LONG TERM



- International Nurse Recruitment programme
- Recruitment of newly quality nurses
- Health Care Support Worker programme
- Trainee Nursing Associates
- Clinical apprenticeship schemes

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Developing Workforce Safeguards

- The publication contains new recommendations to support NHS Providers in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on previous National Quality Board's (NQB) guidance (2013, 2016).
- NHSI will assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. It is based on patients' needs, acuity, dependency and risks, and Trusts should monitor it from ward to board.
- The guidance applies to all clinical staff; however the initial scoping has included Nursing, Midwifery and Medical compliance against the 14 safeguard recommendations.
- Of the 14 recommendations, the Trust is compliant with 8 recommendations, and partially compliant with 6 recommendations.
- An action plan in detailed in Appendix 2 of the document

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Summary

- During the reporting period two establishment reviews have been undertaken with the latter focused upon the recovery agenda and returning many services to pre-covid workforce models.

- The impact of the combined actual RN wte and average sickness absence position modelled across the three divisions is creating a deficit and impacting upon the ability to meet the actual CHPPD, which describes an unmet patient need.

- Close monitoring of nurse sensitive indicators and red flag escalations also demonstrates a trend which corresponds to the RN shortfall position.

26. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

- Finance and Performance Committee
- Quality Committee
- Audit and Risk Committee
- Workforce Committee

To Note

Presented by Richard Hopkin, Denise Sterling, Andy Nelson and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Richard Hopkin, Non-Executive Director
Date(s) of meeting:	4 October 2021
Date of Board meeting this report is to be presented:	4 November 2021

ACKNOWLEDGE

Overall IPR score in June was slightly down at 70% but still highly creditable with good cancer metrics and upper quartile ED performance (despite challenges below)
Recovery update identified further progress on P2 backlog and average wait times and continuing good performance on treating patients with learning disabilities.

ASSURE

Update on Staff Availability/Absence position and planned measures to address existing challenges.
Update on Stroke Deep Dive with progress on key actions.
Review of BAF Risks attributed to F&P, with one increase in rating (risk 5/20)
Work Plan for 21/22 approved.

AWARE

High volumes and acuity of attendances in ED; high Covid bed occupancy
Other challenges noted from IPR are deterioration in F&F Test for A&E and Community, staffing concerns in theatres and on certain wards e.g. elderly care, stroke.

Recovery trajectories reset for remainder of 21/22 based on performance to date
Month 5 financial performance showed an underlying deficit of £2m, due to impact of Covid and recovery costs and recent enhanced pay offer.
H2 Planning Guidance received and initial performance submissions due by 11/10
Efficiency engagement project still to be finalised with new governance arrangements to be put in place for H2 (and beyond).

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	16th August,13th September, 11th October
Date of Board meeting this report is to be presented:	4th November 2021

ACKNOWLEDGE

- Update Q1 Business Better than usual report
- Safeguarding annual report - statutory responsibilities being met, update on key achievements 2020-2021
- Update received on the stroke service and committee agreed further discussions required to understand the stroke workstream in the CAIP and what is required to improve current position.
- JS Stadium Vaccination Programme Report – successful delivery of the vaccination programme despite some challenges with the mixed provider model. Programme decommissioned end of August.
- Clinical Outcomes Group terms of reference approved.

ASSURE

- Infection Prevention and Control Report Q1- performance positive. The Trust in a good position compared to other organisations, in relation to nosocomial infection.
- Noted the report on Governance Arrangements for review of harm HOCI and accepted recommendations for duty of candour where required.
- Maternity Incentive Scheme – Overview provided of the requirements for year 4 , there is an increase in requirements for all 10 safety actions. Multi-disciplinary task and finish groups to work towards all elements of the safety actions being achieved by 30 June 2022.
- CEAG Report – good progress on the monitoring of NICE compliance with introduction of monthly divisional graphs and monthly update on outstanding guidelines.
- Failed Patient Letters Report- assurance provided that the system failure has been fully investigated and resolved with fail safes now in place. Under 1% of patients did not have follow up diagnostic procedures requested on the system through user error. Committee requested information on the outcomes for these patients
- Review of Organisational Performance against 36hr admission to surgery target within Best Practice Tariff (BPT) – received service improvement review and outline of the developing divisional action plan. Division to report back in February 2022 on the outcomes of the work to improve performance and reduce the Trust's hip fracture related mortality rate.
- BAF deep dive 4/19 - Patient and Public involvement, updated and current score remains the same.

- Infection Prevention and Control Report Q2 - Covid19 outbreaks resulted in a significant increase on HOCI cases.
- Quality Report – The roll out of Journey 2 Outstanding Reviews (J2O) continues across the 2 sites. Compliance levels between 72% and 92%
- legal services All six areas of focus within the legal services improvement program have limited assurance and work in ongoing to improve the position. The permanent Head of Legal Services commenced on a part-time basis on 13 September 2021 and is due to commence full-time on 25 October 2021.

- **AWARE**

- Clinical documentation, a more focused link with digital optimisation will further strengthen the approach to this focused quality priority.

- A review has been undertaken of the 24 stillbirths between 1st July 2020 and 30th June 2021. 17 of the 24 women resided in Huddersfield, and 13 of those 17 resided in areas with an Index of Multiple Deprivation (IMD) code of 1 and 2. Four of the women resided in Halifax, and all those women had an IMD code of 1 and 2. 33 % of women are smokers. There was no particular patterns for the reason of still birth identified. There is acknowledgement of the work required around women from areas of greater deprivation and the need to more closely align with the work of the Public Health Midwife.

- Trust PSQB reported issues with medical devices not being appropriately quarantined, specifically with syringe drivers. An incident with a syringe driver being datixed twice highlights a significant risk for the Trust. QGLs to raise awareness of Medical device management policy at divisions.

- IPR – Increased number of non-elective attendances/ high volumes of planned care backlog. Work underway with partners to look at a system approach to the current pressures. On going staffing challenges particularly amongst nursing teams. Increase in the volume of complaints.

- HLRR new risk since last report to Quality Committee ▪ 6453 – Fractured Neck of Femur - repair within 36 hours

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	12th October 2021
Date of Board meeting this report is to be presented:	4th November 2021

ACKNOWLEDGE

- The committee conducts deep dives into the work of the 4 ARC sub-committees. This meeting we had a review of the work done by the Information Governance and Risk Strategy Committee. The committee noted the work done to achieve compliance with the Data Security and Protection Toolkit
- A presentation on Clinical Audit work in the last 12 months was given which showed some excellent progress underpinned by the advent of the Clinical Audit Competition and quarterly meetings of clinical audit leaders

ASSURE

- ARC approved the BAF and noted that the BAF is now being more actively used as a risk management tool as evidenced by the changing scores and thoroughness of updates provided. Some risks still require some more work in terms of identification of gaps and actions to close those gaps to meet target risk scores
- The updated Counter Fraud Policy and the 2022 work plan for ARC were approved

AWARE

- Although some progress has been made in clearing overdue Internal Audit recommendations there are still 16 recommendations outstanding from prior years. The committee was pleased to hear about the engagement of the executive team in clearing overdue recommendations but wants to see these older recommendations cleared in the remainder of this year
- the committee reluctantly supported the recommendation to appoint KPMG as the Trust's external auditor for a three-year period with an option for a one-year extension, subject to ratification by the Council of Governors. Only one bid was received and it represented a price increase of over 100%. However, the proposed pricing aligns with other trusts in the region

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and Organisational Development Committee
Committee Chair:	Karen Heaton, Non-Executive Director
Date(s) of meeting:	Thursday 30 September 2021
Date of Board meeting this report is to be presented:	Thursday 4 November 2021

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 30 September 2021.

- Deep dive in Nurse Staffing (BAF) and agreed to retain existing high score.
- Nursing and Midwifery- two reviews have taken place between January 2021 and June 2021 and measures taken to address risk.
- Positive progress on WRES and WDES
- Developing Workforce Safeguards – action plan in place and annual report will be presented to the Committee February/March 2022.
- He Recruitment Strategy is being updated to develop a new brand and promoting the Trust's values.
- The Committee was introduced to the "Enhance" programme which is the all inclusive approach to talent identification and development.

ASSURE

The Committee is keeping a close watch on the level of sickness absence and expects an improvement in the number of RTWs undertaken. BAF risk remains unchanged for Nurse Staffing.

AWARE

Workforce metrics remain amber and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness EST compliance.

27. Annual / Bi-Annual Reports in the Review Room

1. Huddersfield Pharmaceuticals Specials Annual Report

28. Items for Review Room

• CHS Managing Directors Report – October 2021

• Charitable Funds minutes of the last meeting held 23.08.21

• Organ Donation Committee minutes of the last meetings held 13.01.21 and 07.07.21

29. Date and time of next meeting

Date: Thursday 13 January 2021

Time: 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer